

Burnout in the Trenches:  
Unpacking the Systemic Forces Impacting Community Mental Health Clinicians

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#### **Abstract (academic)**

Across United States (US) history, individual and population-based mental health has been overlooked or outright dismissed within the health care system. In 1955, 77% of all mental health treatment episodes took place in an inpatient setting, and only 379,000 episodes of treatment were provided in outpatient settings. By 1968, the number of inpatient treatments increased to two million. By 2010, Glied and Frank (2016) estimated that the US spent an estimated \$352 billion to provide care and support to people with mental illness. However, even with the large investment from the government, the number of patients needing care outnumber the number of clinicians who can provide care. Due to financial strains as well as increased demands for services, clinicians are experiencing their own problems (e.g., emotional exhaustion, lower job satisfaction, diminished self-concept, and a loss of concern for clients), which are symptoms of burnout. Given the systemic impact that a clinician's experience can produce on the provision of mental health services, it is critical to explore the experiences of community mental health (CMH) clinicians directly in order to inform changes in policy and practice in CMH. Thus, the purpose of this interpretative phenomenological study is to explore the experiences of CMH therapists and how they confront burnout. Through the additional lens of the Mental Health Systems Ecology (MHSE) model, the systemic nature of CMH will be highlighted to identify opportunities for mental health service reform and improved therapeutic interventions. Findings from this study revealed three major themes: exploitation, referring to the

structural and systemic pressures that place undue burdens on CMH clinicians; ethical and moral dilemmas, highlighting the difficult decisions therapists must navigate when balancing client care with institutional constraints; and grounded in purpose as a form of resilience, illustrating how clinicians find meaning in their work to sustain themselves despite ongoing challenges. These themes underscore the need for systemic changes in CMH settings to mitigate burnout and support clinician well-being.

*Keywords:* burnout, community mental health, clinician well-being, workplace stress

## Burnout in the Trenches:

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#### **General Audience Abstract**

Throughout U.S. history, mental health has often been ignored or not given enough attention in the larger health care system. For example, back in 1955, most mental health treatment happened in hospitals, with very few people getting help outside of them. Over the years, the need for mental health care has grown significantly. By 2010, the U.S. was spending around \$352 billion to support people with mental health conditions. Still, even with all that spending, there aren't enough mental health professionals to meet the growing demand for care.

Because of limited funding and the high demand for services, many mental health providers are struggling. They may feel emotionally drained, less satisfied with their jobs, and even disconnected from the people they're trying to help—signs of what's known as burnout. This study takes a closer look at what community mental health (CMH) therapists are going through and how they're coping with burnout. Using a framework called the Mental Health Systems Ecology (MHSE) model, the study also considers how larger systems—like workplaces, policies, and communities—affect these therapists and their ability to provide care.

The research identified three key themes: **exploitation**, where therapists often feel overwhelmed by heavy workloads and pressures within the system; **ethical and moral dilemmas**, which arise when therapists must choose between what they believe is best for their clients and the limitations set by their workplaces; and **grounded in purpose**, which reflects

how many therapists, despite ongoing challenges, stay motivated through a strong sense of meaning and commitment to helping others.

These findings point to a clear need for change in the community mental health system to better support the well-being of the people providing care.

**Keywords:** burnout, community mental health, therapist well-being, workplace stress

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James 1:12 reads: “Blessed is the person who remains steadfast under trial, for when they have stood the test they will receive the crown of life, which God has promised those who love him.” All gratitude and glory go to God and my guardian angels, Joseph and Peggy Fennell, for laying my foundation and continuing to make a way for me. I have been able to sustain myself on this journey because of their love.

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## Chapter 1: Introduction

Across United States (US) history, individual and population-based mental health has been overlooked or dismissed entirely within the health care system (Abrams, 2024; Shim & Algeria, 2025). Prior to the early 1800s, most people who were considered mentally ill were cast out by society, hunted down, and even tortured due to fear of demonic possessions or witchcraft (Farreras, 2019). As the understanding of mental health became more sophisticated, individuals with mental illness were kept in asylums, institutions used to house and confine the mentally ill and otherwise disenfranchised people (i.e., poor, unhoused). In the mid-1800s, policymakers and activists began to understand that people suffering from mental illness needed adequate, humane, and moral care rather than the violence and isolation by which they were often subjected to in the late 1700s to mid-1800s. Because of the work of activists such as Dorothea Dix, state mental hospitals were created to care for the mentally ill across the US and Canada (Farreras, 2019; Ruffalo, 2018). Unfortunately, due to the rapid increase in mental illness over the next century, conditions for patients declined, and mental institutions became overcrowded.

By the 1950s, policymakers and mental health providers again became aware of the inadequacies of the mental health system and began focusing on the mental health care of the population due to its financial impact on the health care system as a whole. For example, 77% of all mental health treatment episodes took place in inpatient settings, while 379,000 treatment episodes involving people with mental disorders were provided in outpatient settings in 1955 (Glied & Frank, 2016). Nearly 13 years later in 1963, the number of treatment episodes increased to two million (Glied & Frank, 2016). Fifty years later in 2010, Glied and Frank (2016) estimated that the US spent approximately \$352 billion to provide care and support to people with mental illness.

In the early 1960s, community mental health centers (CMHCs) arose as a way to offset the widespread deficits in mental health care. Although CMHCs helped reduce hospitalizations and institutionalization, flaws in the well-intentioned policy contributed to the unintended consequences in the ecology of CMH service today (e.g., long waitlists, lack of wraparound support for clients, high clinician turnover). As researchers learn more about the mental health service system, it is important to examine the consequences of a rapidly growing deficit of qualified mental health providers and the effects on their well-being, particularly within the specialty of community mental health.

At the beginning of this 60-year period, we begin to see a shift in the US mainstream social welfare system: Medicaid and Social Security Income (SSI). Medicaid being introduced in 1965 offered federal matching dollars for some of the services provided to people with mental disorders if the services were being provided in other settings, such as nursing homes, which allowed for treatment to be provided in the community (Glied & Frank, 2016). SSI quickly followed in 1972, which was a mainstream income support for people with disabilities including those caused by mental illness, which increased their ability to remain integrated within the community.

In 2020, the National Institute of Health (NIH) reported that 52.9 million adults aged 18 or older reported having a mental illness (NIH, n.d.). In the same year, 14.2 million adults aged 18 or older reported having serious mental illness for a combined total of 67.1 million US adults with varying degrees of mental illness (NIH, n.d.). On an individual level, these people experience reduced quality of life, increased burden of their disease, financial strain and poverty, as well as stigma and social isolation (Ettman et al., 2020; Vos et al., 2017; Ridley et al., 2020; Corrigan et al., 2014). On a systemic level, we see increased demand on healthcare systems,

increased cost to the global economy, under resourced social services and criminal justice systems, and decreases in productivity in the workplace (Salyers et al., 2013; Hoertel et al., 2021; Greenberg et al., 2021; Lamb & Weinberger, 2016; Tsai et al., 2019; Johnston et al., 2019; Petrie et al., 2018).

To confront this problem and to address the staggering numbers, the US Bureau of Labor and Statics (2023) estimated that 415,900 mental health therapists are employed across different entities or an average of approximately 161 clients per therapist—many of whom are professionals that have no requirements for specialty or expertise. Some of the major consequences of this ratio are limited ability to address more complex cases, overload for specialists, burnout and turnover, decreased access to specialized care, and increased potential for misdiagnosis and mistreatment (Thornicroft et al., 2016; Funk et al., 2020; Salyers et al., 2013; Jorm et al., 2017). Given the number of people living with untreated or poorly treated mental illness, and the number of mental health workers currently employed in the US, a deficit of mental health professionals exists and is continuously increasing. The high ratio of patients to workers impinges on an overworked mental health workforce and leaves increasing numbers of inadequately treated people with mental health problems (APA, 2021).

### **Community Mental Health Centers**

The American Psychological Association defines a CMHC as “a community-based facility or group of facilities providing a full range of prevention, treatment, and rehabilitation services, sometimes organized as a practical alternative to the largely custodial care given in mental health hospitals” (Vanden Bos, p. 201, 2007). The history of CMHCs dates back to the early 1960s when the centers were established by the Community Mental Health Centers Construction Act (CMHCCA) of 1963. The CMHCCA was a part of John F. Kennedy’s

presidential platform, which included federal funding to CMH institutions and research facilities across the US (Ray & Finley, 1994). The Act provided four and a half years of federal funding to CMHCs, based on the premise that within four years, the CMHCs would become financially self-sufficient (Ray & Finley, 1994). Although the goal to have CMHCs become financially self-sufficient was well-intentioned, oversights in the development of the CMHCCA exposed issues with which CMHCs continue to struggle with in the present day.

Despite its shortcomings, the CMHCCA made it possible for transinstitutionalization, meaning patients who were sent to psychiatric hospitals could receive services in local support facilities such as halfway houses, clinics, or at home (Blair & Espinoza, 2015). Given the rise of outpatient mental health service utilization as a function of the Act, by the 1970s, funding again became wholly inadequate as federal funds became increasingly scarce and receiving them became highly competitive (Ray & Finley, 1994). By the mid-1980s, CMHCs transformed from federally funded centers into state-dependent institutions struggling to replace the loss of federal funds (Ray & Finley, 1994).

### **The Mental Health Systems Act (1980)**

The next major attempt at reform was the passage of the Mental Health Systems Act (MHSA) of 1980, signed into law by President Jimmy Carter in an effort to provide grants to CMHCs. Unfortunately, the well-intentioned provisions of Carter's MHSA were short-lived and were repealed in 1981 by Congress during the Reagan administration (Goldman et al., 1992; Sharfstein, 2000). Reagan's limited government agenda amplified the strain of an already stretched-thin CMH system. Provisions of the MSHA projected 2,400 centers nationwide by 1989. Instead, with the MSHA gutted, there were only 768 centers in operation by 1989 (Grob, 1991).

Because the number of CMHCs fell so far below the estimated need and compounded by the fact that the number of mental health outpatient services increased to two million by 1976, barriers to providing CMH services (e.g., long waitlists, understaffing, and a lack of preventative care) persist to the present day. Hospital systems became overwhelmed by the increased number of patients they were serving. This situation highlighted the need for wrap-around supports for citizens struggling with mental illness, and the need for community-based mental health care escalated while available resources became insufficient.

### **The Mental Health Parity and Addiction Equity Act (2008)**

Given that the need for better mental health care persisted, legislators continued to create and implement legislation that offered more protections and expansion for mental health care. Almost 30 years after the MHSA of 1980, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was passed as a mechanism to prevent group health plans and health insurance issuers from imposing unfavorable benefit limitations for mental health or substance use benefits (“The Mental Health Parity and Addiction Equity Act (MHPAEA)”, n.d.). The MHPAEA was created to remedy deficits in the Mental Health Parity Act of 1966 (MHPA). The MHPA prohibited large group health plans from imposing annual or lifetime dollar limits on mental health benefits that were less favorable than any limits imposed on physical health care, such as surgical or other medical benefits (“The Mental Health Parity and Addiction Equity Act (MHPAEA)”, n.d.).

Also, the MHPAEA helped equalize the benefits associated with mental health and substance use care to those of the surgical and other medical benefits that insurers provide. A limitation is that the MHPAEA did and does not require that large group health plans or health insurance issuers cover mental health or substance use benefits. The law only applies to large

group health plans that choose to include these benefits in their packages. However, with the implementation of the Affordable Care Act in 2010, mental health and substance use benefits became more accessible than in the past (“The Mental Health Parity and Addiction Equity Act (MHPAEA)”, n.d).

### **The Unity Agenda (2023)**

The Unity Agenda was a 2023 strategy supported by the Biden administration to combat the mental health crisis in America. A White House press release discussed actions to address the nation’s mental health crisis, which included strategies to expand, diversify, and maintain the mental health workforce (The White House, 2023). For example, the Bipartisan Safer Communities Act (BSCA) and the Department of Education (ED) awarded over \$280 million to enhance the pipeline of mental health professionals serving schools and expanding school-based mental health services and support. Additionally, Substance Abuse and Mental Health Services Administration (SAMHSA) received \$200 million for states, territories, call centers, and Tribal organizations to continue to enhance services across nearly 1,000 different operations. The Department of Labor (DOL) and The Occupational Safety and Health Administration (OSHA) have supported mental health workers through the launch of the Mental Health Work Initiative and the Workplace Stress Toolkit, which offers training resources, outreach materials, and tips to reduce burnout among workers (The White House, 2023). This recent initiative from the Biden Administration signals that mental health concerns are becoming a bigger priority nationwide. These recent political initiatives are examples of an ecological perspective (i.e., funding educational and training opportunities, increased funding for CMHCs to improve operations, production of accessible materials for clinicians) applied to the mental health system, which entails examining each level of the system and enacting solutions that help to relieve constraints

at each level. The government's financial and educational investments have the potential to assist in shifting trends that currently exist within the community mental health system.

### **The Future of Community Mental Health Care**

Keeping in mind the interplay between policy, community systems, service providers, and individuals, the Trump administration's proposed mental health policies could have mixed implications for community mental health care. His support for expanding Certified Community Behavioral Health Clinics (CCBHCs) aligns with efforts to enhance accessible, integrated care, potentially strengthening community-based mental health services and addressing treatment gaps (Stainton, 2024). Additionally, the establishment of the 988 crisis hotline under his previous administration improved emergency response systems, enhancing crisis intervention at the macro level (Stainton, 2024). However, broader healthcare policies, such as his past and current efforts to repeal the Affordable Care Act (ACA) and cutting funding for Medicaid, raise concerns about reduced insurance coverage for mental health services, which could disproportionately impact low-income and marginalized communities reliant on Medicaid expansion (Stainton, 2024). Furthermore, his emphasis on mental health within homelessness and crime prevention strategies suggests a shift toward more institutional or legal interventions rather than long-term, preventive community-based care (Riddle, 2024). These policies, if implemented, could create a fragmented service ecology where crisis response is prioritized but sustainable, preventive, and integrated care remains underdeveloped, potentially straining community-based mental health resources.

### **Trends in the Provision of Community Mental Health**

The paucity of funding dedicated to community mental health has impacted the CMH workforce nationwide. Mental Health America (2023) reported that from 2019-2020, the equivalent of more than 50 million American adults were experiencing mental illness, over 93%

of people with a substance abuse disorder did not receive treatment, and almost one-third of adults with mental illness were unable to receive treatment, resulting in human suffering and overall safety concerns.

National trends also affect the mental health workforce. According to Johnson-Kwochka et al. (2020), behavioral health treatment providers have turnover rates between 30-35%, with some reporting a turnover rate as high as 49%. Another trend, especially within the specialty of CMH, are agencies that continue to struggle with funding supports due to the previously mentioned policy changes in the mental health service system, such as the repeal of the MHPA of 1980. According to Luther and colleagues (2017), from 2009-2012, CMH agencies experienced \$4.35 billion in budget cuts. These decreases exacerbated demands placed on CMH clinicians, particularly after the COVID-19 pandemic, which heightened the national need for mental health services. A major consequence as a result of COVID-19 was that clinicians were assigned higher caseloads or more complex cases that forced them to work harder overall and take on more overtime hours in order to serve the increased needs that clients were experiencing as a result of the complex situations and feelings created by the virus (e.g., grief, isolation, relational issues, heightened anxiety and depression) (Bethune, 2021; Luther et al., 2017).

Given the financial strains, coupled with increased demands for services, clinicians are experiencing their own problems including emotional exhaustion, lower job satisfaction, diminished self-concept, and a loss of concern for clients-- all symptoms or consequences of experiencing burnout (Rosenberg & Pace, 2006; Salyers et al., 2013). The systemic impact on clinician experiences can adversely influence the mental health service ecology. Thus, it is critical to explore the experiences of CMH clinicians, collecting information directly from those who are affected in order to inform changes in policy and practice in CMH.

## **Purpose of the Study**

To capture the voices of the people most affected, this research will use interpretative phenomenological analysis (IPA), a method specifically designed to better understand people's lived experiences and how they make meaning of their specific personal and social contexts (Smith & Nizza, 2022). IPA will be used to explore the experiences of CMH therapists and how they make sense of burnout from a systemic lens. A number of quantitative studies have examined factors contributing to clinician burnout (e.g., clinician and supervisor turnover, how working overtime increases burnout and creates poor perceived quality care, ethical decision-making impacted by burnout) (Beidas et al., 2016; Luther et al., 2017; Teixeira et al., 2014). However, little attention has been paid to understanding how the ecology of mental health services affects clinicians' experience of burnout. Habeger and colleagues (2022) used a socio-ecological lens to provide recommendations for preventing burnout in behavioral health workers who have experienced this phenomenon as an outcome of secondary traumatic stress, a recent example that blends the two concepts of burnout and mental health service ecology. Although this research lays the foundation, behavioral health occupations are hardly monolithic; greater contextual understanding is important and could be discovered by focusing the theoretical knowledge of ecological systems on specific specialties, such as that of CMH.

CMH clinicians are uniquely poised to speak to the various ways that working within this specialty has contributed to their experiences of burnout due to the fact that they hold the responsibility of care for their clients with the often-competing responsibility of adhering to higher-level system demands. They have experienced individual, organizational, and service level factors that contribute to burnout. A clinician's role within the ecology consists of responsibilities to the clients they serve and to larger systems whose agenda has a direct impact

on service delivery. CMH clinicians experience and witness the impact that policies have from the top down, which can create psychological and emotional burdens that a clinician must carry. Using their perspective, this study will be a critical addition to the literature on burnout because of the clinicians' unique position within CMH.

Utilizing the Mental Health Service Ecology Model (MHSE) (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2006), CMH clinicians are positioned to explain how they experience different levels of the MHSE in order to offer a unique and systemic perspective currently missing from the burnout literature. Having a systemic perspective about burnout removes responsibility from the clinician to prevent or reduce burnout on an individual level and expands it to that of a shared responsibility from organizational and service levels within the ecology, given that factors contributing to burnout are also systemic in nature. Consequently, the aim of this study is to explore how the ecology of mental health services affects CMH clinicians' contextual experiences of burnout.

## Chapter 2: Literature Review and Theory

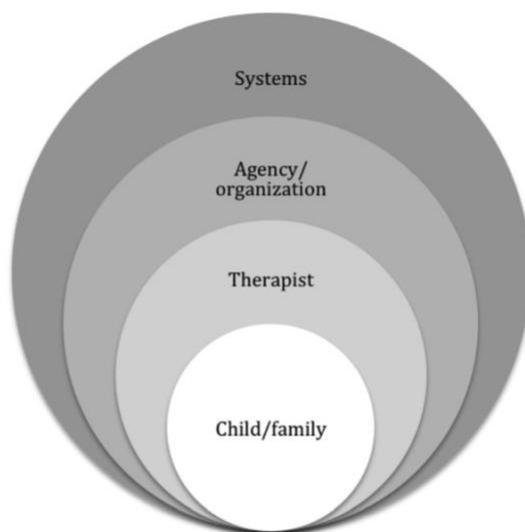
Chapter 2 is a critique of the current literature on burnout in the CMH profession. Specifically, this critique discusses the MHSE and its saliency for categorizing and explaining how different factors that contribute to burnout interact within the current structure of mental health systems. The chapter begins with an in-depth explanation of the MHSE Model and how it uniquely impacts CMH clinicians. Following is a discussion of how burnout is defined across the literature, the risks and consequences of burnout, and different factors that can influence the experience of burnout for mental health clinicians. The chapter concludes with a critique and summary of the literature and a rationale for the study.

### Theoretical Orientation

Scholarship that led to the development of the MHSE was intended to examine the effectiveness and dissemination of research using variables related to the progression of treatment efficacy to dissemination and the mutual roles the variables play in improving mental health services for children and adolescents (Schoenwald & Hoagwood, 2001). Researchers wanted to show how intervention and service research can inform one another when determining interactions between four contextual layers of care delivery defined as client, provider, organization, and service system (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2006) (Figure 1).

*Client level factors* include symptoms, functioning, and the family and ethnic/cultural context. *Clinician level factors* include the level of professional experience, attitude, salary level, and opportunity for increase. *Organizational level factors* are culture and climate, size, and structure of the chain of command. Finally, *service level factors* are policies and practices of referral sources and payers, financing methods, legal mandates of referral sources, and other collaborators and interagency working relationships (Schoenwald & Hoagwood, 2001; Southam-

Gerow et al., 2012). Each of the levels interacts with one another in order to create the CMH ecosystem, which mirrors the MHSE as illustrated by Southam-Gerow and colleagues (2012).



*Figure 1.* Mental Health Systems Ecological model.

Ecological approaches are highly appropriate ways to explain complex structures given their strong emphasis on individual and contextual systems and their interdependent relationships (Eriksson et al., 2018). Based on the MHSE, the clinician level of the ecosystem involves responsibility for the care of others but also answers to higher-level systems that can influence the delivery of mental health care, its value, and the overall clinician experience. For example, agency policies and procedures are determined by governmental systems that determine qualifications for receipt of health care, its payment and reimbursement structure, and provision of services. In some CMHCs, funding from federal insurance programs requires that clinicians use evidence-based practices in order to be reimbursed for services. Usually, evidence-based practices are predicated on behavioral interventions shown to be beneficial. However, that approach may not be an optimal fit for the needs of an individual client. In such situations, the clinician is left with the conundrum of how to provide the highest quality of care for a client

while adhering to the expectations of their organization and the larger government systems that influence the way mental health service is delivered. Such circumstances contribute to clinician stressors, which can result in clinician burnout.

An understanding of the mental health system elucidates the unique role that clinicians play within the system and the factors that contribute to their experiences of burnout. Studies conducted within the last 30 years reveal important connections to clinician, organizational, and systemic factors within the ecology of mental health systems that impact clinicians, including Medicare/Medicaid/health insurance policies, reimbursement or salary (i.e., how clinicians are being compensated for services), complexity of cases, and number of clients on the caseload (Luther et al., 2017; Prosser et al., 1997; Rosenberg & Pace, 2006; Salyers et al., 2013).

Although studies confirm that clinicians are experiencing burnout, few focus on the specialty of CMH. Also, little qualitative data exists that explains the perspectives of these clinicians and their unique experiences with burnout.

### **Burnout**

Burnout is characterized as a syndrome of physical and emotional exhaustion resulting from a negative self-concept and job attitude and a loss of concern or feeling for clients (Rosenberg & Pace, 2006). Most commonly found in the helping professions, particularly in the past 30 years, characteristics of burnout have been investigated and have become more precise. As an understanding of burnout has evolved, the application of causal theory to the issue has emerged, which verifies an implied understanding of the phenomenon: “Certain factors (both situational and individual) cause people to experience burnout, and once burnout occurs, it brings about certain outcomes” (Maslach & Leiter, 2016, p. 105). The following sections explain the

consequences of burnout, risk and protective factors in order to explore their connection to clinician burnout within the MHSE.

### **Consequences of Burnout**

Kirk-Brown and Wallace conducted research on people who work in the helping professions, hypothesizing that they are particularly vulnerable to burnout due to the “consequence of employment in jobs characterized by long-term involvement in emotionally demanding situations and being engaged in extensive face-to-face contact with people and their problems” (Kirk-Brown & Wallace, 2004, p. 29). Employees who experience emotional exhaustion tend to become emotionally withdrawn from clients and are prone to secondary traumatic stress and psychological distress (e.g. sense of burden, avoidance, feelings of horror and fear) (Perkins & Sprang, 2013). Consequences of working in the mental health field can result from individual or organizational risk factors. Identification of risk factors is the predominant focus of the existing literature on burnout. The goal of this study is to build upon this knowledge in order to explore CMH clinicians’ experiences with different ecological factors (i.e., policy issues or agency characteristics) to identify how they contribute to burnout.

Given that clinicians’ work in a helping profession that requires high levels of emotional engagement and relies on the use of “the self” in their work, the following four major consequences of burnout affect the clinician and permeate the ecology of mental health care: emotional exhaustion, decreased job satisfaction, increased turnover, and decreased quality of care.

#### ***Emotional Exhaustion***

Burnout is differentiated from generalized work stress by the emotional investment made by the clinician and the emotional connection between client and therapist, connections that do

not exist outside most helping professions (Perkins & Sprang, 2013). Researchers also note that a clinician's personal beliefs and coping mechanisms also contribute to the emotional exhaustion that clinicians experience when burnt out (Simpson et al., 2019). This explanation is an important one --many therapists go into the field due to their own personal and systemic histories, reasons that increase the likelihood that their own mental health issues may become magnified by workplace pressures (Simpson et al., 2019). Another study that focused on psychologists in Australia found that emotional consequences associated with burnout were prevalent in these helping professionals (Clarke et al., 2019). Examples reported in this finding include needing space from other relationships in personal life, feeling depleted, experiencing compassion fatigue, and having a reduced capacity to provide emotional support among many others (Clarke et al., 2019).

In addition, community-based counselors who had high scores of compassion fatigue but who felt supported in the workplace were unlikely to approach supervisors for assistance when they felt overwhelmed. Research also supports the understanding that clinicians, in particular, community-based clinicians, are experiencing burnout at higher levels than their counterparts in other helping professions likely due to the complex cases they manage (Perkins & Sprang, 2013). This consequence affects a clinician's ability to commit to a huge part of the job, which is providing differentiated and engaged emotional support to clients.

### ***Job Satisfaction***

Job satisfaction is based on research by Smith et al. (1969), which explains that satisfaction with various aspects of a job results from a cognitive process that compares the job experience versus an employee's expectations or ideas of the job. Given the emotional and attitudinal nature of this concept, a person who is satisfied with a job is more likely to remain in

the position. Alternatively, they would be more inclined to leave employment if satisfaction is low.

Studies also reveal that job satisfaction decreases and burnout increases for clinicians based on work stress specific to the mental health field (Prosser et al., 1997; Salyers et al., 2013). For example, Prosser and colleagues identified five sources of work stress: role, poor support at work by administration, clients, future (i.e. career) prospects, and overload (1997). These five sources of work stress are situated within different levels of the MHSE that are outside of the clinician's control. This situation highlights the systemic nature of burnout and helps support the argument that intervention around burnout must exceed the clinician's role.

### ***Turnover***

Turnover is defined as the rate at which employees leave the workforce and are replaced. High turnover rates have been one of the most impactful consequences of burnout on the MHSE and contribute to the work-related stress that clinicians experience due to the inability to maintain a viable, well-balanced workforce. Research on clinician turnover has revealed several factors that influence a clinician's decision to exit a job, with organizational structure being a main predictor. Knudsen, Ducharme, and Roman (2006) reported that turnover was lower when clinicians felt that they had autonomy at work, felt like they were a part of decision-making within the organization, and that distribution of workload and rewards were fairly distributed. Relatedly, Knight and colleagues found that, despite reported levels of stress, burnout, tenure, or job satisfaction, clinicians were more likely to stay with their job if the need was high and they perceived that their organization was making positive organizational changes (2011). The findings emphasize the interdependent relationship between clinicians and their organizations

within the service ecology. Changes on a managerial and organizational level could produce a major impact on retaining the workforce within community mental health.

### ***Quality of Care***

Thus far, research has shown that burnout is occurring across the field of mental health, despite specializations (i.e., marriage and family therapists, licensed professional counselors, psychologists). Moreover, findings emphasize that clinicians and organizations suffer when clinicians experience emotional exhaustion, a major symptom of burnout, which can lead to high turnover, job dissatisfaction, and the quality of care that clinicians provide. Studies, such as the one conducted by Fukui et al. (2021) have revealed that working with higher caseloads and high-risk consumer cases were significant contributors to discordant care and that organizational structure and resources contribute to burnout and undermine the ability of clinicians to provide quality care.

Another contributing factor to decreased quality of care is working overtime. Clinicians who reported working overtime in a typical week had significantly increased burnout, work-life conflict, lower job satisfaction, and poor quality of care (Luther et al., 2017). One of the main priorities of a clinician is the provision of high-quality, differentiated care to clients. However, given the dynamics that exist within the MHSE that continue to strain clinicians more directly than any other part of the ecology, these risk factors (e.g., emotional exhaustion, low job satisfaction, high turnover) affect how clinicians support their clients.

### **Risk Factors of Burnout**

Understanding the consequences of burnout reveals the importance of understanding the risk factors that contribute to the experience of burnout. Hammond and colleagues (2018) noted that precursors or risk factors for burnout include excessive workload and hours of work, life

stresses, mismanaged workload, and transference. Applying an ecological lens to burnout in the mental health system aligns with the clinician level, organizational level, and service level of the MHSE model. Supporting research will highlight the aforementioned risk factors for burnout, as well as many others, to show the real-life implications of this phenomenon.

### ***Clinician Factors***

The MHSE model includes clinician level factors-- professional experience, attitude, salary level, and opportunity for increase (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2012). The clinician level of the MHSE is associated with the professional experience of the clinician and their perceived value in the workplace. Research shows that being a young clinician, having limited work experience, enmeshment in client problems, and identifying as female were factors that contributed heavily to the experience of burnout (Simionato & Simpson, 2018). According to Simpson and colleagues (2019), increased risk for burnout comes from personal factors, which include a clinician's personal beliefs and coping mechanisms. The responsibility that clinicians have for client care can conflict with personal issues that clinicians are navigating, which is concerning given the complex client matters that tend to be found in community-based settings. Salary and opportunities for promotion are also major risk factors for burnout (Knudson, Ducharme & Roman, 2006). If clinicians feel they are not being paid fairly or if there are few opportunities for promotion and increases in economic mobility, then these factors may trigger dissatisfaction with work, compounding the consequences of burnout.

### ***Organizational Factors***

Organizational factors have been identified as the culture and climate of the organization and the size and structure of the chain of command (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2012). At the organizational level, major risk factors for burnout are role

ambiguity, job satisfaction, and quality of organizational knowledge (Kirk-Brown & Wallace, 2004). The findings show that clarity around a clinician's position within the organization plays a significant role in job satisfaction and serves as a protective factor against emotional exhaustion, a consequence of burnout (Kirk-Brown & Wallace, 2004). Along with these factors, an earlier study by Prosser et al. (1997) emphasized that lack of administrative support produces a major impact on CMH clinician's experience of burnout (Prosser et al., 1997). From a systemic perspective, research highlights the importance of an organization's responsibility for clearly defined roles, understanding organizational structure (i.e., organizational charts), and providing appropriate administrative support can prevent CMH clinician burnout.

### ***Service Factors***

Service factors include the policies and practices of referral sources and payers, financing sources, legal mandates, and the working experience of interagency and outside collaborators (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2012). CMHCs are the primary source of affordable and accessible mental health care for low-income clients. A primary part of providing adequate care for this specific population requires collaboration across different social services and health care providers. Two major service factors that contribute to burnout are working with outside entities (e.g., Medicaid, Medicare, Social Security offices) and their lack of responsiveness and constant threats to reductions in funding (Salyers et al., 2013). Lack of responsiveness and concerns around funding can slow or completely halt the care that clinicians are providing to clients. Knowing that working with outside entities is a major part of the MHSE, it is not surprising that these challenges add additional stress and strain to the clinician who is acting as a liaison between the individual client and higher-level entities.

### **Protective Factors Against Burnout**

Despite evidence that burnout affects the quality of clinician care, counterevidence shows that clinicians are *resilient* in their work, which could serve as an important protective factor that prevents burnout among CMH clinicians. A qualitative study by Mack (2022) explored the critical role that supervisors play in addressing the health and wellness of social workers. The importance of awareness of the signs of burnout and communication between supervisor and supervisee to address concerns when they arise was a major theme that emerged (Mack, 2022). A second theme was creating and maintaining supportive relationships (i.e., unconditional support and cultural humility) between supervisors and supervisees in order to enhance resiliency within supervisees. A third theme was encouraging and teaching different forms of self-care to supervisees in order to help them maintain balance on an individual level as well as seeing that self-care practices exist across the organization to increase resilience within the supervisees. Two other themes were matching internal and external resources to needs and addressing work-life balance (Mack, 2022). Researchers in Sweden found that clinicians identified collegial support, an empathetic boss, a high degree of agency at work, and fulfilling activities outside of work as additional protective factors against burnout (Harling et al., 2020).

When clinicians receive support from direct supervision or administrators, which is built into wellness practices within the organization, as well as have their professional needs met across the agency, signs of resilience appear to manifest themselves. Although organizational supports are not always present, clinicians are finding ways to tap into their resiliency and have been able to provide high-quality care, even when burnout has been present.

### **Summary and Rationale for the Study**

A review of the literature reveals that, over the last three decades, studies conducted on burnout have identified several factors and effects across the MHSE (e.g., increased turnover,

decreased job satisfaction, diminished perception of quality care). The MHSE reveals that each of the levels (i.e., client, clinician, organization and system) are distinct yet interdependent. Importantly, clinicians have a unique experience within the MHSE Model and contribute to the dynamic system of mental health, all the while being influenced and shaped by that very system (Knight et al., 2012). The experience of burnout directly affects a clinician's emotional and psychological well-being, which can lead to poor outcomes in job satisfaction, job clarity, and job-related stress, and produces a significant effect on therapist burnout and turnover (Baldwin-White, 2016; Perkins & Sprang, 2013; Simionato & Simpson, 2018; Kirk-Brown & Wallace, 2004; Prosser et al., 1997; Salyers et al., 2013). If clinicians are also trying to manage their own mental and emotional stress, these factors have the potential to significantly affect the quality of care that clinicians provide. These findings are alarming because the increased and acute need for accessible, high-quality care for vulnerable populations in the US is only increasing (Czeisler et al., 2020).

Based on the review of the extant literature above, it is apparent that limited research has been conducted on the important specialty of CMH. A qualitative methodological approach exploring the effect of MHSE on burnout of CMH therapists will bring a much-needed systemic lens to an understanding of burnout and has the potential to create and enhance dynamic interventions to remove the responsibility of self-care practices away from individual clinicians. Moreover, this study can help direct prevention and intervention efforts by systematically exploring the experience of burnout at multiple levels impacting the clinician, and as a result, lead to more systematized approaches for preventing and reducing burnout; approaches that build upon the interdependent relationships among clients, clinicians, organizations, and service stakeholders.

### **Chapter 3: Methodology**

Despite the importance and complexity of their specialty and the unique position they hold within the MHSE, CMH therapists who experience burnout are not widely researched. CMH therapists are responsible for the service they deliver directly to clients, to their respective organizations, and the policies and laws set forth by larger governing entities. All of these obligations contribute to staff work stressors. This study aimed to investigate the experiences of burnout from a systemic perspective for CMH clinicians who have worked at a CMH center/agency for at least a year.

#### **Research Design**

Given the complexities surrounding CMH clinicians' experience of burnout, we used interpretative phenomenological analysis (IPA), an appropriate design for conducting an in-depth examination of this phenomenon. IPA explores the lived experiences of the target population and how participants make sense of their experiences in the context of their personal and social worlds (Smith et al., 2009). Although IPA has been used primarily in the field of psychology, its use has expanded to other social science disciplines in order to address a range of research questions (e.g., becoming a parent, migrating, receiving medical diagnoses, or describing feelings of anger or guilt). Smith and Nizza (2022, p. 4) explain that the main objective of IPA is to “get as close as possible to the lived experiences of participants so that it can be examined in detail.”

One of the main theoretical underpinnings of IPA that make it an especially appropriate methodological fit for this study is idiography. *Idiography* is defined as a focus on the experiences of particular people in particular circumstances, most commonly used in case studies within the larger scope of research (Smith & Nizza, 2022). For the present study, IPA facilitated

the consideration of each individual case in order to gather a detailed account of context and how each person came to terms with their lived experience, probing factors that might be neglected or overlooked (Smith & Nizza, 2022).

Another theoretical underpinning of IPA is *hermeneutics*, which focuses on interpretation (Smith & Nizza, 2022). As with other phenomenological methods, IPA privileges the subjective experience that an individual makes of an encounter and involves a double-hermeneutic, accomplished in the present study when the researcher interprets the participant's meaning-making (Finan et al., 2022). This form of analysis fits well with phenomenological qualitative studies used to supplement extant quantitative studies (Smith, 1996). The theoretical pillars of IPA help elucidate the experience of burnout for CMH clinicians—their lived experience and how they make sense of their role within the mental health ecology in which they operate. The use of IPA enables a rich understanding of the causes and effects of burnout on CMH clinicians and influences ideas for systemic interventions to reduce or prevent it.

### **Participants**

After study approval by the Virginia Tech IRB (HRPP# 23-1208), I recruited nine CMH clinicians who were currently employed or employed with a CMHC within the past year and who had provided clinical care for at least one full year. Participants were located across the US, specifically in Washington D.C., Virginia, Maryland, California, and Illinois. In most research, including a diverse sample would provide a broader range of data to refine the essence of the phenomenon; however, gathering data from a limited number of individuals who have a shared experience and who can provide a detailed account of it is considered sufficient to uncover core themes using this methodology (Starks & Trinidad, 2007). A typical sample size for phenomenological studies ranges from one to 10 persons, the standard used for this study (Starks

& Trinidad, 2007). Participants were included if they demonstrated symptoms according to the Maslach Burnout Inventory (MBI) related to burnout ranging from moderate to high. The MBI was developed to measure the risk of burnout through an exploration of three components-- exhaustion, depersonalization, and personal achievement (Maslach & Jackson, 1981).

### **Organization**

Participants eligible for the study had to be currently employed or previously employed for at least one year at a CMH agency meeting criteria outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). According to SAMHSA, CMH agencies must meet one of the following requirements: a) a nonprofit organization; b) part of a local government behavioral health authority; c) an entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act; or d) an entity that is an urban Indian organization pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (SAMHSA, 2022).

### **Credentials**

Participants had to hold or have held a provisional or full license while employed with their CMH agency. The participants were licensed as marriage and family therapists (LMFTs), licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), or licensed clinical mental health counselors (LCMHCs). Participants were excluded if they had only been in administrative roles at a CMH agency without providing direct client care, were participating in an unpaid internship opportunity, or had not worked in a qualified CMH setting as defined by SAMHSA.

### **Recruitment**

Recruitment was conducted via snowball sampling, a referral-based recruitment method that uses contacts of other participants or the researcher (Smith & Nizza, 2022). This recruitment method is commonly used in IPA research given the need for a small, yet specific group of individuals. Physical flyers were distributed across the Washington, D.C., Maryland, and Northern Virginia (DMV) areas because I (the researcher) am physically located in this area. I also shared digital flyers across alumni listservs and used word of mouth among other practicing clinicians within the US.

### **Procedures**

Participants contacted me via telephone or email. When potential participants contacted me, I sent them a short screening survey (Appendix A) to ensure that they fit all inclusion criteria. Participants were eligible for the study if they were at least 18 years of age; fully or provisionally licensed as an MFT, LPC, LCSW, or LCMHC; had been employed by a CMHC as outlined by SAMHSA requirements within the last year; and had provided direct client care while employed. Along with the screening questions, potential participants were asked to complete the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981) (Appendix B). Participants were eligible to participate if they scored 17 or higher in Section A: Burnout, score 5 or higher for Section B: Depersonalization and score 40 or lower for Section C: Personal Achievement. These scores were based on MBI's scoring rubric, which considered these values as moderate across each measurement. Once I confirmed that they met the selection criteria, I invited them to participate. Those who did not meet the criteria were thanked and asked to share study information with other colleagues whom they felt might meet the criteria.

Each participant was given a participant number prior to scheduling the interview. This was used to de-identify the interviews. Upon confirming that the participant remained interested

and willing to contribute to the study, the participant and I scheduled a time to conduct the semi-structured interview. The interview used Virginia Tech's HIPAA-compliant Zoom platform, which allows for confidentiality to be maintained. At least 24 hours before the interview, by email, participants received an electronic copy of the informed consent document and the interview questions. Before commencing the interview, I reviewed the consent form with each participant to ensure that they had no questions or concerns before proceeding with the interview. I also gained verbal consent from each participant to record and proceed with the interview. Each participant received a \$25 electronic Amazon gift card after completing the interview. Pamela B. Teaster, Ph.D., my dissertation advisor, completed the first two interviews with me to assess the quality and flow of the interviews.

### **Interview Protocol**

Before starting the interview, I had the participants verify their identity by confirming their responses to the demographic questions from the screening survey. Demographic questions include asking participants about their age, their license(s), number of years practicing in the field, the type of agency for which they worked, and their job responsibilities (Appendix A).

Next, I asked each person an open-ended question about their motivation to become a CMH clinician. The interview questions were informed by the MHSE Model (Figure 1) to explore each participant's lived experiences of their role as a clinician, how they navigate the ecological system, and how they make meaning of their role. Questions included asking about consequences of their burnout, navigating ethical and moral dilemmas as CMH therapist, and the various ways that they coped with burnout in and outside of work (Appendix C). The last segment of questions delved into what participants desired to change within the MHSE if they had their own "magic wand" (Appendix C).

## **Process of Analysis**

### **Data Protection**

Interviews were audio and video recorded for transcription and stored in a confidential, password-protected folder via a Virginia Tech OneDrive Folder. The audio file was transcribed verbatim using a transcription service, Rev.com, approved by the VT IRB and provided by dissertation chairperson, Pamela B. Teaster, Ph.D. I kept a digital, de-identified copy of the transcribed interview on a password-protected file on my password-protected computer. All transcripts and recordings were password-protected and stored in the Virginia Tech OneDrive folder.

### **Exploratory Notes**

Before any analyzing began, I read through each transcript once while listening to the audio recording. This allowed me to check for errors in the transcript and helped me remember the context of the interview (Smith & Nizza, 2022). Afterward, I re-read the transcripts and made notes in the margins about my first reactions to participants' responses. Exploratory notes highlighted what I found of interest or importance (Smith & Nizza, 2022). This process helped me identify important passages within the interview by employing descriptive, linguistic, and conceptual notes.

Descriptive notes focused on the content of what participants shared, summarizing explicit meanings and taking their words at face value. For example, a participant described feeling "I've had physical and mental health problems" and "the whole agency has terrible turnover," which clearly reflects the overwhelming workload in CMH. Another participant might detail ethical dilemmas, such as feeling torn between wanting to provide quality care and the

agency's directive to end care with a client for various reasons. These statements were noted as evidence of burnout and systemic pressures contributing to exploitation.

Linguistic notes examined how participants expressed themselves, including word choice, tone, pauses, and nonverbal sounds. For instance, a participant said, "I'm currently looking to leave public mental health for the first time in my career," with a long pause before sighing. The hesitation and sigh could indicate resignation or emotional fatigue, signaling deeper distress beyond their words. Another clinician might laugh while discussing financial mismanagement at their agency and not getting paid, which reflected some nervousness, cynicism related to the experience. One participant even asked for permission to curse which reflected their need to emphasize the anger they experienced. Attention to these linguistic elements provided insight into the emotional weight behind their experiences.

Conceptual notes encouraged deeper analysis by posing questions about underlying meanings and broader implications. For example, after a participant stated, "I remind myself why I started doing this work," I might question: *Is grounding in purpose a conscious strategy for resilience, or a way to justify staying in a difficult system?* When another clinician described being pressured to overlook ethical concerns, I might ask: *How does moral distress contribute to burnout?* or *What does it mean when systemic constraints force clinicians into ethical compromises?* These conceptual reflections helped bridge individual experiences with larger themes related to resilience, burnout, and structural issues in CMH.

This multi-layered approach to note-taking allowed me to engage deeply with the data, ensuring that both the explicit content and the underlying emotions, contradictions, and broader meanings were considered throughout the analysis.

### **Experiential Statements**

After completing the first step of creating exploratory notes, I generated experiential statements. This step required that I re-read the transcripts to identify the meaning that each participant attributed to their experiences. More specifically, each statement was a succinct summary of what emerged as important within the particular section of the participant's unique response and captured their psychological process (Smith & Nizza, 2022). These statements were added to the margins of the physical transcript, helping to distill the essence of the participants' lived experiences while staying grounded in their own words and perspectives.

For example, one a clinician described feeling "the middle man, caught in the middle of meeting agency requirements as well as being a decent human being" when thinking about what they believe contributes to their burnout. An experiential statement might read: *Feeling torn between maintaining their livelihood and doing what they think is right*. This captures the clinician's internal struggle between being employed and protecting their career and their sense of responsibility to their clients.

A clinician who discusses finding meaning in their work despite the systemic challenges might say, "I love the work that I do, and I have been able to pursue my passion while I've been here." The corresponding experiential statement could be: *Reframing adversity by anchoring in personal values as a form of resilience*. This highlights how clinicians actively construct meaning to sustain themselves in a challenging field.

By generating these experiential statements, I was able to interpret the underlying psychological processes that shaped participants' experiences of burnout, exploitation, ethical dilemmas, and being grounded in purpose as a form of resilience. This step helped me move beyond surface-level content to explore the deeper meaning participants made of their struggles and coping strategies.

## Connections and Group Experiential Statements

The third step in the analytic process required refinement of the experiential statements noted throughout the interview. Smith and Nizza (2022) emphasize that the number of experiential statements can vary based on the length of the interview and the density of the identified statements. During this step, I engaged in clustering, defined as putting similar statements together (Smith & Nizza, 2022). I created a list of experiential statements in my notebook and organized statements based on their similarity.

This stage of the analysis proved challenging because it highlighted the interdependent layers of the experience of burnout. Burnout in CMH was not simply about exhaustion or overwork—it was deeply entangled with moral distress, systemic exploitation, and personal resilience. I struggled with determining how best to cluster experiential statements in a way that preserved the complexity of participants' experiences while also revealing overarching themes. Many statements seemed to belong in multiple clusters, reinforcing how burnout is not a singular experience but rather a dynamic and multifaceted phenomenon. This struggle reflected the interwoven nature of burnout as conceptualized in the MHSE, where clinicians navigate organizational constraints, ethical tensions, and personal meaning-making simultaneously.

To refine my understanding of how these themes connected, I experimented with mixing and reordering statements. For example, I initially placed “Feeling a loss of self” in a category focused on physical and emotional exhaustion as the clinician described how they felt in their workplace. However, as I reviewed other statements, such as “Experiencing tension between clinical ethics and systemic demands, leading to feelings of powerlessness,” I realized that burnout was not just about depletion—it was also about the moral weight of being asked to provide care under conditions that compromised clinicians' values, therefore going against who

they believe themselves to be. This led me to merge statements related to exhaustion and ethical dilemmas, forming a new cluster that better captured the emotional and moral burden of burnout.

Similarly, I debated where to place statements related to resilience. A statement like “Reframing adversity by anchoring in personal values as a form of resilience” initially seemed to fit within coping strategies. However, after re-examining participants’ statements on systemic barriers, I recognized that resilience was not only about individual coping but also about resistance to exploitation. This realization prompted me to organize resilience-related statements alongside those describing the struggle to maintain ethical integrity, highlighting how clinicians sustain themselves in environments that often work against them.

Through this iterative process, I gained a clearer narrative of how burnout emerges within CMH as a process shaped by systemic pressures, ethical dilemmas, and the personal strategies clinicians use to navigate these realities. The clustering stage not only refined my analysis but also deepened my appreciation for the complex, layered ways in which participants made sense of their experiences.

## **Themes**

For the fourth step, I identified emerging themes by mapping “the interrelationships, connections, and patterns” (Smith et al., 2009, p. 91) within each participant's original data and my own interpretation. This step was particularly significant because it represented a blending of the raw data with my analytical lens, moving from individual experiential statements to broader themes that captured the depth of participants’ lived experiences. I named each cluster of experiential statements as a specific theme that reflected the core idea of that cluster (Smith & Nizza, 2022). To ensure credibility, I continually checked the themes against the original data, verifying that they accurately represented the participants’ narratives and that my interpretations

remained grounded in their experiences. I analyzed each interview individually before moving to the next, maintaining methodological integrity and ensuring that themes emerged naturally from the data rather than being imposed prematurely.

To organize this process, I created a table for each interview that included the theme, corresponding experiential statements, the page and line number, and a short extract from the interview (Smith & Nizza, 2022). This table not only documented how themes were constructed but also made it clear how they were rooted in both the MHSE model and participants' specific statements.

At this stage, I found that burnout could not be understood in isolation but was deeply intertwined with themes of **exploitation, ethical and moral dilemmas, and being grounded in purpose as a form of resilience**. One emerging theme, *When Passion Meets Systemic Pressure*, captured how clinicians felt taken advantage of by a system that relied on their deep commitment to clients while offering little structural support. Another theme, *The Ethics Tightrope: Navigating Moral Distress in the Face of Systemic Constraints*, encapsulated how clinicians grappled with the tension between providing ethical care and meeting agency demands. Finally, the theme *Resilience Through Purpose: Holding on to the "Why,"* represented how clinicians resisted burnout by grounding themselves in their original motivations.

At this critical juncture of analysis, my dissertation chair played a crucial role. Across multiple meetings, we engaged in deep discussions about the emerging themes, refining my interpretations and ensuring that the themes reflected the complexity of the data rather than oversimplifying the clinicians' experiences. My chair encouraged me to explore the interconnections between themes, helping me see how *exploitation, ethical dilemmas, and resilience* not as distinct experiences but as overlapping dimensions of burnout in CMH.

Through these discussions, I refined my understanding of how clinicians' narratives reflected broader systemic patterns while also revealing deeply personal coping mechanisms.

This collaborative analytical process helped me develop a coherent and nuanced thematic structure, ensuring that the themes captured participants' lived experiences and contributed meaningfully to the broader discourse on burnout in the MHSE.

### **Cross-Case Analysis**

Once all interviews were analyzed individually, I conducted a cross-case analysis. This process enabled me to identify common patterns, as well as idiosyncratic differences within similarities, and to explore how one case might provide insights into another (Smith & Nizza, 2022). The final result was a revised table grouping experiential themes that formed the basis for writing the analysis (Smith & Nizza, 2022). I systematically identified connections, similarities, and differences across cases, comparing themes at both personal and experiential levels. Once the synthesis of themes took place, I also examined discrepancies at the experiential statement level (Smith & Nizza, 2022). The results of these comparisons helped me produce another table of group experiential themes (GETs), with personal themes accompanied by participant quotes, including specific page and line numbers for transparency and traceability (Smith & Nizza, 2022).

This step of the analysis proved to be one of the most difficult because every theme that emerged felt relevant to the experience of burnout in CMH. As I worked through this process, it was challenging to determine which themes were most essential to share and which were more appropriately conceptualized as part of a broader narrative. My dissertation chair was invaluable at this stage, as our discussions helped me process aloud the connections between themes and refine how I structured the findings. Through multiple meetings, we engaged in a collaborative

dialogue that helped me see patterns that were not immediately apparent when analyzing individual interviews in isolation.

One of the most challenging decisions occurred when considering the role of **salary, caseload, and quality leadership** in clinicians' experiences of burnout. Initially, I conceptualized these as distinct themes or subthemes, believing they encapsulated the **pervasive nature of burnout** in the field. However, after discussions with my chair, it became clear that these factors were not merely themes but rather manifestations of a larger systemic issue. Instead of standing alone, they were better understood as integral elements of a broader narrative of **exploitation**—a theme to which multiple participants interviews spoke to. A clinician describing, *I went from 30 to 83 cases because everyone in my department left*, was not just talking about workload and turnover, but about the structural expectation that clinicians will absorb an unsustainable burden. Similarly, another participant stating, *My husband has a GED and makes twice as much money as I do, and I have a master's degree and licensed with 15 years of experience*, was articulating more than a frustration with salary—it was a reflection of the systemic devaluation of their labor.

By shifting my perspective in this way, I was able to move beyond listing challenges as isolated themes and instead highlight the deeper *intersections between burnout, moral distress, and systemic exploitation*. This restructuring ultimately provided a clearer, more compelling analysis that honored the lived experiences of participants while making a meaningful contribution to the understanding of burnout in CMH.

Throughout this iterative process, I gained a stronger grasp of how themes should not only capture participant experiences but also tell a cohesive story. The cross-case analysis, with the guidance of my dissertation chair, allowed me to refine the emerging themes into an

interconnected framework that meaningfully conveyed the realities of burnout, ethical dilemmas, and resilience in the field.

### **Trustworthiness**

Because of the contextual and subjective nature of qualitative methods, it was important for me to employ methods that ensured and enhanced the trustworthiness of the study. During the data-gathering process, I maintained a reflective journal with field notes. The journal allowed me to reflect upon my own thoughts and feelings about the research experience as well as the individual interviews themselves. Keeping a reflective journal helped me organize the data and increased my awareness of personal biases and assumptions, all of which increased the rigor and trustworthiness of the study.

*Sensitivity to context* emphasizes the importance of understanding the theoretical background, knowing the empirical data related to the topic, considering the sociocultural influence of the participants, and centering the perspective of the participant (Yardley, 2000). During each of the interviews, I observed and notated participants' non-verbal behaviors that accompanied what they said in order to outline the contextual information and assist in reducing my own biases.

*Transparency and coherence* refer to the way the study is described (Yardley, 2000). Ensuring that there is a fit between the research question and the methods of investigation and analysis helps ensure coherence. Transparency was supported by using reflexive techniques, such as the reflexivity statement below that I wrote prior to conducting the study in order to frame the effect that my own assumptions, intentions, and actions could have on the product of the research (Yardley, 2000).

## Reflexivity Statement

Similar to the clinicians being studied, I used myself in my work. As a result, any biases, assumptions, and pre-existing expectations I may have will remain with me throughout the research process. Given this acknowledgment, it is important that I participate in a process that allows me to recognize how my own experiences, beliefs, and values are engaging with my work (Smith & Nizza, 2022). This process is more formally known as reflexivity. I bring a lived experience that mirrors the population that I am studying, which means that the reflexive process will enhance the objectivity of the study. Smith and Nizza (2022, p.17) describe the importance of reflexivity when conducting phenomenological work, noting:

As a researcher you are an “insider” to the project topic, meaning that you share the experience that participants will be describing, being reflexive can be particularly challenging. In such cases, it can be helpful to put in writing your ideas and experience before you start your interviews; otherwise preconceptions could sneak in on you when you least expect them, causing you to ask a leading question or inadvertently express a judgement.

Because of this guidance and the personal nature of this research, my own experience as a CMH clinician, and how I made meaning of my own experiences inspired me to ask research questions that I hoped would influence the lived experiences of this population moving forward. I focused on the idea that people within groups have unique experiences and acknowledged that many revelations can be true, so that, as much as possible, I promote objectivity within this study.

### Confessions of a Clinician<sup>1</sup>

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<sup>1</sup> Written prior to data collection in May 2023

From very early in my life, I desired to be a helper. I was always the person people felt comfortable sharing their secrets with or trusted I would give them sound advice. It was beyond my wildest dreams or expectations that I would be able to translate those skills into a career. Growing up in a small rural area and living in many other metropolitan areas across the US, I began to see that the need for support was vast; those who were the most vulnerable needed support the most. This is how I ended up in CMH.

As I began working in the field and learning more about how “the system” worked, I recognized that there were patterns that existed within this specialty that piqued my interest and ignited the advocate within me. My first job after completing my master’s program was at a CMH clinic in my home state of North Carolina. I loved my clients! It brought me a lot of joy to see them every week, spend time with them, and listen to their stories. However, at the beginning of my clinical journey, many clients shared their experiences with other clinicians and the agency where I was working. They regaled me with stories of disengaged therapists, therapists departing with little to no notice, inability to get necessary documentation, and a range of other experiences. I was horrified by these client accounts, and in reaction, I went out of my way to ensure they had a better experience with me. As time went on and I gained a deeper understanding of the system I was working within, I began to see how these patterns persisted.

As a new therapist, I was seeing 15-20 clients per week and was consistently asked to take on additional cases. Even though I was carrying a full caseload, I had to find another part-time position to help supplement my income because my full-time job did not pay enough to cover my bills. I was constantly completing paperwork or revising notes to ensure that Medicaid would reimburse the agency for my time. There was even an instance where I had to stop seeing a client immediately due to their insurance switching to Medicare, which at the time did not

reimburse MFTs or LPCs. This was the moment when my frustration with the system reached an all-time high, and I began to experience symptoms of burnout. I was physically and emotionally exhausted and I was constantly stressed about the never-ending paperwork. There were moments when I would “zone out” in my sessions. I was fighting to stay present, but my mind raced in many different directions. I realized then that I couldn’t continue this work, and I understood that not being at my best was unfair to my clients. After talking with those whom I knew were also providing CMH care, I realized that my experience was not unique but rather an issue that has persisted within the CMH system for decades.

My lived experience and the experiences of my peers have motivated me to research burnout for CMH clinicians. This specialty is vital to our communities, often being one of the few, if not the only, accessible mental health care services available to some of the most vulnerable individuals in our population. Without a strong, supported workforce capable of handling the challenging and exhausting work, many more clients like those I served will have experiences that may deter them from seeking help in the future. Knowing that I identify with the population I am studying, CMH therapists, the biases, and preconceived ideas I have about my research are obvious. This is something of which I am mindful as I enter the data collection phase of my research. As a qualitative researcher, I am just as involved in the research process as my participants, and I recognize that my own lived experiences may influence my approach. Throughout this research process, I will have to make an active effort to remain differentiated and not allow MY individual truth to be THE truth. I must make space for experiences that may be different from mine. Ultimately, my hope is that this research can have a positive impact on the way we care for and support our CMH workers and to revise a system that works more equitably for all.

## Chapter 4: Results

Over the last three decades, research on burnout has identified systemic issues affecting the MHSE, including high turnover, decreased job satisfaction, and compromised quality of care (Prosser et al., 1997; Salyers et al., 2013; Luther et al., 2017; Knudsen, Ducharme & Roman, 2006). The MHSE model highlights the interdependence of clients, clinicians, organizations, and the broader system (Schoenwald & Hoagwood, 2001; Southam-Gerow et al., 2006), demonstrating that clinicians not only provide care but are also shaped by systemic forces (Knight et al., 2012). Burnout directly impacts clinicians' emotional and psychological well-being (Baldwin-White, 2016; Perkins & Sprang, 2013; Simionato & Simpson, 2018), affecting job satisfaction and increasing turnover (Kirk-Brown & Wallace, 2004; Salyers et al., 2013). The nine clinicians in this study revealed how systemic conditions contribute to burnout, exposing the ethical and moral dilemmas they face and the ways in which exploitation manifests within their roles. However, their experiences also highlighted resilience strategies, with many remaining grounded in purpose as a protective factor. Using the MHSE framework, I analyzed clinicians' narratives to offer a systemic perspective on burnout, shifting the focus from individual coping to shared responsibility across organizational and service levels.

### Summary of Data

The nine participants, one male and eight females, ranged in age from 30 to 48, with an average age of 35.1 years. They had been practicing in five states and districts: Washington, D.C., Virginia, Maryland, Illinois, and California. Three participants identified as Black/African American and six as White. All were non-Hispanic. Professionally, six participants were Licensed Marriage and Family Therapists (LMFTs), and three were Licensed Clinical Social Workers (LCSWs). Most were in the early professional stage, having practiced for an average of

six to 10 years. On the Maslach Burnout Inventory (MBI), their average scores were 22.67 for Section A - Burnout, 16.56 for Section B - Depersonalization, and 28.11 for Section C - Personal Achievement, indicating a range of moderate to high burnout among participants (Maslach & Jackson, 1981). These data provide insight into the intersection of professional characteristics, systemic conditions, and clinicians' lived experiences of burnout.

Each interview lasted an average of 44 minutes, during which participants communicated their experiences both verbally and non-verbally. Their words often carried a tone of frustration, exhaustion, or resignation, while moments of resilience were marked by firmer vocal inflection and determined body language. Some participants leaned forward when discussing systemic injustices, their gestures becoming more animated as they described the emotional weight of their work. Others sighed deeply or paused for long stretches, underscoring the internal conflict that arose from moral and ethical dilemmas.

Through iterative analysis, I identified three central themes encapsulating participants' experiences: *Exploitation*, *Ethical and Moral Dilemmas*, and *Being Grounded in Purpose*. *Exploitation* emerged as a critical theme connected to participants' initial motivation to help their clients. Many clinicians entered the field with a desire to serve vulnerable populations, yet they quickly encountered systemic challenges—low salaries, overwhelming caseloads, and insufficient institutional support—that left them feeling undervalued and overworked. *Ethical and Moral Dilemmas* highlighted the profound conflict between clinicians' professional values and the constraints imposed by bureaucratic inefficiencies, inadequate funding, and leadership shortcomings. Participants expressed moral distress over being forced to prioritize institutional mandates over client-centered care, leading to feelings of guilt, frustration, and professional disillusionment. *Being Grounded in Purpose* emerged as a protective factor, allowing clinicians

to withstand systemic barriers. Many participants remained committed to their work through a strong sense of mission, connection to their clients, and reliance on supportive communities both within and outside their workplaces.

These themes emerged through a meticulous process of iterative analysis, pattern recognition, and reflection on the verbal and non-verbal cues expressed by participants. The findings illustrate how burnout is not simply an individual issue, but rather a systemic phenomenon shaped by larger institutional forces. At the same time, the narratives of resilience highlight the importance of purpose-driven work in sustaining mental health clinicians in community settings.

### **Exploitation: The Hidden Cost of Passion**

Clinicians enter community mental health (CMH) with a profound dedication to service, often motivated by personal values of empathy and social justice. Many view their work as a calling rather than just a profession, driven by a desire to support underserved populations and address disparities in mental health care access. This intrinsic motivation shapes their professional identity and informs their commitment to fostering resilience and growth in their clients.

Sophia, an early-career clinician with 1-5 years of experience, reflected on her path into CMH, highlighting how her prior work in education led her to question accessibility in mental health services. She stated:

It was because of wanting to work in a community setting I wanted to do therapy. I was coming from the education field previously and was sort of in a niche world in the education field... But then I [asked], who has access to this? And so, I think that was sort of my entering into how I thought about mental health. Who has access to these

resources? And that was my goal—I would love to work in a community setting for as long as I can do it.

Similarly, Julie, a clinician with a long-term vision for community-based care, emphasized her aspiration to integrate therapy into community spaces, recognizing their significance for local populations:

I already had a desire to do community mental health work. I wanted to, and it is still a dream of mine, to put a therapist in every community center in the southeast region of the United States. Where the kids play basketball, and they go to camp, and the elders go and do line dances in the mornings, where there's the park and a pool and all that—I want to put a therapist there because the communities use that. They use that as a resource. It's a significant resource, especially to communities that are on the borderland...

Both Sophia and Julie articulate a deep commitment to CMH, illustrating how personal values align with professional aspirations. However, this dedication often intersects with systemic barriers that make sustaining such work increasingly difficult.

Despite their passion, many clinicians experience systemic exploitation, particularly in the early stages of their careers. The interplay of low wages, high caseloads, and inadequate institutional support frequently leads to emotional exhaustion and professional dissatisfaction. Evelyn, a clinician with 1–5 years of experience, described the overwhelming caseloads that became her responsibility due to staff shortages:

I have a caseload of 83 clients right now, 83... So basically, when I was trained and I was coming in, we had a full staff, but then the director left to take a different job, and the other clinicians left to take other jobs and all still within the federal government. So that left me alone to essentially kind of carry on the caseload for my particular clinic, which

took my caseload from 30 when they were here to about 80. So I run five group therapy sessions a week on top of a caseload of 30 individuals who are all biweekly or every three week kind of basis.

The rapid turnover in CMH settings exacerbates this issue, as Evelyn explained:

Because of issues of pay, politics, and things like that, and just the normalcy of a lot of people moving around and moving on to other positions in the government, that causes a lot of staff shortages for these mental health clinics because people move on and accept better jobs with higher pay or they don't like the politics of their employment.

This lack of stability forces remaining clinicians to shoulder excessive workloads, reinforcing a culture where burnout becomes inevitable.

Low compensation further compounds clinician exploitation. Many are required to work multiple jobs or overtime to sustain themselves, often without fair remuneration for administrative tasks. Lila, a clinician with over 16 years of experience, voiced her frustration about the financial inequities in CMH:

...watching other people who have master's degrees and license and things like that move on to earn so much more money, and in the financial landscape that we're in, it feels like we work really hard to help a lot of people, and we don't get financially reimbursed for the level of passion we put into it.

For early-career clinicians, delayed or missing pay adds another layer of financial insecurity. One participant, Amelia, was one of few participants who had decided to leave CMH due to her experience of exploitation in her CMHC. Amelia shared her frustration over unpaid labor:

... That's a huge thing with community services is the pay is low, the work is really hard and really long hours, so if you already know that, then validate, give the support in other ways. And they weren't. And then they weren't paying too. We already weren't getting paid enough to survive in the [XXX] area, but then they weren't paying us. There were months without checks happening and no communication about why my check wasn't happening and then discrediting me for being upset about it....

Such financial mismanagement not only demoralizes clinicians but also disrupts their ability to provide consistent care for their clients.

The role of leadership in perpetuating or mitigating systemic exploitation is significant. Poor leadership structures often leave clinicians feeling undervalued and unsupported. Elena, with 11-15 years of experience, who serves in both clinical and managerial roles, actively works to counteract this within her agency:

The leadership is so lacking, and we're trying to get people to do some of the hardest work for very little pay... I'm also a manager in my public mental health agency, and I work my ass off to make sure my people feel appreciated and seen and supported and have super low turnover. The whole agency has terrible turnover. I have super low turnover, so I know it can be done. I know you can help somebody feel valued and make them want to do this kind of hard work.

In contrast, Nathan's 6-10 years of experience illustrates the challenges that arise from administrative instability:

The organization is big and unwieldy, and the nature of grant funding—we sort of live and die by grant funding—and so my agency is constantly reconfiguring itself, and that lack of consistency—I'm noticing. I'm talking a lot about administrative changes and

things like that. That's certainly a big part of that. I don't feel supported by leadership at all. I think they mean well, and I just think they don't have access to what they need to know in such a big organization.

Nathan's reflection highlights how inconsistent leadership decisions contribute to clinician dissatisfaction, creating an unstable work environment.

Beyond organizational instability, some clinicians reported experiences of toxic leadership that directly harmed their financial and emotional well-being. Sophia, with 1 to 5 years of experience, despite initial hesitancy, disclosed how financial mismanagement and lack of human resources (HR) support led to a hostile work environment:

They would blackmail and use it against you. Really toxic, even talking about it now, it's like this activation where it was constant tension, worry about the work environment on top of working at a place where I was doing trauma therapy... There was financial mismanagement and a lack of transparency around that... Not having an HR team, I think, was huge. Not having someone that I felt like I could go to in that process, not feeling like there was any sort of way of accountability or due process.

Sophia's account underscores how systemic failures, particularly within leadership structures, contribute to clinician exploitation and emotional distress.

Clinicians in CMH enter the field with deep commitments to service and social justice. However, their passion often places them in positions of systemic exploitation, where high caseloads, financial instability, and poor leadership create an unsustainable work environment. Without structural changes, the cycle of burnout and turnover will continue, jeopardizing the quality and accessibility of community mental health services.

### **Ethical and Moral Dilemmas: The Emotional Toll of Burnout**

Burnout extends beyond the personal toll on clinicians—it profoundly affects ethical decision-making and professional integrity. Many clinicians experience moral distress when systemic constraints prevent them from providing the quality of care they believe their clients deserve. Camille who has 6-10 years of clinical experience described the persistent tension she faces, stating, “I’m caught in the middle of meeting agency requirements and being a decent human being to a client... It just feels like I am constantly on a tightrope trying to serve two masters.” As she spoke, her brow furrowed, and she leaned forward, emphasizing the emotional weight of her predicament. This ongoing internal conflict illustrates how the relentless demands of the system can erode emotional resilience and professional confidence. Organizations' focus on meeting quotas and navigating bureaucratic red tape further distances clinicians from the relational and transformative work that originally drew them to the field, intensifying their disillusionment and burnout.

High caseloads and bureaucratic inefficiencies compel clinicians to make ethically fraught decisions. Nathan recounted a particularly unsettling experience: “There was one client... termination wasn’t particularly thoughtful, and I ended up maintaining contact just to make sure she had access to services. But of course, that breaks a bunch of rules.” As he shared this, he rubbed his hands together, a nervous response that revealed his lingering discomfort with the ethical compromise he felt forced to make. Clinicians frequently face such dilemmas, whether in deciding how to allocate limited time and energy, choosing between personal well-being and professional obligations, or navigating systemic barriers that impede effective treatment.

Elena is a clinician who has been working in CMH for over a decade and recently began looking for work outside of the CMH specialty due to the impact it has had on her physically,

emotionally and ethically. She articulated her approach to these ethical challenges, emphasizing her determination to uphold her professional standards despite institutional pressures:

I think that what I've always done is make myself take the hit, if that makes sense. So if I was going to be required to see too many clients, I would just, instead of giving them shitty service, I would be the one struggling rather than compromise my client's care. There was a time recently that I went head-to-head with somebody at the agency who was asking me to discharge a client, and I refused to. I just didn't do it because it wasn't ethical. So I had not allowed my ethics to be compromised. I worked my ass off for that license. I'm not going to compromise it.

Elena's stance highlights the moral distress that many clinicians endure—choosing between professional integrity and personal well-being. The emotional burden of such dilemma's compounds burnout, leaving clinicians physically and mentally depleted.

The ethical and moral dilemmas stemming from burnout can have profound and lasting effects on CMH clinicians. Facing repeated untenable situations erodes confidence, leaving many questioning their competency and professional identity. This internal conflict leads to feelings of shame, frustration, and hopelessness, as clinicians struggle with the gap between their ideals and the reality of their constrained work environment. Over time, unresolved ethical conflicts contribute to emotional exhaustion and compassion fatigue, reducing their ability to engage meaningfully with clients.

Beyond ethical concerns, the very nature of CMH work intensifies burnout, affecting clinicians' personal well-being and professional efficacy. The physical and emotional toll of burnout manifests in chronic fatigue, sleep disturbances, and emotional depletion, all of which diminish clinicians' capacity to maintain high standards of care. Many clinicians also grapple

with the systemic dehumanization of marginalized populations, which further complicates their ethical decision-making. Julie, who's been a clinician for 6 to 10 years, shared an experience involving a Black caregiver who was labeled "aggressive" due to systemic bias: "Do I turn her away and have her where she's not going to go get support, or do I see her when this agency said 'no, I'm not allowed to see her?'" As she recounted this, her voice wavered slightly, and she blinked rapidly, as if holding back frustration or sadness. Such dilemmas underscore the broader systemic failures that place clinicians in ethically untenable positions.

Ultimately, burnout within CMH is not merely a byproduct of heavy workloads; it is deeply entangled with ethical conflicts, systemic inefficiencies, and the moral distress of working within a structure that often prioritizes administrative mandates over human-centered care. As clinicians navigate these persistent challenges, the emotional weight of their decisions accumulates, perpetuating and escalating a cycle of distress, disillusionment, and professional exhaustion.

### **Grounded in Purpose: A Form of Resilience**

Despite the persistent challenges of community mental health (CMH), clinicians sustain themselves by remaining grounded in their purpose. Their resilience does not stem from systemic support but rather from an internal commitment to service and a deep connection to the meaning of their work. This intrinsic motivation allows them to navigate the emotional and structural demands of their roles, offering a sense of fulfillment despite external difficulties. For some, the knowledge that they are making a tangible difference in their clients' lives counterbalances the frustrations of inadequate resources or systemic inefficiencies. Julie, who took so much pride in describing her larger purpose as a clinician, reflected on this unwavering commitment, stating, "I still have a dream of putting a therapist in every community center in the southeast... My

grandmother integrated the public library. How I move through the world is not something I am willing to compromise.” As she spoke, her posture straightened. Her quiet determination was evident in her expression, embodying the personal and historical weight of her mission.

Being anchored in a sense of purpose is a powerful protective factor against burnout, offering clinicians a psychological buffer amidst the demands of their work. Some participants described how being part of a mission-driven organization that aligns with their values can serve as an essential safeguard. Julie elaborated on this, emphasizing the significance of organizational integrity: “[Being in an organization] where what people say about how they want to run their organization aligns with what they do and how they run it. So, I think that being in a system that cares about its people in practice and that has a good feedback system and uses feedback from its people to make its system better is a protective factor.” Her words illustrate how alignment between organizational practices and stated values can foster an environment that supports clinician well-being, mitigating the risk of burnout.

Clinicians who remain grounded in their purpose often find that self-awareness plays a critical role in their resilience. Recognizing personal limits and knowing when to recalibrate allows them to navigate the emotional demands of their work with greater stability. Camille, a clinician who recently received her full license after working over 5 years in the field, articulated this awareness, stating, “My brain is just tired... but I recognize when I need to reset. Without that self-awareness, I wouldn’t still be here.” As she exhaled slowly, her body language suggested a moment of reflection, an acknowledgment of the endurance required to sustain herself in the field. Her experience underscores the necessity of self-regulation in maintaining longevity in CMH work, highlighting the interplay between purpose-driven work and the ability to engage in adaptive coping strategies.

Additionally, being part of a supportive community—within and outside of the workplace—is another vital protective factor against burnout. Workplace cultures that prioritize a shared mission, connection, and collective support can buffer against the stressors inherent in community mental health work. Lila, with over 15 years of clinical experience, reflected on the impact of workplace support, sharing, “My boss made sure we had social gatherings... That kind of support makes a difference.” A small smile crossed her face, and her posture relaxed slightly as she recalled these moments of camaraderie. These seemingly minor yet meaningful acts of connection reinforce a sense of belonging, helping clinicians sustain their passion and engagement despite systemic obstacles.

For many clinicians, remaining grounded in purpose is not merely about professional passion but about developing a sustainable approach to their work. While external pressures—such as leadership failures and systemic inefficiencies—contribute to burnout, clinicians who cultivate self-awareness and lean on supportive communities demonstrate a form of resilience that allows them to persist. This finding highlights the critical need for organizational cultures that recognize and reinforce protective factors, rather than places the burden of resilience solely on individual clinicians.

## **Conclusion**

Burnout among CMH clinicians is deeply embedded within systemic structures, with exploitation, ethical dilemmas, and emotional exhaustion shaping their daily experiences. Yet, clinicians continue to navigate these challenges by remaining grounded in purpose, fostering community, and developing self-awareness. These findings highlight the urgent need for structural reforms, advocating for systemic interventions that prioritize clinician sustainability rather than placing the burden of resilience solely on individuals.

## Chapter 5: Discussion

The purpose of this study was to explore how the ecology of mental health services affects CMH clinicians' experiences of burnout. The findings revealed three major themes: **exploitation, ethical and moral dilemmas, and being grounded in purpose**. These themes illustrate the complex interplay between systemic pressures, the internal conflicts clinicians face in their roles, and the personal values that sustain them. **Exploitation** captures how organizational structures demand excessive emotional and physical labor while offering minimal support. **Ethical and Moral Dilemmas** reflect the tensions clinicians experience when agency policies and financial constraints conflict with their professional and ethical responsibilities. Finally, **Being Grounded in Purpose** highlights the ways clinicians anchor themselves in their core values and commitment to clients as a form of resilience against burnout. Together, these themes provide a nuanced understanding of how clinicians navigate the challenges of CMH work.

This concluding chapter situates the findings within the context of existing literature, examining how they affirm, challenge, or expand current understandings of burnout in CMH settings. It explores the implications of these findings for practice, policy, and clinician well-being. Finally, the chapter proposes areas for future research to broaden an investigation of these critical issues.

### Significance of the Themes

Clinicians' initial motivation, rooted in their deep desire to help underserved populations, often became entangled in the systemic challenges of the MHSE, such as exploitative workplace cultures, high caseloads, and inadequate support from administration. Their experiences highlight how structures designed to facilitate mental health care inadvertently contribute to burnout by

placing disproportionate emotional, professional, and ethical burdens on clinicians.

Consequences of burnout—ranging from physical and emotional exhaustion to ethical dilemmas—illustrate the compounding impact of systemic issues, while protective factors like community, organizational stability, and self-awareness provide insights into potential solutions. The themes provide valuable insights into addressing burnout from a systemic perspective, paving the way for the exploration of structural interventions.

### ***Exploitation in Community Mental Health***

A strong desire to help others often draws clinicians into CMH work, with many entering the field out of a deep commitment to social justice and equitable access to care. Their intrinsic motivation to support vulnerable populations aligns with research highlighting how values of altruism and advocacy frequently guide individuals into helping professions (Scanlan & Still, 2019). However, this idealism often collides with systemic barriers, creating a pervasive reality of exploitation within CMH agencies. Poor workplace cultures, combined with organizational priorities that emphasize productivity and financial outcomes over employee well-being, foster exploitative practices that disproportionately affect clinicians—particularly those early in their careers. Many face overwhelming caseloads, chronic understaffing, and inadequate compensation, a pattern that mirrors findings on burnout in nonprofit and public health sectors (Rahaman, Reza, & Rahman, 2024).

Structural inequities within the MHSE further intensify these exploitative dynamics. Underfunded agencies, driven by external pressures to maximize service delivery while minimizing costs, often prioritize quantity over quality of care. This systemic demand forces clinicians into a precarious balancing act—striving to make meaningful change while shouldering workloads that far exceed sustainable limits. Constant turnover, often a byproduct of

burnout, exacerbates the issue by increasing the burden on remaining staff, perpetuating a cycle of overwork and disillusionment. Additionally, financial mismanagement within some agencies leads to wage stagnation, inconsistent funding allocations, and resource shortages, disproportionately impacting frontline clinicians who have little say in organizational decision-making.

The consequences of this exploitation extend beyond physical exhaustion to moral distress—a psychological strain that arises when clinicians are unable to uphold their ethical and professional values due to systemic constraints. Prior literature suggests that when mental health professionals are forced to compromise their ethical standards in response to productivity demands, administrative barriers, and financial limitations, they experience profound emotional strain and professional disillusionment (Agarwal, Rozenblum, & Sherritt, 2020). This dissonance not only fuels burnout but also contributes to a broader societal undervaluation of caregiving roles, reinforcing the chronic underinvestment in mental health infrastructure.

By exploring the deep-rooted connections between exploitation, systemic inequities, and clinician burnout, this theme highlights how the very dedication that draws individuals to CMH becomes both a strength and a vulnerability. Without structural support, their commitment to advocacy and care is frequently leveraged against them, leaving many clinicians trapped in a system that demands far more than it gives. Addressing these challenges requires a critical examination of agency policies, funding structures, and the broader MHSE to ensure that those providing essential mental health care are not themselves casualties of the system they serve.

### ***Ethical and Moral Dilemmas in Community Mental Health***

The systemic nature of burnout among CMH clinicians is deeply rooted in structural and organizational challenges, intensifying feelings of frustration, helplessness, and moral distress.

These ethical and moral dilemmas arise as clinicians navigate overwhelming workloads, financial instability, and leadership structures that prioritize efficiency over clinical integrity. The MHSE further aggravates these tensions, as external pressures—such as funding constraints, insurance limitations, and bureaucratic inefficiencies—force clinicians to compromise aspects of their clinical work, creating profound ethical conflicts.

The COVID-19 pandemic exposed and amplified these systemic cracks, increasing the burden of care while agencies struggled to meet demand. Economic pressures and inadequate workplace policies placed clinicians in untenable positions, where they were expected to shoulder immense responsibility with minimal institutional support. Many clinicians found themselves caught between financial insecurity and professional obligations, particularly as salary stagnation and financial mismanagement by agency leadership left them in precarious positions. Some reported delayed or missing paychecks, adding to the emotional toll of already demanding work. At the same time, high caseloads continued to rise due to chronic understaffing and increased community need, forcing clinicians to make difficult choices about how to allocate their limited time and energy. As more clinicians left the field due to burnout, those who remained faced an even greater workload, creating a cycle of exhaustion that undermined both professional effectiveness and personal well-being.

Leadership plays a crucial role in shaping the ethical climate within CMH agencies, yet the structure of the MHSE often results in managerial decisions that prioritize fiscal sustainability over clinician well-being. Leaders with strong business acumen but little clinical experience may focus on productivity metrics, inadvertently pressuring clinicians to prioritize billable hours over comprehensive client care. Conversely, clinical leaders without administrative expertise may struggle to navigate funding structures or advocate for necessary resources,

leading to operational disorganization that further burdens staff. In both cases, a lack of transparent communication and advocacy for clinicians intensifies the moral dilemmas they face. Research has demonstrated that poor leadership directly contributes to burnout by undermining job satisfaction, employee morale, and retention (Hobfoll et al., 2018; Scanlan & Still, 2019). Within this environment, clinicians often find themselves navigating impossible ethical choices—whether to meet agency demands by sacrificing the depth of care they provide or to uphold clinical integrity at the risk of professional consequences.

These ethical tensions take a profound emotional and physical toll, often leading to moral distress—a state in which clinicians recognize the right course of action but feel powerless to act due to systemic constraints. Over time, this distress can result in compassion fatigue, making it more difficult for clinicians to engage empathetically with clients. Many report feelings of guilt, professional inadequacy, and alienation from their work, exacerbating burnout and diminishing their ability to sustain a long-term career in CMH. Research has shown that unresolved ethical dilemmas not only deepen emotional exhaustion but also reduce clinicians' capacity for resilience, ultimately threatening the sustainability of the workforce (Simionato & Reid, 2019).

The interconnected nature of these challenges underscores the urgent need for systemic reform. Without structural change, clinicians will continue to bear the weight of ethical conflicts that are not of their making, navigating a system that demands more than it gives. Addressing these issues requires a shift toward policies that prioritize clinician well-being, transparent leadership practices, and financial investments that ensure ethical care delivery is sustainable. Only by acknowledging and addressing these systemic failures can CMH agencies create an environment where clinicians are empowered to uphold their ethical commitments without compromising their own well-being.

### *Being Grounded in Purpose as a Form of Resilience*

Despite the many systemic contributors to burnout, CMH clinicians demonstrate remarkable resilience, often anchored in a deep sense of purpose and commitment to social justice. Their ability to persist in the face of overwhelming challenges is shaped by multiple protective factors, including strong professional and personal communities, supportive organizational structures, and a commitment to self-awareness. These factors collectively help clinicians maintain their motivation and sustain their work in an environment that can otherwise feel unsustainable.

A critical source of resilience for many clinicians is their connection to a larger mission of social justice and equity. Many enter CMH work with a passion for serving marginalized communities, addressing systemic inequalities, and advocating for equitable access to mental health care. This sense of purpose acts as a guiding force, helping clinicians push through the emotional and physical exhaustion that often accompanies their roles. Research has shown that professionals with a strong sense of purpose experience greater job satisfaction and are better equipped to manage occupational stressors (Scanlan & Hazelton, 2019). However, staying grounded in this mission requires more than individual motivation—it is sustained through relationships, leadership structures, and organizational cultures that support rather than erode clinicians' values.

Community, both within and outside the workplace, serves as a vital buffer against burnout. The shared experience of navigating a demanding field fosters camaraderie among clinicians, whether through informal peer support, clinical supervision, or personal relationships outside of work. Feeling part of a collective reduces the isolation that can accompany burnout and reinforces the shared commitment to advocacy and client care. Research highlights that

professional networks and social support mitigate stress and enhance emotional resilience (Skovholt & Trotter-Mathison, 2016). Many clinicians report that the encouragement of colleagues and mentors is what allows them to continue in the field, even in the face of systemic challenges.

While individual resilience is important, organizational structure and leadership play a critical role in either reinforcing or undermining clinicians' ability to remain grounded in their purpose. Transparent leadership, stable policies, and a work environment that values clinicians' well-being and values create a foundation for professional sustainability. When agencies invest in supportive supervision, clear communication, and consistent structural practices, clinicians report feeling more empowered to do their work effectively. Research has demonstrated that well-structured organizations reduce role ambiguity and create conditions where employees can thrive rather than simply endure (Green et al., 2014). Unfortunately, when leadership is disorganized or driven primarily by financial priorities, the very structures meant to support clinicians can instead become sources of additional stress.

Self-awareness is another essential component of resilience. Clinicians who recognize their limits, actively manage stress, and set clear professional boundaries are more likely to sustain themselves in CMH work long-term. Developing self-awareness allows them to balance their personal and professional identities, ensuring that their commitment to helping others does not come at the expense of their own well-being. This aligns with research on emotional intelligence, which highlights self-awareness as a key factor in managing workplace stress and preventing emotional exhaustion (Goleman, 1995). Clinicians who prioritize self-care—whether through therapy, supervision, or intentional personal time—are often better able to maintain the emotional capacity needed for their work.

Ultimately, the MHSE itself is both a source of strain and a determinant of resilience. While it often creates conditions that fuel burnout, it also contains the potential for reform—if structures and leadership prioritize clinician well-being alongside client care. Burnout among CMH clinicians is not simply an individual issue but a reflection of how the ecological system that delivers care frequently undermines the professionals who provide it. By fostering stronger community connections, improving organizational policies, and cultivating self-awareness, clinicians can remain grounded in their purpose, transforming resilience from an individual act of endurance into a collective force for systemic change.

### **Implications**

These findings contribute to and challenge existing knowledge about burnout among CMH clinicians by emphasizing its systemic nature within the MHSE. Although prior research has extensively documented individual-level contributors to burnout—such as emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Leiter, 2016)—this study expands the focus to include broader ecological forces shaping burnout. For example, these findings align with research highlighting the role of structural issues, such as inadequate compensation and high caseloads, in driving clinician burnout (Kim et al., 2021). However, they challenge the predominant framing of burnout as an individual deficit by demonstrating how systemic factors, including poor leadership, inadequate organizational support, and societal pressures, perpetuate cycles of clinician overwhelm and turnover.

Additionally, the study findings underscore the dual role of CMH clinicians as both agents of care and victims of systemic exploitation, particularly when their desire to help is undermined by exploitative practices like prioritizing productivity over well-being. This insight adds to the growing body of literature on moral injury in healthcare settings that posits that

systemic barriers to providing quality care create ethical distress and professional dissatisfaction (Dean et al., 2019). Furthermore, the study introduces protective factors such as workplace community, clear organizational structures, and self-awareness, which align with and extend existing knowledge by emphasizing their interdependence within the MHSE. Addressing burnout will require shifting from individually focused interventions toward systemic reforms that create sustainable work environments, further challenging traditional approaches to burnout prevention and intervention (West et al., 2020).

Importantly, these findings highlight the urgent need for systemic interventions, policies, and practices that address the ecological contributors to burnout among CMH clinicians. Existing research emphasizes that addressing burnout effectively requires interventions that go beyond individual-level solutions to focus on broader organizational and systemic reforms (Maslach & Leiter, 2016; West et al., 2020). For instance, the study underscores the need for targeted support at key stages of a clinician's career, beginning with graduate and certification training programs that provide accessible and affordable pathways into the field. Reducing barriers to licensure, such as offering subsidized or employer-sponsored supervision and decreasing the financial burden of continuing education units (CEUs), could further alleviate early-career stress and improve workforce retention (Kim et al., 2021).

Implementing competitive pay structures with comprehensive benefits is critical to addressing the financial strain identified as a subtheme of burnout. Such reforms not only provide financial stability but also convey the value of clinicians' work, potentially increasing job satisfaction and professional longevity (Hall, Korn & Shapiro, 2024). Clear and transparent pathways for promotion, combined with leadership training programs within clinical education pipelines, could also mitigate the impact of poor leadership and provide clinicians with

opportunities to transition into administrative roles with adequate preparation and support. For example, better training structures for clinical administrators could prioritize both managerial competencies and an understanding of the emotional and ethical challenges of frontline clinical work, ensuring leadership that is both effective and empathetic (Dean et al., 2019).

Finally, addressing caseload management through evidence-based staffing models and reducing productivity quotas can create a more sustainable work environment, directly combating burnout caused by high caseloads and insufficient resources. These systemic reforms align with research advocating for structural changes in healthcare organizations to reduce moral injury and promote clinician well-being (Shanafelt & Noseworthy, 2017). Together, these interventions will foster a more supportive and sustainable MHSE, one that ensures that clinicians are equipped to thrive within the field while delivering high-quality care to underserved and deserving populations.

### **Limitations**

This dissertation research, valuable in its exploration of CMH clinicians' experiences of burnout, is subject to several limitations inherent in its methodology and sample. The study aimed to follow the standard IPA methodology of recruiting 10 participants, which allows for depth but limits the breadth of perspectives. Recruitment challenges necessitated that the study end recruitment with a total of nine participants. Although not far from the goal, this number of interview participants could impact the depth of data received. Furthermore, the lack of diversity within the sample, with the majority of participants identifying as female and falling within the six to ten years range of experience, limits the representativeness of the findings. These factors may reduce the transferability of the insights to other demographic or professional contexts.

## **Future Directions for Research**

Future research should address gaps revealed in this study to further advance understanding of burnout within the MHSE. Future studies should include a more diverse sample, incorporating clinicians of varied genders, racial and ethnic identities, and professional experience levels to better capture the nuanced ways burnout manifests across different demographic and systemic contexts. Additionally, exploring the experiences of early-career clinicians, particularly those in their first five years, will provide critical insights into the transition from training to practice and the unique vulnerabilities of this population. Researchers could also examine the effectiveness of systemic interventions, such as reduced financial barriers for licensure, improved workplace policies, and leadership training in mitigating burnout. Using mixed-methods approaches, future studies could combine IPA's depth with broader surveys to enhance the generalizability of findings. Finally, examining burnout through longitudinal designs can illuminate how experiences of burnout and resilience evolve over time, particularly in response to systemic reforms or external pressures like public health crises.

## **Conclusion**

This study explored how the MHSE shapes experiences of burnout among CMH clinicians. The findings highlighted three themes: exploitation, ethical and moral dilemmas and being grounded in purpose. The themes underscore the interconnected challenges and resilience within the MHSE, revealing how systemic issues of inadequate compensation, high caseloads, poor leadership, and structural inefficiencies exacerbate burnout, while being grounded in purpose can buffer its effects. The findings point to the need for systemic solutions that address these structural deficits, beginning with reforms in training, licensure, and workplace policies to foster longevity and sustainability in the field. Ultimately, this research contributes to a deeper

understanding of how systemic conditions within CMH shape clinicians' well-being and effectiveness, emphasizing the urgency of addressing these issues to protect those who care for society's most vulnerable populations.

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## Appendix A: Demographic Questionnaire

1. Participant Name
2. Age
3. Gender identity:
  - a. Male
  - b. Female
  - c. Non-binary
  - d. Transgender
  - e. Other
  - f. Prefer not to say
4. Race:
  - a. White
  - b. Black/African American
  - c. American Indian/Alaska Native
  - d. Asian
  - e. Native Hawaiian/ Other Pacific Islander
  - f. Other
5. Ethnicity
  - a. Hispanic/Latino
  - b. Non Hispanic/Latino
6. Location (city and state)

## Appendix A: Screening Questionnaire

7. Licensure info:
  - a. State(s)
  - b. Type of licenses (drop down options)
    - i. LMFT
    - ii. LPC
    - iii. LCSW
    - iv. LCMHC
    - v. Other (participants write in answer)
  - c. Are you provisionally or fully licensed? (drop down options)
    - i. Yes
    - ii. No
8. How many years have you been practicing post-graduate school? (drop down options)
  - a. 1-5 years
  - b. 6-10 years
  - c. 11-15 years
  - d. 16+ years
9. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), community mental health agencies meet one of the following requirements:
  - a)** be a nonprofit organization, **b)** part of a local government behavioral health authority,
  - c)** an entity operated under authority of the IHS, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS pursuant to the Indian Self-Determination Act, or **d)** an entity that is an urban Indian organization

pursuant to a grant or contract with the IHS under Title V of the Indian Health Care Improvement Act (SAMHSA, 2022).

Does your CMH organization fit the definition provided by SAMHSA? (drop down options)

i. Yes

ii. No

b. Name of current organization: (participants write in their answers)

10. Are you currently working at a community mental health center (CMHC)? (drop down options)

a. Yes (jump to Q7)

b. No (jump to Q6)

11. If you answered “No” to the previous question, were you employed at a CMHC within the last year?

a. Yes (jump to Q12)

b. No (jump to end of survey)

12. How long have you worked in CMH?

a. Less than 1 year

b. 1-5 years

c. 6-10 years

d. 11-15 years

e. 16+ years

13. While employed with your CMHC, did you provide direct client care?

a. Yes (jump to Q14)

b. No (jump to end of survey)

14. Please read instructions carefully on how to complete the Maslach Burnout Inventory

(MBI) below:

### Appendix B: Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI) is the most commonly used tool to self-assess whether you might be at risk of burnout. To determine the risk of burnout, the MBI explores three components: exhaustion, depersonalization and personal achievement. While this tool may be useful, it must not be used as a scientific diagnostic technique, regardless of the results. The objective is simply to make you aware that anyone may be at risk of burnout. (Thank you to the Association des médecins vétérinaires (AMVQ) en pratique des petits animaux for providing us with a copy of this tool).

For each question, indicate the score that corresponds to your response. Add up your score for each section and compare your results with the scoring results interpretation at the bottom of this document.

Questions	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
<b>SECTION A</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
I feel emotionally drained by my work.							
Working with people all day long requires a great deal of effort.							
I feel like my work is breaking me down.							
I feel frustrated by my work.							
I feel I work too hard at my job.							
It stresses me too much to work in direct contact with people.							
I feel like I'm at the end of my rope.							
<b>Total score – SECTION A</b>							

Questions	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
<b>SECTION B</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
I feel I look after certain patients/clients impersonally, as if they are objects.							
I feel tired when I get up in the morning and have to face another day at work.							
I have the impression that my patients/clients make me responsible for some of their problems.							
I am at the end of my patience at the end of my work day.							
I really don't care about what happens to some of my patients/clients.							
I have become more insensitive to people since I've been working.							
I'm afraid that this job is making me uncaring.							
<b>Total score – SECTION B</b>							

Questions	Never	A few times per year	Once a month	A few times per month	Once a week	A few times per week	Every day
<b>SECTION C</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>
I accomplish many worthwhile things in this job.							
I feel full of energy.							
I am easily able to understand what my patients/clients feel.							
I look after my patients'/clients' problems very effectively.							
In my work, I handle emotional problems very calmly.							
Through my work, I feel that I have a positive influence on people.							
I am easily able to create a relaxed atmosphere with my patients/clients.							
I feel refreshed when I have been close to my patients/clients at work.							
<b>Total score – SECTION C</b>							

## **SCORING RESULTS - INTERPRETATION**

### **Section A: Burnout**

Burnout (or depressive anxiety syndrome): Testifies to fatigue at the very idea of work, chronic fatigue, trouble sleeping, physical problems. For the MBI, as well as for most authors, "exhaustion would be the key component of the syndrome." Unlike depression, the problems disappear outside work.

- Total 17 or less: Low-level burnout
- Total between 18 and 29 inclusive: Moderate burnout
- Total over 30: High-level burnout

### **Section B: Depersonalization**

"Depersonalization" (or loss of empathy): Rather a "dehumanization" in interpersonal relations. The notion of detachment is excessive, leading to cynicism with negative attitudes with regard to patients or colleagues, feeling of guilt, avoidance of social contacts and withdrawing into oneself. The professional blocks the empathy he can show to his patients and/or colleagues.

- Total 5 or less: Low-level burnout
- Total between 6 and 11 inclusive: Moderate burnout
- Total of 12 and greater: High-level burnout

### **Section C: Personal Achievement**

The reduction of personal achievement: The individual assesses himself negatively, feels he is unable to move the situation forward. This component represents the demotivating effects of a difficult, repetitive situation leading to failure despite efforts. The person begins to doubt his genuine abilities to accomplish things. This aspect is a consequence of the first two.

- Total 33 or less: High-level burnout
- Total between 34 and 39 inclusive: Moderate burnout
- Total greater than 40: Low-level burnout

**A high score in the first two sections and a low score in the last section may indicate burnout.**

***Note:** Different people react to stress and burnout differently. This test is not intended to be a scientific analysis or assessment. The information is not designed to diagnose or treat your stress or symptoms of burnout. Consult your medical doctor, counselor or mental health professional if you feel that you need help regarding stress management or dealing with burnout.*

### Appendix C: Interview Protocol

1. Can you please confirm the following demographic information:
  - a. Pseudonym
  - b. Type of license(s) you hold
  - c. Number of years you've been a licensed clinician
  - d. Type of CMHC you work in as defined by SAMHSA

I would like to begin by asking some questions related to working in community mental health service.

2. First, how did you become interested in the specialty of community mental health?

Thank you so much for sharing your experience. Now, I would like to ask you some questions about **burnout**. For this study, burnout is a syndrome of physical and emotional exhaustion developing from the results of negative self-concept, negative job attitude, and a loss of concern or feeling for clients (Rosenberg & Pace, 2006).

3. Based on this definition, do you identify with being burnt out? Why or why not?
4. Based on your experience, what has contributed to your experience of burnout?
5. What consequences have you experienced due to being burnt out? (*Theme: Consequences of Burnout*)
6. Based on your experience of burnout, what are/were contributing risk factors? (*Theme: Risk Factors*)
7. Have you ever encountered an ethical or moral dilemma while working at your CMHC? If so, what were the circumstances?
8. What are some protective factors that helped you manage burnout or that you wish existed to assist with burnout prevention? (*Theme: Protective Factors*)
9. How do you cope with burnout when you are at work?
  - a. How does/did your CMHC assist in combating burnout within the organization?
10. How do you cope with burnout when you are at home?
11. If you had a magic wand, what is the first organizational aspect you would change to decrease burnout specifically for community mental health clinicians?
12. Is there anything else you would like to add related to your experience of burnout?