

**Investigating Burnout:
A Comprehensive Literature Review & Case Study Analysis**

by

Inderjeet Kauldher, B.A., B.Ed.

A thesis submitted in partial fulfillment of the requirements
for the degree of

Master of Counselling (MC)

City University of Seattle
Vancouver BC, Canada site

December 2015

APPROVED BY

Glen Grigg, Ph.D, R.C.C, Thesis Supervisor, Counsellor Education Faculty

Jacqueline Walters, M.S.W, Ph.D, Faculty Reader, Counsellor Education Faculty

Abstract

Professional burnout is a prevalent phenomenon among human service workers, especially for those working in public sector mental health. It is not only economically costly with high job turnover rates and absenteeism, but also costly in respect to the quality of life of service providers and those they serve. This study is comprised of an academic review of literature and case study. Through conducting an academic review of literature the burnout phenomenon is explored through investigating its characteristics, causes, risk factors, consequences, rehabilitation and prevention. The case study, of a mental health clinician in the public sector, offers a personal perspective to the academic literature, as well as grounds for comparison and convergence. Through the in-depth analysis of the literature and findings of the case study, this study results in recommendations and necessary adaptations to decrease or eliminate experiences of professional burnout. Major recommendations focus on themes of leadership/management, supervision, training, organizational structure, autonomy, peer support, and self-care practices.

Keywords: burnout, compassion fatigue, vicarious trauma, mental health professionals, work-related stress

Acknowledgments

Firstly, I would like to thank the Counsellor Education Faculty at City University of Seattle, Vancouver campus, for sharing their invaluable professional expertise during the course of this Master of Counselling degree. I would like to especially thank my thesis advisor and instructor, Glen Grigg. Your positive and constructive feedback has been a great source of encouragement.

Last but not least, I would like to thank my parents, Kuldip and Anita Kauldher, and my husband, Paul Dhaliwal, for their understanding and motivation. Their support over the years has helped provide focus for my education, professional and personal goals. This journey would not be as meaningful without them.

Dedication

I dedicate this thesis to my grandfathers, Ujagar Singh Kauldher and Gurdev Ram Toora, who always instilled in me the pursuit of knowledge and education.

Table of Contents

List of Tables.....	6
Chapter I: Introduction.....	7
Chapter II: Review of Literature.....	13
Chapter III: Methodology.....	29
Chapter IV: Results.....	34
Chapter V: Discussion.....	53
References	62
Appendix A: E-mail script.....	66
Appendix B: IRB approved participant informed consent form.....	67
Appendix C: Procedure script.....	69
Appendix D: Survey on professional burnout.....	70
Appendix E: Interview questions.....	73

List of Tables

Table 1. Summary of findings.....48

Table 2. Recommendations for prevention of professional burnout.....58

Chapter I: Introduction

There is a direct correlation between burnout and workplace stress, as stress being “the most significant occupational health problem” (Gray, 2000; as cited in Breen & Sweeney, 2013) in healthcare professionals. Rough estimates, with the aid of the MBI (Maslach Burnout Inventory), have shown 10-25% in social profession in the United States experience some form of burnout (Schaab et al., 1993; as cited in Langle, 2003, p. 108). Although burnout occurs at the individual, organizational or client levels, the largest risk factor for developing professional burnout is human service work in general (Newell & MacNeil, 2010), since this type of work requires an emotional as well as a professional commitment. Moreover, human service workers are at high risk of burnout due to job stressors such as heavy caseloads, demands for brief therapy, and other care limitations (O'Halloran & Linton, 2000; as cited in Puig, et al., 2012). According to the National Institute for Occupational Safety (1999), job stress is “the harmful physical and emotional responses that occur when the requirements of job do not match capabilities, resources, or needs of worker” (as cited in Thomas & Lankau, 2009, p. 417). This results in deterioration of quality of care, absenteeism, high job turnover rates, and low workplace morale (Maslach & Jackson, 1986; Wall & Bolden, 1997; Sherring & Knight, 2009; as cited in Breen & Sweeney, 2013). In order to provide and receive adequate care, the risk of professional burnout must be addressed. Burnout is not only hurting the helping profession, it is also a breach of ethics of care.

Problem Statement

Job burnout is specifically described as “the failure to perform clinical tasks appropriately because of personal discouragement, apathy toward symptom stress, and emotional/physical drain” (Lee, et al., 2007; as cited in Puig, Braggs, Mixon, Park, Kim, & Lee, 2012, p. 99). The results of burnout can be detrimental to both professionals and patients. The aftermath is deterioration of quality of care, absenteeism, high job turnover rate, and low morale (Maslach & Jackson, 1986; Wall & Bolden, 1997; Sherring & Knight, 2009, as cited in, Breen & Sweeney, 2013). When individuals feel they do not have enough resources such as time, energy, and support to balance the demands of their work, they become vulnerable to burnout (Halbesleben & Buckley, 2004; as cited in Thomas & Lankau, 2009; Breen & Sweeney, 2013). There is great irony in such a prevalent consequence to healthcare professions. Burnout is very costly and cannot afford to be ignored in a workplace, especially in the healthcare sector.

Nature of Study

The research questions posed consist of the following: *What are the leading causes for burnout among healthcare professionals? Can a case study, combined with a comprehensive literature review, produce recommendations and necessary adaptations to decrease or eliminate these experiences for these types of professionals?* The purpose of this study is to do an academic review on the causes and conditions of burnout, the possible implications to the medical and mental health care system, and examining recommendations and practices that reduce the effect of burnout.

Purpose of study

The purpose of this study is to do an academic review of the causes and conditions of burnout, the possible implications to the medical and mental health care system, and practices that reduce the effect of burnout. The case study will provide a personal and professional point of comparison and convergence for the literature review. The final research analysis will provide recommendations for preventative practices and rehabilitation for burnout that can be implemented at the workplace and personal realms.

Scholarly Context

Maslach (1982) defined *burnout* as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (as cited in Sprang, Clark, & Whittwoosley, 2007). Burnout has also been described as a “state of physical, emotional and spiritual fatigue caused by long-term exposure to demanding work stressors” (Sherring & Knight, 2009; as cited in Breen & Sweeney, 2013), or “the failure to perform clinical tasks appropriately because of personal discouragement, apathy toward symptom stress, and emotional/physical drain” (Lee, et al., 2007; as cited in Puig, et al., 2012). However, burnout is not exclusively related to work, as findings showed that private life and social peer support played a key role as well (Blom, 2012).

Studies of burnout have revealed that it is highly prevalent among helping professions (Maslach & Jackson, 1984, as cited in Sprang, et al., 2007). Moreover, mental health professionals have higher levels of burnout than other health care workers (Imai, Nakao, Tsuchiya, Kuroda, & Katon, 2004; Korkeila et al., 2003, as cited in Sprang, et al., 2007), with those working in the public sector having higher burnout risks than those in the private sector (Vredenburgh, Carlozzi, & Stein, 1999; as cited in Sprang, et al., 2007). Aspects of burnout are

prevalent in the mental health professions because “such services inevitably involve listening to, and to some degree absorbing, the pain associated with the individual”; this, results in conditions known as *secondary traumatic stress*, *vicarious trauma* and *professional burnout* (p. 58).

However, the leading causes of burnout of mental health professionals are not significantly connected to countertransference or reactions to the traumatic experience of clients, but rather to the workplace environment and caseload (Sprang, et al., 2007).

Exposure factors such as long hours, assignment length, caseloads that include high percentages of trauma clients (Boscarino, Figley, & Adams, 2004; Creamer & Liddle, 2005; Meyers & Cornille, 2002; as cited in Sprang, et al., 2007), matched with organizational factors such as lack of autonomy, low peer support, lack of training (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997; as cited in Newell & MacNeil, 2010) provide conditions in which burnout will inevitably permeate the workplace in some capacity. The results will not only affect the professional but also the effectiveness of the workplace and the levels of care and support to the client.

Definition of Key Terms

Compassion satisfaction (CS) refers to “pleasure derived from working well” (McKenzie, Gurrus, & Traue, 2007, p. 67).

Secondary traumatic stress (STS) is a term that is used interchangeably with *compassion fatigue* (CF), is a more progressive state of VT, including flashbacks, nightmares, and intrusive thoughts (Galek, Flanelly, Greene, & Kudler, 2011; as cited in Thompson, Amatea, & Thompson, 2014).

Compassion fatigue (CF) is also known as secondary traumatic stress (STS). The terms are interchangeable.

Vicarious trauma (VT) is “the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects” (McCaan & Pearlman, 1990; as cited in Sprang, et al., 2007, p. 260).

Assumptions, Limit, Scope

Due to the scope of the study, the case study was done on a single individual whose demographics (gender, socio-economic status, culture, position, etc.) may not be reflective of all mental health workers. These factors may limit reliability when comparing with the literature reviewed and also add a level of bias to the analysis and recommendations. However, it is important to note that the case study is not intended to be definitive, but rather, to add a real-world context to the themes in the literature review.

Significance

The findings will outline the human and monetary costs of burnout in the healthcare professions, particularly in the field of mental health. The recommendations will provide human service workplaces, particularly mental health organizations, a basis for practices that reduce risk factors of burnout, and practices that intervene in cases of workplace burnout. This will hopefully result in lifting of workplace morale, productivity, relationships with clients, overall health of professionals, and result in clients receiving the care needed.

Summery

The link between burnout and workplace stress is undeniable, and furthermore, the consequences have a ripple affect into the overall health of professionals and clients, as well as to the economy. Through employing the case study method and a through review of the literature, this study will explore the phenomenon of burnout in terms of characteristics, causes, risk factors, consequences, rehabilitation, and prevention. The results of this research will narrow down a set of workplace recommendations for diminishing the effects of burnout.

Chapter II: Review of Literature

Introduction

The following review of literature will explore the leading causes of burnout among healthcare professionals, and it will also provide the points comparison and convergence for the analysis of data collected from the case study. The review will begin with the evolving definition of burnout from where it was first observed by Freudenberger, later defined in detail by Maslach, and on to more contemporary definitions involving a more wholistic perspective as it applies to society today. The characteristics, causes and risk factors the burnout phenomenon will be investigated next. Finally, the consequences of burnout will be addressed, and strategies for rehabilitation of sufferers and preventative measures will be examined.

Definition

Freudenberger first identified the phenomenon of burnout in 1974, through his observations of symptoms displayed by volunteers of aid organizations (Langle, 2003). According to Freudenberger (1977), those suffering from burnout find themselves “fatigued, depressed, irritable, bored and overworked” even though their job conditions may not have significantly changed (p. 26). He states that the burnout state builds gradually and therefore the individual suffering may not even be aware of the extent of the impact on his life. He also warns that burnout “can be devastating if allowed to continue unchecked. It can spread, like any burning thing, through an entire organization leaving only ashes behind” (Freudenberger, 1977, p. 27).

Maslach (1982) described burnout as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (as cited in Sprang, Clark, & Whitt-Woosley, 2007, p. 260). Maslach has divided the progression of burnout in four phases (Karazman, 1994; Burisch, 1989; as cited in Langle, 2003, p. 109):

- idealism and overtaxing;
- emotional and physical exhaustion;
- dehumanization as an antidote;
- terminal phase: loathing syndrome and breakdown.

The breakdown may result in illness, leave of absence from the workplace or even professional resignation.

In a more contemporary definition by Maslach (2003), job burnout is a “prolonged response to chronic emotional and interpersonal stressors on the job and is defined here by the three dimensions of exhaustion, cynicism, and sense of inefficacy” (p. 189). Langle (2003) defines the phenomenon of burnout as an existential crisis resulting from a demanding and achievement oriented modern society, resulting in “a life that is alienated and remote from our existential reality and that is determined by the demanding character and the spirit of consumption that marks our present time” (p. 120). More recently, burnout has been described as a “state of physical, emotional and spiritual fatigue caused by long-term exposure to demanding work stressors” (Sherring & Knight, 2009; as cited in Breen, & Sweeney, 2013, p. 12). Compassion fatigue (CF), which is also known as secondary traumatic stress (STS), and vicarious trauma (VT), are the most widely used concepts to describe the symptomology of burnout (McKenzie, Gurriss, & Traue, 2007). These more contemporary definitions of burnout will guide this study and set the grounds for exploration of burnout characteristics.

Characteristics

Observable signs of burnout include “extreme relief” the day is over, avoidant behaviour (eye contact and conversation), clock-watching, irritability, impatience, and nonverbal communication conveying lack of interest in patient or colleagues” (Ficher, Kumar, & Hatcher, 2007; Maslach et al., 1996; McCarthy & Frieze, 1999; as cited in Warren, Schafer, Crowley, & Olivardia, 2013). Characteristics of burnout consist of “cynicism, psychological distress, feelings of dissatisfaction, impaired interpersonal functioning, emotional numbing, and physiological problems” (Fothergill, Edwards, & Burnard, 2004; as cited in Sprang, et al., 2007, p. 260). This can lead to loss of interest in the job, resulting in professional responsibilities being avoided or even mishandled (Maslach, 2003; Hanrahan et al., 2010; as cited in Breen & Sweeny, 2013). These observable signs can also be due to personal issues outside the workplace; just as workplace burnout may affect one’s personal life, the opposite is also true.

The human service professions, particularly those in mental health, are especially at risk of burnout because “such services inevitably involve listening to, and to some degree absorbing, the pain associated with the individual” (Newell & MacNeil, 2010, p. 58). Burnout can result in conditions such as *vicarious trauma (VT)*, *secondary traumatic stress (STS)*, and *professional burnout* (Newell & MacNeil, 2010). VT is “the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects” (McCaan & Pearlman, 1990; as cited in Sprang, et al., 2007, p. 260). STS, a term that is used interchangeably with *compassion fatigue (CF)*, is a more progressive state of VT, including flashbacks, nightmares, and intrusive thoughts (Galek, Flannelly, Greene, & Kudler, 2011; as cited in Thompson, Amatea, & Thompson, 2014).

Burnout is a very complex phenomenon, and a multi-dimensional approach to understanding it is required for its conceptualization (Lee & Ashworth, 1996; Maslach, 1998; as cited in Newell & MacNeil, 2010). Emotional exhaustion, depersonalization or cynicism, and a diminishment in one's sense of personal accomplishment help define the main dimensions of *burnout* (Maslach, 1982; as cited in Sprang, et al., 2007; Maslach, 2003). *Emotional exhaustion* is a "state that occurs when a practitioner's emotional resources become depleted by the chronic needs, demands, and expectations" of clients and the workplace (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010, p. 59); there is a positive correlation between workplace demands and health issues related to stress (Maslach, 2003). Contributing factors can be due to large caseloads and long hours, resulting in a lack of self-care.

Depersonalization is "negative, cynical or excessive detached responses to coworkers or clients (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010, p. 59). According to Maslach (2003), this dimension is a "basic hallmark of the burnout experience—the negative, callous, or excessively detached response to other people and other aspects of the job" (p. 190). Compassion Fatigue (CF) or STS can play significant role in the devaluing of clients (Puig, Braggs, Mixon, Park, Kim, & Lee, 2012). When one becomes disengaged from the work, the practitioner, workplace and clients are all negatively impacted. Continuing to practice in a depersonalized state is irresponsible since the impact of the work affects many lives on a very vulnerable level.

Reduction in sense of personal accomplishment occurs when practitioners feel deficient or inadequate. The mind frame of inadequacy can result from clients not responding to treatment, and "[t]his domain of the burnout phenomenon may also occur in response to bureaucratic constraints and administrative demands" (Newell & MacNeil, 2010, p. 59). This

may be very prevalent in areas of trauma and addiction due to relapses or lack of progress. Some types of therapy need to continue long term, and if clients do not stay the course, a clinician may see this as a personal failure.

If burnout continues “it can lead to the formation of a ‘lens’ that colours all further experience” (Langle, 2003, p. 110). This is detrimental to not only the career of a therapist, but also to the workplace. If burnout is occurring due to workplace issues and environment, many of the employees are likely experiencing it. Continuing with no intervention would not only lead to poor service, it would be engaging in irresponsible practice leading to possible harm. According to the American Counseling Association (2014), a therapist’s practice should not pose “imminent harm to clients” (ACA, 2014, C.2.g). The final stage of burnout, in which there is breakdown and diminished activity, can be seen as a response to protect oneself from further damage (Karazman, 1994; Burisch, 1989; as cited in Langle, 2003). Going into a state of “hibernation” is serving as protection against the environment that has led to this terminal stage of burnout. Burnout is a multi-dimensional phenomenon with a course and stages as defined in this section.

Causes

There is a link between burnout and workplace stress, as stress is “the most significant occupational health problem” (Gray, 2000; as cited in Breen & Sweeney, 2013, p. 14) in healthcare professions; mental health professionals have higher levels of burnout than other health care workers (Imai, Nakao, Tsuchiya, Kuroda, & Katon, 2004; Korkeila et al., 2003, as cited in Sprang, et al., 2007). A survey done by the American Counseling Association found that “75.7% of mental health professionals reported that impaired mental health professionals are significant threat to the profession and 63.5%... reported knowing a colleague whom they would

consider impaired” (ACA, 2010; as cited in Puig, et al., 2012, p. 98). Moreover, mental health professionals working in the public or nonprofit sector have higher burnout risk than those in the private sector (Vredenburg, Carlozzi, & Stein, 1999; as cited in Sprang, et al., 2007).

Burnout theory asserts that when individuals perceive or experience that they do not have enough resources such as time, energy, and support, to balance the demands of their work, they are more likely to be vulnerable to burnout, and may not be as committed to work (Halbesleben & Buckley, 2004; as cited in Thomas & Lankau, 2009, p. 419). Those most at risk within the mental health profession are young females with performance-based self-esteem (PBSE), those with pre-existing mental health issues, and practitioners working with a trauma based population.

According to Sprang, et al. (2007), female gender, younger age, higher educational degrees, least years of clinical experience, and larger percentage of clients with PTSD predicted higher CF levels of burnout. Contrarily, older age predicts compassion satisfaction (CS), which protects against burnout (Sprang, et al., 2007). In the study, these variables “jointly accounted for 42% of the variance in the CF domain, 69% in burnout, and 59% in the CS domain” (Sprang, et al., 2007). Since women experience high PBSE, “this constitutes a highly unstable self-esteem, fluctuating with mistakes and successes” (Blom, 2012, p. 124). Whereas women have a stronger association between PBSE and burnout, men have a stronger association between work stress and burnout (Blom, 2012). Clinicians “with pre-existing anxiety disorder, mood disorder or personal trauma history... may be at greater risk of experiencing compassion fatigue or STS disorder leading to burnout. (Lerias & Byrne, 2003; Dunkley & Whelan, 2006; Gardell & Harris, 2003; as cited in Newell & MacNeil, 2010, p. 61). Be that as it may, burnout is not exclusively related to the workplace; findings have shown that private life and social peer support played a key role as well (Blom, 2012).

Risk factors

Organizational factors. Human service workers are at high risk of burnout due to job stressors such as heavy caseloads, demands for brief therapy, and other care limitations (O'Halloran & Linton, 2000; as cited in Puig, et al., 2012, p. 98). Organizational factors that contribute to burnout include excessive and high caseloads, lack of autonomy, unfairness in structure, low peer support, and poor on the job training (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997; as cited in Newell & MacNeil, 2010, p. 59). Features leading to these negative organization factors include a structure of "bureaucratic constraints, inadequate supervision, lack of availability of resources, and lack of support form professional colleagues" (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Catherall, 1999; as cited in Newell & MacNeil, 2010, p. 62). Such workplaces may also not acknowledge that they have professionals experiencing burnout, and this adds to stigma of seeking help.

Occupational hazards. The nature of the work also plays a crucial role in setting up conditions that can easily lead to VT, CF, and burnout, if care is not taken in prevention. The "confrontation with severe illness and even death" is specific to the healthcare field (Anderson, 2002; as cited in Thomas & Lankau, 2009, p. 418). Exposing oneself to VT "is an inherent part of the process when working with traumatized persons" (Sprang, et al., 2007, p. 259). Some research has shown that CF is directly related to number of hours spent counselling clients who have experienced trauma (Kassam-Adams, 1999; Flannelly, Roberts, & Weaver 2005; as cited in Thompson, Amatea, & Thompson, 2014). However, Baird and Jenkins (2003) found there was no correlation between these two factors (as cited in Thompson, Amatea, & Thompson, 2014).

Psychological dimensions. More personal causes for burnout include unmet

expectations and lack of social support (Van Dierendonck et al., 2001; Janssen, Do Jonge, & Bakker, 1999; as cited in Thomas & Lankau, 2009). The experience of incompetence seems to be “an intrapsychic variable, not an environment-related variable” (Puig, et al., 2012, p. 105). According to Crocker and Park (2004), “being devalued in an environment of scarcity, competition or evaluative focus is a powerful trigger of maladaptive self-esteem pursuits, in particular for women” (as cited in Blom, 2010, p. 124). Findings may reflect women having less influence in work place and having to balance work life with family life—extra hours can cause further stress in these areas; hence, PBSE acts as a stressor in itself (Blom, 2010). Competence and stress management are also related because “competence contributes to the psychological functioning of individuals” (Bhagat & Allie, 1989; as cited in Puig, et al., 2012, p. 105). It must be emphasized “work-setting factors alone do not fully explain these negative outcomes for mental health professionals” (Thompson, Amatea, & Thompson, 2014, p. 60). According to Blom (2010), following PBSE, private life stressors and social peer support were the most significant predictors of burnout over time, for both men and women (p. 126). Organizational factors, work related stressors, and one’s private life all play into experiencing burnout.

Consequences

There are personal, organizational, and economical consequences of burnout. Practitioners experiencing the phenomenon of burnout have more stress-related illness and mental health issues such as the following: depression, anxiety, low self-esteem, increased physical health issues (Ducharme, Knudsen & Roman 2008; Garner, Knight & Simpson 2007; Cherniss & Krantz, 1983; Pines & Maslach 1978; as cited in Oser, Bievel, Pullen & Harp, 2013, p. 18). Hence, feelings of emptiness and lack of meaning, seep from professional to personal

life, and begin engulfing one's life experiences (Langle, 2003). This suffering results in a lower quality of life, as there are contextual, organizational, social, and psychological roots to burnout, and that it can become a totalizing condition.

Warning signs consist of “suppression of emotions, distancing from clients, [and] reenacting of abuse dynamics” (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Schauben & Frazier, 1995; as cited in Newell & MacNeil, 2010, p. 61). The reversal of role between therapist and client may occur, where sessions become more about the helper, and therefore “disrupting the therapeutic process” (Oser, et al., 2013, p. 21). Clients may therefore become more selective in choosing therapists, so that they may find one with whom they can build a better rapport and relationship (Oser, et al., 2013). According to the British Columbia Association of Clinical Counsellors Ethics Code and Standard of Practice (2014), a practitioner must “[r]emain aware of own self-care needs and vulnerabilities” (BCACC, p. 6). In addition to monitoring themselves, practitioners must “assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate” (ACA, 2014, C.2.g).

According to the American Institute of Stress (2007), costs of job-related stress on corporate America are estimated at \$300 billion annually, resulting from burnout and accidents (as cited in Thomas & Lankau, 2009, p. 418). Consequently, there is deterioration of quality of care, absenteeism, high job turnover rate, and low morale (Maslach & Jackson, 1986; Wall & Bolden, 1997; Sherring & Knight, 2009; as cited in Breen & Sweeney, 2013). This is “monetarily draining to the organization, in addition to causing the expending of necessary financial resources to recruited, hire, and train new staff” (Knight, Becan & Flynn, 2012; Eby &

Rothrauff-Laschober, 2012; Maslach, Jackson & Leiter 1997; as cited in Oser, Bievel, Pullen & Harp, 2013, p. 18).

Rehabilitation

There is substantial literature (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013; Langle, 2003; Thieleman & Cacciatore, 2014) asserting that the recovery process for burnout needs to be a wholistic approach focusing on workplace environment and stressors, as well as self-care. According to Hätinen, et al. (2013), burnout starts with an employee facing unfavourable working conditions and it intensifies when the individual participates in dysfunctional coping strategies, thus concluding, “individual coping has a central role in the development, progression, and recovery of burnout” (p. 366). Burnout creates a state of exhaustion due to work, and this state affects the well-being of the individual, “which in turn affects a person’s decisions, attitudes and actions” (Langle, 2003, p. 109). The affected individual’s actions, whether she is aware or unaware of this phenomenon, will thus impact productivity and relationships both at and outside of the workplace. According to Maslach, Leiter, and Jackson (2012), “separating the individual and workgroup dynamics of exhaustion would provide direction for developing distinct interventions that focus on improving management practices at the team level or workplace health practices at the individual level” (p. 299). This approach could aid in both rehabilitation and prevention by delving into the complex dynamics at play.

A wholistic approach to recovery can include “a team comprising of physician, a psychologist, a physiotherapist, an occupational therapist, a social worker, a nurse, and an exercise counselor” (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013,-p. 365). The activities

of such an approach will focus on physical, psychological, and social state of the employee (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013). There is also a strong link between compassion satisfaction (CS) reducing or protecting against burnout. Those suffering from burnout become cynical and detached (Maslach, 2003), and practices such as mindfulness can contribute to regaining empathy, which is essential to any human service work (Thielman & Cacciatore, 2014). Personal self-care practices that nourish us physically, mentally and emotionally are also essential to the recovery process.

In order for employees to recover, changes must be made at the workplace to eliminate the issues that lead to the burnout. Effective leadership of managers and sufficient supervision can reduce burnout levels and renew job satisfaction (Breen & Sweeney, 2013). In theory, it is a reasonable expectation that therapists will feel less isolated, and that their improved functioning will have a systemic effect on others in the workplace, including clients. It has been shown that “professional interaction and empowerment, along with guidance through clinical supervision” reduces levels of burnout (Aiken, et al., 2002; Hyrkas, 2005; Edwards et al., 2006; as cited in Breen & Sweeney, 2013, p. 19).

The recovery process is also influenced by one’s personal life. Therapists must make changes physically, mentally, and emotionally. Wellness, defined as “a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully”, is a holistic approach needed to bring balance and fulfillment to one’s life (Myers, Sweeney, & Witmer, 2000, p. 252; as cited in Puig, et al., 2012, p. 98). The goal of rehabilitation is to help the employee to acknowledge the stressors relating to his or her burnout, and to find ways to cope with these stressors” (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013,-p. 365). It is also well documented in many studies that “positive changes in

physical activity were associated with positive changes in depression, anxiety, and burnout across time” (De Moor et al., 2006; Vallance et al., 2011; as cited in Lindwall, Gerber, Jonsdottir, Borjesson, & Ahlborg, 2013, p. 6). Also, therapy methods such as EDMR, imaginative technique, flooding, etc., have been proven to reduce the effects of burnout (McKenzie Deighton, Curris, & Traue, 2007). Interventions that help employees identify causes for their burnout, empower them to discover and exercise solutions, have proven to produce favourable results (Halbesleben et al., 2006; Häätinen, Kinnunen, Pekkonen, & Kalimo, 2007; Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007; as cited in Häätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013).

According to Kraus (2005), the relationship between CF, CS and burnout gives insight into recovery and prevention. It was found that “self-care does not strongly influence compassion fatigue or burnout. It does, however appear to influence compassion satisfaction. Also, compassion satisfaction might be important in decreasing burnout, but not fatigue”(Kraus, 2005, p. 81). It was also noted that therapists might increase their levels of compassion satisfaction by focusing on their methods of self-care (Kraus, 2005). Mindfulness can be a key focus in self-care as it can improve relaxation and satisfaction among human service workers (Mackenzie, Poulin, & Seidman-Carlson, 2006; as cited in Thielman & Cacciatore, 2014).

Prevention

Burnout prevention needs to occur at the organizational and personal level. It has been shown that “a supportive workplace may help reduce risk for some aspects of compassion fatigue, especially burnout” (Adams et al., 2006; Collins & Long, 2003; as cited in Thielman & Cacciatore, 2014, p. 34). This is not surprising, but too often workplaces are bogged down,

leading to employee isolation. It is also one's ethical responsibility, as a practitioner, to make sure there is no impairment to practice.

A survey by the American Counseling Association in 2004, resulted in the ACA creating 3 ways to begin meeting needs of impaired mental health professionals: a) educational programs targeted for prevention, b) provide intervention and treatment, c) advocate for guidelines so that these professionals do not face any stigma of seeking treatment (ACA, 2010; as cited in Puig, et al., 2012, p. 107). The education of new mental health professionals should include curricula on work related risks such as burnout, so that they may be less vulnerable in the future, and they may be able to see signs of burnout earlier (Newell & MacNeil, 2010).

Specialized training plays a significant role in reducing CF and burnout and increasing CS (Sprang, et al., 2007). Clinical supervisors developing working groups as a source of support to professionals can may help practitioners who are "wrestling with burnout"; these groups can also give the professionals opportunities to learn and participate in wellness strategies such as meditation, etc. (Puig, et al., 2012, p. 106).

Burnout results in "absenteeism, chronic tardiness, chronic fatigue, evidence of poor client care, and low completion rates of clinical administration", and that is why these should be seen as warning signs (Barak, Nissly, & Levin, 2001; Cyphers, 2001; Lloyd, King, & Cheneweth, 2002; as cited in Newell & MacNeil, 2010 p. 59). Organizations can also monitor professionals for burnout by administrating surveys like the Maslach Burnout Inventory (MBI). However, the MBI should not be used alone as a diagnostic tool, because it may over diagnose burnout (Kleijweg, Verbraak, & Van Dijk, 2013). More so, it may give an idea of who is most at risk so that preventative measures can be taken. A more accurate tool that includes a more recent definition of clinical burnout is still needed.

Organizational factors that include “supportive work environments and adequate supervision” reduce incidences of burnout (Boscarino, et al., 2004; Korkeila et al., 2003; Ortelepp & Friedman, 2001, as cited in Sprang, et al., 2007). Instead of relying on one person within an organization, it would be highly recommended to train certain employees so that they can build and maintain a network of support (Thomas & Lankau, 2009). Autonomy and control, as well as access to resources, are conditions that reduce occurrences of burnout (Abu-Bader, 2000; Vrendenburgh et al., 1999; as cited in Sprang, et al., 2007). Also, the optimal “caseload mix” for practitioners includes clients with easier and more difficult challenges, so one is not constantly working with high trauma clients (Sprang, et al., 2007).

A culture of support that acknowledges VT, STS, and CF as “normal reactions to client traumas may significantly contribute to the coping ability of individuals experiencing these conditions” (Newell & MacNeil, 2010). This acceptance helps alleviate the feelings of inadequacy or stigma of having such reactions (Bell, Kilkarni, & Dalton, 2003; as cited in Newell & MacNeil, 2010). This will prevent practitioners from isolation, which may cause early symptoms of burnout to spiral. It is also a practitioner’s personal responsibility to keep an account of his or her mental state when working with clients.

According to the ACA Code of Ethics (2004), “[c]ounselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired” (C.2.g). Counsellors must seek assistance for any “problems that reach the level of professional impairment” (ACA, 2004, C.2.g). The British Columbia Association of Clinical Counsellors Ethics Code and Standard of Practice (2014) states the following: “[e]ngage in self-care activities, in recognition of the unique professional stresses involved in counselling practice, and in order to maintain optimal levels of professional practice”

(p. 5). Preventative measures of professional self-care include therapists maintaining “their own personal, familial, emotional, and spiritual needs while attending to the needs and demands of their clients” (Figley, 2002b; Stamm, 1999; as cited in Newell & MacNeil, 2010, p. 62). Getting enough rest, taking breaks when needed, and engaging in relaxation, offer ways to revitalize the self by reducing or preventing signs of impairment. Also, seeking support from colleagues in the same role, individuals who can truly relate to your experience, aids in the prevention of burnout (Oser, Biebel, Pullen, & Harp, 2013).

Validated strategies of prevention. Strategies that work best in the prevention of burnout are related to the person, organization, and institution (Sonneck, 1994; as cited in Langle, 2003, p. 119). Behavioural adjustments such as decreasing time pressure, adjusting the division of responsibility, and discussing the patterns that lead to a state of burnout can prevent workplace burnout and increase efficiency (Langle, 2003). Langle (2003) poses a few existential questions to ask oneself for burnout prevention: “*Why* am I doing this? Do I *like* doing this? Do I experience that this is good and that therefore I like doing this? Do I get something from this activity right now?” (p. 119). A measure can be to simply ask yourself if you spend half of your time with things you don’t like, in which your heart is not invested, and that do not give you joy—if the answer is “yes”, you will eventually burnout.

Summary

This review of literature has sought to examine the phenomenon of burnout beginning with its definition and characteristics. Burnout is composed of three dimensions including exhaustion, cynicism, and sense of inefficacy (Maslach, 2003), and results from unfavourable

working conditions such as high caseloads. Compassion fatigue (CF), vicarious trauma (VT), and secondary traumatic stress (STS) are used to describe and explain some of the symptoms of burnout. Causes of the burnout phenomenon lead with the factor of mental health professionals being most affected, especially in cases that lacked resources and adequate support within the workplace. There are many risk factors to burnout including age, gender, education, experience, and type of clients/patients on caseload. VT and CF can often result from a lack of support and unbalanced workload. Consequently, this phenomenon proves quite costly to the economy with high job turnover and absenteeism. Moreover, it further burdens the system with more individuals requiring the help it is already struggling to provide. A wholistic approach to rehabilitation is best as it addresses burnout at the individual level and also at the organizational level. Preventative measures such as more training, supervision, peer support and autonomy can begin with diminishing the affects of this phenomenon. Chapters 3 will outline the methodology for the case study and review of literature analysis, and Chapter 4 will examine the findings of the research.

Chapter III: Methodology

Introduction

This study utilizes the case study method, combined with a comprehensive literature. The purpose of this study is to do an academic review on the causes and conditions of burnout, the possible implications to the medical and mental health care system, and examining recommendations and practices that reduce the effect of burnout, illustrating these recommendations with a detailed case study. The research questions posed consist of the following: *What are the leading causes for burnout among healthcare professionals? Can a case study, combined with a comprehensive literature review, produce recommendations and necessary adaptations to decrease or eliminate these experiences for these types of professionals?* The methodology of content analysis of literature will be examined for convergence and contrast to findings of interview and survey results of case study.

According to Yin (2014), case study research is employed because “you want to understand a real-world case and assume that such an understanding is likely to involve important contextual conditions pertinent to your case” (p. 16). The phenomenon of burnout must be studied within a context and cannot be studied in isolation. Using the case study method allows for the depth required for this study “in which there will be many more variables of interest than data points” (p. 17). Yin (2014) also states that a case study can include quantitative evidence, which is what the survey portion of the data collection provides.

This study applies an individual case study. The question of generalization from a single case may commonly arise. Yin (2014) states that, “case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes” (p. 21). Findings from the case study will be compared to main themes and findings in the literature analysis. The

purpose of this study is not solely to determine if findings line up; the case study will provide a real life context to the common themes and motifs. The case study experiences and recommendations will not be provided from an outside observer to this phenomenon of burnout, but from a clinician's lived experiences within the demands of a mental health organization.

Participants

According to Yin (2014), when preparing a research design for the case study, “ you should have a set of operational criteria whereby candidates will be deemed qualified” (p. 95). There will be a single participant for the case study. The participant had indicated interest in the research, was identified and chosen due to the following factors: a qualified mental health practitioner in the public sector, practicing for at least two years, and personally motivated to volunteer for a systematic inquiry. Mental health clinicians working in the public sector tend to be at higher risk of burnout than those practicing in the private sector (Vredenburg, Carlozzi, & Stein, 1999; as cited in Sprang, Clark, & Whitt-Woosley, 2007). The minimum two years experience implies that the individual has had some experience in the field, and this may alleviate some symptoms of adjustment to a new career experience. The participant's eagerness to volunteer for the research indicated openness for the exchange needed in data collection, which took form of a survey and interview.

Treatment Procedures

Case Study Data Collection. When looking for a candidate for participation, the individual was informally contacted through email (See Appendix A). The email explained the nature of the study, the research questions, and how participation would be anonymous and

confidential. Once the participant had agreed to volunteer, both parties agreed on a space and time that would be offer both comfort and privacy for the nature of the data collection. It is important to cater to the interviewee's availability due to the nature of this type of case study research (Yin, 2014). The participant was also emailed a copy of the participant informed consent form approved by the IRB (See Appendix B).

On the date of the survey and interview a participant informed consent form was reviewed and signed in person. This formally solicited their volunteered participation, outlined the protection of the participant from any harm of the study, protection of confidentiality, and ensuring anonymity (Yin, 2014). A script was used to guide this process (See Appendix C). The script started by thanking the participant and allowed for approximately 15 minutes for the completion of the survey. There were opportunities for the participant to ask questions regarding the survey and at anytime during the interview that followed. The participant was told that the interview would be audio recorded and assured of confidentiality and the ethical disposal of any notes and recordings after the study was completed.

Themes and Data Points. Major themes of burnout from the literature review include characteristics, causes, risk factors, consequences, rehabilitation, and prevention. These major themes coincided with crucial data points from the case study. The analysis allowed for comparison between the themes and data points, checking for convergence and contrast. This results of this study showcased how results from an individual case study compare with studies of general populations from the reviewed literature.

Instruments and Materials

There instruments consist of a survey the participant fills out and a set of interview

questions. I created both the survey and interview questions, so copyright permission was not needed. The survey consisted of demographic questions for quick data collection, as well as multiple choice and scaled questions focusing on workload, work place structure, work satisfaction, and self-care (See Appendix D).

The interview questions further implored the participant to elaborate on responses from survey, as well as seeking narratives of personal experience around burnout and workplace stress. The questions also asked for the interviewee's recommendations and suggestions for reducing the phenomenon of burnout in the mental health and broader human service sectors (See Appendix E).

According to Creswell (2009), ensuring qualitative validity consists of checking for accuracy of findings. As previously stated in the introduction, findings from the case study research were compared to major themes in the literature review, pursuing convergence and contrast to findings. This methodical triangulation process added validity to the research (Yin, 2014). The data from the survey was compared against data from the interview for reliability purposes, prior to comparing with the review of literature. Comparing survey results, research notes from the interview, and audio recording of interview are reliability procedures to cross-check for mistakes and inconsistencies (Gibbs, 2007; as cited in Creswell, 2009).

Analysis

The data collected from the case study is compared to findings of literature review on major themes of burnout. The major themes include burnout characteristics, causes, risk factors, consequences, rehabilitation, and prevention. Although the case study data may not line up the literature review, it will serve to compliment findings with a personal and relevant perspective.

Conclusion

The study utilizes a case study and comprehensive literature review. The case study consists of a survey and interview of a single participant. This participant meets the following criteria: a qualified mental health practitioner in the public sector, practicing for at least two years, and personally motivated to volunteer for a systematic inquiry. The findings of the case study are compared to the literature review on the major themes of burnout: characteristics, causes, risk factors, consequences, rehabilitation, and prevention. The case study research methods of a survey and interview will offer a real-world perspective to the burnout phenomenon, further adding a personal human dimension to the review of literature.

Chapter IV: Results

Introduction

The results showcase a case study summarizing participant's responses from the Professional Burnout in the Mental Health Profession survey (See Appendix D) and interview questions (See Appendix E). The process data collection of survey and interview consisted of meeting at a private location that was both familiar and comfortable for the participant, going over the IRB forms, and reviewing informed consent. Next, a script was used to guide the process of survey administration and interview questions (See Appendix C). The process by thanking the participant and stating approximately 15 minutes for the completion of the survey, although more time would be granted if necessary. The participant was encouraged to ask questions or voice concerns at any time during the survey and interview. The participant was notified that the interview would be audio recorded; confidentiality and the ethical disposal of any notes and recordings after the study was completed was assured in the IRB Approved Informed Consent Form (See Appendix B). The audio recording offered a more intimate experience for the interview as it prevented interruptions in the flow of conversation and exchanges between researcher and participant. The personal nature of the interview provided a greater appreciation for the data collected, as it provided a unique and relevant lived experience for the research.

The analysis that follows compares the main themes from review of literature with the data points from the case study, which include burnout characteristics, causes, risk factors, consequences, rehabilitation, and prevention. The analysis allows for checking of convergence and contrast between the themes and data points. Table 1 in the summary section provides a

quick overview of the findings. The case study also serves as a source complimenting literature review findings with a personal and relevant perspective, while also demonstrating how the results of an individual case study compare with studies of general populations. Please note that certain details of the case study subject's life and experiences were omitted from the study to protect anonymity. For readability purposes, the case study subject will be given the pseudonym, Rachel.

Case Study

The case study is of a 38-year-old Caucasian female employed as a public sector mental health clinician in Western Canada, who we will refer to as Rachel. She is married and currently has no children. Rachel has a master's level education and has been practicing as a registered clinical counsellor for six years at the current agency, which is her first work assignment after the completion of her education. She works 30-40 hours per week and manages a caseload of around 25-30 clients. She engages in self-care practices for personal well being such as exercise and socializing 1-2 times per week. She is currently on a long-term leave from her workplace due to a combination of personal and workplace stressors.

The professional roles of mental health providers at the agency consist of one team leader, two child psychologists and eight mental health counsellors. Rachel answered the next four survey questions on a 5-point scale (See Appendix D, survey question 12. A-D):

1. very unsatisfied
2. unsatisfied
3. satisfied
4. very satisfied
5. completely satisfied

Rachel stated she is “unsatisfied” with the level of leadership and management. She is “completely satisfied” with the level of autonomy in decision-making. She feels “unsatisfied” with the level of guidance and supervision within the organization. She is “very satisfied” with the level of training and resources provided by the organization. The following sections correspond with responses to the interview questions (See Appendix E) offering elaboration and detail for the above responses and data collected from the survey.

Duties and roles in the organization. Rachel works primarily as a mental health clinician with a caseload of 25-30 clients, but had also recently taken on the role of an intake coordinator as a new agency initiative. The agency was switching to a walk-in model to provide faster face-to-face service to the community. This role entailed scheduling intake times, designing new agency forms, communicating with the community/public, attending meetings, monitoring waitlists for services, and also serving as a mentor and supervisor for agency interns. Another role Rachel has consists of teaching Dialectical Behaviour Therapy (DBT) within the organization as well as running a DBT group for clients.

Clients and caseload management. The clientele Rachel sees can be of all ages for the intake process, but it is mainly families and children aged 6-19. During this intake process she helps determine if the persons qualify for agency services, the type of service(s), referrals to outside agencies, and determining placement on waitlists. Rachel’s caseload mainly consists of teenagers with presenting issues and concerns mainly around anxiety and depression; however, other presenting issues include trauma, issues with family or relationships, ADHD, and eating disorders.

Rachel stated that there is not much choice in a caseload balance as it is a public government agency and therefore the volume and neediness of the clients is quite high. She

stated that an “unsaid” general rule is one client for every two hours worked, so someone working a 30-hour week would have a caseload of around 15 clients. If a clinician felt the caseload was too heavy or unmanageable, he could speak to a supervisor or other clinicians for suggestions. If time seemed too limited to physically see all the clients on the caseload, she would have a look at the files to see which clients could be seen less, perhaps on a bi-weekly or monthly basis, or clients that could be weaned off of therapy and referred to other resources. For the DBT program, after a cycle is completed clients could be offloaded for 6. Rachel also stated that when a caseload gets too heavy a clinician should avoid taking on new clients; however, it is sometimes difficult when the agency has contractual commitments with other community agencies to take on certain number of clients.

Experience of professional burnout. Rachel “definitely” agrees that professional stress has impacted her personal life. She stated that her body started exhibiting physical symptoms such as high levels of anxiety at work the physical manifestation of menorrhagia, which she confirmed by medical opinion to be a stress response. She did state that there were personal stresses as well as professional stresses, and often it was difficult to “tease out” which was more so causing the unhealthy stress levels.

Rachel was handed the following definitions of burnout during the interview: Burnout is defined as a “state of physical, emotional, and spiritual fatigue caused by long-term exposure to demanding work stressors (Sherring & Knight, 2009, as cited in Breen & Sweeney, 2013, p. 12). Maslach (1982, as cited in Sprang, Clark, & White-Woosley, 2007) defined burnout as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment.” After reading the definitions, Rachel reflected on whether she felt she had experienced professional burnout, and if so to describe her experience.

She agreed with the definitions presented and stated that she had and is currently experiencing professional burnout. She described feeling “hopeless” as work and her level of compassion for clients decreasing, along with her patience. She felt “the weight of the world” on her shoulders with the seemingly never-ending stream of clients. She felt “defeated” and often wondered, “What’s the point?” Nothing she felt she was doing was easing anyone’s burden and the task of helping seemed impossible in itself.

Rachel states that her situation of professional burnout is still a work in progress and she is still learning how to cope. She shares that self-care practices are finally starting to help, but she was not doing a lot of self-care a year ago. She would find herself not taking breaks at work and often working through lunch. A mindset shift regarding the concept of *rest* has helped. Resting does not equal reading self-help books or doing something recreational; rest, for her, is a state doing nothing of any productive significance and feeling guilt-free about it. She also states that “yoga has been huge” in the healing process, along with bibliotherapy, walking, and speaking with friends who have had similar experiences.

Workplace practices for decreasing burnout. Rachel feels the immediate solution for decreasing burnout in her workplace is to simply hire more mental health clinicians, but she does feel this as quite “unrealistic” with it being a government funded public organization. She feels that a “narrowing of goal posts” for who qualifies for services may help reduce the volume of clients, if more staff cannot be hired. She also states that changing the service model to a lower number of sessions per client may also be a possible solution. She added that this is something the workplace is trying to implement, along with “wellness hour coupons” where each clinician gets an hour a month to do what she wants, during work hours. Although she does not want

service to clients to suffer, currently client volumes and clinicians at risk for burnout are too high for optimal service to continue.

Advice on burnout for new professionals. The subject seemed quite enthusiastic about sharing some wisdom for new professionals in the mental health field. She states to “keep your top priority to treat yourself as your number one client.” It is important to practices what you teach or suggest to clients. It is important to take your breaks and to understand that “you can’t save the world” and that is okay. Do the best you can with who is with you at the moment in terms of clients. Try your best to leave your work at work. She also stressed the importance of actively seeking out supervision of a minimum of at least one hour every two weeks, even though she felt this should be much higher.

Analysis of literature review and case study

The analysis allows for comparison between the major themes of burnout from the review of literature and data points of the case study, checking for convergence and contrast. The major themes of burnout from the review of literature include characteristics, causes, risk factors, consequences, rehabilitation, and prevention. This analysis will show how results from an individual case study compare with studies of general populations from the reviewed literature, as well as providing a real-world context for the literature.

Characteristics of burnout. According to the literature, characteristics of burnout consist of “cynicism, psychological distress, feelings of dissatisfaction, impaired interpersonal functioning, emotional numbing, and physiological problems” (Fothergill, Edwards, & Burnard, 2004; as cited in Sprang, Clark, & Whitt-Woosley, 2007, p. 260). There are also observable behaviours such as “irritability, impatience, and nonverbal communication conveying lack of

interest in patient or colleagues” (Ficher, Kumar, & Hatcher, 2007; Maslach et al., 1996; McCarthy & Frieze, 1999; as cited in Warren, Schafer, Crowley, & Olivardia, 2013). Burnout can result in conditions such as *vicarious trauma (VT)*, *secondary traumatic stress (STS)*, and *professional burnout* (Newell & MacNeil, 2010).

Emotional exhaustion, depersonalization or cynicism, and a diminishment in one’s sense of personal accomplishment help define the main dimensions of *burnout* (Maslach, 1982; as cited in Sprang, Clark, & Whitt-Woosley, 2007; Maslach, 2003). *Emotional exhaustion* is a “state that occurs when a practitioner’s emotional resources become depleted by the chronic needs, demands, and expectations” of clients and the workplace (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010, p. 59); there is a positive correlation between workplace demands and health issues related to stress (Maslach, 2003).

Depersonalization is “negative, cynical or excessive detached responses to coworkers or clients (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010, p. 59). According to Maslach (2003), this dimension is a “basic hallmark of the burnout experience—the negative, callous, or excessively detached response to other people and other aspects of the job” (p. 190). Compassion Fatigue (CF) or STS can play significant role in the devaluing of clients (Puig, Braggs, Mixon, Park, Kim, & Lee, et al., 2012). When one becomes disengaged from the work, the practitioner, workplace and clients are all negatively impacted. *Reduction in sense of personal accomplishment* occurs when practitioners feel deficient or inadequate. The mind frame of inadequacy can result from clients not responding to treatment, and “[t]his domain of the burnout phenomenon may also occur in response to bureaucratic constraints and administrative demands” (Newell & MacNeil, 2010, p. 59). This may be very prevalent in areas of trauma and addiction due to relapses or lack of progress. The final stage of

burnout, in which there is breakdown and diminished activity, can be seen as a response to protect oneself from further damage (Karazman, 1994; Burisch, 1989; as cited in Langle, 2003).

Rachel has expressed high levels of anxiety in the workplace, which coincides with irritability, psychological distress, impaired interpersonal functioning, and psychological problems (Ficher, Kumar, & Hatcher, 2007; Maslach et al., 1996; McCarthy & Frieze, 1999; as cited in Warren, Schafer, Crowley, & Olivardia, 2013; Fothergill, Edwards, & Burnard, 2004; as cited in Sprang, Clark, & Whitt-Woosley, 2007). Although Rachel's description of symptomology did not reflect definitions of STS or CF, there is evidence of VT, as she often felt the level of care she provided was not always helping clients on a psychological level that was needed. Emotional exhaustion, depersonalization or cynicism, and reduction in sense of personal accomplishment were all present in the subject's experience. The subject had feelings of hopelessness and being severely overwhelmed as emotional reserves became depleted by professional demands (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010). A detached response of cynicism grew as she felt her levels of compassion drop for clients, along with her patience (Maslach, 1998; Maslach, Shaufeli, & Leiter, 2001; as cited in Newell & MacNeil, 2010). This resulted in a reduction in sense of personal accomplishment with feelings of deficiency and in adequacy. The subject claimed to feel "defeated" and often questioned the point of her work since the demands of the system never seemed to cease. Rachel has also experienced the final state of burnout consisting of breakdown and diminished activity (Karazman, 1994, Burisch, 1989; as cited in Langle, 2003), which resulted in health concerns and a leave from the workplace.

Causes of burnout. Mental health professionals have higher levels of burnout than other health care providers (Imai, Nakao, Tsuchiya, Kuroda, & Katon, 2004; Korkeila et al., 2003; as

cited in Sprang, et al., 2007). Furthermore, mental health professionals working in the public or nonprofit sector have higher burnout risk than those in the private sector (Vredenburgh, Carlozzi, & Stein, 1999, as cited in Sprang, et al., 2007). According to burnout theory, when individuals perceive or experience that they do not have enough resources such as time, energy, and support, to balance the demands of their work, they are more likely to be vulnerable to burnout (Halbesleben & Buckley, 2004; as cited in Thomas & Lankau, 2009, p. 419).

It must be noted that burnout is not exclusively related to the workplace, as research has shown that private life and social peer support played a key role as well (Blom, 2012).

Rachel is employed as a public sector mental health clinician, for a government-funded agency. This immediately places her in a workplace environment at a higher risk of burnout (Vredenburgh, Carlozzi, & Stein, 1999, as cited in Sprang, et al., 2007). Rachel has stated that there is not much choice in caseload balance at a public government agency, due to the nature and volume of services required. Moreover, the agency has contractual agreements to fulfill with other outside agencies, consisting of a certain number of clients despite the lacking number of service providers. Rachel also disclosed personal life stressors that were also affecting her personal well being at the time. These causes of Rachel's professional burnout mirror the findings of the literature.

Risk factors. Female gender, younger age, higher educational degrees, least years of clinical experience, and larger percentage of clients with PTSD are all personal demographics that predict burnout (Sprang, et al., 2007). Young females with performance-based self-esteem (PBSE), those with pre-existing mental health issues, practitioners working with a trauma based population, heavy caseloads, demands for brief therapy, and other care limitations are most at risk (O'Halloran & Linton, 2000; as cited in Puig, et al., 2012).

Organizational risk factors include excessive and high caseloads, lack of autonomy, unfairness in structure, low peer support, and poor on the job training (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997; as cited in Newell & MacNeil, 2010). This is further compounded by “bureaucratic constraints, inadequate supervision, lack of availability of resources, and lack of support from professional colleagues” (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Catherall, 1999; as cited in Newell & MacNeil, 2010, p. 62).

Occupational hazards such as the nature of the work also play a crucial role in setting up conditions that can easily lead to VT, CF, and burnout. Some research has shown that CF is directly related to number of hours spent counselling clients who have experienced trauma (Kassam-Adams, 1999; Flannelly, Roberts, & Weaver 2005; as cited in Thompson, Amatea, & Thompson, 2014). Other research has found no such correlation between CF and the amount of time counselling trauma clients (Baird & Jenkins, 2003; as cited in Thompson, Amatea, & Thompson, 2014)

Psychological causes for burnout include unmet expectations and lack of social support (Van Dierendonck et al., 2001; Janssen, Do Jonge, & Bakker, 1999; as cited in Thomas & Lankau, 2009), because “being devalued in an environment of scarcity, competition or evaluative focus is a powerful trigger of maladaptive self-esteem pursuits, in particular for women” (Crocker & Park, 2004; as cited in Blom, 2012, p. 124). Trailing PBSE, private life stressors and social peer support were the most significant predictors of burnout over time, for both men and women (Blom, 2012).

Rachel is a female with a master’s level education, and with only a few years of experience in the field, and heavy caseload demands on top of other roles within the organization, which are all factors that place her in a vulnerable position for burnout (Sprang, et

al., 2007; O'Halloran & Linton, 2000; as cited in Puig, et al., 2012). She “completely satisfied” with her level of autonomy within the work place, and “very satisfied with the level of training and resources provided to clinicians. These experiences contradict the factors of lack of autonomy and poor job training that lead to burnout (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997, as cited in Newell & MacNeil, 2010). However, Rachel is “unsatisfied” with the level of leadership, management, and level of supervision within the workplace, which are strong contributing factors to burnout (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Catherall, 1999; as cited in Newell & MacNeil, 2010). These factors reflect a reality for the clinician that lacks in peer support, and this compounded by personal life stressors is a predictor of burnout (Blom, 2012).

Consequences of burnout. Those experiencing professional burnout have more stress-related illness and mental health issues such as depression, anxiety, low self-esteem, increased physical health issues (Ducharme, Knudsen & Roman 2008; Garner, Knight & Simpson 2007; Cherniss & Krantz, 1983; Pines & Maslach 1978; as cited in Oser, Bievel, Pullen & Harp, 2013). These issues become part of a professional’s personal life, and begin to immerse one’s life experiences (Langle, 2003). This leads to deterioration in the quality client/patient care, absenteeism, high job turnover rate, and low morale (Maslach & Jackson, 1986; Wall & Bolden, 1997; Sherring & Knight, 2009, as cited in Breen & Sweeney, 2013).

Rachel had stated that she “definitely” agrees that stress from her workplace has affected her personal life and well being, as mentioned by Langle (2003). She experienced high levels of anxiety and stress at work, and this resulted in the physical health issues. She experienced feeling “hopeless” with the constant intake of new clients and found herself working through

breaks and lunch trying to keep up with workplace demands. These experiences and behaviours resulted in further neglect of self-care, setting her onto a path for burnout.

Rehabilitation. A wholistic approach focusing on the workplace environment and stressors, as well as self-care in the personal life is required for rehabilitation. A wholistic approach to recovery can include a team of professionals from different areas of the healthcare field such as a physician, a psychologist, a physiotherapist, an occupational therapist, a social worker, a nurse, and a personal trainer (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013). Although every case of burnout may not require such an elaborate team, these professionals represent all the different areas of one's life that are affected by burnout. Increased physical activity is associated with positive changes in the symptoms of depression and anxiety, thus reducing burnout (De Moor et al., 2006; Vallance et al., 2011; as cited in Lindwall, Gerber, Jonsdottir, Borjesson, & Ahlborg, 2013). Wellness is defined as “a way of life oriented toward optimal health and well-being in which body, mind, and spirit are integrated by the individual to live more fully”, emphasizing a wholistic approach to recovery and prevention (Myers, Sweeney, & Witmer, 2000, p. 252; as cited in Puig, et al., 2012, p. 98).

At the organizational level, Maslach, Leiter, and Jackson (2012), recommend “separating the individual and workgroup dynamics of exhaustion” which would provide opportunities for specific interventions at the management, team and individual levels (p. 299). There is evidence that the encouraged interactions and empowerment of professionals in a workplace, along with clinical supervision, reduce burnout levels (Aiken, et al., 2002; Hyrkas, 2005; Edwards et al., 2006; as cited in Breen & Sweeney, 2013). Mindfulness practices in self-care can also help clinicians suffering from cynicism and detachment regain empathy for clients, as well as improving relaxation and job satisfaction

(Maslach, 2003; Mackenzie, Poulin, & Seidman-Carlson, 2006; Thielman & Cacciatore, 2014).

Whereas it was found that self-care does not have a strong impact on CF, it does impact compassion satisfaction, which does play a role in decreasing burnout (Kraus, 2005).

Although the process has only begun for her, Rachel is finding recent gains in recovery. She does not have a team of professionals aiding her recovery, but she does engage in self-care practices of rest, bibliotherapy, spending time with family, and seeking out peer support from others who have had similar experiences. She takes part in physical activity and mindfulness activities such as walking and yoga. These practices reflect the integrating of body, mind and spirit that define wellness (Myers, Sweeney, & Witmer, 2000, p. 252; as cited in Puig, et al., 2012). Rachel has not started recovery at the organizational level, as she is currently on a leave from the workplace. However, she has voiced workplace recommendations that overlap for recovery and prevention, which will be discussed at the end of the next section.

Prevention. Burnout prevention must occur at the organizational and personal level. The British Columbia Association of Clinical Counsellors Ethics Code and Standard of Practice (2014) states that clinicians must “[e]ngage in self-care activities, in recognition of the unique professional stresses involved in counselling practice, and in order to maintain optimal levels of professional practice” (p. 5). Seeking peer support from individuals who can relate with the specific workplace stressors of mental health work can greatly aide in the burnout prevention (Oser, Biebel, Pullen, & Harp, 2013). Preventative measures of self-care also include practitioners balancing their personal and family lives with the demands of their workplace and clients (Figley, 2002b; Stamm, 1999; as cited in Newell & MacNeil, 2010). Creating and maintaining strong boundaries between professional and personal lives seems to be key in this process.

The American Counseling Association has created three ways to begin meeting needs of impaired mental health professionals: a) educational programs targeted for prevention, b) provide intervention and treatment, c) advocate for guidelines so that these professionals do not face any stigma of seeking treatment (ACA, 2010; as cited in Puig, et al., 2012, p. 107). These processes are especially important for individuals new to the field of work as they are at higher risk of burnout. Clinical supervision and workplaces supportive of those who do find themselves struggling with workplace stress can reduce risks of burnout (Boscarino, et al., 2004; Korkeila et al., 2003; Ortelepp & Friedman, 2001; as cited in Sprang, et al., 2007). This can include supervisors or team leaders developing groups that focus on wellness strategies within the workplace and act as networks of support to professionals (Puig, et al., 2012; Thomas & Lankau, 2009). Other strategies of prevention at the organizational level include ensuring an optimal caseload for clinicians, so they are not finding themselves working with many high trauma clients, and adjusting the division of duties and responsibilities within the organization (Sprang, et al., 2007; Langle, 2003).

Rachel advises new professionals in the field to “treat yourself as your number one client”, take breaks and rest, understand that you can only do your best and cannot save the world, and actively seek out supervision with a minimum of one our every two weeks. These suggestions emphasize self-care and self-advocacy at work.

Rachel’s workplace recommendations for rehabilitation and prevention of burnout are specific to her workplace in comparison with the more general ones from the literature. She feels that hiring more mental health clinicians would help ease the burden on the rest of the team, if there is no way of reducing the number of clients and services. She realizes that this may be “unrealistic” given the nature of a publicly funded organization. If more clinicians cannot be

hired, then there needs to be a “narrowing of goal posts” for those qualifying for services, in hopes to reduce volumes and thus providing better care.

Although she mentions how she can seek peer support when caseloads or work assignments are getting overwhelming, she did mention that other than collegial empathy there were not any changes made to the actual workload, as this needs to happen at the managerial and supervisory levels. She also mentioned the “wellness hour coupon” initiative that was started, granting clinicians an hour a month to practice self-care during the workday; it seems as though this initiative was not enough to offset the ongoing pressures. In the survey portion of data collection she stated dissatisfaction among the levels of leadership and management, and also with the level of guidance and support provided through supervision. According to her experiences, it can be concluded that major changes need to start with the leadership of the organization and a review of processes. Some of the processes have begun to be reviewed with a service model changing to lower number of sessions per client. Without adequate leadership, supervision and a reduction in duties and caseloads of clinicians, the workplace will continue to prove a high-risk environment for burnout.

Summary

Table 1

Summary of Findings

Theme in Literature	Theme in Case Study	Important Comparisons
VT, STS, CF lead to burnout	VT present in burnout	STF and CF not present in case
emotional exhaustion, cynicism, diminishment in sense of personal accomplishment, breakdown	emotional exhaustion, cynicism, diminishment in sense of personal accomplishment, breakdown	characteristics present in some capacity in case

high caseload	high caseload	exact parallel found
lack of autonomy	autonomy present	risk factor absent in case
low peer support	neutral peer support	present in case but did not affect burnout
poor work training	training very satisfactory	risk factor absent in case
private life stressor	private life stressor	risk factor strong in case
depression, anxiety, low PBSE, physical health issues	anxiety, stress, physical health issues	mental and physical stressors present
rehab at workplace: multi-level interventions, clinical supervision, employee empowerment	currently no rehab at workplace	currently N/A to case
self-care: physical activity, mindfulness, peer support	self-care: yoga, bibliotherapy, peer support	self-care practices present
prevention: balanced caseload, adjustment of duties, professional groups focusing on wellness and employee support	prevention: more supervision, hiring more professionals, decreasing client intake, encouraging employees to take breaks	Themes in case were suggestions and recommendations, not currently put into practice

The results of the case study were compared to findings of the literature review for convergence, contrast, and insight. The major themes of the literature review consisted of burnout characteristics, causes, risk factors, consequences, rehabilitation, and prevention. The following is a brief summary of the findings and analysis.

Characteristics of burnout. Emotional exhaustion, depersonalization or cynicism, and a diminishment in sense of personal accomplishment (Maslach, 2003), were all present within the subject’s experience of workplace stress. There was also evidence of psychological stress with the subject’s experience of high levels of anxiety and feelings of hopelessness. Rachel’s experiences did not reflect STS or CF, however there was evidence of the presence of VT. Her experience did reflect the final state of burnout consisting of breakdown and diminished activity

(Karazman, 1994; Burisch, 1989; as cited in Langle, 2003). This has resulted in a long-term leave from the workplace.

Causes of burnout. The subject's experience strongly reflects the causes of burnout from the review of literature. Rachel is employed as a mental health clinician in a public nonprofit agency, and this workplace setting presents the highest risk for mental health providers (Vredenburgh, Carlozzi, & Stein, 1999; as cited in Sprang, et al., 2007). This is due to the nature of clients and caseload volumes in the public sector, and these factors played a significant role in the subject's experience. The literature also states that burnout is not exclusive to workplace stressors, but can be influenced by private life (Blom, 2012), and this was found to be true in Rachel's experience of burnout.

Risk factors. The case study subject meets the burnout risk factors of female gender, level of education, years of exposure to field, and type of demands of the workplace such as caseload (Sprang, Clark, & Whitt-Woosley, 2007; O'Halloran & Linton, 2000; as cited in Puig, et al., 2012). Her levels of high satisfaction with workplace autonomy, training, and resources contradict the findings in the literature. However, her lack of satisfaction in level of leadership, guidance, and supervision, prove agree with the risk factors found in the literature (Dunkley & Whelan, 2006; Farrell & Turpin, 2003; Catherall, 1999; as cited in Newell & MacNeil, 2010). Private life stressors influencing professional burnout are also corroborated in both Rachel's experience and findings of the literature (Blom, 2012).

Consequences of burnout. The literature outlines stress-related illnesses and mental health issues resulting from burnout (Ducharme, Knudsen & Roman 2008; Garner, Knight & Simpson 2007; Cherniss & Krantz, 1983; Pines & Maslach 1978; as cited in Oser, Bievel, Pullen & Harp, 2013). These were present in Rachel's experience of high levels of anxiety and physical

illness resulting from stress. Consequences of professional burnout start to affect one's personal life (Langle, 2003; Blom, 2012). Although Rachel was unable to tease out whether professional stress affected personal life stresses more or vice versa, both were significant in the resulting burnout.

Rehabilitation. The literature suggests a wholistic approach to rehabilitation, which can be comprised of a team of professionals of various health care providers helping those experiencing burnout, as well as self-care practices such as physical activity and exercising mindfulness (Hätinen, Mäkikangas, Kinnunen, & Pekkonen, 2013; De Moor et al., 2006; Vallance et al., 2011; as cited in Lindwall, Gerber, Jonsdottir, Borjesson, & Ahlberg, 2013; Maslach, 2003; Mackenzie, Poulin, & Seidman-Carlson, 2006; Thielman & Cacciatore, 2014). Rachel did not have a team of healthcare providers aiding her recovery, but she did practice self-care by engaging in activities such as walking, yoga, bibliotherapy, and peer support. The workplace recommendations included interventions at the management, team and individual levels, and stressed the importance of clinical supervision for professionals (Aiken, et al., 2002; Hyrkas, 2005; Edwards et al., 2006; as cited in Breen & Sweeney, 2013). Rachel is currently not taking part in rehabilitation at her workplace, but rather focusing on personal rehabilitation.

Prevention. Strategies and practices for prevention outlined in the literature include self-care activities, seeking peer support, and maintaining a balance between personal and work life (BCACC, 2014; Oser, Biebel, Pullen, & Harp, 2013; Newell & MacNeil, 2010). Strategies specific to the workplace include educational programs around burnout, interventions such as groups at work serving as professional networks of support, adequate supervision, and balance of duties and caseloads (Puig, et al., 2012; Thomas & Lankau, 2009; Sprang, et al., 2007; Langle, 2003). Rachel's recommendations reflected the findings of the literature. She mentioned the

importance of self-care, actively seeking out supervision when needed, taking scheduled breaks, seeking peer support, and the importance of strong leadership and guidance. She also mentioned other prevention strategies specific to her workplace, not necessarily found in the literature.

In conclusion, the findings of the case study offer many points of convergence with the literature the major themes of burnout: characteristics, causes, risk factors, consequences, rehabilitation, and prevention; however there are discrepancies between the personal experience of the individual and the reviewed studies of more general populations. The intention of the case study analysis is not simply for comparison with the literature, but to add a personal real-world context to the themes of burnout reviewed in the literature. It is also important to note that certain details of the subject's life and experiences were omitted to ensure anonymity and confidentiality.

Chapter V: Discussion

Purpose and meaning of study

This study consisted of two parts: an academic review of literature and conducting a case study. The purpose of the study was to conduct an academic review of the causes and conditions of burnout, the possible implications to the medical and mental health care system, and practices that reduce the effect of burnout. The case study, done on a participant who was employed as a mental health clinician in the public sector, provided a personal and professional point of comparison and convergence for the literature review. The analysis of the results provided recommendations for evidence-based rehabilitation and preventative practices that can be implemented in areas of professional and personal life.

Interpretations & Research Questions

RQ 1: What are the leading causes for burnout among healthcare professionals?

The review of academic literature outlined major causes of burnout among healthcare professionals included lacking essential resources such as time, energy, and support to balance the demands of the workplace (Halbesleben & Buckley, 2004; as cited in Thomas & Lankau, 2009). Mental health workers have the highest rates of burnout, especially those working in the public or nonprofit sectors (Imai, Nakao, Tsuchiya, Kuroda, & Katon, 2004; Korkeila et al., 2003; Vredenburgh, Carlozzi, & Stein, 1999; as cited in Sprang, Clark, & Whitt-Woosley, 2007). The literature also stated that burnout may not be exclusive to the workplace environment, with private life stressors also playing a key role (Blom, 2012). These findings from the literature reflected the subject's experiences from the case study. These findings reflected the causes of the participant's experience of burnout. She is employed as a public sector mental health

clinician for a government funded agency. Her experience in the workplace includes high caseload volumes, high intake demands, and also the responsibility of coordinating programs and providing mentorship and supervision to interns. The participant also experienced personal life stressors at the time, which compounded by the extreme demands of the workplace, resulted in burnout.

A review of the academic literature provided demographic, organizational, occupational, and psychological risk factors for burnout. The literature outlined demographics of female gender, younger age, higher post-secondary education, least job experience, and working with a higher percentage of trauma clients, as predictors and risk factors for burnout (Sprang, et al., 2007). Organizational risk factors included high caseloads, lack of autonomy, unfairness in structure, low peer support, and poor on the job training (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997; as cited in Newell & MacNeil, 2010). Occupational hazards such as the nature of counselling work also play a significant role in establishing conditions for the possibility of VT, CF, and burnout. Psychological causes included unmet professional expectations leading to low PBSE, lack of social or peer support, and personal life stressors, as dominant causes to burnout over time for both men and women (Van Dierendonck, et al., 2001; Janssen, Do Jonge, & Bakker, 1999; as cited in Thomas & Lankau, 2009; Blom, 2012).

The case study participant's demographics reflected those associated with highest risk of burnout. She is a 38-year-old female with a master's level education, and has had six years of experience in her current position as a mental health clinician in the public sector. Although the participant felt highly satisfied with her level of autonomy and training in the workplace, she was not satisfied with the level of leadership and supervision. The demands of the workplace were not balanced with the level of guidance and peer support required for the competent management

of such a workload, without high risk of staff burnout. Professional workplace stressors as well as personal life situations played a key role in the participant's experience of burnout.

RQ 2: Can a case study, combined with a comprehensive literature review, produce recommendations and necessary adaptations to decrease or eliminate these experiences for these types of professionals? This study, with the combined review of academic literature and case study, provided a unique perspective for recommendations and adaptations for the workplace and self-care. The literature provided evidence reaserch studies on burnout, and the case study offered a personal perspective on the experience. The recommendations will outlined and discussed in the following section.

Recommendations for further professional action

The following are recommendations and adaptations produced by the study to decrease or eliminate professional burnout. These recommendations focus on the following areas: leadership/management, supervision, training, organizational structure, autonomy, peer support, and self-care. Table 2 also offers a summary of these recommendations.

Adequate number of professionals for services provided. If professionals are feeling overwhelmed with high caseloads, CF, and experiencing symptoms of burnout, the demands of the system are far exceeding the resources and manpower of the organization. Unfortunately, this scenario is far too common, especially in the public sector. This type of situation calls for the hiring of more professionals, which in turn will reduce levels of workplace stress, absenteeism, and job turnover rates. If more professionals cannot be hired, then a restructuring of the organization and services must be addressed.

Process to address employee concerns. In the case study, it was found that although

there was peer support and some supervision, little was done to resolve voiced concerns. If a process is implemented where staff concerns are addressed, this increases workplace morale. A process for reporting staff concerns to management through supervisors or peer support groups may be one way to implement this recommendation.

Review of organization structure and making adjustments as needed. If the demands of the workplace are outweighing resources, a re-structuring of the organization and service model needs to be addressed. If more professionals cannot be hired, this may include implementing more brief therapy or narrowing criteria for those who can receive services. Supervision or staff meetings may be a venue for checking workplace climate, and making adjustments to offset some workplace pressures.

Include employees in decision-making. This increases autonomy in the workplace and therefore decreasing levels of burnout. Including professionals in decisions of re-structuring, services and other workplace changes can also provide an invaluable perspective.

Include employee input into resources and training. This is another recommendation that provides more autonomy in the workplace and gives leadership valuable feedback regarding resources and training. Professionals may voice what they feel is lacking in their practice and gaps where more resources and training are required. If management needs to implement new training, feedback from employees may offer in a more efficient way of delivery that helps all parties involved.

Supervision provided based on caseload and experience. This was a key point found in both the literature and case study. Adequate levels of supervision play a significant role in burnout prevention. In the case study it was suggested to seek out a minimum of one hour of supervision every two weeks. However, this should also be increased for professionals with less

experience who may require more supervision, and for those with more complex and heavier caseloads. This needs to be implemented at the organization and management levels, so that it does not solely fall on the employee to seek out supervision.

Implementation of peer support groups. These groups, in addition to supervision, may offer resources, self-care strategies, and much needed support to those vulnerable to burnout. This can be implemented at the organization level by leadership as part of duties of certain staff, but at the same time making sure those members are not feeling overburdened by this extra duty.

Balanced caseloads in respect to numbers and high need clients. Caseloads should be monitored at the organization level or through supervision. Caseloads require balance in respect to overall numbers and high needs clients, such as trauma cases like PTSD. An unbalanced caseload can result in VT or STS. Professionals should also monitor effects on self-care as a result of caseload and other workplace stressors.

Training of leadership/management on professional burnout. Before a workplace can be educated and trained on burnout prevention, leadership and management must undergo such training. This must be implemented at the organization level and is the beginning of much needed professional support.

Provide opportunities for professional development. Providing opportunities for professional growth and new training not only help professionals learn helpful and more efficient practices, but levels of autonomy are also increased within the workplace.

Training for new employees to include burnout prevention. Adequate professional training for new employees may prevent burnout, but including burnout prevention as part of the training itself may reinforce this outcome. This can include education of risk factors, symptoms, and self-care practices; it can also provide resources for support in the workplace and community

to reduce stigma of seeking help.

Ongoing in-services for all employees on burnout prevention. In-service or training on burnout should not only be a part of new employee training, but also should be reinforced throughout the year and as needed. This should be implemented at the organization and management levels, and methods of delivery can benefit peer support as well.

Activities and practices to improve workplace morale. This recommendation is a leadership initiative that may not include any professional practices, but rather focus on team building activities that foster peer support, self-care, and employee appreciation.

Table 2

Recommendations for prevention of professional burnout

	Leadership/ management	Supervision	Training	Organization	Autonomy	Peer- support	Self- care
Employee numbers to reflect services provided	✓				✓		
Process to address employee concerns	✓	✓					
Review of organization structure	✓	✓		✓			
Include employees in decisions	✓			✓	✓		
Employee input into resources and training	✓		✓	✓	✓		
Adequate Supervision time	✓	✓		✓			

Peer-support groups	✓				✓	✓
Caseload Balance	✓	✓		✓		✓
Training of leadership & management	✓		✓	✓		
Professional development			✓		✓	
Employee training to include burnout prevention	✓		✓			✓
In-services for all employees	✓		✓		✓	✓
Practices for workplace morale	✓				✓	✓

Each one of these recommendations and adaptations emphasize the role of strong leadership and management. Training in the area of professional burnout is essential for the leadership or any professional organization, so that strategies may be implemented. The urgency is especially present in public sector mental health services, which have the highest rates of professional burnout.

Implications for further research and scholarly action

Future research on how these recommendations and adaptations fair when implemented in professional workplace practices would offer further reliability to this study. The implementation of these recommendations and adaptations in a controlled study may offer further insight into the nature of the burnout phenomenon and provide evidence for which practices prove most effective. Future research into implementing such training at the

management level should also be explored, as each recommendation emphasizes this component.

Limitations of study

Due to the scope of the study, the case study was done on a single individual whose demographics may not be reflective of all mental health workers. These factors may limit reliability when comparing with the literature reviewed and also add a level of bias to the analysis and recommendations. However, it is important to note that the case study is not intended to be definitive; it adds a real-world context to the themes in the literature reviewed. Also, due to the nature of the study, these recommendations were not implemented and tested, and therefore this is an important area of exploration that would offer this study more conclusive data.

Researcher's Experience

My personal experience of the research process was both eye-opening and extremely relevant to my personal experiences at the time. At the time, I was completing graduate level classes for the Master of Counselling program, was newly married, taking part in rehabilitation as a result of a motor vehicle accident, working full-time in a new position as a high school counsellor, and also completing clinical counselling practicum hours in the evenings. Adapting to new circumstances and pressures from my academic, professional and personal life set up conditions for an experience of burnout of my own.

I shared a very personal connection to both the academic review of literature and the case study. The review of literature helped validate my personal experiences as a larger phenomenon affecting so many others in a similar professional environment. Conducting the case study

research gave my research a genuine real-world perspective. The participant's openness and willingness to share her experiences were invaluable to the study and to my personal experience as a researcher. Burnout tends to intensify in isolation, and sharing the experience with peers can offer a therapeutic outlet, aiding in rehabilitation.

Conclusion and Summary

This study has produced a set of workplace recommendations and adaptations to prevent or decrease professional burnout. The analysis of the academic literature and findings of the case study have provided evidence-based feedback with a real-world perspective. These recommendations are based on areas of management and leadership, supervision, training, organization, autonomy, peer support and self-care. While the research has been focused on public sector mental health organizations, these recommendations may be practiced to the benefit of any workplace providing public service. If we do not take measures to prevent burnout in our workplaces, we will further burden a system that is already struggling to provide levels of care required. The costs of burnout do not only have economic implications, but also result in decreasing the quality of life of both service providers and receivers.

References

- American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.
- Blom, V. (2012). Contingent self-esteem, stressors and burnout in working women and men. *Work, 43*(2), 123-131.
- Breen, M., & Sweeney, J. (2013). Burnout: The experiences of nurses who work in inner city areas. *Mental Health Practice, 17*(2), 12-20.
- British Columbia Association of Clinical Counsellors (2014). Ethics Code and Standards of Practice. Accessed from: <http://bc-counsellors.org/wp-content/uploads/2014/07/BCACC-Code-of-Ethical-Conduct-2014.pdf>
- Creswell, J.W. (2009). *Research design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed.). Thousand Oaks, CA: Sage.
- Freudenberger, H. J. (1977). Speaking from experience. *Training & Development Journal, 31*(7), 26.
- Hätinen, M., Mäkikangas, A., Kinnunen, U., & Pekkonen, M. (2013). Recovery from burnout during a one-year rehabilitation intervention with six-month follow-up: Associations with coping strategies. *International Journal Of Stress Management, 20*(4), 364-390.
doi:10.1037/a0034286

- Kraus, V. I. (2005). Relationship Between Self-Care and Compassion Satisfaction, Compassion Fatigue, and Burnout Among Mental Health Professionals Working with Adolescent Sex Offenders. *Counseling & Clinical Psychology Journal*, 2(2), 81-88.
- Langle, A. (2003). Burnout—Existential Meaning and Possibilities of Prevention. *European Psychology*, 4(1), 107-122.
- Lindwall, M., Gerber, M., Jonsdottir, I. H., Börjesson, M., & Ahlborg, G. r. (2013). The Relationships of Change in Physical Activity With Change in Depression, Anxiety, and Burnout: A Longitudinal Study of Swedish Healthcare Workers. *Health Psychology*, doi:10.1037/a0034402
- Maslach, C. (2003). Job Burnout: New Directions in Research and Intervention. *Current Directions In Psychological Science*, 12(5), 189-192. doi:10.1111/1467-8721.01258
- Maslach, C., Leiter, M. P., & Jackson, S. E. (2012). Making a significant difference with burnout interventions: Researcher and practitioner collaboration. *Journal Of Organizational Behavior*, 33(2), 296-300. doi:10.1002/job.784
- McKenzie Deighton, R., Gurriss, N., & Traue, H. (2007). Factors affecting burnout and compassion fatigue in psychotherapists treating torture survivors: Is the therapist's attitude to working through trauma relevant?. *Journal Of Traumatic Stress*, 20(1), 63-75.

doi:10.1002/jts.20180

Newell, J. M., & MacNeil, G. A. (2010). Professional Burnout, Vicarious Trauma, Secondary Traumatic Stress, and Compassion Fatigue: A Review of Theoretical Terms, Risk Factors, and Preventive Methods for Clinicians and Researchers. *Best Practice In Mental Health, 6*(2), 57-68.

Oser, C. B., Biebel, E. P., Pullen, E., & Harp, K. H. (2013). Causes, Consequences, and Prevention of Burnout Among Substance Abuse Treatment Counselors: A Rural Versus Urban Comparison. *Journal Of Psychoactive Drugs, 45*(1), 17-27.

doi:10.1080/02791072.2013.763558

Puig, A., Baggs, A., Mixon, K., Park, Y., Kim, B., & Lee, S. (2012). Relationship between job burnout and personal wellness in mental health professionals. *Journal Of Employment Counseling, 49*(3), 98-109. doi:10.1002/j.2161-1920.2012.00010.x

Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion Fatigue, Compassion Satisfaction, and Burnout: Factors Impacting a Professional's Quality of Life. *Journal Of Loss & Trauma, 12*(3), 259-280. doi:10.1080/15325020701238093

Thieleman, K., & Cacciatore, J. (2014). Witness to Suffering: Mindfulness and Compassion Fatigue among Traumatic Bereavement Volunteers and Professionals. *Social Work, 59*(1), 34-41.

- Thomas, C. H., & Lankau, M. J. (2009). Preventing burnout: the effects of LMX and mentoring on socialization, role stress, and burnout. *Human Resource Management, 48*(3), 417-432.
- Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and Contextual Predictors of Mental Health Counselors' Compassion Fatigue and Burnout. *Journal Of Mental Health Counseling, 36*(1), 58-77.
- Warren, C. S., Schafer, K. J., Crowley, M. J., & Olivardia, R. (2013). Demographic and work-related correlates of job burnout in professional eating disorder treatment providers. *Psychotherapy, 50*(4), 553-564. doi:10.1037/a0028783
- Yin, R.K. (2014). *Case study research: Design and methods* (5th ed.). Thousand Oaks, CA: Sage.

Appendix A: E-mail script

E-mail script

Hello _____,

I was wondering if you would be willing to be interviewed for a case study for my thesis research? I am doing a literature review on the topic, forming a case study for comparison /convergence of findings, and then discussing results and recommendations.

This study is based around the following research questions: What are the leading causes of burnout among medical and mental health professionals? What are some recommendations and necessary adaptations, to decrease or eliminate these experiences for these types of professionals?

The process will entail a short survey (scales, multiple choice, and short answer), followed by a short interview to go into further depth of responses. The whole process should take an hour to complete. Your participation will be kept anonymous, all of the information will be kept confidential, and the data will be carefully destroyed.

If you agree, please email me back. I hope to hear from you, soon.

Kind regards,

Inder Kauldher

Appendix B: IRB approved participant informed consent form

CITYU RESEARCH PARTICIPANT INFORMED CONSENT

I, _____, agree to participate in the following research project to be conducted by Inder Kauldher, faculty member or student, in the Master of Counselling Program. I understand this research study has been approved by the City University of Seattle Institutional Review Board.

I acknowledge that I have received a copy of this consent form, signed by all persons involved. I further acknowledge that I have been provided an overview of the research protocol as well as a detailed explanation of the informed consent process.

Title of Project:

Exploring the causes of burnout in healthcare professions & recommendations for improvement

Name and Title of Researcher(s):

Inder Kauldher, B.A. B.Ed. Master of Counselling (candidate)

For Faculty Researcher(s):

Department:

Telephone:

Email:

Immediate Supervisor:

For Student Researcher(s):

Faculty Supervisor: Glen Grigg, Ph.D. R.C.C

Department: Counselling

Telephone: 604.986.0534

E-mail: glengrigg@shaw.ca

Program Coordinator (or Program Director):

Colin Sanders

Sponsor, if any:**Purpose of Study:**

The purpose of this study is to gather information to build a case study for convergence and contrast, in respect to literature findings on topic.

Research Participation:

I understand I am being asked to participate in this study in one or more of the following ways (the checked options below apply):

- Respond to in-person and/or telephone Interview questions;
- Answer written questionnaire(s);
- Participate in other data gathering activities, specifically, _____;
- Other, specifically, _____.

I further understand that my involvement is voluntary and I may refuse to participate or withdraw my participation at any time without negative consequences. I have been advised that I may request a copy of the final research study report. Should I request a copy, I understand I may be asked to pay the costs of photocopying and mailing.

Confidentiality

I understand that participation is confidential to the limits of applicable privacy laws. No one except the faculty researcher or student researcher, his/her supervisor and Program Coordinator (or Program Director) will be allowed to view any information or data collected whether by questionnaire, interview and/or other means. If the student researcher’s cooperating classroom teacher will also have access to raw data, the following box will be checked. All data (the questionnaires, audio/video tapes, typed records of the interview, interview notes, informed consent forms, computer discs, any backup of computer discs and any other storage devices) are kept locked and password protected by the researcher. The research data will be stored for 7 years (5 years or more if required by local regulations). At the end of that time all data of whatever nature will be permanently destroyed. The published results of the study will contain data from which no individual participant can be identified.

Signatures

I have carefully reviewed and understand this consent form. I understand the description of the research protocol and consent process provided to me by the researcher. My signature on this form indicates that I understand to my satisfaction the information provided to me about my participation in this research project. My signature also indicates that I have been apprised of the potential risks involved in my participation. Lastly, my signature indicates that I agree to participate as a research subject.

My consent to participate does not waive my legal rights nor release the researchers, sponsors, and/or City University of Seattle from their legal and professional responsibilities with respect to this research. I understand I am free to withdraw from this research project at any time. I further understand that I may ask for clarification or new information throughout my participation at any time during this research.

Participant’s Name:
Please Print

Participant’s Signature: _____ Date: _____

Researcher’s Name: Inder Kauldher
Please Print

Researcher’s Signature: _____ Date: _____

If I have any questions about this research, I have been advised to contact the researcher and/or his/her supervisor, as listed on page one of this consent form.

Should I have any concerns about the way I have been treated as a research participant, I may contact the following individual(s):

Colin Sanders, Program Coordinator (and/or Program Director), City University of Seattle, at 789 W Pender St., Vancouver BC; 604.689.2489; csanders@cityu.edu (address, direct phone line and CityU email address).

Appendix C: Procedure Script

Procedure Script

Thank you again for agreeing to participate in my research.

We will begin with the survey. I have a printed copy for you to complete.

I will give you some time to complete the survey, and I will return in 15 minutes.

If you have any questions or need clarification, you may ask me at that time.

There is no rush to complete this survey, so please take your time.

Thank you for completing the survey portion of our meeting. Do you have any questions or concerns regarding the survey?

I am now going to briefly skim your responses so that I can better focus the interview questions to areas where more detail is required. Please allow 5 minutes for this, and then we will begin.

Now, I'm going to be asking you a series of questions that I have prepared.

I will also be making an audio recording during the interview. Just as with any data you provide me, it will be kept confidential and carefully destroyed once the research has been compiled and published. Do you have any concerns regarding this?

Let's begin.

Appendix D: Survey on professional burnout

Survey: Professional Burnout in the Mental Health Profession

I agree to take part in this study, which has been explained to me. I have been given an opportunity to ask questions about the study. I understand that any questions I answer will be anonymous, and that my identity will not be disclosed at any point. I also understand that my participation is completely voluntary, and I may withdraw from the study at any time. I am 18 years old or over, and am legally able to provide consent.

Signature of participant

date:

I agree with terms above.

Please check all responses that apply, and provide further information where required.

1. Gender:

- Female
- Male
- Other

2. What is your age in years? _____

3. Ethnicity origin (or Race): Please specify.

4. Marital/Relationship Status (choose best answer):

- Single, never married
- Married or domestic partnership
- Widowed
- Divorced
- Separated

5. Do you have any dependents or children?

- No
- Yes

*If you answered “yes””, please provide number of individuals and ages, in the space provided below.

6. What is the highest level of schooling you have completed?

- Some high school, no diploma
- High school graduate, diploma or equivalent
- Some college
- Associate degree
- Bachelor’s degree
- Master’s degree
- Professional degree
- Doctorate degree

7. What is your current professional title & years of practice?

8. Which sector do you work for?

- Public
- Private

9. What are some of the different professional roles of mental health providers in your organization? Please fill out the table below. Estimate if required.

Title of Professional Role	# of Positions

10. How many hours (on average), do you work per week:

- 20-30 hours
- 30-40 hours
- 40-50 hours
- 50-60 hours
- 60+ hours

11. On average, how many clients are on your caseload at a time?

- 5-10
- 10-15
- 15-20
- 20-25
- 25-30
- 30+

12. Please answer the following questions using a 5-point scale, as described below:

Point	Description
1	very unsatisfied
2	unsatisfied
3	satisfied
4	very satisfied
5	completely satisfied

A. Using the 5-point scale, how satisfied are you with the level of leadership and management:

1	2	3	4	5
---	---	---	---	---

B. Using the 5-point scale, how satisfied are you with the level of autonomy in decision making?

1	2	3	4	5
---	---	---	---	---

C. Using the 5-point scale, how satisfied are you with the level of guidance and supervision within your organization?

1	2	3	4	5
---	---	---	---	---

D. Using the 5-point scale, how satisfied are you with the level of training and resources provided by your organization?

1	2	3	4	5
---	---	---	---	---

13. How many times per week do you take part in self-care practices, for personal well-being (ie. yoga, time with friends/family, volunteering, etc.):

- less than 1
- 1-2
- 3-4
- 4-5
- 6-7

Appendix E: Interview Questions

Interview Script for Case Study

1. What are some of your roles and duties in your organization?
2. What are some of the main issues or concerns your clients are receiving services for?
3. How do you decide whether your caseload is balanced?
4. What do you do if you find that your caseload is too “heavy” for you to provide optimal service?
5. Does professional stress ever impact your personal life? If so, please describe how?
6. I'm going to hand you a description of "burnout" so that you have it with you as you reflect.

Burnout is defined as a “state of physical, emotional and spiritual fatigue caused by long-term exposure to demanding work stressors (Sherring & Knight, 2009, as cited in Breen & Sweeney, 2013, p. 12). Maslach (1982, as cited in Sprang, Clark, & Whitt-Woosley, 2007) defined burnout as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment”.

Based on this definition, do you feel that you have experienced professional burnout? If so, please describe.

If and when this situation improved, what helped your restore balance?

7. What do you feel a workplace or organization can do to decrease levels of burnout?
8. What practices are currently in place at your organization, to decrease levels of burnout?
9. What do your self-care practices include?
10. Do you feel that your self-care practices are adequate? Why or why not?
11. What, if any, advice would you give to new professionals entering the field of mental health?

This concludes the data collection for the case study. Thank you again for your time. I really appreciate it. If you have any concerns at all, do not hesitate to contact me.