A MIXED METHODS APPROACH TO INVESTIGATING SELF-CARE, ATTACHMENT AWARENESS, AND BURNOUT IN MARRIAGE AND FAMILY THERAPISTS

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DEDICATION

This dissertation is dedicated to my daughters, Lera and Sylvia. May you both always remember you can achieve anything in this lifetime.

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ABSTRACT

MARY HANNAH KEY

A MIXED METHODS APPROACH TO INVESTIGATING SELF-CARE, ATTACHMENT AWARENESS, AND BURNOUT IN MARRIAGE AND FAMILY THERAPISTS

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The purpose of this convergent mixed methods study was to expand our knowledge of the experience of burnout among marriage and family therapists in terms of attachment experiences, self-care, and clinical practice during the first year of a global health crisis. This study is significant as the voices of marriage and family therapists are underrepresented in the mental health literature concerning burnout and work-life balance. A major goal of this study was to bring increased awareness of the experience of burnout to the mental health field. This study was funded by the Hogg Foundation for Mental Health with grant money from the Frances Fowler Wallace Memorial Award.

Participants were predominantly fully licensed marriage and family therapists (LMFT; *n* = 67) and LMFT Associates (*n* = 27). The quantitative analyses compared participant burnout scores on the three subscales of the Maslach Burnout Inventory – Human Services Survey (MBI-HSS) and participant global adult attachment scores on the Experiences in Close Relationships-Relationship Structures (ECR-RS). Multiple linear regression analyses revealed that therapists with an avoidant attachment style scored higher on the emotional exhaustion and depersonalization subscales, and lower on the personal accomplishment subscale of burnout when compared to therapists with an anxious attachment style. Other variables included therapists' awareness of their attachment style, frequency of self-care practices, and average

number of clients per week. A correlation analysis found the strongest significant association between therapists' frequency of self-care practices and all three subscales of burnout.

Responses to the four qualitative open-ended questions explored participant experiences with personal and work-related challenges during COVID-19, self-care practices, and attachment knowledge and its impact on clinical work. A total of 32 participants (16 males and 16 females) shared data that were coded into themes such as Diminished emotional functioning, Personal dysfunction, Disengaged and detached, and Professional discontent. These themes call attention to the challenges marriage and family therapists face as they juggle managing their personal and professional lives during an ongoing global pandemic. Strategies and interventions can be developed to support therapists' ability to cope with the experience of burnout, maintain overall wellness, and ensure quality therapeutic care in clinical practice.

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CHAPTER I

INTRODUCTION

This study examined the relationship between burnout syndrome and the utilization of self-care practices and awareness of adult attachment style among practicing marriage and family therapists from an attachment theory perspective. Existing research investigating the burnout of marriage and family therapists exclusively is sparse, and the need for greater understanding about the protective factors and predictors associated with the experience of burnout for these helping professionals is warranted (Chen et al., 2019; Rosenberg & Pace, 2006; Sahibzada, 2019). During this exceptional time of a global health pandemic, therapists' ability to take care of themselves is incredibly important. More so now than ever, therapists run the risk of developing symptoms of burnout as they juggle working from home, managing their personal lives, and continuing to provide quality therapeutic care to their clients. Consequently, it is imperative that therapists recognize the need to take time to care for themselves. If therapists are intentional about their approaches to self-care and able to reach out for adequate sources of support, they will likely be better equipped to nourish their overall health and well-being as well as maintain clinical efficacy in their work for helping others (Golshani, 2012; Razo, 2018; Rinn, 2016; Sahibzada, 2019).

Prevalence of Burnout in a Highly Demanding Field

An issue encountered by many marriage and family therapists is the experience of burnout symptoms due to the demand of their work as clinicians, often resulting in a general lack of engagement in self-care practices and the need for positive, dependable support systems (Chen et al., 2019). In fact, many researchers believe that marriage and family therapists are likely to be at greater risk of developing burnout and negative health-related outcomes because of the

stressful nature of their work as systemic mental health providers (Chen et al., 2019; Cunningham, 2015; Franco, 2015; Golshani, 2012; Negash & Sahin, 2011; Razo, 2018; Rinn, 2016; Rosenberg & Pace, 2006; Sahibzada, 2019). According to Maslach et al. (1996), the chronic stress therapists may encounter through their continuous work with clients' problems can be emotionally draining and can lead to burnout. Additionally, elevated rates of burnout and stress among clinicians has been previously linked to various indicators of diminished functioning, including sleep disturbances, headaches, higher degrees of alcohol use, and marital and family problems (Maslach et al., 1996).

In the state of Texas, demographic data indicates the marriage and family therapist workforce is predominately female. In 2020, 70.6% of marriage and family therapists were female while 29.4% were male (Health Professions Resource Center & Statewide Health Coordinating Council, 2021). These data are important to highlight, as more of today's therapists may be faced with evolving feelings of burnout. Researchers that examined the relationship of burnout to gender found that females are more at risk of developing burnout symptomology compared to their male counterparts (Chen et al., 2019; Rinn, 2016). Rinn (2016) found that females scored higher on emotional exhaustion than males. Therapists' workplace setting is also a significant indicator of developing burnout, specifically for those working in community organizations and agency settings who are considered more at risk compared to those in private practice (Franco, 2015; Negash & Sahin, 2011; Rosenberg & Pace, 2006).

For a number of marriage and family therapists, specifically, the level of therapeutic work goes beyond that of just the treatment of an individual client, but often includes working with multiple complex systems (Rosenberg & Pace, 2006). Many systemic therapists work with dysfunctional family systems and highly distressed couples (MacKay, 2017). The couples and

families that systemic therapists encounter may be facing problems such as domestic violence, substance abuse, mental illness, and trauma or abuse (Gottman et al., 2019; Killian, 2008; MacKay, 2017; West, 2015). Recently, Gottman et al. (2019) found that couples entering couples therapy are far more troubled and distressed, with many more co-morbidities, than a majority of the research presented in previous literature had suggested. The results of this sizeable study are quite startling, as the authors point out that the field has significantly underestimated the severity of problems confronting systemic therapists today (Gottman et al., 2019). It is possible that high-risk clients such as those studied by Gottman et al. (2019) would likely take a toll on even the most seasoned mental health professional.

Brief Literature Review

Work-Life Balance and Self-Care

A large majority of mental health providers are often faced with countless struggles regarding their ability to maintain a positive work-life balance and preserve overall health and wellness (Baldwin et al., 2012; Figley, 2002; Gaal, 2009; Jorgensen, 2012; Killian, 2008; Lee et al., 2011; Macchi et al., 2014; Maslach & Leiter, 2016; Rupert et al., 2015). It has been well established in the literature that professionals in the human service and health care industry often have physically, cognitively, and emotionally demanding jobs (Barnett et al., 2007; Killian, 2008; Maslach & Leiter, 2016; MacKay, 2017; West, 2015). Among professionals in the mental health services, the general goal of their work is to help individuals, couples, and families who are experiencing some degree of distress and struggling in life. Highly demanding jobs carry with them a number of challenges and stressors that may add to a therapist's risk of personal and professional impairment (Razo, 2018). It is not uncommon in this line of work for mental health

providers to become distressed themselves and experience symptoms of burnout (Eddington, 2006; Negash & Sahin, 2011).

It is well documented by studies of systemic therapists in the mental health field that the relational work they do with clients can be very challenging and distressing therapeutic work (Chen et al., 2019; Cunningham, 2015; Macchi et al., 2014; Razo, 2018; Rinn, 2016). Therapists that experience heightened levels of work-related stress are considered more vulnerable to developing symptoms of burnout if they are not aware of the importance of self-care and effective boundaries for sustaining a healthy work-life balance (Chen et al., 2019; Cunningham, 2015). The onset of burnout symptoms not only impacts therapists' clinical efficacy, but can also negatively influence their own personal relationships, such as with their romantic partners, children, and other important family members (Cunningham, 2015; Macchi et al., 2014; Negash & Sahin, 2011).

An important element of self-care involves reaching out for adequate sources of support, including family, friends, colleagues, peers, and supervisors. If therapists do not engage in secure ways of support seeking behaviors or recognize the need to have a deeper understanding of themselves in how they cope with distress or effectively practice meaningful self-care, then they are undeniably at-risk for developing symptoms of burnout and the associated negative outcomes (Barnett et al., 2007; Sahibzada, 2019; Scarcella, 2005). Not only will these therapists potentially struggle with such a professional blind spot, but there are significant ramifications at stake for the well-being of their clients as well (Beatty, 2018; Steel et al., 2018).

Therapist Attachment Style and Self-Care

Furthermore, most systemic therapists as professional caregivers are trained to attend to their clients' emotional distress and difficulties (Armes, 2014; Deveraux, 2010; Scarcella, 2005). From this relational perspective, the therapist is often placed as an active participant in the

therapeutic relationship by operating as a secure base and safe haven for clients (Beatty, 2018; Johnson, 2004). As a result, many therapists are potentially at increased risk for overlooking or ignoring their own needs and emotional distress. In relation to burnout, Golkar et al. (2014) found that higher degrees of burnout and stress are linked to difficulties in adequately regulating negative emotions. Failure to focus on one's own needs and personal distress is likely a professional blind spot among many practicing clinicians (Barnett et al., 2007). It is possible that this type of professional blind spot is related to the therapist's own attachment system, which involves their internal working model of self (Bowlby, 1988) and social relations with others. The attachment style of the therapist likely plays an influential role in determining the use of self-care strategies and support seeking behaviors when experiencing symptoms of burnout and distress (Scarcella, 2005).

For a marriage and family therapist, the unfortunate consequence of having such a blind spot may then result in either completely missing the signs of impending burnout, or worse, minimizing and denying them as an attempt to present oneself as the strong, secure professional caregiver (Armes, 2014; Devereaux, 2010; Scarcella, 2005). As Barnett et al. (2007) stated, "such a blind spot may be a major risk factor for allowing emotional distress to lead to impaired professional competence" (p. 605). In these situations, it would be important for the therapist to have a level of awareness of their own attachment behaviors as this may impact their ability to effectively engage with dependable support systems as well as engage in meaningful, self-care practices as a means for preventing or worsening burnout symptoms. However, therapists must feel capable to seek out these dependable support systems and other forms of self-care strategies that will allow them to take better care of themselves (Armes, 2014). In turn, this would allow

the therapist to have a better sense of overall health and well-being as well as maintain clinical efficacy (Beatty, 2018; Gillath et al., 2005).

Theoretical Framework

This study is guided by John Bowlby's seminal work on attachment theory (Bowlby, 1969, 1988) and the expansions his successors added to his early formulations of attachment, including adult attachment and the theory of romantic love (Bartholomew, 1990; Hazan & Shaver, 1987). Additionally, this study considers the empirically validated therapy model, emotionally focused couple therapy (EFT) as an extended framework for which to explore adult attachment and human relationships as an attachment process (Johnson, 2004, 2019). Attachment theory gives this research study a coherent, contextual lens to both conceptualize and explain how healthy and unhealthy forms of patterned behaviors show up across all human relationships, both past and present.

Attachment Theory

The key figure in attachment theory, John Bowlby, formerly presented his study of attachment as a developmental theory of personality (Bowlby, 1969, 1988). Central to Bowlby is the premise that an individual's earliest life experiences largely contribute to the continuing development of their personality. Yet, Bowlby did not characterize individuals by a collection of static traits, rather he viewed individual adaptation as an ongoing process in which an individual reacts to and shapes their interpersonal world in terms of inner working models of self and other (Sroufe, 1986). Bowlby termed the concept, internal working models, as a set of principles used to predict how the world operates. Internal working models unfold into two categories, including models of self and models of other (Bowlby, 1969). From this basic notion, the application of

attachment styles emerged as descriptions of internal working models, which can now be used in a measurable manner (Fraley et al., 2000).

Bowlby (1988) and Ainsworth et al.'s (1978) seminal research of the formation of an attachment relationship between infant and caregiver provided researchers with a map to the intricate landscape of how human attachment bonds are formed during early childhood. From this influential research, Ainsworth et al. (1978) formulated the concept of secure attachment. Ainsworth et al. outlined three distinct patterns of infant attachment behaviors, which she referred to as secure, ambivalent, and avoidant. The terminology she used to characterize attachment behaviors has since expanded and variations now exist in the literature. From Ainsworth et al.'s (1978) seminal work, these behavioral responses were used to describe the differences in how a caregiver demonstrates accessibility, responsiveness, and emotional engagement in attending to their child's signals and need for comfort and closeness.

Adult Attachment Styles

According to attachment theory, individuals develop secure or insecure attachment styles in childhood, and these often remain relatively stable in adulthood (Bowlby, 1988; Fraley, 2002; Hazan & Shaver, 1987). However, as attachment-related research has continued to evolve, it is suggested that individuals develop attachment style orientations, which involve emotional responses and behaviors that are more often relationship specific across multiple contexts (Fraley, 2002; Fraley et al., 2000; Fraley, Heffernan et al., 2011). From this perspective, individuals hold distinct inner working models, both intrapersonal and interpersonal, across different adult relationships (Fraley, Heffernan et al., 2011). When people feel supported and cared for, they are more likely to report feeling secure in their relationships with others.

Similarly, when people do not feel understood and supported, they are more likely to report greater levels of insecurity (Fraley, Heffernan et al., 2011).

Secure Attachment

According to attachment researchers, secure attachment fosters effective dependence, autonomy, and self-confidence (Johnson, 2004). An individual's attachment style serves as a blueprint of their basic assumptions about safety and trust, and often determines whether or not they can successfully give and receive support and handle conflict (Gillath et al., 2005). Furthermore, secure attachment is associated with a more coherent, articulated, and positive sense of self. The more securely connected one is, the more separate and different one can be (Johnson, 2004). For people of all ages, secure attachment creates a safe haven that offers a buffer against the effects of stress and uncertainty (Johnson, 2004).

Anxious Insecure Attachment

Individuals with anxious attachment behaviors tend to have a negative model of self and positive model of others. Adults with anxious attachment often desire close relationships with others, but are fearful in maintaining closeness. Their maladaptive functioning tendencies may include high emotional expressiveness, anxiety, and impulsiveness (Bartholomew, 1990). In romantic relationships, these individuals tend to seek high levels of intimacy, approval, and responsiveness from their partners (Shaver & Hazan, 1988). Additionally, those with anxious attachment often fear closeness with others and may demonstrate behaviors including high emotional reactivity, persistent interpersonal distrust, and fear of rejection (Bartholomew, 1990). These individuals tend to have mixed feelings about close relationships and may also actively avoid social situations. In adult relationships, they usually view themselves as unworthy of love and often do not trust the intentions of their partners (Bartholomew, 1990).

Avoidant Insecure Attachment

Adults with avoidant attachment have a positive model of self and a negative model of others. For individuals classified with an avoidant attachment style, Shaver and Hazan (1988) define these individuals as being somewhat uncomfortable in maintaining closeness with others. Additionally, these adults generally find it difficult to trust or depend on their partners, and often feel nervous in allowing themselves to depend on them. Their maladaptive functioning tendencies typically include high levels of avoidance, defensiveness, and a preoccupation with self-sufficiency (Bartholomew, 1990). In adult relationships, individuals with this style tend to view themselves invulnerable to feelings associated with being close with others and often deny needing close or intimate relationships (Bartholomew, 1990).

Attachment Theory and EFT

Sue Johnson's (2004) emotionally focused couple therapy (EFT) is an experiential therapy model originally created as an approach for specifically working with distressed couples. Since its inception, EFT has continued to develop and grow as an empirically validated model for working with individuals, couples, families, and even high-risk populations (Johnson, 2019). The EFT model originated from humanistic client-centered and systemic approaches and is derived from Bowlby's (1988) attachment theory and Hazan and Shaver's (1987) theory of love and adult attachment styles. Johnson's (2004) integration of knowledge about attachment and bonding in close relationships led to the creation of this prominent and well-researched model of therapy.

The EFT perspective on adult attachment is connected to many basic principles of Bowlby and Ainsworth's attachment theory. The attachment system is viewed as a universal, innate motivating force (Johnson, 2004). In other words, the need to seek out and maintain

connection with significant others is an inherent need of all human beings across the life span. Secure dependence in an individual is valued and seen in terms of autonomy, self-confidence and effective dependence on others. Similarly, positive attachment in close relationships provides protection against the stressors and uncertainty of life and is also directly related to positive psychological health and growth. Secure attachment affords adults with a secure base from which they can explore and adapt to their environment. Furthermore, emotional engagement (i.e., accessibility and responsiveness) is viewed as the building block of forming secure bonds with others (Johnson, 2004).

In the face of distress and uncertainty, the attachment system becomes activated. For instance, when individuals experience a threat, either from a traumatic event or perhaps a more general aspect of everyday life such as stress, powerful emotions emerge, and attachment needs for close connection and comfort become especially prominent (Johnson, 2004). If attachment needs are not met, individuals will demonstrate predictable responses in their behaviors, such as angry protesting, anxious clinging, hostility, or avoidant withdrawal. An EFT therapist understands these attachment behaviors as the basic dramas of distress in close relationships.

In terms of adult attachment styles, from an EFT perspective, there are only a finite number of ways that individuals cope with the unresponsiveness of attachment figures. Conceptually, EFT organizes attachment style responses along two dimensions of insecure attachment, anxiety and avoidance, which closely follows the work of Fraley et al. (2000). On one end of the spectrum, when an individual's attachment system becomes activated, attachment behaviors heighten and often become more intense. The most commonly observed behaviors in anxiously attached individuals include criticism, blaming, and pursing, all of which are attempts to cope with and resolve attachment hurts and fears (Johnson, 2004).

Conversely, avoidantly attached individuals attempt to deactivate the attachment system and suppress attachment needs. From this perspective, commonly observed behaviors include withdrawing, shutting down, and avoiding conflict. These coping strategies are attempts to regulate fears of rejection and confirmation of fears about the unlovable nature of the self (Johnson, 2004). According to EFT theorists, avoidant individuals are often socially skilled but avoid seeking or giving support when attachment needs arise within them or their partner. Ultimately, these insecure attachment styles become habitual self-maintaining patterns of social interaction that involve specific behavioral strategies to regulate emotions and protect the self from rejection and abandonment, as well as cognitive representations or working models of self and other (Johnson, 2004, 2019).

In clinical practice, the EFT approach is considered both integrative and experiential, as it is focused around "how systemic pattern and inner experience and sense of self evoke and create each other" (Johnson, 2004, p. 9). This approach is experiential in that it focuses upon the process of how people actively process and construct their experience in interactions with their environment (Johnson, 2004). Emotions are considered the primary focus in the model, as Johnson (2004) explained, "emotions are privileged precisely because they orient people to their world and tell people what they need and fear" (p. 15). Lastly, the role of the therapist in EFT is to act as a process consultant and collaborator, helping clients reprocess their experience of distress in close relationships and facilitate new corrective emotional experiences from which the therapist operates as a secure base and safe haven for the clients (Johnson, 2019).

Statement of Problem

There are few research studies that have been solely dedicated to using an attachment perspective for examining therapist attachment styles and burnout (Armes, 2014; Carr & Egan,

2017; Devereaux, 2010; West, 2015) as well as the utilization of self-care practices as a protective factor for the experience of burnout among marriage and family therapists (Chen et al., 2019; Cunningham, 2015; Eddington, 2006; Golshani, 2012; Razo, 2018; Rinn, 2016; Rosenberg & Pace, 2006; Sahibzada, 2019). In most research studies that have assessed the predictors and outcomes of burnout and associated adaptive coping strategies, marriage and family therapists are often not included or are grouped with other mental health providers, such as psychologists, social workers, licensed professional counselors, psychiatrists, and occupational therapists (Devereaux, 2010; Lee et al., 2011; Maslach & Leiter, 2016; Reichert Schimpff, 2019). Therapist self-awareness of their attachment style orientation and the utilization of self-care practices as supportive factors against burnout among marriage and family therapists is even more sparse in the literature, as these variables are often only explored separately and with other groups of mental health providers (Barnett et al., 2007; Carr & Egan, 2017; Killian, 2008; Pines, 2004; Scarcella, 2005; West, 2015). These findings point to the need for more research on understanding the experience of burnout among marriage and family therapists as a group, as well as identifying possible protective factors for preventing or mitigating symptoms of burnout and negative health-related outcomes.

Additionally, an overwhelming majority of the current research conducted on this topic have been quantitative studies, which suggests that the voices of marriage and family therapists have not been heard through much of the available research (Lee et al., 2011; Rosenberg & Pace, 2006; West, 2015). A large gap exists in the literature, as past studies have only provided a partial view of this phenomena by using mostly quantitative and, on rare occasions, qualitative approaches. There is certainly a need for a more complete understanding through comparing and

integrating both quantitative and qualitative data, such as from a convergent mixed methods design.

Statement of Purpose

The purpose of this study was to examine the relationship between burnout symptoms and the utilization of self-care practices and awareness of adult attachment style among practicing marriage and family therapists. The study is significant because when more knowledge is associated with the beneficial use of attachment style awareness and meaningful practices of self-care, marriage and family therapists may be better equipped to recognize their own personal limitations and clinical blind spots, which will enable them to approach their work with better care and intentionality. Increasing self-awareness of their own attachment style and having an understanding of their general attachment style will aid marriage and family therapists to effectively engage in healthy coping strategies that may prevent burnout or lead to the improvement of burnout symptoms. If burnout symptomology is detected earlier, the marriage and family therapist can quickly partake in adaptive coping strategies, including effectively seeking and using dependable support systems and engaging in meaningful self-care practices.

Rationale/Significance of Study

With a level of awareness about their attachment style, marriage and family therapists will also be able to assist in helping support the well-being of other clinicians in the field of mental health who may be suffering from symptoms of burnout. Normalizing the experience of burnout as something that many marriage and family therapists will likely experience at some point in their personal and professional lives will help practicing therapists to feel comfortable and confident in assessing their own level of burnout throughout their career (Sahibzada, 2019). As a result, this

may aid in their taking the necessary steps that are needed to decrease burnout levels for themselves and in others, as well as protecting their work-life balance.

Practicing marriage and family therapists will also benefit from this study by considering how they use attachment style awareness in their approach to clinical practice and self-care to maintain work-life balance. The field of marriage and family therapy would benefit by helping graduate family therapy training programs and educators to identify how to best educate therapist interns about the risks of burnout and the importance of engaging in self-care practices. Additionally, findings from the study may help educators and clinicians be better equipped with assessment tools, workshops, and trainings to assess burnout symptoms and integrate attachment style awareness and self-care methods into their programs and practice.

The Researcher's Role

The role of the researcher as the primary investigator necessitates the identification of personal values, insights, and biases at the outset of the research study (Creswell & Creswell, 2018). My perceptions of higher education, burnout, work-life balance, self-of-the-therapist awareness, and practice of self-care have been shaped by my professional and personal experiences. Beginning in August 2014, I began working toward obtaining my doctorate degree in marriage and family therapy at Texas Woman's University (TWU). Throughout this time, I maintained the enrollment status of a full-time student while I worked as a graduate teacher assistant, a clinic manager at the TWU campus community clinic, and a graduate research assistant.

Most recently (2019-2022), I have worked as a licensed marriage and family therapist associate in a group practice setting, which primarily serves couples in the Dallas, Texas metroplex. In addition to my educational and professional experiences, I have become a wife and

new mother within the past 3 years. I have experienced both personal and professional feelings of heightened stress and anxiety, symptoms of burnout as a therapist, a general lack of practicing good self-care, and difficulty in utilizing dependable support systems. As I formed close relationships with other graduate student peers and professional colleagues in the mental health field through the years, I have realized that I am not alone, as it has become more apparent to me that there are many in the helping professions who also struggle with these many parts of their lives. I believe this understanding of the context and my role enhances my awareness, knowledge, and sensitivity to many of the challenges encountered as a marriage and family therapist. I initiated this study with the perspective that managing a healthy work-life balance as a marriage and family therapist is often difficult, as I continue to believe that the awareness and recognition of burnout symptoms and need for therapists to engage in self-care and effective dependence of others is crucial to our well-being in this profession.

Due to these previous experiences, I brought certain biases to this research study. While every effort was made to ensure that my biases did not impact the development of the study, I acknowledge my natural subjectivity may have shaped the ways I understood and interpreted the data I collected. To bracket my biases, I worked with my major professor as my co-coder for coding the qualitative data yielded in this study. More detail is included in Chapter 3.

Research Questions and Hypotheses

The following are the two research questions and related null hypotheses that are the focus of this convergent mixed methods research study.

RQ-1: How does adult attachment style predict level of burnout among marriage and family therapists?

$H_0$1: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and emotional exhaustion subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

$H_0$2: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and depersonalization subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

$H_0$3: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and personal accomplishment subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

RQ-2: What is the relationship between awareness of one's own adult attachment style, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and population of clients to the level of burnout symptoms among marriage and family therapists?

$H_0$4: There will be no statistically significant difference/relationship when the level of awareness of one's own adult attachment style, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and population of clients are compared to the scores of burnout from marriage and family therapists.

Qualitative Open-Ended Questions

The qualitative portion of this study focused on further exploration of participants' quantitative responses regarding burnout symptomology, work-related factors, self-care practices, and own adult attachment style. These four qualitative, open-ended questions identify how participants perceive symptoms of burnout, experience providing mental health services during the COVID-19 pandemic, utilize methods of self-care, as well as determine the degree of familiarity with their own adult attachment style and how they use this self-awareness in clinical practice.

Q1: How do you personally experience the thoughts and feelings of burnout? (i.e., please describe what it means to you to feel "burned out").

Q2: Please describe any personal and professional challenges you have experienced with providing telemental health services and/or in-person services to individuals, couples, and/or families during the COVID-19 pandemic.

Q3: Please describe what self-care means to you, and then identify/list what strategies or methods of self-care practices you currently use that you find most helpful to you.

Q4: Prior to this study, please describe what you know about attachment theory and what your own adult attachment style means to you, and to what extent, if any, this has informed your clinical work as a systemic, relational therapist.

Definition of Terms

Attachment Style: A person's attachment style is "related in theoretically meaningful ways to mental models of self and other," (i.e., social relationships) and "determined in part by early childhood relationship experiences with parents" (Hazan & Shaver, 1987, p. 511).

Burnout Syndrome: A syndrome of three types of feelings including emotional exhaustion, depersonalization, and low personal accomplishment. “Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling” (Maslach et al., 1996, p. 1).

Client: “An individual, family, couple, group, or organization who receives or has received services from a person identified as a marriage and family therapist who is either licensed by the board or unlicensed” (Texas State Board of Examiners of Marriage and Family Therapists, 2019, p. 1).

Depersonalization: “An unfeeling and impersonal response toward recipients of one’s service, care, treatment, or instruction” (Maslach et al., 1996, p. 16).

Distress: “A subjective emotional state or reaction experienced by an individual in response to ongoing stressors, challenges, conflicts, and demands” (Barnett et al., 2007, p. 603). Distress is not just fully present or completely absent, it may develop and progress if left unchecked (Barnett et al., 2007).

Emotional Exhaustion: “Feelings of being emotionally overextended and exhausted by one’s work” (Maslach et al., 1996, p. 16).

Impairment, or Impaired Professional Competence: “The deleterious impact of distress, left untreated over time, on the professional’s competence as well as the negative effects of other personal or professional factors that adversely impact one’s competence” (Barnett et al., 2007, p. 604). Impairment is not just fully present or completely absent, it may develop and progress if left unchecked (Barnett et al., 2007).

Licensed Marriage and Family Therapist (LMFT): “A qualified individual licensed by the board to provide marriage and family therapy for compensation” (Texas State Board of Examiners of Marriage and Family Therapists, 2019, p. 2).

Licensed Marriage and Family Therapist Associate (LMFT Associate): “A qualified individual licensed by the board to provide marriage and family therapy for compensation under the supervision of a board-approved supervisor” (Texas State Board of Examiners of Marriage and Family Therapists, 2019, p. 2).

Marriage and Family Therapy: “The rendering of professional therapeutic services to clients, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapeutic services to those persons” (Texas State Board of Examiners of Marriage and Family Therapists, 2019, p. 2).

Personal Accomplishment: “Feelings of competence and successful achievement in one’s work with people” (Maslach et al., 1996, p. 16).

Self-Care: The use of positive, adaptive coping responses, strategies, and activities as a means of managing ongoing distress and challenges in an individual’s personal and professional life. Awareness of one’s own functioning and the practice of continuous self-care efforts is known to improve psychological wellness and helps to alleviate the risk of developing symptoms of distress, burnout, and impaired professional competence (Barnett et al., 2007).

Delimitations

1. Participants under the age of 21 were excluded from this study.

2. Participants were delimited to therapists who had a graduate degree in marriage and family therapy from a program in the state of Texas. Consequently, most participants were licensed in the state of Texas at the level of associate or fully licensed LMFT. A

small group of participants holding a graduate degree in marriage and family therapy held the license of a licensed professional counselor (LPC), licensed clinical social worker (LCSW), or had a dual license as a marriage and family therapist with another equivalent license.

3. My decision to use qualitative open-ended questions in this study were to give rise to the hidden context of meaning embedded in the quantitative data.

Assumptions

Based on previous research and current theoretical frameworks the following assumptions were made:

1. The participants will answer demographic, quantitative, and qualitative questions entirely and truthfully on the online PsychData survey.

2. The participants included in this study will fit the inclusion criteria required to participate in the present study.

3. Participation in this study is completely voluntary.

Summary

Marriage and family therapists are often inadequately represented in the current literature regarding associations among adult attachment style, the practice of self-care, and burnout syndrome (Lee et al., 2011; West, 2015). The purpose of this convergent mixed methods study was to help build knowledge and awareness that will support systemic therapists' ability to effectively cope with the experience of burnout in a way that fosters resiliency and growth. Having a greater understanding of the symptoms of burnout and the proper means for taking care of oneself in meaningful ways will allow therapists to approach their clinical work with better care and intentionality. By engaging dependable support systems, fostering a sense of deeper

self-awareness of attachment style, and routinely practicing self-care, therapists' health and wellness can also be nurtured. The experience of burnout does not have to be detrimental to the overall health and well-being of the therapist but can be used as a catalyst to redefine what it means to have a positive work-life balance that will nourish them both personally and professionally.

CHAPTER II

LITERATURE REVIEW

Introduction

There is a variety of terminology used in the present literature to describe the experience of occupational distress and poor well-being among professionals in the fields of human services, education, and health care. The most common terms researchers have used synonymously to describe this phenomenon include burnout (Maslach, 2003; Maslach & Jackson, 1981), compassion fatigue (Armes, 2014; Reichert Schimpff, 2019), secondary traumatic stress (Cunningham, 2015; MacKay, 2017), and vicarious traumatization (Maslach & Leiter, 2016; Saakvitne & Pearlman, 1996). Maslach (2003) defined burnout as a psychological syndrome involving the process of depletion of an individual's physical, mental, and emotional resources. Symptoms include emotional exhaustion, disengagement, cynicism, depersonalization, fatigue, helplessness, hopelessness, and incompetence. The initial phase of work-related distress that leads to burnout typically involves the actions of emotional and cognitive distancing, presumably as a way to cope with workload demands and maladaptive stress-related responses.

Burnout in Human Service and Health Care Professions

According to researchers, burnout research has been clearly grounded in the realities of people's experiences in the workplace, particularly in relation to those professionals in the human service and health care occupations (Maslach, 2003). Burnout researchers have focused on both situational factors (e.g., difficult job demands, the presence of conflict, lack of social support and community) and individual factors (e.g., personality, interpersonal conflict, physical and emotional health, ability to cope effectively) that contribute to the development of burnout syndrome (Lee et al., 2011; Maslach, 2003; Maslach & Leiter, 2016). Work overload is

recognized as a major risk factor, as it gives little opportunity for individuals to rest, recover, and restore balance (Maslach & Leiter, 2016). Additionally, lack of support, trust, insufficient recognition, and unresolved conflict all lead to greater risk of burnout and are closely related to feelings of inefficacy and cynicism.

In terms of outcomes, burnout research has been associated with various forms of negative reactions, including job dissatisfaction and withdrawal, lower productivity and impaired quality of work, strained social relationships, and stress-related poor health (Maslach & Leiter, 2016). The factor of quality of health is cyclical in that poor health contributes to burnout and burnout contributes to poor health. Regardless of which comes first for the individual, the feeling of exhaustion is characteristically correlated with burnout and stress-related health, including symptoms of chronic fatigue, headaches, muscle tension, weakened immune system, as well as anxiety and depression (Baldwin et al., 2012; Leiter & Maslach, 2016; Maslach & Leiter, 2016). According to Maslach (2003), a consistent theme described in the burnout literature is the problematic relationship between the individual and the workplace environment. This phenomenon is often described in terms of work-life imbalance. The need for clinicians to be able to separate their personal life from their professional role appears to be a critical factor for lessening the development of burnout. As Negash and Sahin (2011) suggested, a therapist's own family can be affected by the problems that are experienced by their clients, which can simultaneously lead to disintegration of the therapist's clinical efficacy and family life.

Burnout in Psychotherapists

A majority of the literature that has focused on the development of burnout, associated outcomes, and prevention-intervention strategies among the human and health services typically includes nurses, social workers, occupational therapists, psychologists, psychiatrists, and

licensed counselors. Rarely are marriage and family therapists represented as a group in these studies. Yet, as the number of trained and licensed practicing marriage and family therapists continues to grow, so does the vulnerability for these systemic therapists to experience symptoms of burnout. While the literature on burnout among marriage and family therapists is small, the findings echo what has been studied among other mental health professions.

Risk Factors

Risk factors that may be more unique to the work of marriage and family therapists involve several aspects of the therapist's job, including workplace setting (Chen et al., 2019; Razo, 2018), workload demands (Eddington, 2006; Killian, 2008; Macchi et al., 2014), and access to available support systems (Barnett et al., 2007; Rosenberg & Pace, 2006). Researchers have found that therapists working in agency settings, such as community health centers or in-patient hospitals, often face more stressful issues involving administrative tasks and may be more vulnerable to burnout than those who work in private practice (Gaal, 2009; Razo, 2018). However, therapists in private practice are also at risk of being more isolated with limited support systems available in their work environment (Barnett et al., 2007; Rosenberg & Pace, 2006). The number of hours therapists work per week and spend time doing paperwork has been recognized as a contributing risk factor to a therapist's vulnerability for developing symptoms of burnout (Eddington, 2006; Killian, 2008). Macchi et al. (2014) also found that home-based family therapists experienced high caseload responsibilities and demands that contributed to their daily workload, often resulting in increased stress and eventual burnout. The challenging demands posed by these work-related risk factors can lead to greater distress and disturbance among systemic therapists, which is considered a powerful force in fueling the feelings of

emotional exhaustion, cynicism, and inefficacy that lead to professional burnout (Maslach & Leiter, 2016).

Other important risk factors involve aspects of the marriage and family therapist's personal life, including their ability to maintain a healthy work-life balance (Cunningham, 2015; Macchi et al., 2014; Negash & Sahin, 2011). For therapists who are also single-parents, factors such as being the primary caregiver in the home, meeting financial responsibilities, and sustaining household tasks while also meeting the needs of clients increased the likelihood of experiencing burnout (Negash & Sahin, 2011). The risk of burnout may also be higher for those therapists who are experiencing their own personal trauma (Reichert Schimpff, 2019). A therapist's lack of awareness of how burnout symptoms influence their personal relationships, specifically with family members, romantic partners, and friends can contribute to increased symptoms of burnout (Cunningham, 2015). For instance, therapists may feel less connected to their partner and unable to be fully present at home while experiencing symptoms of burnout. This may lead to less communication and more dysfunction in the therapists' close, important relationships with others (Cunningham, 2015) as well as directly influence the therapists' ability to effectively provide treatment to their clients (Negash & Sahin, 2011).

In addition to these personal life factors specific to the therapist, clients can present a wide array of problems that may influence a therapist's risk for experiencing burnout symptoms. For example, therapists who work with trauma victims and their families are more at-risk for developing compassion fatigue and burnout (Killian, 2008). Furthermore, clients who are considered highly resistant or who continually challenge their therapists, often place a strain on the therapeutic relationship, which can impact therapists' feelings of self-efficacy and perceived level of competence (Rosenberg & Pace, 2006).

Concurrent to this notion, Gottman et al. (2019) suggested that findings in previous literature may have underestimated the severity of problems confronting therapists in their clinical work with couples and families. Based on their research, couples initiating therapy suffer from greater distress and many more co-morbidities than once presumed. In fact, their assessment of couple relationship functioning and individual issues indicated that over 80% of the 40,681 couples included in their sample in this study had serious problems dealing with both conflict and intimacy. Gottman et al. also questioned the effectiveness of current evidence-based therapeutic interventions used by therapists for issues the actual clinical population face today, suggesting the need to develop interventions that are far more powerful. This research provides the field of marriage and family therapy with important knowledge about the kinds of issues that many of today's couples bring to the beginning sessions of therapy and serves as a dire warning that therapists may not be equipped to effectively provide treatment to the clients they serve.

Prevention and Coping

There have been several suggestions for ways therapists can prevent and protect themselves against burnout. Barnett et al. (2007) recommended an ongoing focus on self-care as essential for the prevention of burnout and maintaining overall well-being. Golshani (2012) found that the engagement of self-care strategies reported by marriage and family therapist interns were related to lower levels of burnout symptoms. Anxiety-reducing techniques, such as the practice of mindfulness, have also been found to help alleviate the symptoms and development of burnout among therapists (Armes, 2014; Farin, 2015; McCollum & Gehart, 2010). Christopher and Maris (2010) found teaching mindfulness practices in training programs enhanced both the physical and psychological wellness of therapist trainees. Openly expressing feelings about the stressfulness of work and obtaining positive social support networks may also

lead to the prevention of or decline in therapists' symptoms of burnout (Armes, 2014; Rosenberg & Pace, 2006; Scarcella, 2005).

Additionally, regularly receiving clinical supervision is another factor that is found to improve therapists who are struggling with issues of job stress and associated isolation (Franco, 2015; Macchi et al., 2014). Building a strong professional support network also has the potential to provide support, resources, and improve clinical effectiveness among distressed therapists (Barnett et al., 2007; Chen et al., 2019; Razo, 2018; Scarcella, 2005). Spirituality is another important resource that is known as a powerful coping tool among therapists in preventing and decreasing symptoms of burnout (Cunningham, 2015; Giles, 2012). Mindfulness practices, such as meditation, deep breathing exercises, and yoga have been found to be helpful tools in reducing therapist stress (Armes, 2014; Farin, 2015; Ford, 2018). Further suggestions that mitigate burnout symptoms include engaging in one's own psychotherapy (Barnett et al., 2007), establishing boundaries and time management skills (Chen et al., 2019), spending time with family (Killian, 2008), getting adequate rest and maintaining a healthy diet (Barnett et al., 2007), as well as regular physical exercise and activity (Eddington, 2006; Ford, 2018; Rinn, 2016). Sahibzada (2019) suggested that therapists could reframe burnout as a positive experience in terms of their professional and personal growth as a means for increasing self-awareness and self-empowerment.

Attachment Theory and Research

A majority of Bowlby's early research, along with other notable developmentalists including Mary Ainsworth, were focused on the development of affectional bonds in infancy (Ainsworth et al., 1978; Bowlby, 1988). In a series of studies, known as the Strange Situation, interactions between infants and mothers were observed for a length of time in a laboratory

setting. The main purpose of this research was to understand and explain how infants become emotionally attached to their primary caregivers (i.e., attachment figures) and emotionally distressed when separated from them. From these laboratory observations, Bowlby and Ainsworth et al. noticed a series of predictable emotional reactions and behaviors (i.e., attachment behaviors) that infants go through when separated from their mothers. Once separated, disconnection cued separation distress, which involved crying, active proximity seeking, and resistance to the soothing efforts of a stranger.

Following this form of protest, the child would enter a state of passivity and sadness, which Bowlby (1988) characterized as despair. Upon the mother's return, the child would demonstrate specific behaviors that Bowlby referred to as detachment, meaning an active disregard for and avoidance of the mother. Bowlby termed these observed emotional reactions and behaviors of infants as the attachment system. It was through this process that he believed affectional attachment bonds were formed (Bowlby, 1969, 1988).

A caregiver offers their child a safe haven, or secure base, when actively providing comfort, closeness, safety, and reassurance (Bowlby, 1988). With a felt sense of secure connection, a child can explore their world with confidence and autonomy. Conversely, Ainsworth et al. (1978) described when a caregiver is slow to respond to their child's needs or inconsistent in how they respond, a child is more likely to demonstrate anxious behaviors, including crying more than usual, loss of interest in exploration and play, outward expressions of anger, and appearing generally anxious. When a caregiver is consistently inaccessible and unresponsive to their child's attempts to establish closeness, the child is more likely to demonstrate avoidant behaviors, including shutting down, expressions of melancholy, and appearing withdrawn. These early interactions between primary caregivers and young children

play an influential part in the development of internal working models and forms the basis for attachment behaviors in future relationships (Bowlby, 1988; Hazan & Shaver, 1987; Johnson, 2004; Mikulincer, 1995).

Attachment Across the Lifespan

It was from these prominent studies discussed above that attachment theory truly evolved and uncovered a universal need for physical and emotional closeness and connection in humans. Bowlby (1988) shared a basic belief that all humans are motivated by their attachment system and are either effectively or ineffectively dependent on others. Furthermore, Bowlby believed that particular attachment behaviors formed in infancy and early childhood remained consistent into adulthood, as he described it as from "the cradle to the grave" (Bowlby, 1988, p. 180). In later years, he proposed that the central components of personality are derived from an individual's attachment history, noting these predictable patterns of attachment behaviors remain relatively stable over the individual's life course.

Subsequent studies and researchers echoed Bowlby's notion of stability in childhood attachment patterns through longitudinal studies and varying test-retest intervals. For instance, Barnett et al. (1999) assessed the stability of infant and childhood attachment among children at ages 12 and 18 months with stability results at 69% across two points in time. Another study found the stability of secure attachment was 75% and insecure attachment was 81% among children first assessed at ages 12 to 18 months and then again at ages 18 to 24 months (Vondra et al., 1996). Comparably, Solomon and George (1999) found that the overall stability of attachment patterns among individuals from 18 months to 20 years remained as high as 72% to 77%.

In later years, however, attachment researchers have challenged Bowlby's earlier predictions about childhood attachment stability over time by pointing to differences in an individual's attachment patterns across various relationships throughout their lifespan (Brown & Elliott, 2016; Fraley, Vicary et al., 2011; Mikulincer & Shaver, 2003; Scharfe, 2006). Mikulincer and Shaver (2003) were among the first to conceptualize attachment styles as a global orientation but believed that an individual's internal working model of attachment was part of a complex network of both generalized and context specific attachment representations throughout life. Fraley and Roisman (2019) also indicated that while adult attachment has its origins in early caregiving experiences, there is considerable heterogeneity across specific relationships in adulthood. For instance, an individual with a secure relationship with their parents may have an insecure romantic relationship with their partner, which suggests that internal working models in different relationships may diverge across time (Fraley & Hudson, 2017). Nevertheless, these findings emphasize the powerful role of attachment and lends empirical support to how adult relationships are influenced by both our attachment history and current interpersonal experiences with others.

Attachment in Adulthood

Researchers have continued to explore and expand on Bowlby's original work, including a specific focus on adult attachment and aspects of adult relationships. In general, as Bowlby foresaw, internal working models and attachment patterns remain moderately to highly stable through adulthood (Fraley & Hudson, 2017; Scharfe, 2006). The continuity in attachment behaviors among adults has sparked the interest of researchers to explore various social adult relationships including romantic partnerships, close friendships, family relationships, and associations with an individual's work environment (Fraley, Heffernan et al., 2011; Hazan &

Shaver, 1987, 1990; Johnson, 2004). Much of the initial research on adult attachment has focused on romantic relationships (Bartholomew, 1990; Johnson, 2004; Schachner et al., 2006; Shaver & Hazan, 1988).

Attachment and Romantic Relationships

In order to understand adult attachment behaviors in romantic couple relationships, Hazan and Shaver (1987) were the first to propose an attachment framework for conceptualizing romantic love and adult relationships. Hazan and Shaver created a categorical measure for assessing adult romantic attachment style which closely followed the identified infant-caregiver attachment patterns as described by Ainsworth et al. (1978). In their assessment measure, three relational attachment styles (i.e., labeled as secure, anxious, and avoidant) were used to identify the intricate attachment dynamics of couple relationships. Through their research, the core assumption was that romantic relationships involved three intrinsic behavioral systems defined as attachment, caregiving, and sex (Hazan & Shaver, 1987). Unlike infant-caregiver relationships, adult relationships are more complex in that they are no longer one-sided, as the adult relationship involves two equal partners. In such romantic relationships, both partners are in need of comfort and closeness, and both must act as supportive caregivers to their partners in need. The qualities of both partners and their attachment histories form a unique combination that influences emotions, behaviors, and relational outcomes (Schachner et al., 2006).

For several years, attachment researchers used the original three-category measure of romantic attachment style developed by Hazan and Shaver (1987). But, over time, researchers moved from a three-category to a four-category classification measure (Bartholomew, 1990). In broadening the assessment of adult attachment styles, Bartholomew questioned the explicitness of a defined criteria for the three attachment style categories outlined in Hazan and Shaver's

work (1987). Particular attention was given to the need for variations in understanding adult attachment relations, specifically differences in patterns of attachment avoidance. Bartholomew (1990) suggested that a more comprehensive conceptualization was necessary to distinguish between behavioral tendencies and subjective awareness of individual attachment needs.

To address this issue, Bartholomew (1990) developed a four-category classification model of attachment, which was then later tested among young adults concerning their relationships with peers and early relationships within their family-of-origin (Bartholomew & Horowitz, 1991). Bartholomew's (1990) new categorical model of adult attachment styles reflected Bowlby's earlier concept of internal working models of self and other. More specifically, this model measured individual differences in adult attachment style based on the individual's perception of self and other which were outlined by four attachment style types referred to as secure, preoccupied, fearful-avoidant, and dismissing-avoidant. Today, however, most attachment researchers utilize attachment measures that represent adult attachment styles on two continuous dimensions (i.e., anxiety and avoidance) rather than categorical representations such as Bartholomew's attachment model (Brown & Elliott, 2016; Fraley et al., 2015; Schachner et al., 2006).

Attachment Theory Application

It is important to recognize that attachment theory is essentially a theory of trauma (Johnson, 2004). Bowlby's 1969 seminal work described and explained the trauma of withdrawal, rejection, abandonment, and need for acceptance by those we are closest to. The experience of separation and isolation is inherently traumatizing and can have a tremendous impact on an individual's ability to effectively cope with the everyday stressors of life. As a theory of trauma, attachment theory specifically helps us to understand the weight of emotional

pain such as rejection, shame, or perceived abandonment by important loved ones. When an individual is confident that an important loved one will be there for them when they need them the most, that individual is much less prone to intense or chronic fear in comparison to someone who has no such confidence (Johnson, 2004). Distressing experiences and negative emotions, such as the symptoms associated with burnout, can trigger traumatic helplessness and fear in any individual, at which point they tend to adopt stances of fight, flight, or freeze, which are characterized as innate responses to stress and trauma.

In a parallel fashion, this is an isomorphic process about how therapists may respond to the experience of ongoing stress and burnout. Researchers continue to validate this notion of how stressful or traumatic events have a negative impact on the health and well-being of the therapist, as the experience of trauma activates the attachment system (Armes, 2014; Devereaux, 2010; Gillath et al., 2005; Scarcella, 2005; West, 2015). As Johnson (2004) states, "adversity and stress increase a person's need for others and intensify attachment behaviors, no matter what age" (p. 33). It is in these critical moments of distress that individuals need a key primary person who represents a safe haven and secure base to respond with comfort and provide connection. This form of responsiveness and emotional engagement from attachment figures allows for effective dependence on others and aids in the regulation of emotions and distress tolerance.

Just as their clients, therapists come to the therapeutic relationship with their own attachment histories that were developed long before starting their work as a clinician. The current literature examining therapist attachment indicates that both therapists' and clients' attachment style can impact the overall therapeutic process and clinical outcomes (Beatty, 2018; Gillath et al., 2005; Lin-Arlow, 2018; Steel et al., 2018). While a great portion of the research on therapist attachment has examined how this influences the therapeutic relationship and client

outcomes (Christopher, 2012; Kaplan, 2014; Nero, 2016), researchers have also connected therapist attachment (Carr & Egan, 2017; Leiter et al., 2015; West, 2015) and the utilization of self-care practices (Barnett et al., 2007; Golshani, 2012; Rinn, 2016) as predictors of work-related stress and burnout.

Effect of Therapist Attachment on Clinical Outcomes

Seminal research in the field of psychotherapy indicates several important key elements that appear to be responsible in determining therapeutic change and successful clinical outcomes. A large portion of the current literature has focused on client-related factors including pre-therapy variables such as the client's level of motivation, symptomology, and personality (Lynch, 2012), as well as race/ethnicity (Kim et al., 2012). In addition to client contributing factors, researchers have focused on other outcome predictors including those specifically related to the therapist. These characteristics take into consideration the therapist's level of skill and therapeutic orientation (Beatty, 2018), years of experience in clinical practice, level of education and training (Lynch, 2012), personality and genuineness of the therapist (Black et al., 2005; Schnellbacher & Leijssen, 2009), as well as the therapeutic relationship (Bachelor, 2013). Of these predictors, many researchers believe the therapeutic relationship to be the most significant in determining positive clinical outcomes (Bachelor, 2013; Gellhaus Thomas et al., 2005; Lynch, 2012; Soto, 2017).

Therapeutic Relationship

In recent years, the relationship between the therapist and client has become a focal point in contemporary research on what constitutes optimal therapeutic outcomes. The current literature consistently affirms that the quality of the therapeutic relationship, particularly in the early stages of therapy, is linked to positive and successful outcomes in psychotherapy

(Bachelor, 2013; Gellhaus Thomas et al., 2005; Lynch, 2012; Soto, 2017; Wampold, 2015). Among the notable factors that influence the quality of the therapeutic relationship are both the therapist's and client's attachment orientation and past attachment experiences (Gillath et al., 2005). A growing body of researchers have explored how differing attachment styles of therapists' and clients' impact the therapeutic relationship and contribute to the effectiveness of clinical outcomes (Beatty, 2018; Christopher, 2012; Kaplan, 2014; McKay, 2010; Seymour-Hyde, 2018; Soto, 2017; Yoskowitz, 2018). In clinical practice, attachment-oriented therapists often use this perspective to identify and describe ways that their clients interact and relate to other important people in their lives based on their attachment style and attachment history (Chen, 2019; Conrad, 2014; Johnson, 2004, 2019).

According to Gillath et al. (2005), Bowlby also drew parallels between the caregiver-child relationship and the relationship between the therapist and their clients, as he worked as a psychotherapist in addition to being a prominent theorist. Similar to how individuals develop secure or insecure attachments to their primary caregivers, existing research confirms that clients can and do form attachments to their therapists (Effrig, 2014; Gillath et al., 2005). Attachment theory proponents emphasize that one of the defining features related to successful clinical outcomes occurs within the security of the therapeutic relationship, meaning that when a client is able to take risks exploring vulnerable feelings, previous traumas, and self-disclose current problems in the therapeutic process, the therapist is providing a safe haven and secure attachment base for their client (Gillath et al., 2005; Johnson, 2004; Saypol, 2009).

As therapy continues and the secure therapeutic relationship deepens, Gillath et al. (2005) described this process as creating a protective environment and testing ground for clients to safely reassess and restructure their internal working models for other close relationships.

Conversely, the therapist's own attachment style and attachment history can influence the security of the therapeutic relationship (Kaplan, 2014; Orellana, 2012), impact clinical efficacy (Beatty, 2018; Kline, 2017), and affect client outcomes (Black et al., 2005; Seymour-Hyde, 2018; Yoskowitz, 2018). Gillath et al. (2005) also believed that a therapist's sense of attachment security allows them to maintain compassion and empathy in their clinical work, as well as be able to focus on the problems of their clients rather than be overwhelmed by their own personal distress.

Therapist Attachment and Burnout

Differences in adult attachment orientation regarding how therapists cope with work-related distress, including burnout symptoms, greatly depends on the adaptive and maladaptive coping processes adopted from their own attachment style and past attachment experiences. Just as with any person, some therapists do not fare well when working in isolation or with limited support systems in place. In times of heightened distress, the attachment system gets activated, which forms the basis for how the therapist will emotionally and behaviorally respond to such stressful experiences.

Attachment theorists suggest that, in general, therapists with a secure attachment will be able to positively regulate their emotions, cope with stress, and effectively seek and use adequate support from others (Gillath et al., 2005). On the other hand, those with insecure attachment will generally demonstrate quite the opposite in response to intense, prolonged work-related stress. For instance, a therapist with an insecure attachment style may use self-protection strategies such as distancing themselves and withdrawing from others, or conversely may become overly reactive and dysregulated, minimizing their painful emotions of helplessness (Ackerman, 2017). Insecure attachment behaviors such as these do not allow for effective dependence or adjustment

in the face of stress and adversity. The use of maladaptive coping responses to ongoing distress can easily result in a decreased ability to effectively implement and utilize clinical knowledge and skills, which places the welfare of the therapist's professional competence at risk as well as the clients they serve (Armes, 2014; Barnett et al., 2007; Beatty, 2018).

Secure attachment has been associated with lower levels of burnout and effective coping responses, such as emotion regulation and distress tolerance (Leiter et al., 2015). Carr and Egan (2017) suggested attachment security is a predictor of general well-being among therapists. Therapists with secure attachment are more likely to experience higher levels of work satisfaction, report fewer work-related fears and reduced distress (Armes, 2014), and have good, supportive relationships with professional colleagues (Beatty, 2018; Leiter et al., 2015). Furthermore, securely attached therapists, who believe others will be responsive when needed, will likely tend to view others as dependable and worthy of trust (Scarcella, 2005). These individuals are more confident in seeking and gaining support from others in times of stress, resulting in a low likelihood of developing symptoms of burnout (Pines, 2004).

Attachment insecurity has been previously connected to therapist burnout and compassion fatigue in the research literature (Carr & Egan, 2017; Pines, 2004; Scarcella, 2005; West, 2015). Therapists with insecure attachment, both anxious and avoidant styles, often demonstrate poor coping skills in the face of stress and therefore, are more likely to experience increased symptoms of burnout. Specifically, anxious attachment is most often associated with higher levels of stress and burnout symptoms (West, 2015). In a large sample of therapists working in Ireland, therapists who scored as having an anxious attachment style resulted in having higher levels of emotional exhaustion (Carr & Egan, 2017). Maladaptive support-seeking behaviors, such as feeling overly obligated, fear of rejection and failure, and strained work

relationships, are often seen among those with anxious attachment styles (Leiter et al., 2015; Pines, 2004).

Avoidant attachment among therapists is also associated with higher levels of depersonalization and detachment from clients (Carr & Egan, 2017), which is considered a primary symptom of burnout syndrome (Maslach & Leiter, 2016). Therapists with an avoidant attachment style may prefer to work alone and avoid social interactions with others. These individuals are also less likely to seek out support and engage in self-care practices, as they see themselves as self-reliant and often do not self-disclose (Hazan & Shaver, 1990; West, 2015). In fact, some researchers speculate that insecurely attached individuals in general may be less likely to request or accept support and may view this support negatively (Barnett et al., 2007; Scharfe, 2006). Furthermore, a distressed therapist experiencing symptoms of burnout along with insecure attachment behaviors may unintentionally negatively affect their clients too. It is also possible that higher levels of burnout symptoms may cause the therapist to be more insecurely attached to clients, family members, and close friends (Armes, 2014).

Therapist Attachment and Self-Care

It is not uncommon for those therapists working with special populations, such as highly distressed couples, abuse victims, terminally ill clients, and severely disturbed patients to neglect their own needs for self-care while focusing on the intense needs of their clients (Armes, 2014; Maslach & Leiter, 2016; Scarcella, 2005). It is likely that this kind of work with distressing clients can easily result in heightened symptoms of professional burnout (Barnett et al., 2007; Gillath et al., 2005). Additionally, a therapist with higher levels of burnout symptoms may interact differently with their family or friends, which will in turn affect those family members or close friends and could lead to a more stressful home environment (Armes, 2014; Cunningham,

2015). In these situations, it would be important for the therapist to have meaningful practices of self-care to utilize in potentially reducing symptoms of burnout and distress.

However, therapists must feel capable to seek out support from others and engage in forms of self-care that will allow them to effectively take care of themselves, maintain a sense of work-life balance, and preserve clinical efficacy. Barnett et al. (2007) suggested that the failure to focus on one's own needs and personal distress is likely a professional blind spot among many clinicians in the field. The therapist's ability to recognize and actively practice meaningful self-care is likely dependent upon their general attachment style (Scarcella, 2005). According to attachment theory, securely attached therapists will hold a positive sense of self that is worthy of love and care and is confident in seeking out sources of interpersonal support such as engaging in self-care (Johnson, 2019).

Insecurely attached therapists, both anxious and avoidant, are more likely to dismiss and minimize their need for self-care, as this is viewed as a form of an adopted protective strategy involving their internal working model of self. This negative view of self is likely related to risking vulnerability and fears about their own 'lovable-ness' and worth (Johnson, 2004). To combat the issue surrounding therapists' general lack of self-care, recent researchers have made suggestions for normalizing burnout, reframing self-care as a preventive strategy, and engaging in forms of mindful self-awareness as important, necessary steps in preventing and treating burnout (Chen et al., 2019; Sahibzada, 2019). If self-care is prioritized in this way, therapists will likely have a better chance at improving the quality of their work-life balance and protecting their overall well-being.

Summary

This chapter focused on reviewing the current literature of evidence-based studies pertaining to attachment theory, adult attachment styles, self-care practices, and the experience of burnout syndrome among professionals in the field of mental health. Unfortunately, the experience of burnout in the human service and health care professions is not uncommon. Both situational and individual factors have contributed to the development of burnout syndrome among these professionals, including lack of social support and community, interpersonal conflicts, emotional health, and effective coping strategies (Lee et al., 2011; Maslach, 2003; Maslach & Leiter, 2016). These risk factors are all related to feelings of inefficacy, cynicism, and exhaustion (Maslach & Leiter, 2016).

Drawing from concepts of Bowlby's attachment theory, researchers have identified adult attachment orientations as a predictor of how individuals respond to the experience of prolonged distress, such as burnout (Hazan & Shaver, 1990; Leiter et al., 2015). Differences in adult attachment styles regarding how therapists cope with work-related distress, including burnout symptoms, greatly depends on the adaptive and maladaptive coping processes adopted from their own attachment histories (Beatty, 2018; Devereaux, 2010; Scarcella, 2005). Attachment proponent Johnson (2004) suggested that individuals with a secure attachment style are generally better equipped to regulate their emotions, cope with stress, and effectively seek and use social support. Conversely, attachment insecurity, both anxious and avoidant styles, are connected to burnout syndrome among distressed therapists (Carr & Egan, 2017; Leiter et al., 2015; West, 2015).

Therapists with insecure attachment orientations are more likely to demonstrate reduced support-seeking behaviors, engage in limited self-care practices, and have difficulty in

maintaining a positive work-life balance as well as negatively influence their own romantic relationships (Gillath et al., 2005; Scarcella, 2005). Meaningful self-care practices, including mindful self-awareness (Armes, 2014; Farin, 2015), spirituality (Cunningham, 2015; Giles, 2012), attending personal psychotherapy (Eddington, 2006; Sahibzada, 2019), strong social and professional support systems (Chen et al., 2019; Franco, 2015; Razo, 2018), and regular physical exercise (Ford, 2018; Killian, 2008; Rinn, 2016) are among the known successful strategies found to help alleviate the development of and symptoms associated with burnout syndrome. In addition to these practices, normalizing burnout as a positive experience and reframing self-care as preventive strategies were found to help prevent and cope with burnout (Chen et al., 2019; Sahibzada, 2019). Yet, little is known about how marriage and family therapists' knowledge of their own attachment style and use of self-care may help in preventing and protecting therapists against burnout.

CHAPTER III

METHODOLOGY

Introduction

The purpose of this online convergent mixed methods study was to examine the relationship between burnout symptoms and the utilization of self-care practices and awareness of adult attachment style among practicing marriage and family therapists. This convergent mixed methods design consists of collecting and analyzing two separate sets of data, both quantitative and qualitative, at the same time and then merging the two for the purpose of combining and comparing the results (Creswell & Plano Clark, 2018). The rationale in using this research design for this study was to bring together quantitative statistical results with qualitative findings for a more robust and complete understanding of burnout syndrome among marriage and family therapists and the protective factors that may mitigate the development of burnout. Creswell and Plano Clark (2018) recommended this approach as an ideal option, as it allows for the researcher to merge and compare both forms of data from participants in the same sample more easily. Similarly, parallel research questions and concepts were examined in both the quantitative and qualitative data collection process to facilitate successful integration and analysis (Creswell & Plano Clark, 2018).

A convergent mixed methods design was used to collect both quantitative and qualitative data in a parallel process, analyzed separately, and then merged for comparison and integration of results. In this study, therapist demographic variables, scores on the Maslach Burnout Inventory – Human Services Survey (MBI-HSS), and scores on the Experiences in Close Relationships-Relationship Structures (ECR-RS) were used to test the theory of attachment that predicts that therapist attachment style, awareness of attachment style, and frequency of self-care

practices will influence the level of burnout symptoms among marriage and family therapists. At the same time in this study, therapists' experiences of burnout symptoms, of providing mental health services during the COVID-19 pandemic, of utilization of self-care practices, and of awareness of adult attachment style were further explored using open-ended questions. The reason for collecting both quantitative and qualitative data was to bring greater awareness and insight to this phenomenon than would be obtained by either type of data separately (Creswell & Plano Clark, 2018).

A pragmatic worldview operated as the philosophical foundation for this convergent mixed methods design, as it is "oriented toward what works and real-world practice" (Creswell & Plano Clark, 2018, p. 37). This philosophical foundation enabled me to adopt a pluralistic stance since this methodology allowed me to gather different types of data to best answer the research questions posited in my study. Furthermore, this all-encompassing worldview best fit my type of mixed methods design, as it supports my decision to collect both quantitative and qualitative data in the same phase of the study and merged for analysis and interpretation to enhance understanding of the research problem (Creswell & Plano Clark, 2018).

Participant Inclusion Criteria

Participants selected for inclusion in this online study were delimited according to their current license status, which included any marriage and family therapist currently providing mental health services to clients in the state of Texas. Specifically, participants' current license status was designated by the following categorical criteria: LMFT, LMFT Associate, or non-LMFT board licensed clinician with a graduate degree in marriage and family therapy. Only those participants that could be classified as being in one of these three groups were included in

this research study. In addition, eligible participants were at least 21 years of age or older. There were no limitations as to race, gender, sexual orientation or other demographic factors.

Recruitment Plan

This mixed methods study used both purposeful and snowball sampling methods to recruit participants online. I determined that the optimal method of obtaining a sample of licensed marriage and family therapists was to work with the Texas Association for Marriage and Family Therapy (TAMFT), which charges a fee when a researcher requests access to their professional email listserv of marriage and family therapists. To cover the costs of my study, I submitted a Frances Fowler Wallace Memorial Award grant to the Hogg Foundation of Texas for $3,000. Grant funds were used to purchase several important components for conducting this study, including the proprietary fee for 150 copies of the MBI survey and electronic manual, as well as three email blasts and one advertisement post on the TAMFT organization's social media page. The remaining grant funds were used to purchase other research-related expenses such as professional membership dues, office supply items, several mixed methods research design textbooks, and a new MacBook laptop computer. I received approval for funding in November 2020 and immediately purchased the MBI protocols and initiated work with TAMFT.

To recruit participants, TAMFT staff had agreed that I could purchase multiple uses of their professional listserv to send recruitment emails (see Appendix A) to their members who are LMFTs, as well as one social media post on the organization's Facebook page (see Appendix B). I also planned to send the same email recruitment invitation to the TWU Marriage and Family Therapy Program listserv (see Appendix C), which included faculty, graduates, and students. Finally, I sent the email recruitment invitation (see Appendix D) to other mental health professional contacts in various Texas-based practice settings that included former graduate

students and colleagues. According to Dillman et al. (2014), single-mode data collection, such as professional organizations and universities, provides the researcher with access to an accurate and complete list of members email addresses, which allows for effective and successful online only surveys with email contacts.

Sampling

This mixed methods study used both purposeful and snowball sampling methods to recruit participants online. A TAMFT staff member sent the invitation email (see Appendix A) out to the LMFT members three times across 3 months, along with one social media post (see Appendix B) until the desired number of participants was reached. In addition, e-mail invitations were sent to other mental health professional contacts in Texas such as the TWU Marriage and Family Therapy program (see Appendix C), and Texas Wesleyan, Texas Tech, and St. Mary's Marriage and Family Therapy programs (see Appendix D). Snowball sampling was achieved by including a request on each email recruitment invitation for that recipient to forward the email to another eligible professional who might qualify for participation. Each of the above recruitment email invitations, along with the TAMFT social media post, contained the link to the PsychData survey. The survey link was available online during the study timeframe, which was open from November 2020 to January 2021. The survey was closed when I reach 164 participants. It is postulated that those participants who did not complete the online survey in its entirety had a problem with time commitment or internet connection issues/technical difficulties. Another group started and then exited the survey within several seconds, which may have been due to participant inclusion criteria.

Human Subjects Approval

Prior to collecting data, approval by the Institutional Review Board (IRB) at TWU to conduct this study was granted. Outlined in the participant consent form, the potential risks of participating in this study included loss of time, emotional discomfort, and loss of confidentiality (see Appendix E). Participants might have experienced loss of time due to the length of the online survey. If participants became tired or were unable to allocate the estimated 20 to 30-minute completion time, they were encouraged to take breaks as needed. Participants were informed that they could stop answering questions at any time and withdraw from the study without any penalty. Another possible risk participants might have experienced was emotional discomfort due to the nature of questions they were asked in the online survey. To alleviate emotional discomfort, participants were informed that they could choose to skip any questions or withdraw from this study at any time without penalty. If participants felt that they needed to talk to a professional about their discomfort, I provided a list of referrals and resources in the online study (see Appendix F).

Lastly, participants were informed that there was a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions. To protect participants' confidentiality and privacy, survey responses were not linked to participants' email addresses, and all collected data was kept separate and saved on an encrypted USB flash drive. The online questionnaire survey through the PsychData website was password protected with only the researcher and her faculty advisor having access to the data and research records. Any identifable data, such as participants' email addresses, were stored on an encrypted USB flash drive only accessible by the researcher and her faculty advisor. All participant email addresses will be

permanently deleted from the reseacher's encrypted USB flash drive and any hard copies of these email addresses will be shredded following the end date of the research study.

Research Instruments and Variables

There were four sources for data collection identified for use in this study, including participant demographic characteristics, two quantitative measures, and open-ended qualitative questions. A single survey questionnaire was developed to collect both quantitative and qualitative forms of data by including both closed- and open-ended questions (see Appendix G). The quantitative data set consisted of demographic and work-related close-ended questions and two assessment measures. Participant burnout was measured using the MBI-HSS (see Appendix H), and participant adult attachment style was measured using the ECR-RS instrument (see Appendix I). The qualitative data set included four open-ended questions that were designed as parallel add-on items to reflect the same concepts from the quantitative measures (see Appendix J). These open-ended questions gathered information about participant descriptors of burnout, experience of personal and professional challenges during the COVID-19 pandemic, the meaning of self-care and utilization of self-care practices, as well as attachment theory knowledge, attachment style meaning, and its impact on clinical work.

Demographic Characteristics

Basic demographic information was collected on participants at the beginning of this online study, including age, gender, ethnicity, and marital status. Additionally, information was collected pertaining to work-related factors of participants, including current license status, average amount of hours worked per week, level of clinical experience (i.e., number of years in clinical practice), current employment setting, length of time at current workplace, population of clients, most common client problems, and most common client mental health disorders. Lastly,

information was collected on participants' familiarity of attachment theory and degree of their own adult attachment style awareness, frequency of self-care practice and forms of self-care strategies, format of services provided most to clients during the COVID-19 pandemic, as well as both personal and professional levels of experienced stress.

The Maslach Burnout Inventory-Human Services Survey

The MBI-HSS was administered to measure participants' levels of burnout (Maslach & Jackson, 1981). This quantitative assessment measure required purchase and permission for use prior to distributing surveys and collecting data from participants. The MBI-HSS questionnaire is a 22-item self-report measure designed to assess individual job-related feelings of burnout across three subscale dimensions including emotional exhaustion, depersonalization, and personal accomplishment (Maslach & Jackson, 1981). The MBI-HSS is one of the most widely used measures in the field for assessing the burnout experience of human service professionals (Lee et al., 2011; Maslach & Leiter, 2016; West, 2015).

This 22-item self-report questionnaire uses a seven-point Likert scale and each statement is rated on two dimensions with respect to frequency and intensity. The frequency dimension Likert scale ranges from zero to six (0 = *never*, 1 = a *few times a year*, 6 = *every day*), and the intensity dimension Likert scale ranges from one to seven (1 = *very mild, barely noticeable*, 7 = *major, very strong*). The dimension for emotional exhaustion is comprised of nine items, which relate to an individual's feelings of being emotionally overextended and exhausted by their job (Maslach & Jackson, 1981). The depersonalization dimension includes five items concerning an individual's unfeeling and impersonal response towards the recipients of their care or treatment. Lastly, the dimension for personal accomplishment contains eight items reflecting an individual's feelings of competence and successful achievement in their work (Maslach &

Jackson, 1981). Higher mean scores on the first two dimensions indicate higher levels of experienced burnout, whereas lower scores on the personal accomplishment dimension correspond with increased levels of burnout (Maslach & Jackson, 1981).

According to Maslach and Jackson (1981), the MBI-HSS demonstrated good reliability and internal consistency on both dimensions of frequency and intensity (α = .83 and .84, respectively) for the 22-item measure in a relatively large sample (N = 420) of individuals in various health and service occupations. More recently, a meta-analytic study found an average test-retest reliability of .88, .71, and .78, respectively for each of the three dimensions of burnout (Aguayo et al., 2011). Data on test-retest reliability of the MBI-HSS have shown statistical significance beyond the p = .001 (Maslach & Jackson, 1981). Rosenberg and Pace (2006) have also validated the MBI-HSS as an appropriate instrument for measuring burnout among marriage and family therapists.

According to the developers of the MBI-HSS (Maslach & Jackson, 1981), the researcher is required to gain permission for use and must purchase the remote online survey license from the developer website Mind Garden, Inc. to administer the instrument. The cost associated with purchasing the MBI-HSS is dependent on the quantity purchased, with a minimum purchase requirement of 50 surveys. Included in the MBI-HSS remote online survey license is one downloadable PDF file containing one copy of the inventory, scoring keys, and permission to administer the instrument for up to the quantity purchased by the researcher. According to the developer website, Mind Garden, Inc., the estimated average time to complete the 22-item self-report survey is 10-15 minutes.

The scoring procedures for participants level of burnout followed the MBI 4th edition manual (Maslach et al., 1996). Participant responses were calculated and interpreted separately

across the three subscales of the MBI-HSS (i.e., emotional exhaustion, depersonalization, and personal accomplishment) to provide each participant's three scale scores of burnout. For emotional exhaustion and depersonalization, higher scores indicate higher degrees of burnout. Whereas, for personal accomplishment, lower scores indicate higher degrees of burnout (Maslach et al., 1996).

The Experiences in Close Relationships-Relationship Structures

The ECR-RS questionnaire was administered to measure participants' adult attachment style/orientation (Fraley, Heffernan et al., 2011). The ECR-RS questionnaire is a nine item self-report measure designed to assess adult attachment orientations in multiple contexts, including a variety of different relationships (i.e., mother, father, romantic partner, close friend). Furthermore, the ECR-RS can be easily adapted to assess an individual's relationship-general or global attachment orientation more openly (Fraley, 2014; Fraley et al., 2015). The ECR-RS is one of the newer measures of adult attachment derived from the well-known Experiences in Close Relationships-Revised (ECR-R) version that has been widely used over the last two decades in attachment related research (Fraley et al., 2000; Fraley, Heffernan et al., 2011).

There are many notable categorical and dimensional measures of adult attachment that have been widely adopted by researchers. Hazan and Shaver (1987) argued that many researchers "vacillate between using the terms secure, avoidant, and anxious/ambivalent to describe relationships and using them to categorize people" (p. 522). The distinction between choosing from categorical or dimensional measures of adult attachment is important, as many contemporary attachment researchers increasingly point towards the efficacy of adopting a dimensional framework (Brown & Elliott, 2016; Fraley et al., 2015; Johnson, 2019). Fraley et al. (2015) used taxometric techniques to examine whether individual differences in adult attachment

are continuous or categorical, and from this research found that attachment patterns are distributed continuously, both in infancy-early childhood and adulthood. However, there has yet to be an overt majority consensus among attachment researchers in the field as to whether adult attachment styles are intrinsically categorical or continuous, dimensional models (Brown & Elliott, 2016; Fraley et al., 2015; Ravitz et al., 2010; West, 2015).

For the purpose of this study, the ECR-RS was used to assess participants' global adult attachment orientation to conceptualize individual differences rather than targeting distinct relationship-specific representations (i.e., parents, romantic partner, close friend). This nine item self-report questionnaire taps into adult attachment security using a two-dimensional model with respect to attachment-related anxiety and attachment-related avoidance as two continuous variables. Participants were asked to rate a total of nine items with respect to how they "generally think and feel in close relationships" for the purpose of assessing global attachment styles (Fraley et al., 2015, p. 358). Each of the nine items are scored using a seven-point Likert scale (1 = *strongly disagree*, 7 = *strongly agree*).

Three items are used to determine anxiety dimension, reflecting the way in which individuals monitor the availability and accessibility of attachment figures, and include statements such as "I'm afraid that other people may abandon me" (Fraley, Heffernan et al., 2011, p. 618). The remaining six items are used to determine the avoidance dimension, representing the variation in the way in which individuals regulate attachment-related thoughts, and feelings, and behaviors. Sample items within the avoidance dimension include statements such as "I don't feel comfortable opening up to others" and "I find it easy to depend on others" (Fraley, Heffernan et al., 2011, p. 618). Individuals with high scores along this dimension are described as being uncomfortable with closeness and dependency, in comparison to individuals

with low scores being described as comfortable using others as a secure base (Fraley et al., 2015).

The scoring procedures for participant adult attachment style followed the outlined instructions for assessing global attachment using the ECR-RS measure (Fraley et al., 2000; Fraley, Heffernan et al., 2011). For each participant, scores within the two dimensions of attachment (i.e., anxiety and avoidance) were calculated separately and averaged to obtain a global attachment score for each subscale. The total subscale score consists of the mean of the items and ranges from 1 to 7, with higher scores indicating higher attachment anxiety or avoidance.

In a large international sample of adults (N = 14,781), the ECR-RS demonstrated good internal reliability for both subscales measuring global attachment-related anxiety and avoidance (α = .85 and .88, respectively; Fraley, Heffernan et al., 2011a). In a second study by Fraley, Vicary et al. (2011) comprised of a smaller sample of adults in romantic relationships (N = 388), the ECR-RS demonstrated good internal reliability for both subscales (anxiety scale, α = .84, .87, .83, .83, and avoidance scale α = .91, .92, .81, .85, respectively) measuring four separate domains of participants relationships with mother, father, partner, and best friend. The ECR-RS has also been validated for use among other ethnic populations including a Portuguese self-report version in a community sample of Portuguese adults (N = 236) and a Brazilian self-report version in a community sample of Brazilian adults (N = 251), to which both studies showed acceptable reliability for each subscale and construct validity (da Rocha et al., 2017; Moreira et al., 2015).

At this time, permission for use of the ECR-RS is not required nor is there any financial costs associated with use of this measure in the public domain (Fraley, 2013). For administering

the attachment measure to assess participants' general or global attachment style, Fraley (2014) advised the researcher to instruct participants to rate the nine items with respect to "feelings about close relationships in general," leaving the relationship target purposely vague. Fraley (2014) offered a downloadable word document online that contains the formatted RS questionnaire items, which can be copied and pasted for the researcher's use. The estimated average time to complete the nine-item self-report survey is 5-10 minutes.

Qualitative Open-Ended Questions

The qualitative measure in this study consisted of four open-ended questions related to participants' descriptions of burnout, experience of personal and professional challenges during the COVID-19 pandemic, the meaning of self-care and utilization of self-care practices, as well as attachment theory knowledge, attachment style meaning, and its impact on clinical work. Participants were asked to provide a description of how they personally experienced the feeling of burnout symptoms, which is related to the three subscales of burnout on the MBI-HSS measure. Participants were also asked to describe their recent experience of any personal and professional challenges while providing telemental health services to clients during the COVID-19 pandemic. Due to the ongoing changes related to the pandemic, this question was considered timely and relevant, as it relates to participants' scores on the three dimensions of burnout from the MBI-HSS measure as well as the quantitative close-ended questions regarding degrees of stress.

Additionally, participants were asked to describe the meaning of self-care and identify currently practiced strategies or methods of self-care that were the most helpful to them. This open-ended question was related to the quantitative close-ended questions pertaining to frequency of self-care practices and common forms of self-care practices. In regard to adult

attachment, participants were asked what they knew about attachment theory and their own attachment style prior to this study, and whether or not this prior knowledge informed how they approached their clinical work as a systemic therapist. This fourth open-ended question related to participants' attachment style scores on the ECR-RS measure and the quantitative close-ended questions pertaining to familiarity with attachment theory, level of awareness and perception of attachment style, and frequency of use in clinical work.

Procedures

Consent Form

Following the approval by the IRB at TWU to conduct this research project, I created a recruitment email script that was used to invite all participants to review information about the study. Participants were provided with a direct link to PsychData in the email invitation. Once they clicked on that link, they could read more about the study, review the consent form, and then proceed into the online study. Utilizing PsychData, participants completed a single survey questionnaire, which included basic demographic questions as well as close-ended and open-ended questions pertaining to the research topic of burnout, self-care practices, and adult attachment. The estimated time commitment for participants to complete the online questionnaire and open-ended survey ranged from 20 to 30 minutes. The maximum time commitment of 30 minutes included the time for reading and authorizing consent.

At the beginning of the PsychData survey, participants were provided with the informed consent form that outlined the purpose, potential risks and benefits of participating in the study, as well as the responsibilities of the researcher. Participants then clicked on a box that indicated their acceptance of the consent information prior to their moving to the next page of the PsychData survey and starting the study. Participants were notified in the consent form at the beginning of the

survey questionnaire that they had the choice not to answer all of the questions, and that they could choose to withdraw from the study at any time without penalty. Additionally, participants were encouraged to contact the researcher to answer any potential questions or concerns regarding the research study. Upon completion of the survey, participants had a choice of clicking on a link at the end of the PsychData survey, which took them to a second survey where they could provide their email address if they wished to receive an executive summary of the final report from this study (see Appendix K).

Data Collection

My data collection process followed the procedural recommendations for a mixed methods convergent design outlined by Creswell and Plano Clark (2018). I made several important data collection decisions for this convergent design study, including who was selected for the two samples, the size of the two samples, the design of the data collection questions, and the format of data collection. The two samples used in my study included the same participants in both the quantitative and qualitative strands; however, the qualitative subset was sampled from the larger quantitative sample. When the purpose is to corroborate two sets of findings, Creswell and Plano Clark (2018) suggested that participants in the qualitative sample be the same respondents or a subset of respondents who participate in the quantitative sample. In this convergent study, 107 marriage and family therapists were included in the quantitative sample, and 32 of these same therapists were included in the qualitative sample. Because my two samples were different sizes, with the size of the qualitative sample being much smaller, I was able to obtain a more rigorous, in-depth qualitative exploration and a high-power quantitative examination (Creswell & Plano Clark, 2018).

The decision to design parallel data collection questions in both my quantitative and qualitative data was based on the recommendation of Creswell and Plano Clark (2018). Referred to as the "comparability of questions," this phrase means that the same concepts needed to be addressed in both data collection strands so that the two sets could be easily merged (Creswell & Plano Clark, p. 189). In this way, the results of this study compared the same concepts (e.g., burnout, self-care, attachment) from both the quantitative and qualitative analysis. The last phase of my data collection process involved the decision to collect data from a single source, and then, determine the order of data collection. A single survey questionnaire was developed with both closed- and open-ended questions with the intent to capture multiple facets of the burnout experience from each participant. This decision to use a single source of data collection was also based on time constraints, as I opted to gather the data from participants only one time.

Data Analysis Methods

The data analysis methods and interpretation approach used for this research study followed the integrative model outlined by Creswell and Plano Clark (2018) for a convergent mixed methods research design. Through this integrative approach, three distinct steps of data analysis were followed. The first consisted of analyzing separately the quantitative and qualitative data using appropriate analytic methods for each; both the quantitative methods and qualitative methods are described in greater detail below in the subsequent paragraphs. The results of these separate analyses are presented through tables and narrative discussion in Chapter 4. The second step involved merging both data sets using an integrative approach by mixing the quantitative results and qualitative themes. These integrated results are presented and further discussed in Chapter 5. The last step of my data analysis involved analyzing and interpreting the merged data in response to the two research questions and related hypotheses.

The intent of integration in this study was to consider how merged results produced a clearer understanding of the experience MFT therapists had with burnout during COVID-19 and to direct future research. My interpretation of the integrated results is also presented in Chapter 5 through the discussion, recommendations, and limitations sections.

Quantitative Analysis

To address the quantitative data collected for this study, the individual demographic variables, work-related variables, and the results of the MBI-HSS and ECR-RS were downloaded and transferred to the IBM SPSS Statistics software platform for analysis. Results from this quantitative data were used to answer the research questions and test hypotheses. Descriptive statistics were conducted to describe demographical information of participants. With support from the TWU Center for Research Design and Analysis (CRDA) staff, I conducted linear regression analyses to test the first research question: Does adult attachment style predict level of burnout among marriage and family therapists? The dependent variables included participant scores from the three subscales of the MBI-HSS (emotional exhaustion, depersonalization, and personal accomplishment). The independent variables included participant scores from the two dimensions of the ECR-RS (attachment-related anxiety and attachment-related avoidance).

Correlation analyses were conducted to test the second research question: What is the relationship between work-related factors (i.e., adult attachment style awareness, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, hours worked per week, and population of clients) and the level of burnout among marriage and family therapists? The variables included participant scores from the three subscales of the MBI-HSS (emotional exhaustion, depersonalization, and personal accomplishment) as well as adult attachment style awareness, frequency of self-care practices, format of services provided to

clients during the COVID-19 pandemic, hours worked per week, and population of clients. The rationale for selecting the statistical analyses used in this study were based on the research questions, type of level of measurement on assessment scales, and number of variables. Based on the results of an a priori power analysis using G*Power 4, a total sample of 134 participants was estimated to be needed for the overall model to achieve a Cohen's f^2 of .10, alpha of .05, and desired power of 80%. With support from the CRDA staff, I moved forward with the statistical analyses listed above and used the largest sample size of participants for each analysis, which ranged from 101 to 107.

Qualitative Analysis

To address the qualitative data collected for this study, participant-written descriptions for each of the four open-ended questions were copied directly from PsychData into a Microsoft Excel spreadsheet. Salmons (2016) highlighted one helpful aspect of doing qualitative research online is that the participants descriptive responses are already transcribed. For the preliminary data coding process, I manually coded the descriptive data using Microsoft Excel and no other additional coding software programs. A priori codes were identified before examining participants' qualitative responses. These a priori codes are based on the preconceived categories from the four open-ended survey questions; however, other themes did emerge beyond the four qualitative questions.

A codebook was established and shared between coders to ensure reliability and consistency in analyzing the qualitative results. My co-coder and I highlighted and underlined significant quotes based on recurring topics from the participants descriptions. Following this preliminary process, an eclectic coding approach was used as the primary method for moving codes to groupings of codes in developing description categories and themes from the

transcribed data. According to Saldana (2016), eclectic coding is appropriate for a majority of qualitative studies, but particularly for novice qualitative researchers and studies with a wide variety of data forms.

In this qualitative analysis procedure, codes, categories, and themes were identified in first and second round coding. Intercoder agreement was reached after multiple rounds of comparing codes, categories, and final themes. In general, our interrater reliability ranged between 90 and 95% agreement. Once a smaller set of themes were identified from this analysis process, I represented the findings by providing an in-depth discussion of the themes, including descriptions of participants' quotes and multiple perspectives. Visual models were created and presented using several different tables to display the identified themes in Chapter 4 results.

Trustworthiness

To establish trustworthiness throughout the data collection and analysis process, I used my major professor as a co-coder to ensure consistency between the rounds of eclectic coding. Throughout this analysis process, I continuously requested feedback and checked for agreement between myself and my major professor to ensure that categories and themes were appropriately identified and credible. I did not use member checking during this process.

Bracketing

Based on my own personal experiences as a marriage and family therapist, I utilized the process of reflexivity and bracketing to mitigate the potential adverse effects of preconceived notions and biases that may taint this research study. I made every effort to put aside personal experiences and prior research knowledge pertaining to burnout syndrome, self-care practices, and adult attachment theory so that the true experiences of participants were reflected in the analysis interpretation and reporting of results. In order to achieve this, I kept a bracketing

journal throughout the entire research process and took notes of when personal assumptions and biases arose.

Integrated Data Analysis and Interpretation

The intent of combining the two databases was to synthesize them into a complementary picture about the experience of burnout among marriage and family therapists during a global pandemic. The difference of sample size between my quantitative and qualitative sample was not considered problematic, as the purpose was to combine the conclusions from gathering the two different data sets. This decision was supported by Creswell and Plano Clark (2018) in which the quantitative data collection aimed to make generalizations while the qualitative data collection aimed to develop an in-depth understanding from a few therapists.

Once the quantitative and qualitative data sets were analyzed separately, I began the process of merging the results of both data sets. I followed the integration procedures outlined by Creswell and Plano Clark (2018) using a side-by-side comparison approach. My first initial step in this process was to look for common concepts across both sets of findings. I then organized the integrated data by content, common concepts, and identified variables. At this point of interface, I was able to compare and synthesize the integrated results further. I chose to represent the integration results in a narrative, in-depth discussion. The findings from my integrated data analysis are presented in Chapter 5. Only comparisons of statistically significant quantitative variables with qualitative themes were included in the discussion sections.

After merging the results in a side-by-side comparison narrative, I interpreted my findings by considering how the merged results produced a more comprehensive picture of the experience of burnout and practice of self-care among marriage and family therapists during a global pandemic. More specifically, I assessed whether the quantitative outcomes and qualitative

themes were more congruent than incongruent and looked for any discrepancies that might tell a different story between the two data sets. I then present my interpretations of the merged data through narrative discussion, recommendations, and limitations in Chapter 5.

Summary

The rationale in using a convergent mixed methods design for this online research study was to bring together quantitative statistical results with qualitative findings for a more robust and integrated interpretation of burnout syndrome among marriage and family therapists and to determine the protective factors that mitigate the development and symptoms of burnout. Both purposeful and snowball sampling methods were used to recruit participants online. Recruitment sources included the TAMFT, as well as other mental health professional contacts, such as multiple Texas-based family therapy graduate programs. Utilizing PsychData, participants completed a singly survey questionnaire, which gathered both quantitative and qualitative data in a single phase. A total of 164 therapists responded to the online survey and 107 of the participants completed the entire survey.

The dependent variables identified in this study were the three subscales of the MBI-HSS, which included emotional exhaustion, depersonalization, and personal accomplishment. The independent variables were anxious attachment and avoidant attachment from the ECR-RS measure, as well as attachment style awareness, self-care frequency, treatment format to clients, population of clients, and client contact hours per week. The four qualitative open-ended questions included participants descriptions of burnout, experience of providing mental health services during the COVID-19 pandemic, utilization of self-care practices, and adult attachment style awareness.

Once the data collection phase concluded, the quantitative and qualitative data were analyzed and presented separately. Descriptive statistics were used to describe demographical information and work-related characteristics of participants. Linear regression analyses were conducted to determine if adult attachment style predicted level of burnout among therapists across the three subscales of the MBI-HSS. Correlation analysis was conducted to analyze the relationship between work-related factors and therapists scores on the three subscale burnout indicators. Qualitative analysis followed an eclectic coding approach outlined by Saldana (2016). The quantitative and qualitative data were then merged and analyzed for comparison of integrated results. The integration procedures outlined by Creswell and Plano Clark (2018) were followed using a side-by-side comparison approach. Lastly, the integrated results were interpreted through further assessment on how the integrated results expanded and deepened the understanding of burnout symptomology, self-care experiences, and use of attachment awareness among marriage and family therapists.

CHAPTER IV

RESULTS

Introduction

This convergent mixed methods study provided the means for a robust and integrated investigation of burnout among marriage and family therapists in terms of attachment experiences and clinical practices. Statistical analyses tested the relationship between quantitative scores on the ECR-RS attachment style indicators and scores on the three subscales of the MBI-HSS. Additionally, correlation analyses examined the relationship between the three MBI-HSS subscale scores and reported level of participant awareness of their own adult attachment style, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and their identified population of clients. Qualitative questions yielded findings regarding participant descriptors of burnout, experience of personal and work-related challenges during COVID-19, the meaning of self-care and self-care practices, as well as attachment knowledge, its impact on clinical work, and attachment style meaning.

Quantitative Findings

Originally, I recruited 164 participants using a purposive sample of Texas licensed therapists who responded to multiple email blasts across 3 months; these staggered blasts included three rounds purchased from TAMFT as well as Texas-based marriage and family therapy graduate programs and other mental health professional contacts in various practice settings. These recruitment email blasts marketed the online study and provided the link to my research study on PsychData as well. Of these 164 respondents, 107 clinicians completed all four sections of the study, including the demographic questions, MBI-HSS, ECR-RS, and qualitative

open-ended questions. With support from the CRDA staff, I moved forward with the statistical analyses listed above and used the largest sample size of participants for each analysis, which ranged from 101 to 107.

Descriptive Statistics

Data were gathered on demographic variables including current license status, age, race/ethnicity, gender, and current relationship status (see Table 1). Additional tables include participant work-related factors (see Table 2); client reported problems at intake and mental health disorders (see Table 3); descriptive statistics for burnout indicator scores (see Table 4); participant self-care characteristics (see Table 5); participants stress characteristics during COVID-19 (see Table 6); and, participant attachment characteristics (see Table 7).

Demographic Characteristics of Participants

A total of $N = 102$ participants were included in the quantitative analyses, comprised of LMFTs ($n = 67$; 65.7%), LMFT Associates ($n = 27$; 25.5%), and other licensed clinicians with a graduate degree in marriage and family therapy ($n = 8$; 7.8%). These included licensed professional counselors (LPC), licensed clinical social worker (LCSW), supervisors, and dual licenses (see Table 1). The participants ranged in age from 26 years to 89 years, with the mean age of 44.3 years. The median age of participants was 43 years. Survey participants included males ($n = 16$; 13.9%) and females ($n = 91$; 79.1%). The majority of participants were Caucasian ($n = 76$; 74.5%) with Hispanic ($n = 11$; 10.8%), African American ($n = 8$; 7.8%), Asian ($n = 4$; 3.9%), Native Hawaiian or other Pacific Islanders ($n = 1$; 1%), and American Indian ($n = 1$; 1%) completing the sample. Participants' current relationship status included married ($n = 69$; 67.6%), cohabitating/living with a partner ($n = 8$; 7.8%), single/never married ($n = 13$; 12.7%), divorced ($n = 10$; 9.8%), and widowed ($n = 1$; 1%).

Table 1

Participant Demographic Data

Demographic Characteristics	Frequency (*n*)	Percentage (%)
License		
LMFT	67	67.5
LMFT Associate	27	25.5
LMFT Supervisor	3	3
LPC	2	2
LPC Supervisor	2	2
LCSW	1	1
Dual Licensed (LMFT, LPC)	1	1
Gender		
Female	91	79.1
Male	16	13.9
Race/Ethnicity		
Caucasian	76	74.5
African American	8	7.8
Hispanic	11	10.8
Asian	4	3.9
Native Hawaiian/Pacific Islander	1	1
American Indian	1	1
Marital Status		
Married	69	67.6
Cohabitating	8	7.8
Divorced	10	9.8
Separated	0	0
Single	13	12.7
Widowed	1	1

Participant Work-Related Factors

The participant years in clinical practice ranged from less than 1 year to 44 years and the average length of time in clinical practice was 10.27 years (see Table 2). The median years of clinical practice was 8 years and the mode was 2 years. Findings from participants' current mental health workplace setting included private practice (*n* = 65; 63.7%), community

clinic/agency (*n* = 12; 11.8%), faith-based organization (*n* = 5; 4.9%), state hospital/private hospital (*n* = 4; 3.9%), university clinic (*n* = 3; 2.9%), detention center/jail/prison (*n* = 2; 2%), and other (*n* = 11; 10.8%). Participants specified other workplace settings such as, private K-12 school, immigration shelter/residential facility, medical center, as well as a combination of working both in private practice and at an agency. The average length of time of participants current workplace setting was 6 years. Participants identified currently working with a variety of population of clients, including individuals (*n* = 52; 51%), couples (*n* = 28; 27.5%), children/adolescents (*n* = 16; 15.7%), and families (*n* = 6; 5.9%). On an average work week, participants' number of client contact hours consisted of 1-5 hours (*n* = 5; 4.9%), 6-10 hours (*n* = 14; 13.7%), 11-20 hours (*n* = 41; 40.2%), 21-30 hours (*n* = 33; 32.4%), and 30+ hours (*n* = 9; 8.8%).

Table 2

Participant Work-Related Factors

Work-Related Characteristics	Frequency (*n*)	Percentage (%)
Workplace Setting		
Private Practice	65	63.7
Community Clinic/Agency	12	11.8
University Clinic	3	2.9
State Hospital/Private Hospital	4	3.9
Faith-based Organization	5	4.9
Detention Center/Jail/Prison	2	2
Other (please specify)	11	10.8
Client Type		
Couple	28	27.5
Family	6	5.9
Children/adolescents	16	15.7
Individual	52	51
Average Client Contact Hours Per Week		
1-5	5	4.9
6-10	14	13.7
11-20	41	40.2
21-30	33	32.4
30+	9	8.8

Client Reported Problems and Mental Health Issues

Participants identified the most common problems their clients presented at the intake session including interpersonal conflict (*n* = 79; 77.5%), sex/intimacy issues (*n* = 41; 40.2%), infidelity (*n* = 35; 34.3%), women's issues (*n* = 26; 25.5%), substance use (*n* = 26; 25.5%), domestic violence/abuse victims (*n* = 22; 21.6%), suicide/non suicidal self-injury (*n* = 18; 17.6%), low socioeconomic status (SES)/financial distress (*n* = 18; 17.6%), chronic health issues/terminal illness (*n* = 16; 15.7%), premarital (*n* = 13; 12.7%), same-sex couples/sexual orientation-identity (*n* = 12; 11.8%), men's issues (*n* = 11; 10.8%), military/first

responders (*n* = 9; 8.8%), incarceration (*n* = 4; 3.9%), and other (*n* = 34; 33.3%). Additional problems presented at intake included divorce adjustment and discernment, family conflict, immigration and cultural adaption, and general chronic stress. Lastly, participants identified the most common mental health disorders their clients presented with during clinical practice. These mental health disorders, according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.), included adjustment disorders (*n* = 77; 75.5%), trauma (e.g., physical, sexual, psychological abuse, posttraumatic stress disorder; *n* = 74; 72.5%), mood disorders (*n* = 74; 72.5%), severe, comorbid mental illness (*n* = 11; 10.8%), personality disorders (*n* = 9; 8.8%), and other (*n* = 11; 10.8%). A few participants specified other common mental health disorders their clients presented including autism, sexual dysfunction/sex disorders, and relationship/adjustment problems.

Table 3

Client Reported Problems at Intake and Mental Health Disorders

Reported Problems at Intake	Clinicians Reported	Percent of Clinicians
	Frequency (*n*)	Percentage (%)
Client Presented Problems		
Domestic violence/abuse victims	22	21.6
Incarceration	4	3.9
Military/first responders	9	8.8
Same-sex couples/sexual-orientation-identity	12	11.8
Substance use	26	25.5
Interpersonal conflict	79	77.5
Sex/intimacy issues	41	40.2
Infidelity	35	34.3
Suicide/non-suicidal self-injury	18	17.6
Low SES/financial distress	18	17.6
Premarital	13	12.7
Chronic health issues/terminal illness	16	15.7
Women's issues	26	25.5
Men's issues	11	10.8
Other (please specify)	34	33.3
Mental Health Problems Presented		
Severe, comorbid mental illness	11	10.8
Trauma, abuse, stress disorders	74	72.5
Adjustment disorders	77	75.5
Mood disorders	74	72.5
Personality disorders	9	8.8
Other (please explain)	11	10.8

Participant Burnout Characteristics

The categorization of the MBI-HSS scores and scoring procedures for individuals is outlined in the electronic manual purchased by the primary researcher. According to the manual, calculating the SUM is often used in scientific research and respondents three scale scores are interpreted separately rather than all together to create a total burnout score. Higher scores for emotional exhaustion and depersonalization indicate higher degrees of burnout, whereas lower

scores of personal accomplishments indicate higher degrees of burnout. Participants' mean score for emotional exhaustion was 34.15, indicating a higher degree of burnout symptoms. The mean for depersonalization was 1.95, indicating a lower degree of experienced burnout among participants. The mean score for personal accomplishment was 48.53, indicating lower experienced burnout.

Table 4

Descriptive Statistics for Burnout Indicator Scores

Burnout Indicators	*M*	*SD*	*Minimum*	*Maximum*
Emotional Exhaustion	35.15	12.94	9.00	62.00
Depersonalization	1.95	1.02	1.00	5.20
Personal Accomplishment	48.53	5.01	31.00	56.00

Participant Self-Care Characteristics

Using a Likert scale (1 = *Never* to 7 = *Every day*), participants identified how often they practiced self-care methods/strategies as a means of coping with professional stress and maintaining work-life balance (*M* = 5.77, *SD* = 1.41). Respondent scores ranged from *Never* (*n* = 1; .9%), *A few times a year or less* (*n* = 3; 2.6%), *Once a month or less* (*n* = 6; 5.2%), *A few times a month* (*n* = 11; 9.6%), *Once a week* (*n* = 7; 6.1%), *A few times a week* (*n* = 40; 34.8%), and *Every day* (*n* = 39; 33.9%). The participants were also asked to identify which forms of self-care they perceived themselves doing well regarding balancing the demands of work and personal life. Participants were asked to select as many forms of self-care that applied to them, which included meditation/mindfulness techniques (*n* = 57; 49.6%), physical exercise (*n* = 73; 63.5%), getting enough sleep/rest (*n* = 92; 80%), eating a healthy diet (*n* = 60; 52.2%),

spirituality/religion (*n* = 53; 46.1%), personal psychotherapy (*n* = 33; 28.7%), professional development/clinical trainings (*n* = 39; 33.9%), time management skills (*n* = 50; 43.5%), clinical consultation/supervision (*n* = 50; 43.5%), and social support/professional support networks (*n* = 67; 58.3%). Additionally, participants specified other unique forms of self-care, including personal hobbies, being in nature (e.g., camping, hiking, outdoor recreation), relaxation such as taking a bath or engaging in sex, as well as laughing with family, friends, and coworkers.

Table 5

Participant Self-Care Characteristics

Self-Care Related Characteristics	Frequency (*n*)	Percentage (%)
Frequency of Self-Care		
Never	1	.9
A few times a year or less	3	2.6
Once a month or less	6	5.2
A few times a month	11	9.6
Once a week	7	6.1
A few times a week	40	34.8
Every day	39	33.9
Forms of Self-Care Used		
Meditation/mindfulness techniques	57	49.6
Physical exercise	73	63.5
Getting enough sleep/rest	92	80
Eating a healthy diet	60	52.2
Spirituality/religion	53	46.1
Personal psychotherapy	33	28.7
Professional development/clinical trainings	39	33.9
Time management skills	50	43.5
Clinical consultation/supervision	50	43.5
Social support/professional support networks	67	58.3

Participant Stress Characteristics During COVID-19

Since the start of the COVID-19 pandemic in early 2020, participants used three treatment formats with their clients: Face-to-face (i.e., in-person only; *n* = 11; 9.6%),

Technology-assisted services (i.e., telemental health only; *n* = 50; 43.5%), and a Combination of face-to-face and technology-assisted services (*n* = 46; 40%). Participants rated the level of difficulty they had experienced in providing technology-assisted services to clients during the pandemic ranging from 1 (*Very difficult)* to 5 (*Very easy*; *M* = 3.41, *SD* = 1.06). Respondent scores varied from *Difficult* (*n* = 28; 24.3%); *Neutral* (*n* = 25; 21.7%); *Easy* (*n* = 35; 30.4%); and *Very easy* (*n* = 18; 15.7%).

Participants rated their level of stress based on their personal experience of providing treatment to clients during the pandemic (*M* = 2.80, *SD* = .840), as follows: *Not at all stressed* (*n* = 7; 6.1%); *Slightly stressed* (*n* = 29; 25.2%); *Moderately stressed* (*n* = 49; 42.6%); and *Extremely stressed* (*n* = 22; 19.1%). In terms of rating their level of stress based on managing work-life balance during the pandemic (*M* = 2.83, *SD* = .910), participants identified the following: *Not at all stressed* (*n* = 9; 7.8%); *Slightly stressed* (*n* = 27; 23.5%); *Moderately stressed* (*n* = 43; 37.4%); and *Extremely stressed* (*n* = 27; 23.5%). Regarding the challenges experienced in their professional environment during the pandemic (*M* = 2.75, *SD* = .881), participants rated their level of stress as follows: *Not at all stressed* (*n* = 10; 8.7%); *Slightly stressed* (*n* = 28; 24.3%); *Moderately stressed* (*n* = 38; 41.7%); and *Extremely stressed* (*n* = 21; 18.3%). Lastly, participants rated the average level of stress of their clients' lives during the pandemic (*M* = 3.56, *SD* = .535). These scores ranged from *Slightly stressed* (*n* = 2; 1.7%); *Moderately stressed* (*n* = 43; 37.4%); and *Extremely stressed* (*n* = 62; 53.9%).

Table 6

Participants Stress Characteristics During COVID-19

Stress-Related Characteristics	Frequency (*n*)	Percentage (%)
Client Treatment Format		
Face to face/in-person only	11	9.6
Technology-assisted services	50	43.5
Both formats	46	40
Providing Technology Services to Clients		
Very difficult	0	0
Difficult	28	24.3
Neutral	25	21.7
Easy	35	30.4
Very easy	18	15.7
Stress Providing Services During COVID-19		
Not at all stressed	7	6.1
Slightly stressed	29	25.2
Moderately stressed	49	42.6
Extremely stressed	22	19.1
Stress Managing Work-Life Balance		
Not at all stressed	9	7.8
Slightly stressed	27	23.5
Moderately stressed	43	37.4
Extremely stressed	27	23.5
Stress in Professional Environment		
Not at all stressed	10	8.7
Slightly stressed	28	24.3
Moderately stressed	38	41.7
Extremely stressed	21	18.3
Average Level of Clients' Stress		
Not at all stressed	0	0
Slightly stressed	2	1.7
Moderately stressed	43	37.4
Extremely stressed	62	53.9

Therapists' Attachment Characteristics

Six quantitative questions were included in the demographic questionnaire regarding attachment theory and the ECR-RS attachment style indicators. These questions included participants' familiarity with attachment theory, adult attachment styles, clinical use with clients, as well as the current awareness of their own attachment style, perception of attachment security, and its level of importance. For the six attachment-related variables, information from a total of $N = 107$ respondents was collected to describe the characteristics of this subsample. These 107 participants completed the open-ended questions, which included 16 males and 91 females.

Attachment Theory Familiarity

Participant familiarity with attachment theory ranged from 1 (*Not at all familiar)* to 5 (E*xtremely familiar*; $M = 3.78$, $SD = .872$). These participants reported *Slightly familiar* (e.g., I've seen some videos or listened to some podcasts about attachment theory; $n = 8$; 7%); *Somewhat familiar* (e.g., I've read a few attachment theory books or attachment related research/articles; $n = 31$; 27%); *Moderately familiar* (e.g., I've taken a course and been to several trainings on attachment theory; $n = 45$; 39.1%); and *Extremely familiar* (e.g., I've completed advanced trainings on attachment theory and use it in clinical practice; $n = 23$; 20%).

Attachment Styles Familiarity

Additionally, participants rated their familiarity with adult attachment styles, which ranged from 1 (*Not at all familiar)* to 5 (*Extremely familiar*; $M = 3.64$, $SD = .994$). These participants selected *Not at all familiar* (e.g., I'm not exactly sure what adult attachment styles are, I've never heard of them before; $n = 2$; 1.7%); *Slightly familiar* (e.g., I've seen some videos or listened to some podcasts about adult attachment styles; $n = 12$; 10.4%); *Somewhat familiar* (e.g., I've read a few attachment theory books on adult attachment styles; $n = 31$; 27%);

Moderately familiar (e.g., I've taken a course and been to several trainings on adult attachment styles; *n* = 40; 34.8%); and *Extremely familiar* (e.g., I've completed advanced training on adult attachment styles and use it in clinical practice; *n* = 22; 19.1%).

Clinical Use of Attachment Theory with Clients

Participants rated how often they currently used attachment theory, adult attachment style assessments, or EFT in their work with clients. Scores ranged from 1 (*Never use*) to 5 (*Frequently use*; *M* = 3.21, *SD* = 1.18). Participants reported *Never use* (*n* = 10; 8.7%); *Almost never* (*n* = 16; 13.9%); *Occasionally/Sometimes* (*n* = 43; 37.4%); *Almost every time* (*n* = 18; 15.7%); and, *Frequently use* (*n* = 20; 17.4%).

Awareness of Own Attachment Style

Participants rated their current level of awareness of their own adult attachment style, ranging from 1 (*Not at all aware*) to 5 (*Extremely aware*; *M* = 4.06, *SD* = 1.09). Participant scores included *Not at all aware* (*n* = 5; 4.3%), *Slightly aware* (*n* = 4; 3.5%), *Somewhat aware* (*n* = 19; 16.5%), *Moderately aware* (*n* = 31; 27%), and *Extremely aware* (*n* = 48; 41.7%).

Perception of Attachment Security

Participants reported their own perception of attachment security as securely attached (*n* = 83; 72.2%) and insecurely attached (*n* = 24; 20.9%).

Level of Importance

Participants rated the level of importance they placed on their current awareness and knowledge of their own adult attachment style using a Likert scale (1 = *Not at all important* to 7 = *Extremely important*; *M* = 5.26, *SD* = 1.43). Participant scores included *Not at all important* (*n* = 2; 1.7%); *Low importance* (*n* = 6; 5.2%); *Slightly important* (*n* = 3; 2.6%); *Neutral* (*n* = 13;

11.3%); *Moderately important* (*n* = 30; 26.1%); *Very important* (*n* = 33; 28.7%); and *Extremely important* (*n* = 20; 17.4%).

Table 7

Participant Attachment Characteristics

Attachment Characteristics	Frequency (*n*)	Percentage (%)
Attachment Theory Familiarity		
Not at all familiar	0	0
Slightly familiar	8	7
Somewhat familiar	31	27
Moderately familiar	45	39.1
Extremely familiar	23	20
Attachment Styles Familiarity		
Not at all familiar	2	1.7
Slightly familiar	12	10.4
Somewhat familiar	31	27
Moderately familiar	40	34.8
Extremely familiar	22	19.1
Clinical Use with Clients		
Never use	10	8.7
Almost never	16	13.9
Occasionally/sometimes	43	37.4
Almost every time	18	15.7
Frequently use	20	17.4
Awareness of Own Attachment		
Not at all aware	5	4.3
Slightly aware	4	3.5
Somewhat aware	19	16.5
Moderately aware	31	27
Extremely aware	48	41.7
Perception of Attachment Security		
Secure	83	72.2
Insecure	24	20.9

Attachment Characteristics	Frequency (*n*)	Percentage (%)
Level of Importance		
Not at all important	2	1.7
Low importance	6	5.2
Slightly important	3	2.6
Neutral	13	11.3
Moderately important	30	26.1
Very important	33	28.7
Extremely important	20	17.4

Quantitative Research Questions

In the current study, the quantitative research questions were as follows: (1) How does adult attachment style predict level of burnout among marriage and family therapists? and (2) How does awareness of one's own adult attachment style, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and population of clients influence the level of burnout symptoms among marriage and family therapists? There were three hypotheses for Research Question 1 and one hypothesis for Research Question 2 as outlined below. This next section presents the quantitative results for all four hypotheses.

Research Question One

The three MBI-HSS subscale burnout scores (emotional exhaustion, depersonalization, and personal accomplishment) are compared to the ECR-RS adult attachment styles (anxious attachment and avoidant attachment) to address the first quantitative research question, "How does adult attachment style predict level of burnout among marriage and family therapists?" A series of standard multiple linear regression analyses were conducted to answer quantitative research question one.

$H_0$1: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and emotional exhaustion subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

$H_0$2: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and depersonalization subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

$H_0$3: There will be no statistically significant difference/relationship when the attachment style scores from marriage and family therapists on the Experiences in Close Relationships-Relationship Structures (ECR-RS) and personal accomplishment subscale scores on the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) are compared.

Emotional Exhaustion and Anxious and Avoidant Attachment ($H_0$1)

For $H_0$1, a standard multiple linear regression analysis was used to identify how anxious attachment and avoidant attachment predicted emotional exhaustion, a subscale of burnout, in marriage and family therapists. Results indicated that the overall model was significant, $F(2, 97) = 6.194$, $p = .003$, and accounted for 9.5% of the variance in emotional exhaustion. Of the predictors, only attachment avoidance was significant (see Table 8). Based on the positive regression coefficient, higher numbers of attachment avoidance were associated with higher emotional exhaustion scores, $\beta = .213$, $p = .044$. Anxious attachment did not reach significance, $p > .05$.

Table 8

Summary of Multiple Regression Analysis Predicting Emotional Exhaustion Scores ($H_0 1$)

	Unstandardized		Standardized			
Predictor	b	*SE*	β	*t*	*p*	95% CI
Anxious	.372	.204	.190	1.824	.071	[-.033, .777]
Avoidance	.616	.302	.213	2.041	.044	[.017, 1.214]

Note. $F(2, 97) = 6.194$, $p = .003$, $R^2 = .113$, adjusted $R^2 = .095$.

Depersonalization and Anxious and Avoidant Attachment ($H_0 2$)

For $H_0 2$, to address depersonalization, a subscale of burnout, a standard multiple linear regression analysis was used to identify how anxious attachment and avoidant attachment predicted depersonalization in marriage and family therapists. Results indicated that the overall model was significant, $F(2, 98) = 8.596$, $p < .001$, and accounted for 13.2% of the variance in depersonalization. Of the predictors, only attachment avoidance was significant (see Table 9). Based on the positive regression coefficient, higher numbers of attachment avoidance were associated with higher depersonalization scores, $\beta = .283$, $p = .006$. Anxious attachment did not reach significance, $p > .05$.

Table 9

Summary of Multiple Regression Analysis Predicting Depersonalization Scores ($H_0 2$)

	Unstandardized		Standardized			
Predictor	b	*SE*	β	*t*	*p*	95% CI
Anxious	.027	.016	.174	1.712	.090	[-.004, .059]
Avoidance	.065	.023	.283	2.787	.006	[.019, .112]

Note. $F(2, 98) = 8.596$, $p < .001$, $R^2 = .149$, adjusted $R^2 = .132$.

Personal Accomplishment and Anxious and Avoidant Attachment ($H_0$3)

For $H_0$3, a standard multiple linear regression analysis was used to assess how anxious attachment and avoidant attachment predicted personal accomplishment, a third subscale of burnout, in marriage and family therapists. Results indicated that the overall model was significant, $F(2, 97) = 7.04$, $p = .001$, and accounted for 10.9% of the variance in personal accomplishment. Of the predictors, only attachment avoidance was significant (see Table 10). Based on the negative regression coefficient, higher scores of attachment avoidance were associated with lower personal accomplishment scores, $\beta = -2.52$, $p = .017$. Anxious attachment did not reach significance, $p > .05$.

Table 10

Summary of Multiple Regression Analysis Predicting Personal Accomplishment Scores ($H_0$3)

	Unstandardized		Standardized			
Predictor	b	*SE*	β	*t*	*p*	95% CI
Anxious	-.129	.078	-.170	-1.64	.104	[-.284, .027]
Avoidance	-.282	.116	-.252	-2.44	.017	[-.512, -.053]

Note. $F(2, 97) = 7.04$, $p = .001$, $R^2 = .127$, adjusted $R^2 = .109$.

Research Question Two

The second quantitative research question was, "What is the relationship between awareness of one's own adult attachment style, frequency of self-care practices, format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and population of clients to the level of burnout symptoms among marriage and family therapists?" The $H_0$4 stated: There will be no statistically significant difference/relationship when the level of awareness of own adult attachment style, frequency of self-care practices,

format of services provided to clients during the COVID-19 pandemic, average number of clients per week, and population of clients are compared to the scores of burnout from marriage and family therapists. A Pearson's product-moment correlation was conducted to examine if participant levels of burnout symptoms were influenced by attachment style awareness, frequency of self-care practices, and other clinical variables.

Levels of Burnout and Factors Related to Clinical Variables ($H_0 4$)

A Pearson's product–moment correlation was conducted to examine the relationship between attachment style awareness, frequency of self-care practices, format of services during COVID-19, client contact hours, and population of clients and the three subscales level of burnout among marriage and family therapists. Table 11 displays the correlations between all variables. Results indicated that the strongest significant association was the correlation between frequency of self-care practices and all three subscales of burnout. Attachment style awareness was positively associated with personal accomplishment ($r = .28$, $p = .004$). Frequency of self-care practices was negatively associated with emotional exhaustion ($r = -.36$, $p < .001$) and depersonalization ($r = -.26$, $p = .007$), as well as positively associated with personal accomplishment ($r = .39$, $p < .001$). Format of services during COVID-19 had a weak, negative correlation with depersonalization ($r = -.19$, $p = .05$) but no statistically significant correlation to emotional exhaustion and personal accomplishment. The average number of client contact hours per week was positively associated with personal accomplishment ($r = .33$, $p = .001$). Lastly, population of clients had no statistically significant correlation to any of the subscales of burnout.

Table 11

Pearson's Product-Moment Correlations between Variables

Variables	1.	2.	3.	4.	5.	6.	7.	8.
1. Emotional exhaustion	-							
2. Personal accomplishment	-.487**	-						
3. Depersonalization	.651**	-.573**	-					
4. Attachment style awareness	-.116	.283**	-.122	-				
5. Frequency of self-care practices	-.356**	.390**	-.260**	.106	-			
6. Format of services	-.002	.120	-.189	.158	-.059	-		
7. Population of clients	.116	-.031	-.038	-.160	.056	-.174	-	
8. Client contact hours[a]	-.020	.325**	-.071	.048	.178	.231*	.124	-

Note: [a]Number of hours per week.

*$p < .05$. **$p < .01$.

Qualitative Open-Ended Questions

In this convergent mixed-methods study, qualitative results provided further insight and meaning to the three subscale items of burnout on the MBI-HSS measure and the two dimensions of adult attachment styles on the ECR-RS measure. Additionally, challenges associated with providing counseling services during the COVID-19 pandemic were explored to illuminate participants' unique personal and professional experiences working as clinicians

throughout the past year. Self-care strategies were also explored to determine if certain practices were associated with alleviating symptoms of burnout. Lastly, participants' foundational knowledge of attachment theory was considered regarding understanding their own adult attachment style, as well as if or how this understanding had informed their clinical work as a therapist. The quantitative and qualitative findings are merged in the discussion sections in Chapter 5.

Three of the four qualitative questions were coded for themes. The third question contained two parts; the first section was coded into categories for how the respondents described self-care, and the second provided a list of the strategies respondents used for self-care. A total of 107 participants completed the four open-ended questions that included 16 males and 91 females. To balance the voice of participant responses, it was decided to select 16 of the 91 female participants who along with the 16 male participants would form a small qualitative subsample of 32 participants. These 16 female participants were selected using an online random number generator.

Personal Experience of Burnout

Participants were asked to describe how they personally experienced the thoughts and feelings of burnout, specifically what it meant to them to feel burned out. The first qualitative question, "How do you personally experience the thoughts and feelings of burnout?" was answered by 31 participants. Participant descriptions were categorized according to the MBI-HSS subscale items, which include emotional exhaustion, depersonalization, and personal accomplishment. Four themes emerged from this data: (1) Diminished emotional functioning, (2) Personal dysfunction, (3) Disengaged and detached, and (4) Professional discontent. These four themes are associated with the three MBI-HSS subscales but (2) Personal dysfunction was

identified as an additional theme. The theme, Personal dysfunction, emerged as an extension of the emotional exhaustion subscale, as it depicts participant self-reports of a range of health-related somatic symptoms associated to their experience of burnout. The four themes that emerged from this data are listed in Table 12.

The first theme, Diminished emotional functioning, supported the emotional exhaustion MBI-HSS subscale as it relates to participant feelings of being emotionally burdened and exhausted by their work. Participant descriptors included phrases such as, "emotionally unavailable," "depressed," "cloudy thinking," "compassion fatigue," "anxious," "distracted and disorganized." One participant stated, "Every day it seems that I wake up with less overall energy and by the time lunch comes around my emotional resources feel spent." Another participant described feeling on the edge of burned out, stating, "I notice that I pay less attention in sessions and that I'm less effective as a therapist."

The second theme, Personal dysfunction, emerged as an extension of the emotional exhaustion subscale. This additional theme identified participants descriptions of the physical effects of feelings surrounding emotional and mental exhaustion related to burnout. Responses included somatic symptoms such as "difficulty sleeping," "physical tension and pain," "muscle fatigue," "gaining weight," "changes in appetite." Additional indicators related to physical health and personal dysfunction included increased use of alcohol and relationship problems with spouse and family. For example, one participant reported, "When I feel burnout I start to feel lethargic and lazy, and I want to drink more." Another participant stated, "I feel more emotionally reactive in personal situations and it's easier to fight with my spouse."

The third theme, Disengaged and detached, aligned with the depersonalization MBI-HSS subscale of burnout. This subscale indicator characterized participant descriptors of unfeeling and negative thinking towards their clients and clinical work. Responses included phrases such as “increasingly cynical,” “robotic,” “annoyed and less patient with clients,” “avoidant,” “jaded.” One participant described burnout as, “Dreading going into work and dreading having to see my clients.” Similarly, another participant reported, “Feeling of dread when it comes to work and work-related responsibilities.” Other participants identified difficulty connecting with their clients in session. For example, one participant stated, “I do not feel like having my sessions or listening to people at all.” Another participant stated, “I can’t stand my clients.”

The final theme, Professional discontent, supports the personal accomplishment MBI-HSS subscale of burnout which measures participant feelings of professional competence and achievement in their work as clinicians. Participant descriptions included “self doubt as a therapist,” “lacking motivation to complete clinical documentation,” “feeling inadequate,” “increased anxiety about performance” One participant reported, “I don’t want to think about my caseload and don’t look forward to consulting with my supervisor about difficult cases.” Another participant stated, “Overall I’m less motivated to get important tasks done at work.”

Table 12

Personal Experience of Burnout

Qualitative Theme	MBI-HSS Subscale	Participant Descriptors
Diminished emotional functioning	Emotional exhaustion	"Withdrawn," "Emotionally unavailable," "Emotional resources feel spent," "Distracted," "Cloudy thinking," "Frustrated," "Depressed," "Distracted and disorganized," Short tempered," "Anxious," "Hopeless," "Compassion fatigue," "Irritable and impatient," "Mentally unfocused"
Personal dysfunction	Extension of emotional exhaustion	"Tired," "Muscle fatigue," "Difficulty sleeping," "Disconnect from my important relationships," "Lethargic and lazy," "Physical tension and pain," "Changes in appetite," "Gaining weight," "Chronic stress," "Physically exhausted"
Disengaged and detached	Depersonalization	"Cynical," "Disengaged," "Robotic," "Dreading work and seeing clients," "Annoyed and less patient with clients," "Can't stand my clients," "Avoidant," "Jaded," "Disconnected from clients," "Not paying attention in session"

Qualitative Theme	MBI-HSS Subscale	Participant Descriptors
Professional discontent	Personal accomplishment	"Considering job change," "Avoid writing progress notes," "Self doubt as therapist," "Lacking motivation to do my job," "Feeling inadequate," "Complacent," "Generally want to quit what I'm doing to recharge," "No longer look forward to working," "Thinking of retirement"

Personal and Professional Challenges During COVID-19

The second qualitative question, "Please describe any personal and professional challenges you have experienced with providing telemental health services and/or in-person services to individuals, couples, and/or families during the COVID-19 pandemic" was answered by 32 participants. The eight themes that emerged from this data are listed in Table 13.

The first theme, Technology problems, included participant descriptions of common professional challenges surrounding the use of technology to provide telemental health services to their clients. An overwhelming majority of responses described issues with internet connection, both for the therapist and clients. For example, one participant reported, "My screen always freezes in the middle of sessions." Another participant stated, "Most of my clients do not have great internet." Other participants described technology difficulties related to their software platform for telehealth services. As one participant stated, "Several clients have struggled to navigate the platform I use."

The theme, Clinical challenges online, encompassed the professional related challenges participants experienced while providing telemental health services throughout the pandemic.

Several participants described new challenges that were associated to moving to online sessions in comparison to meeting with their clients in-person. One participant described their experience as, “Difficultly with family counseling with three members on different devices.” Another participant reported, “Online counseling provides an inability to be authentically present with my clients.” Additionally, participants responses included, “Hard to hear client statements due to poor connection,” and “Hard to read clients body language online.”

The Interpersonal and physical stressors theme emerged from multiple participant descriptions related to the personal challenges they experienced while providing services to clients throughout the pandemic. Several participants reported experiencing physical health problems, such as, “Eyestrain due to long hours online,” “Frequent migraines due to back-to-back virtual sessions,” and “Physical discomfort from sitting too long.” A few participants also described challenges regarding experiencing the same fears and concerns about the pandemic alongside their clients. As one participant stated, “Difficult to help people when both the client and therapist are dealing with the same traumatic stressor.”

The theme, Negative impact on client progress, surfaced through multiple participant descriptions of increased levels of stress among their clients since the start of the pandemic. For example, one participant stated, “My clients are experiencing worse than usual symptoms.” Another participant reported, “Clients seem to be more distressed which adds to the difficulty of helping them.” One participant described the decline in client progress as a lack of available resources due to the pandemic, stating their experience as, “Challenging to adjust coping skills when so many resources have been unavailable to clients while in quarantine.”

The Work-life imbalance theme included both personal and professional experiences as it related to participant descriptions of the many challenges of working from home. Responses

included, “No dedicated office space for online appointments at home,” “Hard to live and work in the same room,” and “Difficult to maintain work-life boundaries.” One participant reported their working from home challenge as, “My husband watches loud movies on the other side of the wall from my office.”

The theme, Pandemic safety concerns, comprised descriptions of the many safety challenges participants identified surrounding the ongoing pandemic. Most participants described feelings of unease regarding their own health and safety as well as that of their clients. Responses included, “Fear and worry about seeing clients in person,” “I have to care about my own safety even though clients are only wanting in-person sessions,” and “Have to focus on cleaning and contact tracing.” One participant described their challenge with new clients, stating, “Wearing a mask in the office makes it hard to communicate with new clients.”

The Lack of professional support systems theme emerged as several participants described challenges related to no longer working in-person at an office or having direct access to colleagues as support. For example, one participant reported, “I lost my professional network.” Another participant stated, “Deciding whether to keep my office after friends and colleagues have left.” Other participants described a lack of support from their supervisors/practice owner. As one participant explained, “I had to learn a lot on my own with no support or resources from my practice owner.”

The final theme, Depleted professional success and efficacy, supported participant descriptions of professional challenges related to a general lack of feeling effective as a therapist and the decline of their practice/business because of the ongoing pandemic. Several responses described challenges, such as, “Income has dropped due to decreased caseload,” and “Loss of clients due to moving to all virtual sessions,” “I’ve suffered financially, and my caseload has

dropped as the months go on." Some participants questioned their effectiveness as a therapist, stating "Not being able to be present with the client feels like I am wasting their time," and "I lost a client after our telehealth meeting and now feel responsible because I'm working in a new environment."

Table 13

Personal and Professional Challenges During COVID-19

Qualitative Themes	Participant Descriptions
Technology problems	"Many internet connection issues," "Internet challenges with online therapy platform," "My screen always freezes in the middle of sessions," "Most of my clients do not have great internet," "The internet is not always best for connection, literally and figuratively," "Several clients have struggled to navigate the platform I use"
Clinical challenges online	"Telehealth is frustrating," "Hard to read clients body language online," "Clients not in appropriate settings for online counseling," "Hard to hear client statements due to poor connection," "Concerns about client privacy and confidentiality," "Clients easily distracted by people or pets in their environment," "Online counseling provides an inability to be authentically present with my clients," "It's been more difficulty to interact with children clients and hold their attention spans," "Difficultly with family counseling with three members on different devices"
Interpersonal and physical stressors	"Eyestrain due to long hours online," "Frequent migraines due to back-to-back virtual sessions," "Physical discomfort from sitting too long," "More tired at the end of the day which limits my self-care abilities," "Difficult to manage children's at home education and scheduling virtual sessions," "Difficult to help people when both the client and therapist are dealing with the same traumatic stressor"
Negative impact on client progress	"Pandemic resulted in loss of client progress," "Some clients unprepared for session," "Clients refused teletherapy," "Clients more anxious and depressed," "Challenging to adjust coping skills when so many resources have been unavailable to clients while in quarantine," "My clients are experiencing worse than usual

Qualitative Themes	Participant Descriptions
	symptoms," "Clients seem to be more distressed which adds to the difficulty of helping them"
Work-life imbalance	"No dedicated office space for online appointments at home," "Difficult to maintain work-life boundaries," "Hard to live and work in the same room," "It's exhausting helping clients through the same pandemic related stressors I'm going through at the same time, which makes having healthy work-life boundaries more challenging"
Pandemic safety concerns	"Have to focus on cleaning and contact tracing," "Therapist and clients feel unsafe coming in person," "Clients do not want to follow safety protocols," "Fear and worry about seeing clients in person," "Wearing a mask in the office makes it hard to communicate with new clients," "I have to care about my own safety even though clients are only wanting in-person sessions"
Lack of professional support systems	"My group practice did nothing to help navigate how to handle anything at the start of the pandemic," "I lost my professional network," "I had to learn a lot on my own with no support or resources from my practice owner," "Deciding whether to keep my office after friends and colleagues have left"
Depleted professional success and efficacy	"Income has dropped due to decreased caseload," "Struggling with issues of isolation and uncertain about the future," "I feel less effective with teletherapy," "Loss of clients due to moving to all virtual sessions," "Not being able to be present with the client feels like I am wasting their time," "Adjusting to novel ways of having clients complete electronic paperwork has been stressful," "I've suffered financially and my caseload has dropped as the months go on," "I lost a client after our telehealth meeting and now feel responsible because I'm working in a new environment"

Self-Care Meaning and Methods of Self-Care Practiced

The third qualitative question, "Please describe what self-care means to you, and then identify/list what strategies or methods of self-care practices you currently use that you find most

helpful to you" was answered by 31 participants. Fewer participants (n = 24) provided descriptions of what self-care meant to them and those descriptions have been grouped in four categories in Table 14 below. All respondents identified or listed strategies or methods of self-care practices they currently used that they found most helpful (see Table 15). The six groupings of self-care strategies were determined for this study based on a self-assessment worksheet for helping clinicians to improve the effects of vicarious traumatization; the groupings are described below (Saakvitne & Pearlman, 1996).

Descriptions of Self-Care Meaning

Participant descriptions of the meaning of self-care were grouped into four categories, including Time for self, Awareness of personal needs, Ability to meet needs, and Positive internal energy. The first category, Time for self, included responses such as, "Prioritizing time to care for me," "Routinely taking time to do things you enjoy," and "Managing my time to be sure my own needs are met." The second category, Awareness of personal needs, supported participant descriptors of self-care as being attentive to one's own needs. Responses included, "Checking-in with myself to determine what is needed," "Recognizing its importance," and "Monitor my stress level." The third meaning of self-care category, Ability to meet needs, focused on participant responses that described the value of taking action. Responses included, "Counteracting the impact of life stressors," "Restoring physical and mental energy," and "Recharging oneself." The final category, Positive internal energy, encompassed participant descriptions of achieving internal balance and resources. Responses included, "Cultivating equanimity," "Holistically taking care of oneself," "Maintaining a self-mantra," and "Maintaining positive energy and boundaries."

Table 14

Four Descriptive Categories of Self-Care Meaning

Categories of Self-Care Meaning	Participant Descriptions
Time for self	"To take time for self-nurture," "Prioritizing time," "Making it a routine," "Able to take time for myself," "Managing my time to be sure my own needs are met," "Prioritizing time to care for me," "Routinely taking time to do things you enjoy"
Awareness of personal needs	"Aware of internal imbalance," "Self-compassion," "Ensuring personal needs are met," "Checking-in with myself to determine what is needed," "Recognizing its importance," "Having awareness of what brings you positive energy," "Monitor my stress level"
Ability to meet needs	"Taking action to disengage my professional mindset and regain self-resources," "Restoring physical and mental energy," "Recharging oneself," "Prioritizing my own needs," "Counteracting the impact of life stressors"
Positive internal energy	"Managing my energy," "Maintaining positive energy and boundaries," "Feeling in the soul," "Regaining energy, enjoyment, and enrichment," "Holistically taking care of oneself," "Maintaining a self-mantra," "Regain mental/emotional resources," "Cultivating equanimity"

Strategies for Self-Care

Participant's descriptions of self-care strategies were sorted into six groupings of self-care for this study based on a self-assessment worksheet for helping clinicians identify effective strategies to maintain self-care and healthy coping skills to improve the effects of vicarious traumatization (Saakvitne & Pearlman, 1996). The groupings of strategies listed on the self-assessment worksheet were found to be common methods of practice among all participants. These six strategies of self-care included, Psychological, Spiritual, Emotional, Physical, Workplace/professional, and Work-life balance.

The self-care grouping, Psychological, included participant descriptions of activities that focused on engaging the inner self and mind. Many of participants described they ways in which they nourish their mental health and activate healthy internal awareness. Responses included, "Attend my own therapy regularly," "Making time for self-reflection," "Moving toward secure relationships in my life for support," "Being mindful," "Practicing mindfulness," "Monitoring my stress level," and "Being self-aware."

The Spiritual self-care grouping illustrated participant descriptors of activities related to religiousness and a meaningful connection to God and nature. Responses included, "Daily reading of scripture," "Reading devotional material and prayer," "Meditation," "Being in nature," "Deep breathing exercises," "Practice Buddhism, "Going to church," "Bible study," "Spending time in prayer," and "Feeling my soul."

The Emotional self-care grouping supported participant descriptions of fostering their intrapersonal and familial relationships. For example, participant responses included "Socializing," "Spending time with my wife and kids," "Hanging out with friends," "Talking to loved ones," "Staying connected with friends and family," "Visiting adult children and grandkids," and "Nurturing my relationships." Several participants also described comforting activities including, "Reading for pleasure," "Laughing," and "Making art."

The Physical self-care grouping encompassed participant words and phrases that were focused on fun physical activities, such as "Dance," "Playing sports," "Getting exercise," "Hiking," "Going on walks," "Swimming at the pool," "Hunting and fishing," "Weightlifting," "Martial arts," and "Cycling." Multiple participants described taking care of their physical health including, "Getting enough sleep," "Eating healthy," and "Attending to medical health." Additional physical self-care strategies were identified as "Cuddling with my partner," "Taking

mini-vacations," "Getting manicures and pedicures," "Taking bubble baths," and "Watching TV."

The self-care grouping Workplace/professional, represented participant descriptions of strategies focused around engaging with colleagues and systems of support as well as setting healthy boundaries for work-related tasks and managing their caseload. Participant descriptors for sources of support included, "Professional trainings," "Consultations," "Connecting with other professionals," "Having weekly supervision," and "Networking." Strategies for self-care and the workday included participant responses, "Having firm boundaries with clients," "Saying no to new tasks and projects," "Scheduling clients with rest periods between meeting times," "Staying on top of case notes," and "Not working harder than my clients are in session."

The final grouping of self-care, Work-life balance, depicted the ways in which participants described striving for balance among work and personal life. Participant phrases included, "Good time management," "Maintaining a structured routine," "Taking time off work to help with my stress," "Carve out time for hobbies," "Setting firm boundaries personally and professionally," "Scheduling time off frequently," and "Keeping work to certain hours."

Table 15

List of Strategies for Self-Care

Strategies for Self-Care	Participant Descriptions
Psychological	"Attend my own therapy regularly," "Making time for self-reflection," "Moving toward secure relationships in my life for support," "Being mindful," "Practicing mindfulness," "Monitoring my stress level," "Being self-aware"
Spiritual	"Daily reading of scripture," "Reading devotional material and prayer," "Meditation," "Being in nature," "Deep breathing exercises," "Practice Buddhism, "Going to church," "Bible study," "Spending time in prayer," "Feeling my soul"
Emotional	"Socializing," "Spending time with my wife and kids," "Hanging out with friends," "Talking to loved ones," "Staying connected with friends and family," "Making art," "Visiting adult children and grandkids," "Reading for pleasure," "Laughing," "Nurturing my relationships"
Physical	"Dance," "Playing sports," "Getting exercise," "Getting enough sleep," "Eating healthy," "Attending to medical health," "Hiking," "Going on walks," "Cuddling with my partner," "Swimming at the pool," "Taking mini-vacations," "Hunting and fishing," "Weightlifting," "Martial arts," "Cycling," "Getting manicures and pedicures," "Taking bubble baths," "Watching TV"
Workplace/professional	"Professional trainings," "Consultations," "Having firm boundaries with clients," "Saying no to new tasks and projects," "Scheduling clients with rest periods between meeting times," "Connecting with other professionals," "Having weekly supervision," "Staying on top of case notes," "Networking," "Not working harder than my clients are in session"
Work-life balance	"Good time management," "Maintaining a structured routine," "Taking time off work to help with my stress," "Carve out time for hobbies," "Setting firm boundaries personally and professionally," "Scheduling time off frequently," "Keeping work to certain hours"

Source: *Transforming the Pain: A Workbook on Vicarious Traumatization* (Saakvitne & Pearlman, 1996)

Attachment Theory Knowledge, Impact on Clinical Work, and Attachment Style Meaning

Participants were asked to describe what they know about attachment theory and what their own adult attachment style meant to them, and to what extent, if any, this has informed their clinical work as a systemic, relational therapist. The fourth qualitative question, "Prior to this study, please describe what you know about attachment theory and what your own adult attachment style means to you, and to what extent, if any, this has informed your clinical work as a systemic, relational therapist" was answered by 28 participants. Two themes emerged from this data (see Table 16): (1) Integrates knowledge of theory and application in clinical work (n = 24) and (2) Identifies own attachment style and demonstrates understanding of its meaning (n = 13). Of those 28 participants, four stated that there was no connection between attachment theory and application at work; these participants did not know attachment theory and did not apply it in their practice.

The first theme, Integrates knowledge of attachment theory and application at work, was a common finding among a majority of participant descriptions regarding their perceived knowledge of attachment theory and how they integrate their understanding of attachment into their work with clients. A few participants described how their knowledge and understanding of attachment theory and secure attachment style have positively impacted their clinical work. One participant stated, "My secure attachment style helps me be able to model healthy communication, identify clients engaged in unhealthy relationship practices and help them identify healthier coping skills." Several participants also identified how their understanding of their insecure attachment style and attachment theory knowledge has had a positive influence on their clinical work. For example, one participant reported, "I tend to have an avoidant-dismissive attachment style, which helps me offer compassion and understanding to those with similar

attachment injuries…also requires more intentional rapport and empathy building with anxiously attached clients." Similarly, another participant stated, "It's easier for me to work with clients that are also avoidant attachment style because I understand them better." One participant also described how their additional training on attachment theory has expanded their awareness of attachment in clinical practice, stating, "I feel like my EFT trainings helped me realize how I might be more reactive to certain clients or when I need to take a step back in the system."

The second theme, Identifies own attachment style and demonstrates understanding of its meaning, supported descriptions of participants perceived attachment style and its meaning. A few participants identified having a secure attachment style, as one participant reported, "I had an anxious attachment style the majority of my life but have become securely attached through seeking my own therapy." Another participant stated, "I have worked to have a secure attachment through the years of my own therapy and personal work, it's critical as a therapist." Several participants identified having an insecure attachment style while demonstrating an understanding of its meaning. For example, one participant responded, "I have used attachment assessments on myself and know that I have a tendency to be more avoidant and less likely to ask for support or receive help from others."

Table 16

Knowledge of Attachment Theory, Application at Work, and Understanding Own Attachment Style

Qualitative Themes	Participant Descriptors
Integrates knowledge of attachment theory and application at work	"I tend to have an avoidant-dismissive attachment style, which helps me offer compassion and understanding to those with similar attachment injuries…also requires more intentional rapport and empathy building with anxiously attached clients," "My secure attachment style helps me be able to model healthy communication, identify clients engaged in unhealthy relationship practices and help them identify healthier coping skills," "I use my experience related to attachment to determine the level and type of attachment my clients have and focus treatment on repairing unhealthy attachment," "It's easier for me to work with clients that are also avoidant attachment style because I understand them better," "I feel like my EFT trainings helped me realize how I might be more reactive to certain clients or when I need to take a step back in the system"
Identifies own attachment style and demonstrates understanding of its meaning	"I had an anxious attachment style the majority of my life but have become securely attached through seeking my own therapy," "I have worked to have a secure attachment through the years of my own therapy and personal work, it's critical as a therapist," "Given my early upbringing of insecure attachment I have grown immensely to achieve a secure attachment style," "My parents were sometimes emotionally unavailable leading to some experiences of avoidant attachment," "My avoidant attachment can contribute to my taking longer to be aware of my own feelings and needs and how they may be impacted in my work with couples," "I personally identify myself as anxious-preoccupied because of my dependence on my partner and how I've struggled with being overly concerned about our relationship future," "I have used attachment assessments on myself and know that I have a tendency to be more avoidant and less likely to ask for support or receive help from others"

Summary

This study used a convergent mixed methods approach to address two quantitative questions about therapist burnout and therapist attachment style, as well as use of self-care practices, knowledge of attachment style, format of client services provided during COVID-19, and other work-related variables. Qualitative themes emerged from participant responses to three open-ended questions and a list of self-care strategies was drawn from the fourth qualitative question.

A series of standard multiple linear regression analyses were conducted on the three hypotheses from Research Question 1 to examine if participant adult attachment style predicted burnout symptoms on the three MBI-HSS subscales. Of the predictors, only attachment avoidance reached statistical significance across all three subscales of burnout (e.g., emotional exhaustion, depersonalization, and personal accomplishment). For Research Question 2, a Pearson's product-moment correlation was conducted to examine if participant levels of burnout symptoms were influenced by attachment style awareness, frequency of self-care practices, and other clinical variables. Results indicated that the strongest significant association was the correlation between frequency of self-care practices and all three subscales of burnout.

Qualitative themes emerged through participant's descriptions of what it means to feel burned out, experiences of personal and professional challenges during COVID-19, meaning of self-care and methods of self-care practices that are most helpful, as well as participant's reports on knowledge of attachment theory, application at work, and attachment style meaning. Four themes such as Diminished emotional functioning and Personal dysfunction supported participants experience of feeling burned out. Descriptions of personal and professional challenges during COVID-19 included eight themes such as Technology problems and Work-life

imbalance. Two themes emerged through participants' responses regarding their understanding and application of attachment theory, including Integrates knowledge of attachment theory and application at work and Identifies own attachment style and demonstrates understanding of its meaning. Participant responses to the meaning of self-care identified four categories including, Time for self and Awareness of personal needs. Additionally, participants identified self-care strategies that were sorted into six groupings based on a self-care assessment worksheet for improving the effects of vicarious traumatization (Saakvitne & Pearlman, 1996).

CHAPTER V

RECOMMENDATIONS AND CONCLUSIONS

Discussion

The purpose of this study was to examine the relationship between the experience of burnout and the utilization of self-care practices and awareness of adult attachment style among marriage and family therapists from an attachment theory perspective. An online convergent mixed methods study was conducted and yielded data describing the experiences of 102 therapists providing counseling services in the state of Texas during the COVID-19 pandemic. The quantitative results of this study yielded findings of therapist burnout symptoms based on a comparison of scores on the three subscales of the MBI-HSS and participant global adult attachment scores on the ECR-RS.

Additionally, this study assessed the association of marriage and family therapists' level of burnout symptoms to their reported frequency of self-care practices, awareness of their own adult attachment style, average number of clients per week, type of client population, and the format of services used to provide therapeutic services to clients throughout the pandemic. Qualitative findings from this study generated rich descriptions of therapists' burnout experiences, both personal and work-related challenges during COVID-19, identified the meaning of self-care and methods of practices used, as well as the therapists' understanding of their own adult attachment style and its impact on clinical work. Therapists' qualitative responses aided in expanding the quantitative results of this study, which provided a deeper understanding of marriage and family therapists experience of burnout and the ways in which they take care of themselves to maintain work-life balance during a global pandemic. In this final

chapter, the quantitative and qualitative findings are presented and integrated together in greater detail below, then interpreted in the summary section.

Quantitative Review

Avoidant Attachment as a Predictor of Burnout

In this study, anxious attachment and avoidant attachment as measured by the ECR-RS were tested to predict levels of burnout across three subscales of the MBI-HSS which include emotional exhaustion, depersonalization, and personal accomplishment. As predicted, marriage and family therapists with avoidant attachment scored significantly higher on both emotional exhaustion and depersonalization but lower on personal accomplishment. My hypothesis that marriage and family therapists with anxious attachment would also score higher on emotional exhaustion and depersonalization but lower on personal accomplishment was rejected. It is likely that anxious attachment did not reach significance in my analysis because it was underpowered due to sample size.

In West's (2015) systematic review, multiple studies found significant associations between insecure attachment and burnout symptoms among various healthcare providers, including mental health professionals. Several findings in the literature conclude that both avoidant and anxious attachment are strongly related to therapist burnout (Carr & Egan, 2017; Devereaux, 2010; Leiter et al., 2015; Scarcella, 2005). However, much of the current research examining adult attachment styles as a predictor against burnout demonstrate mixed findings (West, 2015). This is largely in part due to methodological limitations and inconsistencies among researchers' choices in selecting from the various instruments available for assessing adult attachment style and levels of burnout in health and human service professionals (West, 2015).

It is also striking that there exists such little research into the attachment styles of therapists and burnout using the MBI.

Avoidant Attachment and Emotional Exhaustion

In my study, high avoidant attachment was found to predict emotional exhaustion in marriage and family therapists, reaching statistical significance. This finding supports previous research which also revealed significant associations between avoidant attachment style and burnout among various healthcare workers (West, 2015). However, another study found incongruent results, with avoidant attachment not being related to emotional exhaustion in a second sample of therapists (Carr & Egan, 2017). I also found that a high level of avoidant attachment was a significant predictor of how marriage and family therapists reported their emotional exhaustion. When asked, therapists verbalized their avoidance by stating they felt withdrawn, emotionally unavailable, and disconnected from their important relationships.

Cunningham's (2015) phenomenological study found marriage and family therapists who experienced burnout also experienced emotional exhaustion, which led to distancing within their adult relationships and participating in fewer social activities. These behaviors are indicative of attachment avoidance, such as the reluctance to seek out support when needed and withdrawing into themselves for support. The findings in Cunningham's sample of therapists are suggestive of how burnout can influence the personal and professional relationships of therapists with an insecure attachment style, leading to isolation and negative coping strategies such as avoiding friends and loved ones.

Other research by West (2015) also found that attachment style and burnout were associated as reported by various healthcare workers. However, Carr and Egan (2017) did not find a significant relationship between avoidant attachment and emotional exhaustion when they

studied clinical therapists. The relationship between avoidant attachment and emotional exhaustion is not yet clear. It is possible that for some therapists, when they are overwhelmed by exhaustion they simply want to pull away and protect themselves rather than risk asking for support and needing to care for the support person as well.

Avoidant Attachment and Depersonalization

I found that high levels of attachment avoidance predicted high levels of depersonalization in marriage and family therapists, reaching statistical significance. Past research has shown avoidant attachment among therapists is associated with higher degrees of stress and depersonalization (Carr & Egan, 2017; West, 2015). In a sample of Irish therapists, Carr and Egan (2017) found avoidant attachment style predicted higher levels of detachment from clients, which is considered a feature of depersonalization. Emotional detachment from the suffering of others is a defining characteristic of avoidant individuals (Gillath et al., 2005).

Deactivation strategies may encourage feelings of disdain or pity and decrease the inclination to provide effective compassion (Gillath et al., 2005). Similarly, results from a prior study of psychotherapists indicated that those with an insecure attachment style, including avoidant, scored higher in levels of burnout (Devereaux, 2010). These findings coincide with West's (2015) systematic review of burnout in health and human service workers across a range of disciplines, indicating significant positive correlations between avoidant attachment and burnout in four of the 10 reviewed studies. As mentioned above, West (2015) found in her review of burnout studies that results for avoidant attachment were less consistent, as two studies revealed no significant findings.

Avoidant Attachment and Personal Accomplishment

Lastly, I found that high levels of avoidant attachment predicted low personal accomplishment, reaching statistical significance. Previous research also found attachment avoidance was negatively correlated with the professional efficacy dimension of burnout among healthcare workers (Leiter et al., 2015). This finding is not surprising as individuals higher on attachment avoidance are more likely to be self-reliant and prefer to avoid emotional closeness in relation to others (Bartholomew, 1990). A therapist who exhibits avoidant attachment is more likely to rely upon herself than receive support from others.

To summarize the relationship between avoidant attachment and burnout experienced by marriage and family therapists, high avoidant attachment leads to high emotional exhaustion, high depersonalization, and low personal accomplishment. Those therapists who reported higher emotional exhaustion during COVID-19 and reported feeling a higher sense of depersonalization with the isolation of COVID-19 also reported a lower sense of personal accomplishment. What was surprising was that anxious insecure attachment did not reach significance in this study.

Review of Integrated Quantitative and Qualitative Results

Using convergent mixed methodology, I wanted to learn how the qualitative themes generated by this study integrated with the quantitative findings noted in the paragraph above. In the section below, I discuss how both the quantitative and qualitative findings of my study expand or explain the other. This side-by-side comparison presents a detailed discussion of how the qualitative findings come together with the quantitative results to either confirm or challenge the significant statistical results.

In the following discussion, therapists' burnout scores from the MBI-HSS subscales are compared to the qualitative themes and descriptions of experienced burnout. In addition, the

themes that emerged from therapists' descriptions of personal and professional challenges experienced during COVID-19 are compared to the scores on the MBI-HSS burnout subscales, stress-related characteristics associated to format of therapeutic services, and work-related characteristics. The statistical results from frequency of self-care are compared to burnout scores on the MBI-HSS, participant's categorized descriptions of the meaning of self-care as well as the strategies of self-care commonly practiced. Lastly, therapist attachment scores on the ECR-RS, burnout scores on the MBI-HSS subscales, and quantitative attachment characteristics are compared to the qualitative themes and participant's descriptions related to knowledge of attachment theory, application to clinical practice, and attachment style meaning.

The Experience of Burnout Among Marriage and Family Therapists

Convergent data analysis revealed therapist burnout scores on the MBI-HSS and qualitative descriptions of their experience of burnout were reflective of the three subscale indicators of burnout syndrome, which include emotional exhaustion, depersonalization, and personal accomplishment. Results from the quantitative data found that avoidant attachment was related to emotional exhaustion, depersonalization, and personal accomplishment but that anxious attachment was not related to any of the burnout subscales. Interestingly, the quantitative results also revealed that therapists rated themselves significantly higher in emotional exhaustion and personal accomplishment compared to Maslach's national study with mental health professionals (Maslach et al., 1996). It is very likely that these higher scores can be attributed to my sample responding to this study in the first year of COVID-19 when so little was known about the disease.

Emotional Exhaustion

In this sample, therapists scored highest on the emotional exhaustion subscale of burnout, indicating therapists felt emotionally overextended and exhausted by their work with clients during the first year of the pandemic. When symptoms of emotional exhaustion were high, most therapists reported their experience of burnout as defined by the qualitative themes, Diminished emotional functioning and Personal dysfunction. Therapist descriptions were reflective of higher degrees of emotional exhaustion, such as, emotionally unavailable, mentally unfocused, distracted and disorganized, as well as compassion fatigue. Similarly, therapist descriptors of emotional and mental exhaustion were also reflective of higher degrees of somatic symptoms, including reports of difficulty sleeping, physical tension and pain, and muscle fatigue.

These findings do not appear to be unique to marriage and family therapists, as previous research that examined MBI-HSS burnout indicators with samples of other mental health professionals have demonstrated parallel findings. In fact, the feeling of exhaustion and stress-related health problems are amongst the most common experienced symptoms of burnout by practitioners in the clinical field (Baldwin et al., 2012; Lee et al., 2011; Maslach et al., 1996; Maslach & Leiter, 2016; Negash & Sahin, 2011). Compared to Maslach's national study with mental health professionals, therapists in this study scored significantly higher in emotional exhaustion (Maslach et al., 1996). It is likely that this significant difference on the emotional exhaustion subscale score in my study is a result of the ongoing COVID-19 pandemic.

Depersonalization

Quantitative findings from previous research examining levels of burnout among mental health providers found similar results to this current study. For example, Golshani (2012) reported low scores on the depersonalization subscale of burnout in their sample of marriage and

family therapists, as did Baldwin et al. (2012) in their study on burnout in licensed mental health counselors. Like these other studies, therapist scores on the depersonalization subscale were low in my study, indicating a lower degree of experienced burnout in relation to feelings of cynicism and disengagement with their clients and/or clinical treatment.

Although statistical results did not reveal higher symptoms of depersonalization among therapists in this sample, the qualitative theme Disengaged and detached supported therapists' descriptions of negative thinking and unfavorable feelings towards their clients and clinical work. Examples of numerous therapist responses that were reflective of depersonalization included increasingly cynical, robotic, avoidant, and jaded. Therapists also reported phrases such as annoyed and less patient with my clients, I can't stand my clients, and I do not feel like having sessions or listening to people at all.

My results are a replication of those found in another mixed-methods study by Rinn (2016) who also found low levels of depersonalization among her sample of marriage and family therapists but identified similar experiences of depersonalization in therapists' qualitative descriptions of burnout symptomology. The similarity of our findings is curious as clearly the qualitative data from both studies show that the marriage and family therapists were exhibiting signs of cynicism and detachment, but the quantitative results do not. In conclusion, the low scores on the depersonalization subscale failed to indicate higher degrees of burnout while the personal reflections clearly support detachment.

Personal Accomplishment

The burnout scores on the personal accomplishment subscale were high, indicating lower degrees of burnout regarding therapist feelings of competence and successful achievement in their therapeutic work with clients. While personal accomplishment scores among therapists in

this sample were significantly high, several qualitative descriptors from their responses indicated otherwise, as represented by the Professional discontent theme. Responses included phrases such as, increased anxiety about job performance, self-doubt as a therapist, and feeling inadequate. Some therapist responses included statements about lower productivity and job satisfaction. For example, one therapist reported lacking motivation to complete clinical documentation while another stated [I am] no longer look forward to working and [I am] considering a job change.

In this study, the qualitative findings on personal accomplishment were similar to those in previous studies. For instance, Rinn (2016) also reported that therapists in her study questioned their career choice as a marriage and family therapist. Razo (2018) found that burnout had a significant impact on job performance among a majority of marriage and family therapists in their phenomenological study. These findings are also indirectly supported by other studies examining burnout and job satisfaction among mental health professionals (Golshani, 2012). In a meta-analytic study on burnout in psychotherapists, Lee et al. (2011) found a strong correlation between job satisfaction and the personal accomplishment subscale, as the experience of burnout lowers job satisfaction. Additionally, therapists in this study scored significantly higher in personal accomplishment compared to Maslach's national study with mental health professionals (Maslach et al., 1996).

Clinical Factors as Predictors of Burnout

Five quantitative variables related to clinical factors were examined as predictors of burnout across the three subscales of the MBI-HSS. These clinical factors included, format of therapeutic services provided during COVID-19, average number of client contact hours per week, population of clients served, frequency of self-care practices, and attachment style awareness. The four open-ended qualitative questions provided richer description and

understanding of quantitative results. The themes that emerged from therapists' responses to the open-ended questions are compared to the statistical outcomes and described in greater detail below.

Format of Therapeutic Services and Personal-Professional Challenges

Descriptive data indicated that online, technology-assisted services were reported as the most frequently used format for providing therapeutic services during COVID-19 among therapists in this sample. The second most frequently used format reported among therapists was a combination of both face-to-face and telehealth therapeutic services. It was hypothesized that therapists unexpected transition from meeting clients in-person to providing online telemental health services due to the pandemic lockdowns would be associated with higher levels of burnout symptoms. In this study, I found a weak relationship between the format of therapeutic services and the sense of detachment and cynicism (i.e., depersonalization) felt by therapists. This finding suggests that some therapists did experience higher levels of cynicism and disengagement in relation to providing online telehealth services during the pandemic. No significant association was found between reported format of services and the emotional exhaustion or personal accomplishment subscales of burnout.

Interestingly, data from participant stress-related characteristics revealed that more therapists rated themselves as moderately stressed while providing treatment to clients during the pandemic and a smaller group reported that it was difficult providing technology services to clients. Most therapists reported that it was moderately stressful to manage their professional environment and their work-life balance. The stress-related characteristics just discussed were not predictor variables in the analyses in this study, but the therapists' reports of moderate stress would suggest that these variables could be informative in future research.

While the format of therapeutic services provided during COVID-19 was not found to have a significant relationship to participant's burnout scores, it certainly imposed higher degrees of stress as therapists navigated through providing clinical services online throughout a global pandemic. The qualitative findings from participant descriptions of the personal and professional challenges they experienced during the first year of COVID-19 broadened my understanding of the many struggles therapists faced. For instance, therapists reported that their stress was moderate to high when using online technology due to poor internet connection and issues with online software platforms. The qualitative aspect of this study also yielded information on new challenges when providing online telehealth, such as therapist concerns about client privacy and confidentiality, difficulty reading client body language/non-verbal cues, and trouble with keeping clients engaged during video sessions.

Most therapists rated their clients' level of stress during the first year of COVID-19 as being extremely stressed. For example, several therapists believed that online services presented challenges such as client lack of clinical progress, clients experience of increased distress, and clients report of worse than usual symptoms. Other therapists described their clients as more anxious and depressed than before the pandemic. Many therapists believed that the transition to telemental health services had posed a negative impact on client progress as some clients came unprepared for their online sessions and some clients simply refused to meet for teletherapy.

While therapists rated their level of stress as moderate to high regarding both personal and professional challenges related to providing therapeutic services during the pandemic, qualitative findings yielded more in-depth descriptions of therapist experiences of heightened stress indicating symptoms of burnout. The themes that emerged from therapist descriptions supported the data on stress-related characteristics and previous literature on predictors of

burnout (Gillath et al., 2005; Killian, 2008; Razo, 2018; Rosenberg & Pace, 2006; Scarcella, 2005).

In my study, pandemic safety concerns and lack of professional support systems were among the identified themes related to professional challenges and characteristics of stress. For example, many therapists reported feelings of unease and concerns about their health and safety due to the ongoing pandemic. Therapists reported that they now lacked their professional face-to-face support systems as they no longer worked in an office with supportive colleagues and could not easily access supervisors. Previous research has shown that a lack of strong social support systems is major risk factor of developing burnout (Gillath et al., 2005; Killian, 2008; Scarcella, 2005). Maintaining both collegial and supervisor support appears to be a critical tool for mitigating the development of burnout.

Furthermore, specific elements about one's work environment, such as the transition from a traditional therapeutic setting to a non-traditional setting (e.g., home office), may predispose therapists to burnout. The two themes, work-life imbalance and depleted professional success emerged from therapists' descriptions of having to work in the same place they lived as a result of the pandemic. Several therapists reported difficulty in maintaining work-life boundaries, feeling ineffective as a therapist, and many indicated an initial decline in the success of their practice/business because of the pandemic. Other researchers, such as Razo (2018), have also found therapists' workplace setting to be a significant indicator of burnout. Although their study examined burnout among marriage and family therapists working in community agency settings, parallels can be drawn here, since not having a consistent workspace following therapist transition to a non-traditional work setting due to the pandemic shutdowns appears to have had an impact on therapists' level of stress and heightened feelings of burnout symptoms.

Client Contact Hours

In this sample, descriptive data indicated that most therapists' client contact hours averaged between 11-20 hours and 21-30 hours per week. It was predicted that the higher number of average hours of clients seen per week during the pandemic would be associated with higher levels of burnout symptoms among therapists. Quantitative results revealed that average hours of client contact per week was not observed as a significant predictor of burnout in this study. Similarly, a previous study found no significant association to hours of client contact per week and burnout in their sample of Irish therapists (Carr & Egan, 2017). In my study, the average number of client contact hours per week was positively associated with the personal accomplishment subscale of burnout, reaching statistical significance. This finding suggests that therapists experienced higher levels of competence and professional success in relation to the higher number of hours spent working with clients per week, despite the ongoing pandemic. Past research supports this finding, as more client contact per week has been found to have a positive correlation to personal accomplishment (Rosenberg & Pace, 2006). In contrast, Killian (2008) found that higher hours of clinical contact were associated with lower compassion satisfaction among a sample of clinicians (including marriage and family therapists), in which the researcher suggests setting limits to avoid role strain and feeling overworked.

Population of Clients

In this study, therapists reported meeting with more individuals as clients, with couples as the second most common type of client. It was hypothesized that the population of clients, specifically couples and families, would be associated with higher levels of burnout due to the more multifaceted nature of systemic counseling. Specifically, it was predicted that couples would be associated with higher rates of burnout among participants in this sample, as Gottman

et al. (2019) suggested that today's couples entering therapy are far more distressed than once believed. The findings in this study did not support this hypothesis as quantitative results observed no significant associations between type of clients served and any of the MBI-HSS subscales of burnout. Still, other researchers reported that working with at-risk populations such as abuse victims, individuals with severe mental illnesses, and or emotional disabilities can result in emotional exhaustion and burnout (Gillath et al., 2005; Killian, 2008; Scarcella, 2005).

Frequency of Self-Care and Meaning of Self-Care

Most of the therapists reported engaging in self-care practices a few times per week. It was hypothesized that the higher frequency reported and utilization of meaningful self-care practices would be associated with lower levels of burnout symptoms among therapists. Quantitative results supported this hypothesis which found the strongest significant association between frequency of self-care practices and all three subscales of burnout. Results from this study revealed that the frequency of self-care practices among therapists was negatively associated with the emotional exhaustion and depersonalization subscales of burnout, while self-care was positively associated with the personal accomplishment subscale. As therapists engaged more often in self-care activities throughout their week, symptoms of emotional exhaustion and depersonalization decreased while feelings of personal accomplishment increased. Previous research supports these findings, which suggest that adaptive coping strategies and increased frequency of self-care are significant indicators of lowered burnout (Golshani, 2012; Scarcella, 2005).

The qualitative categories that emerged from therapist descriptions of the meaning of self-care and the strategies they found most helpful enhanced our understanding of why therapists reported engaging in self-care so frequently. Therapist descriptors of the meaning of

self-care were sorted into four categories, including (1) Time for self, (2) Awareness of personal needs, (3) Ability to meet needs, and (4) Positive internal energy. These categories of self-care highlighted the importance and value therapists place on taking care of themselves, which requires prioritizing your time, being attentive to your own needs, maintaining internal balance, and the ability to take action to care for yourself when needed. This increased self-awareness of the importance of self-care practice has been supported in previous research (Chen et al., 2019; Sahibzada, 2019).

Therapist Utilization of Self-Care Practices

Physical Self-Care. In this study, regular physical exercise was the highest utilized method of physical self-care among therapists. Therapists identified activities involving regular physical exercise, such as working out, hiking, playing sports, going on walks, cycling. Physical health was also a major component of physical self-care among therapists, including getting enough sleep/rest, eating a healthy diet, and attending to medial health. In addition to these, leisure activities were a common form of physical self-care, such as taking mini vacations, camping and outdoor recreation, taking bubble baths, and watching TV. This finding is supported by previous research studies that reported physical exercise (Eddington, 2006; Ford, 2018; Rinn, 2016) and physical health (Barnett et al., 2007) as effective strategies for mitigating burnout among similar samples of therapists.

Spirituality and Religious Practices. Spirituality and religious practices were identified as key strategies practiced by more than half of the therapists in this study. Therapist descriptions of spiritual self-care strategies included daily reading of scripture, reading devotional material and prayer, spending time in prayer, and feeding my soul. Examples of religious practices include going to church and Bible study. Results from previous research have also identified

spirituality as a critical resource for self-care and counteracting burnout symptoms (Cunningham, 2015; Giles, 2012; Killian, 2008). Giles (2012) found that spirituality provided therapists with a sense of meaning and inspiration as they navigated the emotional and physical demands of being a mental healthcare provider. Cunningham (2015) also found a need among marriage and family therapists to engage in spiritual practices for self-care and connect with God or a higher power to mitigate the feelings of burnout. Similar to Giles's (2012) research, I found that prayer was among the most commonly reported strategies used by therapists for self-care. This finding highlighted how therapists utilize their connection with God to mitigate symptoms of burnout, which is of particular importance in these very challenging and uncertain times as the pandemic continues. The use of spirituality may be a vital protective factor against burnout as well as an effective strategy for heightening a therapist's sense of security, as religion provides beneficial support.

Psychological Self-Care. Another highly reported method of self-care practiced among therapists in this study was psychological self-care. Several qualitative strategies focused on engaging the inner self and mind, as many therapists described the ways in which they nourish their mental health and enhance their internal awareness. Descriptive data supported these qualitative findings, in which more than half of the therapists reported practicing meditation and mindfulness techniques and a slightly smaller group reported attending their own psychotherapy. In previous research studies, mindfulness practices were also found to be a powerful tool in reducing stress (Armes, 2014; Chen et al., 2019; Farin, 2015). Armes (2014) proposed that different types of mindfulness practices, such as Mindfulness Based Cognitive Therapy and Mindfulness Based Stress Reduction, aid in decreasing therapist's levels of burnout. Taking part in any form of meditation can be a positive method for enhancing self-awareness and emotional

stability (Negash & Sahin, 2011). Additionally, results from Eddington (2006) reported personal therapy lessened burnout among MFTs. Regardless of whether the reason is work or family difficulties, seeking personal therapy can substantially reduce the symptoms of burnout (Negash & Sahin, 2011).

Emotional Self-Care. Therapists used emotional self-care strategies to help them foster their intrapersonal and familial relationships. Forms of engaging in emotional self-care included reports of socializing, spending time with friends and family, nurturing personal relationships, and staying connected with loved ones. Other researchers support using emotional self-care to offset stress (Figley, 2002; Killian, 2008; Negash & Sahin, 2011; Rosenberg & Pace, 2006; Scarcella, 2005). Enhancing social support for therapists is a critical aspect of mitigating burnout. Figley (2002) emphasized how important it is for therapists to remember they may need help coping with life's challenges too. Maintaining strong relationships with family and friends can provide the therapist with a healthy escape from their professional responsibilities (Negash & Sahin, 2011). Engaging in laughter and fun with family and friends has proven to be an effective strategy in preventing burnout (Negash & Sahin, 2011).

Workplace and Professional Self-Care. When reporting on workplace and professional self-care strategies, therapist-identified strategies focused on engaging with colleagues and maintaining systems of support. Descriptive data on self-care characteristics revealed that more than half of the therapists in this sample utilized social support/professional support networks, while fewer than half of the therapists reported involvement in professional development and clinical trainings. Therapist identified workplace/professional self-care strategies include attending professional trainings, regular supervision, professional networking, and clinical consultations. Other valuable forms of professional self-care strategies reported by therapists

included setting firm boundaries with clients, staying on top of case notes, and scheduling rest periods between client meetings. Other researchers also support these findings (Chen et al., 2019; Figley, 2002; Franco, 2015; Macchi et al., 2014; Razo, 2018; Scarcella, 2005). Expanding their social support systems in both number and a variety of relationships is vital to the therapist's ability to manage and treat symptoms of burnout (Figley, 2002). Creating a positive work environment and maintaining consistent levels of supervision is important for preventing and managing the negative effects of burnout (Franco, 2015; Negash & Sahin, 2011). Good supervisors and supportive professional networks can serve as secure attachment figures to help lessen burnout when stressors activate the therapist's attachment system (Gillath et al., 2005). Killian (2008) also confirmed that social support was among the most significant factors associated with lower reported work stress.

Strategies for Work-Life Balance. The final self-care strategy, work-life balance, depicted the ways in which therapists described striving for balance within the personal and professional life. Descriptive data on self-care characteristics indicated that just fewer than half of therapists identified time management as a form of self-care for coping with professional stress and maintaining work-life balance. These results support the qualitative descriptors of therapist strategies for achieving work-life balance, including maintaining a structured routine, scheduling time off frequently, keeping work to certain hours, taking time off work regularly to help with stress, carving out time for hobbies, setting firm boundaries personally and professionally. Other researchers have also identified similar strategies for achieving work-life balance (Chen et al., 2019; Killian, 2008; Negash & Sahin, 2011). Reducing caseloads is a proactive and positive self-care strategy that is supported in previous literature on therapist

burnout (Killian, 2008). Sustaining a balance between the therapist's personal life and professional life is also essential (Negash & Sahin, 2011).

Heightened Awareness of Attachment Style

A majority of therapists in this sample rated their current level of awareness of their own attachment style as moderately to extremely aware. In addition, more than half of therapists rated the level of importance they placed on their current awareness and knowledge of their own attachment style as moderately important to extremely important. More therapists reported that they identified as having secure attachment whereas only a small group rated themselves as having an insecure attachment style. Consequently, the average ECR-RS scores were low on both attachment anxiety and avoidance, indicating that most of the therapists in this sample were relatively secure in their global attachment orientation. The hypothesis was confirmed that those therapists who perceived themselves as having prior self-awareness of their own adult attachment style would score lower on burnout dimensions of emotional exhaustion and depersonalization, but higher on the dimension of personal accomplishment. Therapists with heightened awareness of their own attachment style also demonstrated a positive association with the personal accomplishment subscale of burnout.

Other researchers support this finding as Armes (2014) found that therapists with secure attachment were more likely to report satisfaction in their work performance. Similar to having a heightened awareness of one's own attachment style, Killian (2008) also described the concept of emotional self-awareness among therapists as a critical tool in preventing burnout. Paying close attention to emotional reactivity, a common sign of burnout, through practicing self-awareness and self-monitoring is also known to be an effective strategy for noticing the warning symptoms of burnout (Negash & Sahin, 2011).

Attachment Style Meaning

Most therapists from the quantitative sample rated their current level of awareness of their own attachment style as moderately to extremely aware. Most therapists from the smaller, qualitative sample identified their own attachment style as secure with a few identifying as insecure. Among those with a secure attachment, one therapist stated, "I have worked to have a secure attachment through the years of my own therapy and personal work, it's critical as a therapist." Of the few who identified with having an insecure attachment style, one therapist reported "My avoidant attachment can contribute to my taking longer to be aware of my own feelings and needs and how they may be impacted in my work with couples." Not surprisingly, most therapists in the larger quantitative sample rated the level of importance they placed on their current awareness and knowledge of their own attachment style as moderately important to extremely important.

Attachment Theory Knowledge and Clinical Use

Quantitative data also revealed that most therapists in this sample rated themselves as somewhat to moderately familiar with both attachment theory and adult attachment styles prior to the study. More therapists rated their clinical use of attachment theory, attachment style assessments, or practice of EFT as happening on an occasional to frequent basis in their work with clients. Nearly all therapists in the qualitative sample stated how they integrated their knowledge of attachment theory and applied that knowledge in their clinical work. One therapist described her knowledge of EFT as "I feel like my EFT trainings helped me realize how I might be more reactive to certain clients or when I need to take a step back in the system." Another therapist described her experience using attachment style assessments as "I use my experience

related to attachment to determine the level and type of attachment my clients have and focus treatment on repairing unhealthy attachment."

Discrepancies between the Quantitative and Qualitative Data

In the sections above, I have discussed the points of integration between the quantitative and qualitative data yielded by this study. It is now important to note those discrepancies reported in the previous chapter on study results. The interpretation approach followed in this discussion allows me to share how the qualitative themes often tell a different story than the quantitative results. A few differences existed on a few concepts, themes, and scales. These are examined in greater detail in the discussion below.

Divergence in Attachment and Burnout Findings

Therapist MBI-HSS scores on the depersonalization subscale of burnout were low, but qualitative descriptions revealed otherwise as indicated by the supported theme Disengaged and detached. Past research has shown that both anxious and avoidant attachment among therapists is associated with higher degrees of general stress and depersonalization (Carr & Egan, 2017; West, 2015). Even though I selected my qualitative sample using a random numbers table, it is possible that I selected a group of therapists who had more disengaged and impersonal responses. Furthermore, it is also possible that by balancing the men and women's voices, I actually elevated the voices of the male therapists among the qualitative subsample. The ratio of men to women in the quantitative study is much lower than in the qualitative subsample.

There was also a substantial difference on therapists' personal accomplishment subscale scores compared to scores from Maslach's national study with mental health professionals (Maslach et al. 1996). In my study, therapists scored significantly higher on the personal accomplishment subscale, indicating lower levels of burnout regarding their feelings of

competence and successful achievement in their therapeutic work with clients. What was surprising was that anxious insecure attachment did not reach significance in this study. Qualitative findings indicated otherwise, as multiple therapists reported feeling inadequate, increased job performance anxiety, and lower productivity and job satisfaction. It is possible that therapists did not recognize these feelings as an indicator of burnout. There appears to be a protective factor in anxious attachment behaviors that prevented therapist burnout scores to reach significance.

Emergence of COVID Fatigue Theme

The COVID-19 pandemic has undoubtedly been a world-changing, life-altering experience. It appears that the MFTs with secure attachment in this study have pivoted and adapted to such changes in both their personal and professional life. The findings from this study indicate that while COVID-19 impacted therapists' level of stress and the way in which they provided clinical services to their clients, many were still able to take care of themselves in meaningful ways. The theme, COVID fatigue, supports therapists' descriptions of heightened stress and its impact on their emotional & physical health. This ad hoc theme was generated from examining therapists' responses across all the data.

How Mixed Methods Enhanced the Study

A major strength of this mixed methods study was that I could expand the concepts examined through the quantitative data such as attachment and burnout using qualitative questions that focused on those concepts as well. Utilizing qualitative open-ended questions to capture the experiences of marriage and family therapists' personal and professional lives related to burnout and stress allowed for greater meaning and understanding behind the MBH-HSS scores. Additionally, the use of open-ended questions provided therapists to identify and describe

forms of meaningful self-care practice that have not yet been illuminated in prior studies, as the pandemic presented new challenges faced by therapists. Furthermore, the use of the qualitative question pertaining to therapists' knowledge of their own attachment style and how their particular style has impacted their clinical work provided additional insight into their individual ECR-RS scores. It also pointed to how attachment awareness can be used as a resourceful tool for healthy coping and maintaining professional efficacy.

Application to Theory

I chose Bowlby's attachment theory as the lens for this dissertation because I am curious about how secure and insecure attachment can mediate emotional exhaustion, depersonalization, and personal accomplish among marriage and family therapists. It was anticipated that the findings of this study would be consistent with Bowlby's attachment theory, which assumes that an individual's earliest childhood experiences with their primary attachment figure are important predictors of later social and emotional functioning. Based on this theory, the findings from this study were interpreted as supporting the hypothesis that secure attachment in childhood helps therapists to effectively cope with heightened stress and burnout. Similarly, insecure attachment (either avoidant or anxious) is likely to lead to poor coping and higher degrees of burnout.

Indeed, using the lens of attachment theory was informative because the research questions posited in this study were supported by testing the study hypotheses such that avoidant attachment was associated positively with emotional exhaustion and depersonalization and negatively with personal accomplishment. This study is in line with the current literature on attachment theory as it was expected that those therapists with secure attachment styles would report low levels of burnout symptoms (Scarcella, 2005), whereas those with insecure attachment styles (i.e., anxious and avoidant) will report higher levels of burnout symptoms (Carr & Egan,

2017; Leiter et al., 2015). The three hypotheses posited in this study were supported when scores on avoidant attachment were tested. Anxious attachment comparisons with the three burnout subscales were not supported.

Attachment theory continued to add meaning to this study when it was posited that that therapists with secure attachment would report more novel and meaningful forms of self-care through their open-ended responses. For instance, one therapist reported, "I had an anxious attachment style the majority of my life but have become securely attached through seeking my own psychotherapy." This secure individual described how they demonstrate adaptive coping strategies (i.e., seeking support through personal therapy) and maintain their attachment security when stresses activate the attachment system. For therapists who rated lower frequency and utilization of engaging in self-care practices, it was expected that these therapists would score higher on burnout dimensions and report insecure attachment (anxious or avoidant). For example, one therapist stated, "My avoidant attachment can contribute to my taking longer to be aware of my own feelings and needs and how they may be impacted in my work with couples." When confronted with chronic stress, this insecure therapist was less likely to be aware of their need for support or need to engage in self-care activities.

How therapists used their knowledge of attachment theory supports the notion that theory can be used to explain and predict our worldview (Boss et al., 1993). It was also anticipated that those therapists that perceived themselves as having prior self-awareness of their own adult attachment style would score lower on burnout dimensions of emotional exhaustion and depersonalization but higher on the dimension of personal accomplishment. In comparison, it was predicted that those therapists with less knowledge or awareness of their own adult attachment

style would score higher on all three subscales of burnout. As one therapist stated, “I never think in terms of attachment theory.”

Limitations

1. Having only 16 males in this study limited generalization of the findings to male therapists.
2. The high dropout rate (37%) in this online study is difficult to analyze. It is likely that the online study appealed to a wide variety of therapists who found when they opened the study and reviewed the inclusion criteria that it did not fit them.
3. By appealing to therapists from Texas, it is possible that the generalizability of the findings is limited.
4. The smaller than expected sample may have resulted in the quantitative data analyses not reaching statistical significance for anxious attachment and burnout scores.

Implications

This study is significant as marriage and family therapists are underrepresented in the mental health literature regarding burnout. Furthermore, this study is timely as the need for mental health services, arguably, has never been greater as the COVID-19 pandemic has affected the lives of so many across the United States. A strength of this research was the concentrated participant sample of marriage and family therapists across the state of Texas. While the measurable variables of attachment style and methods of self-care related to burnout have been previously researched across other disciplines, the mixed methods design utilized in this study enhanced research outcomes. Specifically, this study differed from others that have not examined a sample comprised solely of marriage and family therapists using an online mixed methods research design. Therapists’ experiences that were unique to the COVID-19 pandemic also added novel

insight. The results of this study yielded new findings on burnout, self-care, and attachment that have not yet been concluded in other research studies on the topic.

Implications for Therapists and Clinical Practice

If more knowledge is associated with the beneficial use of attachment style awareness and meaningful practices of self-care, clinicians across multiple mental health professions may be more equipped in recognizing their own personal limitations and clinical blind spots. For those in community mental health clinics and agencies, supervisors and administrators could benefit from implementing a screening of burnout among clinicians for managing symptoms of chronic stress and burnout prevention planning. Similarly, utilizing an assessment tool to measure therapist attachment style may provide supervisors and administrators with useful resources for identifying clinicians who are at higher risk for burnout and provide appropriate guidance and support when needed. Supporting attachment security and effective dependence on others in these ways may also have the power to increase career satisfaction, longevity, and aid in clinician's overall health and well-being (Chen et al., 2019; Razo, 2018; Rosenberg & Pace, 2006).

In addition, those clinicians that focus their clinical practice in providing therapy to other mental health providers could benefit from the findings of study in terms of how they approach their clinical work with these individuals. For clinicians who are unfamiliar with attachment theory, this study may prompt curiosity and a desire to obtain a higher level of training and skill for using attachment theory in their own practice. This research will hopefully serve as a sounding board for becoming competent in working from an attachment perspective in clinical practice, and perhaps more specifically to clinicians interested in learning how to use attachment theory or emotionally focused therapy with individuals, couples, and families.

Increasing self-awareness of one's own attachment style may also aid in the ability for clinicians to effectively operate as a secure base for their clients and feel more confident in facilitating corrective emotional experiences in session with clients. Likewise, having more knowledge and understanding of attachment representations that are specific to burnout symptoms and maladaptive attachment style coping responses may allow therapists to improve symptoms of distress by using dependable support systems and engaging in meaningful self-care practices.

Implications for Educators, Supervisors, and Graduate Training Programs

Marriage and family therapy graduate training programs, educators, and clinical supervisors are in a unique and influential position regarding their role in molding future systemic therapists. For this reason, it seems imperative that the need to pay careful attention to the attachment patterns of therapist interns or therapist associates and the ways in which they engage in self-care throughout the graduate training and supervision process as vital to their well-being and clinical success. Furthermore, recognizing the occurrence of burnout as a common experience among marriage and family therapists in training provides an opportunity for educators, supervisors, and graduate training programs to confront this issue preventively and proactively.

Normalizing the experience of burnout, rather than as an indicator of personal or professional failure, may allow those professionals in supervisory roles and training positions to better assist therapist graduate students in attending to their own needs and making timely adjustments, such as by emphasizing an investment in routine self-care practices (Chen et al., 2019; Sahibzada, 2019). If self-care is prioritized in this way, therapist trainees will likely have a better chance at maintaining a sense of overall well-being and effectively engage the self through

various adaptive coping methods. In addition to this, clinical supervisors and faculty in graduate training programs can foster the use of therapeutic self as a primary clinical tool by facilitating supervision meetings, class discussions, and course assignments around self-of-the-therapist exercises that allow for deeper self-awareness. It would also be beneficial to incorporate attachment informed courses into graduate training programs or offer clinical trainings as a means to learning one's own attachment style and equip students with effective ways in which they can use this self-awareness for enhancing their ability to cope with distress and work towards attachment security if needed.

Recommendations for Future Research

Future research is certainly needed to determine ways to protect marriage and family therapists against the development of burnout.

1. Future studies are recommended to investigate the effectiveness of how attachment awareness and engagement in self-care practices influence different dimensions of burnout symptoms among marriage and family therapists.
2. Research into attachment style and burnout continues to be needed as uniformity in studying burnout is lacking which yields inconsistent results.
3. Further investigation is needed for why the comparison of scores on anxious avoidance and burnout did not reach statistical significance when comparisons of avoidant attachment and burnout were significant.

Summary

The intent of integration in this convergent mixed methods design was to "develop results and interpretations that expand understanding, are comprehensive, and are validated and confirmed" (Creswell & Plano Clark, 2018, p. 221). To accomplish this intent, after collecting

both quantitative and qualitative data concurrently, I first analyzed the data separately and then merged the two data sets together. After combing the two data sets, I then compared statistical outcomes of therapists' level of burnout from the MBI-HSS measure, scores on attachment style from the ECR-RS measure, and therapists' demographic responses along with the descriptions of their personal experiences from the four open-ended qualitative questions. The parallel research questions and concepts were examined in both the quantitative and qualitative data collection process to facilitate successful integration and analysis. The quantitative results and qualitative open-ended findings have increased our understanding of therapist burnout experiences during COVID-19 through gathering therapists' rich descriptions of possible protective factors they used against burnout syndrome.

The findings from this study may help bring greater understanding and increased awareness of the experience of burnout to the mental health field by advocating for a system that supports those who work in it now. By the year 2023, 59.6% of the workforce will be of retirement age in the state of Texas. Therefore, it is imperative that we help build knowledge and beneficial strategies that will support today's systemic therapists' ability to effectively cope with the experience of burnout in a way that fosters resiliency and growth. The results of this research study have the potential to strengthen the field of working marriage and family therapists and provide essential support to this group of clinicians.

Conclusion

Therapists that experience heightened levels of work-related stress are considered particularly more vulnerable to developing symptoms of burnout, including emotional exhaustion, disengagement, and feelings of inefficacy and cynicism. If they are not aware of the importance of self-care and effective coping methods for sustaining a healthy work-life balance,

therapists are at risk of experiencing stress-related health issues, such as chronic fatigue, weakened immune system, anxiety, and depression. The onset of burnout symptoms not only impacts therapists' physical and mental health, but can also negatively influence their clinical efficacy and quality of work, as well as strain personal relationships with romantic partners, children, family members, friends, or colleagues.

Through the use of an online questionnaire and open-ended survey questions, this research study explored current burnout symptoms of marriage and family therapists and how the experience of burnout impacted their ability to take care of themselves, access sources of support, and maintain clinical efficacy during the COVID-19 pandemic. Numerous personal- and work-related factors appear to play a crucial role in the development of burnout among this group of mental health professionals, thus, this study aimed to provide a more robust understanding of the burnout experience using an online convergent mixed methods research design. This study was guided by Bowlby's attachment theory and Fraley's attachment styles as an extended framework for which to explore an individual's sense of security in relationships with others as an attachment process. The goal of this study was to attain a greater understanding of the symptoms of burnout and the proper means for taking care of one's self in meaningful ways that would allow for marriage and family therapists to approach their clinical work with better care and intentionality.

Moreover, this study sought to identify ways marriage and family therapists recognize and manage burnout as well as to elucidate how their own attachment style awareness and use of self-care practices may help in managing its impact. By obtaining a greater understanding of the predictors and protective factors associated with burnout, such as engaging dependable support systems, fostering a sense of deeper self-awareness of attachment style, and routinely practicing

self-care, therapists' overall health and wellness may also be nurtured. Findings from this research may help to inform policymakers in the field of mental health, educators, and clinicians of the risks associated with burnout and the importance of engaging in healthy ways of coping with work-related distress. With this heightened level of awareness, therapists would be able to nurture their own mental and physical health, as well as assist in supporting the well-being of other clinicians in the field that may be suffering from symptoms of burnout amid the COVID-19 pandemic.

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APPENDIX A

RECRUITMENT EMAIL SCRIPT FOR TEXAS ASSOCIATION FOR

MARRIAGE AND FAMILY THERAPY

Have you experienced symptoms of burnout during the COVID-19 pandemic?
Have you struggled to maintain a healthy work-life balance?

My name is Mary Hannah Key and I am a doctoral student in the Marriage and Family Therapy graduate program at Texas Woman's University. I am conducting a dissertation research study examining the professional experience of therapist burnout during the COVID-19 pandemic, use of self-care practices, and self-awareness of attachment style among marriage and family therapists in Texas.

To be eligible for this study, participants must:

- Be at least 21 years of age or older
- Be currently licensed as a Marriage and Family Therapist (LMFT), LMFT Associate in the state of Texas, or hold a graduate degree in Marriage and Family Therapy if your license is not MFT.

The research study is being administered online through PsychData and will take approximately 20 to 25 minutes to complete. Your involvement in this study is completely voluntary and you may withdraw from the survey at any time.

To participate in the study, please click on the following link:
https://www.psychdata.com/s.asp?SID=190872

If you have any questions about this research study, or for more information, please contact the lead investigator:

Mary Hannah Key, M.S., LMFT Associate
Doctoral Candidate, Marriage and Family Therapy Program

Texas Woman's University
Email: mkey2@twu.edu

APPENDIX B

TAMFT SOCIAL MEDIA ADVERTISEMENT

YOUR SUPPORT IS NEEDED!

Please consider participating in this important study*

My name is Mary Hannah Key and I am a doctoral student in the Marriage and Family Therapy graduate program at Texas Woman's University. I am conducting a study on therapist burnout, use of self-care, and understanding of attachment style during COVID-19.

To qualify for this study, you must:

- Be at least 21 years of age or older
- Be currently licensed in the state of Texas with any of the following-
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Marriage and Family Therapist Associate (LMFT Associate)
    - Have a graduate degree in Marriage and Family Therapy if your board license is not LMFT (e.g., LPC, LCSW, Psy.D.)

The research study is being administered online through PsychData and will take approximately 20 to 25 minutes to complete. Your involvement in this study is completely voluntary and you may withdraw from the survey at any time.

To participate in the study, please click on the following link:
https://www.psychdata.com/s.asp?SID=190872

If you have any questions about this research study, or for more information, please contact the lead investigator:

Mary Hannah Key, M.S., LMFT Associate
Doctoral Candidate, Marriage and Family Therapy Program
Texas Woman's University
Email: mkey2@twu.edu

APPENDIX C

RECRUITMENT EMAIL SCRIPT FOR UNIVERSITY MFT GRADUATE PROGRAM

Dear Dr. (Name of Graduate Program Director),

My name is Mary Hannah Key and I am a doctoral candidate in the Marriage and Family Therapy graduate program at Texas Woman's University. I am conducting an online mixed methods study for my dissertation examining the professional experience of therapist burnout during the COVID-19 pandemic, use of self-care practices, and self-awareness of attachment style among marriage and family therapists in Texas.

I am asking for your help in representing marriage and family therapists in this important study by requesting that you forward this recruitment e-mail invitation and study link to the graduate students and alumni of your graduate program's listserv.

Your response is voluntary, and I appreciate your considering this request.

Sincerely,

Mary Hannah Key, M.S., LMFT Associate
Doctoral Candidate, Marriage and Family Therapy Program
Department of Human Development, Family Studies, & Counseling
Texas Woman's University

Please copy and paste the text below to forward this recruitment invitation to your program's listserv

Have you experienced symptoms of burnout during the COVID-19 pandemic?
Have you struggled to maintain a healthy work-life balance?

My name is Mary Hannah Key and I am a doctoral student in the Marriage and Family Therapy graduate program at Texas Woman's University. I am conducting a dissertation research study examining the professional experience of therapist burnout during the COVID-19 pandemic, use of self-care practices, and self-awareness of attachment style among marriage and family therapists in Texas.

To be eligible for this study, participants must:

- Be at least 21 years of age or older
- Be currently licensed as a Marriage and Family Therapist (LMFT), LMFT Associate in the state of Texas, or hold a graduate degree in Marriage and Family Therapy if your license is not MFT.

The research study is being administered online through PsychData and will take approximately 20 to 25 minutes to complete. Your involvement in this study is completely voluntary and you may withdraw from the survey at any time.

To participate in the study, please click on the following link:
https://www.psychdata.com/s.asp?SID=190872

If you have any questions about this research study, or for more information, please contact the lead investigator:

Mary Hannah Key, M.S., LMFT Associate
Doctoral Candidate, Marriage and Family Therapy Program
Texas Woman's University
Email: mkey2@twu.edu

APPENDIX D

RECRUITMENT EMAIL SCRIPT FOR MENTAL HEALTH PROFESSIONAL CONTACTS

Hello,

My name is Mary Hannah Key and I am a doctoral candidate in the Marriage and Family Therapy graduate program at Texas Woman's University. I am conducting an online mixed methods study for my dissertation on investigating the experiences of clinical burnout, attachment awareness, and self-care among marriage and family therapists (MFTs).

I am asking for your help in representing marriage and family therapists in this important study by requesting your participation in this research study. If you qualify for participation in this online study, you will be asked to complete a brief demographic questionnaire and open-ended survey about your professional experiences related to symptoms of clinical burnout, awareness of adult attachment style, and use of self-care practices as a marriage and family therapist. *If you are not a fully licensed marriage and family therapist (LMFT), LMFT Associate, or hold a graduate degree in Marriage and Family Therapy if your license is not MFT, then you do not meet the criteria for this study. Please consider forwarding this invitation e-mail to your friends and colleagues who might qualify for participation. Thank you for reviewing this email!

A goal of this study is to better understand the experience of burnout syndrome among marriage and family therapists. This study aims to expand on the current, sparse literature and offer a more robust and complete understanding of burnout syndrome, as well as generate new insights of the protective factors that may prevent or mitigate the development of burnout and negative health-related outcomes. Such information will help in highlighting the need for practicing meaningful self-care and accessing critical support systems when necessary for this group of at-risk mental health professionals.

The demographic questionnaire and open-ended survey are short and should take about 20 to 25 minutes to complete. You will need to complete the consent form prior to taking the online survey. To begin, simply click on the link below:

(https://www.psychdata.com/s.asp?SID=190872)

This survey is confidential. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings, and internet transactions. Your participation is voluntary, and if you come to any question you prefer not to answer please skip it and go on to the next. You may also choose to withdraw from this study at any time without penalty. Should you have any questions or comments please contact Mary Hannah Key, the lead investigator, at (903) xxx-xxxx or mkey2@twu.edu.

Your response is voluntary, and I appreciate your considering this request.

Sincerely,

Mary Hannah Key, M.S., LMFT Associate
Doctoral Candidate, Marriage and Family Therapy Program
Department of Human Development, Family Studies, & Counseling
Texas Woman's University

APPENDIX E

PARTICIPANT CONSENT FORM

TEXAS WOMAN'S UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Title: *A Mixed Methods Approach to Investigating Attachment Awareness, Self-Care, and Burnout in Marriage and Family Therapists*

Investigator: Mary Hannah Key, MS…….....mkey2@twu.edu 903-xxx-xxxx
Advisor: Linda Ladd, PhD, PsyD……...……...lladd@twu.edu 940-xxx-xxxx

Key Information

You are being asked to participate in a research study for Ms. Key's dissertation at Texas Woman's University. The purpose of this research is to understand the professional experience related to symptoms of burnout, use of self-care practices, and awareness of adult attachment style among marriage and family therapists. You have been asked to participate in this study because you have identified yourself as a fully licensed marriage and family therapist (LMFT) or LMFT Associate.

Description of Procedures

As a participant in this study you will be asked to spend 20 to 30 minutes of your time to complete a demographic questionnaire and open-ended survey created by the researcher and administered online through the PsychData website. The demographic questionnaire and open-ended survey will ask you questions about your experiences of professional burnout as a marriage and family therapist and how this relates to your awareness of your own attachment style as well as your current use of self-care practices or strategies you use to cope with these lived experiences. In order to be a participant in this study, you must be at least 21 years of age or older and be currently providing mental health services to clients as a fully licensed marriage and family therapist (LMFT) or LMFT Associate.

Potential Risks

Through the use of an online demographic questionnaire and open-ended survey, the researcher will ask you questions about yourself and questions pertaining to your professional status as a marriage and family therapist, including current license status, number of hours working with clients per week, current employment, workplace setting, population of clients served, and level of clinical experience (i.e., number of years in clinical practice). Additionally, you will be asked questions regarding current symptoms of burnout, frequency and utilization of self-care practices, providing services to clients during the COVID-19 pandemic, as well as assess your own adult attachment style. The researcher will also ask you four open-ended questions about your experiences of burnout, the challenges you have encountered with providing mental health

services during a pandemic, your knowledge and use of attachment theory, and the methods of self-care practices you use to cope with distress.

A possible risk in this study is fatigue with these questions you are asked. If you become tired or upset, you may take breaks as needed. You may also stop answering questions at any time and withdraw from the study without any penalty.

Another possible risk in this study is emotional discomfort with these questions you are asked. You may choose to skip any questions or withdraw from this study at any time without penalty. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a list of referrals and resources.

Another risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by the law. Survey responses will not be linked to email addresses. All data will be kept separate and saved on an encrypted thumb drive. There is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and internet transactions.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time without penalty. Your involvement in this study may benefit you in your approach to clinical practice and help you achieve work-life balance. If you would like to know the results of this study, you will have an opportunity to click on a link at the end of the PyschData survey and provide your email address to receive a summary of the final report of the study.

Questions Regarding the Study

You have the option to print this consent page for your own records. If you have questions about the research study, you should ask the researchers; their phone numbers are at the top of this form. If you have any questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

If you consent to participate in this study, please check the box below and then proceed to the next page where the survey begins. Thank you for your consideration in participating in this study.

☐ By checking the box to the left, you are consenting to participate in this study. Please proceed after you have checked the box.

APPENDIX F

REFERRAL LIST

Thank you for completing this survey regarding attachment awareness, self-care, and burnout among marriage and family therapists. If you feel you need to talk to a professional about your participation in this study, including any emotional discomfort, the researcher has provided you with the following referral list of mental health professionals and community agency resources.

Counseling and Family Therapy Clinic (CFTC) at Texas Woman's University
Phone: (940)898-2600
Address: 1202 Old Main Circle, Room 114 of Woodcock Hall, Denton TX 76204

Child and Family Resource Clinic (CFRC) at University of North Texas
Phone: (940)565-2066
Address: 1180 Union Circle, Denton TX 76203

Counseling and Human Development Center (CHDC) at University of North Texas
Phone: (940)565-2970
Address: 425 S. Welch Street, Denton TX 76203

American Association for Marriage and Family Therapy (AAMFT)
Website Referral Link: https://www.aamft.org/Directories/Find_a_Therapist.aspx

American Psychological Association (APA)
Website Referral Link: https://www.apa.org/helpcenter/index.aspx

Psychology Today
Website Referral Link: https://www.psychologytoday.com/us/therapists

Mental Health America (MHA)
Website Referral Link: https://mhanational.org/finding-help

APPENDIX G

PARTICIPANT DEMOGRAPHIC QUESTIONNAIRE

Directions: In the questionnaire below, there are 26 demographic questions that ask for information about you and your professional experiences as a marriage and family therapist. At no time will you be asked for your name or other identifying piece of information.

1. Please create a unique participant ID code by including your first initial and the last four digits of your telephone number (example: H5874)
   - _____

2. What is your current age?
   - _____

3. What is your sex?
   - Male
   - Female
   - Other (please specify): _____

4. What is your race/ethnicity?
   - Caucasian
   - African American
   - Hispanic
   - Asian
   - Native Hawaiian or Other Pacific Islander
   - Other (please specify): _____

5. What is your current marital status?
   - Married
   - Cohabitating (living with a partner)
   - Divorced
   - Separated
   - Single (never married)
   - Widowed
   - Other (please specify): _____

6. What is the current license status?
   - LMFT (fully licensed)
   - LMFT-Associate
   - Other (please specify): _____

7. On an average week, how many hours per week do you see clients?
   - 0 hours
   - 1-5 hours

- 6-10 hours
- 11-20 hours
- 21-30 hours
- 30+ hours

8. How many years have you been in clinical practice once you received your license status as an LMFT Associate?

- _____

9. Where are you currently employed or working as an LMFT or LMFT Associate?

- Private practice
- Community clinic/agency
- University clinic
- State hospital/private hospital
- Faith-based organization
- Detention center/jail/prison
- Other (please specify): _____

10. How long have you been at your current workplace setting?

- _____

11. What population of clients do you work with the most in your current practice? Select only one group.

- Couples
- Families
- Children/Adolescents
- Individuals

12. When you consider the problems that your clients present at intake, which of the following are the most common in your practice currently? Check all that apply.

- Domestic violence/Abuse victims
- Incarceration
- Military/First responders
- Same-sex couples/Sexual orientation-identity
- Substance use
- Interpersonal conflict
- Sex/Intimacy issues
- Infidelity
- Suicide/Nonsuicidal self-injury
- Low SES/Financial distress
- Premarital
- Chronic health issues/Terminal illness
- Women's issues
- Men's issues

- Other (please specify): _____

13. When you consider the mental health disorders (DSM-5) that your clients present with, which of the following are the most common in your practice currently? Check all that apply.

- Severe, comorbid mental illness
- Trauma (physical, sexual, psychological abuse, PTSD)
- Adjustment disorders
- Mood disorders
- Personality disorders
- Other (please specify): _____

14. On a scale of 0 to 4, select the phrase that represents how familiar you are with attachment theory.

- 0- Not at all familiar
  - (E.g., I'm not exactly sure what attachment theory is, I've never heard of it before.)
- 1- Slightly familiar
  - (E.g., I've seen some videos or listened to some podcasts about attachment theory.)
- 2- Somewhat familiar
  - (E.g., I've read a few attachment theory books or attachment related research/articles.)
- 3- Moderately familiar
  - (E.g., I've taken a course and been to several trainings on attachment theory.)
- 4- Extremely familiar
  - (E.g., I've completed advanced trainings on attachment theory and use it in clinical practice.)

15. On a scale of 0 to 4, select the phrase that represents how familiar you are with adult attachment styles.

- 0- Not at all familiar
  - (E.g., I'm not exactly sure what adult attachment styles are, I've never heard of them before.)
- 1- Slightly familiar
  - (E.g., I've seen some videos or listened to some podcasts about adult attachment styles.)
- 2- Somewhat familiar
  - (E.g., I've read a few attachment theory books on adult attachment styles.)
- 3- Moderately familiar
  - (E.g., I've taken a course and been to several trainings on adult attachment styles.)
- 4- Extremely familiar
  - (E.g., I've completed advanced trainings on adult attachment styles and use it in clinical practice.)

16. On a scale of 0 to 4, how often do you currently use attachment theory, adult attachment style assessments, or emotionally focused therapy (EFT) in your work with clients?

- 0- Never use
- 1- Almost never
- 2- Occasionally/Sometimes
- 3- Almost every time
- 4- Frequently use

17. On a scale of 0 to 4, select your current level of awareness of your own adult attachment style.

- 0- Not at all aware
- 1- Slightly aware
- 2- Somewhat aware
- 3- Moderately aware
- 4- Extremely aware

18. In general, do you perceive yourself as a securely attached individual or an insecurely attached individual?

- Securely attached
- Insecurely attached

19. On a scale of 0 to 6, rate the level of importance you place on your current awareness/knowledge of your own adult attachment style.

- 0- Not at all important
- 1- Low importance
- 2- Slightly important
- 3- Neutral
- 4- Moderately important
- 5- Very important
- 6- Extremely important

20. On a scale of 0 to 6, select how often you practice self-care methods/strategies (i.e., the ways you take care of yourself) as a means of coping with professional stress and maintaining work-life balance.

- 0- Never
- 1- A few times a year or less
- 2- Once a month or less
- 3- A few times a month
- 4- Once a week
- 5- A few times a week
- 6- Every day

21. Which forms of self-care do you perceive you do well in regard to balancing the demands of your work and personal life? Check all that apply.

- Meditation/Mindfulness techniques

- Physical exercise
- Getting enough sleep/rest
- Eating a healthy diet
- Spirituality/Religion
- Personal psychotherapy
- Professional Development/Clinical Trainings
- Time Management Skills
- Clinical Consultation/Supervision
- Social Support/Professional Support Networks
- Other (please specify): _____

22. Since the start of the COVID-19 pandemic earlier this year, select the treatment format you use the most with your clients now. Select only one answer.

- Face to face (i.e., in-person only)
- Technology-assisted services (i.e., telemental health only)
- Both face to face and technology-assisted services

23. On a scale of 0 to 4, rate the level of difficulty you've experienced in providing technology-assisted services to clients during the COVID-19 pandemic.

- 0- Very difficult
- 1- Difficult
- 2- Neutral
- 3- Easy
- 4- Very easy

24. On a scale of 0 to 3, rate your level of stress based on your personal experience of providing treatment services to clients during the COVID-19 pandemic.

- 0- Not at all stressed
- 1- Slightly stressed
- 2- Moderately stressed
- 3- Extremely stressed

25. On a scale of 0 to 3, rate your level of stress based on your personal experience of managing your work-life balance during the COVID-19 pandemic.

- 0- Not at all stressed
- 1- Slightly stressed
- 2- Moderately stressed
- 3- Extremely stressed

26. On a scale of 0 to 3, rate your level of stress based on the challenges you've experienced in your professional environment during the COVID-19 pandemic.

- 0- Not at all stressed
- 1- Slightly stressed
- 2- Moderately stressed
- 3- Extremely stressed

27. On a scale of 0 to 3, rate the average level of stress of your clients as they manage their lives during the COVID-19 pandemic.

- 0- Not at all stressed
- 1- Slightly stressed
- 2- Moderately stressed
- 3- Extremely stressed

APPENDIX H

MASLACH BURNOUT INVENTORY- HUMAN SERVICES SURVEY (MBI-HSS)

SAMPLE ITEMS

The purpose of this survey is to discover how various persons in the human services or helping professions view their job and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instructions. When answering this survey, please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following pages are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, select the Never option. If you have had this feeling, indicate how often you feel it by selecting the option that best describes how frequently you feel that way. The phrases describing the frequency are: Never, A few times a year or less, Once a month or less, A few times a month, Once a week, A few times a week, Every day

1. I feel emotionally drained from my work.
   - Never
   - A few times a year or less
   - Once a month or less
   - A few times a month
   - Once a week
   - A few times a week
   - Every day

2. I have accomplished many worthwhile things in this job.
   - Never
   - A few times a year or less
   - Once a month or less
   - A few times a month
   - Once a week
   - A few times a week
   - Every day

3. I don't really care what happens to some recipients.
   - Never
   - A few times a year or less
   - Once a month or less
   - A few times a month
   - Once a week

- A few times a week
- Every day

APPENDIX I

EXPERIENCES IN CLOSE RELATIONSHIPS-RELATIONSHIP STRUCTURES (ECR-RS)

QUESTIONNAIRE

The purpose of this questionnaire is to more explicitly measure people's global, or general, attachment styles. This questionnaire is designed to assess the way in which you mentally represent important people in your life. You'll be asked to answer 9 questions about how you generally think and feel in your close relationships. Please indicate the extent to which you agree or disagree with each statement by selecting a number on a scale of 1 to 7 for each item.

Instructions: Please read each of the following statements carefully and rate the extent to which you believe each statement best describes your thoughts and feelings with respect to the important people in your life.

1. It helps to turn to people in times of need.
   - 1- Strongly disagree
   - 2- Disagree
   - 3- Somewhat disagree
   - 4- Neither agree or disagree
   - 5- Somewhat agree
   - 6- Agree
   - 7- Strongly agree

2. I usually discuss my problems and concerns with others.
   - 1- Strongly disagree
   - 2- Disagree
   - 3- Somewhat disagree
   - 4- Neither agree or disagree
   - 5- Somewhat agree
   - 6- Agree
   - 7- Strongly agree

3. I talk things over with people.
   - 1- Strongly disagree
   - 2- Disagree
   - 3- Somewhat disagree
   - 4- Neither agree or disagree
   - 5- Somewhat agree
   - 6- Agree
   - 7- Strongly agree

4. I find it easy to depend on others.
   - 1- Strongly disagree

- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

5. I don't feel comfortable opening up to others.
- 1- Strongly disagree
- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

6. I prefer not to show others how I feel deep down.
- 1- Strongly disagree
- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

7. I often worry that other people do not really care for me.
- 1- Strongly disagree
- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

8. I'm afraid that other people may abandon me.
- 1- Strongly disagree
- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

9. I worry that others won't care about me as much as I care about them.

- 1- Strongly disagree
- 2- Disagree
- 3- Somewhat disagree
- 4- Neither agree or disagree
- 5- Somewhat agree
- 6- Agree
- 7- Strongly agree

APPENDIX J

PARTICIPANT OPEN-ENDED SURVEY

Directions: In the survey below, there are 4 open-ended questions that ask about your experiences related to burnout, providing services to clients during the COVID-19 pandemic, utilization of self-care practices, and adult attachment style awareness. Please provide a description of how you personally experience each of the questions below.

1. How do you personally experience the thoughts and feelings of burnout? (i.e., please describe what it means to you to feel "burned out").

2. Please describe any personal and professional challenges you have experienced with providing telemental health services and/or in-person services to individuals, couples, and/or families during the COVID-19 pandemic.

3. Please describe what self-care means to you, and then identify/list what strategies or methods of self-care practices you currently use that you find most helpful to you.

4. Prior to this study, please describe what you know about attachment theory and what your own adult attachment style means to you, and to what extent, if any, this has informed your clinical work as a systemic, relational therapist.

APPENDIX K

PSYCHDATA SCRIPT: PARTICIPANT REQUEST FOR EXECUTIVE SUMMARY

Thank you for your participation in this study on A Mixed Methods Approach to Investigating Attachment Awareness, Self-Care, and Burnout in Marriage and Family Therapists. Your information will add to our understanding of how burnout syndrome affects marriage and family therapists, as well as uncover possible protective factors for preventing and mitigating symptoms of burnout and negative health-related outcomes. If you would like to receive the results of this study, please click on the link below. You will be able to leave your email address only and you will receive the executive summary when the study is complete (your email address cannot be linked to your answers in the survey).

Please note, this study is currently active, and results of this study may take several months. Additionally, there is a potential risk of loss of confidentiality in all email, downloading, and internet transactions.

1. Would you like to have an executive summary sent to you at the conclusion of this study?
   - ☐ Yes
   - ☐ No

2. If you answered "yes" to question #1, please provide the email address you would like to use in order to receive the executive summary.
   - ☐ _____