

EXPERIENCING MEANINGFUL WORK AND BURNOUT
IN COMMUNITY MENTAL HEALTH

By

Edward Suarez, Jr.

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Approved:

Leihua Edstrom, Ph.D., Program Director, Chair

Matt Nelson, Ph.D., Dean, Committee Member

Becky Frink Sherman, Ph.D., Committee Member

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Abstract

The purpose of this study was to examine community mental health staff, the depth to which they are experiencing their work as meaningful, and the level of burnout they are experiencing. Though research on burnout in community mental health is plentiful, existing research has not adequately addressed the role of experiencing meaningful work in community mental health. Thus, I examined whether or not meaningful work and burnout have an inverse relationship. This is one of the first studies to use the Work and Meaning Inventory (WAMI) and the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) together. Participants were individuals currently working in community mental health. Once the data was retrieved, a backwards, stepwise multiple regression analysis was calculated to determine if there is a relationship between total meaningful work score from the WAMI and each of the subscales of the MBI-HSS. Results suggest a significant predictable relationship between work meaning, emotional exhaustion, depersonalization, and personal accomplishment.

Keywords: burnout, meaningful work, community mental health

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Chapter One

Research has indicated that members of today's workforce are requesting that companies implement ways to increase meaning in the work lives of their employees (De Klerk, 2005). Employees today are increasingly seeking significance in their work and purpose in their lives (De Klerk, Boshoff, & Van Wyk, 2006; Diddams, Whittington, & Davigo, 2005). Work not only provides a way to earn a living through wages, but it also provides the opportunity to offer significance and meaning for individuals. Because work is a part of one's existence, it can provide an arena in which people can search for meaning (DeKlerk, 2005). By 2025, millennials will make up the majority of the workforce, and they have been found to value meaningful work more than they value money (Michels, 2015). Thus, the search for meaning in work is likely to gain momentum as millennials begin to find their career paths.

Work can be a purposeful activity, one in which both its content and results can influence its meaning (Brief & Nord, 1990). For the most part, the majority of individuals want to be working toward a goal or purpose of some kind. Healthcare settings such as hospitals, clinics, and community mental health centers in particular are workplaces that provide significance, meaning, and purpose. Community mental health centers represent one such example. The purpose of community mental health centers is to provide services to community members who are experiencing mental health symptoms.

I have spent the past seven years working in community mental health (2011-2018). During that time, I have witnessed staff members working to heal their clients by providing various types of service. These services include counseling, case management, psychiatric medication management, chemical dependency treatment, crisis interventions, intensive

outpatient treatment, and transitional housing programs. Time spent working in mental health has provided me an opportunity to gain an understanding of the meaning behind the work.

Embedded within the pursuit of helping another person is a great sense of purpose and meaning. At the same time, the meaning behind the work does not safeguard the mental health staff member from the pressures of dealing with clients who are considered high risk and high need on a daily basis. Though the work might be meaningful, employees at community mental health centers are burning out at an alarming rate (Onyett, 2011). Although scholarly articles investigating burnout among mental health professionals exist (Acker, 2010; Acker & Lawrence, 2009; Bakker, 2009; Freudenberger, 1974; Maslach, 1976; Maslach & Jackson, 1981; Morse, Salyers, Rollins, Monroe-Devita, & Phafter, 2012), researchers have not spent significant time observing whether or not mental health staff members are experiencing their work as something meaningful. Furthermore, few researchers have been able to examine whether or not experiencing work as something meaningful reduces the risk of burnout (Salyers et al., 2011; Tei et al., 2014).

The few researchers who have been able to investigate the phenomenon have suggested that medical professionals who experience their work as meaningful are less likely to suffer from burnout (Salyers et al., 2011; Tei et al., 2014). Tei et al. (2014) reported that burnout has become a pervasive problem and that programs to prevent it should be introduced. Their findings have provided evidence that “enhancement of sense of meaning in one’s work can have protective effects on burnout, thereby improving quality of care” (Tei et al., 2014, p. 123). But Tei et al. suggested that further research is needed to better understand how promoting a sense of meaning in one’s work could impact burnout.

The following sections will define burnout and explain how it impacts clinicians, organizations, clients, and the community. I will then explain how assessing meaningful work might help explain the symptoms of burnout and might help create interventions that increase meaningful work as Tei et al. (2014) suggested. This study is being conducted to add relevant findings to research investigating meaningful work and burnout. Understanding the dynamics involved between burnout and meaningful work might lead future researchers and practitioners towards creating interventions that could one day save professionals who are working in the community mental health industry from experiencing burnout.

Burnout

Definition and origins. Burnout in mental health workers is an important issue in today's workforce. Burnout is defined as a condition that occurs when a provider of services becomes emotionally and physically exhausted (Maslach & Leiter, 2005). Maslach, Schaufeli, and Leiter (2001) described burnout as something that "is more of a social phenomenon than a personal one" (p. 409) and refers to chronic interpersonal stressors on the job.

Burnout is often conceptualized as a syndrome that affects the employee's psyche and emotional health (Maslach & Leiter, 2005). It does not materialize instantly but through a gradual process, where the worker becomes emotionally, mentally, and physically exhausted from providing service to other people (Maslach & Leiter, 1997). The basis of burnout research can be found in Freudenberger's studies with social service workers during the 1970s and early 1980s (Freudenberger, 1974; Maslach & Jackson 1982). It was Freudenberger who coined the term burnout, and researchers used this term to define the phenomenon of work-related mental and emotional exhaustion.

Maslach conducted the first empirical research on burnout in the mid-1970s to better understand how the phenomenon was affecting human service providers, such as police officers, teachers, and social workers (Maslach, 1976). Maslach viewed burnout as a syndrome and risk factor for those in the human services field, and her research led to the development of the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1982). Maslach developed and defined three components to measure and explain burnout. These components are used most often in research to define and measure the symptoms of burnout (Morse et al., 2012).

Maslach and Jackson (1982) named the first component of burnout emotional exhaustion. This refers to feelings of being overextended and depleted of emotional and physical resources. The second component was termed depersonalization. This refers to the worker having a cynical, negative attitude toward clients and co-workers and an excessive detachment from various aspects of the job. The third component of burnout is reduced personal accomplishment. This third component refers to the outcome of the stress-strain-coping sequence and is defined as a perception of a lack of enthusiasm and effectiveness that comes from working with people (Maslach & Jackson, 1982).

Burnout in human services. Burnout amongst mental health staff is a condition that continues to be examined. Researchers have focused on various contributing factors of burnout. Two good examples are Hardiman and Simmonds (2012) and Lasalvia et al. (2009). Hardiman and Simmonds (2012) studied spiritual well-being and emotional exhaustion in mental health workers, and Lasalvia et al. (2009) studied the impact of burnout on the recipients of mental health care services. Researchers have also continued to explore new approaches to previous burnout research, including job satisfaction and compassion fatigue (Ray, Wong, White, & Heaslip, 2013; Rossi et al., 2012).

As stated in the Introduction, one type of organization in which burnout is occurring at a consistent rate is community mental health centers (Onyett, 2011). Some researchers have found burnout rates in mental health workers as high as 50%, making this issue paramount to address (Lasalvia et al., 2009). Community mental health staff ranging from chemical dependency counselors, case managers, therapists, nurses, psychologists, and psychiatrists are at high risk for burnout (Covington, 2007). This could be due to lack of prestige in their job and poor wages. Clinicians can experience great difficulty working on a daily basis with clients who deny their problems, are homeless, lack the motivation to change, relapse, have considerable health problems, are involved with the legal system, and sometimes have co-occurring mental health disorders (Ducharme, Knudsen, & Roman, 2008; Garner, Knight, & Simpson, 2007; Lasalvia et al., 2009; McNulty, Oser, Johnson, Knudsen, & Roman, 2007).

Although burnout can occur in other occupations, it is most commonly seen in the human service industry due in part to the emotional aspect of the relationship between caregiver and client (Ducharme et al., 2008). Maslach et al. (1997) stated that burnout is tied to work that is demanding and involves emotional investment. It is the emotional contact and investment that differentiates burnout from occupational stress. This helps explain why mental health staff members are susceptible to suffering from the symptoms of burnout and why burnout is well documented in mental health workers (Lee, Lim, Yang, & Lee, 2011).

Statistics. Morse et al. (2012) reviewed the results from eight burnout studies and discovered that 21% to 67% of mental health workers were found to be experiencing high levels of burnout. Additionally, Webster and Hackett (1999) administered the MBI to 151 community mental health workers and found that 54% had high emotional exhaustion and 38% reported high depersonalization rates, but most participants reported high levels of personal accomplishment as

well. Siebert (2005), wanting to explore burnout in mental health professionals, surveyed 751 social workers. Of the 751 participants, 36% scored in the high range of emotional exhaustion. Furthermore, Rohland (2000) used a supplementary single item burnout measure and found that 18% of the participants endorsed the statement: "I currently have problems with burnout". Moreover, when a sample of 29 directors of community mental health centers in Iowa were given the MBI, over 33% reported high emotional exhaustion and low personal accomplishment. Additionally, nearly 50% reported high levels of depersonalization (Rohland, 2000).

In another study, 71 forensic mental health staff members were surveyed, and 54% of them reported high rates of emotional exhaustion (Oddie & Ousley, 2007). This study was conducted in the United Kingdom, and prior UK study findings reviewed by Oddie and Ousley (2007) revealed a range indicating that 21% to 48% of mental health workers experienced high emotional exhaustion. These statistics indicate that the prevalence of burnout amongst mental health staff workers is significant. Many factors contribute to the high prevalence of burnout, and some of these factors will be discussed in the following sections.

Demographics. Personal characteristics such as age, gender, and educational level have been associated with burnout (Lim, Kim, Kim, Yang, & Lee, 2010; Rupert & Kent, 2007). Among demographic factors, researchers have observed a negative relationship between age and emotional exhaustion (one of the subscales of burnout), showing that older individuals are less likely to experience emotional exhaustion (Ackerley, Burnell, Holder, & Kurdek, 1985; Maslach et al., 2001). Research has also indicated that employees under the age of 30 appear to be at higher risk for burnout than are employees between the ages of 30 and 40 (Maslach et al., 2001; Rupert & Kent, 2007).

Jiang, Yan, and Shuyue (2004) also studied the relationship between age and burnout in certain mental health professionals. They examined 171 counseling psychologists using the MBI and a demographic questionnaire. Jiang et al. reported that younger counseling psychologists experienced a higher level of emotional exhaustion than older counseling psychologists did. These researchers also found that counselors with less experience (less than one year) experienced lower personal accomplishment than those who had more experience. Marital status and education did not show a significant effect on burnout in this study.

In contrast to the relatively consistent results based on age, results based on gender have been inconsistent, with some study findings supporting higher burnout levels among women (Maslach et al., 2001), while others have revealed higher burnout levels in men (Ackerley et al., 1985). Maslach and Jackson (1985) conducted their own research in this area. One study consisted of 845 participants who were asked to take the MBI to measure their levels of burnout. Results showed that women were less vulnerable to burnout than men were (Maslach et al., 1985). However, the difference was very small, suggesting that the sex of the employee might not be a major factor in occupational burnout.

Findings from the same study also showed that participants who were married or had children experienced less burnout than participants who were single or who had no children (Maslach et al., 1985). The research exploring sex differences in experiences of overall burnout in mental health staff is equivocal at best, except that men tend to have higher scores on the dimension for cynicism/depersonalization and women tend to have higher scores on the emotional exhaustion dimension (Maslach et al., 2001; Purvanova & Muros, 2010; Rupert & Morgan, 2005).

In addition to gender, race and ethnicity are demographic areas that researchers have explored to determine possible factors that contribute to burnout in mental health professionals (Gilbody et al., 2006; Maslach et al., 2001; Rupert & Morgan, 2005). For example, Salyers and Bond (2001) utilized the MBI to examine the effects of racial differences in burnout among case managers working with clients with severe mental illness. They found that African American case managers reported significantly less emotional exhaustion and depersonalization than case managers from other ethnicities did. There were no differences in feelings of personal accomplishment.

Another demographic contributor to high rates of burnout seems to involve level of education (Maslach et al., 2001; Thomas, Kohly, & Choi, 2014). Research suggests that a high level of education might be related to burnout rates (Thomas et al., 2014). However, the explanation for these findings is not very clear. Even though a high level of education is associated with high socioeconomic status, it also comes with higher levels of responsibility at work and more stress (Maslach et al., 2001).

Occupational factors. Maslach (1982) identified several non-demographic factors that contribute to burnout among mental health and human services employees: (a) working with families in crisis, (b) receiving little positive feedback or support, (c) having an external locus of control, (d) a lack of power or control to change problems combined with the influence of funding source requirements, (e) difficulty in defining one's role as a result of conflict between implicit and explicit rules governing the client/worker relationship, (f) difficulty in changing careers due to narrow experience in a field, (g) a demanding workload, (h) low social support, and (i) feeling ineffectual.

Burnout can occur in any occupation. However, research findings have revealed that certain types of professionals appear to be more prone to the symptoms of burnout than are other professionals. Research within the last two decades has demonstrated that practitioners in the helping professions experience high levels of burnout (Gilbody et al., 2006; Golembiewski & Munzenrider, 1988; Leiter & Schaufeli, 1996; Maslach et al., 2001; Salyers, Rollins, Kelly, Lysaker, & Williams, 2013). Physicians, nurses, teachers, special educators, psychologists, social workers, and mental health workers have been identified as ultimate candidates for occupational burnout (Maslach et al., 2001).

Researchers have suggested that mental health service workers are susceptible to burnout because of having to deal with high risk or high need clients on a constant basis (Hellmann Morrison, & Abramowitz, 1986; Phillips, Andrews, & Hickman, 2014). In fact, therapists who served clients displaying negative behavior were at higher risk for burnout than were therapists who served clients who did not display negative behavior (Hellman et al., 1986). High risk and high need clients being served at community mental health centers are at risk to relapse, to disengage with services, or to be arrested (Phillips et al., 2014). These are variables over which the clinician has little control. Unfortunately, researchers discovered that mental health staff who felt as though they had little control to change outcomes significantly correlated with emotional exhaustion and low personal accomplishment (Ackerley et al., 1985; Hellman et al., 1986; Morse et al., 2012).

In addition, the number of years in direct practice was negatively correlated with emotional exhaustion and depersonalization (Ackerley et al., 1985). Researchers do not yet know why this is the case, though researchers have proposed that there is a survivor bias (Maslach et al., 2001). Survivor bias means that employees who do not quit early in their careers

are likely to report lower levels of burnout (Maslach et al., 2001). In addition to job-related stressors (e.g., workload, time pressure, role conflict, etc.), mental health professionals experience high levels of client-related stressors such as difficulties interacting with clients, frequency of interaction with chronically or terminally ill clients, and other stressors that the client might be bringing in to the session. This creates a “compounding effect,” which increases their risk of burnout (Maslach et al., 2001). Often, the compounding effect can be seen at community mental health centers. The next section will describe organizational factors related to burnout.

Organizational factors. Maslach et al. (2001) stated that research in the area of organizational characteristics related to burnout is still new and that employment opportunities in which employees are having to give excessive time, effort, skills, and flexibility for less than satisfactory career opportunities, lifetime employment, and job security need more attention. Today’s mental health care system exists within a business model that is always evolving and is dependent on managed care and controlled costs (Acker & Lawrence, 2009). For the mental health staff, managed care has increased paperwork, stressful role confusion, and managerial changes (Acker & Lawrence, 2009).

In terms of location and type of clinical setting, Prosser et al. (1997) found differences in burnout and related factors between in-patient and community-based work settings. They found that in-patient staff experience lower levels of burnout and work stress compared to community-based staff. Also, mental health professionals in private practice reported experiencing less emotional exhaustion and depersonalization as well as more personal accomplishment, and thus were at less risk to experience burnout than were community-based mental health professionals (Ackerley et al., 1985; Shinn, 1982). More recently, Rupert and Kent (2007) found higher levels

of personal accomplishment for psychologists working independently or in group practices compared to psychologists working in “agency” settings, such as hospitals or community-based programs.

Within the organization or clinical setting, lack of support from supervisors has been found to correlate more highly with burnout than lack of support from colleagues has (Maslach, Schaufeli, & Leiter, 2001). Research has shown that disorganized community mental health centers can increase symptoms of burnout and lack of personal accomplishment (Salyers et al., 2015). Furthermore, supervisors at community mental health centers have so many clinicians working under them that they are unable to appropriately support the individuals with proper supervision. Other job factors linked to burnout included lack of autonomy, lack of feedback, and low levels of participative decision-making (Maslach, 2001).

Regarding counseling in the community mental health system, workers are placed in a position in which they must constantly convey active presence of emotion or active suppression of emotion to get the job done effectively. Research has suggested that this level of emotional labor accounts for a significant amount of variance in levels of burnout (Zapf, Seifert, Schmutte, Mertini, & Holz, 2001). Organizational characteristics at community mental health centers, such as (a) operating policies and procedures; (b) paths for career growth in hierarchical, bureaucratic, or non-profit environments; and (c) policies for work-family balance can impact the professional’s perceptions of fairness, value, and autonomy and are highly likely to contribute to levels of burnout (Maslach et al., 2001).

Though methodological complications are common in many prevalence studies (Lim, Kim, Kim, Yang, & Lee, 2010; Tam, Shui, Kee, & Mong, 2012; Thomas, Kohli, & Choi, 2014), the rates across studies indicate that burnout might indeed be widespread among mental health

workers, and there is reason to believe that rates will remain on the upswing (Morse et al., 2012). Community mental health staff work in a paradigm in which they are at times dependent on external funding such as grants and government contracts. Regardless of how much money comes in to the mental health agency, the costs for employee healthcare benefits and other expenses continue to rise.

Thus, mental health agencies are increasing standards in “staff productivity” for billable services. In an already stressful work setting, the added burden of meeting these obligations is likely to trigger greater levels of burnout (Morse et al., 2012; Salyers et al., 2013). In fact, some of the first researchers to observe burnout in mental health workers found that high numbers of patients and ambiguity in the job environment have greatly affected the levels of burnout among therapists (Gann, 1979).

Consequences. The consequences of burnout are numerous and can be seen at both organizational and personal levels (Zapf et al., 2001). Stages of burnout begin with various forms of physical job withdrawal (Maslach et al., 2001). Some employees might spend as little time at work as possible, might take very long breaks, and might sometimes avoid going to work altogether. This is quickly followed by emotional detachment. Burned-out staff members who stay at their jobs exhibit lower productivity and effectiveness. Additionally, burnout can lead to consequences for the counselor, for the organization, and for the client (Lasalvia et al., 2009). This can lead to diminished work satisfaction and reduced professional commitment, which usually negatively affect other workers and the client (Burke & Greenglass, 2001).

Consequences on physical and mental health. Negative health symptoms have also been linked to mental health worker burnout. Acker (2010) surveyed 591 social workers in New York and found that high levels of burnout, predominantly emotional exhaustion and

depersonalization, were related to workers' increase in reporting flu-like symptoms and symptoms of gastroenteritis. Eventually, burnout might lead to physical and psychological problems. Excessive use of medication and alcohol is also common among social workers (Maslach et al., 2001), and burnout has been correlated with an increase of substance use in directors of mental health agencies (Rohland, 2000).

Stress and poor mental health represent additional negative health symptoms linked to burnout in mental health professionals. Mental health staff experiencing burnout have reported high levels of stress-related illness and mental health issues, including depression, anxiety, and decreased self-esteem (Morse et al., 2012). They have also reported increased rates of physical health problems such as insomnia, headaches, and a general increase in overall illness (Cherniss & Krantz, 1983; Ducharme et al., 2008; Garner, Knight, & Simpson, 2007; Oser, Biebel, Pullen, & Harp, 2013).

Consequences on home life. In addition to negative health symptoms, Burke and Greenglass (2001) reported that burnout leads to behaviors that cause deterioration in the personal lives of those afflicted. Typically, the individual transfers stress from the workplace into the home environment, resulting in intensified tension, anxiety, frustration, and anger. People suffering from burnout have a tendency to withdraw from family and friends, and over the course of time, family and friends experience increasing difficulty supporting the afflicted individual.

The obligations associated with working in human services require a certain type of emotional exertion that can use up a person's emotional energy, leaving them unable to communicate effectively at home. One study examining approximately 500 American psychologists found that conflict between work and family responsibilities resulted in higher

scores on all three dimensions of burnout than when conflict was absent (Rupert, Stevanovic, & Hunley, 2009). In addition, Rupert et al. (2009) found that the greater the work-family conflict a psychologist experienced, the greater the negative feelings experienced about his or her job, and as work demands increased, so did the conflict.

Bakker (2009) further examined the relationship between burnout at work for mental health professionals and its consequences on their home lives. Bakker presented findings from two separate studies that outline the impact of burnout on partners who are intimate with one another. The results of surveying intimate partners of burned-out medical residents and teachers illustrated that the partners' self-perceived health was low, and their depression was elevated. The medical residents who scored high on burnout also rated self-perceived health as low. This study was a follow-up from a previous study by the same researcher that illustrated a significant cross-over of job burnout between husbands and wives (Bakker, Demerouti, & Schaufeli, 2005).

Consequences on the organization. In addition to poor health symptoms and a deteriorating home life, burnout can also increase the chances of the mental health staff taking time off for medical and psychological issues. In time, rates of absenteeism in the clinic rise, sometimes to the point of turnover (Oser, 2013). High levels of turnover within a clinical workforce can significantly impact the quality of service a mental health agency provides (DeStefano, Petersen, Potter, & Zweig, 2003). When an organization faces high rates of absenteeism and turnover, this is financially draining to the organization. Agencies respond to burnout by consuming financial resources used to recruit, hire, and train new staff (Eby & Rothrauff-Laschober, 2012; Knight, Becan, & Flynn, 2012; Maslach, & Leiter 1997; Oser et al., 2013).

Burnout does not only cause some employees not to come to work, but it can also affect an employee's quality of performance while at work. Mental health staff experiencing burnout have low productivity, are less effective, and have more interpersonal conflicts than those counselors who are not experiencing burnout (Bowen & Twemlow, 1978; Cherniss & Krantz, 1983; McKay, 2009; Oser et al., 2013). People who are suffering from burnout tend to cause interpersonal conflict, which obstructs the job performance of their co-workers (Maslach & Jackson, 1982). This impacts the organization as a whole and can add stress at the workplace, which in turn might provide further opportunity for burnout to occur in other workers. Perhaps most ironic is that there are times when mental health professionals, who are devoted to helping others manage and overcome burnout, are suffering from the same issue, and their co-workers and colleagues can do little about it.

Consequences on the client. The client's commitment to participating in treatment is an integral part of mental health programs. Unfortunately, burnout can cause clients to de-commit to treatment. Findings from one study indicated that within out-patient, drug-free treatment programs, higher organizational stress led to burnout, and this was associated with lower client participation (Landrum, Knight, & Flynn, 2012). Additionally, clients engage in fewer high risk behaviors, remain abstinent from substances for a longer period of time, and are more involved in their treatment when they have positive, therapeutic relationships with their counselors. Conversely, the opposite occurs when clients form weak alliances with their counselors (Ducharme et al., 2008; McKay, 2009; Oser, 2013).

In regards to how the clinician perceives the client when experiencing burnout, Holmqvist and Jeanneau (2006) found a clinically significant correlation between feelings of burnout and negative perceptions of recipients and of the helping relationship. The strongest

correlations found were between low energy and emotional exhaustion and feelings of rejection and unhelpfulness in the client. In terms of patient satisfaction, multiple researchers have suggested that there is a reduction in client satisfaction when burnout spreads amongst a health care setting (Landrum, Knight, & Flynn, 2012; Oser, 2013; Vahey, Aiken, Sloane, & Clarke, 2004).

Garman, Corrigan, and Morris (2002) examined burnout among a treatment team at a psycho-social rehabilitation facility, and these researchers also found that higher burnout was predictive of lower client satisfaction. Furthermore, Leiter, Harvie, and Frizzell (1998) found that patients who were receiving care from in-patient facility nurses who reported emotional exhaustion and who expressed an intention to quit were less satisfied with the care they received. Along with participation and commitment, patients should feel some type of satisfaction from treatment for it to be effective (Garman et al., 2002). These research findings reveal that burnout is getting in the way of this critical step of the treatment process, and this is negatively impacting the client.

As all of the above findings illustrate, mental health professionals experience burnout for many reasons, and burnout negatively effects (a) the individuals who are experiencing it directly, (b) the people at home and at work with whom they interact, and (c) the community at large. The findings disclosed in this section indicate that there is a need to continue developing strategies and interventions focused on preventing burnout. Recent literature indicates that helping someone find meaning in their work might prevent burnout (Krasner et al., 2009; Steger, Littman-Ovadia, Miller, Menger, & Rothmann, 2012; Tei et al., 2014). The purpose of this study is to measure the strength of the relationship between experiencing meaning in work and experiencing burnout. The end goal is to supplement the existing literature, with the hope that

future scholars and practitioners can use the information in this study to develop interventions focused on increasing meaning and preventing burnout.

Burnout prevention intervention. There has been research focused on reducing staff burnout in the healthcare industry. Corrigan, McCracken, Edwards, Kommana, and Simpatico (1997) used a staff needs assessment and a program development committee to identify training needs. These needs were then addressed during behavioral rehabilitation training. Following eight months of meetings that involved trainings, the program reduced emotional exhaustion at the post-test among direct care staff. However, the program did not reduce emotional exhaustion among clinical staff working in psychiatric rehabilitation programs.

Ewers, Bradshaw, McGovern, and Ewers (2002) also attempted to reduce burnout in healthcare industry professionals. They provided training in psychosocial interventions to improve nurses' attitudes and coping skills and found substantial reductions in all three components of burnout (emotional exhaustion, depersonalization, and reduced personal accomplishments) at post-test for in-patient forensic psychiatric nurses. Their training program included educational information about severe mental health disorders and intervention strategies (e.g., engagement skills, rapport building, and interventions for disputing delusions and hallucinations).

Additionally, Krasner et al. (2009) developed a continuing medical education program for primary care physicians that used narrative exercises, mindfulness practices, and appreciative inquiry to help medical doctors increase communication skills and awareness. Using a pre and post-test design with multiple follow-up assessments over the span of 15 months, Krasner et al. reported significant reductions in all facets of burnout and improvements in mood.

Van Dierendonck, Schaufeli, and Buunk (1998) wanted to reduce staff burnout by reducing feelings of inequity in workers through improving the congruence between workers' "motives, needs, and capacities and the organizational demands and provisions" (p. 395). The program incorporated cognitive behavioral interventions (relaxation training and restructuring) for individual staff members. Supervisors were also trained in communication and social skills. The researchers reported a reduction in burnout, absenteeism, and feelings of being deprived over one year among the intervention group in a quasi-experimental design; however, research attrition was quite elevated. In all, 58% of the participants left the study after submitting only the first of three questionnaires. The surveys of the dropouts were still used, and researchers concluded that absenteeism in the study participants might have skewed the study results.

Furthermore, Scarnera, Bosco, Soleti, and Lacioni (2009) provided assertiveness training to mental health staff. In addition, they provided direct care staff with additional cognitive behavioral training for managing emotions while working with consumers who had severe mental illness. Managers received extra training on task planning, leadership styles, and supporting their staff. This study revealed decreased depersonalization at post-test and 18 months after baseline. Additionally, in another attempt to reduce burnout, a recent program for community mental health staff combined coping skills derived from cognitive-behavioral orientations with other strategies, including mindfulness, meditation, identification of personal meaning, and development of practices of gratitude in a one-day training intervention (Salyers et al., 2013). Results showed a reduction in emotional exhaustion and depersonalization and an increase in positive perceptions of consumers six weeks later. Both of these intervention studies also included time for participants to develop personal strategies for coping with their own individual stressors (Salyers et al., 2013; Scarnera et al., 2009).

An interesting and emerging set of strategies falls within the broad rubric of third generation cognitive behavioral interventions (Hayes, Follette, & Linehan, 2004). These interventions involve utilizing methods derived from spiritual practices or Eastern religions (e.g., meditation and mindfulness). Acknowledging that meditation is a coping mechanism to prevent burnout, Murphy (1996) found that meditation programs and programs that offered a combination of intervention strategies tended to be effective at reducing burnout. Regarding mindfulness, Hayes et al. (2004) used a randomized controlled trial and found that a one-day workshop that was centered on acceptance and commitment therapy reduced burnout for substance abuse counselors at post-training and after a three-month follow-up.

Preventing burnout by assessing meaning in work. The literature above suggests that interventions can reduce burnout among mental health staff. The limited existing literature that was reviewed clearly indicates the need for developing additional interventions and using more controlled research to evaluate these programs. These studies also illustrate another important issue: Although improving coping skills for stress is an important element for reducing burnout, preventing burnout by increasing other positive human qualities and abilities, such as a sense of meaning and purpose, has been the center of very few studies. Increasing such qualities and abilities were critical elements in the Krasner et al. (2009) program and in the Salyers et al. (2011) study.

As mentioned in the consequences of burnout sections of this paper from page 18 to 22, individuals who suffer from burnout become distressed, experience emotional detachment, and exhibit lower productivity and effectiveness at the workplace than individuals who do not suffer from burnout. According to Steger, Dik, and Duffy (2012), the same is true in individuals who lack meaning in their work, “Absence of work meaning may be predictive of poor work

engagement, low commitment to one's organization and intentions to leave, and low motivation" (p. 2). Robey, Ramsland, and Castelbaum (1991) focused on helping employees increase their sense of personal (and organizational) meaning. They found that interventions that allowed employees to speak about meaning in their lives increased job satisfaction, which decreased the likelihood of burnout. There is something to be said about that correlation. Could experiencing work as meaningful decrease the likelihood of burnout among community mental health staff?

This potential correlation, the relationship between experiencing meaning in one's work and experiencing burnout in one's work, has yet to be fully addressed in the research. One study investigating this potential relationship involved examining the degree of burnout physicians exhibited (Tei et al., 2014). The study results revealed that possessing a sense of meaning in one's work negatively correlated with experiencing burnout in one's work (Tei et al., 2014). In other words, experiencing a sense of meaning in work might prevent burnout triggered by excessive distress. These results are likely due to medical professionals' ability to obtain a sense of meaning by recognizing the greater purpose of their work, which helps them view critical situations (e.g., helping patients cope with pain and suffering) as more fulfilling than distressing (Tei et al., 2014). Inversely, without a sense of meaning in one's work, exposure to patients' distress can prompt excessive empathic distress and thereby burnout. Physicians were the focus of this study, but if a similar study were conducted on community mental health staff, would the relationship between burnout and experiencing meaning in work be the same as what Tei et al. found?

Age and meaning in work. A study of over 8,000 internet users assessed the presence of meaning in life and the search for meaning across life-stage groups (Steger, Oishi, & Kashdan, 2009). The researchers used a global meaning in life measure that assessed the presence of

meaning in one's life. They found that the mean level of the presence of meaning in life subscale was greater in middle-aged adulthood (45-64 years of age) and in older adulthood (65 or more years of age) than in emerging adulthood (18-24 years of age) and young adulthood (25-44 years of age). This is another study providing results that suggest that as people get older, they are more likely to exhibit higher levels of meaning in life.

It appears that age is one of the demographic variables examined most frequently in meaningfulness research. Lim et al. (2010) conducted a meta-analysis on 15 studies in which 3,600 mental health workers were examined. The researchers found that age was the most significant factor in experiencing the emotional exhaustion of burnout. Furthermore, Hoole and Bennoma (2015) also conducted a study to explore the relationship between age, work engagement, and work meaningfulness. They found that Baby Boomers (born between 1946-1964) have the highest level of meaningfulness, Generation X members (born between 1964-1981) have the second highest level, and Generation Y members (born between 1981-1999) have the lowest levels of the three cohorts (Hoole & Bennoma, 2015). In keeping with this theme, results from a study conducted on university employees showed that older workers were slightly more likely to find positive meaning in their work experience than younger workers were (Steger et al., 2012). Also, researchers have observed that older individuals are less likely to experience emotional exhaustion, one of the subscales of burnout, (Ackerley et al., 1985; Maslach et al., 2001) than are younger employees, who appear to be at a higher risk for burnout (Maslach et al., 2001; Rupert & Kent, 2007).

Hoole and Bennoma (2015) have found that this trend is connected with finding a sense of meaning in one's work. The research findings in this area are particularly noteworthy for millennials (generation Y). Millennials are now the largest labor force in the United States (Fry,

2012), and millennials constitute approximately 20% of the healthcare workforce, including front desk/clerical staff, health technicians, nurses, and physicians (Piper, 2012). Due to their age, millennials in the workforce might be at great risk of burnout (Rupert & Kent, 2007). Unlike the generations that preceded them, millennials are driven not by money but by meaningful work (Michels, 2015).

Personal factors related to meaningful work and burnout. Because finding meaning in work has become so important, researchers have begun to focus on developing instruments to measure this quality (He, Pang, Zhang, Tang, & Fielding, 2017; Steger et al., 2012). Instruments like the Work and Meaning Inventory (WAMI) (Steger et al., 2012) have made it possible to examine how much or how little employees experience their work as meaningful. The WAMI has three subscales that are summed up to uncover the total Meaningful Work Score. Prior to development of the WAMI, researchers used a personal meaning in-patient care scale that consisted of six items. These researchers found a strong inverse relationship between meaning and burnout (Geller, Bernhardt, Carrese, Rushton, & Kolodner, 2008). Additionally, meaning was positively associated with gratitude and modestly associated with professional satisfaction (Geller et al., 2008). Participants in the studies noted above consisted of physicians, nurses, and genetic counselors. In the summary of their studies, they concluded that future researchers should continue to aim at determining if these relationships hold up in other fields of health care. This is one reason why the current study will focus on mental health staff members.

Also prior to the WAMI, Maslach and Leiter (1997) developed their own instrument to help measure burnout. Maslach and Leiter (1997) suggested “energy, involvement, and efficacy are the direct opposites of the three dimensions of burnout” (p. 34). In their view, burnout is an erosion of engagement, whereby “energy turns into exhaustion, involvement turns into cynicism,

and efficacy turns into ineffectiveness” (p. 24). Job engagement is evaluated by assessing the opposite pattern of scores on the three MBI dimensions. Therefore, low scores on exhaustion and cynicism and high scores on efficacy are indicative of job engagement. Thus, Maslach and Leiter (1997) considered burnout and engagement to be the opposite poles of a continuum that is entirely covered by the MBI.

The material presented in the previous section indicates that in addition to burnout, lack of job engagement can also occur for people who experience an absence or low level of meaning in their work. In a Steger et al. (2012) study, employees who found their work meaningful were less likely to miss work than employees who did not. Acknowledging that lack of job engagement, such as absenteeism, is one of the symptoms of burnout (Maslach & Leiter, 1997), researchers found that measuring the experience of meaningful work was actually better than measuring job satisfaction at predicting absenteeism (Littman-Ovadia & Steger, 2010).

Furthermore, Rosso, Dekas, and Wrzesniewski (2010) noted that finding meaning in one's work has been shown to increase motivation, engagement, empowerment, career development, job satisfaction, individual performance, and personal fulfillment and to decrease absenteeism and stress. Could this imply that those who experience meaningful work in community mental health are less likely to burnout? This question is yet to be answered by the research that is out there today. One of the reasons for this gap in research has to do with the unavailability of measures that quantify experiencing meaningful work (Adams, 2012). Now that the WAMI is available, progress can be made towards reaching an answer (Steger et al., 2012).

Organizational factors related to meaningful work. “Examining meaning in specific life domains holds promise for understanding the origins of perceived meaning in life” (Steger &

Dik, 2009, p. 304). One of these life domains includes work. Those who work in community mental health might find meaning in their work and possibly in their lives because of the mission related to their occupation. Two of the major obligations that community mental health staff take on are to advocate on behalf of those suffering from mental illness and to serve others (Nelson & Prilleltensky, 2005). In addition, Lips-Wiersma and Wright (2009) found two themes that emerged regarding those who serve others: making a difference and meeting the needs of humanity. These two themes are also found in healthcare occupations, and they provide insight into why community mental health staff might be able to experience a significant degree of meaning in their work and why burnout can often occur.

Meaningful work can come from the employee or the organization, and the same can be said about burnout. Some people bring a sense of meaning and mission with them to the workplace, and some organizations excel at creating meaningful workplaces where every employee becomes part of creating success, cohesiveness, and culture at work (Steger, 2015). In these kinds of organizations, employees discover what their work entails, see a purpose to pursuing this work, and are driven to help some greater good (Steger, Littman-Ovadia, Miller, Menger, & Rothmann, 2012). When employees are engaged in meaningful work, they are likely to be more cognitively present and available in their work, to become dedicated, to experience efficacy, and to stay involved (Steger et al., 2012). Conversely, research has shown that these attributes tend to dissipate when employees are experiencing burnout (Maslach & Leiter, 1997).

Maslach and colleagues (1982) described burnout as a point at which important, meaningful, and challenging work becomes unpleasant, unfulfilling, and meaningless. This theory would lead to the suggestion that experiencing meaningful work will have some type of effect on experiencing burnout, but can experiencing meaningful work safeguard a mental health

professional from burnout? Or at the very least, can it delay the process of burnout? The goal of this study is to shed light in this area.

Rationale

Community mental health staff members help heal those who are living with mental illness. The literature reviewed suggests that the provider might perceive the services rendered at community mental health centers as meaningful. This could be due to the provider partaking in work that adds to the greater good (Baumeister, Vohs, Aaker, & Garbinsky, 2013; Lips-Wiersma & Morris, 2011; Steger & Dik, 2009). On the other hand, research has indicated that serving others and experiencing the situations that mental health staff are confronted with on a daily basis produce burnout (Morse et al., 2012).

Though numerous articles cover burnout in community mental health (Cherniss & Egnatios, 1978; Kumar, Fischer, Robinson, Hatcher, & Bhagat, 2007; Onyett, 2011; Onyett, Pillinger, & Muijen, 1997; Prosser et al., 1997; Salyers et al., 2013), research exploring meaningful work and community mental health is lacking. This will be the first study to examine community mental health staff and the depth to which they “experience their work as meaningful, as something they are personally invested in, and which is a source of flourishing in their lives” (Steger, Dik, & Duffy, 2012, p. 2).

As noted above, research investigating community mental health staff members has focused largely on burnout and job satisfaction. Morse et al. (2012) recommended that further research be focused on burnout prevention programs that help individuals to not only cope with stress but also to develop more positive qualities, such as a sense of meaning, gratitude, and fulfillment in work. Additionally, the researchers suggested that additional attention be paid to

the positive aspects of working, such as the process by which mental health workers experience compassion, joy, meaning, and fulfillment in their jobs (Morse et al., 2012).

In this study, I seek to provide a better understanding of community mental health staff and the level of meaning they derive from their work. I then intend to see how experiencing meaning in work affects experiencing burnout. My hope is that the evidence found can spur further discussions on creating trainings aimed at preventing burnout by focusing on ways to increase employees' chances of experiencing meaning in their work. To prove that this is worth pursuing, I must first explore the nature of the relationship between perception of meaningful work and burnout. I believe the best way to ask this question is by examining the relationship between meaningful work and burnout. This study is only a foot in the door to understanding the relationship between meaningful work and burnout in community mental health staff, but it is a starting point.

Research Questions and Hypothesis

For this study, Burnout is represented by the three subscales of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Maslach & Jackson, 1981). The first subscale is Emotional Exhaustion, which measures feelings of being emotionally overextended and exhausted by one's work. The second subscale is Depersonalization, which measures an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction. The last subscale is Personal Accomplishment, which measures feelings of competence and successful achievement in one's work (Maslach & Jackson, 1981).

The total Meaningful Work score is represented by the three subscales of the Work and Meaning Inventory (Steger, 2015). The first subscale is Positive Meaning, which reflects the degree to which people find their work to hold personal meaning, significance, or purpose. The

second subscale is Meaning-Making through Work, which reflects the fact that work is often a source of broader meaning in life for people, helping them to make sense of their life experience. The last subscale is Greater Good Motivations, which reflects the degree to which people see that their effort at work makes a positive contribution and benefits others or society (Steger, Dik, & Duffy, 2015). The intention of this current study is to utilize a non-experimental survey research design using the MBI and WAMI to explore the relationship between meaningful work and burnout.

My hypotheses are as follows:

1. The total Meaningful Work Score will significantly predict Emotional Exhaustion.
2. The total Meaningful Work Score will significantly predict Depersonalization.
3. The total Meaningful Work Score will significantly predict Personal Accomplishment.
4. Age will demonstrate a statistically significant relationship with each of the subscales of the MBI-HSS.

Chapter Two

The purpose of this study was to examine community mental health staff, the depth to which they are experiencing their work as meaningful, and the level of burnout they are experiencing. Although research examining burnout in community mental health is plentiful, existing research has not adequately addressed the role of experiencing meaningful work in community mental health. Thus, I examined whether or not meaningful work and burnout are inversely related. This was the first study to involve use of the WAMI and MBI-HSS in conjunction.

Participants

Participants included a convenience sample of at least 100 individuals who were 18 years of age or older and were employed at a community mental health center as clinicians. The sample included male and female participants who were credentialed to perform mental health services. They were recruited individually and in groups from places of employment as well as from referrals of other participants and colleagues. At the onset of recruitment, I obtained participants and asked these participants if they knew colleagues who were willing to participate in the study as well. Specific clinics that were used for recruitment of participants were not compensated for their involvement in this study, nor was the employer able to access any documents related to this study.

A majority of the participants were employees of mental health agencies in Washington State and Florida. Participants received a document via email and in person containing an informed consent form, which included the parameters of confidentiality for the information they shared and potential risks of involvement in the study. Names were not collected, thus ensuring

anonymity and confidentiality. Participants were provided with the overall findings of the study upon request.

Materials

Demographics. Participants completed a demographic form by filling out their age, sex, marital status, yearly wages earned, ethnicity (White, Black, Hispanic, Asian, or Other), educational attainment (high school graduate, college graduate, master's level graduate, doctoral level graduate), employment status (full-time or part-time), and amount of time spent in the mental health field.

Work and meaning inventory. Within the last decade, Steger and his colleagues developed a way to quantify and measure how much or how little a person experiences her or his work as meaningful (Steger, 2015; Steger & Dik, 2009; Steger, Dik, & Duffy, 2012; Steger, Dik, & Shim, 2009; Steger et al., 2012). Stemming from previous research on meaningfulness, Steger et al. (2012) were able to design the WAMI. In the model, work is viewed as a “subjectively meaningful experience consisting of (a) experiencing positive meaning in work; (b) sensing that work is a key avenue for making meaning; and (c) perceiving one's work to benefit some greater good” (Steger et al., 2012, p. 2). The WAMI has three subscales, which are summed up to create the total Meaningful Work Score.

Steger et al. (2012) discovered that low scores on any of the scales of the WAMI (Positive Meaning, Meaning-Making through Work, and Greater Good Motivations) indicate a lack of meaning in work. Low scores likely indicate that the individual experiences a low sense of commitment to his or her organization, which might prompt intentions to leave, low motivation, reduced work engagement, and a perceived lack of support from management (Steger et al., 2012). Additionally, individuals with low scores are more likely to experience

emotional distress and low levels of well-being than are individuals with high scores (Steger et al., 2012).

The WAMI is a 5-item, 5-point Likert-type scale (1-*strongly disagree* to 5-*strongly agree*) that creates a composite by using subscales for Positive Meaning, Meaning-Making through Work, and Greater Good Motivations. These three subscales are added up to obtain the total Meaningful Work Score. The WAMI was utilized to measure meaningful work, that is, the depth to which community mental health staff experience their work as meaningful, “as something they are personally invested in, and which is a source of flourishing in their lives” (Steger, 2012, p. 2).

Researchers performed a confirmatory factor analysis on the WAMI. Results indicated that the three-dimensional meaningful work model (Positive Meaning, Meaning Making through Work, and Greater Good Motivations) was acceptably fit ($\chi^2=69.05$, $df=30$, $RMSEA=.090$, $CFI=.97$) (Akin & Saricam, 2013). The Cronbach’s alpha internal consistency of the scale was .89 for the positive meaning dimension, .82 for the meaning making through work dimension, .83 for the greater good motivations dimension, and .93 for the whole scale (Akin & Saricam, 2013).

Validity and factor structure estimates for the Meaningful Work score are reliable, indicating that it might be a promising measure (Steger et al., 2012). It was discovered that individuals who score low on the WAMI scales are more likely to miss work, to experience low levels of well-being, and to experience higher levels of psychological distress (Steger, 2012). In terms of the WAMI’s validity, Steger, Dik, and Shim (2009) found that total and subscale scores correlated in projected directions when compared to measures of organizational commitment, job satisfaction, well-being, work motivation, withdrawal intentions, and days absent from work.

Many of these characteristics are related to burnout. The authors of the WAMI state that it can be used in research and educational capacities without restriction (Steger, 2012).

Preliminary investigation with an earlier version of the WAMI uncovered that Meaningful Work scores were positively correlated with job satisfaction and using one's strengths at work (Littman-Ovadia & Steger, 2010). I have gained permission to use the WAMI via the author's website. The inventory can be found in Appendix C of this paper.

The Maslach burnout inventory. The second inventory that was used in this study was the Maslach Burnout Inventory (MBI). Steger (2012) stated that results from the total Meaningful Work Score of the WAMI correlated in projected directions with characteristics that relate to burnout. To further investigate this observation, I needed a way to gauge burnout. As mentioned in Chapter One, burnout commonly describes the three-dimensional aspects of (1) emotional exhaustion (inability to feel compassion for clients), (2) depersonalization (detachment from the emotional needs of their client), and (3) lack of personal accomplishment (being critical of oneself [Maslach et al., 1997]).

These dimensions, emotional exhaustion, depersonalization, and personal accomplishment, are found as subscales on the MBI (Maslach & Jackson, 1981). The MBI was developed from qualitative research conducted by analyzing interviews, questionnaires, and observations of healthcare professionals. It was established using a factor analytic approach instead of a random set of items (Shaufeli, Bakker, Hooguin, Schaap, & Kladler, 2001).

The MBI was developed on the foundation that burnout involves emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1981). The MBI inventory includes 22 items representing three aspects of burnout syndrome: Five items cover the depersonalization dimension, eight items cover the personal accomplishment dimension, and

nine items cover the emotional exhaustion dimension. Each dimension is measured on a 7-point Likert scale (Maslach & Jackson, 1981).

According to Maslach and Jackson (1981), emotional exhaustion refers to feelings of being overextended and depleted of emotional and physical resources. A sample prompt is “I feel emotionally drained by my work” (Maslach & Jackson, 1981, p.102). Depersonalization denotes a cynical, negative attitude toward clients and co-workers and excessive detachment from various aspects of the job (Leiter & Maslach, 1988). An example prompt from the depersonalization dimension is “I don’t really care what happens to some recipients” (Maslach & Jackson, 1981, p. 103). The third dimension has to do with reduced perception of personal accomplishment. Reduced personal accomplishment is an outcome of the stress-strain-coping sequence and is defined as a perception of a lack of enthusiasm and effectiveness that comes from working with people. An example of a personal accomplishment dimension prompt is “I have accomplished many worthwhile things in this job” (Maslach & Jackson, 1981, p. 102).

The MBI is psychometrically sound, and it is well documented in the literature with internal consistencies above the 0.70 Cronbach alpha level, except for the depersonalization scale in some samples (Schaufeli et al., 2001). Test-retest reliability ranging from three months to one year has been reported in the range of 0.50 to 0.82 (Maslach et al., 1981). There are three editions of the MBI. The MBI-GS (General Survey) was published in 1996, and the MBI-ES (Educators Survey) was published in 1986. The MBI-HSS (Human Services Survey) is considered the original and the edition most commonly used to observe burnout in health care settings (Schaufeli & Buunk, 2004). The three subscales of the MBI-HSS are internally consistent, and the three factor structure has been shown to be invariant across occupations and national contexts (Schaufeli et al., 2001). I have gained permission to use the MBI by purchasing

the inventory from the author's website. The inventory can be found in Appendix D of this paper.

Procedures

Participants were recruited via email and social media (e.g., Facebook, LinkedIn, and Twitter). If they chose to participate, they clicked on the link included in the email or message on Facebook, LinkedIn, or Twitter. The link sent the prospective participant to the survey via Google drive. The participant was presented with the informed consent section as soon as she or he clicked on the link in Google drive. If the person chose to participate, he or she pressed "next". Participants were then presented with the demographics section and filled it in accordingly. They were then prompted to click "next". Subsequently, participants were asked to complete the WAMI (Steger et al., 2012). Once this was completed, the participant was asked to complete the MBI-HSS (Maslach & Jackson, 1986). After completing the MBI-HSS, the participant hit "next" and received a message thanking him or her for the responses. In all, the average time to complete the survey is about 7 minutes. Once all the data were collected, they were transferred from the Google drive template to a Microsoft Excel sheet to run a statistical analysis.

Statistical Analyses

Backwards, stepwise multiple regression analyses were calculated to determine if there was a statistically significant relationship between total Meaningful Work Score from the WAMI and each of the subscales of the MBI-HSS. The strength of the relationship was observed as well as the effects of the demographic variables on this relationship. Categorical demographic variables (e.g., gender and level of education) were dummy-coded prior to being entered into the model. The assumption of multicollinearity was investigated by calculating the tolerance value

of the analysis (tolerance value greater than .100). For all p -values, the significance level was set at .05.

Summary

In this study, burnout was measured by asking participants to fill out the MBI-HSS (Maslach & Jackson, 1986) and the WAMI (Steger et al., 2012). This was one of the first studies to examine the WAMI and MBI together. The findings that emerged while investigating the relationship between burnout and meaningful work might benefit the community mental health centers to help avoid burnout in their clinical staff. Past research has been used to direct supervisors, human resource departments, and administrators to focus on burnout (Bowen & Twemlow, 1978; Cherniss & Krantz, 1983; Maslach & Jackson, 1982). This study was designed to begin steering the focus of conversation towards the topic of meaning at work in addition to burnout. Findings discovered in this study might be able to add value to burnout prevention programs because researchers have found that observing, quantifying, and speaking about meaningful work with mental health staff might help enhance job satisfaction and reverse the effects of burnout (Tei et al., 2014).

The objective of this current study was to determine the relationship between meaningful work and burnout in community mental health clinical staff. Researchers have found burnout rates in mental health staff to approach 50% of those surveyed (Bressi et al., 2009), but recent literature indicates that helping someone find meaning in their work might prevent burnout (Krasner et al., 2009; Steger et al., 2012; Tei et al., 2014). The intention of this study was to continue adding significant findings to the topic of meaningful work and burnout in the research literature.

Chapter Three

The purpose of this current study was to examine the relationship between meaningful work and burnout by using a nonexperimental survey research design. One of the two surveys used was the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Maslach & Jackson, 1981). This survey consists of three subscales. The first subscale is emotional exhaustion, which refers to feelings of being overextended and depleted of emotional and physical resources. The second subscale is depersonalization, which denotes a cynical, negative attitude toward clients and co-workers and excessive detachment from various aspects of the job (Leiter & Maslach, 1988). The last subscale is personal accomplishment. Reduced personal accomplishment is an outcome of the stress-strain-coping sequence and is defined as a perception of a lack of enthusiasm and effectiveness that comes from working with people (Maslach & Jackson, 1981, p. 102).

The second of the two surveys used was the Work and Meaning Inventory (WAMI) (Steger, 2012). The Total Meaningful Work Score from the WAMI can be used to quantify and measure how much or how little a person experiences his or her work as meaningful. By comparing the results from the two different surveys, the relationship between the three dimensions of the burnout scales (Maslach & Jackson, 1986) and the extent to which community mental health staff are experiencing their work as meaningful was explored.

My hypotheses were as follows:

1. The total Meaningful Work Score will significantly predict Emotional Exhaustion.
2. The total Meaningful Work Score will significantly predict Depersonalization.
3. The total Meaningful Work Score will significantly predict Personal Accomplishment.

4. Age will have a statistically significant relationship with each of the subscales of the MBI-HSS.

Burnout, Work Meaning, and Their Associations

Of the 75 respondents on the survey, the majority were female (79%, $n = 59$), and most of them identified as Caucasian (69%, $n = 41$). Male respondents were more diverse but represented a smaller sample size compared to female respondents. Mean scores on each of the MBI-HSS subscales were similar between genders, although higher standard deviations were found for males on each of the MBI-HSS subscales. For instance, males scored higher on all three subscales of the MBI-HSS and had a lower score on the WAMI. Yet, both male and female respondents reported feeling a moderate level of emotional exhaustion. The males in this study scored higher for burnout than the female participants. This is congruent with previous research that has shown women to be less vulnerable to burnout than men (Maslach et al., 1985). See Table 1 for overall descriptive statistics as well as descriptive statistics for each gender.

Correlation analyses were performed to assess the relationships among age, WAMI scores, and the individual subscales of the MBI. Age was not significantly correlated with WAMI scores or any of the individual subscales of the MBI. Conversely, WAMI score was significantly negatively correlated with the depersonalization subscale, $r(75) = -.27, p < .05$, and the emotional exhaustion subscale, $r(75) = -.39, p < .01$. WAMI scores were also positively correlated with the personal accomplishment subscale, $r(75) = .67, p < .01$. Table 5 details all of the correlations between age, WAMI score, and the three subscales of the MBI-HSS.

Regression Models Predicting Burnout

In addition to correlation analyses, a backwards stepwise multiple regression was conducted to probe deeper into the relationships amongst the variables. The backwards stepwise

multiple regression helped determine which independent variables (age and Total Meaningful Work score) were significant predictors of each subscale of the MBI-HSS. For each regression analysis, the full model (including both WAMI score and age as predictors) was compared to a model including only WAMI score as the predictor and then to a model with just age as the predictor. For each regression analysis, the model that minimized the Akaike Information Criterion (AIC) was selected.

Regression model assumptions. For each regression model, assumptions of linear regression were evaluated to ensure that there were no violations. Visual analysis of scatterplots indicated that the assumption of linearity was met. Within the full dataset, the assumption of multivariate normality was violated; multivariate outliers were subsequently detected and removed from the dataset for each regression analysis. After removal of outliers, the assumption of multivariate normality was met for each regression model.

After performing a backwards stepwise regression for each model, age was removed from each model. Because there was only one predictor variable (WAMI score) in each model, the assumption of multicollinearity among predictor variables did not apply. Durbin-Watson tests were calculated to determine if auto-correlation existed for each regression model. Results from the Durbin-Watson tests indicated that this assumption was not violated for any of the models. In addition, analysis of the residuals and leverage was used to determine if the assumption of homoscedasticity was violated. In each model, no residual had a Cook's distance greater than 0.5, suggesting that no regression model violated the assumptions of homoscedasticity.

Emotional exhaustion. A stepwise multiple regression was conducted to evaluate whether or not both WAMI score and age predicted the score on the emotional exhaustion

subscale of the MBI-HSS. The results of the regression analysis indicated that WAMI score significantly predicted the score on the emotional exhaustion subscale and explained 14% of the variance, $R^2 = .14$, adjusted $R^2 = .13$, $F(1, 58) = 9.71$, $p = .0028$. These results confirmed the original hypothesis that the Total Meaningful Work Score from the WAMI would predict the score on the emotional exhaustion subscale; however, the results did not support the hypothesis that age would also predict the score on the subscale. The predicted mean score on the emotional exhaustion subscale was 68.31 -.99. The average level of reported emotional exhaustion was predicted to decrease .99 for every point increase in work meaning. See Tables 4 and 5 for model coefficients and Figure 1 for a plot of the regression model.

Depersonalization. A stepwise multiple regression was conducted to evaluate whether or not both WAMI score and age predicted the score on the depersonalization subscale of the MBI-HSS. The results of the regression analysis indicated that WAMI score significantly predicted the score on the depersonalization subscale and explained 29% of the variance, $R^2 = .29$, adjusted $R^2 = .27$, $F(1, 56) = 22.34$, $p = 0.000016$. These results confirmed the original hypothesis that the Total Meaningful Work score from the WAMI would predict the score on the Depersonalization subscale; however, the results did not support the hypothesis that age would also predict the score on the subscale. The predicted mean score on the depersonalization subscale was 34.16 -.62. The average level of reported depersonalization was predicted to decrease .62 for every point increase in work meaning. See Tables 6 and 7 for model coefficients and Figure 2 for a plot of the regression model.

Personal accomplishment. A stepwise multiple regression was conducted to evaluate whether both WAMI score and age predicted the score on the Personal Accomplishment subscale of the MBI. The results of the regression analysis indicated that WAMI significantly

predicted the score on the Personal Accomplishment subscale and explained 43% of the variance $R^2 = .44$, adjusted $R^2 = .42$, $F(1, 56) = 43.08$, $p = 0.000000018$. These results confirmed the original hypothesis that the Total Meaningful Work Score from the WAMI score would predict the score on Personal Accomplishment subscale; however, the hypothesis that age would also predict the score on the subscale was not supported by these results. The predicted mean score on the personal accomplishment subscale was $-.45 + .92$. The average level of reported personal accomplishment was predicted to increase .92 for every point increase in work meaning. See Tables 8 and 9 for model coefficients and Figure 3 for a plot of the regression model.

Descriptive Statistics

Table 1

Overall Descriptive Statistics

Variable	Overall	Males	Females
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>
Age	39.61 (12.20)	41.86 (10.35)	39.00 (4.28)
WAMI	42.80 (4.90)	41.13 (6.63)	43.25 (4.28)
Emotion	24.85 (10.78)	25.00 (10.54)	24.81 (10.93)
Depersonalization	7.07 (6.23)	8.94 (7.55)	6.56 (5.80)
Personal Accomplishment	24.63 (4.01)	23.69 (4.38)	24.88 (3.90)

Note. $N = 75$

Table 2

Counts and Percentage of Self-Reported Ethnicity by Gender for Survey Respondents

Gender	White / Caucasian	Hispanic / Latino	African American	Asian or Pacific Islander	Persian
Female	41 (69%)	11 (19%)	6 (10%)	1 (2%)	0 (0%)
Male	5 (31%)	7 (44%)	2 (13%)	1 (6%)	1 (6%)

Note. N = 75

Correlation Matrix

Table 3

Correlation Matrix of Regression Model Variables

Measure	1	2	3	4	5
1. Age	--	.04	-.12	-.29	.12
2. WAMI		--	-.27*	-.39**	.67**
3. Emotional Exhaustion			--	.58**	-.06
4. Depersonalization				--	-.33**
5. Personal Accomplishment					--

Note. Each value on the table represents the R^2 value. For the asterisks, * $p < .05$, ** $p < .01$ for the corresponding R^2 value.

Table 4

Summary of Full-Model Regression Analysis for Variables Predicting Emotional Exhaustion Subscale Score

Variable	β	<i>SE</i>	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	62.81	15.46	4.06	0.00015**
WAMI score	-0.9766	0.3180	-3.071	0.00327**
Age	0.1447	0.1885	0.768	0.44580

Note. * $p < .05$, ** $p < .01$.

Table 5

Summary of Final-Model Regression Analysis for Variables Predicting Emotional Exhaustion Subscale Score

Variable	β	<i>SE</i>	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	68.3065	13.6536	5.033	0.0000056**
WAMI score	-0.9866	0.3166	-3.116	0.00285**

Note. **p* < .05, ***p* < .01

Table 6

Summary of Full-Model Regression Analysis for Variables Predicting Depersonalization Subscale Score

Variable	β	<i>SE</i>	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	34.4535	6.8402	5.037	0.00000543**
WAMI score	-0.6254	0.1338	-4.677	0.0000193**
Age	-0.0074	0.0950	-0.078	0.938

Note. * $p < .05$, ** $p < .01$.

Table 7

Summary of Final-Model Regression Analysis for Variables Predicting Depersonalization Subscale Score

Variable	β	<i>SE</i>	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	34.1599	5.6727	6.022	.00000014**
WAMI score	-0.6246	0.1321	-4.727	0.0000158**

Note. * $p < .05$, ** $p < .01$.

Table 8

Summary of Full-Model Regression Analysis for Variables Predicting Personal Accomplishment Subscale Score

Variable	β	<i>SE</i>	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	-3.9639	6.9080	-0.574	0.676
WAMI score	0.9421	0.1415	6.658	0.000000014**
Age	0.0734	0.0677	1.084	0.230

Note. * $p < .05$, ** $p < .01$.

Table 9

Summary of Final-Model Regression Analysis for Variables Predicting Personal Accomplishment Subscale Score

Variable	β	SE	<i>t</i> -value	Sig. (<i>p</i>)
Intercept	-0.4524	6.1114	-0.074	0.941
WAMI score	0.9228	0.1406	6.563	0.000000018**

Note. **p* < .05, ***p* < .01.

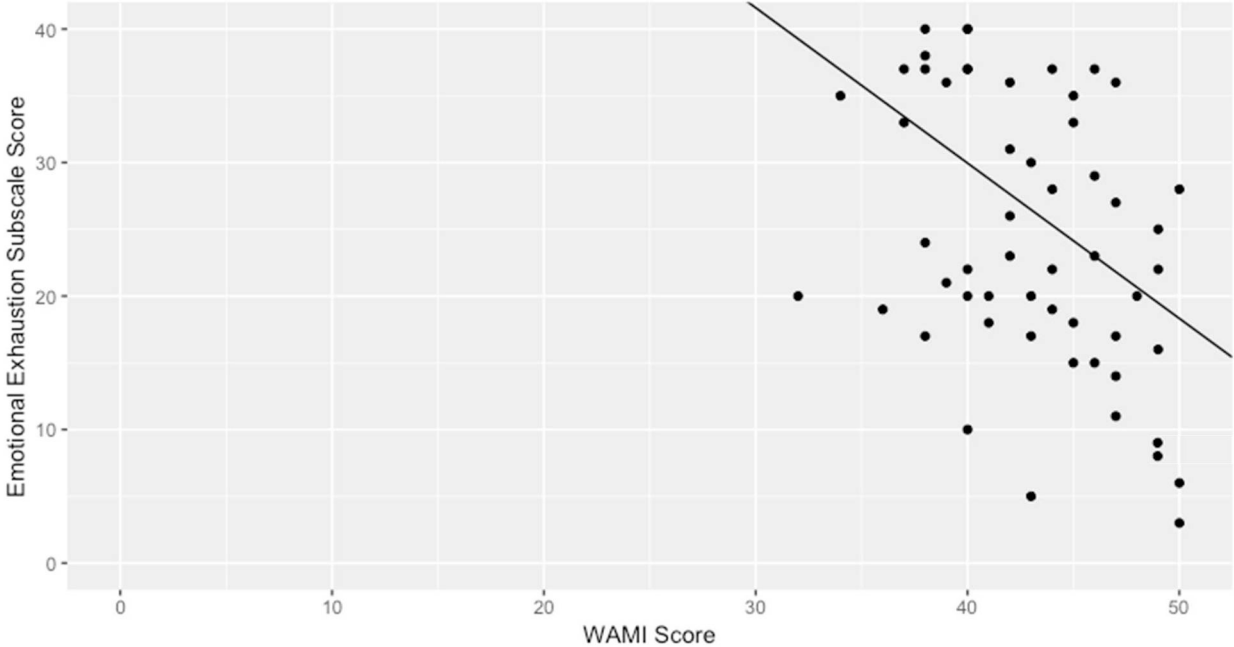


Figure 1. Plot of Emotional Exhaustion Subscale Score by WAMI Score with Regression Model Line.

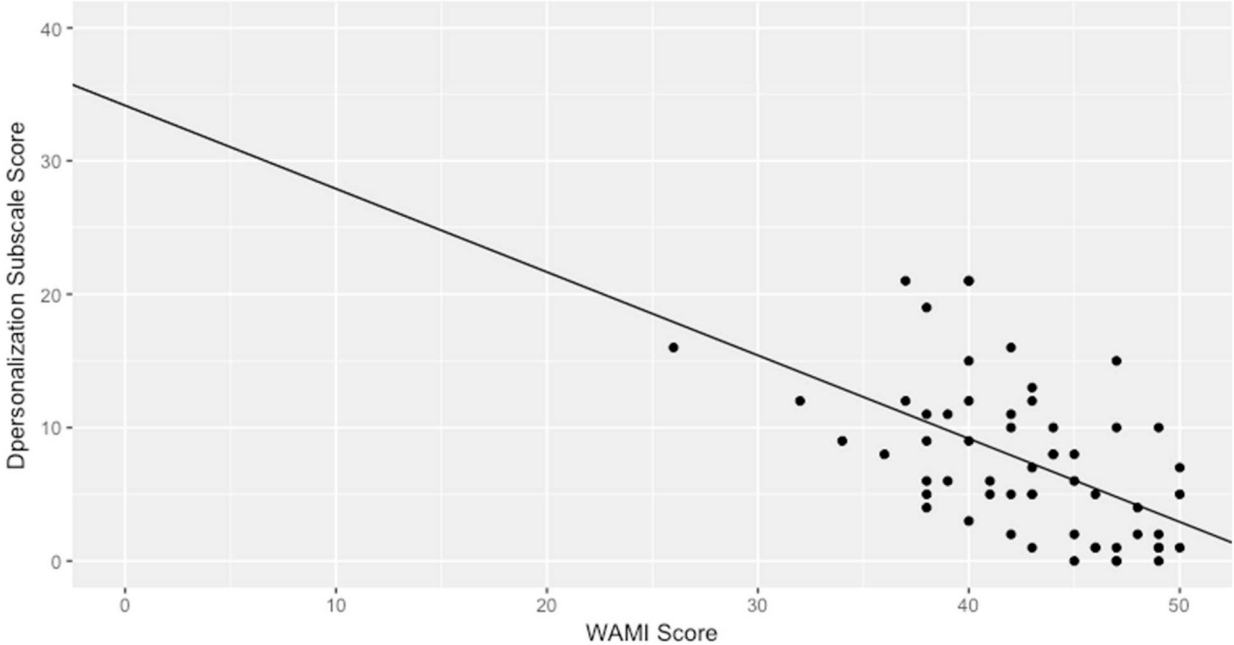


Figure 2. Plot of Depersonalization Subscale Score by WAMI Score with Regression Model Line.

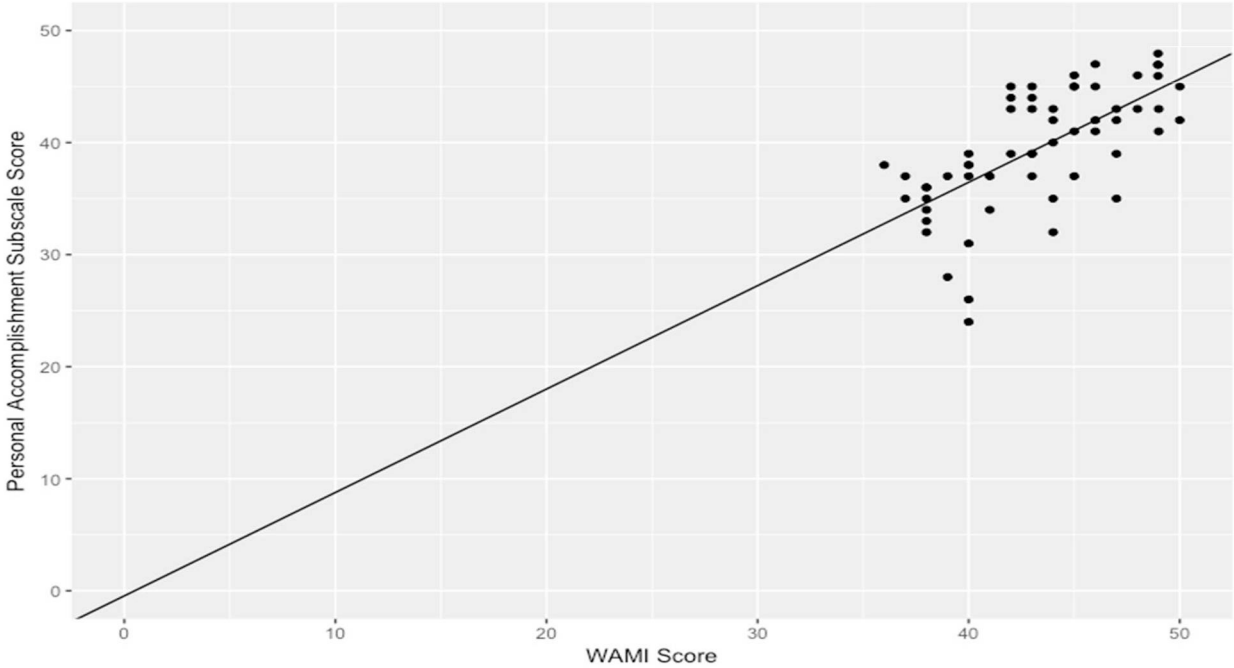


Figure 3. Plot of Personal Accomplishment Subscale Score by WAMI Score with Regression Model Line.

Chapter Four

In community mental health centers with scarce resources, the challenge of balancing daily clinical demands with additional responsibilities may lead to unexpected and sometimes negative outcomes. Burnout is one of these negative outcomes, and it is on the rise (Aronsson et al., 2017; Morse et al., 2012). Interventions on reducing burnout can be found in the literature (Corrigan et al., 1997; Ewers et al., 2002; Halbesleben & Buckley, 2004; Stalker & Harvey, 2002), but the concept of meaningful work as it is related to burnout is one aspect still missing from the literature. This gap led the present researcher to explore the relationship between burnout and meaningful work. With results from this study indicating that a predictable relationship exists between experiencing meaningful work and burnout, a valid reason for future researchers to explore this topic has been established.

Emotional exhaustion among mental health workers. Overall, 41% of the respondents in this study reported an elevated level of emotional exhaustion. The findings showed that participants who experienced a higher sense of meaning in their work also exhibited significantly less emotional exhaustion. The link found here between having a high sense of meaning in work and exhibiting less emotional exhaustion might have to do with what the participants in this study are bringing to the workplace. Certain individuals bring a sense of meaning and mission with them to the workplace, but other times, it is the culture of the organization that creates a meaningful workplace (Steger, 2015). Since a community mental health center adds a positive contribution to society, the type of work that is found at these organizations might produce a greater sense of work meaning for the employee than other types of work (Bailey, Madden, Alfes, Shantz, & Soane, 2017).

As for the study participants who reported an elevated level of emotional exhaustion, researchers in the past have found that emotional exhaustion is largely the result of organizational factors (Aronsson et al., 2017; Fiabane, Giorgi, Sguazzin, & Argentero, 2013; Leiter et al., 2013). The organization may offer the clinician meaningful work, but the work within the organization might lead the employee towards experiencing emotional exhaustion. For instance, Siebert (2005) surveyed private and public-sector healthcare workers. Respondents who once worked at community health centers wrote notes on their surveys stating that they left their former employer because of a stressful workplace that they felt resulted in their burn out.

Findings from this present study add to the current research literature because they suggest that when community mental health workers find their work to be meaningful, they report feelings of emotional exhaustion less often. Similarly, previous researchers used a pre and posttest design and found that when community mental health organizations facilitated trainings and workshops on the concept of well-being and finding meaning, participants reported less feelings of emotional exhaustion (Salyers et al., 2011; Scarnera et al., 2009). It might be beneficial for organizations to note that work is most meaningful when community mental health workers have authentic relationships with clients, work as a team, believe in the care model, and practice autonomy and creativity (Cain et al., 2017). These are also the types of factors that help promote emotional energy and safeguard from emotional exhaustion (Cain et al., 2017).

Depersonalization among mental health workers. In this study, 16% of respondents scored high on the depersonalization subscale. This outcome is low when compared to findings from previous research (Hojat, Vergare, Isenberg, Cohen, & Spandorfer, 2015; Rohland, 2000; Webster & Hackett, 1999). Another explanation for this outcome is also noted in previous research. It seems that emotional exhaustion might lead to the depersonalization stage of

burnout (Maslach et al., 2001), and these two symptoms of burnout develop parallel to each other (Demerouti, Bakker, Nachreiner, & Schaufeli, 2007). A considerable number of participants in this study did not feel emotionally exhausted, and this might have contributed to a small number of respondents feeling depersonalized. I discovered that the higher the sense of meaning that the mental health worker experienced in his or her work, the lower the likelihood that the mental health worker reported feeling detached or impersonal in her or his work (i.e., depersonalized). This adds something that was previously unknown to the research literature.

Researchers in Australia administered the WAMI and MBI to healthcare workers with the same titles and degrees as those in this study and found that for every additional point in meaningful work, the odds of experiencing moderate to high depersonalization slightly decreased (Rasmussen et al., 2015). In addition, researchers in China who studied the same population of participants by administering the WAMI and MBI found nearly the same results (He, Pang, Zhang, Tang, Fielding, 2017). In this current study, the average level of reported depersonalization was predicted to decrease .62 for every point increase in work meaning. These findings, along with the research coming from Australia and China, suggest that there is a relationship between meaning in one's work and feelings of depersonalization.

Another safeguard from depersonalization might have to do with time spent working in the mental health field. Ackerley et al. (1985) found that the longer mental health workers are in practice, the less likely they are to feel depersonalized. The respondents in the current study averaged about nine years in practice. Consequently, it could be possible that respondents in the current study who scored low on depersonalization are feeling less depersonalized due to their sense of meaning in work rather than because of their years in practice. Though mental health workers are going to experience depersonalization at some level or another, it is interesting that

respondents in this study rendered lower rates of depersonalized respondents than the community mental health workers in Webster and Hackett's (1999) study. Furthermore, the percentage of participants (38%) who reported high depersonalization rates in Webster and Hackett's study seems low compared to the 50% of mental health workers who reported high levels of depersonalization in Rohland's (2000) study.

In another study, community health workers were administered the MBI by a research team in Brazil and 34% of participants felt depersonalized (Correia da Silva & Menezes, 2008). Overall, the 16% of participants who scored high in depersonalization found in the current study represent a low proportion compared with the three studies cited above. Yet, from a clinical standpoint, it is still concerning to see clinicians feeling depersonalized. Especially when those who seek treatment at community mental health centers need a clinician who is present and aware. To combat depersonalization, interventions based on mindfulness, meditation, and staying in the moment could be the best way to help (Salyers et al., 2011; Scarnera et al., 2009; Van Dierendonk et al., 1998).

Personal accomplishment. The amount that someone experiences their work as meaningful significantly predicted how much personal accomplishment someone derives from her or his work. Of all the respondents, 56% had a high sense of personal accomplishment in their work. This is comparable to previous studies that included community health workers. In Correia da Silva and Menezes' (2008) study, 47.5% of their respondents had a high sense of personal accomplishment, and 55% of respondents had a high sense of personal accomplishment in Webster & Hackett's (1999) study. Maslach and Jackson (1981) suggested that a low level of personal accomplishment is related to feeling incompetent and unsuccessful. For a mental healthcare worker, a lack of personal accomplishment might also be related to wages, level of

education, and policies that negatively impact the industry (Tam, Shui, Kee, & Mong, 2012).

The low levels of personal accomplishment by some of the respondents in this study can possibly be explained by the fact that the public sector has fewer feedback mechanisms and personal accomplishment strategies in place compared to the private sector (Raftopoulos, Charalambous, & Talias, 2012). The respondents of this study were selected from community health settings; these facilities are considered public health organizations and often have high turnover and low wages (Tam et al., 2012; Salyers et al., 2015). This might explain why respondents scored low on the personal accomplishment scale to some degree.

The trend of healthcare workers lacking in personal accomplishment can be seen in various healthcare industries and might be on the rise. For instance, physicians who responded to an MBI survey in 2011 were asked about their sense of personal accomplishment (Shanafelt, Hasan, Dyrbye, & Sinsky, 2015). Roughly 12% had a low sense of personal accomplishment. When these physicians took the MBI again in 2014, 16.3% had a low sense of personal accomplishment (Shanafelt et al., 2015). Other studies conducted involving healthcare workers in community mental health settings suggest that professionals working in community settings are at substantial risk for experiencing burnout (Oddie & Ousley, 2007; Rohland, 2000; Siebert, 2005) and a diminished sense of personal achievement (Maslach & Leiter, 1997).

There is also a subjective piece to answering questions on the MBI for personal accomplishment. An example of an item in the personal accomplishment dimension is “I have accomplished many worthwhile things in this job” (Maslach & Jackson, 1981, p. 102). In community mental health, large numbers of patients and a wide array of psychiatric disorders within those large numbers of patients likely factor into why mental health workers feel that they have not accomplished worthwhile things in their jobs (Onyett, 2011). Additionally, there is

high turnover in patient populations at community mental health centers (Thornicroft, Deb, & Henderson, 2016), and this could lead clinicians to believe that they are not accomplishing their personal mission to help others.

Researchers discovered that once a clinician experiences diminished feeling of personal accomplishment, the clinician is unable to see his or her efforts as contributing to client's healing (Young & Cashwell, 2016). This current study discovered that there is a relationship between feelings of personal accomplishment and work meaning. More specifically, the average level of reported personal accomplishment was predicted to increase .55 for every point increase in work meaning. Thus, if organizations can somehow utilize trainings and workshops to increase work meaning within the workplace, it might help guide the mental health worker towards feeling more personal accomplishment (Salyers et al., 2011).

Age did not predict the MBI-HSS subscales. Age was not a predictor of any of the three subscales on the MBI-HSS. This result might have been related to the sample characteristics of this study. The 75 respondents averaged 39 years of age. Of the three MBI-HSS subscales, the respondents' average score was highest for emotional exhaustion. Past researchers have indicated that younger age was a significant factor in the emotional exhaustion and depersonalization of front line workers in community health settings (Gomez-Urquiza, Vargas, De la Fuente, Fernandez-Castillo, & Canadas-De la Fuente, 2016). In addition, researchers have observed that older individuals are less likely to experience emotional exhaustion, one of the subscales of burnout, (Ackerley et al., 1985; Maslach et al., 2001) than are younger employees, who appear to be at a higher risk for burnout (Maslach et al., 2001; Rupert & Kent, 2007).

Schaufeli (1999) also found a higher percentage of younger sufferers of burnout than older sufferers of burnout. In Schaufeli's study, 23% of the respondents were in their 20s, 25% were older than 30 but younger than 35 years old, and 15% were older than 35 but younger than 40 years old. On average, participants scored highest on the emotional exhaustion subscale. This might be due to the average age of the participants (below 40 years of age). Findings from previous research studies indicate that if older respondents had taken part in this study, a decrease in the average score for emotional exhaustion would have likely occurred (Salyers, 2013). It is also possible that utilizing a larger population might have led to discovering a stronger relationship between age and the subscales of the MBI-HSS.

Limitations

Sampling issues. Lack of random sampling, due to the convenience nature of the sample, might have affected the results of the present study. Age of participants was skewed towards younger individuals; the sample had a limited number of participants over the age of 50. In addition to age, the low proportion of males might have been a limiting factor and that any perceptions that may vary by gender were less likely to be reflected. Only 16 males completed the survey, which raises concerns regarding whether or not these 16 respondents are representative of the male population in the mental health industry. As a result, additional research replicating this study with a larger sample that is representative of workers in the mental health industry is recommended.

Sample characteristics. Additionally, a substantial proportion of the participants self-reported having earned Master's degrees, which could potentially have influenced the results of the study. Due to the small sample size and the limited diversity of degree-types earned, highest level of education was not factored into the regression model. In their study on burnout, using

the MBI, Maslach and Jackson (1981) found significant relationships between education and scores on each of the subscales of the MBI. Overall, amongst the sample of respondents, wages were normally distributed, and most of the respondents working at the community mental health centers had Master's degrees.

Tools and measurements. The data gathered were limited to the MBI-HSS (Maslach & Jackson, 1986) and the WAMI (Steger et al., 2012). Although several studies (Akin & Saricam, 2013; Littman-Ovadia & Steger, 2010; Schaufeli et al., 2001) have demonstrated the validity of using these tools to measure burnout and meaningful work, the data gathered in this study could have been further supplemented and correlated using the Copenhagen Burnout Inventory (CBI) (Kristensen, Borritz, Villadsen, & Christensen, 2005). The CBI measures burnout experienced in three different domains: personal burnout, work burnout, and client related burnout (Kristensen, Borritz, Villadsen, & Christensen, 2005). Using the CBI in the current study would have allowed for further analysis in investigating the relationship between experiencing meaning in one's work and experiencing client-related work burnout and general work-related burnout.

Future Directions

Findings from this current study have created one way for future researchers to further the discussion about preventing burnout by assessing meaning in work. Future research should be focused on creating meaning making interventions that decrease burnout in workers. Past study findings have indicated a common link between meaning in work and burnout. Robey, Ramsland, and Castelbaum (1991) focused on helping employees increase their sense of personal (and organizational) meaning. They found that interventions that allowed employees to speak about meaning in their lives increased job satisfaction, which decreased the likelihood of burnout. Other researchers also found that a sense of meaning in one's work predicted lower risk

of burnout (Tei et al., 2014). Tei and his colleagues found that a sense of meaning in one's work predicted burnout by a negative correlation, and sense of meaning was a significant mediator. Though the design of this current study was different, the results also showed a predictable relationship between meaningful work and burnout.

The current researcher administered the Work and Meaning Inventory to assess employee's sense of meaning in their work which differs from Tei and his colleagues, who administered the Sense of Coherence scale (SOC) inventory to assess employees' sense of meaning in their work. Though different inventories were administered in these studies, comparable results were found in relation to burnout. These studies used different inventories to assess meaningful work and found a similar result regarding healthcare professionals. The higher the sense of work meaning, the less likely they are to experience burnout. The next step might be to revisit the topic of meaningful work and burnout from an interventions level. Problematic levels of burnout should be defined and validated to determine whether interventions focused on increasing work meaning can reduce job burnout to sub-threshold levels. For example, a study that identifies participants experiencing burnout and provides these participants with interventions that increase meaning in one's work may be helpful. Data taken before the work meaning intervention can be compared after the work meaning intervention is administered.

There is meaning to community mental health work. Interventions based on therapeutic techniques such as narrative therapy might be useful in helping mental health workers see the meaning in their work. For instance, Krasner et al. (2009) developed a continuing medical education program for primary care physicians that used narrative exercises, mindfulness practices, and appreciative inquiry to help medical doctors increase communication skills and

awareness. Using a pre- and post-test design with multiple follow-up assessments over the span of 15 months, Krasner et al. (2009) reported significant reductions in all facets of burnout as well as improvements in mood. The same techniques can be used to increase work meaning in hopes of decreasing burnout (Shanafelt, 2015). For example, the narrative exercises could begin with the worker detailing how his or her work has a positive impact on the lives of both their clients and the client's families. A sense of meaning can be uncovered by having the worker understand that their work is meaningful to the client and their workplace is a vessel where meaningful events are set into motion. Mindfulness practices could be used to help increase meaning in work by having participants take part in grounding exercises where they focus on all the positive changes they made in people's lives while working at their community mental health.

A current program for community mental health staff combined coping skills derived from cognitive-behavioral orientations with other strategies, including mindfulness, meditation, identification of personal meaning, and development of practices of gratitude in a one-day training intervention (Salyers, Rollins, Kelly, Lysaker, & Williams, 2013). Results showed a reduction in emotional exhaustion and depersonalization as well as an increase in positive perceptions of consumers six weeks later. This intervention study included time for participants to develop personal strategies for coping with their own individual stressors (Salyers et al., 2013).

Krishnana and Scullion (2017) have suggested that employees can respond positively to employers' strategies aimed at raising their level of experienced meaningfulness. However, this occurs only when workers feel that these strategies are authentic. Though burnout seems to be most prevalent in the healthcare industry (Geller et al., 2008; Papathanasiou, 2015; Smith, 2014), future researchers could administer the WAMI and MBI-HSS to workforces across different

industries. Researchers have linked burnout to other specific groups of professionals, including first responders (Smith, 2014), pilots (Fanjoy & Harrison, 2010), and veterinarians (Mastenbroek et al., 2014). However, minimal research has been performed to investigate meaning in work for these professionals, which presents a research opportunity for future studies.

Conclusions

Meaningful work is something that many individuals desire and many organizations aim to endorse (Pratt & Ashforth, 2003). Cascio (2003) noted that meaningful work is the single most appreciated feature of employment for most workers. Though research on the beneficial effects of meaningfulness has been sparse, some researchers have indicated that a sense of meaningfulness from work is linked to one's psychological and even one's physical health (Pratt & Ashforth, 2003).

I gathered and analyzed information and discovered that increasing the sense of meaningfulness in one's work is related to burnout, which in turn may improve work performance and increase longevity in the mental health field. Employees often respond positively to employers' strategies aimed at raising their level of experienced meaningfulness (Krishnana & Scullion, 2017), and this is an indicator that discussions on experiencing meaningful work have a rightful place in human resource departments. When employees discover what their work entails and see a purpose to pursuing this work, they become driven to help some greater good (Steger, Littman-Ovadia, Miller, Menger, & Rothmann, 2012), and this can increase meaning in one's work.

When employees are engaged in meaningful work, they are likely to be more cognitively present and available in their work, to become dedicated, to experience efficacy, and to stay

involved (Steger et al., 2012). The current study shows that Steger and his colleagues are correct in what they have surmised. Building work meaning is an authentic and often subjective experience (Bailey et al., 2017), but it is an endeavor worth pursuing if one wishes to have a career in community mental health. If community mental health workers cultivate appreciation for their work's meaning, this capacity might have the potential to sustain their efforts over the long term.

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Appendix A

Informed Consent Form

PSYC 8963-Dissertation

Informed Consent

Study Title: Meaningful Work and Burnout in Community Mental Health

Northwest University
Edward Suarez, Jr.

Purpose: As a member of a mental health organization, you are being invited to participate in this study conducted by Edward Suarez, Jr. at Northwest University in Kirkland, WA. The study is being conducted as part of a dissertation to fulfill degree requirements. The purpose of this study is to examine the relationship between the depth to which individuals experience their work as meaningful and burnout.

What is expected of you: If you agree to participate in the study you will participate in two short questionnaires in addition to demographic questions. The first questionnaire consists of ten questions on a five point Likert scale. The second questionnaire consists of twenty-two multiple choice questions. This assignment should take less than ten minutes to complete.

Risks and Benefits: There are minimal risks associated with participation. Some individuals may be uncomfortable answering personal questions. You may choose not to participate in this research study. The benefit of taking part in this study is the opportunity to participate in the research process as a research subject. Answering questions regarding meaning and work may lead the participant to evaluate their current relationship with their work place. Emotions may arise due to this. If for any reason, this questionnaire provokes feelings related to anxiety or depression, please seek assistance from a counselor. The participant may benefit by answering questions about their relationship to work because observing their own responses may likely provide the participant objectivity.

All responses are confidential: Participation in this study is voluntary. You may choose not to participate in this study at any time and for any reason. There will not be any negative consequences for you if you refuse to participate. You may refuse to answer any questions asked. All responses are anonymous; therefore it is important that you **DO NOT** put your name on your response sheet. You may keep this consent form for your records. By completing the survey, you are giving permission to use your responses in this research study.

The results from this study will be presented in a doctoral dissertation. All data forms will be destroyed 11/07/2017.

If you have any questions about this study, contact the principal investigator, Edward Suarez, Jr. Cell: 305-609-7059 Email: edward.suarez11@northwestu.edu

If further questions, please contact my faculty advisor Dr. Becky Sherman, PhD. becky.sherman@northwestu.edu You may also contact the Chair of the Northwest University IRB, Professor James Heugel, at provost@northwestu.edu or 425-889-5763.

Thank you for your consideration of this request.
Edward Suarez, Jr. MA, LMHC, MBA

Becky F. Sherman, PhD

Appendix B

Demographics

Participants will be given the following demographics form prior to starting the survey.

Demographics

Please write in your age: _____

Gender: (circle one) M/F/O

Marital Status: (circle one) Single Engaged Married Separated Divorced Widowed

Employment Status: (circle one) Full-Time Part-Time

Yearly Wages Earned: _____ Time spent working in Mental Health (in years) _____

Please specify your ethnicity: White Hispanic or Latino Black or African American
(circle one)

Native American or American Indian Asian / Pacific Islander

Other

Please specify highest level of education: No high school diploma

High school graduate, diploma or the equivalent
(i.e., GED)

Bachelor's degree

Master's degree

Doctorate degree

Do you work at a community mental health center? _____ Yes _____ No

“Service to Others” entails direct contact with consumers/customers in such a way that the provider/employee serves the needs of the consumer.

Does the excerpt written above describe the kind of work you do? _____ Yes _____ No

How many HOURS do you have direct contact with a consumer/customer in a week? (Does not need to be exact)

Appendix C

Work and Meaning Inventory

The Work and Meaning Inventory. Work can mean a lot of different things to different people. The following items ask about how you see the role of work in your own life. Please honestly indicate how true each statement is for you and your work.

	Absolutely Untrue	Mostly Untrue	Neither True nor Untrue	Mostly True	Absolutely True
1. I have found a meaningful career	1	2	3	4	5
2. I view my work as contributing to my personal growth.	1	2	3	4	5
3. My work really makes no difference to the world.	1	2	3	4	5
4. I understand how my work contributes to my life's meaning.	1	2	3	4	5
5. I have a good sense of what makes my job meaningful.	1	2	3	4	5
6. I know my work makes a positive difference in the world.	1	2	3	4	5
7. My work helps me better understand myself.	1	2	3	4	5
8. I have discovered work that has a satisfying purpose.	1	2	3	4	5
9. My work helps me make sense of the world around me.	1	2	3	4	5
10. The work I do serves a greater purpose.	1	2	3	4	5

© 2011 Michael F. Steger. *The Work and Meaning Inventory (WAMI)* can be used in research and educational capacities without restriction. Permission for commercial or revenue-generating applications of the WAMI must be obtained from Michael F. Steger prior to use.

Scoring instructions for the WAMI (Steger, Dik, & Duffy, 2012).

- Add the ratings for items 1, 4, 5, and 8 to get the “*Positive Meaning*” score. The *Positive Meaning* scale reflects the degree to which people find their work to hold personal meaning, significance, or purpose.

- Add the ratings for items 2, 7, and 9 to get the “*Meaning-Making through Work*” score. The *Meaning-Making through Work* score reflects the fact that work is often a source of broader meaning in life for people, helping them to make sense of their live experience.
- Subtract the rating for item 3 from 6 (e.g., if a client gave item 3 a rating of 2, then their converted rating would be 4 [6-2=4]); add this number to the ratings for items 6 and 10 to get the “*Greater Good Motivations*” score. The *Greater Good Motivations* score reflects the degree to which people see that their effort at work makes a positive contribution and benefits others or society.
- The *Positive Meaning*, *Meaning-Making through Work*, and *Greater Good Motivations* scores can all be added together to get the test-taker’s overall **Meaningful Work** score. The **Meaningful Work** score reflects the depth to which people experience their work as meaningful, as something they are personally invested in, and which is a source of flourishing in their lives.

Low scores on any of these scales reflect an absence of work meaning, and may be predictive of poor work engagement, low commitment to one’s organization and intentions to leave, low motivation, a perceived lack of support and adequate guidance from leadership or management. People who score low on these scales are also more likely to be absent from work and experience both low levels of well-being and higher levels of psychological distress.

For more information on the development of the WAMI, please consult:

Steger, M. F., Dik, B. J., Duffy, R. D. (in press). Measuring Meaningful Work: The Work and Meaning Inventory (WAMI). *Journal of Career Assessment*.

For a case vignette of how to use the WAMI with individual clients, please consult:

Steger, M. F., Dik, B. J., & Shim, Y. (in press). Assessing meaning and satisfaction at work. In S. J. Lopez (Ed.), *The Oxford handbook of positive psychology assessment* (2nd Ed.). Oxford, UK. Oxford University Press.

To contact the test developer, please contact michael_f_steger@yahoo.com.

Appendix D

Maslach Burnout Inventory (MBI)

For use by Edward Suarez only. Received from Mind Garden, Inc. on June 7, 2016



www.mindgarden.com

To whom it may concern,

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Instrument: **Maslach Burnout Inventory, Forms: General Survey, Human Services Survey & Educators Survey**

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Sincerely,

Robert Most
Mind Garden, Inc.
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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.

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
SECTION A	0	1	2	3	4	5	6
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.							
Total score – SECTION A							