ADDRESSING COMPASSION FATIGUE, VICARIOUS TRAUMA, AND BURNOUT IN A COMMUNITY MENTAL HEALTH ORGANIZATION: AN ACTION RESEARCH STUDY

by

JEMECIA NATASHA CALVIN-CLAXTON

(Under the Direction of Karen E. Watkins)

ABSTRACT

The turnover rate of clinicians working in community outpatient mental health centers is alarming. The significant turnover at a community mental health organization prompted a study of burnout, compassion fatigue, and vicarious trauma. An action research (AR) study was conducted using Price and Mueller's (1981) causal model of turnover theory and a mixed methods approach to study the problem. The following research questions guided the study:

1) What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion fatigue, vicarious trauma, and burnout in an outpatient community mental health organization?
2) What organizational culture and systemic factors affect the experiences of burnout, compassion fatigue, and vicarious trauma in clinicians working in outpatient mental health centers?

The study's findings indicated that for mental health clinicians working in community mental health outpatient centers, inclusion in their organization's decision-making develops a growth mindset about organizational change and impacts clinicians' perceptions of their value to their

organization. In addition, AR methodology can effectively manage organizational politics, role duality, and the implementation of interventions to address burnout, compassion fatigue, and vicarious trauma. The findings indicated that navigating the complexities of a learning system requires teams to take risks, unlearn learned helplessness, shift perspectives, and execute change strategies. The study also found that a systemic culture of large caseloads, high numbers of acute clients, copious documentation, routinization, and long hours impacts clinicians' turnover and experience of burnout, compassion fatigue, and vicarious trauma.

INDEX WORDS: Burnout, Compassion Fatigue, Vicarious Trauma, Mental Health Clinicians, Community Outpatient Mental Health Centers, Turnover, Retention, Action Research, Causal Model of Turnover Theory

ADDRESSING COMPASSION FATIGUE, VICARIOUS TRAUMA, AND BURNOUT IN A COMMUNITY MENTAL HEALTH ORGANIZATION: AN ACTION RESEARCH STUDY

by

JEMECIA NATASHA CALVIN-CLAXTON

BS, Jacksonville State University, 1996

MS, Jacksonville State University, 1998

A Dissertation Submitted to the Graduate Faculty of The University of Georgia in Partial Fulfillment of the Requirements for the Degree

DOCTOR OF EDUCATION

ATHENS, GEORGIA

2024

ADDRESSING COMPASSION FATIGUE, VICARIOUS TRAUMA, AND BURNOUT IN A COMMUNITY MENTAL HEALTH ORGANIZATION: AN ACTION RESEARCH STUDY

by

JEMECIA NATASHA CALVIN-CLAXTON

Major Professor:	Karen E. Watkins
Committee:	Juanita Johnson-Bailey
	Rosemary E. Phelps

Electronic Version Approved:

Ron Walcott
Vice Provost for Graduate Education and Dean of the Graduate School
The University of Georgia
December 2024

DEDICATION

This dissertation is dedicated in loving memory of my father, Sergeant First Class Albert Bennett Calvin, Sr., who supported me through my doctoral journey but passed away prior to seeing me complete it. You would have been extremely proud of my accomplishment. Also, I dedicate this dissertation to my amazing family, my wonderful husband, mother, sister, sisters-in-laws, brothers, brothers-in-law, bonus children, grandchildren, aunts, uncles, nieces, nephews, cousins, and friends who covered me with their prayers, love, words of encouragement, understanding of absenteeism at times, and immense support.

ACKNOWLEDGEMENTS

To my amazing husband, David Claxton, Jr., you are truly a Godsend. Thank you for praying over me and with me, your unwavering love, and positive “You Got This” attitude. I am eternally grateful for how you supported me through this journey. You hold an honorary doctorate in my heart. The “you got this” sign you bought for my desk will always remind me of this journey. You are my biggest cheerleader, and I could not have done this without you.

To my mom, you are truly a blessing, and I could not have asked for a better mother. You set the example by showing me that I can do anything that I put my mind to. During the highs and lows of this journey, your steadfast reminders that I was made for this journey, your pride, and optimism meant the world to me. Thank you!

To my sister-friend, Dr. Kenya McKinley Cistrunk, my appreciation of you can never be expressed enough. You were the first person to tell me about this program and encouraged me to step out on faith to obtain the dream that I have had for many years to receive my doctoral degree. Thank you for your prayers, guidance, friendship, sisterhood, knowledge, wisdom, and listening ears.

To my sister, brothers, nieces, and nephews, thank you so much for supporting me through this journey. I appreciate the check-ins, words of encouragement, and aspirational conversations. I look forward to celebrating with each of you on your journey.

To the Learning, Leadership, and Organization Development Cohort 6, Better Together subgroup, Melanie Prasad-Dehaney, Heather Williams, Cortney Laughlin, Dr. Latrese Ferguson, Dr. Michelle Eaton, and Dr. Liz Hubbs, thank you for being a part of this journey and for

cheering me on to the end. Soror Latrese, I greatly appreciate your text messages, being a trailblazer, and check-ins to encourage me to keep pushing forward.

To my action research team, supervisor, and organization, this journey could not have been achieved without your support, participation, and willingness to learn with me and from me. I am eternally grateful.

To Dr. Lisa Oliver, I am so grateful that Dr. Karen Watkins connected us. Thank you for sharing the knowledge and wisdom you gained from this program to guide me. I will pay it forward.

To Dr. Karen Watkins, thank you for your brilliant mind, amazing support, interest in my research project, and the guidance you provided me. I could not have asked for a more complete major professor. To my other committee members, Dr. Juanita Johnson-Bailey and Dr. Rosemary Phelps, you all are the essence of a doctoral dream team. Thank you for your time, support, guidance, and wisdom.

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

This chapter outlines the context of this study and the purpose/research questions. I review the relevant theoretical and empirical literature and situate the study within that literature. I then outline the conceptual framework that undergirds the action research (AR) study. The chapter proceeds according to the following structure: First, terms are defined; second, a brief overview of mental health organizations and services is provided; third, the problem of this study is defined; fourth, a review of the relevant literature is offered. Finally, the chapter concludes by describing the organization that forms the core of this AR study.

Mental Health, Mental Illness, and Mental Health Organizations

Background and Definitions

The news media portrays a barrage of stories about individuals with mental illnesses. Often, these stories depict people with mental illness as the active shooter who guns down innocent bystanders at a church service or the individual who enters a school and unleashes unprovoked torment on school children. As heinous and disturbing these images are, mental illness ranges beyond these extreme examples. Mental illness also encapsulates the individual who experiences suicidal ideation from a sexual assault, the child who exhibits explosive behaviors because s/he does not have the vocabulary to verbalize the trauma s/he has witnessed and/or expressed, or the person with a substance abuse problem who started abusing prescription medication after treatment for a back injury. In this chapter, I provide definitions of mental health and mental illness, examine the establishment of community mental health services,

explore the work environment of clinicians who work at community mental health organizations, and demonstrate the need for the reform of outpatient mental health centers to mitigate the exposure of clinicians to compassion fatigue, burnout, and vicarious trauma.

Definitions of Terms

In this section, I provide definitions of mental health, mental illness, and the conditions of compassion fatigue (CF) (also known as secondary traumatic stress [STS]), burnout, and vicarious trauma (VT), the impact of which will be examined in the present study.

Mental Health

For the purposes of this work, *mental health* is defined as follows:

> a dynamic state of internal equilibrium which enables individuals to use their abilities in harmony with universal values of society. Basic cognitive and social skills; ability to recognize, express and modulate one's own emotions, as well as empathize with others; flexibility and ability to cope with adverse life events and function in social roles; and harmonious relationship between body and mind represent important components of mental health which contribute, to varying degrees, to the state of equilibrium. (Galderisi et al., 2015, pp. 231–232)

When individuals struggle in one or more of these areas, they can experience what is termed as mental illness.

Mental Illness

Mental illness is known as a variety of "health conditions involving changes in emotion, thinking or behavior (or a combination of these) … [that] are associated with distress and/or problems functioning in social, work or family activities" (American Psychiatric Association, 2021). According to the Substance Abuse and Mental Health Services Administration

(SAMHSA, 2020), mental illness is diagnosable in individuals experiencing "mental, behavior, or emotional disorder;" serious mental illness (SMI) causes "serious functional impairment, which substantially interferes with or limits one or more major life activities" (SAMHSA, 2020). Mental illnesses are disorders that can be diagnosed by licensed mental health professionals such as psychiatrists, psychologists, licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), physicians, and nurse practitioners. According to the National Institute of Mental Health (NIMH, 2023), nearly one in five American adults, in the course of their lifetime, will suffer from a mental illness. SMI diagnoses include schizophrenia, mood disorders, psychotic disorders, and major depression with psychotic symptoms. Although researchers, service providers, and people with lived experience have joined together to generate evidence-based practices, many people with SMI do not seek treatment or fully participate in treatment (Corrigan et al., 2014).

Compassion Fatigue

Compassion fatigue (CF) means to experience or to bear someone's suffering with them. According to Figley (2002a), "the very act of being compassionate and empathic extracts a cost under most circumstances" (p. 1434). CF is sometimes referred to as *secondary traumatic stress* (STS), which is characterized as stress and negative feelings experienced by a person who is exposed to work-related trauma (O'Callaghan et al., 2020).

Burnout

Burnout is characterized as the cumulative state of frustration, physical, and mental exhaustion that a person feels over time with their work environment that leads to reduced ability to cope (O'Callaghan et al., 2020).

Vicarious Trauma

Vicarious trauma (VT) is the transformation that occurs in clinicians because of their empathic engagement with clients' trauma narratives (Pearlman & Mac Ian, 1995).

Mental Health Organizations and Services

In the past, people with severe mental illness would be locked up in mental institutions or asylums (Dvoskin et al., 2020). Today, there are many types of mental health organizations, such as private practice agencies, hospitals, educational institutions, partial hospitalization programs, and community outpatient mental health centers, which provide mental health services. Mental health providers offer different types and levels of services, which can range from individual and group counseling to medication management or mental and substance abuse treatment. Community mental health centers can be privately operated or commissioned and funded by the state to provide services. Public mental health programs were developed in the United States to address the needs of individuals with severe and persistent mental illnesses (Drake & Latimer, 2012). The development of community-based mental health care programs began in 1963 with the passing of the Community Mental Health Act (Drake & Latimer, 2012). According to SAMHSA (2020), the focus of this initiative was to use federal resources to support state, local and private entities to provide services to the mentally ill and developmentally disabled individuals.

Community-Based Mental Health Services and Recipients

Community mental health organizations often serve individuals with trauma histories, witnessed or experienced sexual assaults, childhood trauma, substance abuse, depression, and suicide attempts (Rosenberg, 2011). Moreover, community mental health organizations offer an array of services that are typically affordable and accessible to the community. According to

NIMH (2023), in 2019, an estimated 13.1 million adults aged 18 or older in the United States had a serious mental illness, and 8.6 million (65.5%) of these adults received mental health services. According to the 2018 National Mental Health Services Survey (N-MHSS), 46% of the nearly four million individuals who received mental health services in the United States in 2018 were served by community-based outpatient mental health facilities.

Development of Community Mental Health Services in Georgia

One example of the emergence of community mental health services is observable in the state of Georgia. Rosalynn Carter, mental health advocate and wife of former Georgia governor Jimmy Carter, was instrumental in supporting mental health policy and change in the state (Ellingson, 2020). While many states developed programs through the Community Mental Health Act of 1963, Georgia was slow in its progression to implement accessible mental health programs. In 2009, the governor and general assembly created the Georgia Department of Behavioral Health and Developmental Disabilities (GDBHDD). Its focus was to develop policies, programs, and services for individuals with mental illness, developmental disabilities, and substance abuse disorders in the state of Georgia, with the goal of creating mental health services that were accessible to individuals in their communities (GDBHDD, n.d.). Through this initiative, the GDBHDD established community service boards (CSBs) to operate as comprehensive community providers of mental health, substance abuse, and developmental disabilities services to Georgia's mental health population. CSBs are also considered safety-net providers of mental health treatment for individuals with chronic and acute needs regardless of their ability to pay for services.

Rules for Mental Health Services Providers

In the mental health profession, counselors adhere to their professional discipline's code of ethics, follow professional standards, and maintain best practices. There are strict guidelines, a code of conduct, and disciplinary processes in place to ensure that standards of care and operating procedures govern the behavior of counselors and ensure that practitioners "do no harm" to their clients. A significant amount of attention and education is directed toward the entrance into the field of counseling and the delivery of services; however, there is limited information on how the day-to-day exhaustion, fatigue, and stressful work environment affect counselors' mental and physical health and job performance.

Community Mental Health Services Problem Framing

In the United States, community mental health organizations employ several types of mental health professionals, including psychiatrists, nurse practitioners, nurses, LPCs, LCSWs, and other credentialed mental health professionals. Community mental health organizations are often fast-paced, high-volume, and high-stress environments. Green et al. (2014) and others have described the elevated levels of role conflict and role overload in these high-stress organizational environments. In a study conducted with 182 clinicians, 94 (52%) reported having to work overtime hours (Luther et al., 2017). Cetrano et al. (2017) explained that mental health professionals are subjected to additional emotional strain due to the nature of their work. Clinicians are being stretched to capacity to meet the demands of the job, often in the absence of proper self-care practices. This approach can lead to exhaustion and burnout in mental health professionals.

According to Green et al. (2014), high levels of burnout can negatively influence the quality of care that clients receive and affect clinicians' physical and mental well-being. A study

conducted in Italy that surveyed a sample of 2,000 mental health staff found that nearly two-thirds of the psychiatric staff suffered from exhaustion and burnout (Lasalvia et al., 2018). The primary reasons for exhaustion were face-to-face interaction with clients and high workloads (Lasalvia et al., 2018). A 2012 study (Morse et al., 2012) highlighted that 21% to 61% of mental health professionals experience significant signs of burnout; a 2022 report by SAMHSA cited this figure as over 50%. According to Sultana et al. (2020), the global COVID-19 pandemic has increased the workload, psychological stressors, and symptoms of burnout in healthcare professionals.

Impact of the Problem on Mental Health Clinicians

Many mental health clinicians enter the mental health field with deep compassion and a desire to help people. In the process of helping those who are suffering, clinicians often neglect or are unaware of the signs of distress or burnout within themselves. The literature review helps identify and examine characteristics of workplace environments that increase stress, CF, VT, and burnout. Based on these findings, this study examines the influence of these conditions on mental health clinicians working in outpatient community mental health settings, explores factors contributing to CF, VT, and burnout, and considers theories that are used to address this problem.

According to Morse et al. (2012), several studies have examined aspects of burnout among mental health providers, but few have explored systematic attempts to better understand or ameliorate burnout in mental health; this is noteworthy as burnout is a stress-related psychological condition that is often manifested within the workplace. Maslach et al. (1996) defined burnout as the psychological syndrome of increased emotional exhaustion, depersonalization, and decreased personal accomplishment that is often experienced by people

who work with other people. Studies have increasingly shown burnout to be a significant factor faced by many mental health clinicians (Luther et al., 2017; Morse et al., 2012; Yang & Hayes, 2020). One study estimated that the cost of workplace burnout is between $125 billion and $190 billion annually (Blanding, 2015). Additionally, as noted by Borysenko (2019), burnout is responsible for between 20% and 50% of employee turnover. A Gallup study noted that employees experiencing burnout are 63% more likely to take sick days (Blanding, 2015). Although mental health clinicians are essential to mental health organizations, they are suffering burnout at increasingly high levels.

The work of mental health clinicians requires building relationships, establishing trust, and having compassion for clients. Brown (2020) concluded that mental health clinicians in community-based settings provide services to some of the most vulnerable individuals in society and are exposed to higher levels of stress, which can lead to VT, CF, and burnout. Additional literature has identified that the problem of CF exists at a higher rate in organizations where clinicians work long hours, manage high-volume caseloads of acute clients with severe trauma histories, and are provided with minimum supervision or trauma training in environments where self-care is not prioritized. These types of organizations also have high employee turnover. Salston and Figley (2003) and Dagan et al. (2015) have agreed that clinicians with higher caseloads and chronic life stressors face greater risk of secondary traumatization. According to Killian (2008), the repeated frequency of clinicians' exposure to clients' traumatic material can result in VT and symptoms of posttraumatic stress disorder (PTSD).

Employee turnover in community mental health organizations significantly impacts the continuity of care for clients, employee morale, and the stability of an organization's infrastructure. In short, CF and burnout can significantly impact organizations' finances,

workplace morale, clinicians' psychological well-being, and the quality of service delivery. Despite its significance, this area of research is vastly understudied.

Horizon Mental Health Outpatient Clinicians' Demographics

For the purposes of this study, the organization being studied will be referred to as Horizon Community Mental Health Center (HCMHC). The outpatient mental health clinician demographic information was collected from clinicians at all five outpatient centers and included clinicians' age, gender, ethnicity, and academic degree level and license type. Data regarding the number of years in the mental health field and number of years with the agency was requested, but there were significant gaps in the submission of this information. A total of 38 clinicians were represented across the five outpatient centers. A total of 33 individuals identified as female and five as male. Of the 38 clinicians, 13 clinicians were African American, 12 Hispanic, 12 Caucasian, and 1 Asian. Clinician ages ranged from the 20s to 60+ years of age. A total of 12 clinicians reported being between the ages of 20–29, 10 clinicians between 30–39, seven clinicians between 40–49, six clinicians between 50–59, and three clinicians above the age of 60.

In terms of professional license type and academic degree level, all clinicians were licensed to practice in the state of Georgia. Thirteen clinicians were licensed professional counselors (LPCs), 10 were licensed clinical social workers (LCSWs), seven were licensed associate professional counselors (LAPCs), and four were licensed master social workers (LMSWs). The status of LAPC or LMSW is a licensure status given to clinicians who hold a master's degree in mental health counseling or social work but have not yet fulfilled the requirements and supervision needed to obtain full licensure as an LPC or LCSW in the state of Georgia. Three clinicians were classified as student trainees (S/Ts). This title is provided to clinicians who hold a master of science degree in mental health counseling or social work but

have not yet acquired associate-level licensure. Finally, one clinician identified as a psychologist with a doctorate of philosophy (PhD). The pie charts shown in Figures 1.1–1.4 delineate the gender, age, ethnicity, and licensure types and percentages of the clinicians working in an outpatient program at HCMHC. Table 1.1 identifies the clinicians' demographics per outpatient program.

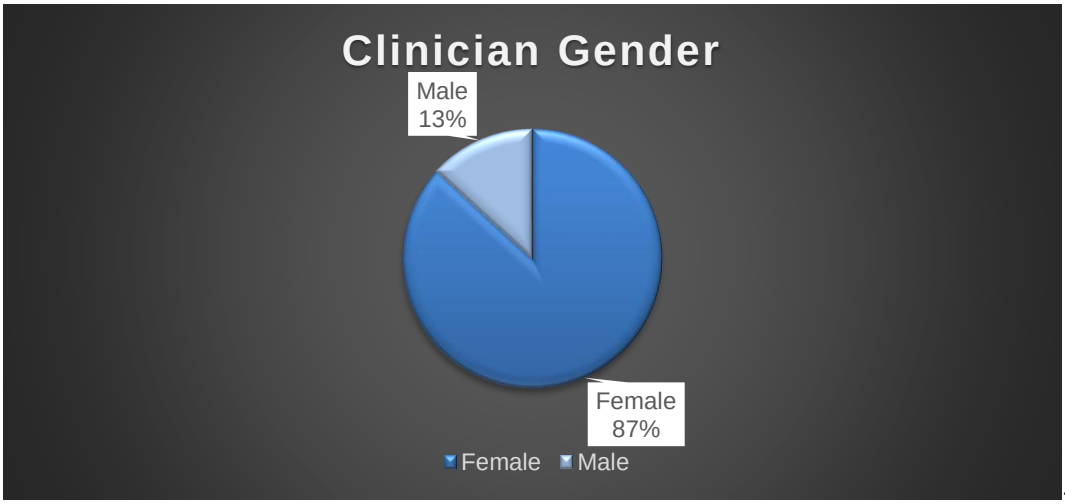

Figure 1.1. *Clinician Gender Pie Chart.*

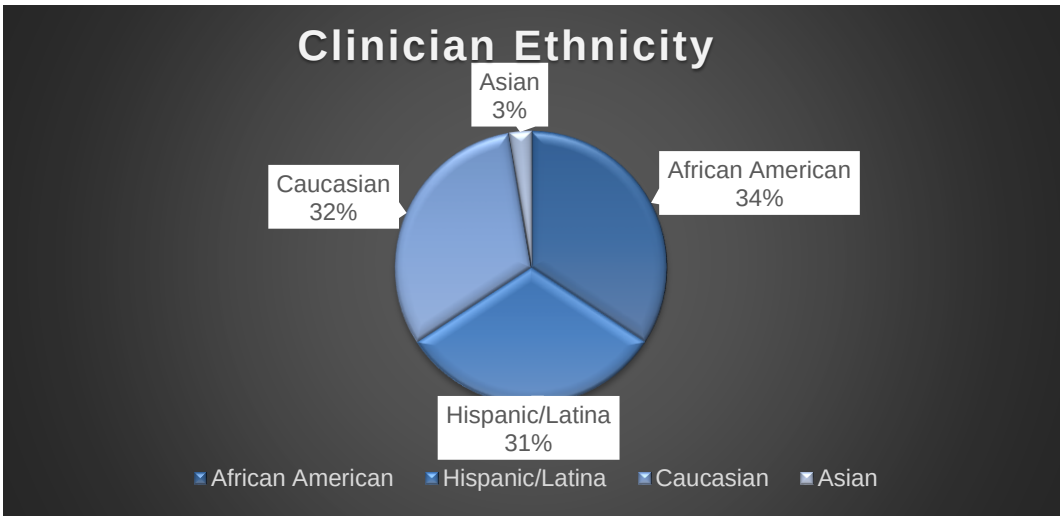

Figure 1.2. *Clinician Ethnicity Pie Chart.*

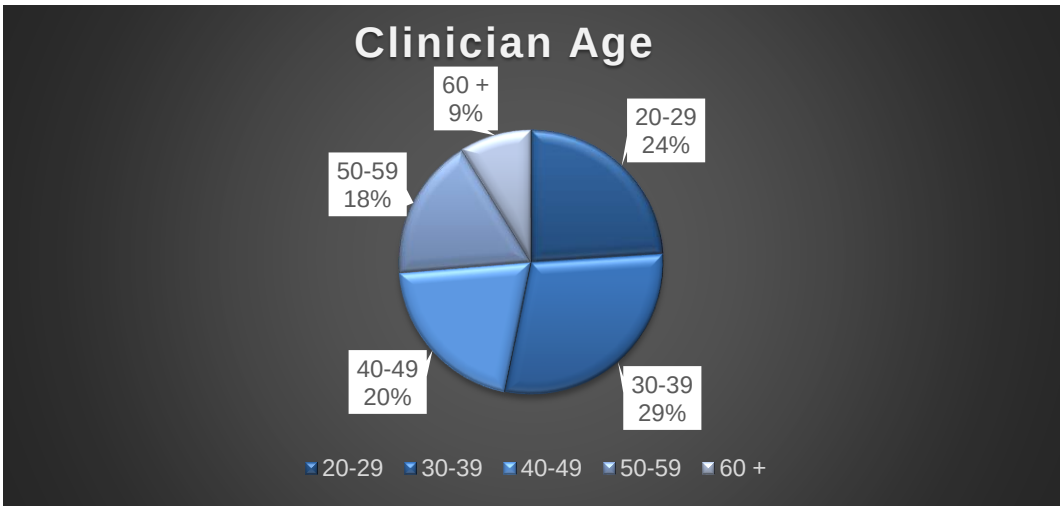

Figure 1.3 *Clinician Age Pie Chart.*

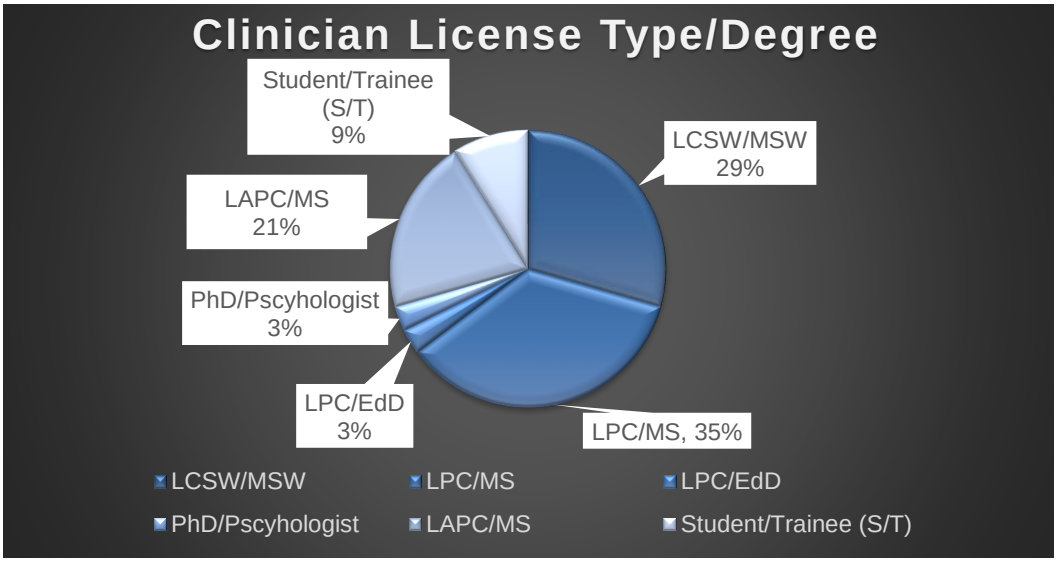

Figure 1.4. *Clinician Licensure & Degree Pie Chart.*

Table 1.1

Clinician Demographics per Outpatient Program

Gender	Clinician age	Degree	Time in field	Time with agency	Race
Program D					
Female	20s	LMSW	3 years	2 years	African American
Female	20s	LAPC	1 year	Less than 1 year	Caucasian
Female	20s	LMSW	1 year	1	Asian
Female	20s	S/T	< 1 year	< 1 year	African American
Male	30s	LCSW	8 years	7 years	Caucasian
Female	30s	LCSW	-	3 years	Latina
Female	50s	PhD	-	-	Latina
Female	60s	LCSW	-	-	African American
Program C					
Female	20s	LPC	-	1 year 7 months	Caucasian
Female	30s	LAPC	-	1 year 5 months	African American
Female	40s	LPC	-	2 years	African American
Female	40s	LCSW	-	6 years 9 months	African American
Female	60s	LCSW	-	8 years	Caucasian
Female	70s	LCSW	-	10 years 2 months	Caucasian
Program L					
Female	20s	LPC/MS	5 years	2 years	Caucasian
Female	20s	LCSW/MSW	4 years	2 years	Caucasian
Female	30s	LAPC/MS	5 years	6 months	African American
Female	40s	LAPC/MS	2.5 years	1 year	African American
Female	40s	S/T	1 year	1 month	African American
Female	40s	LCSW/ MSW	22 years	22 years	Caucasian
Female	50s	LPC/EdD	4 years	3 years	African American
Male	60s	LCSW/MSW	10 years	3 years	Caucasian
Program E					
Female	20s	LMSW	2 years	1 year	Caucasian
Female	30s	LPC	3 years	10 months	African American
Female	30s	LPC	3 years	3 years	Caucasian
Male	40s	LPC	25 years	10 years	African American

Gender	Clinician age	Degree	Time in field	Time with agency	Race
Female Program A	50s	LCSW	27 years	8 years	African American
Female	20	APC/MS	-	1 year	Hispanic
Male	20	LPC/MS	6 years	3 years	Hispanic
Male	20	ST/MS	-	2 months	Hispanic
Female	20	LPC/MS	5	3	Hispanic
Female	30	LPC	7.5 years	3 years	Hispanic
Female	30	LPC/MS	5	3	Hispanic
Female	30	LPC/MS	10	3	Hispanic
Female	40	APC/MS	-	8 months	Hispanic
Female	50	LMSW/MS	-	2 years	White
Female	50	APC/MS	5 years	3 years	Hispanic
Female	50	LPC/MS	14	3	Hispanic

Literature Review

An array of empirical studies have focused on burnout, CF, STS, and VT. Various theories have also examined the problems of CF, VT, and burnout at the individual and organizational levels. Numerous studies have involved health care workers (primarily nurses) to examine theory-based interventions used to inform the study of CF, VT, and burnout. Other studies focused on specific social service fields, for example, addictions counseling and child protection services. However, there is a gap in the literature regarding the impact of CF, VT, and burnout on mental health clinicians working in outpatient community mental health organizations. The research reviewed showed correlations among CF, VT, and burnout. Although some studies used these terms interchangeably, the literature review provides clarity and notes the distinctions among these three concepts. Furthermore, most of the literature reviewed does not focus on one specific area but combines research in the areas of burnout, CF,

and VT. Thus, the literature review provided in this section examines (a) Maslach's burnout inventory, (b) Figley's theories of STS and CF, and (c) McCann and Pearlman's theory of VT. Table 1.2 depicts the differences and overlap in descriptions of CF, VT, and burnout.

Table 1.2

Characteristics and Comparison of Burnout, Compassion Fatigue, and Vicarious Trauma

Burnout (Lingard, 2010)	Compassion fatigue (Figley, 2002)	Vicarious trauma
• Occurs over a period of time • Experience of emotional exhaustion • Diminished sense of accomplishment • Cynicism • Combines individual and environmental factors	• Empathy (motivation to respond to someone's pain) • Exposure to the client (emotional energy) • Desensitization (feelings of helplessness) • Sense of isolation • Presence of traumatic memories	• Empathetic engagement and exposure to clients' trauma material • Depression • Cynicism

Burnout

Much modern psychological research on work-related burnout was influenced by the work of German-born American psychologist and psychoanalyst Herbert Freudenberger, who coined the term *burnout* in 1974. His research focused extensively on staff burnout, which he noted was related to the expectations and motivations of the team or workplace leader. Freudenberg described physical and behavioral signs of burnout experienced by staff. He later published books and articles on staff burnout such as *The High Cost of Achievement* (1980). In short, he asserted that burnout is a phenomenon that can be experienced by individuals in various

professions. Thus, it is not confined to individuals working only in a helping profession or caused by direct exposure to the clients' trauma narratives.

Building on Freudenberger's work, in the 1980s, Christina Maslach, an expert on work-related burnout, developed an assessment tool to measure burnout, the Maslach Burnout Inventory (MBI), which assesses the three components of burnout: (a) emotional exhaustion, (b) depersonalization, and (c) reduced personal achievement (Maslach et al., 1996). This scale is widely used today in measuring burnout in individuals. In 1982, Maslach further defined burnout as a syndrome. According to Maslach and Leiter (2005), there are six categories of burnout:

1) workload (too much work, not enough resources)
2) control (micromanagement, lack of influence, accountability without power)
3) reward (not enough pay, acknowledgment, or satisfaction)
4) community (isolation, conflict, disrespect)
5) fairness (discrimination, favoritism)
6) values (ethical conflicts, meaningless tasks) (p. 44)

Maslach and Leiter (2005) concluded that to remedy burnout, individuals and organizations must identify where they are misaligned and then work to bridge a solution.

Multiple studies have also considered interrelationships among CF, VT, and burnout. The literature supports Maslach and Jackson's (1981) theory that burnout can emerge from extreme VT and CF. Sansbury et al. (2015) investigated the impact of trauma stress responses in clinicians as well as the impact of VT, CF, and burnout on organizations. The result of this research determined that self-care practices benefit the client, clinicians, and organization and can provide clearer thinking and emotional stability of the clinician (Sansbury et al., 2015). Additionally, the research found that trauma responses in clinicians occur when clinicians are

exposed to prolonged trauma material; this should be monitored and assistance provided from the organization to promote clinicians' overall well-being (Sansbury et al., 2015). Organizations with high demands on staff and minimal support systems experience a higher level of burnout among the mental health professionals they employ. One study conducted with 782 police officers, firefighters, and child welfare workers corroborated the relationship among CF, burnout, and VT (Argentero & Setti, 2011). Although this study provided supportive data that burnout and CF exist in the helping professions, insufficient data were available showing the impact of CF, VT, and burnout in mental health clinicians working in an outpatient mental health organization. Nonetheless, this article concurred with Sprang et al. (2007), Rossi et al. (2012), and Dagan et al. (2015) that organizations that provide a supportive education base and collaborative infrastructure can help mitigate the effects of burnout and VT in helping professionals.

Other factors inhibit organizations from eliminating the impact of CF, VT, and burnout. Allsbrook et al. (2016) examined the relationship among the supervisory role, CF, and burnout in genetic counselors. The purpose of the study was to determine whether there was an increased correlation of CF and burnout among genetic counselors who held a supervisory role versus those who did not. Genetic counselors who were supervisors completed online surveys that gathered specific information on demographics and used the Professional Quality of Life (ProQOL) scale and the State-Trait Anxiety Inventory (STAI). The findings showed evidence that supervisors with less experience were more likely to experience CF and a decrease in compassion satisfaction (CS); those supervisors with a lower degree of CS were more likely to be less effective in providing adequate supervision to clinicians. Additionally, the levels of trait anxiety and other factors contributed to increased CF among these supervisors. Overall, the study

determined that genetic counselors and genetic counselor supervisors are at higher risk for CF and burnout. Moreover, CF and burnout disproportionately impact supervisors due to factors such as education level, training, experience, confidence, and management of stress. However, this study did not suggest evidence-based measures to decrease the risk of burnout and CF in supervisors and genetic counselors.

Secondary Traumatic Stress

In 1978, Charles Figley, founder of the Traumatology Institute, introduced the concept of secondary traumatic stress disorder (STSD), which can be diagnosed in those who experience distress from hearing the trauma narratives of another person. Figley defined STSD as a syndrome associated with PTSD; however, STSD occurs in the person connected to the sufferer (Figley, 2002a). The term "disorder" in STSD held a negative connotation as it was closely related to the diagnosis of PTSD and what was experienced by war veterans. Figley (2002b) later noted that "compassion fatigue (CF) is a more user-friendly term for STSD, which is nearly identical to PTSD, except that it applies to those emotionally affected by the trauma of another" (p. 3). Thus, Figley (2002b) posits that CF was a more appropriate term than STSD. Additionally, Figley's research noted the congruence of STSD with countertransference, an element found in psychodynamic therapy. Research by McCann and Pearlman (1990) identified connections between STSD and clinicians' cognitive schemas (Figley, 1995). Their findings concluded that clinicians' experiences, history, and schemas play a role in how they respond to the trauma narratives of their clients (McCann & Pearlman, 1990).

Compassion Fatigue

Nurse and researcher Carla Joinson introduced the term "compassion fatigue" to the medical field in 1992. Joinson identified CF as a unique form of burnout that is directly linked to

helping professionals, particularly nurses (Carlson-Johnson et al., 2020). Based on the foundation established by Joinson, Charles Figley (1995) expanded CF theory beyond nurses to include other helping professionals whose careers require deep compassion, care, and empathy for others. Figley further postulated that CF is a natural phenomenon arising from working with people who have experienced extremely stressful events in their lives. Figley's initial study of CF sought to understand the impact of helping veterans who had been traumatized by the Vietnam War. In interviewing veterans, Figley (2002a, 2002b) associated the memories and flashbacks that the veterans had with what was later diagnosed as PTSD. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes PTSD as caused by trauma that is experienced or witnessed (American Psychiatric Association, 2022). Figley's research eventually expanded beyond veterans to include others exposed to traumatic distress.

Compassion fatigue is an area of concern for mental health clinicians working in mental health organizations. As Figley (2002a) noted, "In our effort to view the world from the perspective of the suffering, we suffer" (p. 1434). An Italian study concluded that mental health professionals experience organizational stressors similar to those encountered by professionals in other helping professions but that the nature of mental health work introduces additional emotional strain and stress, especially when working with distressed individuals for extended periods of time (Cetrano et al., 2017). Cetrano et al. proposed that, to address compassion fatigue within an organization, managers should pay attention to time pressures, build trusting relationships, provide adequate training for therapists, and build solid support systems. Killian (2008) concluded that mental health clinicians who work within a clearly defined team environment experienced less psychological strain and reported greater job satisfaction and longer organizational commitment.

Sprang et al. (2007) used the ProQOL scale, a self-assessment tool that measures risk levels of CF, compassion satisfaction (CS), and burnout, to examine factors impacting the professional quality of life of clinicians, especially those working with high-risk clients with a persistent mental illness and trauma history. Their research concluded that the work environment is a factor that increases clinicians' exposure to CF, VT, and burnout, which decreases CS. Additionally, risk factors associated with clinicians' long workhours, acute clients, and large caseloads were noted to increase CF and STS. Sprang et al. also reiterated the limited number of studies that have examined CF and STS.

Rossi et al. (2012) conducted a qualitative study examining CF as an occupational hazard specific to mental health clinicians who work with severely emotionally distressed clients. Their research delineated the differences in CF, burnout, and compassion satisfaction (CS). The research used General Health Ethical Review Board-approved questionnaires that were submitted anonymously to mental health workers. Rossi et al. analyzed stress exposure, high caseloads, and exposure to clients' trauma narratives as indicators of CF and STS. While the research did not present identifiable ways on how organizations can address CF, STS, and burnout, it did acknowledge that specialized trauma training, reflective writing, and fixed-term contracts can increase individuals' CS. This study further supports the need for an AR study to identify growth opportunities at outpatient mental health organizations to address CF, burnout, and VT.

Vicarious Trauma

Prior to the conceptualization of vicarious trauma (VT), the term burnout was used to describe the challenges experienced by helping professionals in working with complex clients. In 1990, McCann and Pearlman coined the term vicarious trauma when they introduced their VT

theory. The authors used constructivist self-development theory to understand the psychological impact of working with trauma survivors (McCann & Pearlman, 1990). According to McCann and Pearlman (1990), continued exposure to VT can lead to burnout. Furthermore, McCann and Pearlman espoused that Freud's concept of countertransference supports understanding the complex phenomenon of VT, as personal schemas exert considerable impact on therapists' response to traumatic exposures. McCann and Pearlman's research determined that the psychological impact of clients' trauma experiences can have a lasting and painful effect on the clinician months or even years after working with the traumatized client.

Countertransference continues to be rooted in the understanding of the mental health professional's reaction to the client's trauma narratives. In 1992, Judith Herman, an American psychiatrist and researcher expanded on this concept. Herman (2002) and Figley (2002) agreed that vicarious traumatization is what therapists experience when hearing their clients' trauma narratives. According to Herman (2002), trauma is contagious and "destroys the social system of care, protection, and meaning that supports human life" (p. S98). Herman's research recognized the negative impact of trauma on the system, trauma victims, and therapists. She asserted that therapists who work with traumatized clients need a strong support system.

Finklestein et al. (2015) investigated variables that linked PTSD and VT to mental health clinicians who were exposed to high levels of trauma after a rocket attack on the Gaza Strip. Factors that contributed to the trauma were specifically connected to the mental health clinician's training, work demands, caseload, and job-related support system. Finklestein et al. (2015) asserted that organizational support provided through debriefings, supervision, and training were ways to mitigate the effect of VT in mental health professionals.

In the same vein, Dagan et al. (2015) examined contributing factors for secondary traumatization in therapists working with clients with significant trauma histories. Dagan et al. (2015) defined secondary traumatization as "a situation in which traumatic events affect not only the survivors themselves but also people in their environment" (p. 593). This study revealed factors that link STS and the exposure to traumatic material to other organizational factors that contribute to secondary traumatization. The findings further suggested that high caseloads and chronic life stressors pose greater risks for secondary traumatization. However, the study concluded that with social, environmental, and organizational support, clinicians were more resilient when working with individuals with trauma histories. This research further emphasized the role of the organization in cultivating a culture that mitigates CF, secondary traumatization, and burnout in outpatient mental health counselors.

Hyatt-Burkhart (2014) conducted a qualitative study that discussed vicarious posttraumatic growth as a theory that describes mental health clinicians' experience of positive outcomes when working with children and adolescents with significant trauma histories. The study sought to elucidate the experiences of mental health clinicians who found psychological benefit in working with traumatized children. The researcher specifically targeted mental health clinicians who expressed experienced CF and vicarious posttraumatic growth. The data was collected with the ProQOL scale through the organization's Continuous Quality Improvement program (CQI). The findings from this study played a pivotal role in the development of theory that suggests a correlation among stress, trauma, and coping. Furthermore, it suggests vicarious that posttraumatic growth develops through three categories: self-perception, interpersonal relationships, and philosophy of life. This is noteworthy as Hyatt-Burkhart (2014) suggested that "the mental health professions are, for the most part, pathologically focused" (p. 7).

As illustrated by this brief review of studies, there are overlaps in the research, theory, and definitions of burnout, STS, CF, and VT. Over the years, researchers have added or adapted new terminology to explain the profound effects helpers experience when treating clients with extensive trauma histories.

Causal Model of Turnover

Turnover models have been studied by personnel researchers, behavioral scientists, and management practitioners, among many other disciplines (Mobley et al., 1979). An abundance of research on turnover has examined the relationship between job satisfaction and turnover (Mobley, 1977). In William Mobley's (1977) model of employee turnover, the act of thinking about resigning is usually the next step after an individual experiences job dissatisfaction. Mobley's theory was further researched by Price and Mueller, who conducted longitudinal research on voluntary turnover in registered nurses (Price & Mueller, 1981). Price, a sociologist, developed a causal model of turnover focused on its specific determinants that suggested that an individual's satisfaction on the job exerted a direct impact on his/her decision to stay or leave an organization (Bluedorn, 1982; Price, 1989). Additionally, Price's findings determined that demographic variables such as age, length of service, and education also exert a significant impact on turnover in organizations (Bluedorn, 1982). Price and Mueller's (2001) research focused on three categories of elements that impact turnover intention: environmental, individual, and structural (Price & Mueller, 2001). The literature on turnover suggests that there are 13 determinants that impact turnover: opportunity, routinization, participation, instrumental communication, integration, pay, distributive justice, promotional opportunity, professionalism, general training, kinship responsibility, job satisfaction, and intent to stay (Price & Mueller, 1981). Table 1.3 defines these determinants.

Table 1.3

Price and Mueller's Definitions of Determinants

Variable	Definition
Opportunity	The availability of alternative jobs in the organization's environment.
Routinization	The degree to which a job is repetitive.
Participation	The degree of power that an individual exercises concerning the job.
Instrumental communication	The degree to which information about the job is transmitted by the organization to its members.
Integration	The degree to which an individual has close friends among organizational members.
Pay	The amount of money, or equivalents, distributed in return for service.
Distributive justice	The degree to which rewards and punishments are related to the amount of input into the organization.
Promotional opportunity	The amount of potential movement from lower to higher strata within an organization.
Professionalism	The degree of dedication to occupational standards of performance.
General training	The degree to which the occupational socialization of an individual results in the ability to increase the productivity of different organizations.
Kinship responsibility	The degree of an individual's obligations to relatives in the community in which an employer is located.
Job satisfaction	The degree to which individuals like their jobs.
Intent to stay	The estimated likelihood of continued membership in an organization.

Note. The definitions of each determinant identified in Price and Mueller's causal model of turnover. From "A Causal Model of Turnover for Nurses", by J. L. Price and C. W. Mueller, 1981, *Academy of Management Journal*, *24*(3), pp. 545–546 (https://doi.org/10.5465/255574).

The causal model of turnover is well recognized in the literature, but few studies have been conducted on the turnover intentions of clinicians working in community mental health organizations. This study sought to examine the causal model of turnover and the variables associated with burnout, CF, and VT to help identify what is learned at the individual, group, and systems levels when interventions are designed that address turnover in outpatient mental health clinicians. The diagram shown in Figure 1.5 is a modification of Price and Mueller's (2001) causal model of turnover showing the positive and negative relationships among determinants.

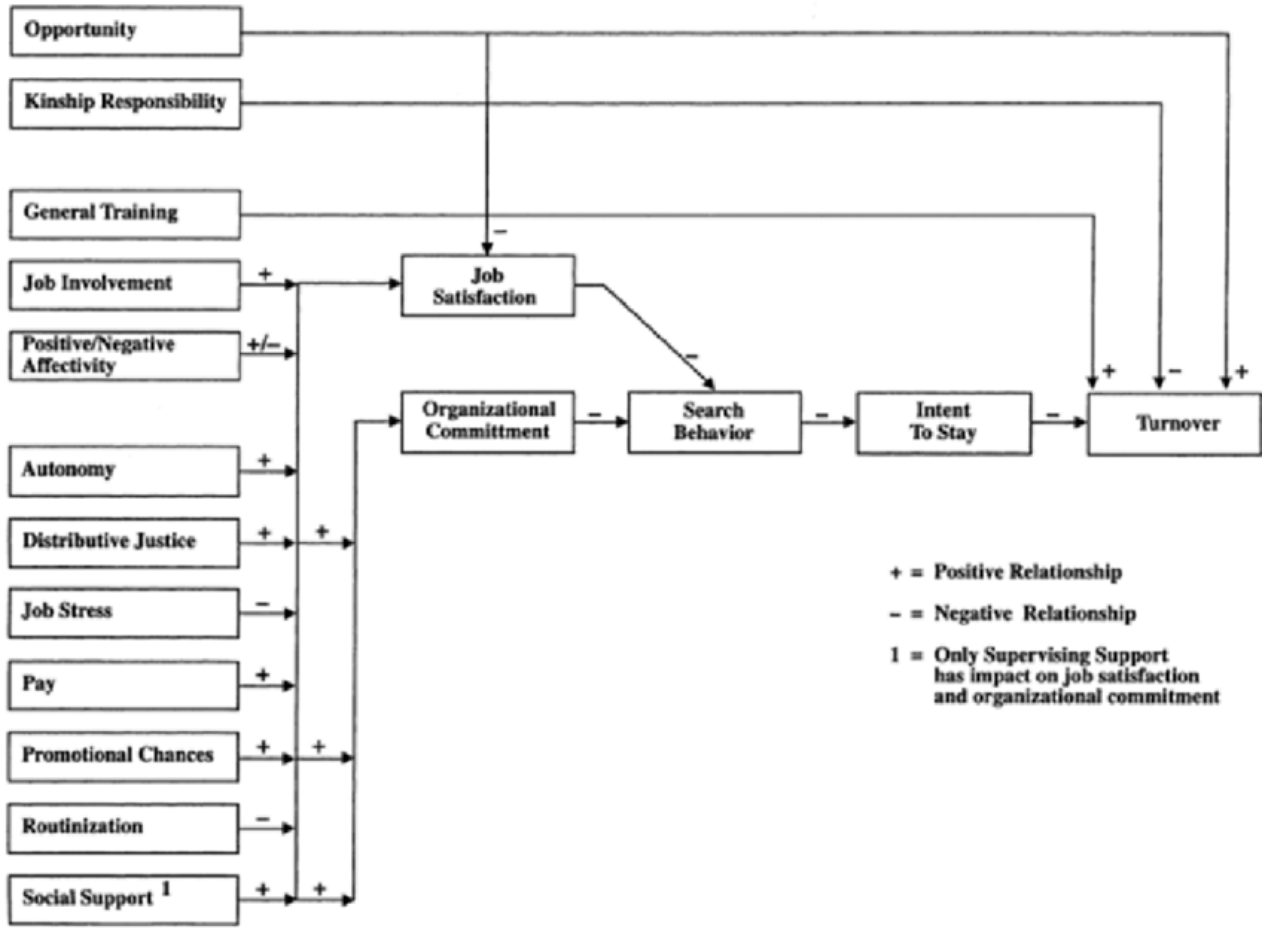

Figure 1.5. *The Causal Model of Turnover. Note.* Modified causal model of turnover (Price, 2001).

Table 1.4

Literature Review Summary: Burnout, CF, VT, and the Turnover Model

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999)	Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists	The effects of trauma work on women psychotherapists	Should psychotherapists limit their clinical work with trauma survivors to avoid being traumatized themselves?	Exploratory national surveys; event scales; the Traumatic Stress Institute (TSI) belief scale; spiritual well-being; one-way ANOVA	A national randomized sample of 1,000 women psychotherapists who work with sexual abuse survivors.	Women psychotherapists with a high caseload of trauma survivors are more likely to experience symptoms of trauma themselves. Organizations and agencies that provide trauma treatment for survivors of sexual trauma should ensure that they establish an emotionally and physically supportive environment for clinical staff.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., Manthorpe, J., & Amaddeo, F. (2017)	How are compassion fatigue, burnout, and compassion satisfaction affected by quality of working life? Findings from a survey of mental health staff in Italy	This study analyzed indicators of quality of work life that can lead to CF, burnout, and CS.	How does the quality of work life affect the risk of CF, burnout, and CS among mental health practitioners?	Professional Quality of Life Scale; Quality of Working Life Questionnaire.	461 staff members were invited to complete the survey. 416 staff members responded to the questionnaires. 400 surveys were retained for analysis.	Findings are useful for health care managers. CF and burnout impact work performance and the quality of services. Specific strategies identified: training, meetings, and building trustful relationships.
Devilly, G. J., Wright, R., & Varker, T. (2009)	Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals	Assess secondary traumatic stress, vicarious trauma, and workplace burnout for mental health professionals in Australia.	Does exposure to a client's traumatic material significantly increase a therapist's risk of STS (also known as VT) and burnout?	Recruited 152 participants by random selection of mental health professionals to complete a questionnaire by post or online. Analysis involved self-report on questionnaire.	The results of this study found no significant impact on mental health professionals exposed to clients' traumatic material, but work-related stressors predicted distress in therapists.	Both workplace and individual factors contribute to the distress of therapists.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Halbesleben, J. R. B., Osburn, H. K., & Mumford, M. D. (2006)	Action research as a burnout intervention: Reducing burnout in the federal fire service	Collaborative AR	To highlight the efficacy of AR in advancing the understanding of burnout in organizations.	Federal fire department on a United States military installation.	The findings of the study indicated that AR is a valuable tool for reducing burnout and that its approach can be adapted to fit any organization.	The article demonstrated that the utilization of collaborative AR techniques can lead to advancement in the understanding of burnout and provide an opportunity for organizational development.
Holmes, M. R., Rentrope, C. R., Korsch-Williams, A., & King, J. A. (2021)	Impact of COVID-19 pandemic on posttraumatic stress, grief, burnout, and secondary trauma of social workers in the United States	The study's purpose was to measure posttraumatic stress, grief, burnout, and secondary trauma experienced by social workers in the USA.	What is the psychological impact of COVID-19 on social workers in the United States?	Data was used from COVID-19 pandemic and emotional well-being study that included a sample size of 181 social workers; univariate analyses were used.	The results of the study found the 26% of social workers met the criteria for PTSD; 16% reported severe grief symptoms; 99% reported CS; 65% reported burnout and 49% reported secondary trauma.	Social workers are reporting rates of PTSD higher than the national average; more emotional support during COVID-19 is needed; organizations should provide resources for immediate and ongoing support of their staff.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Killian, K. (2008)	Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors	The impact of extended exposure to traumatized populations on helping professionals. Self-care in clinicians working with trauma survivors.	What can and should be done to address burnout and CF in mental health providers?	Multimethod study used focused on therapists' stress and coping in working with trauma survivors. Cross-sectional data and semi-structured interviews were used.	Semistructured interviews were conducted with 20 clinicians. A questionnaire was administered to 104 clinicians who specialize in the treatment of trauma survivors. Results: Social support significantly impacted therapists' feeling CS; being proactive with self-care and networking with other professionals helped in mitigating CF and burnout.	Trauma exposure can impact the well-being of helping professionals. Organizational factors may contribute to exposure to VT, but no specific strategies were identified for improving the personal and professional effects of VT. Additionally, individualized coping strategies did not directly impact resilience.
Leiter, M. P., & Harvie, P. L. (1996)	Burnout among mental health workers: A review and a research agenda	Analyzing probable antecedents of burnout related to mental health workers	How does burnout impact mental health workers compare to others in similar fields?	Review of several articles regarding components of burnout	The study used integrative approaches: Self-control model of stress, causal model, and longitudinal	Research shows significant factors that contribute to burnout; more research is needed to understand ways

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
					analysis. Results indicated a process model of burnout.	to prevent or alleviate burnout.
Lluch-Sanz, C., Galiana, L., Vidal-Blanco, G., & Sansó, N. (2022)	Psychometric properties of the Self-Compassion Scale-Short Form: Study of its role as protector of Spanish nurses' professional quality of life and well-being during the COVID-19 pandemic	Self-compassion scale	To provide evidence of the psychometric properties of the Self-Compassion Scale in a sample of Spanish nurses. To study the role of self-compassion as a protector of Spanish nurses' professional quality of life and well-being during the COVID-19 pandemic.	115 Spanish nurses	Self-compassion predicted professional quality of life; professional quality of life positively predicted well-being and strong relationship.	The study concluded that self-compassion is important to nurses' well-being, balance, and professional quality of life.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012)	Burnout in mental health services: A review of the problem and its remediation	Reducing or preventing burnout among mental health professionals	To what extent is burnout a problem for mental health staff and the service delivery system? What can and should be done to address burnout among mental health providers?	Computerized literature review using keywords. Manually examined citations and references lists; multiple quasi-experimental or randomized controlled trial studies were examined to study burnout reduction across career fields.	The study found numerous organizational environmental variables that are related to burnout (time pressure, role conflict, excessive workload, etc.) Additionally, other factors outside the organization's control may contribute to burnout.	The mental health field is lacking in studies examining burnout in mental health workers; organization-level interventions appear effective for reducing staff burnout; the most effective method of mitigating burnout is through individual and organizational interventions.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Price, J. L., & Mueller, C. W. (1981)	A causal model of turnover for nurses	Causal model of turnover	To assess the importance of the various determinants in the model and understand the power of the model.	Longitudinal study on 1,091 registered nurses in seven different hospitals	The study found that the four determinants that exerted the greatest impact on determining turnover were the intent to stay, opportunity, general training, and job satisfaction.	The study concluded with suggestions for further research on the determinant. Eight recommendations were provided, including adding the size of the organization as a determinant. In addition, the intent to stay as a determinant should be identified under commitment.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Sklar, M., Ehrhart, M. G., & Aarons, G. A. (2021)	COVID-related work changes, burnout, and turnover intentions in mental health providers: A moderated mediation analysis	Job demands-resources model	This study examined burnout experienced by mental health providers through COVID-19.	The study included surveys of 96 service providers from six community mental health centers in a midwestern state in the United States.	Surveys were completed; path analysis tested the indirect relationship between work changes and turnover intention through burnout. The results of the study indicated relationship turnover intentions and burnout.	The study noted that burnout was low when work changes were low and job resources were high. Organizations are encouraged to strengthen organizational trust and organizational support to mitigate burnout and turnover intentions.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Sung, K., Seo, Y, & Kim, J. H. (2012)	Relationships between compassion fatigue, burnout, and turnover intention in Korean hospital nurses	Using CF and burnout theory, this article focused on the relationship among CF, burnout, and turnover intention.	Is there a correlation among CF, burnout, and turnover intention in Korean hospital nurses?	In this study, 142 nurses were surveyed with a questionnaire; tools used to conduct the study were the CS/CF self-test for helpers and MBI.	The study identified a positive relationship between CF & burnout and turnover intention.	The study conclusion found that it is necessary to reduce CF to mitigate intention turnover; there is a correlation between CF and burnout in Korean nurses.

Author/ date	Title	Theoretical/ conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014)	Personal and contextual predictors of mental health counselors' compassion fatigue and burnout	Transactional stress and coping theory	Understanding how contextual factors can contribute to CF and burnout in counselors	213 mental health counselors completed an online survey.	The study used multiple regression analysis to study factors of gender, years of experience, work conditions, use of coping strategies, and personal resources to predict CF and burnout of mental health counselors. Results: Better perceived work environment was a predictor for less CF. The length of time counselors had in the field was associated with lower CF and burnout.	Counselors noted that the use of emotion-focused techniques were instrumental in reducing burnout; counselors' work conditions and personal resources perceptions are predictors of CF and burnout.

Table 1.5

Literature Review Summary: *Burnout, Turnover, and the COVID-19 Pandemic*

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
Ashcroft, R., Sur, D., Greenblatt, A., & Donahue, P. (2021)	The impact of the COVID-19 pandemic on social workers at the frontline: A survey of Canadian social workers	The objective of this study was to understand the experiences of social workers during the first wave of the COVID-19 pandemic.		Cross-sectional, web-based survey, comprising closed and open-ended questions. Survey participants were social workers in Ontario, Canada. 2,470 participants.	Descriptive statistical analyses were performed on the closed questions; qualitative data from open-ended surveys were entered into an Excel spreadsheet. Results: increased workload, loss of employment, redeployment to new settings, early retirement, concern for personal health and safety, clients with increasing complexities, challenges with transition to virtual care, and impact on personal well-being.	Social workers have experienced innovative ways to deliver services during the pandemic. However, social workers have experienced personal and professional burdens, stress, fatigue and burnout incurred from the cost of caring. We need to nurture collaborative professional communities to ensure the well-being of social workers for the

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
						duration of the pandemic and beyond.
Fish, J. N., & Mittal, M. (2021)	Mental health providers during COVID-19: Essential to the US public health workforce and in need of support	Given the mental health effects of isolation, stress, economic strain, researchers forecast a devasting increase in poor mental health as a result of the coronavirus disease.	Will the increase in mental health need burden an already-strapped mental health care system?	Brief online survey conducted on mental health providers with five open-ended questions; 137 individuals completed the survey.	112 of the 137 mental health providers surveyed shared that the pandemic had negatively affected their ability to serve clients. Stressors for the counselors also contributed to negative influences on their mental health. Counselors reported teletherapy fatigue, challenging work environment, susceptibility to compassion fatigue, burnout, and	National organizations, state behavioral health networks, and professional organizations should develop programs that provide integrated mental health support to clinicians, confidential screenings, and development of a support

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
					secondary traumatic stress.	group for clinicians. Organizations should develop policies and practices that emphasize workplace wellness and self-care (adjusted caseloads, walking clubs, meditation, and exercise classes). Mental health providers need protection and support as they tackle the mental health wave of this pandemic.
Litam, S. D.A., Ausloss, C. D., & Harrichand, J. J. S. (2021)	Stress and resilience among professional counselors during the	The purpose of this study was to contribute to the research examining the experiences of professional counselors	To what extent do perceive stress, coping responses, resilience, and posttraumatic stress predict	A total of 161 individuals participated in the study. The study used the PSS to measure the	The study identified a strong association between posttraumatic stress and perceived stress on the overall professional quality	The study emphasized the importance of professional counselors cultivating resilience and

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
	COVID-19 pandemic	providing services during the Covid-19 pandemic	professional quality of life as measured by the total score and subscale scores of the Professional Quality of Life Scale (ProQOL)	perception and degree of stress experienced, the ProQOL to measure professional quality of life, the CSI-SF to measure coping strategies inventory, RS, and the PCL-5 PTSD self-report.	of life among counselors. Findings indicated that levels of perceived stress and posttraumatic stress are strong predictors of professional quality of life among counselors providing services during the pandemic.	self-care practices during the pandemic.
Sinsky, C. A., Brown, R. L., Stillman, M. J., & Linzer, M. (2021)	COVID-related stress and work intentions in a sample of U.S. health care workers	The aim of the study was to evaluate the relationships between COVID 19-related stress and work intentions in a sample of U.S. health care workers.	Are stress, burnout, and factors that lead to them (anxiety, fear, depressive symptoms) associated with greater intention to reduce work hours or leave current practice?	Survey of health care workers (clinical and nonclinical) Burnout was assessed using the Mini Z single-item burnout measure	Descriptive statistics were run on all variables; 20,665 respondents at 124 institutions. Results: Intention to reduce hours were higher in nurses (33.7%). Intentions to leave the practice highest among nurses (40.0%). Burnout, fear of exposure, COVID-19 related	Approximately 1 in 3 physicians, APRNs, and nurses surveyed intended to reduce work hours. 1 in 5 physicians and 2 in 5 nurses intended to leave their

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
					anxiety/depression, workload were predictors of intent to leave and reduction of hours. Feeling valued by organization was protective of reducing hours and intending to leave.	practice altogether. Reducing burnout and improving a sense of feeling valued may allow health care organizations to better maintain their workforces post pandemic.
Slone, H., Gutierrez, A., Lutzky, C., Zhu, D., Hedriana, H., Barrera, J. F., Paige, S. R., & Bunnell, B. E. (2021)	Assessing the impact of COVID-19 on mental health providers in the southeastern United States	The COVID-19 pandemic has resulted in employment disruptions within the U.S. healthcare system.	How has the pandemic affected mental health providers and their practice?	In July 2020, a web-based survey completed by 500 licensed mental health providers assessed employment and caseloads, logistics of care, quality of care, patient-provider relationships,	Over 90% of providers reported changes to their employment, with 60% no longer practicing.	The study concluded that COVID-19 resulted in serious concerns to mental health providers' employment status, continued practice, and ability to stay in contact with potentially high-risk

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
				communication during the pandemic.		patients. However, providers showed resilience throughout the pandemic.
Tabur, A, Elkefi, S., Emhan, A., Mengenci, C., Bez, Y., & Asan, O. (2022)	Anxiety, burnout and depression, psychological well-being as a predictor of healthcare professionals' turnover during the COVID-19 pandemic: Study in a pandemic hospital	During the COVID-19 pandemic, healthcare professionals have faced stressful situations that have negatively impacted their psychological health. This study explored the impacts of emotional wellbeing of healthcare professionals on their intention to quit their jobs.	Is psychological health a predictor of intention to leave the job among healthcare professionals who were working during the COVID-19 pandemic?	A cross-sectional survey design was used for this study. Respondents based on simple random sampling. A total of 345 questionnaires were returned. Respondents were doctors, nurses, midwives, and technicians.	Emotions including anxiety, burnout, and depression were measured using validated scales. The study found that the COVID-19 situation increased turnover intention, especially among doctors and nurses. Mediating the emotional pressures providers felt were anxiety related work-pressure and burnout, which were the main emotional predictors of turnover intention.	The increased workload and responsibilities have added an emotional load on healthcare professionals. Anxiety and burnout caused the providers to consider quitting their jobs. This was noticed most among doctors and nurses who had the most stressful jobs. Attention needs to be

Author/date	Title	Theoretical/conceptual framework	Research question(s)	Methodology	Analysis & results	Conclusions
					The more severe the anxiety, the more the professional considered quitting.	given to the healthcare professionals' emotional wellbeing to support them in their jobs and avoid losing a scarce resource.

Purpose of the Study and Research Questions

The purpose of this action research (AR) study is to identify insights gained from an outpatient community mental health organization's attempt to increase retention and increase the well-being of mental health clinicians at the individual, group and organizational levels by addressing CF, VT, and burnout. The research questions that guided this study are as follows:

1) What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion fatigue and burnout in an outpatient community mental health organization?
2) What organizational culture and systemic factors affect the experience of burnout, CF, and VT in clinicians working in outpatient mental health centers?

Introduction and Overview of the Problem

The community mental health organization on which this AR study focused has five outpatient mental health centers that span three counties in the state of Georgia. It is governed by a 13-member board appointed by the County Board of Commissioners. According to its 2020 annual report, Horizon Community Mental Health Center (HCMHC) is one of 27 agencies created by the state to provide a safety net for individuals in need of accessible behavioral health services.[1] This organization serves individuals in need of care for mental health disorders, substance abuse disorders, and intellectual developmental disabilities. Clients range in age from children as young as 3 to senior adults. Individuals who seek services do so for mental health crisis intervention, mental health treatment, and mental health medication management. As

[1] In keeping with APA 7 recommendations (sections 1.15, 8.36), HCMHC-related texts and materials are discussed in the manuscript but not included in the reference list to maintain confidentiality. In addition, participants have been anonymized to avoid accidental disclosure of their identities.

indicated in the center's 2020 annual report, the number of clients receiving mental health services at this organization has risen from 13,742 in 2017 to 15,402 in 2018—a 12.08% increase. In 2019, the organization served 16,530 individuals (an increase of 7.32%). The organization had served 15,892 individuals in 2020 at the time of the 2020 report's publication. The operating budget for 2019 was $20,453,458 and for 2020 was $21,977,892 (a 7.45% increase); however, the structure of receiving these funds is based on a fee-for-service model, in which health care providers receive payment for each service rendered (Koenecke, 2019). According to one research participant, there was a turnover rate of 48% from July 1, 2018 to June 30, 2021.[2] This participant further noted that a total of 111 resignations and four terminations of employees identified as clinicians had occurred within this 3-year period.

In September 2022, the researcher collected an updated report of the organization's turnover data from July 1, 2021 through August 15, 2022, with the assistance of research participants. The data showed continued turnover trending up in HCMHC and specifically the outpatient centers. The outpatient centers experienced turnover at the rate of 54.05% during this reporting period. The data in Table 1.6 includes a comparison of turnover within the whole agency to that in outpatient centers, the number of separated clinicians from each outpatient program, and the reasons provided for the separation.

[2] The identity of this source has been hidden to protect the identity of the organization.

Table 1.6

Horizon Community Mental Health Turnover Data, 7.1.2021–8.15.2022

How many staff members currently work at HCMHC?		654
How many staff are classified as clinicians (LMSW, LPCs, LAPCs, APCs, LCSW, S/Ts)?		137
How many clinicians work at an outpatient center (Program 1, Program 2, Program 3, Program 4, Program 5)?		37
How many clinicians have separated from the agency between 7/1/2021 and 8/15/2022?		46
Number of terminations	Agency-wide?	3
Number of terminations	Outpatient centers?	1
Number of resignations	Agency wide?	43
Number of resignations	Program 1 Program 2 Program 3 Program 4 Program 5	8 2 1 4 5
Were exit interviews conducted?		Inconsistent data gathered (some but not all staff exiting received an exit interview)
What reasons were provided for the separation?		Pay, workload, life required changes, growth opportunities, issues with leadership
What were the most repetitive reasons given for the separation?		Pay, increase in workload
Outpatient centers only: How many clinicians employed at the start of FY21 (7/1/2021)?		37
In the beginning months of FY 2022 (8/15/2022), how many of the original number of clinicians were lost due to turnover (separation or resignation)?		20

How many new clinicians were hired at an outpatient center between 7/1/2021 and 8/15/2022?	10
How many of these clinicians remain with the agency as of 8/15/2022?	7
Outpatient centers only: Of the number of clinicians that have separated from the organization between 7/1/2021–8/15/2022, how many were fully licensed (LCSW or LPC)?	10
Average turnover rate among clinicians? Full company?	32.12%
Average turnover rate among clinicians? Outpatient centers only?	54.05%
Compared to other HCMHC programs, what is the percentage of turnover at an outpatient program?	31.69%

Mental health clinicians are striving to meet the growing demand posed by this influx of clients seeking treatment with the same or even lower levels of available resources. However, as noted in Table 1.6, clinicians are succumbing to the pressure and separating from the organization. The results of HCMHC's annual organizational climate survey for 2021 reported the lowest scores in the following areas: (a) I am paid fairly for the work I do, (b) Procedures to do my job do not involve unnecessary steps, and (c) My workload is appropriate. Additional data supporting the problems of CF, VT, and burnout was obtained through a focus group, review of archival data, critical incident interviews, meeting notes, surveys, and AR team meetings. The diagram in Figure 1.6 depicts the problem of retention that was studied at this organization and the antecedents of CF, VT, and burnout that were hypothesized to contribute to clinicians separating from the organization.

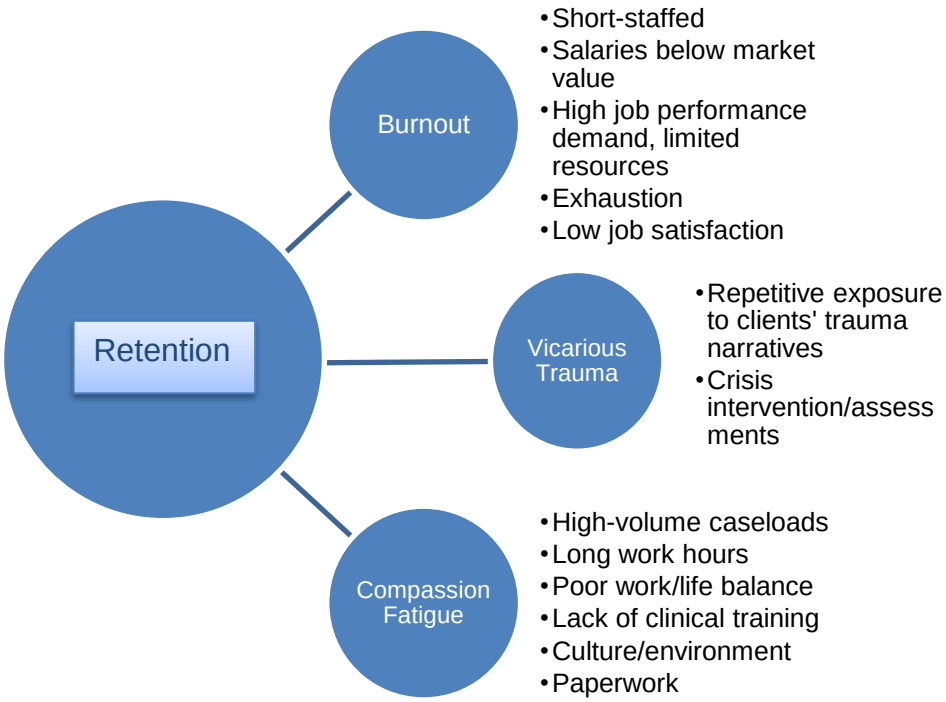

Figure 1.6. *The Problem of Retention and Possible Antecedents.*

Logic Model

A logic model describes and tells the story of the logical linkage among resources, activities, participation, short-term, intermediate, and long-term outcomes (McLaughlin & Jordan, 1999). The researcher used the logic model illustrated in Figure 1.7 to describe the problem at HCMHC, guide the interventions, and evaluate the change process. Additionally, the logic model was used to question assumptions and articulate identified gaps within the organization.

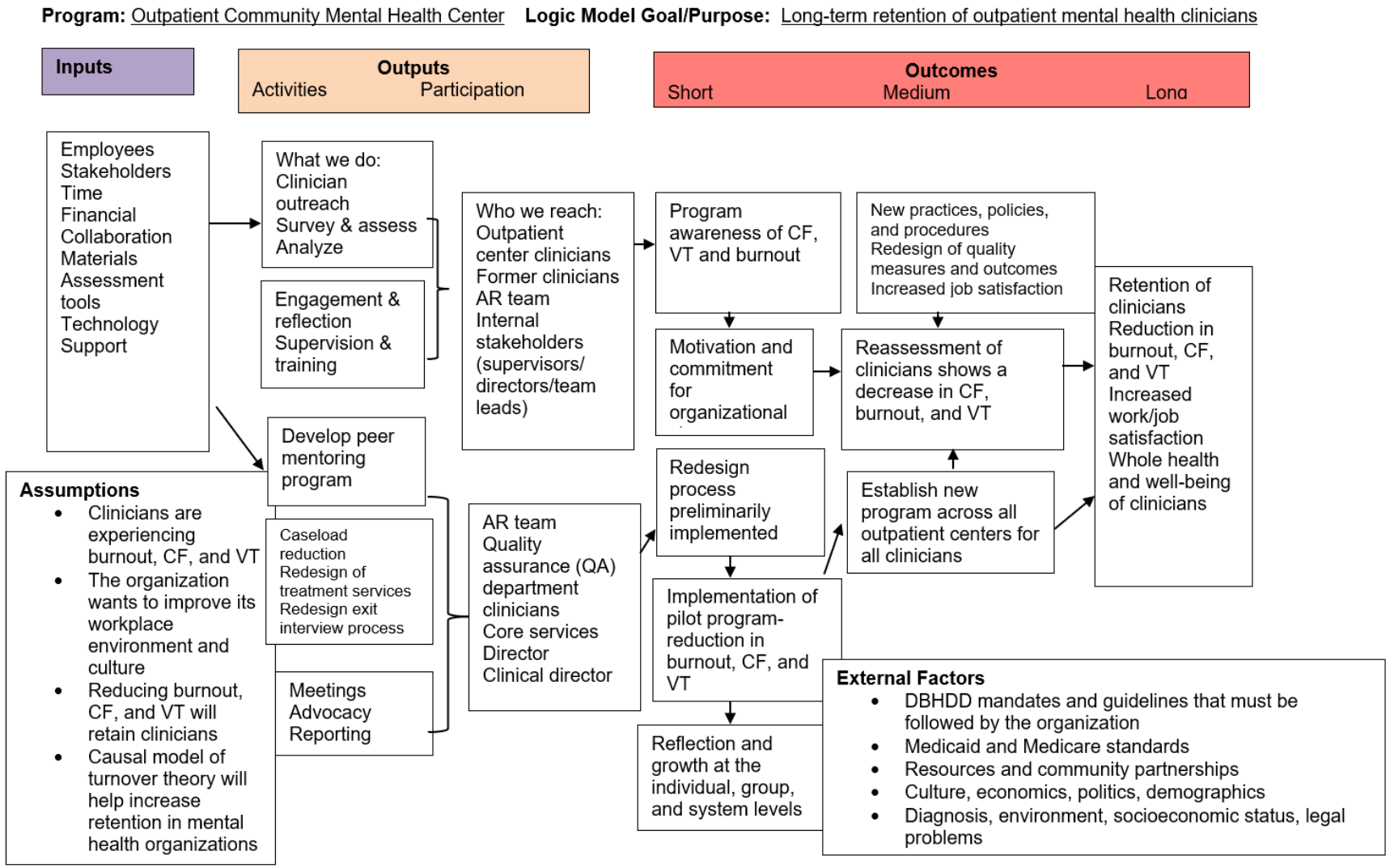

Figure 1.7. *Logic Model*.

The purpose of this AR study was to examine the influence of CF, VT, and burnout in mental health clinicians working in outpatient community mental health settings and potential organizational interventions to address these debilitating conditions. This study explored factors contributing to CF, VT, and burnout by considering theories and practices that are currently used to address the problem. Additionally, this study aimed to explore one organization's attempt to increase clinician retention and well-being at the individual, group, and system levels to address CF, VT, and burnout.

At present, the organization collects very limited data to identify the reason(s) why employees separate from the organization. There is inconsistency in conducting exit interviews or exit surveys to collect data about terminations or resignations. When attempting to obtain exit interview data, this researcher was informed that exit interviews were not conducted consistently and usually occur only at the request of a supervisor. According to a personal communication and organizational documents, the exit interviews that were conducted indicated pay, caseloads, stress (personal and workplace), and issues with supervisors/working environment as reasons for separation. To supplement this limited data, the AR team used both qualitative and quantitative data collection methods to gather data for this study, which will be discussed in greater detail in Chapter 2.

CHAPTER TWO

METHODOLOGY

This chapter describes the action research (AR) approach that guided the design and implementation of the AR study. Chapter 2 provides an overview of the AR methodology, the benefits of AR methodology, a description of the AR team, and overview of the AR study participants. Additionally, I outline the data collection methods, data analysis procedures, and show how I ensured rigor, ethics, and trustworthiness throughout this research project.

Overview of Issues

Compassion fatigue (CF) and vicarious trauma (VT) are factors impacting burnout in community mental health organizations. As the literature review indicated, burnout, CF, and VT are issues currently being studied within the helping professions but are less examined in the context of community mental health organizations. According to Sansbury et al. (2015), organizations have enormous power and play a significant role in mitigating CF, burnout, and VT. Compassion fatigue has been referred to as “the cost of caring” (Figley, 1995) and can impact many clinicians who provide direct treatment to individuals. As a result, community mental health clinicians report feeling overwhelmed, physical and mental exhaustion, and a lack of compassion for clients. In addition, community mental health organizations experience high levels of turnover, and employees report high levels of work dissatisfaction. As director of an outpatient mental health center, I sought to understand these issues and aimed to find ways to address the growing turnover rate at Horizon Community Mental Health Center (HCMHC). Given the challenges with clinician retention at HCMHC’s outpatient centers, the purpose of this

study was to gain insights from an outpatient mental health organization's attempt to address CF, VT, and burnout in outpatient community mental health clinicians. The research questions that guided this study were:

1) What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion CF and burnout in an outpatient community mental health organization?
2) What organizational culture and systemic factors affect the experience of burnout, CF, and VT in clinicians working in outpatient mental health centers?

Overview of AR Methodology

As lead researcher, I used AR methodology to effectively address the problem of burnout, CF, and VT at Horizon Community Mental Health Center (HCMHC). Action research is utilized in organizational development to solve a real-world problem within an organization (Coghlan, 2019). It is an effective process for creating and leading change that the organization cares about (Coghlan, 2019). Action research was chosen due to its effectiveness in addressing organizational cultural challenges, navigating organizational politics, and achieving organizational change. Conducting AR within one's organization (i.e., insider AR), whereby a member undertakes dual roles as a member of the organization and researcher, can provide a unique opportunity for the organizations' stakeholders to address a real problem (Coghlan, 2019).

In my dual role as program director and lead action researcher, I used AR methodology to foster an opportunity for organizational growth. The role of a lead researcher is to examine areas for growth within the organization by studying how others have addressed the problem in similar

fields, applying theory to practice, and working with a core AR team. Action research in organizational development requires a solid team engagement through a democratic process aimed to address practical issues. According to Coghlan (2019), the AR process utilizes a commitment to reflective practices individually, as a group, and as an organization. The AR team and I, committed to actuating reflective practices, adhering to a democratic process, and checking our own biases which cultivated a growth mindset in facilitating organizational change.

AR methodology emphasizes the significance of the core project and thesis project in action research. The thesis project is larger in scope, includes theory, and contributes to the field of study (Coghlan & Brannick, 2014). The core project is the change project that occurs at the organizational level (Coghlan & Brannick, 2014). The strength of this study was its aim to improve the work environment for clinicians working at HCMHC and to add to the current research on burnout, compassion fatigue and vicarious trauma through the use of the causal model of turnover theory and AR methodology.

Cycles of Action Research

Action research is an iteratively cyclical four-step process that involves constructing the problem or general objective, planning action, taking action, and evaluating the action (Coghlan, 2019). Figure 2.1 depicts the AR cycle.

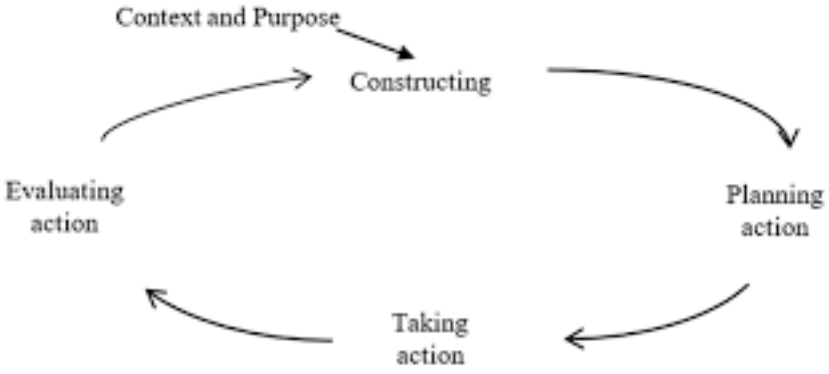

Figure 2.1. *The AR Cycle. Note.* Adapted from Coghlan (2019).

At each stage, the problem is being identified or reframed and decisions are made to determine next steps, implementation of the planned action, and evaluation of the results (Coghlan, 2019). The AR process emphasizes the research team's commitment to learning in action, whereby the researchers learn simultaneously about themselves, group, and organizational system (Coghlan, 2019). In the three cycles and phases of action research, the AR team's understanding of theory, scholarly literature review, and professional knowledge contributes to the development of interventions to address burnout, VT, and CF.

According to Coghlan (2019), the iteration of these research cycles increases the rigor and trustworthiness of a study. Repeating the AR cycle once is insufficient, but the iteration of cycles across a longer period increases the rigor and reliability of the study. The AR team engaged in a total of 15 months and 26 weeks of AR team meetings in which we focused on constructing, planning, taking, and evaluating action.

The AR team and I collected and analyzed data in three action research cycles. In each cycle of inquiry, the AR team engaged in reflective practices, member checks, journaling, and

document review. The process of evaluating the research, reflecting, and deepening my learning at each phase influenced the action of the next phase, which is referred to as the metacycle (Coghlan, 2019). Melrose (2001) and Coghlan (2019) asserted that repetition and reflection deepens the learning, growth, and understanding that is accomplished through the AR process.

The AR team's engagement in team meetings, reflection activities, and data collection added to the rigor, quality, and validity of this project. Marshall and Rossman (1989) posited that research team meetings keep the team members aware of fieldwork, facilitate the discussion of emerging problems or data collection problems, and ensures continued feedback among the team. The AR team used team meetings to discuss issues and concerns that emerged throughout the study.

Furthermore, the iteration of the AR cycles increased others' awareness of the project, which expanded the project's circle of influence. The AR cycles are complex, and each cycle expands the project's awareness to stakeholders (Coghlan, 2019). Some cycles can take longer, and phases can be repeated. It was important for the AR team to navigate the AR cycles while also navigating the organizational politics to increase others' awareness of the project. Key stakeholders' support garnered more support, buy-in, and understanding of the project, which led to the approval of the intervention plan.

Benefits of Quality Action Research

Action research methodology offers organizations many benefits, including the opportunity for growth and enhancement of organizational practices. Action research fosters the opportunity for the core AR team to examine systems, policies, organizational culture, and social constructs that can unconsciously create barriers for organizational growth and sustainability. Moreover, AR methodology can promote trustworthiness in the change process because, by its

nature, it promotes inclusivity, participation, and triangulation in data collection. This AR study aligned with the HCMHC organization's strategic goals and plans, providing an opportunity to review the turnover rate of clinicians at HCMHC and study the impact of VT, burnout, and CF on outpatient mental health clinicians.

Quality and Rigor of AR Methodology

A review of AR methodology literature provided guidelines for establishing quality and rigor in this study. According to Coghlan and Shani (2014, 2018, as cited in Coghlan, 2019), the rigor and quality of an AR study is determined by its context, the quality of relationships developed with participants, the quality of the AR process itself, and the outcomes of the research. It was thus important for the AR team and I to understand how the quality and rigor of a research study supports the reliability of the study.

To ensure rigor and quality research, the AR team and I used the causal model of turnover theory to guide the research, answer the research questions, and develop appropriate interventions. As will be elaborated in more detail in the Data Collection section below, the AR team also employed multiple strategies, such as member-checking, audit trails, and triangulation, to ensure the trustworthiness of the data and our interpretations. The quality of the research is evidenced by the AR team's participation in each phase of the AR study, data analysis, discussion of emerging issues or problems, data collection, and continuous reflection.

The AR Team

As the lead researcher, I assembled a small group of clinicians, managers, and supervisors to participate in a focus group to determine an agreed-upon approach to address the problem of burnout, CF, and VT in outpatient clinicians. The AR team members were selected based on their dual role as clinicians and program leaders. The AR team members formerly

participated in the focus group and consented to being members of the AR team. The AR team members represented various diverse ethnic groups, genders, professional license type, and years of experience at the organization. Table 2.1 summarizes the AR team members' demographic information, including that of the lead action researcher. The participants have been assigned pseudonyms to maintain anonymity.

Table 2.1

AR Team Members

Pseudonym	Race	Gender	Age	Professional License	Years at HCMHC
Cierra	African American	Female	52	Licensed professional counselor	7
Aaron	Caucasian	Male	34	Licensed professional counselor	7
Natalie	African American	Female	44	Licensed clinical social worker	7
Lauren	Caucasian	Female	38	Licensed clinical social worker	13
Maria	Hispanic	Female	52	Licensed professional counselor	6
*Jemecia	African American	Female	48	Licensed professional counselor	10

*Denotes lead researcher

Participation in the AR team was voluntary and added additional responsibility for the team members, but their interest in retaining clinicians was important and kept them motivated to participate. To maintain the quality of research and project reliability, it was important to maintain the core AR team members. As lead researcher, I often revisited with the AR team the purpose of the team, project, and what we hoped to achieve through our commitment to the

process. The AR team meetings were recorded, transcribed, and reviewed with the team for accuracy.

Data Collection

The AR team used both qualitative and quantitative approaches to collect and analyze data in our study of what can be learned about burnout, CT, and VT in clinicians working at an outpatient mental health center. A mixed methods approach was chosen to strengthen the reliability and validity of the research results. Creswell and Creswell (2018) posit that "at a practical level, mixed methods provide a sophisticated, complex approach to research that appeal to those on the forefront of new research procedures" (pp. 297–298). A convergent mixed method design merges quantitative data and qualitative data to compare the results of a study (Creswell & Creswell, 2018). Figure 2.2 depicts the convergent mixed methods design used in this study.

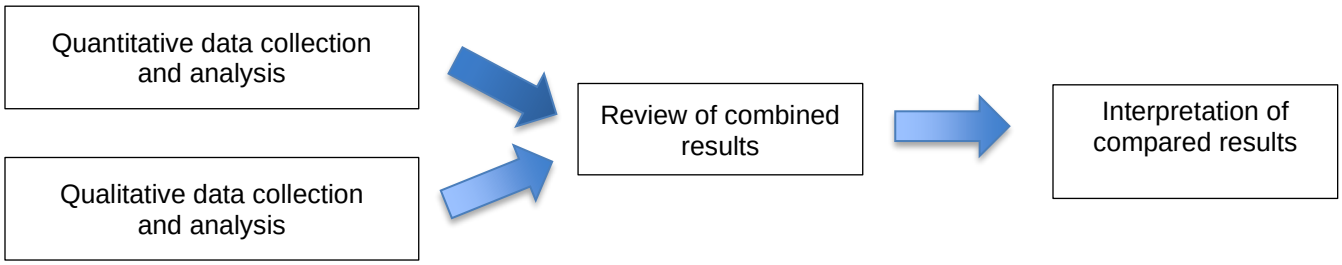

Figure 2.2. *Convergent Mixed Methods Design. Note.* This figure was adapted from an original figure. Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

The study received approval by the University of Georgia's Institutional Review Board (IRB).

Qualitative Data

This dissertation used multiple qualitative approaches to collect and analyze data, including a focus group, semistructured interviews using the critical incident technique (CIT; Flanagan, 1954), exit interviews with the AR team, document review, and researcher and AR team meetings and observations. The focus group, interviews, and AR team meetings were all held via the platform Zoom and were recorded via the platform.

Focus Group

I conducted a preliminary focus group to explore whether there was evidence of CF, VT, and burnout experienced by mental health clinicians within the organization. Five organizational leaders participated in the group, representing four of the five outpatient centers. Participants were selected based on their leadership roles, ability to influence program decisions, and work as clinicians. The focus group was held via Zoom and lasted for 75 minutes. Table 2.2 identifies the demographics of the focus group participants.

Table 2.2

Focus Group Members and Demographics

Participant #	Demographic makeup	Gender	Age	Position/ program	License type	Education level	# of years with agency
5	2 African American women 2 Caucasians (1 man and 1 woman) 1 Latina woman	4 women 1 man	Ages range from 35–55	All participants work at an outpatient center and hold the position of team lead, program manager, and/or director.	All participants are licensed as a licensed associate professional counselor (LAPC), LCSW, or LPC.	All participants hold an advanced degree.	Less than 1 year to 11 years.

I began the meeting by providing a welcome and introduction to the group. I explained the purpose of the research, reviewed the concept of action research, discussed confidentiality and its limitations. The definition of burnout, VT, and CF were reviewed with the participants. The researcher asked eight predetermined questions that facilitated the exploration of group members' experiences with CF, VT, and burnout:

1. In what ways do you think CF, VT, and burnout are a problem or challenge we face as a mental health organization?
2. Is one of these (CF, VT, burnout) more prevalent than the others?
3. How do you recognize CF, VT, and burnout?
4. What do you see as contributing factors or source of CF, VT, or burnout? What are the contributing factors to stress or clinicians feeling overwhelmed?

5. Describe the current workplace culture. What is the environment like? Does the current organizational culture support clinicians? How so or how not?
6. How have CF, VT, and burnout impacted your program? What changes, if any, have you noticed regarding clinical outcomes, employee retention, employee job satisfaction or clinicians' engagement with clients?
7. In which population of clinicians do you see CF, VT, and burnout in the most, i.e., seasoned clinicians, new clinicians, interns, or administrators? What have you noticed?
8. What do you think are the problems we face as an organization?

The focus group members provided detailed examples of clinicians' shared feelings of being overwhelmed by staffing shortfalls and managing high-volume caseloads. The focus group meeting was recorded, transcribed using otter.ai, and analyzed by the AR team.

Interviews

As lead researcher, I obtained consent from study participants and used video and audio to record one-on-one CIT interviews. As pioneered by Flanagan (1954), the CIT comprises procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles (p.1). These interviews were conducted voluntarily and privately, and the limitations of confidentiality were explained. The interviewees who consented to the interview were provided with a list of predetermined, open-ended questions that were reviewed and approved by the principal investigator, Dr. Karen Watkins, prior to the interview.

The purpose of the CIT interviews was to give clinicians the opportunity to discuss experiences of compassion fatigue, vicarious trauma, and burnout in their own words without the limitations imposed by more structured interview techniques. Each clinician was asked to tell me

about a situation or experience when they felt exhausted from their work, burned out, compassion fatigue, or vicarious trauma. The open-ended questions allowed the clinicians to present their experiences in a story format. The interviews were recorded, transcribed using Otter.ai transcription software, and re-storied in a poem or narrative format.

Additionally, interviews were used at the end of the AR project. I conducted group and individual exit interviews with the AR team using open-ended questions. The interview questions were crafted to focus on what the team had learned about themselves, the group, and the system throughout the study. The interviews were recorded on Zoom, transcribed using Otter.ai, and analyzed through NVivo software.

Document Review

I received approval from my sponsor to access organizational documents that would support the study. The AR team and I reviewed archival data including organizational climate surveys, personal emails, turnover statistics, and other documents in this study. This data was used to frame the problem and define the research questions and was iteratively returned to as necessary in the AR cycles.

AR Team Meetings and Observations

The AR team met via Zoom twice a month for 1.5 hours each meeting. This study took place during the global coronavirus pandemic, so virtual meetings for HCMHC had become the norm during this time. Meeting virtually also made it more convenient for team members to attend meetings with minimal travel and more acceptable time commitments. These meetings were recorded via Zoom, and recordings were kept on a separate computer that was not accessible to others. As lead researcher, I maintained meeting notes, journal entries, video tapes, and memos. The review of the collected data, progress of the project, and accuracy of the data

were communicated to the AR team consistently and transparently through member checks. Documents of data and transcribed recordings were reviewed for accuracy by the AR team. The AR team did not request any changes to be made of the transcribed documents. Maintaining strict records and documentation helped us recall information and reflect on previous meetings and also served to strengthen the trustworthiness of the study.

Using AR methodology required participatory action and reflective practices from all team members (Coghlan, 2019). Immersion in the AR methodology and consistent reference to our framework of the causal model of turnover theory (Price & Mueller, 1981) enabled the AR team to collaborate effectively.

Quantitative Data

The quantitative data used for this study was collected from three quantitative data collection instruments: the Maslach Burnout Inventory (MBI; Maslach & Leiter, 1996), the Professional Quality of Life (ProQOL) Scale (Stamm, 2010), and the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004). The strong quantitative framework used in support of our theory and qualitative data further supports the validity and reliability of this AR study.

Participant Sampling

In instances when everyone in the population being studied cannot participate in the study, nonprobability sampling allows the researcher to take a portion of the population to represent the total population being researched. The sampling process allowed the lead researcher and AR team to collect data in fast, cost-effective, and reliable ways (Langer, 2018). Nonprobability sampling is often used for qualitative research (Langer, 2018). The AR team used nonprobability sampling, specifically, uncontrolled quota sampling, to survey the outpatient mental health clinicians to understand the organizational problem better. This sampling was not

intended to be used for the general population or general statistical data but specifically to include outpatient clinicians working at HCMHC. The lead researcher collected data from clinicians currently working at HCMHC's outpatient centers. The representation of clinicians included clinicians who held various professional clinical license types, degree of clinical experience, ethnicity, gender, and age. This mixed representation of clinicians from HCMHC strengthens the trustworthiness of the data.

Survey Instruments

The AR team used these three surveys to collect data and glean knowledge from study participants regarding their experience with burnout, CF, and VT.

Maslach Burnout Inventory (MBI). The MBI is a 22-item instrument that measures three dimensions of burnout: emotional exhaustion (EE, 9 items), depersonalization (DP, 5 items), and personal achievement (PA, 8 items) (Maslach & Leiter, 1996). The *emotional exhaustion* subscale assesses the depressive and anxiety syndrome of chronic fatigue, trouble sleeping, and physical health problems associated with burnout (Maslach & Leiter, 1996). Unlike depression, burnout (i.e., occupational exhaustion) usually disappears outside of work (Maslach & Leiter, 1996). The *depersonalization* subscale focuses on the loss of empathy or feelings of detachment from clients (Maslach & Leiter, 1996). Depersonalization symptoms can lead to cynicism and negative attitudes toward the client and even dehumanizing the client (Maslach & Leiter, 1996). The *personal achievement* subscale assesses changes in the way a person views themselves and their abilities at the job. Decreased personal achievement reflects a decrease in personal confidence, failure despite efforts, and increased doubt in abilities to accomplish things (Maslach & Leiter, 1996).

Professional Quality of Life Scale, version 5 (ProQOL). The ProQOL is a 30-item instrument that measures CF, burnout, and compassion satisfaction (CS) (Stamm, 2010). The ProQOL is a Likert-type scale that rates responses from 1 (*never*) to 5 (*very often*). Initially, the AR team had planned to use the ProQOL as a pre/post study measure; however, due to the substantial clinician turnover, the ProQOL was used only to establish the context and frame the problem. The mental health clinicians who participated rated their feelings and experiences in each section.

Secondary Traumatic Stress Scale (STSS). The STSS is a 17-item self-report questionnaire used to measure clinicians' exposure to traumatic events and secondary traumatic stress (STS) (Bride et al., 2004).

Survey Administration

Prior to administering any of the surveys to the clinicians as part of the quantitative data collection, I first introduced the MBI, ProQOL, and STSS surveys to the AR team to familiarize the team with the instruments. The AR team determined that the instruments would be used to frame the problem and gain insight into the clinicians' experience with burnout, CF, and VT at HCMHC. I administered the initial assessments to the AR team. A PDF version of the MBI, ProQOL, and STSS scales were emailed to the AR team to be printed and completed. Each survey was scored independently, and the results were submitted anonymously with the collection of the surveys completed by the clinicians. The completed surveys were placed into plain white envelopes and mailed to the lead researcher through interoffice mail.

Following these initial assessments, I sent an email notification to each program leader describing the research study and data collection methods. The AR team facilitated team meetings with the clinicians at their centers to introduce the surveys, read the email I sent

explaining the study, the volunteer nature of the survey completion, and informing the participants about how the information would be used. Confidentiality was explained, and implied consent obtained from participants to maintain anonymity and due to the low-risk of the study. The surveys were made available to the clinicians through physical printed copies and electronically emailed copies. To ensure anonymity, the clinicians were informed to not include identifying information on the surveys and to place the completed, sealed surveys in a plain envelope that was provided to them.

These individual white envelopes were combined into a larger envelope and mailed to me through the interoffice mail system. Each envelope was examined to ensure that none of the seals had been broken. I was the only person to unseal the envelopes and complete the initial analysis of the data. The results of the surveys were then aggregated and discussed during the AR team meeting.

Table 2.3

Data Collection and Sampling Table

Data collected	No. of included participants	No. completed	Participants/sample	Analysis type
MBI survey	38	29	Clinicians and AR team members	Descriptive analysis
ProQOL survey	38	29	Clinicians and AR team members	Descriptive analysis
STSS survey	38	29	Clinicians and AR team members	Descriptive analysis
CIT interviews	6	3	Clinicians	Poems and narrative analysis
AR team exit interviews	5	5	AR team members	Audit trail, member check, transcribed and coded for themes
Focus group	5	4	Program leaders and clinicians	Transcribed, content analysis
Post intervention survey, MBI survey	5	5	AR team members	Descriptive analysis
AR team meeting notes, agenda, reflections and journaling posts	5	5	AR team members	Audit trail, member checks, transcribed and coded for themes
Archival documents	Varied	Varied	Organizational data	Triangulations of research, literature, and theory

First-Person Learning

Data collection is an intricate part of the growth, learning, and change that occurs in an AR study and the practice of first-person learning. Coghlan (2019) asserted that keeping a journal of observations and experiences is significant in developing first-person reflection skills and first-person learning. The practice of journaling and reflecting increased my learning about myself and the change project. I kept reflection memos, field notes, and journal entries throughout the AR process. Journaling helped me reevaluate the various ways to approach new experiences and challenges faced throughout the AR cycles. I also met regularly with the principal investigator to ensure that the study was progressing and remaining trustworthy. Furthermore, I continued to review video recordings and documents of the AR team meetings, interviews, research literature, coding, and data analysis to further first-person learning.

Second-Person Learning

Coghlan (2019) noted that practices that engage the researcher in co-inquiry, which includes shared actions and mutual concerns, are processes of second-person learning. Second-person learning was achieved through the focus group, AR team meetings, and AR group exit interviews. The AR team participated in group reflections, journaling, and document review. The AR meetings were recorded, transcribed, and reviewed by the team. This co-learning helped the AR team frame the problem and convey a shared purpose and group expectations. The AR team learned about themselves as members of the group, developed an understanding of the group cultural norms, and used the group as a source of support for one another. The sharing of the group members' observations and experiences supported the constructing, planning, taking action and evaluating action throughout the AR cycles. Moreover, the multiple data collection

methods and the iterative AR cycles ensured the rigor and trustworthiness of the study (Coghlan, 2019).

Third-Person Learning

The AR team collected and analyzed quantitative and qualitative data on the contributing factors that lead to burnout, CF, and VT in outpatient clinicians. The data was compiled and presented in a PowerPoint presentation to key stakeholders at HCMHC. The findings increased buy-in and gained approval to implement the research interventions. Three interventions were implemented in the study: (a) organizational value statement, (b) reduction of paperwork by redesigning an internal referral form, and (c) flexible schedules for clinicians to include 1 hour each day of self-care time. In order for these interventions to be implemented, new policies and procedures were developed at the system level. Additionally, the new practices and implementation of the interventions at the system level included the support of board members, key stakeholders, other organizational leaders, and clinicians.

Data Analysis

This portion of the paper describes the data analysis process. As mentioned, the AR team used qualitative and quantitative data methods for this study. The quantitative data was collected from surveys and the qualitative data was obtained from documents, interviews, focus group, reflections, and AR team meetings. According to Marshalls and Rossman (1989), “data analysis is the process of bringing order, structure, and meaning to mass of collected data” (p. 112). The various data sets were separated, labeled, and placed in electronic folders to maintain organization and structure. Excel spreadsheets and Word documents were used to organize and analyze the survey data.

I used Otter.ai software to transcribe the CIT interviews, focus group, and AR team meetings. Computer-assisted qualitative data analysis software (CAQDAS) was used for the management and analysis of qualitative data (Miles et al., 2020). I used NVivo as the CAQDAS in this study as it was recommended by my major professor as a user-friendly tool. To ensure accurate use of the data software, I reviewed tutorials on how to use NVivo effectively for qualitative data analysis.

The data collected was uploaded, transcribed and analyzed inductively and deductively. Once the videos were transcribed, I met with the interviewees and team members to determine the accuracy of the transcripts. According to Yin (2018), member checking and the review of transcribed documents to confirm their accuracy increase the accuracy and validity of the data. The coded information of patterns and themes were shared with the AR team and used to answer the research questions and to develop the interventions. The AR team members were asked to participate in data analysis, group reflections, and member checking throughout the study.

Table 2.4 describes the research questions, timeline, sampling, and data collection strategy.

Table 2.4

Research Plan

Purpose or guiding question(s)	Data collected	Sample	Data collection timeline	Analysis strategy
1. What is learned at the individual, group, and system levels that advances theory and practice	MBI, ProQOL, and STSS surveys Value survey	AR team and clinicians Clinicians	August 2022 May 2023	Content analysis Triangulation analysis

about organizational interventions aimed at decreasing the impact of professionals' CF and burnout in an outpatient community mental health organization?	Focus group CIT and AR team exit interviews Journaling	Program leaders and clinicians Clinicians and AR team members	March 2021 Sept 2021–Dec 2021	Member check Triangulation Content analysis
	Archival records	AR team and lead researcher	June 2022-August 2023	
	Documentation	Human resources, document review, emails, organizational climate surveys, meeting notes	June 2022–August 2023	
2. What organizational culture and systemic factors affect the experience of burnout, CF, and VT in clinicians working in outpatient mental health centers?	MBI, ProQOL, and STSS surveys	AR team meeting notes, meeting agendas, field notes, organizational documents AR team and Clinicians	June 2022–August 2023 August 2022 and January 2024	

Ensuring Trustworthiness

As lead researcher, I used multiple data collection sources, which Yin (2018) referred to as *triangulation*, to strengthen the validity of this study. As previously described, the AR team used observation, CIT interviews, documentation review, surveys, and AR team meetings as data collection sources. I used comparative data analysis and maintained ethical practices to support the validity of the data (Yin, 2018). I demonstrated a clear use of construct validity and reliability

of this study by aligning interventions that are guided by theory and answer the research question.

Ethics

To ensure quality AR, ethical considerations were maintained throughout this study. The study participants were informed that their participation in the study was voluntary and that they could withdraw from the study at any time. Informed consent documents were explained to and signed by all participants. The study participants were informed of the limitations and the risks of the study. There was a risk that discussing CF, VT, and burnout could trigger participants or bring up uncomfortable feelings. Furthermore, the participants were informed that complete anonymity could not be ensured with other participants involved in the study. However, I emphasized the importance of maintaining trust within the group and honoring others' confidentiality.

I also took careful consideration to maintain data collection systems that did not expose the identity of the participants. Each person's identity and privacy were protected to the greatest extent possible in this study. Distinguishing information in recorded videos and documents was removed or provided a codename to maintain confidentiality.

Coding

Coding is using the words and experiences within the data to understand the phenomena experienced by study participants; it allows the researcher access to the study participants' thoughts and reaction to a study (Miles et al., 2020; Williams & Moser, 2019). According to Williams and Moser (2019), data coding assists with the construction of meaning that is developed from the collected data. To further augment the rigor and trustworthiness of this study, I employed inductive and deductive coding to derive coding schemes and themes. As explained

by Williams and Moser (2019), “deductive research focuses on causality and testing theory” while “inductive research focuses on generating theory from collected data” (p. 47). As lead researcher, I coded, recoded and cross-coded the data to increase credibility and trustworthiness. Table 2.5 provides a summary of the various data collection methods, using both qualitative and quantitative data, and ways the lead researcher sought to increase validity and trustworthiness of the study.

Table 2.5

Strategies to Increase Validity and Trustworthiness

Collection method	Triangulation	Audit trail	Member check	Reflexivity
MBI, ProQOL, and STSS surveys	X	X		X
CIT interviews		X	X	X
Meeting notes		X	X	X
Archival documents	X			
Focus group		X	X	X
Journaling/reflections				X

Subjectivity Statement and Limitations of Data Analysis

The AR team was made up of supervisors and clinicians who worked directly with clinicians and clients at HCMHC. Being closely related to the study provided us with insight into the problem and promoted a space for advocacy for change. Nevertheless, with my close relationship to the study, I had to understand how my values, beliefs, and biases could impact the lens through which I viewed the research problem. I understood that being closely tied to the problem and having first-hand encounters with clinicians experiencing burnout, CF, and VT, as well as experiencing these challenges, increased my emotional connection and bias regarding the problem.

Another bias I held was that I understood the problem better than other stakeholders who did not work directly with outpatient center clinicians or clients. My day-to-day contact with clinicians and the management of the clinical services, documentation needs, and fast-paced environment provided me a deeper understanding of the challenges and, as a leader, I was more personally invested in the problem than others not directly working in this environment. However, in order for me to study the challenges and develop opportunities for organizational growth, I was granted this opportunity by key stakeholders who were as passionate as I am about the retention of clinicians and a sustainability plan to reduce burnout, CF, and VT.

In my leadership role, it is important for me to understand my core beliefs, values, biases, and theories that guide my perspective on leadership and how they align with those of the organization. Values helped me to determine what actions to take and how to assess one's professional actions and the actions of the system (Anderson, 2020; Russell, 2001). I pride myself on being a values-based, ethical leader: I value honesty, respect, and integrity and respect these attributes in others. During this project, it was important to me to uphold my values and use them to build professional relationships and continue to gain buy-in from key stakeholders.

I am a compassionate, reflective leader who believes that my words and actions should encourage and support others to reach their full potential. Therefore, I engage in first-, second-, and third-person reflections to be an effective leader (Coghlan, 2019). My priority as a leader is to exercise wisdom, collaboration, commitment, and compassion as I work with others to achieve our goals and make a positive difference for people and the organization. Due to my deep desire to help others, I aspire to be a servant leader who leads through solid ethics and caring behavior, seeks to involve others in decision-making, and enhances workers' growth while improving the care and quality of organizational life (Spears, 1996). These attributes are important in leading

change through AR methodology. According to van Dierendonck (2011), leadership is rooted in ethical, person-centered care and prioritizes employees' well-being. As a leader of change, I used the servant leadership model as a guide throughout this project. As an insider action researcher, my goal was to help enhance the organization's culture in relation to the experiences of clinicians working in high-stress environments.

Study Limitations

There are also certain limitations of the data collection and analysis in this study. The awareness of a study's limitations and biases increases the credibility and trustworthiness of the study. Horizon Community Mental Health Center (HCMHC) has experienced significant turnover throughout this study. This clinician turnover limited the AR team's ability to collect and analyze pre/post MBI, STSS, and ProQOL surveys. The study had a limited sample size and focused on the associations of burnout, CF and VT with turnover intention. The data collection did not extensively include other external and personal factors that could contribute to the turnover phenomenon at HCMHC outpatient centers. Additionally, other external factors that contribute to burnout, CF, and VT on a macro level were not considered extensively in this study. Another limitation is that other key stakeholders may have a different perspective on the problem, and their understanding of the causation of turnover may be different than that of the study lead researcher, AR team members, and study participants. The data collected did not include clinicians who did not work at an outpatient center.

Summary

In summary, the AR methodology is the anchor to the change process. The iterative cycle comprises constructing, planning, taking actions, and evaluating action as key factors that promote the quality and rigor of the study. Action research contributed to the organization's

growth, learning, and change at the individual, group, and system levels. Furthermore, considering the ethical implications and quality of the data collection process increased the trustworthiness of the study. The care taken to ensure the rigor and validity of the data collection methods reinforced the reliability of the study. The lead researcher and AR team worked diligently to maintain the rigor, validity, and quality of the study. Through this process, the AR team was able to identify the organization's strengths, develop interventions aimed to increase retention, understand system growth opportunities, and enhance the experience of clinicians working at HCMHC. The story of that process is elaborated in more detail in Chapter 3.

CHAPTER 3

THE ACTION RESEARCH STORY

This chapter of the dissertation tells the full story of the action research (AR) project and research—that is, the context/problem and what the AR team did to develop and change the system. The story is told through my lens as the lead researcher and outpatient center director. This story will be narrated in three sections. The initial section introduces the organization's environment using a descriptive metaphor that describes how the lead researcher entered the system. Then, the problem and organizational context, the role of the researcher, key stakeholders, and the AR team are described. The next section presents the research questions and briefly overviews the AR research process, followed by the bulk of this chapter, which is devoted to describing the multiple, iterative phases of the AR cycles. The last section of this story discusses postsurvey themes, reflections, and key learnings.

Introduction to the System: Ground Zero

Chapter 3 tells the AR story through the often-untold stories of exhaustion, compassion fatigue (CF), and burnout of clinicians working in an outpatient mental health organization. Below is a narrative I wrote that looks through the eyes of first responders entering the scene of a devastated community that has been ravaged by a natural disaster.

It's an early Saturday morning. I open the blinds to embrace the morning light and observe the wonders of nature from the trees behind my home that are lightly blowing in the wind. I open the door to feel the air against my skin and the gentle breeze wafting in the quietness of the morning. It feels so peaceful and calm. Then, out of nowhere, the severe weather

sirens begin to blare. I rush to turn on the television to hear that a tornado watch has been issued in my area. After hours of hunkering down in my safe space and regaining electricity, I learned that the storm had wreaked havoc in neighboring towns.

First responders are dispatched from near and far, risking their safety to help those in need. The first responders are met with sights of calamity, homes reduced to rubble, streets blocked by floating debris and keepsakes once cherished by the neighboring homes floating past them. The first responders spring into action and begin to assist survivors of this devastation. The residents, with tear-filled eyes and blank stares of shock and disbelief, are assisted with gentleness and care by the first responders. After days and weeks of pulling the deceased from the wreckage and reuniting survivors with their worried and grief-stricken families, the first responders are hailed as heroes, but little attention is given to the trauma they have witnessed and experienced, the compassion fatigue that ensues or the feelings of exhaustion and burnout they may feel over time. I asked myself, what happens to these first responders? Who takes care of those who take care of others?

These images are not far from what is experienced by mental health clinicians working in outpatient mental health settings. Like first responders, outpatient mental health clinicians provide direct care to those who have experienced severe trauma or have a severe and persistent mental illness. The fast-paced environment of outpatient mental health clinics is filled with clinicians under considerable pressure to manage large caseloads, copious notes, low salaries, and depleting morale. The clinicians put the needs of the clients first, often not thinking of themselves or the potential hazards of the job.

Organizational and Problem Context

Horizon Community Mental Health Center (HCMHC)[3] is a quasi-state organization whereby the organization operates under state guidelines but is not considered a state agency. The state of Georgia is one entity that provides funding to the organization to pay for services rendered to individuals with limited resources. As outlined in HCMHC's 2020 annual report, it is governed by a 13-member board and is one of 27 agencies in the state of Georgia created to provide a safety net for individuals who need accessible behavioral health services. The organization provides services to clients ranging in age from children aged 2 and up to senior adults. In fiscal year 2022, HCMHC employed 601 employees, of whom 101 were classified as clinicians.

HCMHC employs a team of psychiatrists, nurses, licensed counselors, social workers, and other mental health professionals to provide services to individuals in need of services for mental illness, substance abuse, and intellectual and developmental disabilities. Services are distributed into four categories across three counties in Georgia: outpatient services, community services, specialty services, and acute services. This project focused on the clinicians working at the five outpatient mental health centers serving three major Georgia counties. Each outpatient center has a center director, program manager, a team of psychiatrists, nurse practitioners, nurses, clerical staff, and licensed mental health clinicians.

HCMHC's vision statement is outlined in its 2020 annual report and focuses on providing high-quality, comprehensive care to foster "healthy lives and healthy families." This vision is a daily goal that employees and programs aim to meet. To increase access to services, HCMHC offers walk-in services at all outpatient centers. Individuals are assessed by a licensed mental

[3] As noted in an earlier chapter, pseudonyms have been used for both the clinics and the research participants to preserve confidentiality.

health clinician for imminent suicidal and/or homicidal risks, psychosis, depression, anxiety, and substance abuse. The clinicians use assessment tools such as the Patient Health Questionnaire (PHQ-9), which is a depression scale; the Generalized Anxiety Disorder–7 (GAD-7) scale, which measures the severity of anxiety; the Columbia Suicide Severity Rating Scale (C-SSRS), which is used to assess suicide risk; and the Adverse Childhood Experience (ACEs) test, which is used to assess childhood trauma that can be linked to adult health issues. Additionally, clinicians are trained to administer naloxone (also known by the brand name Narcan), a medication that is used to quickly reverse an opioid overdose (National Institute on Drug Abuse, 2022).

According to its 2020 annual report, HCMHC provides mental health services to approximately 16,000 individuals per year, on average. Since 2020, HCMHC has experienced higher-than-average turnover of mental health clinicians, which was further exacerbated during the COVID-19 global pandemic. Accordingly, the problem under study is the turnover of community mental health clinicians and an outpatient mental health organization's attempt to mitigate turnover and increase retention.

The Problem of Clinician Turnover at HCMHC

In the span of 11 months (March 2020 to February 2021), seven clinicians either chose to separate from HCMHC or requested to be moved to a different program. From July 2021 through August 2022 (13 months), HCMHC continued to experience significant turnover. Of the 37 clinicians who worked at one of the five outpatient centers during this timeframe, 21 (54.05%) separated from the organization. The remaining clinicians assumed additional responsibilities, including rotating shifts to provide triage and assessments to individuals in crisis, completing clinical assessments for clients recently discharged from a behavioral health hospital, and

managing large client caseloads. Clinicians reported that the external and internal processes of working with clients in crisis were particularly mentally and physically exhausting.

Clients in crisis present with a complexity of issues that require management of high-risk behaviors to self or others, the use of controlled or illegal substance, and psychotic behaviors. The limited availability of external crisis hospitalization beds and transportation for clients to access inpatient hospitalization formed a barrier to adequate and timely care for clients. Clinicians reported high levels of anxiety and stress when they received notice that a client had presented in crisis due to the fear of not having access to available resources. Clinicians feared that their limited resources would delay the client's acceptance into a crisis hospital and that they would be "stuck" after hours trying to arrange transportation and contacting multiple hospitals in an attempt to get the client accepted into a hospital bed.

As director, I met with each person separating from my program to complete exit interviews. In these interviews, clinicians reported that their choice to separate from the organization was due to feeling burned out and overwhelmed by the job. Additionally, clinicians reported feeling unsupported by the organization, not feeling valued as a person, and only hired "to bill" for services. Prior to transferring to this outpatient center 2 years ago, I was the director at another outpatient center within the same organization. Both centers experienced similar concerns with clinicians separating from the agency due to feeling exhausted from the day-to-day expectations of outpatient center clinicians.

Role of the Researcher

As director of HCMHC's largest outpatient mental health center, I oversee the day-to-day operation of the center. In my role, I work with interdepartmental team members, program leaders, nonclinical and clinical staff to meet deliverables and personify the vision, mission, and

goals of the organization. As a leader within an organization that provides mental health services and employs many clinicians, I am privy to the many challenges that clinicians experience at HCMHC. I receive feedback from clinicians who express feelings of being overwhelmed, frustrated, and exhausted from their daily routines.

On average, clinicians conduct counseling sessions for 6–7 hours in an 8-hour day, in addition to completing other administrative duties. Clinicians' caseloads are full, and counseling sessions are scheduled with minimum breaks in between. Clinicians prioritize the times a client does not show for a session to complete case notes, return calls, make referrals, and plan for the next sessions. The time constraints in which to have documentation completed and planning for the next day often pushes clinicians to work beyond regular work hours. Several clinicians have resigned and reported finding suitable employment in less stressful environments with better compensation.

The organization's culture expects clinicians to perform in a high-stress environment while seemingly marginalizing them; clinicians try to mitigate their stress through resignations. When burnout is discussed at leadership team meetings, statements such as "this is what you signed up for" or "community mental health is not for everyone" abound. In my role as a director, licensed professional counselor (LPC), and insider action researcher, I have a unique opportunity to understand the needs, concerns, and opportunities for organizational growth and realignment.

Key Stakeholder Analysis

As lead researcher, I used my position and relationships to introduce the project and gain support from key stakeholders in the organization. Using the stakeholder prioritization matrix, I identified key stakeholders and their perceived influence on the success of this project and their

level of interest. I strategically communicated the goal(s) of the project to key stakeholders during informal lunches, one-on-one meetings, and emails, and they verbalized their interest and support of this project. A description of key stakeholders is provided below; all names are pseudonyms to maintain confidentiality.

Jill is the chief executive officer of HCMHC. She is a key stakeholder and wrote a sponsor letter in support of this project. Jill is a licensed clinician and has worked for a number of years as an outpatient clinician at HCMHC. As an administrator, Jill approved the clinicians' use of work time to participate in the AR process as well as the implementation of interventions developed by the team.

Maggie is the deputy clinical director. In her role, she makes decisions regarding policies and procedures that guide all clinical services. Maggie's support of this project was vital as she had to approve any changes made to the clinicians' workflow and procedures.

Jennifer is the director of core services and my immediate supervisor. Jennifer is a licensed clinician and has worked in the capacity of a clinician and director at one of HCMHC's outpatient centers. Her support was vital in this process as she provided moral support and approval for me to use work hours to work on this project.

The Action Research Team

The AR team members were selected to represent the five outpatient mental health centers located in the three county catchment areas of the organization. Participants were identified and were invited to participate in an initial focus group, after which they accepted the invitation to continue as members of the AR team. Each AR team member has dual responsibilities in providing direct clinical services to clients and performing supervisory responsibilities for a team of clinicians. The AR team members have diverse levels of

clinical/supervisory experience and various tenure with the agency. The AR team is a general collection of associate-level and fully licensed clinicians who hold licenses as LPCs or licensed clinical social workers (LCSWs). Additionally, this AR team includes myself as lead researcher and program directors, program manager, and team leads who represent the levels, duties, and clinical structure of the organization. Table 3.1 depicts the members of the AR team, their positions, gender, licensure status, and age, as well as their unique position that makes them an asset to the team.

Table 3.1

Action Research Team Members

Pseudonym	Race	Gender	Age	Position/program	License type	License level	Years in agency	Description of AR team members
Cierra**	AA	Female	50	Outpatient center director	LPC	MS	5	Cierra has worked with various organizations (community mental health organizations and private for-profit organizations). At HCMHC, she has worked as a licensed mental health clinician, program manager, and director of an outpatient mental health center. She is the current center director of one of the five outpatient centers with HCMHC.
Aaron**	C	Male	32	Team lead	LPC	MS	5	Aaron has worked at HCMHC in various programs. His experience provides him with a wealth of knowledge about being a clinician in an outpatient setting as well as a day service program. Aaron has completed his clinical supervision and recently obtained full licensure as an LPC in March 2021. Aaron also has an MBA degree; both his clinical and business backgrounds can be an asset to the team.

Pseudonym	Race	Gender	Age	Position/program	License type	License level	Years in agency	Description of AR team members
Natalie**	AA	Female	42	Team lead	LCSW	MSW	5	Natalie works at one of the smallest outpatient centers at HCMHC. She is a team lead who manages other mental health clinicians as well as her own caseload of clients. She has the unique position of being a team lead and active clinician at an outpatient mental health center.
Lauren**	C	Female	36	Program manager	LCSW	MSW	11	Lauren has been with the organization for more than 11 years. She has worked in various capacities and at various outpatient mental health centers. Lauren started as an entry-level clinician and has advanced to team lead and is now program manager. She has a wealth of knowledge as a clinician and administrator.
Maria**	H	Female	35	Program manager	LCSW	MSW	4	Maria is a program manager who holds the dual role of manager and clinician. She manages a caseload of clients and provides clinical supervision to her team of clinicians. Maria works at the outpatient center that treats clients who are primarily Spanish speakers.

Pseudonym	Race	Gender	Age	Position/program	License type	License level	Years in agency	Description of AR team members
Jemecia*	AA	Female	46	Outpatient center director	LPC	MS	8	Insider action researcher

*****Denotes lead researcher and doctoral student; ** denotes pseudonym used for confidentiality
Race/ethnicity = AA, African American; C, Caucasian; H, Hispanic

The Action Research Study Questions and Approaches

Research Questions

The following research questions guided the design of the AR study and interventions:

RQ1. What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion fatigue, vicarious trauma and burnout in an outpatient community mental health organization?

RQ2. What organizational culture and systemic factors affect the experience of burnout, CF, and VT in clinicians working in outpatient mental health centers?

Action Research Cycles

As described in Chapter 2, AR methodology is used to examine complex issues within an organization through the use of 4 steps of 1) constructing action, 2) planning action, 3) taking action, and 4) evaluating action (Coghlan & Brannick, 2014, p. 6). The AR story in the following sections is told in the chronological order of the AR cycles as the AR team conducted them. Each of the three AR cycles are explained, and the steps taken in each phase are described (see Table 3.2 for a summary). The cycles have been given thematic names to describe the main processes within each one (see Figure 3.1 for a visualization):

1) Cycle 1, The Invisible Truth: Acknowledging the Problem and Building Capacity for Organizational Growth;
2) Cycle 2, The Dawning of New Light: Purposeful Planning and Intervention Implementation; and
3) Cycle 3, The Awakening: Evaluating the Emergence of a New Mindset and Sustainable Organizational Growth.

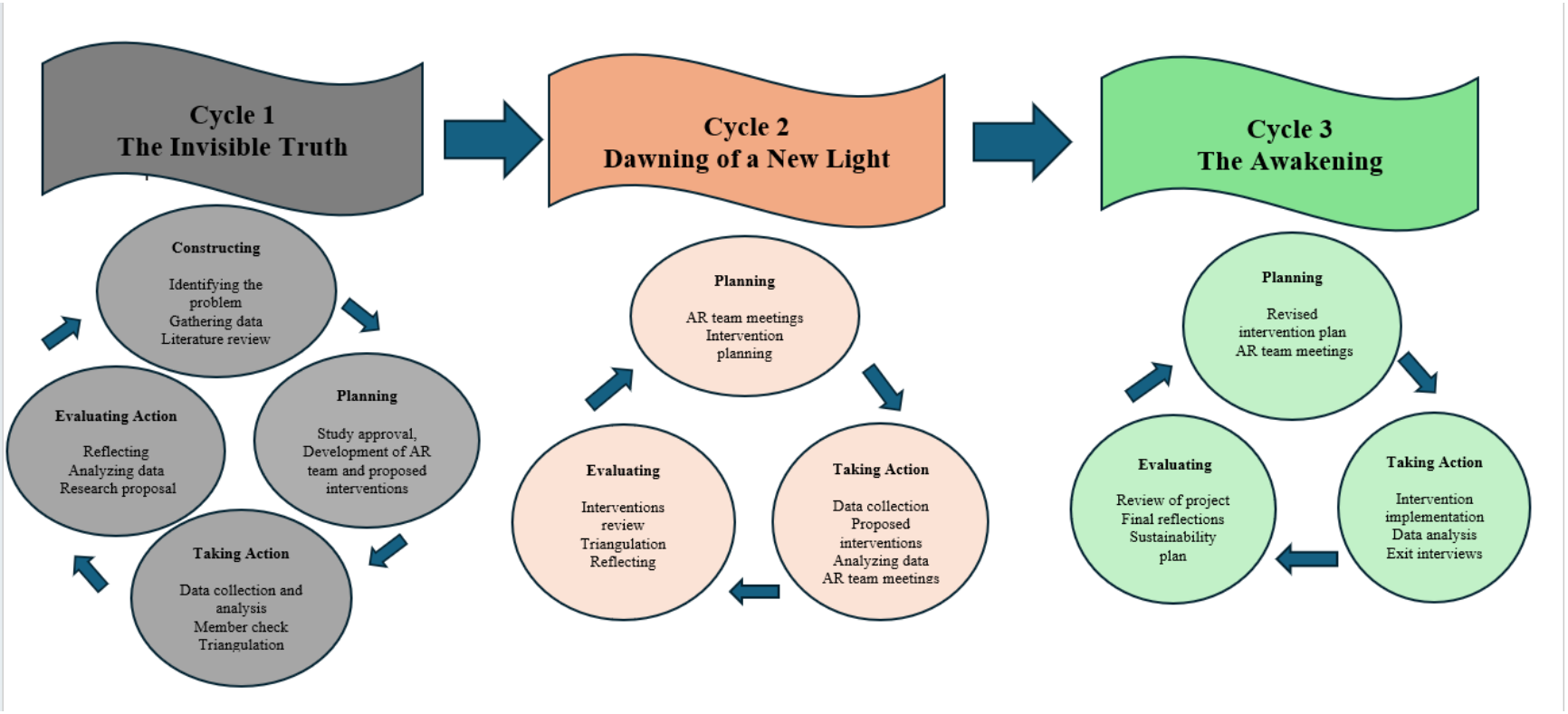

Figure 3.1. *Overview of HCMHC Action Research Cycles and Phases.*

Table 3.2

Overview of Key Action Research Team Activities

Date	AR cycles	AR phase	Activity type	Activity description
	Cycle 1			
3/11/2021		Constructing	Focus group Literature review	Met with outpatient program leaders and clinicians; discussed the problem of burnout, CF, and VT; does it exist at HCMHC?
9/2021–12/8/2022		Planning	CIT learning and interview scheduling IRB education, testing, and submission	Scheduled CIT interviews; IRB application completed, submitted, and approved
10/1/2021–11/1/2021		Taking action	CIT interviews	Conducted CIT interviews; recorded and retold individual stories of burnout, CF, and VT; Review of separation exit interviews and organizational archival data; literature review
		Evaluating action	Lead researcher development of research plan	AR lead researcher review of CIT interviews, focus group, and literature; Development of the AR team
	Cycle 2			
6/2/2022		Planning action Taking action	Initial AR team meeting	Establishment of the communication agreement; problem framing; what is AR job aid review

7/11/2022	AR team meeting	Literature review of burnout, CF, and VT; understanding turnover; review of collected organizational data on turnover
8/8/2022	AR team meeting	Review of the causal model of turnover; discussed disseminating quantitative data surveys–MBI, STSS, ProQOL
8/31/2022	AR team meeting	Team not trusting the group process; closed off; low energy "we are more open discussing feelings of the clinicians than our own"; Tuckman's stages of group development reviewed
9/9/2022	Data analysis/AR team meeting	Surveys sent and collected from clinicians on burnout, VT, and CF
9/26/2022	AR team meeting	Reviewed the results of the collected data from the surveys; discussed possible interventions; reflecting on what we are learning
1/31/2023	AR team meeting	Watched TEDTalk video "Getting Stuck in the Negatives and How to Get Unstuck"; watched video "Learned Helplessness" by Derek Versitalium

3/13/2023		Evaluating action	AR team meeting	Synergy develops; reflecting on what we are learning; review of proposed intervention review–flexible schedules for clinicians; prep time or debriefing time
	Cycle 3			
3/27/2023		Planning action	Intervention presentation/AR team meeting	Review of the three interventions and deriving an implementation plan
4/24/2023		Taking action	Intervention implementation/AR team meeting	PowerPoint presentation regarding the need, data, and request to implement a 2-week flexible schedule (care coordination time); Organizational value statement
5/12/2023			AR team meeting	Care coordination pilot study started in five outpatient centers for 2 weeks
5/23/2023			AR team meeting	Reviewed clinicians' feedback regarding what makes them feel valued and heard; feedback from the flexible schedule study; team worked on the development of a value statement for the organization
7/10/2023			Organizational leadership meeting	Lead action researcher and two AR team members attended this meeting to discuss the

			need to review the internal referral process; see notes from meeting
7/17/2023		Strategic planning meeting	Lead action researcher attended the strategic planning meeting; value statement proposal approved
8/17/2023		AR team meeting	Flexible schedules/care coordination presented and approved
9/7/2023	Evaluating action	AR team meeting/ Exit interviews/sponsor follow-up	Group exit interview/individual exit interviews/sponsor communication
1/17/2024		AR team postintervention surveys	Post survey—AR team members completed nine questions on the MBI focusing on emotional exhaustion

Note. AR = action research; CF = compassion fatigue; CIT = critical incident technique; HCMHC = Horizon Community Mental Health Center; MBI = Maslach Burnout Inventory; ProQOL = Professional Quality of Life Scale; STSS = Secondary Traumatic Stress Scale.

AR Cycle 1. The Invisible Truth: Acknowledging the Problem and Building Capacity for Organizational Growth

Cycle 1 Constructing Phase

The key component of the constructing phase was to develop an understanding of the problem based on the literature and initial research findings. This section outlines how I, as the lead researcher, became interested in studying burnout, compassion fatigue, and vicarious trauma; obtained sponsorship; assembled a preliminary focus group; and reviewed literature and archival data.

The Beginning of the Research Journey

At the beginning of the study, I sought to gain a deeper understanding of the challenges I was experiencing with clinicians expressing feelings of frustration, burnout, and desire to separate from the organization. Was I the only director experiencing high rates of turnover? Was it just the clinicians at one outpatient center experiencing burnout?

I had worked at HCMHC for 8 years and was at the start of a new position as the new outpatient center director in a different county. I did not have a relationship with the staff at the center I was joining. I quickly began to realize that clinicians needed an outlet to vent their frustrations and discuss their needs. I was a new face and, in essence, brought a sense of hope to a collapsing situation. One by one, clinicians came to my office and asked to speak privately. I sensed the desperation on their faces and in their voices. Clinicians expressed feeling overwhelmed, fatigued, and burned out. Clinicians began to request personal time off, a reduction in work hours, and more remote work. A review of clinicians' documentation showed that clinicians were behind on the completion of notes and were struggling to manage their current caseloads.

In the first month of this new position, we received notice of the global COVID-19 pandemic, which required an urgent and immediate shift in how clinicians worked. Initially, clinicians verbalized feeling relieved at being able to work from home. As the remote days began, however, I experienced a shift in clinicians and staff commitment to staying with the organization. Over the next 11 months, resignation after resignation ensued, totaling 14 departing staff members—seven of whom were clinicians. The situation was grim, and we worried if the program's doors would remain open. As I held back my own feelings of despair, I listened to two other leaders speak their truth: "I am at a loss for words," "I just want to cry in a corner," "I am trying not to cry and throw up at the same time," "I just want to yell at the top of my lungs…HELP US!!!!!" I listened with empathy but struggled to find a solution to this problem.

I became compelled to understand more about what I was experiencing. Were burnout, compassion fatigue (CF), and vicarious trauma (VT) issues at HCMHC? Were similar issues occurring in other mental health centers? Was this a nationwide issue? What could be done to address clinician turnover and improve retention? I approached the CEO of the organization to gain approval to conduct an AR study to identify growth opportunities at HCMHC. With the support of the CEO as my sponsor, I began to assemble a group of leaders and clinicians to join a focus group.

Assembling the Focus Group

To gain more insight and determine whether clinician turnover was a systemic problem across all outpatient programs or only an issue at the outpatient center where I work, I invited leaders from all five outpatient centers to join a virtual focus group, held over Zoom, which I facilitated on March 11, 2021. In deciding invitees, I sought to ensure representation from each outpatient program was included. Although the services at each outpatient center are similar, the

demographics, location, staffing size, and client number vary. I wanted to ensure that each participant was a clinician and also held a supervisory position that would provide them with knowledge of the clinical team.

Administering the Focus Group

This focus group was an initial opportunity for leaders to discuss, in an open forum, their experiences at all the outpatient center programs in HCMHC and to share knowledge that could help frame the problem.

I began the focus group by reviewing the purpose of the focus group, reviewing confidentiality, and explaining how I intended to use the information collected. I explained the reason why the session would be recorded and the use of pseudonyms to preserve the confidentiality of the group members and the organization. The focus group began with an overview of the definitions for CF, VT, and burnout. Eight predetermined questions, which had previously been approved by Dr. Karen Watkins (the principal investigator), were used as the primary questions for the group, but secondary questions were asked for clarification or further explanation (see Chapter 2 for the specific questions). Each person weighed in through nodding their heads in agreement, verbalizing their affirmations, and providing examples, including personal commentary, or by referencing other clinicians' comments.

The focus group members provided detailed examples of clinicians who had shared feelings of being overwhelmed by their clients' level of trauma, illness, and severity of diagnosis. The excerpts in Table 3.3 are themes drawn from this feedback.

Table 3.3

Focus Group Excerpts and Themes

Themes	Excerpts
Burnout	*If you don't complete documentation at that moment, you see it pile up…If you get off track, it's at 5:00 o'clock, you're still completing, and it flows into your home life and the boundaries.* *They don't even have time to go use the restroom let alone get outside and just take a breather or stretch your arm for 5 or 10 minutes.* *People start taking off more or needing time off or feeling sick or feeling ill. Those are definitely significant signs you know, when someone's physically or mentally exhausted.* *I'm just hearing a lot more about some health issues, headaches, you know, things such as that.* *There's so much redundancy in the paperwork…all of that stuff combined just kind of leads to that experience of burnout and compassion fatigue.* *I'm just so overwhelmed with so much…I'm feeling so tired, or it takes me so much energy to get this task done, you know, and I have this on my desk, but it's just taking a lot of energy to focus in on it.* *Now, granted, this place and population is not for everybody…But I think even for the ones that it does fit for, it's like you just can't, you can't constantly be running a marathon.*
Compassion fatigue	*You see the same clients for five hours a day, for five days a week, for years at a time… And you just like, I just don't see where this is going…And I feel like I'm not doing anything for them.* *I think the paperwork sometimes becomes even more burdensome than the work with the clients face to face.* *If you lose sight of that collaborative documentation for just a moment and you get behind, it can feel like a marathon.* *Some of them are irritated and irritable with clients and even today one of my clinicians said, I don't have any more compassion for the clients…So a lot of them are suffering.*
Vicarious trauma	*A clinician that has an intense caseload and they are seeing clients back-to-back, one trauma after another trauma after another trauma.*

Themes	Excerpts
	I've heard it…severity of clients that are being seen. The level of sickness…the level of trauma, just back-to-back hearing these stories over and over again.

The focus group participants agreed that contributing factors to clinicians' burnout, CF, and VT included feelings of being overwhelmed by the documentation, caseload size, acuteness of clients' mental illness, and limited time to complete tasks, as well as environmental factors. In addition, group consensus determined that clinicians' requests for "mental health days," sick leave, and resignations had been on the rise across programs. The insurmountable amount of paperwork was another focus of the group's attention that raised a collective response regarding the redundancy of paperwork, not having enough time for adequate bathroom breaks, nor having time to stretch or practice self-care as notes are due within 24 hours. It was also expressed that the use of telehealth services appeared to have exacerbated feelings of being stressed and overwhelmed. One of the challenges that clinicians faced was not being able to set adequate boundaries while working remotely. Particularly during the COVID-19 pandemic, clinicians were juggling work, their children's homeschooling, and personal schedules, and these collided into untenable burdens.

The central theme noted was that across the four outpatient centers represented in the focus group, clinicians from all programs have verbally and/or physically shown signs of burnout, CF, and VT, although the group expressed that the younger clinicians or clinicians who are newer to the field appeared to need more coaching and supervision to support them in these areas. Opinions differed somewhat regarding the overall organizational culture and the specific

environmental factors that may contribute to CF, VT, and burnout. The data that I collected through the focus group helped me to better frame the problem.

Reviewing the Literature

Following the focus group, I reflected on the themes that had emerged as I began to examine the literature for studies that addressed burnout, CF, and VT in outpatient mental health clinicians. I hoped to learn how others in similar fields had addressed the problems of burnout, CF, and VT in hopes to address what I suspected was happening at my organization. Although I found an abundance of data on burnout in nurses and healthcare personnel, I was astounded to learn how few studies had been done involving outpatient mental health clinicians. This was clearly a gap in the research on which I wanted to focus.

Next, I began to talk with my colleagues to learn more about what they were experiencing in their programs. I reviewed exit interviews from HCHMC and listened closer to what clinicians were communicating verbally and nonverbally. I extended an invitation to each of the focus group members to become members of the AR team, informing them of the voluntary nature of participation, and each returned a signed consent form and their agreement to participate.

Cycle 1 Planning Phase

The key components of the planning phase were (a) the review of what was learned from the focus group, literature, and archival data and (b) the development of next steps. This section outlines how I received UGA IRB approval to conduct a human study, planned one-on-one interviews with clinicians, and collected data.

Obtaining IRB Approval

As the lead researcher, I received approval in December 2021 by the UGA Institutional Review Board (IRB) to conduct a study regulated by the human research protection program. Formal invitations and consent forms were then sent to each former focus group member, who signed and returned them. I then sent a scheduling email to participants to schedule the initial AR team meeting and worked to develop a meeting format to present to the AR team. I also developed an AR executive summary to educate our key stakeholders, sponsor, and AR team members on what AR is and how it would be used to conduct the research study.

Planning CIT Interviews

I continued to gather archival data and review literature to present at the AR team meeting. I reviewed exit interviews with former clinicians and the organizations' employee climate survey results, and continued to observe clinicians' workflow and behaviors. In addition to my observations, however, I wanted to hear from the clinicians in their own words. Accordingly, I determined that I would use the critical incident technique (CIT) to conduct interviews with clinicians. Critical incident interviewing is a proven qualitative research technique that offers a practical step-by-step guide to collecting and analyzing information about human activities and experiences (Hughes, 2008; Stitt-Gohdes et al., 2000). I reached out to the center directors to request permission to invite clinicians to participate in voluntary, recorded one-on-one interviews. I was intentional to ensure that clinicians representing each center would have the opportunity to participate in the interviews. Inclusion criteria for the interviews and study were that participants currently work or worked at an outpatient mental health center and held an active license as mental health clinician. A total of six outpatient mental health clinicians, each representing one of the five outpatient centers, were invited to participate in the

interviews. Three clinicians completed the interview, two additional clinicians consented and were not interviewed due to scheduling, and one declined.

Cycle 1 Taking Action Phase

The taking action phase for this cycle consisted of conducting the CIT interviews, data collection, data analysis, and the initial AR team meetings.

Conducting the CIT Interviews

The CIT interviews were conducted over Zoom and recorded with the participants' consent. The interview format included several questions designed for the researcher to learn more about clinicians' experiences with burnout, CF, and VT. Participants were emailed the consent form and interview questions prior to the interview. The CIT interviews were video recorded with participants' consent and transcribed using Otter.ai transcription software. The completed transcript was emailed to each participant to review and confirm accuracy.

Storying the CIT Interview Data

After participants confirmed the transcripts, I analyzed and reconstructed their experiences using their own words in chronological order, and placed them in a narrative or poem format. Pseudonyms were used to maintain the privacy of the participants and clients described in the incidents. Below are four incidents described by three outpatient mental health clinicians.

Compassion or Just Plain Fatigue

Working with client for 1 year
Have not improved very much
Diagnosis dysthymia
Persistence of depression is no longer episodic
Really, really depressed
Working with him for a year

We've had good days

Working on consistency of just basic self-care
I enjoy working with him
He's receptive to therapy
Never missed an appointment
They're gonna get better

Fatigue starting to set in
Like stone
Everything we talked about
I forgot all that
It made me feel powerless
He's given others power
Working on being assertive
Complicated relationship with roommate who is ex-girlfriend

Like, this frustrates me
You say you hate the relationship
I work with him a lot
Set clear boundaries in the relationship
He's been in two of my other groups

The fatigue and the compassion fatigue
Just felt like this sense of hopelessness
How can I keep caring about him if he won't do anything?
I've dealt with it
Made it personal growth

Negotiator, Bomb Specialist or Clinician?

Client acute
Recently discharged from the hospital
Reporting psychosis, alcohol use, self-harm, and suicidal ideation
I'm calling to conduct a suicide risk follow-up call
I had an intake
This should be simple
I talked to him the week before and he sounded okay

I called
Immediately I could tell he was inebriated or intoxicated
He had been drinking and had not slept all night
He tells me he wanted to kill his family
He did have a plan to harm himself with a knife
I was immediately overwhelmed
I don't know where he is
He is in the community right now

This is why we make suicide risk follow-up calls
This is going to be a 1013
Clinical license for 34 weeks
Don't feel equipped
Try to maintain rapport
Contact police
Figure out where he's at

I had to stay on the phone
One hour and a half
Supposed to be 5-minute call
I'm trying to negotiate
He's paranoid
It's like being a bomb specialist
Just gotta stay calm
Stay calm
Keep his rapport

Arguing with cousin
Oh my gosh, its gonna happen while I'm on the phone
Cousin intervenes
I'm going to take him home
Supported by my clinical director
Police met him at his house
He's mad
I feel really bad
Relationship comes second to personal safety and community safety
And then Monday came
How are you not in the hospital?

No Time to Breathe

I assessed a lady with a history of depression, she had just lost her husband. She cried during the assessment. I found myself kind of tired, you know, listening to the same kind of stories; just a different person. I realized I was rushing her through the assessment. I wasn't really giving her any empathy. I was swamped with assessments that day. I felt like I wasn't going to be able to help her. I couldn't take time to sit with her at the moment. I felt tired. I'm not motivated to really give her what she needed in that moment. That day, we had just lost another clinician. I'm the primary one doing the assessments, and I was swamped. Typical day maybe six or seven assessments and at the time we were only getting 30-minute lunch breaks. It's a lot doing assessments, having to check emails, failed claims, follow-up with the high risk for suicide clients, and go, go, go, go. I rarely have time just to sit back and breathe. I checked myself and spoke with my supervisor, but that day I had to get the data. I had to do my job. Not only was I overwhelmed and irritable at work, I realized that I was projecting that on to my

friends and family. I was kind of being really moody, emotional, and tired. I thought about that day and not only was I checking out at work, I was checking out for my friends and family.

Unable to Save Her

This one day, I was assessing a foster kid that had a history of sexual abuse. I started feeling overwhelmed with the presenting issues assessing her. We have a shortage of clinicians. I found myself feeling bad that I wasn't gone to be able to help her. I wished I could do more than my role as the intake clinician. I felt bad as if it was my fault that this client was going through this and it started showing in other ways. One night, I woke up out of my sleep from having a nightmare about her presenting issues. I realized that I needed to figure out some ways to disconnect from work at the end of the day. I have a soft spot for kiddos. I was in disbelief that she could have experienced something like that. I felt bad that I wasn't there to protect her or help her. It affected me in ways I didn't think it would. Sometimes I feel like I'm disconnected with my feelings in assessments, desensitized almost. At the end of the day, I have a job to do. I can't process my feelings in the moment so I have to just complete my assessment. I provided empathy as much as I could in the moment. Lots of time after work, I go sit outside and imagine things I've heard for the day that's dramatic drifting away.

Analyzing the CIT Interview Data

The interviews provided additional insights into the problems of CF, VT, and burnout experienced by clinicians working in an outpatient mental health program. Several themes were identified in the interviews: All three clinicians expressed similar experiences of burnout, VT, and CF from working long hours with clients and completing other administrative duties. Additionally, the interviews suggested that the copious amounts of documentation, limited time to complete tasks, and experiencing little progress in clients' outcomes also contributed to burnout, VT, and CF. Other noticeable similarities across interviews included clinicians' limited clinical experience and the similarity of VT symptoms they experienced due to exposure to clients' trauma narratives. When the clinicians were asked if they wanted to add any additional information related to the problem, their responses were similar in suggesting higher pay, decreased caseload sizes, and being provided with additional time to complete notes. In contrast to these negative focuses, the interviewees also experienced feelings of being energized by working as outpatient clinicians when clients achieved their treatment goals and exhibited

positive outcomes. Additionally, each clinician credited the support of their team members, colleagues, and supervisors as significant contributors to their success in navigating difficult situations with clients.

Cycle 1 Evaluating Action Phase

In the evaluating action phase, I reviewed and reflected on what I learned from the focus group, CIT interviews, and organizational data. I compared the data from the focus group with that from the CIT interviews to contrast the experiences as described by clinicians and by clinicians who were also supervisors. The data from the CIT interviews was compelling and highlighted clinicians' perspectives on the challenges they faced. I used this data to inform my decisions and planning for cycle 2.

AR Cycle 2. The Dawning of New Light: Purposeful Planning and Intervention Implementation

Cycle 2 Planning Action Phase

The key components of the planning phase in cycle 2 were to build upon what had been learned in cycle 1. The title of this cycle, The Dawning of New Light, emphasizes the evolution of change and the learning that occurred. This section outlines the initial AR team meetings, reflective practices, and first- and second-person learning as we established the team norms.

Launching the AR Team

I developed a short presentation to review with the AR team the initial data collected on burnout, CF, and VT at HCMHC. The presentation consisted of literature reviews on helping professionals and burnout as well as a summary of the data from the CIT interviews and focus group. It had been 16 months (March 11, 2021 through June 2, 2022) since the focus group had been held, marking the beginning of the AR team. Accordingly, it was important to check in with

the team to evaluate their needs and continuing desire to participate in the study. Prior to the initial AR meeting, I communicated with the team to gauge their readiness to start the project. Although some members expressed the challenges and limited time in their schedules, they all expressed a commitment to working together to find ways to make the system better for clinicians.

The first AR team meeting was held on June 2, 2022. The four outpatient center leaders from the focus group, plus the one outpatient center leader who had been invited to participate but could not due to a medical emergency, joined the meeting. The goal for this initial meeting was to build rapport, establish a working relationship to define the context and purpose of the AR team, and collaborate to determine what data needed to be collected, the data collection methods to be used, and the proposed intervention goals.

We began by reviewing the two-page executive summary on the purpose and goal of AR research. I educated the team on the AR cycles, data collection, and reflective learning as tools that would be used guide the study. The team was cautiously optimistic and listened to the presentation, although we were still clearly in the beginning stages of developing our group identity. I led the group in establishing group norms and understanding the team's purpose, guidelines, and communication agreement. Table 3.4 presents the communication agreement, context, and purpose statements developed by the AR team.

Table 3.4

Team Context and Purpose Construction Table

Communication agreement	Burnout, CF, and VT: As a supervisor, what problems are you hearing, observing, and experiencing from clinicians?	Challenges experienced by clinicians in outpatient mental health programs at HCMHC	What can we learn about being more clinician-centered? What has kept clinicians at the organization?
1. What is said here stays here unless it needs to be reported for safety or ethical concerns 2. Nonjudgmental–no bad ideas 3. Allow each person to complete their thoughts, sentence–no talking over each other 4. Respect of person and individuality 5. Respect each other's time	• Overwhelmed or anxious • Requesting frequent PTO • Call outs • Inability to sleep/nightmares • Tearfulness • Anxiety • Tiredness • Resigning • Shutting down • Irritability • Feeling on edge • Avoidant behaviors • Passive-aggressive attitude • Anger • Unmotivated • Unable to find solutions to problems • Feeling hopeless • Complaining • Negative attitude	• Lack of training and supervision • A lot of crisis triages • Not having enough resources for crisis • Clients presenting with issues we don't have the answers to • We know the need of the client and can't meet the need (hospital full, homelessness, transportation, not able to purchase medication, hospital on diversion) • Inability to say "no" we can't see you • We treat everyone • Clinician availability doesn't match the clients' needs • High caseloads and not enough clinicians to support a lower caseload	• Clinicians not feeling like they have a voice/say in policy/change • No pathway up to leadership or other areas of growth • Fully licensed clinicians don't stay unless they are in leadership • Mental health is important for clinicians • No separate sick day/leave and PTO **What keeps clinicians here:** • Leadership or you are out • Finding a niche • The clients/environment • Treated well by supervisor • Don't micromanage clinicians • Respected and supported by the supervisor • Don't contact clinicians outside work; we remind them of work

Communication agreement	Burnout, CF, and VT: As a supervisor, what problems are you hearing, observing, and experiencing from clinicians?	Challenges experienced by clinicians in outpatient mental health programs at HCMHC	What can we learn about being more clinician-centered? What has kept clinicians at the organization?
6. Everyone agrees to participate–participation is key and important 7. Be present at all meetings as much as possible	• Lack of engagement • Avoidant behavior • Feeling overwhelmed • Sad/flat affect • Decrease concentration • Taking shortcuts • Feelings of helplessness when clients' outcomes are not met, or treatment is not effective • Less empathy/compassion for clients • Decrease in productivity • Distracted–not present with clients	• Clinicians are working more than a 40-hour work week to get everything done-documentation, seeing clients, etc. • Caseload with lots of high-risk clients • External stakeholders influence on policies and standards for billing • High risk client on caseload and if client die or attempt SI the clinician is interrogated. • Extreme exposure to high trauma and abusive stories • Everyone that walks through the door becomes a person on your caseload even if you don't have the expertise to work with the client • Collective trauma • No time for bathroom break	

Note. This table was developed by the AR team to illustrate the communication agreement, problem framing, and data collection (June 2, 2022).

At the end of the meeting, I asked the team to reflect and to share thoughts that emerged from the meeting. I provided reflection prompts with three questions to help facilitate the onsite of reflective practice. Table 3.5 provides these prompting questions and samples of the team members' reflections.

Table 3.5

Team Reflection Prompts and Sample Responses

Reflection prompts	Reflection responses
Now that the first meeting is over, what are my thoughts about the overall project? Are they mostly optimistic or negative?	*Optimistic! I think we have the chance to influence company policy that could really make things better for the clinicians. I know that these groups ultimately do lead to a change in an agency, and that is the kind of thing we need.*
What thoughts, feelings, and ideas am I reflecting on?	*This is a "systems" problem which is reflected in the organizations we work for. My reflection is more a question: what will it take to reconstruct old mindsets?* *As I reflect, I find myself hoping that this change really does stick – that it isn't just something that is talked about like so many other things that get brought up in meetings. I hope we all stick with the plan and stay committed as well.* *I'm reflecting on how well the group participated with each other and seemed to be eager to share.*
What were some of the most interesting comments or ideas shared about this project/problem?	*What was most interesting was the similarity of some of the concerns reported from each center which is an indication of an overall problem.*

Learning From AR Team Meetings

In subsequent AR meetings, the team continued to focus on problem framing and constructing the purpose of the team and project. I facilitated team-building activities to establish working team relationships, identify a shared purpose, and begin proposing intervention ideas. For example, in one activity, team members were grouped in pairs and placed in Zoom breakout rooms. The dyad had to listen, learn, and report back to the larger group some things they had learned about their partner. In another form of this activity, team members were split into dyads in Zoom breakout rooms to brainstorm and report back to the larger group about the top problems the two-member team believed were the most significant issues to be addressed to mitigate burnout, CF, and VT in clinicians. Another activity was a liberating structure group activity, which helped the team establish a unified purpose for the group. These activities helped the team to learn about each other, begin to build relationships, and think about ways to address the issues before us. As we continued to meet, the team continued to participate in reflective practices and provided their reflections with less prompting. However, the work to build a cohesive team relationship remained difficult, as the team appeared apprehensive to trust the process and to be authentic with themselves and their fellow team members.

I understood that the AR process was new to everyone. There was optimism but a lack of trust and transparency. To help smooth the way, I decided to review Tuckman's stages of group development—forming, norming, storming, performing, and adjourning (Tuckman et al., 2010)—with the AR team in our next meeting. I have used these stages throughout my career as a clinician and group facilitator and have often found them helpful. According to this model, groups move through various tasks and interpersonal relationships in each stage of group development (Tuckman et al., 2010). In the forming stage, group members rely heavily on the

group facilitator for guidance, group norms are being developed, and the building of interpersonal relationships are underscored (Tuckman, 1965). In the storming phase, the group is faced with a conflict where there is an assertion of autonomy, there is an emotional response to tasks, and the team experiences leadership struggles (Miller, 2003). The norming stage is the beginning of group cohesion and the establishment of group culture norms (Tuckman, 1965). There is an emergence of insight and roles being defined in this stage (Miller, 2003). In this phase, group members are more open to emotionally discussing their thoughts and feelings (Tuckman, 1965). The performing stage is when the group cohesiveness increases, there is an openness in performing tasks, and the group works together to problem solve and complete tasks (Miller, 2003). The adjourning stage was a stage that was later added by Tuckman and occurs as groups disband (Miller, 2003). In our next AR team meeting, I reviewed these stages to discuss my observations of what we were experiencing as a team and to normalize this developmental process.

Forming Stage. In the forming stage, I noticed that team members were more open to sharing their thoughts individually through emailed reflections shared with me than openly sharing with the team. One AR team member journaled:

> *Vulnerability – this word produces a lot of anxiety in many individuals because for most it signifies weakness. The thought of expressing your feelings about a particular matter or expressing your needs for support and help is very personal and have a feeling of lack of control. The fear of retaliation or being judged is real but I think in life we have to take the risk of breaking down the protective walls we have and give ourselves the opportunity to be "real". Being vulnerable is real, raw and delicate but it is the opportunity to develop real trust and camaraderie between individuals. It is the opportunity to learn*

about you and others and it helps to make things more universal (we are not in this by yourself).

Teams in the forming stage are mere strangers (Tuckman et al., 2010). I recognized the need for the team to work on building trust, engagement, and cohesiveness to overcome this stage. Accordingly, I devoted several AR team meetings to team-building activities, refresher training on Tuckman's stages of group development, and group work with team members.

Storming Stage. In the storming stage, the AR team talked about the exhaustion, fatigue, and frustration experienced by the clinicians but would stop short of expressing their own experiences. The team demonstrated their physical and mental exhaustion verbally and through physical manifestations, and it appeared to be easier for team members to engage from a transactional perspective and to remain emotionally detached. However, it was important to the success of the project to reiterate the purpose of the team and reflect on what was being learned. In the storming phase, I reflected on where we were as a team:

This meeting was very sobering. The energy of the team was low, and the team appeared closed off. It was difficult to get the team to talk. Two team members reported feeling distracted by work and/or feelings about their work. The topic and focus of the group was vulnerability. I noticed that team members would acknowledge some of their thoughts and fears in their reflections but wouldn't share those feelings during the meeting. Oftentimes, the reflections of the group mirrored one another; however, it appeared that team members thought their feelings were unique. I engaged the team in reviewing the fallacy of uniqueness, Brené Brown's TED talk on vulnerability in groups, stages of group development, and reviewed group communication agreement. I left this meeting questioning if I addressed this topic too soon or well. I fear that the team don't trust the

> *group to share their true feelings. This is blocking our growth as a team as everyone wants to stay "safe and comfortable". We are more open in discussing the feelings of the "clinicians", but not as open to addressing the feelings we are experiencing as clinicians, managers, and team members. This was the first time I only received one reflection from the group. So far, no one else has submitted their reflection. I look forward to talking with my MP regarding this dynamic and learning ways to address what's happening.*

Norming Stage. At the end of each AR meeting, I asked the team to submit their reflections. At the beginning of each meeting, we reflected on the previous meeting as a group. The process of reflecting helped the team move beyond being transactional to becoming transformational in our thinking. In the norming phase, the team's participation and engagement began to shift. The AR team members began to openly share their thoughts and feelings, which developed synergy within the team. The quotes below followed a team activity and strategic planning AR meeting and reflect this growing enthusiasm. One member reflected:

> *It was interesting to see that most, if not all of us are experiencing some of the same issues. Ideas were similar and desire for change is there, yet the feeling of impotence lingered. However, I also felt a spirit of hope and optimism in the group…It was a good activity to get the group thinking about the strategies that might be needed to get this project going. It also gave perspective about the individuals/organizations that will need to be involved for this to succeed.*

Another AR team member reflected:

> *It was a good way of putting all the pieces together – to be able to think about and cover all the necessary pieces needed to initiate and facilitate change across all levels.*

As evidenced by these reflections, the team began to think strategically and cohesively. We documented our individual and group-level learnings through journaling, reflections, and group discussions. We planned to continue to receive feedback, review documents, report observations, attend AR team meetings, and engage in journaling and reflection.

Cycle 2 Taking Action Phase

In the taking action phase, which was also the performing stage of group development, the AR team used multiple qualitative datasets—including data from the literature review, CIT interviews, archival documents, feedback, observations, and focus group—to refine our understanding of the problem and inform interventions.

Understanding Turnover

I introduced the AR team to Price and Mueller's (1981, 2001) causal model of turnover theory and the determinants that suggest a positive or negative relationship to turnover and job satisfaction. The team reviewed each determinant and drew correlations between the concerns expressed by the outpatient center clinicians and the determinants leading to turnover.

In addition, our review of the current and available data on turnover prompted a deeper exploration and need for updated organizational data. The AR team developed additional questions seeking to understand the suspected increase in turnover at the outpatient centers. I collaborated with other departments to acquire the updated data, which was then analyzed by the AR team. Based on this information, the AR team agreed that gathering additional quantitative data would support implementation of interventions that would address the growing challenges of turnover in clinicians. Accordingly, the AR team decided to use surveys to gather quantitative data from the clinicians. The initial purpose of the surveys was to be used as a pre/post intervention assessment. However, the multiple roles and insurmountable duties began to take

their toll, and HCHMC continued to experience dramatic clinician turnover. The team wondered if the study would be able to continue through this loss of clinicians and how we could provide evidence of the impact of our interventions without conducting a postsurvey. Ultimately, we decided to use the quantitative data sets as baseline data to support the evidence of burnout, CF, and VT in HCMHC outpatient center clinicians.

Surveying the AR Team

Before we surveyed the clinicians with our chosen instruments, I introduced the AR team to the purpose and use of the Maslach Burnout Inventory (MBI; Maslach & Leiter, 1996) self-assessment, which measures burnout; the Professional Quality of Life Scale (ProQOL; Stamm, 2010), which measures compassion fatigue, burnout, and compassion satisfaction; and the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004). As a team, we completed the MBI, STSS, and ProQOL self-assessments. The results confirmed that the AR team members were experiencing the stress responses associated with burnout. Team member Natalie noted:

> *I just felt a little anxiety doing this burnout survey- not sure if it made me reflect on certain circumstances where the items applied but I noticed it (heart racing, chest got tight) as I was going through this…Yikes.*

Analyzing the Results from Clinician Surveys

I distributed the three instruments to the AR team, who then made the surveys available to the clinicians in their respective programs. Twenty-nine of the 38 outpatient clinicians (76%) participated in these surveys.

I used Excel spreadsheets to record and tabulate all of the responses to the MBI, STSS, and ProQOL. I created tabs that grouped the raw data into categories that were organized by programs and by survey type. Then, I created tables that displayed the raw data and color-

coordinated the questions to delineate the survey subscales. I calculated the data sets manually and through Excel to obtain the means, medians, and standard deviations as well as percentages. I used descriptive statistics to explain and summarize the quantitative data (Creswell & Creswell, 2018). Together, the AR team analyzed and reviewed the survey data and noted important correlations. These results are presented in detail in Chapter 4.

Reaching a Team Turning Point

At this point in the project, the AR team had been meeting bimonthly for 7 months (6/2/2022–1/10/2023); we would continue to meet bimonthly for a total of 26 times over 15 months, which was a total of 3–6 months longer than we had initially planned. We talked extensively about burnout, CF, and VT, but had yet to implement a plan to address these issues. A major challenge in solidifying the interventions was that although the proposed interventions met the needs of the organization, based on the data, team members worried that they would not be accepted by the organization's leadership team due to the financial or time cost. All this was taking a toll on the team, who were getting tired and beginning to express feeling stagnant. Team members began to appear distracted or disengaged in meetings and reluctant to engage in discussion. Team members were committed to remaining part of the research, but their competing responsibilities were becoming insurmountable.

In one meeting, I brought up my observations about the change in the group's energy and focus. One AR team member was vulnerable with the group and began to share her feelings of being burnt out and being overwhelmed by all the competing responsibilities, saying: "*I had to take a mental health day last week because I'm just super overwhelmed.*" I highlighted the growth and cohesion of the group that had allowed this group member to feel safe to share her feelings. I also acknowledged that team members were showing up to meetings out of duty and a

commitment to the process even though they were feeling fatigued and exhausted. In our efforts to improve clinicians' situation, team members were ignoring their own feelings of compassion fatigue and burnout. The AR team members expressed feeling positive about the AR process and their goal to continue to work to make a difference in the experience of the clinicians and organization. This team was not just another team they were a part of; this team and this time, they felt things would be different.

We continued to study the data to determine the next steps. Throughout this process, I continued to check in with the AR team to discuss their feelings, reflections, and experiences. The tasks of managing the day-to-day operations of the outpatient centers, high-volume caseloads, acute clients, and multiple clinician job vacancies were overwhelming for the team at times. The excerpts below reflect the general mood of the team members at this point. As one AR team member stated:

> *It's just been overwhelming. Last week, I just called out I was like, you know, I can't do it today. I just can't, I'm not coming in…I need a day, I mean, just to kind of regroup.*

Another AR team member stated:

> *I think one of the things that I've learned is how quickly and easily I can like ebb and flow between feeling like completely hopeless, that any change is possible, and then feeling like completely hopeful. Like, sometimes I walk away from these conversations like, yes, like, we're going to change the world, you know, like, you just feel really good and really empowered. And like, you know, six of us can come together and have these amazing discussions. And then I feel like you get flung back into the workload of everything.*

These emotions were supported by a field note I recorded during this stage:

> *Studying burnout, compassion fatigue, and secondary trauma has been heavy. Team members have acknowledged the same in their reflections. I shared some of the data that have already been pulled from the agency and that information added to the heaviness of the study. One member reflected on our ability to effect change or if our work together would add meaning. It's heavy for me too. I have continued to lose clinicians (3 adult clinicians and 2 child and adolescent clinicians remaining)...I feel overwhelmed and unsure how to keep the team on track while managing the stress of the project.*

I reached out to my major professor for guidance, who advised me to allow the team to work together to problem-solve and validate one another's feelings. This approach strengthened the team's relationship and reduced my efforts to problem solve independently. I provided articles and YouTube videos on learned helplessness and getting stuck in the negatives. Together, we watched a TEDTalk by Alison Ledgerwood and a video on learned helplessness by Derek Versitalium. These videos helped refocus and reenergize the team's efforts to think creatively on ways to address the problem. To help us brainstorm, I provided a reflection prompt to the team: *What are you learning about yourself throughout this process*? *What are you learning as a group throughout this process?* Table 3.6 provides samples of the AR team members' reflections.

Table 3.6

Action Research Team Reflection Table

Reflection prompt	Pseudonym	Example reflections
What are you learning about yourself throughout this process?	Lauren	*How passionate I can be about trying to find ways to create change to make HCMHC a more desirable company for people. I'm loving the idea of changing the culture of HCMHC!*
	Natalie	*I'm definitely not alone, I can be an agent of change*

	Cierra	*I'm learning that I struggle with trusting the process*
What are we learning as a group throughout this process?	Lauren	*How powerful we can become together. When you bring people together who share similar values but maybe have different experiences it creates something pretty amazing – and we get to see that unfold every 2 weeks.*
	Natalie	*We are able to support each other's ideas, feel comfortable enough to be transparent with each other, our thoughts and feelings are validated.*
	Cierra	*I believe as a group we have learned that we are not alone in our thinking and that change can either happen quickly or slowly, but the important thing is to identify which area to focus on that would make a huge difference to start the momentum.*

The shared experiences and new mindset of the team was a pivotal moment in the group dynamics. The other team members began to provide emotional support and began to be more transparent about their own feelings and experiences.

Proposing the Interventions

The AR team continued to meet bimonthly to discuss interventions that would support organizational change that would address the problem of turnover, but in contrast to our previously flagging morale, there was now a revitalized energy. The team initially developed five potential interventions focused on the individual, group, and system changes. We discussed key stakeholders, clinicians, departments, and managers who would need to be involved in this project for collaboration and support. We discussed ways to disseminate the proposed interventions to key stakeholders. Table 3.7 summarizes the initial proposed interventions, justification for the interventions, AR team activity, and timeline.

Table 3.7

Proposed Interventions

Proposed intervention	Justification & anticipated outcomes	AR team activities	Timeline	Data to be collected
Maslach Burnout Inventory (MBI), Professional Quality of Life Scale (ProQOL), and Secondary Traumatic Stress Scale (STSS) self-assessments	The MBI, ProQOL, and STSS are evidence-based self-assessments that will be used to gauge the presence or level of burnout, CF, and STS in outpatient clinicians. These assessments were used to assist in framing the problem; however, these assessments will continue to be used to measure the changes in clinicians' self-report of burnout, VT, and STS after the implementation of the interventions.	Data collection and data analysis	Initial assessment September 2022 Self-assessment of new clinicians June 2023 Final reassessment September 2023	Survey results
Develop a value statement for the organization that recognizes the value of its employees and establishes a culture of appreciation	Currently, HCMHC does not have a value statement or language in policy that recognizes the employees as a valuable asset to the organization. The creation of a value statement that embodies the employees will provide written accountability and a policy that supports employees. Moreover, the value statement will serve as the written acknowledgement of how the organization will demonstrate a culture that values its employees. The organization's current core values, mission, and vision statements are outwardly focused on the client only.	Survey clinicians to understand what makes them feel valued (what's working and not working at the organization). The AR team will develop a value statement that reflects the organization's value of its employees' health and well-being. Review current policies, organization's core values, mission, and vision.	Spring–Summer 2023	Focus group and/or interview notes; AR team notes; survey data

Proposed intervention	Justification & anticipated outcomes	AR team activities	Timeline	Data to be collected
		Review other organizations' value statements. Connect the new value statement to the organization's strategic goals.		
Employee health and wellness packet	The employee health and wellness packet will provide employees with the opportunity to engage in health and wellness opportunities through the organization and individually. This packet will address employees' physical, mental, financial, and spiritual health of employees and will provide them with the opportunity to engage in self-care as an organizational value.	The AR team will develop a wellness and benefits packet. Identify current fringe benefits offered by the organization that employees or potential employees are not aware of or that are underutilized (Employee assistance program, loan forgiveness program, medical health plans that provide incentives for preventative health actions, paid time off, etc.) Create website space and weekly newsletters (*Staying Connected*) with health tips, advertising group fitness challenges and opportunities, game nights, etc. Identify spa and fitness centers with	Summer–Fall 2023	Survey data; AR team notes

Proposed intervention	Justification & anticipated outcomes	AR team activities	Timeline	Data to be collected
		corporate discount opportunities. Establish wellness zones and spaces at each outpatient center as employee recharge areas. Meet with HCMHC's director of marketing and HR director to develop and incorporate newly designed marketing packet for internal and external posting.		
Clinical training and professional development academy	The organization currently has a leadership academy for individuals interested in growing leadership skills. However, the organization does not have a clinical track for clinicians who are interested in leadership but who want to augment their clinical skills. The clinical training and professional development academy will be designed as a pathway for clinicians to receive mentoring, peer consultation, supervision for licensure, training on evidence-based treatment modalities, internship, and case consultation. The goal is for clinicians to grow clinically, build confidence, and build a network of support that can improve the quality of care provided to clients.	AR team to develop and facilitate the planning of a new education and training track for clinicians at all levels (internship, mentorship, supervision for licensure, play therapy training, group peer consultation, etc.).	Summer–Fall 2023	Survey data; AR team notes; interview notes
Flexible work schedules and increase autonomy of clinicians	At HCMHC, clinicians are expected to schedule seven to eight clients daily with the expectation that someone will not show. Clinicians are expected to complete documentation while in sessions with the clients. It is	Review current workflow and clinicians' schedules.	Summer–Fall 2023	Interview notes; AR team notes;

Proposed intervention	Justification & anticipated outcomes	AR team activities	Timeline	Data to be collected
	not acceptable behavior for clinicians to add block time on their schedules for client engagement and completion of documentation. The implementation of a flexible work schedule will allow clinicians to design their schedules that best supports them, reduce the number of clients added to the schedule per day, increase the clinician's availability for client engagement, and build client return intentions. The goal is to reduce burnout and CF by embedding time to complete tasks. According to the causal model of turnover, flexibility and autonomy have a negative relationship to turnover. Clinicians are more inclined to stay when they feel a sense of autonomy and flexibility.	Conduct a pilot study that allows clinicians to manage their own schedules in a way that best fits their needs. Review the outcome of the pilot (clinicians' Increased feeling of autonomy and maintaining of outcome measures)'		survey data; quality assurance data
Reduce the amount of documentation at intake	The data that has been collected through interviews, archival documents, AR team meeting transcripts and literature on burnout indicates a significant relationship among large caseloads, copious documentation, and clinicians' expressed feelings of burnout.	Review current workflows and documentation requirements. Identify documentation that can be eliminated, streamlined or completed after the initial intake appointment.	Fall 2023	Interview notes; AR team notes; survey data; quality assurance data

As we discussed further, the AR team realized that five interventions was a lofty goal, so we narrowed our focus to three interventions that would provide an immediate response to the clinicians' voiced needs. We sought to implement interventions that would directly impact clinicians and would provide evidence that their concerns had been heard and were being addressed. We chose three interventions that we believed would be most impactful to the clinicians and organization. Table 3.8 depicts the three interventions the AR team ultimately implemented.

Table 3.8

Revised Intervention Plan

Applied intervention	Theoretical framework	AR team action	Completion date	Output
Organization commitment statement (value statement)	Causal model of turnover theory determinants show a positive relationship to job satisfaction when employees feel cared for, have better communication about changes within the organization, reduced stress, participation in decision making, and reduced routinization.	The AR team collected feedback from clinicians on what makes them feel valued. The AR team analyzed the data, categorized the answer, and prioritized the top responses. The AR team worked together to develop a value statement.	February–July 2023	The organization's commitment statement was approved and implemented as part of the employee handbook, new hire orientation training, and turned into a video for marketing and career fairs.
Reduction of redundant paperwork (internal referral process)		Discussed the problem regarding the duplication of paperwork needed to refer a client to an internal program.	June–August 2023	The health informatics team created a subsidiary work group to review the data and obtain further feedback from the different programs. The team reported back to the larger group with a new form that was implemented to be used by the entire organization for internal referrals.

Applied intervention	Theoretical framework	AR team action	Completion date	Output
		Reviewed the current process and documents to refer a client. Developed a plan to address the concern with all program leads. Presented the reduction of paperwork plan at programs meeting		The pilot study results were reviewed by key stakeholders and the AR team. The results of the data showed no significant changes in clinicians' billing rate by adding the 1 hour of flexible time per day. The flexible time will allow clinicians time to catch up on documentation or take care of themselves.
Flexible time for clinicians (care coordination time)			March 2023-August 2023	
		Surveyed the clinicians, reviewed the data, created a PowerPoint to present to key stakeholders; conducted two rounds of pilot studies, analyzed the		

Applied intervention	Theoretical framework	AR team action	Completion date	Output
		data, implemented care coordination time		

Cycle 2 Evaluating Action Phase

In this phase, the AR team met to review, reflect, and evaluate what we had learned in the Cycle 2 planning and taking action phases. By this point, the AR team had become established, with a sense of unified purpose and established group norms. We reflected on the journey thus far and the team activities that had helped us bond, trust one another, and work together to develop the intervention plan. We reflected on the high optimism in the beginning stages of group development and the group lows experienced during the intervention planning. The team also reflected on what we had learned regarding learned helplessness and negative thinking. Understanding learned helplessness freed the minds of the group members and positioned us well to plan for Cycle 3, in which we would implement the interventions.

The AR team evaluated the team's effectiveness in obtaining surveys from the clinicians and maintaining reflective practices individually and as a group. We continued to observe behavior patterns and turnover intentions of the clinicians. We took a closer look at the actions that we had taken thus far and used the review of what was learned to situate the beginning of the implementation plan.

AR Cycle 3. The Awakening: Evaluating the Emergence of a New Mindset and Sustainable Organizational Growth

Building from what we had learned at the individual and group levels in Cycles 1 and 2, the AR team moved swiftly to Cycle 3. The third and final cycle took place between February and August 2023. By this point, we had renewed energy and a clear vision to move forward with our intervention implementation plan. In this cycle, the AR team implemented three interventions that were ultimately approved for incorporation at the systems level:

1) Organizational commitment statement

2) Reduction in paperwork plan and new internal referral process

3) Flexible schedule/care coordination time

Cycle 3 Planning Action Phase

Each intervention had separate commencement dates, but they continued concurrently throughout the cycle. The AR team began with the implementation of the organizational value statement, which was eventually called the organizational commitment statement. As we had learned from a review of organizational and archival data, feeling valued by the organization was important to clinicians. We believed that having a written statement that embodied and highlighted the value of our clinicians to our organization was thus crucial, yet prior to this, we lacked any uniform, cohesive organizational messaging. Then, we planned to reduce the paperwork by addressing the internal referral form. Last, the team planned to add schedule time each day for clinicians can care for themselves or planning time.

Cycle 3 Taking Action Phase

Previous organizational climate surveys had indicated higher pay as one a top concern for HCMHC employees. The AR team understood this need but felt there was limited influence we would have to make this change for clinicians. Instead, we decided that increasing pay for clinicians would be added to the sustainability plan and HCMHC strategic planning committee points.

Surveying Clinicians

Since our previous data was primarily from previous organizational surveys and archival data, the AR team decided to survey clinicians during clinical team meetings to hear directly from them about what made them feel valued at HCMHC. The following questions were asked:

1) Other than a pay increase, what would make you feel valued at HCMHC?

2) What is working at HCMHC?

3) What is not working at HCMHC?

The AR team members reassembled at the next AR meeting to discuss what we had learned from these surveys. We compiled the data on a Zoom whiteboard. Table 3.9 summarizes the aggregated feedback the AR team received from the outpatient center clinicians.

Table 3.9

Aggregate Feedback from Clinical Team Meeting Surveys

Other than a salary change, what will make you feel valued at HCHMC?	What is working?	What is not working?
• *Lunch and learns for all employees monthly* • *Free stuff – like merch (sweaters, shirts, tote bag, mugs…just something more or anything* • *Performance incentives* • *Front load sick time* • *More training opportunities* • *Better communication*	• *Management offering hybrid work options* • *Management advocating for staff* • *Putting staff first* • *Freedom to support exploring interests in clinical growth (figuring out what you want to specialize or grow in)* • *The people at the center are genuine, and caring and very supportive of one another personally* • *OP Internship Program*	• *Tired of all the documentation needs and assessments for intakes and authorizations* • *Documentation efficiency is broken, redundant, and CareLogic feels antiquated* • *Non-CareLogic referrals are problematic* • *PTO is not enough, not having anything front loaded as a new employee* • *No company phones for remote work to not use blocked numbers* • *Feeling punished for sick days due to not having enough PTO, having to make a choice to push through it or use PTO*

In analyzing the results of the clinicians' feedback, the AR team noticed an emphasis on documentation, with clinicians repeating issues with the amount of documentation, redundant documentation, and not having enough time to complete documentation. We planned separate interventions to address these problems that will be discussed later in this section. Furthermore, the AR team noticed that clinicians valued the support shown to them by their individual teams, the ability to experience clinical growth at the organization, and a hybrid work model.

Developing the Organizational Value Statement

To develop the organizational value statement, the AR team reviewed multiple datasets and organizational data. Our goal was to create a value statement that would encompass clients, employees, community, and the fiscal responsibility of HCMHC. To maintain anonymity, the final statement will not be disclosed here. I sent the final organizational value statement to the CEO and sponsor of this project for review, and it was determined that I would present the document at the organization's strategic planning meeting to key external and internal stakeholders. These stakeholders determined that the value statement was more in line with an organizational commitment statement and approved its addition to the organization's official employee documents.

This intervention was the first to be approved and integrated into the system, and at our next AR meeting, the team was eager to hear about it. Team momentum was high. As a team, members reflected on how much time had been invested in fear of moving forward, and in hindsight, we wished that we had mobilized the interventions sooner. The team felt very strongly about the importance of organizational commitment statement in particular, as shown in the following excerpts from team member comments. One AR team member reflected:

Out of every single thing that we've done, this one was the most important to me because I think if you cannot acknowledge your people, the work is not going to be done no matter how much you try to browbeat them. I think acknowledgement is important.

Another AR member reflected on what was learned:

If you come from a place of openness, that's how decisions get made.

Reducing Paperwork Burden for Clinicians

Concurrent with the development of the organizational commitment statement, the AR team began to devise a plan to reduce the amount of redundant paperwork clinicians had to complete. The literature on burnout, CF, and turnover had shown that exorbitant paperwork requirements were often a contributor to occupational exhaustion and turnover. One specific area that clinicians identified as creating redundant paperwork was the internal referral process. Accordingly, the AR team reviewed the current referral process, highlighting the redundant questions and reviewing the multiple ways in which different programs were requesting referrals to be sent to them. The team noted that this variation increased the time needed to complete a referral and created inconsistencies and inefficiency.

To present these new findings, several AR team members attended a program leadership meeting that included key stakeholders from programs across the organization. There, the team discussed the current internal referrals process and its associated challenges. To the AR team members' surprise, other stakeholders began to emphasize the challenges they were experiencing with the current process as well. Problem-solving as a team, it was determined that a subgroup would be created to look closer at the current process, apply the feedback provided, and develop a process that would work for the organization.

At the next meeting, the AR team reflected on this experience and what we had learned. One AR team member stated:

> *The feedback that was given and the way it was received during the meeting…I thought it was going left and it went so right… I think if you have an idea whether or not you think it is bad or good, or wouldn't work, it is best to put it out there….I've also heard from people since the meeting concluded about how happy they were that was presented.*

Implementing Flexible Scheduling for Clinicians

The last intervention in this phase was the implementation of the flexible schedule for clinicians, which the team termed *care coordination time*. This time consisted of 1 hour of "flexible time" added to clinicians' daily schedules to use at their discretion. The AR team felt a personal connection to this intervention as it directly impacted the clinicians' wellbeing and provided clinicians with some autonomy over their schedules. It also had a solid grounding in research, since Price and Mueller (1981) posited that providing autonomy to employees has a positive relationship with employees' expression of job satisfaction. In the taking action phase, the care coordination time pilot study was conducted, with the monitoring of the AR team, in two 2-week intervals from June 5–19, 2023, and June 25–July 9, 2023. The focus of this pilot study was to ascertain the impact of care coordination time on clinicians, including their billing opportunities. Billing data was included in the pilot study due to team concerns that the larger intervention would not be approved by key stakeholders if the pilot study did not consider the potential impact on clinicians' billing opportunities.

The results of the pilot study showed that clinicians' billing potential stayed the same or even increased. The AR team presented the results of the study to key stakeholders, who agreed

to implement the plan in the daily schedules of outpatient center clinicians. Table 3.10 provides sample feedback from clinicians involved in the care coordination time pilot study.

Table 3.10

Sample Clinician Feedback on Care Coordination Time

1st round clinician feedback	2nd round clinician feedback
• The blocks were helpful; I used some of the blocked time to complete referrals. • I was able to check on housing referrals and follow-up • I was able to review caseload and complete discharges • Provided me with the time to be more productive, especially with high-risk clients because it was the only time to get things done. • I really appreciated the time • I believe that at least a 30-minute block per day would be helpful • We are excited. Thank you for hearing us. This has been something we needed.	• I was very appreciative of the blocks; it allowed me extra time with progress notes. • I was able to finish up with paperwork for intakes. • There were days when I had 6-7 clients schedule, and it allowed me to decompress • I had time to decompress after intakes • It gave me time to prep for sessions, and review notes in detail from my previous sessions. • I was able to make productivity with blocks. • I was able to monitor my schedule.

Cycle 3 Evaluating Action Phase

In the evaluating action phase, after the interventions had concluded, the AR team met to debrief and to reflect on what we had learned at the individual, group, and system levels. It was customary to start each team meeting with check-ins and reflections. During this time, the team debriefed on the personal and professional challenges we had faced in the past few months. The team shared their personal struggles with loss of family members, personal health challenges, hospilizations, and continued resignations of team members, including clinicians. The resiliency of the team was apparent, but it came at a cost. The physical and mental fatigue were apparent,

yet the optimism for sustained change remained. I was concern for the team's wellbeing and glad that the AR meetings were coming to an end. Although this work is important, it was also important to reduce the responsiblities borne by the team. One member reflected:

> *Getting excitement from staff feels like the payoff for these meetings.*

The care coordination time was the last intervention to be fully executed, and its impact on clinician workflow (and morale) was immediately and directly observable. One AR team member reflected:

> *I do think… the handbook is great, but the care coordination time will make a daily impact on clinicians that are here.*

The team reflected that the initial purpose of the AR team was to learn from the interventions aimed to mitigate burnout, CF, and VT in outpatient mental health clinicians. The implementation of the care coordination time provided additional evidence of the organization's willingness to make changes in an effort to retain clinicians, which was in itself an encouraging result. One team member reflected:

> *I think we value our employees, and this is the first step in showing that we do… If you want to keep your clinicians, this right here made such a big impact.*

The AR team further discussed what takeaways had been learned. One member stated:

> *I've been doing this for a very long time…you know, change is something that, somehow, it's resisted. But I'm happy that we had the courage to ask one person and at least get the feedback and continue to try. So for me, the takeaway is always to be willing to ask.*

During this meeting, the AR team breathed a sigh of relief and expressed a sense of accomplishment. On a less enthusiastic note, the team also expressed ambigous feelings about

our team effort drawing to a close. We had met bimonthly for 15 months. One AR team member reflected:

> *What do we go from here…six months, and eight months go by, and then all of a sudden, this was the norm.*

Another team member reflected:

> *Well, I just appreciate being part of the group.*

Another AR team member stated:

> *It felt good to be like a change agent and helping to create change.*

I also discussed a possible sustainability plan with the team. One team member stated:

> *We've planted the seed, and seeds take a moment to grow. So we plant and someone else will throw a little water in there, and then it will increase, and we may not see the increase. But I, believe that when you plant a seed, it's there.*

Although our 15-month study pales in comparison to the longitudinal study it would take to study the long-term impact of a culture change, we discussed the impact that our team and study had made in setting a foundation for further study. We also experienced so much growth personally and professionally. One team AR member reflected:

> *I believe as a group we have learned that we are not alone in our thinking and that change can either happen quickly or slowly, but the important thing is to identify which area to focus and that would make a huge difference to start the momentum.*

Conclusion

Following the conclusion of our project, I sent a group email to the AR team documenting the approval of the three interventions (organizational commitment statement, paperwork reduction process, and care coordination time) that the team had worked so diligently

to bring into fruition. I was excited to provide the news that the organization had accepted the changes and communicated a sustainability plan. Some responses received from the AR team are below:

- ***Well done!*** *It was a pleasure to be a part of this team and to have accomplished goals that will prove to be beneficial throughout the agency.*
- *Awesome work team!!*
- *Huzzah! That's awesome news!!*
- *This is FANTASTIC news!!!!! Thank you so much for your continued support and advocacy.*

As a team, we remained intact for 15 months and persevered to learn at the individual, group, and system levels from the interventions aimed at reducing burnout, CF, and VT. As evidenced by this statement by one team member, though, it had all been worth it:

> *Change is hard!!...It is hard to go from a big problem, to very specific solutions. To come up with feasible solutions, to get everyone at the table to listen, and to get everyone who it could impact to be honest about the problem is impacting them. Change is hard …. not impossible …. and we can do hard things.*

CHAPTER 4

INSIGHTS AND ACTIONABLE KNOWLEDGE

The purpose of this research study was to explore the impact of burnout, compassion fatigue (CF), and vicarious trauma (VT) on mental health clinicians working in an outpatient mental health setting and to gain insight into an organization's attempt to mitigate its effects. Mueller and Price's (1981) causal model of turnover theory and its nine determinants were used to learn the relationships of outpatient clinicians' intentions to stay or leave an organization. Additionally, Christine Maslach's research on burnout and Charles Figley's research on CF and VT further supported the findings and actionable knowledge learned in this study. Maslach and Figley's research were used to learn about the organizational factors, such as environment, culture, and processes, that contribute to outpatient clinicians' experience with burnout, CF, and VT. The following research questions guided this study:

> *RQ 1: What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion fatigue, vicarious trauma, and burnout in an outpatient community mental health organization?*
>
> *RQ 2: What organizational culture and systemic factors affect the experience of burnout, CF, and VT in clinicians working in outpatient mental health centers?*

This chapter will provide a synthesis of what was learned from the study, key insights and actionable knowledge. The study was grounded in action research (AR) methodology. It used qualitative and quantitative data to analyze what was learned at the individual, group, and

systems level. The chapter is split into three sections: first, key findings and overarching conclusions; second, insights and implications for further study; and third, limitations of the study and personal reflections.

Study Findings

I used triangulation, critical incident interviews, exit interviews, surveys, AR team meetings, document review, and a focus group to generate and collect data. Based on our analysis of this data and our interventions, this AR study generated eight findings for RQ1 and two findings for RQ2. These findings provided evidence of a relationship between current organizational practices and burnout, CF, and VT in outpatient mental health clinicians. Table 4.1 identifies the research questions, themes, and findings at the individual, group, and system levels.

Table 4.1

Research Questions, Themes, and Findings

Research question	Level of the system	**Findings**
What is learned at the individual, group, and system levels that advances theory and practice about organizational interventions aimed at decreasing the impact of professionals' compassion fatigue, vicarious trauma, and burnout in an outpatient community mental health organization?	Individual	• Clinicians' participation and inclusion in decision making in an organization develops a growth mindset about organizational change. • Providing opportunities for clinicians to engage in the organization's bureaucratic processes impacts clinicians' perception of their value to the organization and minimizes routinization. • Integration, moving outside your comfort zone, intentional engagement, and open and honest communication build social support. • Personal reflections can facilitate change in individual, group, and system perspectives.

	Group	• Navigating learning systems is inherently complex, which requires team collaboration to take risks, unlearn learned helplessness, shift perspectives, and execute change strategies. • Action research methodology can effectively manage organizational politics, role duality, and implementation of interventions to address burnout, CF, and VT in mental health clinicians.
	System	• Including clinicians and employees in the decision-making process can increase buy-in and increase feelings of being valued by the organization. • Providing internal advancement opportunities for clinicians in leadership roles but not providing advancement opportunities for clinicians in clinical roles exhibits distributive injustice that unconsciously increases turnover intention.
What organizational culture and systemic factors affect the experience of burnout, compassion fatigue, and vicarious trauma in clinicians working in outpatient mental health centers?		• Organizational cultures that focus solely on the client's health and do not factor in clinician well-being lead to clinician burnout and turnover. • Community mental health organizations with fast-paced, high-stress environments and limited resources, autonomy, and social supports can lead to burnout, CF, and VT; however, the presence of compassion satisfaction has a positive relationship to retention.

Findings: Research Question 1

Individual Learning

Finding 1: Clinicians' participation and inclusion in decision making in an organization develops a growth mindset about organizational change

A key finding at the individual level is that clinicians' participation in organizational change produces a growth mindset about change. A "mindset change" was coded 12 times and referenced in two AR team members' exit interviews and countless times in the AR team meetings. When conducting the study, the AR team was challenged to see whether the organization could change, and if so, how. As stakeholders in the organization, the AR team members had to shift their mindset, make different inferences about the organization, recognize individual schemas contributing to each clinician's belief system, and recognize that their contributions effect change.

The AR team began to reassess their assumptions, recognizing that the organization's development of new programs or systems can be frustrating and unintentionally negatively impact other existing systems. The shift in mindset created opportunity for the team to make different inferences and feel more empowered to add their voice to the change initiative. In addition to learning about organizational change, we found that first-person reflections provided the team members with insight about the changes occurring within them.[4] As Aaron described in his exit interview, this realization led him to challenge existing biases and see the organization's challenges as opportunities from a more inclusive, constructive perspective.

[4] All respondents have been given a pseudonym

Aaron noted in the exit interview:

> *I don't have to accept things as they are…And so, you have this realization… organization stuff doesn't happen from a malicious standpoint, and you get to feel frustrated with different programs…That was a huge moment for me. And the second was, you can actually challenge stuff because often it was made with best intentions at the time, and they're unaware that those best intentions are now creating problems…*

In another meeting, Aaron stated:

> *Speak up and ask; don't feel like, well, it's not going to happen so, I'm just going to keep my mouth shut...*

Natalie noted:

> *I learned about myself and learned maybe that my voice can be impactful, that I can make a difference in the way things are changed.*

Finding 2: Providing opportunities for clinicians to engage in the organization's bureaucratic process impacts clinicians' perception of their value to the organization and minimizes routinization

Over the course of this project, group members shared how being a part of the research project and decision-making had energized them and given value to their voice. The themes "value" and "voice" were coded 22 times and referenced by four of the five AR team members' exit interviews. There has not been much research on the impact of one's values on job stress, but current research suggests that it may play a key role in predicting levels of burnout and work engagement (Leiter & Maslach, 2004). In this study, group members found that being asked to move outside the routine of their everyday jobs and participating in change initiatives energized them and, consequently, helped them feel valued by the organization. This finding is supported

by evidence, such as Price and Mueller's (1981) assertion that "low routinization, high instrumental communication, high promotional opportunity, and high participation in decision making all contribute to greater job satisfaction" (p. 555).

One AR team member noted:

> *For me, I think that makes me feel valued like a valued member of this agency… I've been energized by that because we get stuck in like the mundane of every day just like doing the stuff that we have to do as part of our job. But when I get asked to be able to do special things like this, it makes me feel like okay, I'm not just a little robot…I am seeing I'm valued, I'm appreciated. And because I'm getting asked to do these things like that's what gives me a sense of value.*

Another AR team member noted:

> *Most meaningful was being able to be heard, being able to first of all, have this group and have our leader really wholeheartedly embrace the group and being curious as to our findings and our outcome.*

Finding 3: Integration, moving outside your comfort zone, intentional engagement, and open and honest communication build social support

A key factor in individual and group learning was the importance of feeling connected to others within the organization. One key determinant of the causal model of turnover is integration, which Price and Mueller (1981) defined as "the degree to which an individual has close friends among the organization members" (p. 545). This integration has a positive impact on job satisfaction and a negative relationship to turnover. Maslach and Leiter (2017) framed the integration of human interaction in an organization as community, or "the overall quality of

social interaction at work, including issues of conflict, mutual support, closeness, and the capacity to work as a team" (p. 46).

Initially, the team was guarded with what they would share and concerned about whether the group was a safe space in which to be transparent about their experiences with burnout, CF, and VT. Over 15 months, through self-reflections, intentional engagement activities, and open group reflections, the team became more open and integrated, as evidenced by more engaged and transparent dialogue. Having a connection to others in the organization and AR team was coded 15 times and referenced by three of the five AR team members during the AR team exit interview.

One AR team member stated:

> *Individual learning (vulnerability): I learned that I did not have to be in this alone. I learned that what I was experiencing others were experiencing the same thing…I learned that I needed to speak up. I learned to just kind of embrace the moment, embrace the change and share my thoughts no matter if I thought it could be implemented or not.*

Another AR team member echoed similar statements:

> *I learned, you know, sometimes I just need to let the guard down a little bit and just be open.*

Another AR team member agreed:

> *I think I'm just so burnt out myself…I think we were like a cohesive group, like we support each other. And, you know, I think even that time that I had mentioned, how much I was struggling on the job, they all said, well, you need any help, or you need anyone to talk to or need help with this or that…they would help. So, I just thought it was good, you know, it felt like a, like bonding.*

Another AR team member stated:

> *It's harder for me, I guess, being a former remote employee to like, feel that candid connection…so, it was most meaningful to me to come and talk to people openly from different programs in different centers across the agency…And, feel a sense of validation, connection, and feeling seen, so to speak.*

As evidenced by these statements, integration (Price & Mueller, 1981) and feeling the connection to others within the organization contributed to the AR team's feelings of support and belonging. Maslach (2016) noted that having support within an organization's network can mitigate the effects of burnout. We found that integration was a significant attribute in this study as it aided in the motivation and behavior of the team to engage more, subsequently creating team cohesion and the ability to work succinctly throughout the AR cycles.

Finding 4: Personal reflections can facilitate change in individual, group, and system perspectives

Initially, the AR team members were more comfortable with submitting individual reflections using a reflection prompt; however, over the months, the team began to reflect without prompts, openly participating in group reflections, and became more self-aware of their own biases and stress responses from compassion fatigue. The perception that "we are in this alone" shifted to communicating ways in which the team saw the organization was investing and embracing our ideas to meet the needs of the clinicians. Additionally, the AR team members began to reflect on the impact they believed the AR team had on the system and on the influence of their individual voices. As one team member noted:

> *So what I learned about the organization… I learned that the organization was willing to embrace change. This was not the first time this organization had discussions about*

> *burnout, or compassion fatigue, but we were having meetings just to be heard. This group allowed us to be heard and to bring about change and real change. I learned that this organization embraced the change that we brought to the organization, I learned that this organization really values clinicians, and it shows because they embrace that value statement that this group developed, which is inclusive of the clinician, this organization embraced being able to reduce all the paperwork.*

Another AR team member noted in the exit interview:

> *I've probably never met somebody that is at the top, you know, CEO, who's been so understanding and able to just kind of listen and hear the voices of the people that are like, not just below her, and, you know, in the organization, and she is super helpful. So, I mean, what I learned is that she cares about the people who work for the organization. And, you know, I feel like that's the same way from the majority of the leadership as well. They do genuinely care about the people that work there.*

Also in the exit interview, another AR team member agreed on the positive change witnessed:

> *I learned that I'm . . . pretty grumpy when it comes to like, optimism about change… But I learned that I don't need to be like just fatalistic and about, like, changing possibility in the organization…. it's a learned helplessness. It's . . . a way of coping… I don't have to accept things as they are... I am more open and flexible to alternatives and the possibility of change.*

Another AR team member summed up our individual learnings well in the exit interview:

> *And so, I think like, we just have to as leaders, be strong advocates. You know, when we see an issue, address it head on, try to resolve it and just speak up because if we don't, then nothing, nothing's gonna get done.*

Group Learning

Finding 5: Navigating learning systems and organizational change is inherently complex, which requires team collaboration to take risks, unlearn learned helplessness, shift perspectives, and execute change strategies

According to Coghlan (2019), organizational change requires attending to change strategies, policy, structures, procedures, attitudes, roles, and the skills of its members. Sometimes, challenges experienced in this project involved the mindset of the team members and the willingness of the team to collaborate and educate other team members on what we were learning. We recognized that we felt powerless in our situation and thought the organization was inflexible about change.

As a team, we read an article on learned helplessness and watched TEDTalk videos on negative thinking. We saw ourselves for the first time as leaders who were experiencing the weight of burnout, compassion fatigue, and VT, not only in the clinicians we supervised but in ourselves. We observed the stress responses Maslach (2016) described, in which chronic exhaustion and burnout leads to a negative, cynical view of the job. There was an awakening during this meeting and a collective shift in our thinking. We discussed how we were experiencing paralysis of the mind yet continued to find new motivation to take risks, speak out, and advocate for the needs of the clinicians. We initially believed that the problem the organization was experiencing was bigger than our influence. Once we became "unstuck," however, we were able to develop a PowerPoint presentation of our research findings and intervention plan. Without hesitation, the plan was accepted and went before the executive team, board members, and key stakeholders, where it was also approved. As one AR team member reflected:

> *It was the moment when we finally agreed that we were going to do something and put something forth. And then like, the moment there's actually action taken, that was the turning point…And so, but the moment we like had something, and it was like, Cool. This was presented and accepted. I was like, oh, shit. You know, that's cool. And then it felt like, alright, well, what's the next thing? You know, it felt like reenergized*

Another AR team member agreed:

> *I feel like we had to keep fighting for that because the clinicians just felt so heard and seen by having that little flexibility in their schedule.*

In the group exit interview, another AR team member stated:

> *A lot of people have a really hard time with change. But it doesn't have to be a bad thing.*

Another AR team member's comments reflect the shift in mindset we experienced:

> *The most meaningful part of it was when we started including not only the group members discussing, but when we branched out and started including the team members into this.*

AR team member summed up our ability to counter our original negativity this way:

> *I started thinking about that video that we watched on negativity, and how hard it is when we hear something negative. To counter that with something positive, like the negativity just like rises right up to the top and all of the positive stuff, like, you can hear a lot of positive stuff, but that one negative is gonna like completely outweigh all of it.*

Action research evokes considerable self-exploration and collaboration. It is not neat and requires stepping outside your comfort zone. Because it is "research in real-life action," AR "has a large degree of messiness and unpredictability about it" (Coghlan, 2019, p. 129). We did not initially know the impact that the AR process would have on our group learning and

understanding of organizational change, yet the process of taking action, evaluating action, and reflecting on action proved to be instrumental in learning at the individual, group, and system levels.

An AR team member reflected on the importance of "real-life action":

> *They were receptive of our requests…if you want change, if you really do, all it takes really is just to speak up.*

Another AR team member noted:

> *And so that's probably the moment like, oh, man, like, we can be heard and seen. And we are kind of stacking the deck against our own selves when we just worry that people don't want to change. They want all this, and you know, mindset. You know, when we just ended up fatalistic mind, like, nothing's gonna change, why bother? And when we got just a little bit of momentum, it felt like, oh, and that just like, it was like, someone just threw a match on the gasoline.*

Finding 6: Action research methodology can effectively manage organizational politics, role duality, and implementation of interventions to address burnout, CF, and VT in mental health clinicians

One important finding at the group level concerned the effectiveness of AR methodology in leading this change effort and navigating the messiness of organizational politics. Prior to initiating the interventions, the AR team discussed approaches to obtaining buy-in from key stakeholders. We ultimately decided to leverage our influence through already established relationships with key stakeholders.

Relationships in an organization are effective in garnering buy-in and approval to make organizational changes. As the lead researcher, I have been learning that the ideas I have may be

better accepted if said by someone else. I have also learned that each person's sphere of influence can be used to support the overall objective of this study. System change is messy and requires influence, relationships, and the ability to motivate others to effect change. I originally tried independently to make a change using only my own influence; however, a systems problem requires multiple members of the system to address the problem. As one AR team member noted in the exit interview:

> *Burnout is a real thing and compassion fatigue. We go into this field with the understanding that we want to be of help, we want to be upheld, but who helps the helpers? And if we don't recognize what help the helpers need, then that's when we are no longer able to provide the quality and quantity of service that's needed for the community.*

Another AR team member noted in the group exit interview:

> *We sometimes work in our own silos, but we all are experiencing the same thing…so it was good to know that we aren't alone.*

System Learning

Finding 7: Including clinicians and employees in the decision-making process can increase buy-in and increase feelings of being valued by the organization

Coghlan (2019) espoused that "systems thinking refers to seeing organizations as a whole, made up of interrelated and interdependent parts." (p. 145). A key finding at the system level concerns when the AR team began to identify themselves as part of "the system." The system was no longer the individuals in certain roles or who held certain titles, but each person who contributes to the organization. One group- and system-level learning was the shift that the AR team noticed in our mindset as others—key stakeholders, clinicians, and executive team

members—became more involved in the AR interventions and process. The momentum built and the desire to implement interventions that would align with the needs and expressed values of the team members were significant. The AR team recognized our unique role duality of being clinicians and organizational leaders. We were able to take the data collected from the clinicians, present the interventions in meetings with members from all agency programs, and receive buy-in to make a system change. The AR team conducted three interventions, two of which were system change initiatives: a new internal referral process and a new organizational value commitment.

The referral form was an intervention that outpatient clinicians had initially requested to be condensed and centralized into one location. Previously, the referral form was in the electronic health records (EHR) with additional documents requested through email. Different programs were requesting different information for clients to be referred to their program internally. There were several redundant questions and demographic information requested by these internal programs even when this information was already accessible to all agency employees through the EHR. The intervention was proposed by the AR team and discussed in a larger committee of agency leaders. The data collected from these meetings showed a multilevel problem with the current process affecting multiple providers and programs. The implementation of the referral form intervention had an impact on the system, as several programs were positively impacted by the change.

One agency member stated:

> *I'm so glad Jemecia brought up this topic…with having limited clinicians at outpatient centers, many high acuity clients…having referrals and quick documentation regarding referral status allows everyone involved in the client care to be on the same page.*

Another AR team member noted in the exit interview:

> *We can change the referral form? It may not happen quickly, but it can be done, and you can raise these issues. But, you have to have the confidence to do so.*

The input from the clinicians and key stakeholders was pivotal in executing the interventions proposed. We found that the more involved the clinicians and employees were in the decision-making process, the greater their buy-in was regarding the change. Over time, clinicians reporting feeling more heard by the agency. Price and Mueller (1981) asserted that "successively higher amounts of participation will likely produce successively higher amounts of job satisfaction" (p. 546). We found that organizational change begins at the individual level but expands to the system level of learning.

Another system-level learning and change initiative was the implementation of the organizational value statement, which was brought before the executive body, program leaders, and board members to be considered for implementation at the system level. Following the meeting and board approval, a key stakeholder communicated:

> *At our Strategic Planning session, we reviewed and established the attached Organizational Commitment. We all agreed that we should create a video with some of our leaders using the Organizational Commitment as a script…just wanted to let you know that the document you helped draft is officially added to our Employee Handbook and New Employee Orientation.*

Maslach and Leiter (2017) noted that "people use the quality of the procedures, and their own treatment during the decision-making process, as an index of their place in the community. They will feel alienated from that community if they are subject to unfair, cursory, or disrespectful decision making" (p. 46). The AR team's participation and collaboration with organizational

stakeholders enhanced the feeling of respect and inclusivity in decision making and created opportunities to promote further organizational development. One AR team member asserted the value of being able to see the end result of our work:

> *I thought this was a valuable research project. And I liked seeing the end result of the mission statement that Jill added to correspondence and to the handbook. So it's nice to see you know . . . our hard work or ideas or brainstorming, just kind of have a nice final end result.*

Finding 8: Providing internal advancement opportunities for clinicians in leadership roles but not providing advancement opportunities for clinicians in clinical roles exhibits distributive injustice that unconsciously increases turnover intention

Price and Mueller (1981) provide insight into the relationship between distributive justice and turnover. When clinicians perceive themselves as being treated unjustly or unfairly, this can lead to turnover intention (Price & Mueller, 1981). A key finding at the system level was that the organization does not have a pathway for advancement monetarily or professionally for clinicians who want to stay in the clinical role and grow at the organization. We learned that the organization has invested in a leadership academy for individuals looking to advance into supervisory roles; however, we lack advancement in clinical roles. This new knowledge offers implications for further research. One AR team member noted:

> *I still feel that as far as an organization, we don't have a place for good therapists. Like if I want to hyper specialize and I want to be really good at this therapy and I want to be respected and passionate about my field…if a company throws it out the window…like I give up the thing that I love and I'm passionate about and I give up the thing I went to school for to leave to lead others which I did not go to school for…I found that we just*

lose those people, they go somewhere else where they can do what they love and they're passionate about.

Maslach and Leiter (2017) also noted the importance of how individuals perceive fairness and equitability in the workplace to their job satisfaction.

Findings: Research Question 2

The quantitative data for this research project provided insight into the effects of burnout, CF, and VT in clinicians working in an outpatient program and aimed to show how the organization worked to mitigate its effects. The results of this study showed an organization embattled by significant clinician turnover yet open to embracing new initiatives to reduce the turnover rate and improve employee retention. The organization was already experiencing significant turnover prior to COVID-19, and it only increased during and after the pandemic. The clinicians who completed the presurveys were no longer with the organization to complete a postsurvey. Thus, the AR team used the survey data collected from our quantitative instruments—the Maslach Burnout Inventory (MBI; Maslach et al., 1996), the Professional Quality of Life Scale, version 5 (ProQOL; Stamm, 2010), and the Secondary Traumatic Stress Scale (STSS; Bride et al., 2004)—to establish the baseline context and frame the problem and as a postintervention team survey.

Group Learning

Finding 1: Organizational cultures that focus solely on the client's health and do not factor in clinician well-being lead to burnout and turnover of clinicians

In multiple AR team meetings, the AR team reviewed the organization's mission and value statement. The value statement focused exclusively on the health and well-being of the client and did not acknowledge the importance of clinicians' health and well-being. The

quantitative and qualitative data aligned in indicating that this sole focus on clients often left clinicians feeling that their well-being was not significant to the organization. The AR team used aggregate data from the three instruments to establish a baseline of clinicians' well-being or distress. As previously noted, many of the clinicians who completed the presurvey were no longer with the organization at the time of the postsurvey, which illustrates the impact of burnout and negative perceptions on HCMHC clinicians and the organization as a whole. Overall, the quantitative data confirmed the presence of burnout in HCMHC outpatient center clinicians. The results of the MBI subscales (emotional exhaustion, depersonalization, and personal achievement) will be further explained in this section.

Maslach Burnout Inventory. The emotional exhaustion, depersonalization, and personal achievement subscales of the MBI were used, and the version of the MBI used for this study had 22 items. The surveys were distributed to the 38 clinicians working at outpatient centers, and 29 clinicians returned the completed surveys. All five outpatient programs at HCMHC were represented in the study. However, demographic information, such as age, gender, years with the agency, and license type was not collected for this study due to the small sample size and to maintain the anonymity of the clinicians. Table 4.2 depicts the number of surveys returned per program, the percentage of total surveys completed by each program, and the mean score by program.

Table 4.2

Quantitative Data Chart

Program	Number of surveys returned	Percentage of surveys by program	Mean score by program
P1	10	34.50%	24.5
P2	5	17.24%	24.8
P3	6	20.68%	26.16
P4	3	10.34%	30.33
P5	5	17.24%	22.6
Total	29	76%	25.678

The mean, median, variance, and standard deviation were calculated using the data set from all 5 programs; see Table 4.3 for descriptive statistics. The mean scores for emotional exhaustion (M = 26.478, depersonalization (M = 7.384), and personal achievement (M = 34.464) indicated a moderate degree of all three aspects among clinicians. In particular, the moderate scores for emotional exhaustion and depersonalization suggest that clinicians at HCMHC outpatient centers are experiencing burnout syndrome. Additionally, the data shown in Table 4.3 provides descriptive statistics of the MBI scale which describe the emotional exhaustion, depersonalization, and personal achievement subscale results. Since these statistics represent a small sample size and do not involve hypothesis testing, p-values were not included.

Table 4.3

Maslach Burnout Inventory Subscale Results

Maslach Burnout Inventory	**Median**	**Mean**	**Variance**	**Standard deviation**
Emotional **exhaustion (EE)**	26.16	26.478	5.42052	2.38201
Depersonalization	7.6	7.384	16.82348	4.101644
Personal achievement	33.2	34.464	10.38868	3.223148

Figure 4.1 illustrates the mean scores on the emotional exhaustion subscale by outpatient center. Notably, the mean score of 26.478 is close to the upper end of the range for moderate emotional exhaustion (≥30 = high EE).

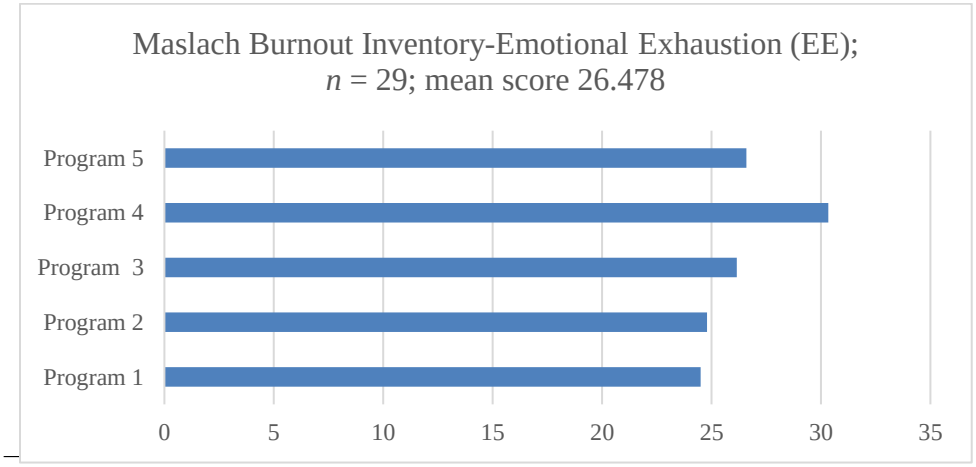

Figure 4.1. *MBI Emotional Exhaustion Scores by HCHMC Outpatient Center.*

Figure 4.2 illustrates the mean scores on the depersonalization subscale by outpatient center. This dimension is particularly important in understanding the impacts of burnout on clinician and client well-being. The degree to which clinicians can understand the client's experiences from the perspective of the client requires the ability to empathize. As Figley (2002)

explained, “we cannot avoid our compassion and empathy. They provide the tools required in the art of human services” (p. 1434). The loss of empathy impacts the quality of the services and human relatability that a clinician provides.

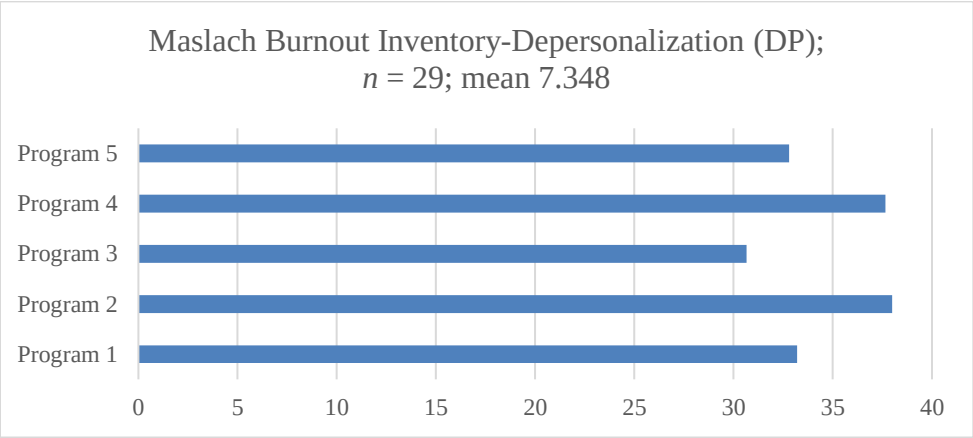

Figure 4.2. *MBI Depersonalization Scores by HCHMC Outpatient Center*.

Finally, Figure 4.3 illustrates the mean scores for the personal achievement subscale by outpatient center. Notably, the mean score of 34.464 is close to the lowest end of the range indicating a moderate sense of personal achievement (< 33 indicates low PA).

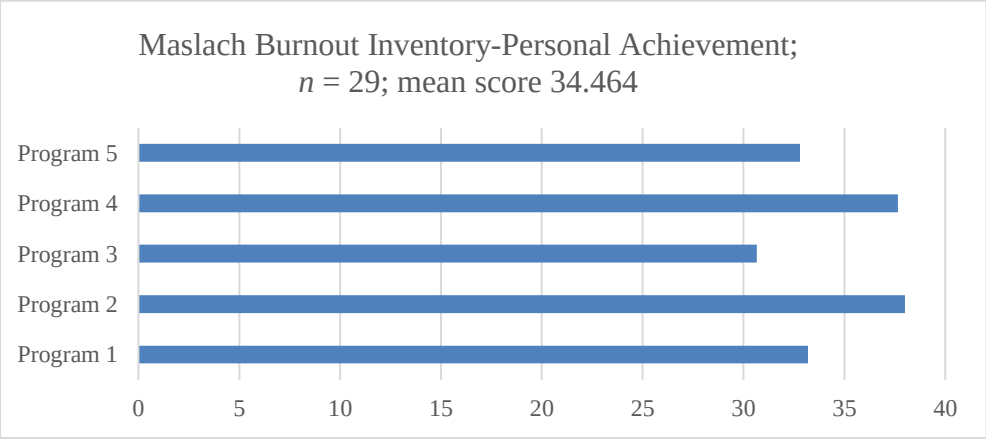

Figure 4.3. *MBI Personal Achievement Scores by HCHMC Outpatient Center.*

AR Team MBI Scores. The five members of the AR team also completed the emotional exhaustion subscale of the MBI at the end of the study, after we concluded our interventions. Our goal was to ascertain what impact, if any, our interventions and project had had on the system. The results of the postsurvey revealed no significant change in burnout in outpatient clinicians. At the beginning of the study, AR team members scored as having a moderate degree of emotional exhaustion (M = 25.6781), and they continued to reflect a moderate level at the postsurvey (M = 21). It is noted that the limited timeframe of this project did not provide evidence of significant long-term culture or system changes, but it did provide insights into the sustained impact of burnout, CF, and VT on a mental health organization and mental health clinicians. Furthermore, the findings of this study showed the significance of HCMHC to implement practices that would demonstrate a more balanced approach in valuing the physical and mental health of the clinicians to decrease the experience of CF, burnout and increase job satisfaction.

Finding 2: Community mental health organizations with fast-paced, high-stress environments and limited resources, autonomy, and social supports can lead to burnout, CF, and VT; however, the presence of compassion satisfaction has a positive relationship to retention

As this study, theory, and literature found, the demands of clinicians working in fast-paced, high-stress environments can be overwhelming and impact the mental wellness of clinicians. The limited available resources, lack of autonomy, and social supports can increase the feelings of VT, CF, and burnout. A combination of these factors can reduce clinicians' ability to empathize with clients, increase feelings of inadequacy, and emotional exhaustion. Additionally, this study found that clinicians can experience feelings of burnout and compassion fatigue, yet concurrently feel a level of satisfaction in working with clients. This is not surprising

as many clinicians enter the field wanting to make a difference in the lives of others. The notable issues with the fast-past and stressful environment in community mental health organizations has an impact on clinicians wellbeing. As noted early, there is a cost to the care that is provided to clients; therefore, organizations should implement mental supports to include adequate resources, greater autonomy, and processes that reduces workplace stressors. The results of the ProQOL and STSS scale was analyzed by the AR team and further explains the group learning in this section.

The Professional Quality of Life Scale (ProQOL). The 30-item version of the ProQOL (Stamm, 2010) assesses burnout, secondary traumatic stress, and compassion satisfaction via three subscales, indicating whether the respondent reflects a *low*, *average*, or *high* degree of these elements.

The results of the ProQOL burnout subscale for our 29 clinicians (M = 24.538) correlated with those of the MBI, indicating an average degree of burnout among clinicians, but near the lower end of this range (scores < 22 indicate low burnout). Figure 4.4 illustrates the results for the burnout subscale by outpatient center.

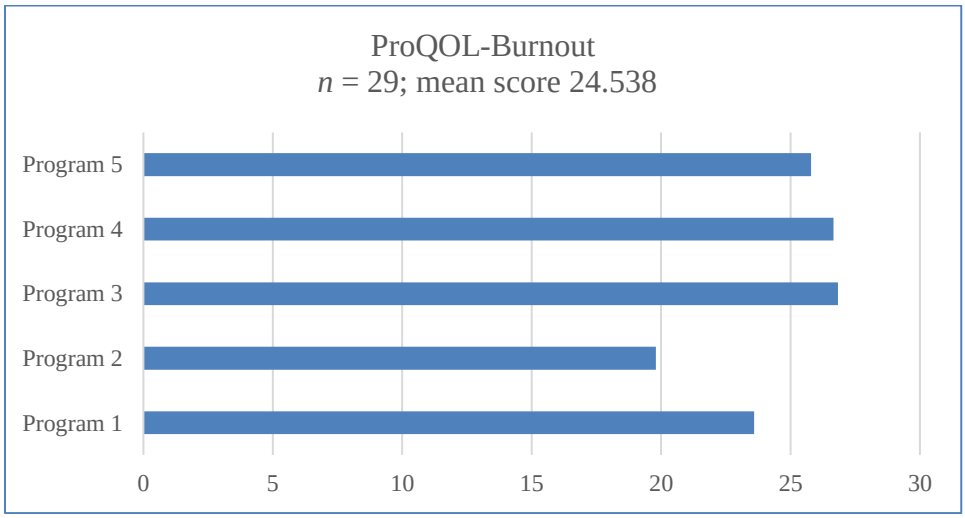

Figure 4.4. *ProQOL Burnout Scores by HCHMC Outpatient Center.*

Perhaps surprisingly, the results of the ProQOL secondary traumatic stress subscale indicated a low degree of secondary trauma stress among the 29 outpatient center clinicians who responded (M = 21.012), although this figure was at the high end of this range (scores ≥ 23 indicate average or high burnout). Figure 4.5 illustrates the mean scores by outpatient center.

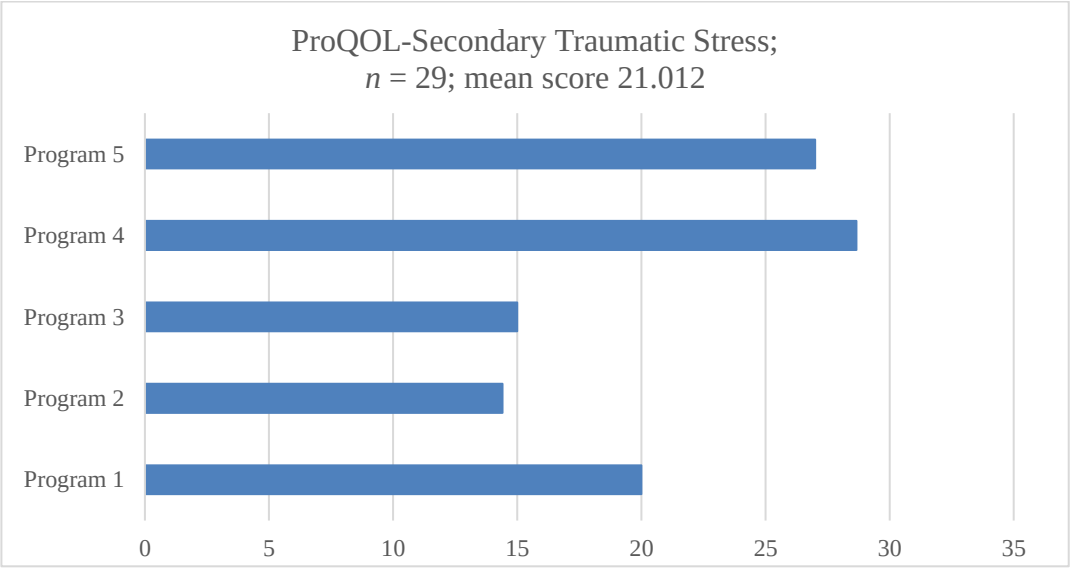

Figure 4.5. *ProQOL Secondary Traumatic Stress Scores by HCHMC Outpatient Center.*

The ProQOL subscale for compassion satisfaction assesses the degree to which a person is satisfied with their job (Figley, 2002). The results of the compassion satisfaction subscale indicated an average degree of clinician compassion satisfaction (M = 35.838), well within the range for this level (23–41 = "average" compassion satisfaction). Figure 4.6 illustrates the mean scores for this subscale by outpatient center.

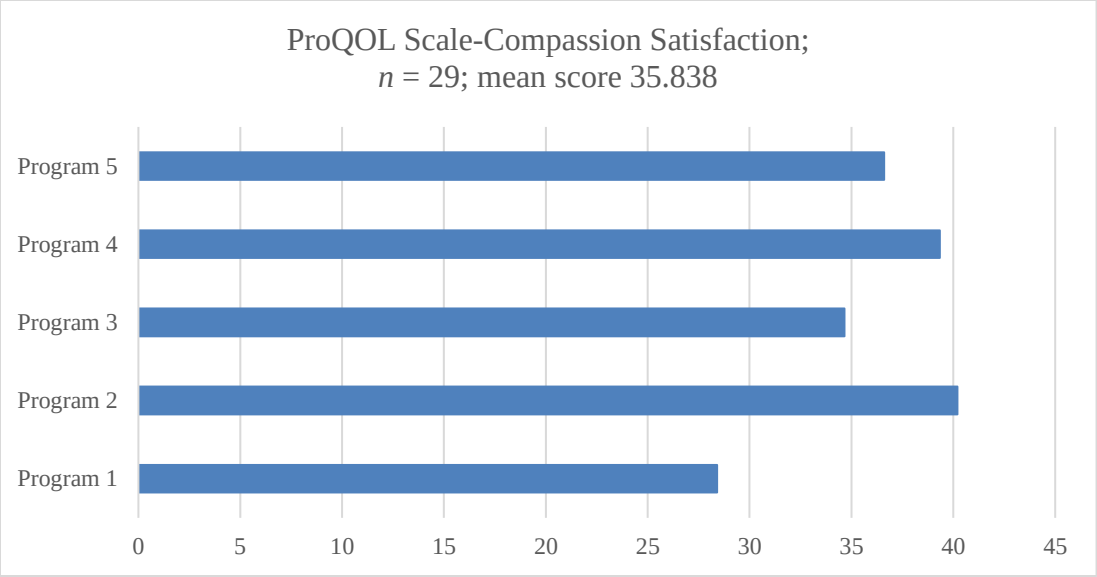

Figure 4.6. *ProQOL Compassion Satisfaction Scores by HCHMC Outpatient Center.*

Secondary Traumatic Stress Scale. The STSS assesses for intrusive thoughts, avoidance behavior, and arousal associated with the exposure to clients' traumatic material (Bride et al., 2004). The STSS version used in this study had 17 items. The 29 clinicians had an overall mean score of 20.66, indicating a surprisingly low level of secondary traumatic stress among HCMHC outpatient center clinicians. Four of the five programs scored within the "low" range on the STSS (≤ 27); one program scored slightly higher, in the "mild" range (38–43). The mean scores on the STSS align with those on the ProQOL subscale for secondary traumatic stress as well. Figure 4.7 illustrates the mean scores on the STSS by outpatient center.

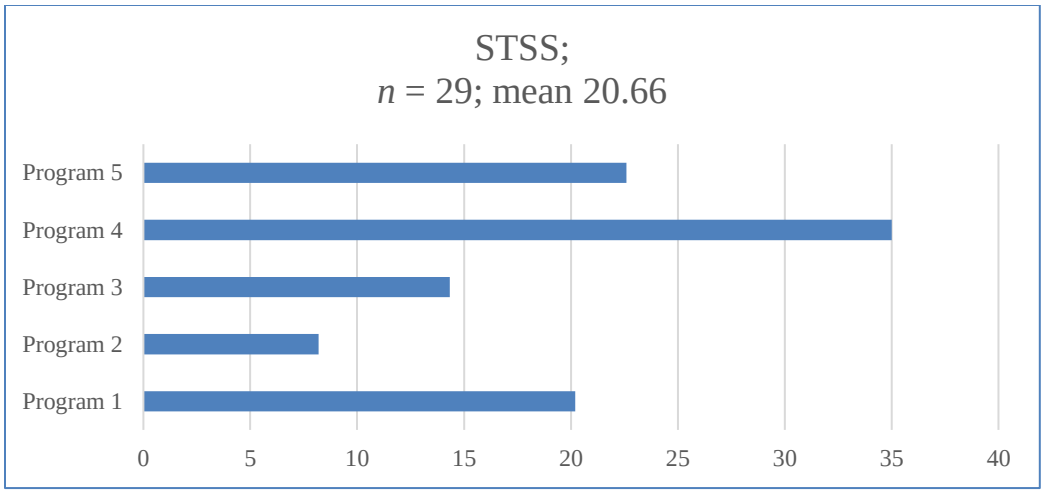

Figure 4.7. *STSS Scores by HCHMC Outpatient Center*.

Overall, the AR team found that the ProQOL results were consistent with those of the MBI, indicating the presence of burnout in HCMHC clinicians. Additionally, the scale further indicated a low presence of secondary traumatic stress and low levels of intrusive thoughts as a result of STS. However, the ProQOL results also showed the presence of compassion satisfaction, which aligned with the MBI's personal achievement scale and indicated that clinicians experience personal achievement in working with clients. Although there is the presence of burnout and a degree of STS, HCMHC clinicians continue to view their work with clients as gratifying. Thus, HCMHC's aim to reduce the environmental and cultural factors impacting burnout, CF, and VT can not only reduce the stressors that clinicians experience but also amplify this existing sense of achievement, thereby encouraging greater job satisfaction.

Conclusion

Clinicians can experience burnout and fatigue from being compassionate, and the impact of their compassion can affect the clinicians' mental and physical wellbeing. According to Figley (2002), "in our effort to view the world from the perspective of the suffering we suffer" (p.

1434). The long hours, highly acute clients, and tireless work can take a toll on clinicians and ultimately impact the quality of the care provided to clients. As a coping mechanism, clinicians may "begin to detach themselves from their work, develop negative reactions to the job, and treat people in callous and cynical ways—a response of depersonalization" (Maslach & Leiter, 2017, p. 42). Moreover, if the situation does not improve, clinicians may "begin to question their ability to do the job well, and would experience feelings of inadequacy and failure, or reduced personal accomplishment" (Maslach & Leiter, 2017, p. 42). These feelings were reflected in the quantitative survey data we collected. An organization's culture, clinicians' individual schemas, and the system overall contribute to the experience of burnout, CF, and VT in clinicians working in an outpatient mental health program. Organizations that understand and take actions to develop system practices and attitudes to reduce the experience of burnout, compassion fatigue, and vicarious trauma can influence clinicians' job satisfaction. The AR team's goal in this project was to learn from the literature, turnover theory, and study. We learned that a system's culture of long hours, copious documentation, high caseloads, routinization, high acute clients, and not including clinicians in decision-making impacts outpatient clinicians' turnover intention.

Insights

The purpose of this study was to understand what is learned at the individual, group, and system levels regarding an organization's attempt to mitigate the effects of CF, VT, and burnout in clinicians working in an outpatient mental health program. The literature on burnout, CF, and VT emphasized the connection of high caseloads, scarce resources, exposure to trauma narratives, and organizational environments to low job satisfaction to turnover. Furthermore, these empirical studies provided antecedents to increase job satisfaction, which in turn decreases the impact of burnout, CF, and VT and turnover. As we learned in the AR study at HCMHC, the

causal model of turnover theory determinants and empirical studies on burnout, CF, VT demonstrated the need for organizations to establish supportive environments that emphasize workplace wellness and self-care to improve a sense of value in clinicians and strengthen their commitment to stay with the organization. Moreover, establishing organizational policies and practices that decrease unnecessary steps in work and emphasize increasing social supports, pay, and job involvement can improve job satisfaction.

The insights I gained from the qualitative and quantitative research study are as follows:

1) Organizations that are willing to self-assess and implement changes within the system can change the perspective of key stakeholders and improve job satisfaction;

2) System change is complex, requires conscious efforts to maintain the change, and happens over time;

3) A diverse group of professionals with unique, individualized histories, and similar purposes can enhance group learning and affect system change.

4) Burnout, vicarious trauma (VT), and compassion fatigue (CF) impact mental health clinicians working at smaller outpatient mental health centers disproportionately compared to those at larger outpatient centers.

The study data, triangulation, and reflection practices showed the shift in the mindset of the AR team. At the onset of the project, the team were skeptical about their ability to effect change; however, at the end of the study, team members expressed how their mindset had changed as they experienced change. Although the significant changes desired would require a longitudinal study, change did not occur at the system level until the AR team learned about “learned helplessness” and were able to step outside of our comfort zone to allow other stakeholders to be involved in the process. Once we were able to move from learned helplessness

and negative thinking, we became more motivated to share the findings of the quantitative and qualitative data. As we became more transparent in sharing the findings of our data, we found that the system was eager to learn more about the findings and interventions.

Insight 1: An organization's willingness to self-assess, implement strategies to mitigate factors contributing to burnout, vicarious trauma, and compassion fatigue demonstrates an organization with a growth mindset.

Organizations that are willing to self-assess and implement changes within the system can change the perspective of key stakeholders and improve job satisfaction. As Fish and Mittal (2020) asserted, mental health is public health. It is essential for HCMHC and other mental health organizations that employ clinicians to take an active role in self-assessing and develop policies and practices that promote clinician well-being. The literature and the findings of this AR project concur that such policies and practices include addressing caseload adjustment, including clinicians in decision making, and providing social support promote workplace wellness, which can, in turn, lead to improved job satisfaction. Moreover, organizations that self-assess can be proactive in detecting the early signs of burnout, CF, and VT among clinicians. The data from this study indicates that ongoing monitoring, screening, and assessing can help HCMHC develop other interventions that can mitigate the impact of burnout, CF, and VT and promote clinician well-being.

Furthermore, it is suggested that organizations establish a culture of emotionally and physically supportive environments for clinicians working with trauma survivors (Brady at el., 1999). Research has increasingly emphasized the intersection between the physical and mental well-being of clinicians and impacts on service delivery (Fish & Mittal, 2020). The role of the clinician is vital; without them, the clinical services provided to clients could not exist. However,

clinicians are not immune to physical, mental, or social challenges in a mental health organization simply because they are clinicians. Research suggests that working with trauma survivors increases the likelihood of clinicians experiencing trauma symptoms themselves (Brady at el., 1999). The results at HCMHC supported this assertion: Scores for clinicians at outpatient centers indicated the presence of STS, albeit at a low percentile. To help provide emotional and clinical support for clinicians, HCMHC protocol is for all clinicians to receive ongoing and regular supervision or consultation. At HCMHC, clinical supervision is structured to help clinicians navigate challenges experienced working with clients, address how working with particular clients may impact the clinician, and ensure that best practices are observed. This clinical and social support can help shift clinicians' perspective, which can bolster positive emotions, decrease job stress, and increase job satisfaction (Brady et al., 1999; Killian, 2008; Price, 2001). Clinicians have acquired the skills and knowledge to help individuals with various levels of mental health needs; however, when organizations demonstrate a vested interest in the implementation of practices that emphasizes the overall well-being of clinicians as well, this can lead to improved organizational culture and job satisfaction.

Another key insight for me from this study was the impact of escaping the routine of the job and collaborating with other stakeholders, which consequently impacted the AR team's individual learning. The AR team initially believed that the system would be resistant and inflexible to change, viewing the situation as "us against them." We did not believe that the organization was conscious of the increase in clinician turnover or about the burnout, CF, and VT expressed by clinicians. Initially, we did not see ourselves as being able to change a system, but we learned throughout the process of reflecting on our actions (or inaction) that the initial

change was needed at the individual level. The system was open to learning and embraced the opportunity to implement effective changes to increase employee job satisfaction.

The vision and mission of the agency focus on the client; however, through studying the areas of growth opportunity, the organization has begun to incorporate language, behaviors, and ideas that acknowledge the impact of this work on the clinicians. Furthermore, the organization has created other communication methods to include clinicians and other employees in conversations that impact the organization. The executive team visits each program to talk directly to team members, a diversity, equity, and inclusion (DEI) program was created to develop more ways to be inclusive, the CEO started a synchronous forum where employees could join and talk with the CEO, and a newsletter was created to keep employees informed of changes occurring in the organization.

Although the AR team initially struggled to find their voices to advocate for the needs of the clinicians, we learned that our voices and influence have power, change can occur, and as an organization, we all share the same goals for the organization.

Insight 2: System change is complex, requires conscious efforts to maintain the change, and happens over time.

One insight gained regarding the complexity and requirements to sustain change in an organization is that it requires time. When the AR team members were asked what they had learned about the organization or the system during the exit interview, one member noted:

> *It's complex…I understand that as an organization or system, the thought has to be how it would affect the whole…and not just one entity…it is a very difficult thing to do.*

Another AR member stated that "*Organizational change is naturally a slow process.*"

The AR team and I learned that system change takes time to build core relationships, navigate organizational politics, and obtain buy-in at all levels. This last factor may be one of the most impactful. In this study, the AR team had to be the first buy in, at the individual and group levels, to develop and deliver the interventions and execute the change initiatives. As mentioned in Chapter 3, the AR team had to move beyond learned helplessness. This process was challenging because the team believed in the interventions and understood the data that supported them, yet doubt paralyzed our team for months, prolonging intervention implementation. In this process, the AR team and I learned how difficult change can be and how long it can take to shift mindsets and change your perspective.

At the systems level, buy-in is essential for organizational change. The clinicians provided their feedback, which helped the AR team develop the interventions. After the AR team became unstuck, the team used their individual influence and relationships to engage other stakeholders and executive team members regarding the change initiatives. When discussing how we would disseminate the information, the AR team worked strategically to identify which team members would be most effective in reaching other stakeholders. Often, the information was disseminated to key stakeholders in various meetings and informal settings. One intervention that demonstrates the complexity and buy-in that are needed to make a system change involved care coordination time. The AR team believed that this intervention would not be approved if we could not provide data regarding potential impacts on billing targets. We collected additional data from each program that described the billing patterns of clinicians before and after two separate pilot studies, which indicated no significant changes. In fact, for some clinicians, the billing increased. This data helped us achieve buy-in from a key stakeholder, which in turn influenced other stakeholders' approval of the care coordination time implementation.

In addition to buy-in, system changes often require a review of policies and reevaluation of practices. An example of addressing burnout and compassion fatigue at HCMHC was our attempt to address documentation redundancies. The AR team reviewed the referral form and identified the areas where the information was redundant. We then developed an intervention to reduce the amount of redundant paperwork by addressing the internal referral process. The AR team understood the challenges faced in obtaining buy-in from other programs and individuals that were accustomed to the current referral process. The AR team decided to address the internal referral process at a large interdisciplinary program meeting, which provided the opportunity for other stakeholders to voice their thoughts and experiences. This process garnered more support regarding the need to review the challenges in the current process and make recommendations for changes. The AR team and I learned that the process of change requires the support of others; that it can be achieved indirectly through the support of others who buy in to the change; and that a minority of individuals who support an initiative can become the majority through this process. As one AR team member stated in the exit interview, "*change can happen*."

Insight 3: A diverse group of professionals with unique, individualized histories and similar purposes can enhance group learning and affect system change.

Group reflection and collaboration can transform the mindset of key stakeholders. At the beginning of this research project, we looked at the system as being the executive team members and team members who had influential relationships with the executive team and those who make the decisions for the organization. However, through this process, the AR team came to see our own strength and position to influence change within the system. Each team member brought their unique influences, experiences, and knowledge to the team. We were able to identify and use our unique skillsets to influence the changes we sought for the organization. Initially, the AR

team had to acknowledge that burnout, CF and VT existed at the organization, ultimately leading us to acknowledge how we were being impacted ourselves. We had not been immune to the effects of burnout, but because we were able to experience it, we were able to relate to the clinicians, and we were in positions to effect change based on this understanding.

The first turning point in the project occurred when the team began to bond and build trust with one another. The AR team members became more open to expressing their experiences and how they viewed the challenges at the organization. This allowed for greater reflection and collaboration in developing the interventions. The second turning point was when the team demonstrated vulnerability and willingness to take a risk to propose the intervention plan with key stakeholders. When we began to include other key stakeholders in the conversation, we quickly saw the organization's willingness to embrace the interventions to increase job satisfaction and to reduce turnover intentions, which energized the team.

Although the discomfort of the unknown was great, the desire to advocate for the needs of the clinicians was greater. The ambiguous state between the AR team's awareness of the problem and an identified future plan to address the problem was a difficult space for the AR team (Coghlan, 2019) but was also a space of deep growth and reflection. The experience of learning together reaffirmed that the values the AR team held are the values the system holds yet in our various roles, we are all working on ways to increase a sustainable workforce.

Clinicians enter into the mental health field with the genuine desire to utilize their knowledge, skills, and genuine desire to help others, but at what cost? How can clinicians pursue a career in mental health counseling without the cost of their own mental and physical health being compromised? This study identified ways that community mental health organizations can use AR to improve organizational policies and procedures to mitigate burnout, CF, and VT in

outpatient mental health clinicians. The collaborative nature of AR and participatory action of the AR team in collaboration with other agency stakeholders can address burnout, CF, and VT in clinicians working at community outpatient mental health centers.

Insight 4: Burnout, vicarious trauma, and compassion fatigue impact mental health clinicians working at smaller outpatient mental health centers disproportionately than larger outpatient centers.

The impact of burnout, CF, and VT on outpatient mental health clinicians was documented through our research, which generated insight. In this study, clinicians from five outpatient mental health centers participated in data collection. The quantitative data showed the presence of burnout, CF, and VT in all five programs. The smallest outpatient program, program 4, had the fewest clinicians prior to the start of the study due to program size but lost additional clinicians due to turnover. Our findings showed that program 4 was impacted significantly in the areas of emotional exhaustion, secondary traumatic stress (STS), and depersonalization. Research suggests that limits in resources, administrative support and staffing can reduce clinician wellness and increase stress levels.

Additionally, a smaller staff can lead to the remaining clinicians experiencing higher caseloads, fewer breaks, more notes, and increased frequency of exposure to clients' trauma narratives. These factors underscore the link between the lack of resources and clinicians experiencing intense feelings of emotional exhaustion, depersonalization, and STS. Importantly, smaller programs also lack the opportunities for peer support, flexibility, and collaboration that are present in larger settings, leading to a sense of increased isolation. It is recommended that outpatient mental health organizations acknowledge the burden of clinician turnover and the effects of limited resources on outpatient centers, especially on smaller centers and those with

few resources. Additionally, outpatient mental health organizations should prioritize the hiring and training of staff and the development of targeted interventions to address the burden of turnover on outpatient centers, especially smaller programs.

Implications for Further Study

Practical Implications

This study has practical and real-world implications. This research study builds upon current literature, research, and findings on burnout, CF, and VT, finding that organizational culture and systemic factors impact the experience of burnout, CF, VT in mental health clinicians and lead to turnover in a community outpatient mental health organization. Clinicians who are impacted by these negative experiences lack job satisfaction, which can negatively impact service delivery and performance (Cetrano et al., 2017). Accordingly, mental health organizations must become proactive in recognizing the signs of CF, VT and burnout and have strategies in place to mitigate these experiences in clinicians. Mental health providers also need to be well versed in self-care strategies and recognize factors that contribute to these negative experiences (Fish & Mittal, 2021). Organizational environmental interventions that support clinicians' wellbeing have been found to be more effective at reducing the effects of burnout than individual interventions (Morse et al., 2012). The results of this study suggest that organizations need to support clinicians' well-being individually through work-life balance and systemically through an organizational culture that supports clinician health and self-care.

Furthermore, it is recommended that community mental health organizations prioritize sustainability practices by developing a long-term commitment plan, inclusive of a monitoring system for the implemented interventions, and regular review of ongoing practices, policies, and procedures to ensure continued growth and sustainability. The findings of this study concurred

with studies conducted by Cetrano et al. (2017) and Morse et al. (2012) that organizations should pay close attention to the time pressure, training needs, and the benefit of building a trusting relationship between employees and management. Both new and veteran clinicians have needs that must be met. New clinicians can feel overwhelmed due to their lack of experience and training. The implementation of a mentoring program, peer support and clinical supervision can address issues of insecurity, positively influence clinicians' well-being, and develop clinical confidence. Additionally, it is important for the organization's well-being officer to work with key stakeholders to provide support to veteran clinicians, who have often acquired full licensure as an LPC or LCSW and no longer seek clinical supervision. However, ongoing supervision helps clinicians maintain ethical practices, boundaries, professional development, and identify issues that may impact the clinician or the quality of care rendered. In addition, conscientious leaders should take an active role in normalizing and discussing organizational healthcare strategies for clinicians. It is important for leaders to understand the risks of burnout, VT, and CF and that they are not due to personal weaknesses but the nature of the organizational environment. Organizational leaders should model prioritizing their own self-care and setting boundaries between work and home without feeling guilt or judgement.

The quantitative and qualitative data that impacted the findings of this study confirmed that the fast-paced nature of community mental health organizations, copious amount of required notes and documentation, time pressures, and routinization limit clinicians' autonomy and impact turnover intention. It is recommended that community mental health organizations include clinicians in decision-making and provide opportunities for internal growth and autonomy as well as leadership development. Employing a well-being officer whose primary responsibility is to provide continual oversight, review of interventions, and implement strategies

to retain clinicians is another practical implication. Finally, organizations should expand efforts to improve their messaging and behavior to emphasize the value of its clinicians.

Last, it is recommended that this study be expanded beyond HCMHC to encompass other community mental health organizations. By doing so, we will extend our knowledge of specific populations that may be adversely impacted by burnout, CF, and VT, such as newer clinicians to the field as well as those of varying genders and gender identities, experience levels, and ethnicities.

Theoretical Implications

The causal model of turnover theory guided this research project. The research showed that turnover theory has been used with different career fields and disciplines; however, there is limited research applying this theory to study turnover in community mental health clinicians. The research study at HCMHC adds to the body of knowledge regarding turnover determinants that impact community mental health clinicians. For example, this study provided evidence that the causal model of turnover can be used to study turnover in clinicians working in an outpatient community mental health organization. This study also reinforced the accuracy of the factors asserted in previous research as having both positive and negative relationships to turnover in clinicians working in outpatient community mental health organizations. Furthermore, the study found that clinicians' growth opportunities, job involvement, social supports, and autonomy had a positive relationship with clinicians feeling valued by the organization, which increases job satisfaction.

It is recommended that further study be conducted on a macro level to measure the reliability of these findings. Furthermore, additional studies can show other factors that contribute to turnover and other ways the causal model of turnover theory can be used to retain

clinicians working at community mental health organizations. Finally, it is recommended to study the difference between turnover and turnover intentions of clinicians working in community mental health organizations.

Limitations

This study provided valuable insights and actionable knowledge for further study on burnout, CF, and VT in clinicians working in community outpatient mental health organizations; however, there were some notable limitations. The limitations of this study did not compromise the integrity or the contributions this study provided to the core and thesis project, but they do provide greater opportunity and areas for future study.

COVID-19 Pandemic

This project was conducted during the COVID-19 global pandemic, an intense global situation that impacted businesses across the United States and, specifically, HCMHC. The immediate shifting of available resources, schools closing, increase in illnesses and fear of death changed the landscape of services and service providers. Throughout and after the pandemic, clinician turnover continued to rise, resulting in only 29 of 38 clinicians working at outpatient centers at HCMHC participating in the surveys. Unfortunately, a larger sample was not available for pre/post data collection. Our limited sample size affected the data pool, which impacted the researchers' ability to collect postintervention data to determine the impact of the interventions.

Demographic Impact Data

Another limitation was the small sample size. The small sample did not provide enough people to look at the racial/ethnic makeup, age, or gender of the clinicians impacted by burnout, CF, and VT. Accordingly, there were questions that could not be addressed, such as the following: Do burnout, CF, and VT impact ethnic minorities and women disproportionately more

than other demographics? Do burnout, CF, and VT impact new clinicians more than seasoned clinicians who work at community mental health centers? The current research on new clinicians entering the clinical field shows a higher turnover rate for this population than among seasoned clinicians. According to Price and Mueller (1981), there is a higher rate of turnover in younger, newer clinicians because newer clinicians have the most routine jobs, limited participation in decision making, less knowledge of their jobs, fewer friends, and lower pay.

Final Reflections

As I reflect on this dissertation journey, a quote by former president Barack Obama quoting June Jordan and Mahatma Gandhi came to mind: “Change will not come if we wait for some other person or some other time. We are the ones we've been waiting for. We are the change that we seek.” This quote epitomizes why I started on this journey, why I remained, and why I plan to continue to apply my leadership skills and the knowledge I have gained as an action researcher. Leading this AR project in an effort to make systemic changes for mental health clinicians and my organization was an honor that I am grateful to have been granted.

I had first-hand experience of being an organizational leader who implements policies and a clinician who experienced the effects of burnout, CF, and VT. I believe this unique position helped me to develop growth opportunities for the organization, clinicians, and myself. This journey has helped me to understand my leadership style more fully. I am a compassionate, transformative servant leader. I had the unique opportunity of being an insider action researcher who gained many insights and learnings from this program that I applied directly to my leadership style.

When I started this study, I was a veteran clinician with years of leadership experience. In this journey, I was able to apply key lessons in communication, develop being a T-shaped leader,

improve collaboration skills, became a better data-driven decision-maker, created a more supportive work environment for my team, and developed opportunities for clinicians to lead. One initiative I started was the Employee, Incentive, Retention, and Engagement Committee (ERIE). The ERIE team is a group of volunteer clinicians who showcase their leadership skills through leading in-service trainings, providing positive feedback to peers, developing networking opportunities, and engaging in team collaboration activities. I found that empowering the clinicians to take an active role in leadership decreased routinization, increased buy-in, garnered more support with implementing new initiative, and built a more cohesive team.

I am grateful to have had the opportunity to learn, grow, and change with an incredible group of leaders and clinicians. I have learned that system change is difficult, messy, and requires collaboration, participation, and mindset change from stakeholders at different levels. It requires perseverance and occurs over time. Systems change can feel chaotic and intense like a tornado: One minute it is calm, and the next, complete calamity.

Initially, I saw the "system" as being separate from myself and the group. However, as we navigated our way through the AR process, I gained a clearer understanding of the change that was occurring at the individual level, which ultimately impacted the learning at the group and system levels. At the individual level, AR required self-reflection and introspection that helped me become more aware of my own thoughts, experiences, and biases. However, my experiences also provided the catalyst for me to lead this change project. I had to learn to be uncomfortable with not having the answers and develop the willingness to use the support of the AR team to problem solve. I recognized how significant the team dynamics were to the success of this project and the successful implementation of the interventions. This could not have been

achieved without the synergy of the team that was developed through team members learning to trust, support, and be honest with one another.

As a leader, I have grown and find myself utilizing AR cycles, AR methodology, and leadership skills to facilitate other change projects within my organization. I see this project as the beginning of an opportunity to study and continue to learn ways to mitigate burnout, compassion fatigue and vicarious trauma in clinicians and other individuals in the helping field.

REFERENCES

Allsbrook, K., Atzinger, C., He, H., Engelhard, C., Yager, G., & Wusik, K. (2016). The relationship between the supervision role and compassion fatigue and burnout in genetic counseling. *Journal of Genetic Counseling*, *25*(6), 1286–1297. https://doi.org/10.1007/s10897-016-9970-9

American Psychiatric Association. (2021). *What is mental illness?* https://www.psychiatry.org/patients-families/what-is-mental-illness

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Anderson, D. L. (2020). *Organization development: The process of leading organizational change* (5th ed.). Sage.

Argentero, P., & Setti, I. (2011). Engagement and vicarious traumatization in rescue workers. *International Archives of Occupational and Environmental Health*, *84*(1), 67–75. https://doi.org/10.1007/s00420-010-0601-8

Ashcroft, R., Sur, D., Greenblatt, A., & Donahue, P. (2022). The impact of the COVID-19 pandemic on social workers at the frontline: A survey of Canadian social workers. *The British Journal of Social Work*, *52*(3), 1724–1746. https://doi.org/10.1093/bjsw/bcab158

Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Human Services*, *84*(4), 463–470. https://doi.org/10.1606/1044-3894.131

Blanding, M. (2015, January 27). *National health costs could decrease if managers reduce work stress.* Harvard Business School. https://hbswk.hbs.edu/item/national-health-costs-could-decrease-if-managers-reduce-work-stress

Bluedorn, A. C. (1982). A unified model of turnover from organizations. *Human Relations, 35*(2), 135–153. https://doi.org/10.1177/001872678203500204

Borysenko, K. (2019, May 29). *Burnout is now an officially diagnosable condition: Here's what you need to know about it.* Forbes. https://www.forbes.com/sites/karlynborysenko/2019/05/29/burnout-is-now-an-officially-diagnosable-condition-heres-what-you-need-to-know-about-it/

Brady, J. L., Guy, J. D., Poelstra, P. L., & Brokaw, B. F. (1999). Vicarious traumatization, spirituality, and the treatment of sexual abuse survivors: A national survey of women psychotherapists. *Professional Psychology: Research and Practice, 30*(4), 386–393. https://doi.org/10.1037/0735-7028.30.4.386

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. Research on Social Work Practice, 14(1), 27-35. https://doi.org/10.1177/1049731503254106

Brown, M. (2020). Hazards of our helping profession: A practical self-care model for community practice. *Social Work, 65*(1), 38–44. https://doi.org/10.1093/sw/swz047

Carlson-Johnson, O., Grant, H., & Lavery, C. F. (2020). Caring for the guardians: Exploring needed direction and best practices for police resilience practice and research. *Frontiers in Psychology, 11*, 1874. https://doi.org/10.3389/fpsyg.2020.01874

Cetrano, G., Tedeschi, F., Rabbi, L., Gosetti, G., Lora, A., Lamonaca, D., Manthorpe, J., & Amaddeo, F. (2017). How are compassion fatigue, burnout, and compassion satisfaction

affected by quality of working life? Findings from a survey of mental health staff in Italy. *BMC Health Services Research, 17*, 755. https://doi:10.1186/s12913-017-2726-x

Charmaz, K. (2014). *Constructing grounded theory.* Sage.

Coghlan, D. (2019). *Doing action research in your own organization* (5th ed.). Sage.

Coghlan, D., & Brannick, T. (2014). Doing action research in your own organization (4th ed.). Sage.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

Creswell, J. W., & Creswell, J. D. (2018). *Research design* (5th ed.). Sage.

Dagan, K., Itzhaky, H., & Ben-Porat, A. (2015). Therapists working with trauma victims: The contribution of personal, environmental, and professional-organizational resources to secondary traumatization. *Journal of Trauma & Dissociation*, *16*(5), 592–606. https://doi.org/10.1080/15299732.2015.1037038

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress, or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373–385. https://doi.org/10.1080/00048670902721079

Drake, R. E., & Latimer, E. (2012). Lessons learned in developing community mental health care in North America. *World Psychiatry*, *11*(1), 47–51. https://doi.org/10.1016/j.wpsyc.2012.01.007

Dvoskin, J., Knoll, J., & Silva, M. (2020). A brief history of the criminalization of mental illness. *CNS Spectrums*, *25*(5), 638–650. https://doi.org/10.1017/S1092852920000103

Ellingson, L. (2020, October 6). *The first lady of mental health: A 50-year journey*. The Carter Center. https://mentalhealthjournalism.org/the-first-lady-of-mental-health-a-50-year-journey/

Figley, C. R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorders in those who treat the traumatized*. Brunner-Routledge.

Figley, C. R. (2002a). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology, 58*(11), 1433–1441. https://doi.org/10.1002/jclp.10090

Figley, C. R. (2002b). *Treating compassion fatigue*. Brunner-Routledge.

Finklestein, M., Stein, E., Greene, I., and Solomon, Z. (2015). Posttraumatic stress disorder and vicarious trauma in mental health professionals. *Health & Social Work, 40*(2), e25–e31. https://doi.org/10.1093/hsw/hlv026

Fish, J. N., & Mittal, M. (2021). Mental health providers during COVID-19: Essential the US public health workforce and in need of support. *Public Health Reports*, *136*(1), 14–17. https://doi.org/10.1177/0033354920965266

Flanagan, J. C. (1954). The critical incident technique. *Psychological bulletin*, *51*(4), 327.

Freudenberger, H. (1974). Staff burn-out. *Journal of Social Issues*, *30*(1), 159–165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Freudenberger, H. (1975). The staff burn-out syndrome in alternative institutions. *Psychotherapy*, *12*(1), 73–82. http://dx.doi.org/10.1037/h0086411

Galderisi, S. Heinz, A., Kastrup, M., Beezhold, J., & Sartorius, N., (2015). Toward a new definition of mental health. *Official Journal of the World Psychiatry Association*, *14*(2), 231–233. https://doi.org/10.1002/wps.20231

Georgia Department of Behavioral Health and Developmental Disabilities. (n.d.). *DBHDD agency information.* Retrieved April 26, 2022, from https://dbhdd.georgia.gov/organization/be-informed.

Green, A. E., Albanese, B. J., Shapiro, N. M., & Aarons, G. A. (2014). The roles of individual and organizational factors in burnout among community-based mental health service providers. *Psychological Service, 11*(1), 41–49. https://doi.org/10.1037/a0035299

Halbesleben, J. R. B., Osburn, H. K., & Mumford, M. D. (2006). Action research as a burnout intervention: Reducing burnout in the Federal Fire Service. *The Journal of Applied Behavioral Science, 42*(2), 244–266. https://doi.org/10.1177/0021886305285031

Herman, J. L. (2002). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*(51), S98–S103. https://doi.org/10.1046/j.1440-1819.1998.0520s5S145.x

Holmes, M. R., Rentrope, C. R., Korsch-Williams, A., & King, J. A. (2021). Impact of COVID-19 pandemic on posttraumatic stress, grief, burnout, and secondary trauma of social workers in the United States. *Clinical Social Work Journal, 49*, 495–504. https://doi.org/10.1007/s10615-021-00795-y

Hughes, H. (2008). Critical incident technique. In S. Lipu, A. Lloyd, & K. Williamson (Eds.), *Exploring methods in information literacy research* (pp. 49–66). Centre for Information Studies, Charles Sturt University.

Hyatt-Burkhart, D. (2014). The experience of vicarious posttraumatic growth in mental health workers. *Journal of Loss & Trauma, 19*(5), 452–461. https://doi.org/10.1080/15325024.2013.797268

Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 32–44. https://doi.org/10.117/1534765608319083

Koenecke, A. (2019). A game theoretic setting of capitation versus fee-for-service payment systems. *PLoS ONE*, *14*(10), e0223672. https://doi.org/10.1371/journal.pone.0223672

Langer, G. (2018). Probability versus non-probability methods. In D. L. Vannette & J. A. Krosnick (Eds.), *The Palgrave handbook of survey research* (pp. 351–362). Palgrave Macmillan.

Lasalvia, A., Bonetto, C., Bertani, M., Bissoli, S., Cristofalo, D., Mariella, G., Ceccato, E., Cremonese, C., De Rossi, M., Lazzarotto, L., Morandin, I., Zucchetto, M., Tansella, M. (2018). Influence of perceived organisational factors on job burnout: Survey of community mental health staff. *British Journal of Psychiatry*, *195*(6), 537–544. https://doi.org/10.1192/bjp.bp.108.060871

Leiter, M. P., & Harvie, P. L. (1996). Burnout among mental health workers: A review and a research agenda. *International Journal of Social Psychiatry*, *42*(2), 90–101. https://doi.org/10.1177/002076409604200203

Lingard, H. (2010). The impact of individual and job characteristics on "burnout" among civil engineers in Australia and the implications for employee turnover. *Construction Management and Economics*, *21*(1), 69–80. https://doi.org/10.1080/01446193200006512 6

Litam, S. D. A., Ausloos, C. D., & Harrichand, J. J. S. (2021). *Journal of Counseling & Development*, *99*(4), 384–395. https://doi.org/10.1002/jcad.12391

Lluch-Sanz, C., Galiana, L., Vidal-Blanco, G., & Sansó, N. (2022). Psychometric properties of

the self-compassion scale-short form: Study of its role as a protector of Spanish nurses professional quality of life and well-being during the COVID-19 pandemic. *Nursing Reports*, *12(*1), 65–76. https://doi.org/10.3390/nursrep12010008

Luther, L., Gearhart, T., Fukui, S., Morse, G., Rollings, A. L., & Salyers, M. P. (2017). Working overtime in community mental health: Associations with clinician burnout and perceived quality of care. *Psychiatric Rehabilitation Journal*, *40*(2), 252–259. https://doi.org/10.1037/prj0000234

Marshall, C., & Rossman, G. B. (1989). *Designing qualitative research*. Sage.

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, *2*(2), 99–113. https://doi.org/10.1002/job.4030020205

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory* (3rd ed.) Consulting Psychologist Press.

Maslach, C., & Leiter, M. P. (2005). *Banishing burnout: Six strategies for improving your relationship with work.* Jossey-Bass.

Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: recent research and its implications for psychiatry. *World Psychiatry*: official journal of the World Psychiatry Association (WPA), 15(2), 103-111. https://doi1.org/10.1002/wps.20311

Maslach, C., & Leiter, M. P. (2017). Understanding burnout: New models. *The handbook of stress and health: A guide to research and practice*, 36-56.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131–149. https://doi.org/10.1007/BF00975140

McLaughlin, J. A., & Jordan, G. B. (1999). Logic models: A tool for telling your programs performance story. *Evaluation and Program Planning, 22*(1), 65–72. https://doi.org/10.1016/s0149-7189(98)00042-1

Melrose, M. J. (2001). Maximizing the rigor of action research: Why would you want to? How could you? *Field Methods, 13*(2), 160–180. https://doi.org/10.1177/1525822X0101300203

Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). *Qualitative data analysis: A methods sourcebook* (4th ed.) Sage.

Mobley, W. H. (1977). Intermediate linkages in the relationship between job satisfaction and employee turnover. *Journal of Applied Psychology, 62(*2), 237–240. https://doi.org/10.1037/0021-9010.62.2.237

Mobley, W. H., Griffeth, R. W., Hand, H. H., & Meglino, B. M. (1979). Review and conceptual analysis of the employee turnover process. *Psychological Bulletin, 86(*3), 493–522. https://doi.org/10.1037/0033-2909.86.3.493

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-Devita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health, 39*(5), 341–352. https://doi.org/10.1007/s10488-011-0352

National Institute on Drug Abuse. (2022). *Naloxone DrugFacts.* National Institutes of Health. https://nida.nih.gov/publications/drugfacts/naloxone

National Institute of Mental Health. (2023). *Mental illness*. https://www.nimh.nih.gov/health/statistics/mental-illness

O'Callaghan, E. L., Lam, L., Cant, R., & Moss, C. (2020). Compassion satisfaction and compassion fatigue in Australian emergency nurses: A descriptive cross-sectional study. *International Emergency Nursing, 48*, 100785. https://doi.org/10.1016/j.ienj.2019.06.008

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, *26*(6), 558–565. https://doi.org/10.1037/0735-7028.26.6.558

Price, J. L. (1989). The impact of turnover on the organization. *Work and Occupations*, *16(*4), 461–473. https://doi.org/10.1177/0730888489016004005

Price, J. L. (2001). Reflections on the determinants of voluntary turnover. *International Journal of Manpower*, *22(*7), 600–624. https://doi.org/10.1108/EUM0000000006233

Price, J. L., & Mueller, C. W. (1981). A causal model of turnover for nurses. *Academy of Management Journal*, *24(*3), 543–565. https://doi.org/10.5465/255574

Rosenberg, L. (2011). Addressing trauma in mental health and substance use treatment. *The Journal of Behavioral Health Services & Research*, *38*(4), 428–431. https://doi.org/ 10.1007/s11414-011-9256-9

Rossi, A., Cetrano, G., Pertile, R., Rabbi, L., Donisi, V., Grigoletti, L., Curolo, C., Tansella, M., Thornicroft, G., Amaddeo, F. (2012). Burnout, compassion fatigue, and compassion satisfaction among staff in community-based mental health services. *Psychiatry Research*, *200*(2–3), 933–938. https://doi.org/ 10.1016/j.psychres.2012.07.029

Russell, R. F. (2001). The role of values in servant leadership. *Leadership & Organization Development Journal, 22*(2), 76–84. https://doi.org/10.1108/01437730110382631

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress*, *16*(2), 167–174. https://doi.org/10.1023/A:1022899207206

Sansbury, S. B., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma*, *17*(2), 114–122. https://doi.org/10.1177/1460408614551978

Sinsky, C. A., Brown, R. L., Stillman, M. J., & Linzer, M. (2021). COVID-related stress and work intentions in a sample of US health care workers. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes*, *5*(6), 1165–1173. https://doi.org/10.1016/j.mayocpiqo.2021.08.007

Sklar, M., Ehrhart, M. G., & Aarons, G. A. (2021). COVID-related work changes, burnout, and turnover intentions in mental health providers: A moderated mediation analysis. *American Psychological Association*, *44*(3), 210–228. https://doi.org/10.1037/prj0000480

Slone, H., Gutierrez, A., Lutzky, C., Zhu, D., Hedriana, H., Barrera, J. F., Paige, S. R., & Bunnell, B. E. (2021). Assessing the impact of COVID-19 on mental health providers in the southeastern United States. *Psychiatry Research*, *302*, 114055. https://doi.org/10.1016/j.psychres.2021.114055

Spears, L. (1996). Reflections on Robert K. Greenleaf and servant-leadership. *Leadership & Organization Development Journal*, *17*(7), 33–35. https://doi.org/10.1108/01437739610148367

Sprang, G., Clark, 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. https://doi.org/10.1080/15325020701238093

Stamm, B. H. (2010). The concise ProQOL manual (2nd ed.). ProQOL.org.Stitt-Gohdes, W. L., Lambrecht, J. J., & Redmann, D. H. (2000). The critical-incident technique in job behavior research. *Journal of Vocational Educational Research, 25*(1), 59–84. https://doi.org/10.5328/JVER25.1.63

Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental health findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/2009%20NSDUH%20Detailed%20Tables/2009%20NSDUH%20substance%20use%20detailed%20tables.pdf

Substance Abuse and Mental Health Services Administration. (2018). *National Mental Health Services Survey (N-MHSS): 2018, data on mental health treatment facilities.* https://www.samhsa.gov/data/report/national-mental-health-services-survey-n-mhss-2018-data-mental-health-treatment-facilities

Substance Abuse and Mental Health Services Administration. (2022). *Addressing burnout in the behavioral health workforce through organizational strategies* (Publication No. PEP22-06-02-005). National Mental Health and Substance Use Policy Laboratory. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf

Sultana, A., Sharma, R., Hossain, M., Bhattacharya, S., & Purohit, N. (2020). Burnout among healthcare providers during COVID-19: Challenges and evidence-based interventions. *Indian Journal of Medical Ethics*, *4*(1), 1–6. https://doi.org/10.202529/IJME.2020.73.

Sung, K., Seo, Y., & Kim, J. H. (2012). Relationships between compassion fatigue, burnout, and turnover intention in Korean hospital nurses. *Journal of Korean Academy of Nursing*, *42*(7), 1087–1094. https://doi.org/10.4040/jkan.2012.42.7.1087

Tabur, A., Elkefi, S., Emhan, A., Mengenci, C., Bez, Y., & Asan, O. (2022). Anxiety, burnout and depression, psychological well-being as predictor of healthcare professionals' turnover during the COVID-19 pandemic: Study in a pandemic hospital. *Healthcare*, *10*(3), 525. https://doi.org/10.3390/healthcare10030525

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. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

van Dierendonck, D. (2011). Servant leadership: A review and synthesis. *Journal of Management*, *37*(4), 1228–1261. https://doi.org/10.1177/0149206310380462

Williams, M., & Moser, T. (2019). The art of coding and thematic exploration in qualitative research. *International Management Review*, *15*(1), 45-55.

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, *57*(3), 426–436. http://doi.org/10.1037/pst0000317

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage.