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The Impact of Burnout on Career Commitment Among Physicians, Clergy, and Law Enforcement During the COVID-19 Pandemic: A Quantitative Study

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The Impact of Burnout on Career Commitment Among Physicians, Clergy, and Law Enforcement During the COVID-19 Pandemic: A Quantitative Study

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THE IMPACT OF BURNOUT ON CAREER COMMITMENT AMONG PHYSICIANS, LAW ENFORCEMENT, AND CLERGY: A QUANTITATIVE STUDY

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Abstract

The long-term effects of the COVID-19 crisis among helping professionals such as physicians, law enforcement officers, and clergy remain unknown. The strain and enormous stress encountered by these professionals are profound and concerning (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020). In this study, the researcher explored the effects of burnout (emotional exhaustion, depersonalization, and personal accomplishment) on career commitment among helping professionals including physicians, law enforcement officers, and clergy during the COVID-19 pandemic. Further, the findings provided insight on the general causes and effects of burnout including possible solutions to counter its effects. Additionally, the researcher the causes, effects, and potential solutions regarding burnout for each of the participating helping professions. The data for this quantitative study were collected through a survey completed by 484 participants located in two southwestern states in the United States. This study contributes to the body of literature by confirming a relationship between burnout and low career commitment for the aggregate sample, and by confirming that the three factors of burnout (emotional exhaustion, depersonalization, and personal accomplishment) significantly predicted scores of low career commitment. Further, the findings revealed that there are statistically significant differences in levels of the three factors of burnout and career commitment between the three professions.

Keywords: burnout, career commitment, COVID-19, emotional exhaustion, depersonalization, personal accomplishment, stress, physicians, doctors, law enforcement officers, police, clergy, pastors

Dedication

This dissertation was completed in fulfillment of a commitment to the Lord. He called me, equipped me, and strengthened me throughout this journey and any good that comes from it is to His glory. I dedicate this dissertation to my wife, Tricia. She is my helpmate, best friend, coach, and faithful companion. Without your love, prayer, and steadfast support, this journey would never have come to completion. You walked with me all the way through and encouraged me when I wanted to give up. Thank you for believing in me when I didn't believe in myself. I also want to dedicate this work to our children: Taylor, Myles, Kennedy, Austin, and my grandson Lincoln (and those that will follow). May this dissertation be a reminder that you can achieve more than you ever believed when God is involved. To my Uncle Garry and Phyllis Clem, thank you for your love and encouragement in this process. I want to thank my parents, Bill and Rhydonia Clem. You have always set a high standard for Marcus and me, and you always encouraged us to dream big and do big things. I hope this dissertation brings you joy. Finally, to the helping professionals represented in this study: physicians, law enforcement officers, and clergy. You are my heroes. Thank you for your service and sacrifice. My passionate prayer and hope are that some of the work completed here will lead to better lives for you, your families, and those you serve.

Job 22:21–30 New International Version

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At the age of 16, I had an encounter with God on a mountaintop in New Mexico that changed this Texas boy's life for eternity. Lord, thank you for never leaving me or giving up on me. Please use this work to change hearts and lives so that people will know that you are God and that you love them.

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To Rob (My Bro) and Roni Alwin and Russ and Rae Blackburn, your prayer, passion, and support for Tricia and me go beyond words. Thank you.

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Chapter 1 – Introduction

The long-term emotional and psychological effects of the COVID-19 pandemic among helping professionals in the United States, such as physicians, law enforcement officers, and clergy, are currently unknown. The strain and enormous stress on these professionals is profound and concerning, potentially leading to personal burnout (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020). West et al. (2018) posited that 50% of physicians in the United States experienced substantial burnout symptoms, nearly twice the national average, negatively impacting patient care, the healthcare workforce, costs, and physician health. According to Gold (2019), burnout is a significant factor for physicians throughout their careers, and the problem of burnout is becoming more prevalent. Further, the end of the COVID-19 pandemic and the timeframe for returning to a state of normality is unknown, exacerbating the effects of the crisis on helping professionals (Heath et al., 2020).

Law enforcement consistently ranked among the most stressful occupations worldwide, and researchers have indicated that stress harms officers' mental, emotional, and physical health, negatively impacting their job performance (Dantzer, 1987; Queirós et al., 2020). Police officers face unique stresses and stressors, both externally due to the inherent danger of their role in dealing with frequent peril and trauma and internally due to the law enforcement system's organizational and administrative composition (Anderson et al., 2002; Gaines & Jermier, 1983; Gershon et al., 2009; Miller, 2015; Shane, 2010). Additionally, chronic exposure to the stress of policing impacts officers' psychological health, potentially leading to burnout (Malach-Pines & Keinan, 2006; Martinussen et al., 2007).

While significant academic and media attention remains focused on medical professionals and law enforcement, the effects of clergy burnout and psychological distress during the crisis remain largely overlooked (Greene et al., 2020). According to Taylor et al. (2006), most Americans turn to their faith to cope with traumatic situations and their aftermath. Although not involved in patients' medical care or physical safety, the clergy provide a critical role in supporting individuals,

families, and communities in coping with crises and traumatic situations (Greene et al., 2020).

The American Medical Association (AMA) has expressed concern that the COVID-19 pandemic exacerbated burnout and moral injury among healthcare workers and could reduce engagement, enthusiasm, and commitment to the healthcare profession, leading medical professionals to exit the field entirely (Berlin, 2021). Perez et al. (2010) found that continued exposure to stressors positively impacted burnout and turnover intentions in law enforcement officers. The results of pre-COVID research among clergy indicated that up to 40% of ministers experienced fatigue and depression and considered leaving the profession entirely (Francis et al., 2008; Jackson-Jordan, 2013). Due to the impact of career commitment on turnover intentions, job performance, and work satisfaction, researchers have emphasized the effect of various stressors, including burnout, on career commitment (Aryee & Tan, 1992; Blau, 1988; Chang, 1999). Each of these helping professions is vital to the public welfare; therefore, understanding the causes of burnout and its impact on career commitment is vital to organizational, community, and societal well-being.

The purpose of this study was to conduct a correlational quantitative research design utilizing the Maslach Burnout Inventory (MBI) and the Blau Career Commitment Measure (BCCM). I analyzed a cross-sectional dataset and compared and contrasted the effects of burnout on career commitment among physicians, law enforcement officers, and clergy. Further, I examined specific stressors, implications, and potential resolutions for burnout and career commitment.

Statement of the Problem

Because of the recent nature of the COVID-19 pandemic, there was little to no research on burnout and its impact on career commitment among physicians, law enforcement officers, and clergy. The study of burnout and its effects gained increased attention in the 1970s when authors such as Freudenberger and Maslach observed the phenomenon and began measuring its impact on individuals and organizations. After decades of disagreement on a universal definition of burnout, the World Health Organization (WHO) in 2019 defined burnout as “a syndrome

resulting from chronic workplace stress that has not been successfully managed" (Moss, 2021, p. 2). While a significant exploration of burnout in various organizational contexts existed, several significant gaps remain.

Numerous overarching themes regarding deficiencies in burnout research have been identified. Researchers have recommended examining the influence of societal culture, economic dynamics, and political factors and their impact on individual burnout (Manzano-García & Ayala, 2017; Maslach & Leiter, 2016). Additionally, scholars have suggested examining burnout's lasting effect on diagnosed individuals reentering their workplace and impacting the workforce and organizational environment (Maslach & Leiter, 2016). Eckleberry-Hunt et al. (2018) proposed evaluating positive psychology and its ability to create strength, resilience, growth, and happiness to counteract, reduce or eliminate burnout. Bianchi et al. (2018) advocated research on the impact of burnout and its correlation with depression. Most of the existing research on burnout centers on personal impact and individual prevention strategies, and academics indicated the need for studies on the organizational factors that influence or contribute to personal burnout and prevention (Heinemann & Heinemann, 2017). Specific gaps in the research regarding the medical profession, law enforcement, and clergy also exist.

According to West et al. (2018), gaps in the research existed regarding physician burnout's consequences on patient outcomes and safety, physician practice behaviors, healthcare costs, healthcare systems' ability to care for populations, and burnout's economic impact on the medical field. Shanafelt, Gorringe et al. (2015) recommended studies among frontline physician leadership across various multicenter geographical locations to measure leadership's influence on physician burnout and well-being. Further, Ornell et al. (2020) called for expanded research on mental health initiatives designed to reduce burnout and increase well-being among frontline healthcare workers. Finally, according to Gold (2019), research regarding interventions that address, prevent, and decrease burnout at the individual, team, and organizational levels is needed.

Various studies cited gaps in burnout research in the law enforcement field. Scholars have cited the need for studies examining the law enforcement organizational environment and culture and its impact on officer burnout (Biggs, 2016; Lambert et al., 2017). Talavera-Velasco et al. (2018) recommended studies to evaluate the impact of the gender and rank of officers on individual burnout. Further, Jaramillo et al. (2005) suggested studies regarding burnout and group cohesiveness and the corresponding effect on organizational effectiveness. Perez et al. (2010) advocated studies measuring varying levels of exposure to traumatic situations and their impact on officer burnout over time. Russell et al. (2014) advised studies comparing law enforcement officers and other high-stress groups' burnout results and contrasting leadership styles and environments and their influence on burnout. Finally, McCarty et al. (2019) suggested studies to assess and evaluate numerous law enforcement agency programs on burnout mitigation and prevention to compare results and correlate findings.

Fee (2018) recommended studies both inner and cross-denominationally on the impact of organizational leadership styles and church structure and their impact on burnout among pastors. Burnette (2016) suggested continued research on pastoral burnout and its significant implications on pastors, their families, their congregations, and the denominations they serve. Researchers have called for further investigation of the correlates and predictors of clergy burnout in large samples utilizing structural equation modeling (Barnard & Curry, 2012). Adam et al. (2018) advocated studies that examine a predictive process model for clergy burnout that outlines what combinations of personal and environmental stressors predict clergy burnout.

Career commitment refers to an individuals' dedication to their career, profession, or occupation and is an essential correlate of an individual's career satisfaction and career withdrawal intentions (Arnold, 1990; Aryee et al., 1994; Aryee & Tan, 1992; Blau, 1985, 2003; Kim et al., 2016). Researchers have indicated that burnout correlated negatively to an individual's career commitment (Aryee & Tan, 1992; Blau, 1988; Chang, 1999). Starmer et al. (2016) recommended research into interventions and resources designed to reduce burnout

and increase physicians' career satisfaction. Additionally, Leiter and Maslach (2009) encouraged further research into burnout and interventions to reduce the intention to leave among nurses. Similarly, Chang et al. (2017) suggested further research on burnout and career commitment among young nursing professionals. Lambert et al. (2017) advocated research on burnout and continuance commitment among law enforcement officers, which they defined as staying with an organization because it is too costly to leave. Miner et al. (2013) recommended conducting longitudinal studies incorporating behavioral data, ratings by observers, and other indirect measures to examine the role of burnout and career commitment among the clergy.

Helping professionals such as physicians, law enforcement, and the clergy faced significant burnout and career commitment challenges before the pandemic. Further, occupational burnout and its effect on career commitment are not a new challenge; however, COVID-19 acted as an accelerant, significantly intensifying the syndrome's effects (Moss, 2021). Researchers have predicted that the crisis's effects may extend years beyond the initial outbreaks prolonging and exacerbating the negative impact among helping professionals (Park et al., 2020). To date, no scholars had examined the correlation between burnout and career commitment regarding physicians, law enforcement, and clergy. Further, burnout and career commitment had not been compared or contrasted between these three helping professions.

Purpose of the Research

In this study, I addressed the impact of burnout on career commitment during the COVID-19 pandemic among physicians, law enforcement, and clergy. While the long-term physical, emotional, and psychological effects of the COVID-19 pandemic among helping professionals were not currently known (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020), I fulfilled the need for more research in this area and contributed to the body of knowledge on this phenomenon. Further, I compared burnout's effects on career commitment between these helping professionals during the crisis. Finally, I examined best practices for addressing the effects of burnout for individuals and organizations.

In this study, I utilized the Maslach Burnout Inventory Human Services Survey (MBI-HSS) and the Blau Career Commitment Measure (BCCM) to measure burnout and career commitment among medical professionals, law enforcement, and the clergy. Further, I utilized a correlational quantitative research design to analyze a cross-sectional dataset and compare burnout's effects on career commitment among these helping professionals.

Research Questions and Hypotheses

In this study, I explored the impact of burnout on career commitment during the COVID-19 pandemic among physicians, law enforcement officers, and the clergy. Further, I compared the findings between these three groups of helping professionals. The three primary research questions that guided this study, as well as the hypotheses that I tested to answer these questions, were as follows:

RQ1: What is the level of burnout among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How does the level of burnout compare between the three groups?

H1a: There is a high level of burnout among physicians, law enforcement officers, and clergy.

H1b: There is a difference in levels of burnout between physicians, law enforcement officers, and clergy.

RQ2: What is the level of career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How do the levels of career commitment compare between the three groups?

H2a: There is a low level of career commitment among physicians, law enforcement officers, and clergy.

H2b: There is a difference in levels of career commitment in physicians, law enforcement, and clergy.

RQ3: What is the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy? How do the correlations between burnout and career commitment compare between the three groups?

H3a: There is a negative correlation between burnout and career commitment.

H3b: There is a negative correlation between burnout and career commitment in physicians.

H3c: There is a negative correlation between burnout and career commitment in law enforcement officers.

H3d: There is a negative relationship between burnout and career commitment in the clergy.

H3e: There is a difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy.

I administered an online anonymous survey instrument to participants through the partnering organizations. Comparative data were gathered via voluntary, anonymous online surveys using the MBI-HSS; (Maslach et al., 1996) and the BCCM (Blau, 1988).

Significance of the Research

Prior to this study, no scholars had examined the correlation between burnout and career commitment regarding physicians, law enforcement, and clergy during the COVID-19 pandemic. Further, burnout and career commitment had not been compared or contrasted between these three helping professions. The rigorous design of this study made the results more generalizable and trustworthy for drawing conclusions and implications from the findings.

Conceptual Framework

The conceptual framework for this research provided a simple visual design to guide the data analysis for the project. The independent variable was job burnout, as exhibited through three dimensions: emotional exhaustion, depersonalization, and personal accomplishment (see Maslach et al., 1986). In this study, career commitment was the dependent variable. The control variables utilized in the analysis included job professions among three groups of physicians, law enforcement officers, and clergy. The chosen variables were used to eliminate the influence of all potential confounding third variables on the dependent variable, ensuring that every feature of the environment except the manipulated variable remained constant (see Cozby & Bates, 2012). Given that no researchers to date

had explored the differences in the levels of burnout and career commitment among different professions, I examined three groups of frontline helping professionals: physicians, law enforcement officers, and clergy. The majority of the sample was composed of respondents in Texas and Arkansas.

Methodology

I used a quantitative methodology with a correlational design to guide my examination of whether a relationship exists between burnout and career commitment among physicians, law enforcement officers, and the clergy. According to Creswell (2008), a correlational research design can identify relationships between variables and predictive patterns within the samples. Based on the outcomes of the ANOVA, I used a post hoc test to analyze the data. Linear regression analysis and ANOVAs provided these comparisons. Regression analysis is an analytical method used to "predict the changes in the dependent variable response to change in the independent variables" (Hair et al., 2012, p. 16). In the current study, I conducted multiple regression analyses to examine the predicted continuous or noncontinuous effect of an independent variable on the dependent variable (see Girden & Kabacoff, 2010).

Instrumentation

The independent variable of burnout was measured using the MBI-HSS tool designed by Maslach and Jackson (1981) to measure burnout among the participating helping professionals. The MBI-HSS was designed for professionals in the human services industry, including physicians, nurses, health aides, social workers, health counselors, therapists, law enforcement, correctional officers, pastors, and other fields focused on serving people by offering guidance, preventing harm, and ameliorating physical, emotional, or cognitive problems (Maslach & Jackson, 1981). The MBI-HSS consists of 22 questions that measure three factors: emotional exhaustion, depersonalization (cynicism), and low personal accomplishment (personal efficacy). In the MBI, burnout is conceptualized as a continuous variable and not dichotomous. As such, burnout can range from low to moderate to high degrees.

Each question consists of a scale rating from 0 (*never*) to 6 (*every day*); based on the responses, independent subscale scores are calculated for each factor of the burnout level. High scores on personal exhaustion or depersonalization indicate burnout, and conversely, low scores on the personal accomplishment subscale indicate burnout. The BCCM measuring career commitment employs a 5-point Likert-type scale consisting of seven questions with one variable of career commitment (Blau, 1988). Respondents choose from values from 1 (*strongly agree*) to 3 (*unsure*) to 5 (*strongly disagree*).

The MBI is grounded in a theoretical perspective that views burnout as a psychological response to an individual's frequency of certain feelings in the workplace (Maslach et al., 1986). The three factors of burnout measured by the MBI include emotional exhaustion, depersonalization, and low personal accomplishment. Convergent validity for the MBI-HSS is demonstrated in several ways, including correlating scale scores with the observations of others, with job conditions that hypothesized association with burnout, and by relating burnout to other personal attitudes and reactions, and various longer-term outcomes (Maslach et al., 1996). Wheeler et al. (2011) analyzed 84 published studies that reported sample-specific reliability of estimates for the three MBI scales. Using data from initial assessments that completed the original MBI, the internal reliability using Cronbach's coefficient alpha yielded estimates for the MBI-HSS scales as .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment. Each scale's standard error of measurement is estimated and includes 3.80 for emotional exhaustion, 3.16 for depersonalization, and 3.73 for personal accomplishment (Maslach et al., 1996). Across a wide range of samples, reliability coefficients have generally shown adequate internal consistency for each of the three MBI-HSS scales.

The findings from the MBI-HSS research tool can be interpreted for individual respondents or a group of respondents and can be treated as aggregate data (Maslach & Jackson, 1981). Means and standard deviations for each scale are computed for the entire group and compared to the normative data created by MBI. As appropriate, the conditions that best predict MBI scores and the outcomes

associated with each scale can be assessed by multiple regression or other statistical techniques.

The dependent variable of career commitment was measured by utilizing the BCCM (Blau, 1988), which has received widespread use since its creation in 1989 (Reilly & Orsak, 1991). Coefficient alpha values for reliability ranged from .76 to .88 (Cohen, 1995; Reilly & Orsak, 1991; Somers & Birnbaum, 1998). Blau (1985) defined career commitment in terms of an individual's attitude toward their profession or vocation instead of organizational commitment. Although the original construct was described as career commitment, the measure asks participants to think about their profession rather than their career (Katz et al., 2019). MBI scores correlate well with information acquired through other instruments (Maslach & Jackson, 1981); therefore, data gathered from the BCCM provides a reliable and valid source for comparative statistics.

Control Variables

Control variables help to eliminate "the influence of all potential confounding third variables on the dependent variable…making sure that every feature of the environment except the manipulated variable is held constant" (Cozby & Bates, 2012, p. 81). The control variables for this study included job profession: physicians, law enforcement officers, and clergy. Nominal scales were used to describe the categorical variables (see Dean, 2017). Before the regression analysis, an ANOVA was utilized to determine whether the control variables were statistically significant.

Population and Sample

The purpose of sampling is to collect data from a small subset of the populace and analyze the data as representative of the population (Fields, 2013). Hair et al. (2012) posited that a study should achieve .80 of the desired significance level and an effect size of .5 or smaller through a 20:1 ratio of responses to the independent, moderating, or mediating variable. As measured by the MBI-HSS, the independent variable burnout has three components, which were treated as independent variables. The control variable in this study included job profession:

physicians, law enforcement officers, and clergy. Therefore, the control variables counted as a total of three variables in calculating the sample size. Therefore, the estimated sample size for this study included six variables, bringing the sample size to 120 respondents per group.

The sample population for this study included helping professionals from Texas and Arkansas. These sample groups included the Smith County Medical Society, a 1,000-member physician group located in Texas. The Arkansas District and North Texas District of the Assemblies of God with approximately 900 senior pastors. Law enforcement departments from both Arkansas and Texas participated in the study, with approximately 800 officers in the representative sample. Participants received a self-administered online survey to capture quantitative data. Creswell (2009) indicated that the self-administered survey method is often used to make generalized claims about a population.

Scope and Limitations

There are several limitations to the study that may affect the interpretation of the collected data and the results. The following assertions are potential constraints of the study. The study took place in Texas and Arkansas; therefore, the findings may not be generalizable to other geographic regions. The size of the sample populations utilized in the study may not be generalizable. In this study, I did not determine the predictors or antecedents of burnout. Further, the impact of the COVID-19 pandemic on burnout cannot be measured; however, I took a statistical view of burnout during the pandemic to analyze the phenomenon's impact.

Inherent limitations arise out of the research method and design used in the study. I examined the effects of burnout on career commitment among physicians in the medical profession, limiting the study's scope. In the law enforcement realm, the scope of this study was limited to law enforcement officers. Examining the impact of burnout and career commitment on administrative personnel and support teams within the law enforcement community is recommended. Senior or lead pastors were the only clergy examined in the study, which restricted the findings. Examining the impact of burnout and career commitment on associate pastors,

youth pastors, children's pastors, and additional and other support staff was advised. Additionally, survey scales are closed questions, limiting the explanations available to participants provided with open-ended questions (Creswell, 2014). Finally, the study design did not allow for errors from question nonresponses.

Definition of Terms

In this section, I provide clarity on how the below terminology was utilized in this research study.

Burnout: This is a result of chronic job-related stress that manifests in symptoms of emotional exhaustion, depersonalization or severe cynicism, and reduced personal accomplishment (Maslach et al., 1986). Further, the term defines a person who has extended beyond a reasonable level of fatigue or stress.

Clergy: This is a broader term than pastor, which includes ministers who serve in various capacities such as seminarians and chaplains (Holland, 1997). For this study, this term refers to the senior or lead pastor who has oversight and primary leadership of a church.

Cynicism: This is a state of being apathetic, indifferent, or cynical toward constituents, clients, or work (Maslach & Leiter, 2016).

Depersonalization: This is a loss of a sense of personal identity (Maslach & Leiter, 2016).

Emotional exhaustion: This is the feeling of being physically drained and emotionally fatigued. Emotional exhaustion is the first dimension of burnout (Maslach & Leiter, 2016).

Exhaustion: This term refers to fatigue, depletion, and loss of energy (Maslach & Leiter, 2016).

Helping professionals: This refers to a range of vocations whose role is to help, interact, educate, protect, and care for individuals (Cameron, 2008; Egan, 2013; Westergaard, 2016).

Law enforcement officer: A law enforcement officer is any person who is elected, appointed, or employed by any municipality, county, or state; who is vested with the authority to carry and use firearms, make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement

of the penal, criminal, traffic, or highway laws (Scarborough et al., 2002; Sekhon, 2017).

Medical professional: In this study, this term refers only to physicians.

Moral injury: This occurs when an individual perpetrates, bears witness to, or fails to prevent an act that transgresses their deeply held moral beliefs (Dean et al., 2019). For this study, moral injury is included in the definition of burnout.

Personal accomplishment: The feeling of worth and effectiveness at the workplace (Maslach & Leiter, 2016).

Physician: physician is a medical doctor licensed in one of the 50 United States, District of Columbia, or Puerto Rico who works in direct patient care, administration, medical teaching, research, or other nonpatient care activities. Physicians include those with a Doctor of Medicine (MD) or a Doctor of Osteopathic Medicine (DO) degree (AMA, 2021).

Posttraumatic stress disorder: This disorder stems from a traumatic event to an individual who continues to experience recurrent or intrusive recollections and dreams from the event. Symptoms may include difficulty sleeping, startling reactions, challenges concentrating, uncontrolled anger, hypervigilance for danger, and a sense of a foreshortened future. Additionally, PTSD can cause avoidance issues, including emotional numbing and an inability to remember aspects of the traumatic event (Keane et al., 2009).

Professional efficacy: This is described as a feeling of competency, effectiveness, self-efficacy, and workplace efficacy (Maslach & Leiter, 2016).

Psychological well-being: This is referred to in this study as an individual's psychological health and cognitive health related to their enhanced ability to build and broaden psychological perspectives that advance productivity and cognitive functioning (Fredrickson, 2001).

Registered nurse: An RN is academically trained and licensed by a state authority after passing registration examinations (Mills et al., 2016).

Self-care: This refers to a methodology of decreasing stress, improving well-being through empowerment and health stress, and employing emotional management techniques (Lee & Miller, 2013).

Stress: This is an interaction between the individual and the environment (stressors), which the individual appraises as threatening or overwhelming his or her resources and well-being (Lazarus & Folkman, 1984).

Trauma: Mental health providers define trauma as a stressful occurrence outside the range of usual human experience, which would be markedly distressing to almost anyone (National Collaborating Centre for Mental Health, UK., 2005).

Summary

Burnout and its impact on helping professionals such as physicians, law enforcement, and clergy are significant concerns for society. In this study, I examined the effect of burnout on career commitment among physicians, law enforcement officers, and clergy in Texas and Arkansas during the COVID-19 pandemic. I utilized the MBI-HSS burnout instrument and the BCCM career commitment survey to obtain data. The findings were compared to determine the levels of burnout among and between the groups.

Chapter 2 – Literature Review

This chapter contains a review of general burnout theory literature and an examination of burnout pertaining to physicians, law enforcement officers, and clergy. Additionally, I explore the concept of career commitment generally and specifically among physicians, law enforcement officers, and clergy.

General Burnout

The study of burnout and its consequences increased in the 1970s when Freudenberger and Maslach examined the phenomenon and assessed its impact on individuals and groups of service workers. Although early studies focused on people in service professions, research expanded into additional fields and industries, especially fields where emotional demands are high, such as healthcare, education, social welfare, and clergy (Bakker et al., 2014). In the decades following Freudenberger's and Maslach's initial findings, interest in burnout grew to generate more than 6,000 books, dissertations, and journal articles related to the phenomenon (Freudenberger, 1974; Halbesleben & Buckley, 2004; Schaufeli & Enzmann, 1998).

For many years, social scientists and researchers struggled to agree on a proper definition of burnout. Maslach and Jackson (1981), in their early research, defined burnout as a "syndrome of emotional exhaustion, depersonalization and a reduced sense of personal accomplishment" (p. 1). Perlman and Hartman (1982) summarized and synthesized various definitions of burnout as a response to chronic emotional stress exhibited through three components: emotional or physical exhaustion, lowered job productivity, and over-depersonalization. Schaufeli, Leiter et al. (2009) defined burnout as a consistent, negative, work-related state of mind characterized by exhaustion, reduced effectiveness, dysfunctional work attitudes and behaviors, and decreased motivation. After decades of disagreement on a universal definition of burnout, the World Health Organization (WHO) in 2019 defined burnout as "a syndrome resulting from chronic workplace stress that has not been successfully managed" (Moss, 2021, p. 2).

The MBI is considered the gold standard for measuring burnout, with around 90% of burnout studies utilizing the instrument (Tomic et al., 2004). The MBI separates the condition of burnout into three categories, including (a) emotional exhaustion, characterized by emotional depletion and loss of energy; (b) depersonalization or cynicism, also described as dehumanization, detachment from work and clients, and emotional hardening; and (c) reduced personal accomplishment or inefficacy—that is, a feeling of personal or professional inadequacy as well as reduced productivity and coping skills (Maslach & Jackson, 1981; Maslach & Leiter, 2016). Burnout is a complex, continuous, and heterogeneous construct that manifests itself uniquely in distinct individuals expressed by differing degrees resulting in burnout being best considered a continuum rather than a dichotomous variable. Maslach et al. (1996) recommended evaluating the relationship between symptoms by examining the individual domain scores as continuous data. Additionally, examining categorized results separately using established definitions of low, average, and high scores for each domain provided helpful information. According to Schaufeli, Bakker et al. (2001), a high score on either the emotional exhaustion or depersonalization scales but not a low score on the personal accomplishment scale can distinguish the clinically burned out from the non-burned-out. Additionally, an individual may be considered clinically burned out when a high emotional exhaustion score combines with a high depersonalization score or a low personal accomplishment score (Dyrbye et al., 2009). Therefore, it is necessary to examine all three components of burnout to understand an individual's burnout level best.

Moral Injury

The definition of burnout has met resistance among certain specialized groups, particularly medical professionals. According to Dean et al. (2019), the increasing demand for healthcare, coupled with rule-driven healthcare practices and disconnected top-down administration, has increased physician distress. Further, the massive technology investments that promised efficiency for healthcare providers unfortunately diverted capital resources away from new staff acquisition, redirected attention away from patient care, and did not improve projected patient

outcomes contributing to the challenge (Menachemi & Collum, 2011; Palabindala et al., 2016; Squires, 2015). Further, medical professionals reference that solutions for burnout in other industries have not proven as successful in the healthcare industry due to the subtle but tangible difference between burnout and moral injury (Dean et al., 2019). The differences between moral injury and burnout are vital because using different terminology reframes the problem and the solutions.

Moral injury occurs when an individual witnesses or fails to prevent an act that transgresses their deeply held moral beliefs (Dean et al., 2019). Each time a decision occurs for physicians or other professionals that contravenes the best interest of the patient or client, a transgression occurs. Over time, the repetitive decisions amass into moral injury. In summary, moral injury occurs when an individual understands what should be done to help someone; however, the proper solution is not provided due to circumstances or constraints beyond the caregiver's control.

According to Berlin (2021), burnout implies that the issue could be avoidable based on the responses or safeguards incorporated by the helping professional implying that the individual is exclusively responsible for their physical, emotional, and psychological welfare. Moral injury reframes the diagnosis and implies that the organization and the helping professional each have a responsibility to examine both the individual and organizational framework and practices and make adjustments to facilitate a healthier environment (Dean et al., 2019). In the context of the current study, the terms *burnout* and *moral injury* are synonymous.

Posttraumatic Stress Disorder

Researchers have found a link between burnout and PTSD, as increased exposure to stress and trauma in multiple life domains, including acutely increased workplace stress such as the COVID-19 pandemic, could compound both syndromes (Restauri & Sheridan, 2020). Mental health providers define trauma as a stressful occurrence outside the range of the average human experience, which would be markedly distressing to almost anyone (NCCMH, 2005). This type of stressor involves a perceived intense threat to life, physical integrity, intense fear,

helplessness, or horror (American Psychiatric Association, 2013). Although PTSD is commonly associated with active military conflict, the context and definition of a traumatic event pertain to the COVID-19 pandemic and other stressors frequently encountered by helping professionals (Restauri & Sheridan, 2020). Therefore, the COVID-19 pandemic provides a catalyst for chronic workplace stress, leading to decreased job performance and burnout.

Consequences of Burnout

Personal burnout can have a negative influence on an individual's physical, psychological, and relational well-being. It can also lead to significant challenges for both the individual and the organization because of its short- and long-term impact on job satisfaction, performance, and career commitment. In this review, I examine the general physical, psychological, relational, and organizational impact of burnout, as well as specific connections to three high-stress helping occupations: physicians, law enforcement, and clergy.

General Physical Consequences of Burnout

The physical consequences associated with burnout can be significant for working adults and can be life-threatening. The most frequently investigated physical outcomes associated with burnout included cardiovascular diseases, comprising coronary heart disease (CHD), and hospitalization for cardiovascular diseases. For example, Salvagioni et al. (2017) examined CHD-related risk factors in longitudinal studies related to burnout in the United States, Europe, Asia, and South Africa. The research confirmed that burnout negatively related to obesity, hyperlipidemia, type 2 diabetes, large waist circumference (WC), high body mass index (BMI), metabolic syndrome, hypertension, high triglycerides, low HDL cholesterol, high LDL cholesterol, and impaired fasting glucose, all contributing to CHD. The data clearly show that if left untreated, burnout can pose potentially life-threatening risks to helping professionals.

In a 1-year study of a group of Finnish workers, Ahola et al. (2012) examined the relationship between burnout, obesity, and alcohol consumption. Participants exhibiting exhaustion due to burnout indicated lower physical activity

and diminished personal efficacy. Additionally, among respondents exhibiting burnout and chronic stress, alcohol consumption increased during the testing period, compounding the problem. Increased alcohol consumption impacted both genders equally, with no significant difference noted. Finally, obesity and alcohol consumption negatively impacted the employees' organizational productivity and overall well-being.

According to Aghilinejad et al. (2014), musculoskeletal pain and disorders are twice as likely for those experiencing burnout than those without burnout symptoms. During a quantitative study, researchers assessed employees of various foreign embassies discovering that occupational stress is associated positively with burnout and musculoskeletal disorders (MSD). In addition, smoking and occupational stress surfaced as independent predictors of MSD among embassy personnel. Further, factors such as work environment, ergonomic situation, and cultural conditions contributed to the syndrome.

Burnout symptoms among individuals may also result in sleep deprivation. For example, Brand et al. (2010) linked the syndrome with sleep complaints in a study sample consisting of 1,183 females and 1,048 males. The results indicated that emotional and physical exhaustion related to burnout led to sleep deprivation in both populations. The relationship between sleep patterns and working conditions may be inverted because adverse working conditions may also cause sleep balance disturbances. Conversely, the results indicated that higher satisfaction with life and low pessimism contributed to healthy sleep patterns. The findings of this study confirm that chronic sleep deprivation, precipitated by burnout, can create a risk to helping professionals and those they serve by reducing their overall functionality.

Scholars have found that neck, shoulder, and back pain are correlated with burnout. Grossi et al. (2009) conducted a longitudinal study in Sweden and found that burnout contributed to the onset and maintenance of pain and impairment associated with all three discomforts. Both pain frequency and pain localization associated with increased or decreased burnout linked to increases or decreases in

tension and listlessness. The negative onset and aggravation of burnout and pain could negatively impact helping professionals to fulfill their job tasks.

In a 3-year study in California, Kim et al. (2011) discovered a link between burnout and increased gastrointestinal and respiratory issues among social workers. As workers scored higher on the burnout scale, they experienced more physical ailments and increased physical deterioration from year to year. The increase in detrimental physical issues negatively impacted the social workers ability to nurture relationships with clients, thereby decreasing job performance and adversely impacting the quality of service for clients. The physical ailments and deterioration precipitated by burnout increase over time and—if left untreated—could diminish a helping professional's ability to accomplish their daily duties.

In a Dutch study, Leone et al. (2009) found a correlation between burnout and prolonged fatigue. Prolonged fatigue typically comes from a medical or physiological experience (Wessely, 2001), while burnout is associated with psychological underpinnings (Schaufeli & Taris, 2005). Researchers have determined that rather than a unidirectional relationship, burnout and prolonged fatigue tend to co-occur in time rather than alternating or switching, creating a "downward spiral" effect (Leone et al., 2009, p. 372). Burnout and prolonged fatigue significantly and substantially predicted the onset of the other, and researchers recommended future studies on the timing and type of interventions needed to reduce or eliminate both burnout and fatigue symptoms.

A study of the connection between burnout and chronic stress conducted by Melamed et al. (2006) linked burnout to type 2 diabetes. Workers who exhibited burnout symptoms had a 1.84-fold increased risk of diabetes than workers not demonstrating burnout symptoms. Even after adjusting for age, gender, BMI, smoking, alcohol consumption, leisure-time activity, and job category, the findings indicated that chronic burnout poses a significant risk factor for the onset of type 2 diabetes in apparently healthy workers. The potential for personal burnout and chronic stress associated with helping professionals such as physicians, law enforcement, and clergy could also put them at risk of type 2 diabetes and other physical infirmities.

Research regarding the general physical consequences of burnout indicates that individuals experiencing burnout due to a wide range of causes are at higher risk for illness, disease, and disorders than those without burnout symptoms. Because some of these consequences can be life-altering and life-threatening, they could have a significant negative impact on the well-being of helping professionals like physicians, law enforcement, and clergy who need to function at optimal capacity to fulfill their mission of helping others.

General Psychological Consequences of Burnout

Personal and career burnout can also have negative psychological consequences. From a psychosocial perspective, burnout is manifest by emotional exhaustion, characterized by emotional depletion and loss of energy, depersonalization, or cynicism, also described as dehumanization, detachment from work and clients, and emotional hardening; and reduced personal accomplishment or inefficacy represented by a feeling of personal or professional inadequacy, as well as reduced productivity and coping skill (Maslach & Jackson, 1981; Maslach & Leiter, 2016).

In a 2003 study of dentists in Finland, the authors found a correlation between burnout and depressive symptoms (Ahola & Hakanen, 2007). The researchers examined the role and sequence of job strain, burnout, depressive symptoms, and then job strain, depressive symptoms, and burnout using logistic regression. They found a significant reciprocal relationship between burnout and depressive indicators. Job strain predisposed individuals to depression, contributing to burnout and vice versa. Their findings determined that job strain predisposed individuals to burnout, advancing to depression, which could undoubtedly negatively influence the helping professional's ability to fulfill their responsibilities (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020).

According to Armon et al. (2014), there is a significant link between burnout, depression, and chronic medical illness (CMI). These researchers found that CMI are prevalent in over half of the workforce, and individuals struggling with a CMI are 50% more likely than their coworkers to develop depression. A longitudinal study of working individuals revealed that burnout is associated with

increased depressive symptoms for those battling a CMI. Burnout also intensifies the negative experience of workers already dealing with a CMI. The findings indicated that employees with a CMI had a higher mean score of depressive symptoms than their healthy counterparts. Employees with CMI who also exhibited burnout potentially exacerbated the medical symptom increasing their functional disability and increasing healthcare utilization, which would put helping professionals struggling with a CMI at higher risk of burnout and accompanying depressive symptoms than others (Armon et al., 2014).

Toker and Biron (2012) conducted a full-panel, three-wave longitudinal study with a group of employees measuring the link between burnout and depression. The findings confirmed that depression from Time 1 to Time 2 predicted increased job burnout from Time 2 to Time 3 and vice versa. Their results also showed that physical activity mitigated the effects of burnout and job depression by showing that employees not engaged in physical activity exhibited higher levels of both conditions. As a result, helping professionals who reduce or cease physical activity because of burnout are likely to be at higher risk for depression.

The findings of a Danish study by Madsen et al. (2015) linked burnout with an increased risk of antidepressant use among tested individuals. The study examined a group of human service workers where 81% were female, and 19% were male. The three-wave study examined burnout and antidepressant treatment, with males 5.17% more at risk than females 0.96% of antidepressant treatment due to burnout. The findings indicated a stronger association between burnout and antidepressant treatment in men than women suggesting more severe consequences of psychological distress related to burnout among men. In the United States, 63.7% of physicians are male (Boyle, 2021), 88.3% of law enforcement officers are male (Federal Bureau of Investigation, 2017), and 78.3% of clergy are male (Census Bureau, 2019), indicating that burnout among male physicians, law enforcement, and clergy could impair their ability to do their work while also putting them at higher risk of depression and related disorders.

General Relational Consequences of Burnout

While burnout has significant physical and psychological consequences for helping professionals, the relational impact may also impede performance and well-being. As burnout manifests in the individual's work-life experience, they will invariably carry the syndrome into their personal life, potentially introducing work-family conflict (Mete et al., 2014). Burnout and work-family conflict pose severe consequences for both employees and the organizations they serve by putting a strain on essential relationships (Jerg-Bretzke et al., 2020; Medrano & Trógolo, 2018; Palenzuela et al., 2019; Smith et al., 2018; Terry & Woo, 2021). A study by Netemeyer et al. (1996) discovered a significant link between work-family conflict and family-work conflict, finding that work-family conflict was a causal determinant of burnout. Conditions such as the COVID-19 pandemic and the consequences precipitated by the phenomenon heighten the potential of burnout, work-family conflict, and its adverse effects (Kao et al., 2020).

Work-family conflict occurs when workers have multiple roles from their associated groups, creating incompatibility and frustration from not meeting professional or familial expectations (Mete et al., 2014). In a 2014 study, researchers found statistically significant and positive correlations between work-family conflict and burnout factors (67%) and work-family conflict and family-work conflict (36%). Furthermore, the relationship between work-family conflict and burnout factors featured the highest conflict rate in the study. Consequently, individuals who are not experiencing fulfillment at work have a high possibility of undergoing conflict in their home life. Those experiencing conflict at home also have a 47% higher possibility of achieving burnout in the workplace. As conflict increased in the individual's home-life, family-work conflict increased, triggering a cyclical pattern that escalated burnout symptoms in the workplace. Therefore, helping professionals experiencing burnout at work are more likely to experience conflict at home, intensifying the work-family conflict dynamic and degrading performance and personal efficacy in both areas.

Jerg-Bretzke et al. (2020) identified work-family conflict as predictors of burnout and emotional exhaustion. Extra work and overcommitment surfaced as

predictors of work-family conflict and family-work conflict. In the study, 31% of the variance of the work-family conflict predicted occupational burnout related to the dimension of emotional exhaustion. Furthermore, working overtime and overcommitment to work increased stress and compounded the work-family conflict dynamic. No significant gender differences surfaced in the research related to burnout and work-family dynamic as both gender's results correlated similarly. Therefore, creating a work-life balance for helping professionals can help reduce burnout and foster organizational and family health.

Researchers have found that the relational impact of burnout, while not gender-specific, affects both sexes profoundly in similar and distinctive ways. While women tend to have greater family demands (Quinn & Smith, 2018), men tend to suffer more from work demands, leading to rising research interest in work-family conflict and its consequences from a gender perspective. Meta-analyses did not suggest a moderating role of gender between work-family conflict and unique gender consequences (Amstad et al., 2011; Nohe et al., 2015); however, Recuero and Segovia (2021) found that work-family conflict and family-work conflict positively relate to male emotional exhaustion. Female emotional exhaustion was more often associated with conflict from work-family challenges.

Butler and Skattebo (2004) found that job performance decreased among men experiencing work-family conflict, whereas men not experiencing work-family conflict showed no overall performance decrease. A longitudinal organizational study of a predominantly female workforce (70%) conducted by Demerouti et al. (2004) found that work-family conflict and work-home interference significantly related to emotional exhaustion, a primary dimension of burnout. In addition, job satisfaction, another dimension of burnout, was negatively related to work-family conflict for married women and men professionals (Wayne et al., 2004). Therefore, regardless of gender, once burnout initiates in the individual's life, the adverse effects may compound, exacerbating the negative consequences unilaterally.

General Occupational and Organizational Consequences of Burnout

In addition to individual and family stressors, burnout can have an adverse effect on occupational and organizational settings. First, job dissatisfaction can be linked directly to burnout as a significant negative occupational outcome (Lizano & Barak, 2015). Second, the mental issues, behavioral problems, and physical issues attributed to burnout often contribute to increased absenteeism in the workplace (Roelen et al., 2015). Workers who displayed high burnout symptoms averaged 13.6 days absent annually compared to an average of 5.4 days for workers scoring low on a burnout scale (Salvagioni et al., 2017). Third, Ahola et al. (2009) noticed that as burnout increased, disability pensions for workers displaying burnout symptoms increased, creating a negative long-term impact for employers. It is clear that without appropriate action to counter the effects of burnout, employees may choose to leave the occupation or organization much sooner than either they or their employers would like (Ciftcioglu., 2011).

Absenteeism due to burnout poses a significant negative impact on organizations. Roelen et al. (2015) found a link between burnout and absenteeism related to long-term sickness. Specifically, absence due to mental illness attributed to burnout surfaced as the number one cause for the phenomenon, followed by musculoskeletal and other somatic illnesses. Further, the MBI-GS predicted future mental long-term sickness absence for employees currently recognized as nonsick. Therefore, employees struggling with burnout pose a significant risk for increased absenteeism, negatively impacting organizational productivity. Finally, physicians, law enforcement officers, and clergy classified with burnout symptoms face an increased risk of absenteeism due to the occurrence.

To reduce the impact of absenteeism on employees, Westermann et al. (2014) conducted a multination study that recommended a combined intervention approach where work-directed (circumstance-oriented) and person-directed (individual behaviors) mediations merged. Work-oriented methods involved decreasing workload or increasing job control. Person-directed interventions involved teaching skills and techniques to lessen the effects of stressors through various relaxation or cognitive-behavioral techniques. The work-directed study

showed statistically significant reductions in staff burnout, particularly emotional exhaustion and work-related stress. Likewise, positive results occurred from the person-directed intervention approach where emotion exhaustion decreased, and intrinsic motivation and work dissatisfaction increased. While the positive results of the interventions in one group lasted up to 1 year, multiple groups showed no improvement. The researchers cited a lack of management support as the primary factor inhibiting the interventions.

In an 8-year study, the researchers found that workers with severe burnout contributed to work disability and increased worker's pensions (Ahola et al., 2009). Significantly, the dimension of exhaustion predicted employee disability due to mental and miscellaneous disorders. Furthermore, burnout also significantly predicted new disability pensions for workers, creating a negative long-term financial impact for employers. The possibility of severe burnout among helping professionals could directly lead to worker disability expenses for employers in the long term.

The impact of burnout on occupational commitment and turnover intention among workers has significant consequences for various organizations. For example, a study of certified public accountants by Ciftcioglu (2011) revealed that emotional exhaustion as a dimension of burnout negatively correlated with occupational commitment and intention to leave. Moreover, this scholar found that burnout significantly and adversely influenced occupational commitment and occupational turnover. Certain personalities seem to be more prone to burnout, particularly individuals with an external locus of control rather than an inward locus. Because accountants typically exhibit a higher external locus of control, they are at a higher risk of developing burnout (Ciftcioglu, 2011). It is possible that helping professionals who exhibit a higher locus of control and experience burnout would be at higher risk for organizational turnover than those not exhibiting the symptoms.

Wang et al. (2016) found that burnout contributed negatively to the perception of job demands and job resources among employees. A 1-year, three-wave longitudinal study among Chinese workers showed that job demands directly

led to job burnout. They analyzed the mediating role of personal resources and their relational impact between job resources and job burnout, and they found a connection between job demands and job burnout. Further, these researchers analyzed the reverse effect of job burnout on job demands and job resources. The higher the employees perceived level of job resources for completing the task, the higher their levels of self-efficacy, self-esteem, and optimism, and the lower their levels of job burnout. Job burnout, however, had a reverse effect on job demands and job resources. The relationship between job burnout and job characteristics is reciprocal rather than unidirectional, underscoring the balancing of organizational demands and resources to keep burnout down and turnover limited. Equipping helping professionals with the proper job resources could also build self-efficacy, self-esteem, and optimism lessening the risk of burnout and turnover.

Demerouti et al. (2009) linked burnout with increased job demands and presenteeism in the job force. The longitudinal study among nursing professionals confirmed that exhaustion led to presenteeism, which in turn caused more exhaustion. Also, the burnout dimension of depersonalization, where workers emotionally distanced themselves from patients, appeared over time as a byproduct of presenteeism. The research suggested that both high external job demands and internal feelings of irreplaceability induced pressure on employees to work through sickness, facilitating burnout. Finally, the researchers suggested that job demands are causally related to burnout through emotional exhaustion and depersonalization.

Like other groups, burnout among helping professionals such as physicians, law enforcement, and clergy can result from a wide range of individual, family, job, or organizational factors. As burnout diminishes personal performance, it can also harm the organizations that employ and manage these individuals and those they serve. The physical, psychological, relational, and organizational costs of burnout are tangible and costly. The long-term negative impact on helping professionals requires further study to mitigate the risks for both individuals and organizations.

The Impact of Burnout on Physicians

Physician burnout is a widespread and growing problem with the COVID-19 pandemic worsening stressors in a healthcare system in which physician burnout

is already prevalent. Burnout among physicians is a public health crisis that negatively influences patient care, healthcare system costs, and physicians' well-being and safety (Shanafelt et al., 2016; West et al., 2006). According to Dyrbye and Shanafelt (2016), approximately 50% of the physicians and physicians-in-training in the United States exhibited burnout symptoms. International studies suggested similar findings among their healthcare professionals (Linzer et al., 2001). There is evidence that certain physician specialties are at greater risk for burnout, including family medicine practitioners, internal medicine specialists, and emergency medicine physicians (Shanafelt et al., 2014). Unfortunately, according to Benham et al. (2020), widespread medical events impacting helping professionals, such as the COVID-19 pandemic, serve as an accelerant that intensifies the phenomenon's effects in a medical professional's life, increasing the risk of burnout. Consequently, an industry with an already high rate of personal burnout faces increasing challenges that may adversely impact a physician's performance and overall well-being.

The stresses facilitating burnout begin early in a physician's career. According to a study by Dyrbye, Sotile et al. (2014), the instruction period for physicians, including medical school, residency, and early career (EC; 5 years or less), placed them at higher risk of burnout, including emotional exhaustion and depersonalization than students and peers in nonmedical schools or fields. According to Ishak et al. (2009), 28–45% of medical students and 27–75% of medical residents encounter burnout during this career phase. Additionally, findings suggested that burnout is more prevalent among medical trainees and EC physicians than among similarly aged individuals in the general U.S. population. The symptoms of suicidal ideation, depression, and low self-efficacy were most prevalent during medical school and declined incrementally through the educational process. Additionally, overall burnout, high depersonalization, and high fatigue were most prevalent during residency. Alarmingly, EC physicians in the study indicated the peak career stage for distress occurred when launching a career and starting a practice, with 40%–50% of respondents indicating symptoms of burnout, depression, and high fatigue. Therefore, physicians begin dealing with

burnout early in their careers, with levels of the phenomenon noticeably higher than similarly aged peers.

As physicians transition from training into their practicing careers, burnout continues to impact their professional effectiveness. According to Dyrbye et al. (2013), a national study of AMA physicians found that middle career physicians (11–20 years of practice) exhibited higher levels of burnout, characterized by emotional exhaustion and depersonalization than both early-career physicians (10 years or less) and late-career physicians (21 years or more). In addition, middle-career physicians reportedly worked additional hours, took more call duty, reported the lowest specialty satisfaction, were more dissatisfied with work-life balance, and struggled substantially with burnout and emotional exhaustion more than their colleagues (Dyrbye et al., 2013). A notable finding of the study was the observation that middle-career physicians, regardless of gender, experiencing burnout and emotional exhaustion were more likely to leave their practice and pursue a career outside medicine altogether due to frustration and exhaustion. Early-career physicians tended to have more work-home conflicts and appeared less capable of resolving those conflicts than their colleagues, increasing the impact of burnout. Late-career physicians reported the intention to reduce work hours and leave the career entirely. There is evidence that late-career physicians and early career physicians exhibited the most job satisfaction. Thus, regardless of the stage of their medical career, burnout is a significant and negative factor impacting physicians.

The Effects of Physician Burnout

Approximately one half of physicians in the United States will experience burnout throughout their careers, with studies indicating that the percentage will continue to grow (Shanafelt, Gorringe et al., 2015). Significantly, widespread events like the COVID-19 pandemic intensify and accelerate burnout symptoms among medical professionals, creating concern for front-line workers' mental health, productivity, and well-being (Braquehais et al., 2020). Burnout among physicians negatively impacts three broad categories: patient care, healthcare organizations, and physician well-being.

Burnout and Physician-Patient Care. The effect of burnout on physicians created suboptimal patient care practices in a study conducted by Shanafelt et al. (2003). The results of a study done with medical residents revealed that 76% of the residents met the criteria for burnout. Compared with non-burned-out residents, 53% of the medical residents experiencing burnout self-reported suboptimal patient care practices. In a dose-response relationship, the burnout dimension of depersonalization surfaced as the primary factor for the decrease in positive patient care practices. Depersonalization amongst physicians entails treating patients as objects rather than human beings (West et al., 2018). Therefore, physicians experiencing burnout risk depersonalizing their patients and reducing the quality of patient care.

Increased medical errors were negatively associated with burnout and reduced quality of patient care in a study at the Mayo Clinic by West et al. (2009). The 6-year longitudinal study of internal medicine residents confirmed that higher levels of burnout associated with increased odds of medical errors. Of the resident physicians reporting burnout symptoms, 68.7% reported at least one significant medical error during the analysis period. Further, the researchers found that self-perceived medical errors were associated with worsening burnout, depressive symptoms, and decreased quality of life, suggesting a bidirectional relationship between medical errors and distress. Additionally, as fatigue or depressive symptoms increased, medical error risk increased up to 28%. Therefore, as burnout increased among physicians, the risk of a medical error also increased, potentially endangering patient safety.

Halbesleben and Rathert (2008) found a link between physician burnout, adverse patient recovery time, and patient satisfaction. The study paired physicians with patients that were hospitalized and treated by them in the previous 12 months. The results indicated that after accounting for various factors, including length of hospitalization, physician burnout associated with lower patient satisfaction and longer patient-reported recovery times. The researchers proposed that when a physician's resources diminish, they are less likely to spend time with the patient to ensure quality treatment, reducing patient recuperation time. In conclusion, as

burnout deteriorates a physician's capacity to function optimally, the patient-provider relationship suffers, thus increasing potential recovery time for the patient.

Haas et al. (2000) found a link between burnout, physician job satisfaction, and patient's satisfaction with their physician's care. The results of their study set in the United States included that physicians who self-reported higher personal efficacy in their practice received high or extremely high patient satisfaction responses. Additionally, the authors suggested that promoting physician self-awareness early in their academic medical training helped them choose the best medical practices suited to their proficiencies and interests, leading to higher personal career satisfaction. Therefore, physicians who are satisfied with their work exhibit fewer burnout symptoms, exhibit higher personal efficacy, and increase patient satisfaction and care.

Physician burnout adversely impacts patients and negatively affects the physician workforce, ultimately impacting the entire healthcare system. Shanafelt et al. (2014) found that physicians experiencing burnout decreased productivity, increased job dissatisfaction, and displayed the intent to leave their current practice for reasons other than retirement. Even among oncologists who found great personal fulfillment in their profession, excessive work hours negatively impacted their work-life balance (WLB). Further, researchers have indicated that 18% of oncologists planned to leave their current position in the next 24 months, citing burnout and WLB as the dominating. Twenty percent of oncologists indicated they planned to retire earlier than they originally intended, straining the medical workforce by reducing the number of qualified physicians. Therefore, physician burnout increases a medical professional's intent to leave their practice, negatively impacting the healthcare workforce and potentially reducing quality patient care.

Burnout and Physician-Healthcare System Impact. The economic impact of physician burnout is monumental. Han et al. (2019) conducted a cost-consequence analysis to investigate the economic effect of physician turnover and reduced productivity attributed to burnout, accrediting the costs of $4.6 billion annually to the phenomenon in the United States alone. According to the findings, the analysis is conservative, omitting other burnout-related losses such as

malpractice lawsuits, inferior quality of patient care, and lower patient satisfaction, increasing the deficit. These findings suggest a strong financial motivation for organizations to invest in remediating physician burnout.

A longitudinal study of physicians at the Stanford School of Medicine by Hamidi et al. (2018) discovered that the economic loss from physicians leaving a teaching practice due to burnout or retirement averaged between $15 million to $55 million annually. Compounding the financial impact, the cost of recruiting a physician ranged between $268,000 to $957,000 based on specialty, expertise, and experience. Further, a physician's intent to leave correlated positively with burnout, where 28% of physicians in the study indicated intent to leave within 2 years, and 24.8% percent of those left the organization. Therefore, the existent shortage of physicians, compounded by physicians exiting the field due to burnout, creates additional financial challenges for healthcare organizations.

Physician burnout also poses significant financial implications for the healthcare industry outside of the United States. A Canadian study by Dewa et al. (2014) found that burnout was a significant indicator of early retirement for physicians, conservatively estimating a $185.2 million decrease in annual revenue. Additionally, physicians experiencing burnout reduced their clinical hours and reduced the number of surgical procedures conducted, creating an extra annual income loss of $87.8 million. In sum, the total estimated cost of burnout among Canadian physicians was $213.1 million annually. Consequently, the healthcare workforce in Canada faced a decrease in physicians due to burnout, negatively impacting the quality of patient care and creating significant damaging financial repercussions to their healthcare system.

Burnout and Physician Well-Being. Physician well-being and job performance suffer from burnout with a variety of challenges arising from the phenomenon. According to a cross-sectional survey of physicians in the United States, 13.9% of male surgeons and 25.6% of female surgeons self-reported alcohol abuse or dependence, with burnout being a contributing factor (Oreskovich et al., 2012). The findings indicated that depersonalization resultant from burnout strongly and independently indicated higher percentages of alcohol abuse or

dependence. The findings suggested that surgeons struggling with alcohol abuse or dependency constituted 77.7% of the physicians committing a significant medical error. Alcohol abuse or dependence was also strongly associated with physician distress, including emotional exhaustion, depersonalization, depression, suicidal ideation, quality of life concerns, and career satisfaction. Therefore, burnout contributes to alcohol dependence or abuse among physicians, potentially impacting their quality of care for patients and their quality of life.

Physicians experiencing burnout also risk a higher percentage of suicidal thoughts than the general population. A Dutch study of medical residents found that 20.5% of the respondents indicated burnout symptoms (Van der Heijden et al., 2008). Additionally, the medical students exhibited a high percentage of suicidal ideation (12%) than the general population sample (3.9%) among a similar age group. Further, the study results showed a significant correlation between burnout dimensions and suicidal thoughts with no significant associations between age or gender. Therefore, burnout relates to increased suicidal ideation among medical professionals causing great concern for their personal and professional health.

Physicians exhibiting burnout symptoms had a significantly higher possibility of being in a vehicle accident than those not exhibiting burnout. The findings of a 5-year longitudinal study by West et al. (2012) of medical residents at the Mayo Clinic were that 56% of the physicians in the study reported a vehicle incident during the reporting period, with 11.3% reporting a crash and 43.3% citing a near-miss motor vehicle crash. With each 1-point increase of the burnout dimensions of emotional exhaustion or depersonalization, a 3%–8% increase in the possibility of a motor vehicle incident occurred. Therefore, physicians exhibiting burnout symptoms are at high risk for being in a motor vehicle incident.

Work-life conflict and work-life balance are both associated with burnout among physicians and their working partners. A national study of physicians in the United States found that physicians experiencing burnout symptoms were 20.5% more likely to experience work-home conflicts than their peers who did not exhibit symptoms. Additionally, those living with a home partner with burnout symptoms had an 18.6% higher possibility of experiencing work-home conflict due to their

partner's burnout issues. Most work-life conflicts that resolved successfully favored the physician's place of work (28.4%) over their employed partner's place of work (19.7%). Further resolution of home issues mostly favored the physician (10.9%), leaving the employed partner (20.1%) left to handle the home responsibility. In summary, physicians and their employed home partners experiencing burnout have more work-home conflict than their peers who do not work outside the home or have burnout symptoms.

Three significant factors associated with physicians' developing burnout included hours worked per week, work-home conflict, and how the work-home conflict resolved (Dyrbye et al., 2011). The respondents indicated that of those who worked ≤ 49 hours, 68% reported recent work-home conflicts, those working 50–59 hours per week reported 69.1% work-home conflict, and physicians working ≥ 60 hours per week reported 82.1% of recent work-home conflicts. The resolution of the work home conflict divided 56.6% of the time toward the physician's work and 43.4% of the time toward the home responsibilities. Therefore, work-home conflict and its resolution may be central factors related to physician burnout.

In summary, physicians suffering from the effects of burnout face decreased job performance, increased work-home conflict, and a reduction in overall well-being. If left unresolved, burnout contributed to reduced patient-care outcomes, reduced personal efficacy, and the increased possibility of the physician leaving practice early for reasons other than retirement. Multiple challenges contribute to burnout, with the significant causes detailed in the following section.

Contributors to Physician Burnout

An array of issues contribute to burnout in physicians, with most of the causes divided into either work-related or individual factors. Work-related factors are the principal drivers of physician burnout (Williams et al., 2007). The usual causes of burnout among these helping professionals include lack of meaning in work, inefficient work processes, high workload, absence of autonomy, and challenges with work-life integration (Shanafelt et al., 2016). These factors may negatively affect the physician's home life, staff, affiliated organizations, and patients.

Work Factors. A physician's time invested in their "most meaningful activity" was the single most significant predictor of burnout. According to Shanafelt et al. (2009), physicians (68%) identified patient care as their most desired professional activity. Findings suggested that physicians' disproportionate amount of time on administrative and clerical functions contributed to a loss of sense of meaning from work and escalated burnout (Shanafelt et al., 2016). Further, findings indicated that 43.7% of physicians were dissatisfied or very dissatisfied with their electronic practice environment citing inefficiency and frustration with the process. Administrative and clerical concerns related to a patient's electronic health records (EHR) can often distract from patient care requiring up to 49% of a physician's time, thereby reducing time spent with clients. Therefore, the administrative systems initially intended to increase physicians' time for patients instead reduced their time and potentially stimulated burnout.

High workload contributed to burnout in a multivariable analysis of data from cross-sectional studies of physicians. West et al. (2018) discovered that for each overtime hour worked by physicians, the risk of burnout increased by 3%. Night or weekend call duties increased the odds of burnout by 3%–9% per hour, and time spent working from home during off-duty hours increased the odds of burnout by 2% per hour. Additionally, when working from home, the odds of work-home conflict increased significantly more than doubling the risk of burnout when present. Therefore, physicians and their organizational administrative leaders should monitor the number of overtime hours worked by physicians to reduce or eliminate the impact of burnout.

Organizational factors also positively or negatively influence physician burnout. According to a study at the Mayo Clinic by Shanafelt, Hasan et al. (2015), negative leadership behaviors, limited interprofessional collaboration, reduced opportunities for advancement, and limited social support for physicians in an organizational system affect burnout. Significantly, these researchers found that supervisors who scored more proficiently in leadership decreased the likelihood of burnout by 3.3% and increased the likelihood of satisfaction by 9% of their team members. Therefore, the leadership qualities of physician supervisors appear to

impact the productivity, job satisfaction, and well-being of individual physicians within their healthcare organizations.

Burns et al. (2021) discovered a link to increased burnout symptoms and negative perceptions of their organization in physicians who experienced unprofessionalism, increased work hours, and uncivil behavior at the workplace. In organizational environments where addressing unprofessional behavior appropriately and facilitating inclusion, respect, and civility existed, the risk of burnout decreased. In summary, creating and maintaining an organizational culture that creates a safe environment for healthy confrontation, inclusion, civil discourse, and mutual respect facilitates physician well-being and reduces burnout.

Individual Factors. While organizational factors substantially influence burnout among physicians, several individual considerations can enable the phenomenon. Although gender is not considered an independent predictor of burnout, the results of a longitudinal study indicated that female and male physicians react to burnout inversely in some situations (Langballe et al., 2011). These findings indicated that workload was the strongest predictor of burnout among male physicians. In female physicians, workload only had a moderating effect on burnout; however, while negatively impacting both genders, work-home conflict represented the most significant source of burnout for female physicians. Additionally, female physicians who experienced high-value congruency dimensions at work risked investing too much time and energy in their occupation, facilitating work-home conflict. Conversely, work-home facilitation had a significant and protective effect for female physicians. In summary, burnout negatively impacts both male and female physicians and can adversely impact productivity and well-being regardless of gender.

Age appears to be a factor in burnout among physicians, with physicians under the age of 55 years being twice as likely to experience burnout than their older peers (West et al., 2018). Findings suggested that physicians with families having a child younger than 21 years old increased the risk of burnout by 54%. Burnout and its effect on early retirement among older physicians while a factor is underresearched, and the results are unclear on the impact of the phenomenon on

this age group. Therefore, burnout is present in the different stages of the aging process in a physician's life and work cycle and can impact job productivity and well-being.

Individual attributes such as personality, relational skills, and personal experiences may also impact burnout in the physician's life. A 12-year longitudinal study of physicians in the United Kingdom measured the effects of burnout related to personality traits and learning style from medical school and into their first decade of practice. Findings indicated that 20% of the physicians were burned out in this period citing high workload and an unsupportive work climate as significant factors (McManus et al., 2004). The researchers found that the members who indicated burnout at the latter stages of their careers also exhibited burnout in their early careers, suggesting that personality traits influenced individual burnout and career satisfaction. Additionally, physicians exhibiting burnout, stress, and emotional exhaustion scored higher on the neuroticism scale and were more likely to be surface-disorganized. Lower conscientiousness on the personality measure also predicted more significant stress. Extraverts reported more personal accomplishments and were more satisfied with their career. In summary, longitudinal data suggest that personality and learning style correlate with burnout and career satisfaction and significantly cause and predict the phenomenon.

Personal life events also contribute to stress and professional burnout among physicians. A study in the United States of physician residents at the Mayo Clinic found that 50% of the helping professionals indicated burnout symptoms (Dyrbye et al., 2009). Thirty-seven percent of the physicians experienced at least one significant adverse life event (divorce, major illness, death of a family member) during the testing period). Adverse personal life events demonstrated a significant relationship with professional burnout ($p = .002$). The findings also indicated that while demographic characteristics and year in training correlated with burnout, the magnitude of these effects was less than personal life events. Further, positive personal life events are associated with a lower prevalence of depression and at-risk alcohol use. Therefore, both positive and negative life events among physicians significantly influence burnout on productivity and well-being.

Physician Burnout Interventions

Interventions to prevent or alleviate the effects of burnout require organizational and individual solutions. Scholars have shown that appropriate strategies for physician well-being are multidimensional and include factors that relate to each physician as an individual and the environment in which the physician works (Kuhn & Flanagan, 2017). The literature on burnout intervention collectively demonstrated that organizational and individual solutions applied to physician burnout reduced emotional exhaustion by 14%, 4% for depersonalization, and 10% for overall burnout symptoms (West et al., 2018). Researchers have indicated that successfully reducing physician burnout is a shared responsibility requiring commitment and interaction from both institutions and individual physicians (Shanafelt et al., 2017; Shanafelt & Noseworthy, 2017; Wallace et al., 2009). The following sections address recommended individual and organizational interventions for reducing and preventing burnout among physicians.

Physician Individual-Level Interventions. Various individual strategies have proven effective for reducing or preventing physician burnout. These strategies include mindfulness, self-care techniques, exercise, stress management training, communication skills development, peer connection, and support groups that facilitate community, connectedness, and reinforce meaning (Regehr et al., 2014; Ruotsalainen et al., 2014; West et al., 2016). Therefore, physicians can apply various techniques and tools that may reduce or eliminate the negative impact of burnout.

Kabat-Zinn and Hanh (2009) defined mindfulness as the awareness that arises when paying attention in the present moment, on purpose, and nonjudgmentally. Scholars have found that the application of mindfulness practices reduced stress and anxiety related to physician burnout (Roy et al., 2020). Specifically, mindfulness helps individuals identify preservative worry thought patterns that reinforce anxiety loops and perceive thoughts and emotions as mental and physical events and sensations instead of propagating the cycle. Further, practicing mindfulness can decrease the degree to which individuals are identified with thoughts and emotions, effectively deconditioning or extinguishing the

reinforcement learning process that perpetuates anxious behaviors. A study of physicians exhibiting burnout symptoms in the United States utilized mindfulness techniques and experienced a 48%–57% reduction in anxiety, a 50% reduction in cynicism, and a 20% reduction in emotional exhaustion (Roy et al., 2020). Therefore, utilizing mindfulness practices may increase resiliency against burnout and bolster physician well-being and productivity.

Self-care techniques have also proven effective in reducing the effects of burnout in helping professionals. Mahoney (1997) defined self-care as any activity that fuels the body and mind allowing an individual to function more fully in daily life. As a training domain for helping professionals, self-care is a spectrum of knowledge, skills, and attitudes, including self-reflection and self-awareness, identifying and preventing burnout, setting appropriate professional boundaries, and grief and bereavement preparation (Sanchez-Reilly et al., 2013). Physicians applying self-care may more appropriately care for patients and ease their suffering, thereby giving the physician a renewed sense of self-efficacy, strengthening their sense of connectedness and idealism, and reminding them of life's preciousness and fragility. Therefore, physicians practicing self-care may reduce the effects of burnout and achieve higher levels of professional satisfaction and personal well-being.

Exercise as a self-care activity has beneficial effects on general health, promoting positive interactions with others and producing salutary effects on depression (Kuhn & Flanagan, 2017). A 12-week study of resident physicians at the Mayo Clinic found that those who participated in organized exercise programs had reduced burnout scores (24% vs. 29%; $p = .17$) than their peers who abstained from exercise (Weight et al., 2013). Further, participants' quality of life scores exceeded those of nonparticipants (75 vs. 68; $p < .001$). Therefore, exercising provides physicians a barrier against burnout and increases professional productivity and improved quality of life.

Stress-management training practices for physicians have proven effective in reducing the effects of stress, which can lead to burnout. A study of physicians in Australia found that participants who attended stress management courses reduced

stress between 59% to 74% in postintervention analyses (Gardiner et al., 2004). The findings suggested that consistent improvements in quality of life, work-related morale, work-related distress, and general psychological distress improved following the stress management training intervention. Physicians in the training group scored significantly lower in general psychological distress, with a 50% reduction in the group scoring above the threshold for minor psychological morbidity. In contrast, the control group of nonattendees experienced a 13% increase in general psychological distress during the postintervention testing analyses. In summary, stress management training for physicians may lead to reduced levels of burnout and higher levels of well-being.

The development of communication skills in physician residents improved self-efficacy and reduced stress in a study by Bragard et al. (2010). The Belgian longitudinal study included a 30-hour communication and 10-hour stress management program, which assessed the students before and after the training. The results reflected an increase in personal efficacy by improving communication skills and reducing stress in the communication process with patients. While the communication training led to increased personal efficacy and decreased stress, the study did not confirm a decrease in burnout symptoms, citing a need to observe participants over several months to evaluate the expected reduction in burnout symptoms. Therefore, communication skills training is valuable in producing self-efficacy and reducing stress in physician-patient interaction practices.

Peer connections for physicians provide a safeguard against the harmful effects of burnout and social isolation. According to Greenawald (2020), physicians' culture and training can condition and socialize these professionals to isolate themselves and conceal their problems instead of seeking peer connections to support and help them overcome burnout and its symptoms. Further, the pace and intensity of clinical practice and excessive administrative responsibilities limit the physician's time to create peer relationships. The investigator of an 8-week physician study found that participants who engaged in an intentional one-to-one peer connection program experienced a 2.2 to 2.6 out of 4 increase in their well-being index (Greenawald, 2020). Therefore, physicians who engage in peer-to-peer

connections can achieve higher states of well-being and create professional support in defense against the effects of burnout.

Support groups that facilitate connection, community, and coaching opportunities for physicians improve burnout reduction and increase career commitment among physicians. Brooks et al. (2018) linked organizational coaching and support systems to physician burnout, wellness, and career commitment. The researcher's interviewed physicians in the United States undergoing treatment for mental health issues related to their medical practice. Nearly 50% of the attendees believed their problem manifested earlier than the diagnosis but remained unrecognized. Other than themselves, respondents said spouses (51%), clergy (21%), and coworkers (20%) might detect early warning signs. Forty-nine percent of the respondents said they commented about burnout and stress before their diagnosis. Fifty-seven percent of the respondents were unaware of peer assistance programs. Significantly, respondents believed prevention care through collegial interactions (51%) and mentorship (48%) may have prevented burnout. In summary, support groups, coaching, and mentoring opportunities create preventive barriers to burnout, potentially increasing physician productivity and well-being.

A study by West et al. (2018) identified five standard drivers for burnout, including excessive workload, work inefficiency, challenges with work-home integration, loss of control and autonomy, and loss of meaning from work. To counter the effects of excessive physician workload, they suggested physicians consider part-time status to reduce the number of hours worked. Researchers have suggested training physicians in time management, leadership skills, and work delegation to counteract the effects of work inefficiency. The implications of scholarly findings are that work-home integration strategies for physicians should include reflecting on life priorities and values and integrating self-care practices. Suggestions to counteract the loss of control and autonomy included applying stress management and resiliency training, positive coping strategies, and mindfulness. To neutralize the effects of loss of meaning from work, researchers have recommended that physicians understand their most fulfilling work roles and seek to spend as much time as possible within those roles.

The challenges related to individual physician burnout are significant, potentially negatively impacting their productivity, work-home life, well-being, and the patients they serve. While stress and stressors may always be a regular part of a physician's professional experience, the COVID-19 pandemic has introduced unique stresses to the healthcare system and healthcare workers (Shanafelt et al., 2003). Various strategies can help mitigate the causes of burnout and benefit physicians in their professional and personal lives. Although physicians must take responsibility for their well-being, the organizations they serve also play a crucial factor in preventing and combatting the effects of burnout.

Physician Organizational Level Interventions

Although individual physician response to burnout is necessary, organizational intervention and action are vital to reducing physician burnout and prevention. According to Shanafelt and Noseworthy (2017), organizational and administrative issues are the primary factors that drive physician burnout. Unfortunately, many hospital systems appear to operate under the assumption that burnout and well-being are the sole responsibility of the individual physician (Scheurer et al., 2009). As one physician stated, "It's not the physician that needs to be healed. It's a system that needs to be healed. There's nothing inherently broken about myself" (Berlin, 2021, p. 20). From an organizational point of view, various strategic framework initiatives can bolster physician burnout resistance, increase well-being, enhance patient satisfaction, and ultimately benefit institutional objectives. These programs include problem assessment, leadership development, targeted interventions, cultivating community, rewards and incentives, values and cultural alignment, flexibility, and work-life integration, and promoting self-care strategies against burnout.

Acknowledge and Assess the Problem

Organizational acknowledgment of burnout is the initial step in the prevention and reduction of the phenomenon. It implies that the administration cares about the well-being of its physicians (Shanafelt & Noseworthy, 2017). Additionally, by instituting programs that systematically measure physician well-

being using validated instruments that provide results regarding burnout, engagement, professional satisfaction, emotional health, and other dimensions of well-being, leadership teams can better serve physicians. Further, regular assessments of physician well-being provide work-unit-level teams important updates, allowing them to adjust attention and resources to identified problems rapidly. Therefore, the first step in addressing physician burnout and career commitment is acknowledging the problem and consistently monitoring feedback from team members to address issues.

The Power of Leadership

The role of leadership significantly impacts organizational success and directly affects a physician's productivity and well-being. A 2013 study of 2,800 physicians by Shanafelt, Gorringe et al. (2015) at the Mayo Clinic found that each 1-point increase in the leadership score (60-point scale) of a physician's immediate supervisor was associated with a 3.3% decrease in the likelihood of burnout ($p <$. 001) and a 9.0% increase in satisfaction ($p <$. 001). Importantly, the findings indicated that organizations should provide ongoing training for existing team leaders and have the courage to make leadership changes of underperforming supervisors to facilitate the positive effects of leadership (Shanafelt & Noseworthy, 2017). Therefore, a physician supervisor's leadership qualities appear to impact burnout, well-being, and satisfaction of physicians inferring that the training and selection of physician leaders are vital to achieving organizational objectives.

Targeted Interventions

Analyzing specific work units, departments, and individual physicians struggling with burnout via measurement tools allows leaders to create specialized interventions to address the identified challenges. The findings of a study by Swensen et al. (2016) at the Mayo Clinic revealed the correlation of burnout factors with underperforming work units. The intervention partnered with physicians in their work units and incorporated the principle of participatory management, collaborative action planning, and evaluation of how burnout drivers manifested in their department. According to Shanafelt and Noseworthy (2017), the process

helped "transform the physicians' mindset from that of a victim in a broken system to an engaged and empowered partner working constructively with leaders to shape their future" (p. 7). Among the seven units participating in the study, each group reported improvements in their burnout reduction scores of between 4%–46%.

Additionally, five of the seven groups noted improvement in satisfaction scores, with a median change of 8%. Of significant interest at the end of the intervention, six of the seven workgroups no longer met the organizational criteria utilized to classify them as at-risk units. In summary, by analyzing physician burnout and satisfaction and identifying work unit challenges, leadership teams in partnership with physicians can make changes that improve physician well-being, productivity, physician work-unit performance, and reduce burnout.

Cultivating Community

Physician support or community groups can provide valuable professional development and relational tools to build community and protect against burnout among medical professionals. According to West (2017), mutual support groups help physicians deal with the challenges of being a physician, help peers manage stress related to practicing medicine, reduce burnout, and foster meaning at work. In a 2015 study, physician-led small groups called Colleagues Meeting to Promote and Sustain Satisfaction (COMPASS) groups consisting of six to 10 participants met a minimum of 12 times over 6 months to consider three to four discussion questions per session. Fifteen minutes of the meeting/dinner were semistructured to address the assigned questions, with the remainder of the time open for general discussion and socialization. At the end of the 6 months, over 95% of polled group leaders indicated that they planned to continue the meetings due to the positive feedback and engagement of the participants. The barriers to group involvement and meaningful connections consisted primarily of busy work schedules.

A study of physicians who engaged in topical peer-led, small groups showed promising results for reducing burnout and increasing physician well-being. West et al. (2014) found that physician-facilitated, curriculum-based discussion groups promoting mindfulness, self-reflection, shared experience, and small group learning met biweekly for 9 months and demonstrated positive results

in reducing burnout. Three months into the study, the burnout dimension of depersonalization decreased by 15.5%. Further, emotional exhaustion and overall burnout decreased substantially with sustained results 12 months after the study. Therefore, physicians who participate in peer groups can experience decreased burnout, improved peer comradery, mutual support, and enhanced overall well-being.

Rewards and Incentives

Physicians receive compensation based predominantly on two models: compensation based on productivity or a base salary with productivity bonuses (Shanafelt & Noseworthy, 2017). Productivity measures typically include three components: seeing more patients by shortening patient visit times, ordering more tests and procedures, or working longer hours. Consequently, rewards and incentives based solely on productivity can erode patient quality care and lead to physician burnout (Shanafelt et al., 2014). Additionally, physicians can be susceptible to overwork due to compensation incentives, high education debt, patient need, unhealthy role modeling from colleagues, and the normalization of excessive work hours during their training tenures (Shanafelt & Noseworthy, 2017). To balance the adverse effects of productivity-based pay, compensation practices linked to patient satisfaction, physician self-care and well-being, and fulfilling organizational values and goals warrant consideration.

Aligning Values and Strengthening Culture

Most healthcare organizations have a mission and vision statement that centers on serving patients and providing quality medical care. According to Shanafelt and Noseworthy (2017), a healthcare system's adherence to its culture, values, and principles determines to a large degree whether it will achieve its stated objectives. The Mayo Clinic, formed in 1883 by Dr. William Mayo, is world-renowned for medical academic excellence, innovative medical practices, medical research and consistently ranked nearly three times higher than the second-leading academic medical center in the United States (Berry & Seltman, 2014). The longevity and success of the Mayo Clinic are attributed to the creation and

sustenance of its corporate culture, which focuses on patient-centeredness and medical teamwork facilitated through leadership excellence and supportive governance (Berry & Seltman, 2014). The organization's culture is sustained through ongoing staff assessments that evaluate how well the organization adheres to its stated values, reinforcing the partnership between the clinic and its employees.

Additionally, the organization responds to physician and staff feedback and adjusts policies and procedures to address variances and maintain values alignment (Shanafelt & Noseworthy, 2017). Physicians who participated in values assessment and alignment processes at the Mayo Clinic overwhelmingly endorsed the practice (95%) as a tool to reinforce values and maintain a healthy partnership between the clinic and employees. Therefore, organizations that examine factors that influence culture to assess ways to keep values relevant and consistently examine action and values alignment can create an environment that promotes physician well-being and meets patients' needs.

Create Flexibility and Support Work-Life Integration.

Physicians tend to work longer hours than many other American workers, leading to challenges with work-life integration and possible burnout. Shanafelt, Hasan et al. (2015) found that approximately 45% of physicians in the United States worked more than 60 hours per week, compared with less than 10% of worker's hours in other fields. For each overtime hour worked by physicians, the risk of burnout increased by 3% (West et al., 20180). Night or weekend call duties increased the odds of burnout by 3%–9% per hour, and time spent working from home during off-duty hours increased the odds of burnout by 2% per hour. Compounding the challenge, a study by Zhang et al. (2020) projected a significant shortage of physicians throughout the United States by 2030, potentially intensifying the issue of work-life integration due to increased workloads. Shanafelt, Hasan et al. (2015) recommended that giving physicians the option to adjust professional work effort (with a commensurate reduction in compensation) or allowing physicians to create their work calendar to accommodate family schedules could reduce work-life conflict and reduce burnout. Further, Shanafelt et

al. (2016) discovered that reduced work hours correlated with reduced burnout scores among physicians. In summary, providing physicians the flexibility to balance work-life commitments and adjust work schedules can reduce burnout and increase physician work-life balance.

Promoting Physician Self-Care

Although a healthcare system's principal responsibility should be to optimize the practice environment and organizational culture, providing physicians with tools and resources to combat burnout is also the organization's responsibility and may reduce the phenomenon's impact. Further, offering physicians tools for self-calibration, resources that promote self-care, and training in skills that promote resiliency against burnout can positively impact the organization's objectives (Shanafelt & Noseworthy, 2017). The recommended resources and training for burnout prevention among physicians may include information on work-life integration, exercise and fitness, sleep habits, diet, personal financial health, relationships, hobbies, and preventative medicine (Hlubocky et al., 2016). To facilitate self-care and organizational commitment, medical centers may provide practical solutions to assist with work-life integration such as childcare, exercise facilities, personal coaching and development, and professional growth opportunities such as leadership training. Additionally, physicians experiencing burnout or other stressors should have access to confidential, off-site professional counselors or psychologists endorsed by the healthcare system. In summary, given the prevalence of burnout and its negative impact on organizational objectives and a physician's well-being, it is the organization's imperative to provide resources to assist physicians struggling with burnout and related stressors.

Summary of Physician Burnout

Physician burnout is a global problem and adversely impacts individual physicians, physician's families, healthcare systems, and patients. The COVID-19 pandemic has compounded this phenomenon, placing physicians and other medical professionals at enhanced risk of succumbing to burnout. Drivers of the phenomenon exist primarily in many healthcare systems and processes; however,

physicians also play a significant role in burnout prevention and reduction. Based on the significant negative impact of burnout, organized healthcare systems and physicians each have a vested interest in addressing the challenge and mutually committing to discovering and implementing solutions.

The Impact of Burnout on Law Enforcement Officers

Due to the essential nature of police work for community safety, well-being, and stability, job-related burnout and its effects on law enforcement officers is a significant concern for police administrators, government authorities, community leaders, researchers, and the general public (McCarty et al., 2019). Historically, law enforcement has consistently ranked among the most stressful occupations worldwide, and research indicated that the stress of the profession could negatively impact an officers' mental, emotional, and physical health, adversely impacting their job performance and well-being (Dantzer, 1987; Queirós et al., 2020). A nationwide, multidepartmental study in the United States by Lilly and Curry (2020) discovered that 47% of officers screened positive for PTSD, a negative mental health factor closely associated with burnout; the results are nine to 10 times greater than the prevalence of PTSD in the general population. A nationwide study of over 13,000 officers representing 89 departments found that on average, most officers scored 3.40 on the emotional exhaustion scale, placing them at significant risk of burnout, with 19% of the officers scoring in the severe burnout range (McCarty et al., 2019). The study also showed that most officers have become callous and emotionally hardened (2.84), indicating depersonalization as a significant indicator of burnout. Police work necessitates that officers face unique strain and stressors due to the inherent danger of their role in dealing with frequent externally generated peril and trauma and internal challenges related to the law enforcement system's organizational and administrative composition (Gershon et al., 2009; Miller, 2015; Shane, 2010). In summary, the stressful environment that law enforcement officers experience creates an atmosphere that facilitates burnout and reduces officer well-being and effectiveness, potentially leading to burnout.

In 2020, law enforcement officers experienced a dramatic shift in public perception. Initially, the public celebrated officers alongside other helping

professionals risking their lives during the COVID-19 pandemic (Lilly & Curry, 2020). Following the death of George Floyd, public perception shifted, and officers experienced increased verbal, psychological, and, at times, physical assaults. Additionally, public calls for defunding the police in conjunction with pressure for radical law enforcement reform exacerbated the pandemic's adverse effects, compounding the pressure on the individual officer to perform their duties under increased public scrutiny, distrust, and hostility. A study generated prior to the pandemic by De Lucca (2017) discovered that officers faced many professional challenges, including higher performance standards, expanded crime prevention, and enhanced community engagement, which cumulatively strained officers' emotional, physical, and mental well-being, potentially leading to burnout. Lilly and Curry (2020) noted that the increased stress and strain placed on law enforcement officers facilitated a "dramatic increase in retirement filings, as officers who can leave the profession are now exiting in droves, leaving more work for fewer officers" (p. 2). In summary, law enforcement officers faced significant external and internal pressures before the COVID-19 pandemic; however, the current anti-police environment coupled with the ongoing COVID-19 contagion amplified officer stressors facilitating burnout, decreased productivity, and intention to leave the profession.

The Causes of Burnout Among Law Enforcement Officers

Law enforcement is an inherently stressful career, with officers facing trauma and stressors based on their interactions externally with the general public and internally from their departments and administrative systems (Violanti & Paton, 1999). Most officers recognize that exposure to trauma and the associated stress is an unavoidable occupational hazard (Tuckey & Scott, 2014). The accumulation of ongoing stress and trauma factors merge and contribute to burnout, decreased productivity, and diminished well-being among law enforcement officers. Significant critical factors impacting officer burnout include trauma, workload imbalance, work-life conflict, personality dimensions, and administration challenges.

Trauma. The American Psychiatric Association (2013) has defined trauma as an event involving actual or threatened death or serious injury or a threat to the physical integrity of self or others. Kilpatrick et al. (2013) discovered that trauma had a cumulative effect, and as trauma exposure increased, the risk for adverse mental health outcomes increased substantially. Kohan and Mazmanian (2003) claimed that the cumulative effects of dealing with negative experiences and traumatic events throughout a police officer's career could increase the risk of burnout. Lilly and Curry (2020) posited that the significant increase in trauma and stress associated with the COVID-19 pandemic blended with the socio-political and anti-police environment facilitated the rise in mental health challenges among law enforcement officers. On average, Patterson (2001) discovered that law enforcement officers experienced more than three traumatic events for every 6 months of service. In a similar study, Hartley et al. (2013) found that most officers experienced multiple types of trauma within 12 months. Therefore, increased exposure to trauma raises the risk of burnout and adverse mental health outcomes for law enforcement officers.

A study of Israeli police officers linked the frequency of stress and trauma to burnout. The results indicated that 64% of the officers experienced a high frequency of traumatic events primarily related to terrorism, relatively high burnout scores (*SD* = 1.43), and high levels of job satisfaction (*SD* = .85; Malach-Pines & Keinan, 2006). The researchers posited that officers' high levels of job satisfaction linked directly to the officer's sense that their work was important and made a difference to the public's safety; however, officer burnout in the study correlated significantly with job dissatisfaction and a desire to leave the force. Officers in the study (76%) felt that they did not have adequate training for handling stress. Therefore, officers may experience high levels of job satisfaction in performing their functions; however, if left unmanaged, burnout-related symptoms initiated by trauma and stress can lead to officer dissatisfaction and intent to leave police work.

In addition to negatively impacting an officer's mental health, trauma can also affect a police officer's motivation and job performance. Violanti and Paton (1999) discovered that officers experiencing traumatic occurrences over time risked

burnout, increased cynicism, and negative interactions with the general public, adversely impacting their motivation to "live up to their ideals…to protect and serve" (p. 62). Therefore, the frequency and cumulative effects of trauma and stressors experienced by law enforcement officers increase adverse mental health outcomes, facilitate burnout, and reduce motivation.

While facing threats to themselves, officers may also encounter trauma as they care for victims injured or affected by accidents or criminal activity. This type of trauma, described as secondary trauma, compassion fatigue, or vicarious trauma, occurs when an emotional connection to a traumatized individual exists and the primary trauma sufferer passes their symptoms onto another (the carer; Figley, 2013). Foley and Massey (2020) discovered that repeated exposure to secondary trauma is related to and interchanges with burnout, secondary stress, and potentially officer suicide. Further, some types of trauma experienced by officers, mainly when dealing with sexual assault, child homicide, or child abuse, increased the likelihood of experiencing secondary trauma. Therefore, officers risk developing secondary trauma when caring for trauma victims, leading to long-term adverse mental health outcomes and burnout.

Workload Imbalance and Work-Life Conflict. The mission of law enforcement to protect and serve the citizenry and maintain order require constant awareness and involvement, potentially creating workload imbalance for police officers. Additionally, the outbreak of the COVID-19 virus and the accompanying civil unrest introduced additional stress to an already stressful occupation, exacerbating the possibility of workload imbalance and work-life conflict in law enforcement officers (Ahmad et al., 2019). Netemeyer et al. (1996) defined the imbalance of workload and work-family conflict as "a form of inter-role conflict in which the general demands of time devoted to, and strain created by the job interfere with performing family-related responsibilities" (p. 40). Griffin and Sun (2018) found that work-family conflict positively related to burnout and stress among law enforcement officers and their families. Ilies et al. (2007) discovered a direct correlation between daily workload and work-family conflict. Therefore,

workload imbalance can instigate work-family conflict, negatively impacting officer well-being and performance, leading to burnout.

Griffin and Sun (2018) discovered a significant correlation between work assignment and work-family conflict in a cross-sectional study of police officers in a mid-Atlantic department located in the United States. The majority of the sample was male (87%), between the ages of 31 and 45 years old (68.8%), had a rank of corporal or below (73.9%), had a bachelor's degree or above (76.8%), and worked in the patrol division (54.3%). Patrol assignment, education, and race impacted officer stress and burnout in the study. Non-White, better-educated officers and those assigned to patrol duty experienced less stress than Caucasian, less educated, and non-patrol-assigned officers. Further, work-family conflict positively associated with stress, while resiliency reduced stress in the study group. Therefore, duty assignment and education are positively associated with stress and work-family conflict. In summary, understanding the relationship and mediating effect of duty assignments on work-family conflict and resilience could directly inform law enforcement leaders about reducing officer stress, burnout, and work-family conflict while cultivating resiliency.

Sadiq (2020) found a direct correlation between workload and work-family conflict. This scholar found that workload is positively related to work-family conflict ($r = .62$, $p < .01$), job stress ($r = .53$, $p < .01$), and job dissatisfaction ($r = .48$, $p < .01$). Further, the study found that work-family conflict had a significant impact on job stress ($CR = 3.958$, $p <. 01$) and correlated with job dissatisfaction ($CR = 3.931$, $p < .01$). Additionally, the researcher observed that workload imbalance drained officers' emotions, energy, and time, leaving them unlikely to fulfill their family roles. Therefore, as officers' workload increased, their work-life conflict escalated, job-related stress increased, and job satisfaction decreased.

Personality Dimensions. Researchers have indicated a strong link between personality characteristics and burnout, with some profiles providing resilience and others being susceptible to the phenomenon (Louw, 2014). Morris and Maisto (2012) suggested that personality includes an individual's behavior, thought patterns, and feelings which persist over time and across situations. Researchers

typically classify personality traits into a system grouped by characteristics and dynamic processes that impact how individuals operate socially and, in the workplace, (Gatewood et al., 2015). Goldberg (1990,1992) identified five broad personality dimensions as the five-factor model: introversion versus extraversion; antagonism versus agreeableness; lack of direction versus conscientiousness; emotional stability versus neuroticism; and closedness versus openness to new experiences. In additional studies, researchers discovered an impact between personality dimensions, social support, and burnout (O'Connell et al., 2008; Van Yperen & Hagedoorn, 2003). A study by Baruch-Feldman et al. (2002) found that emotional and social support from family members positively associated with reduced burnout among law enforcement officers. Therefore, personality dimensions and social support positively correlated with either an increase or reduction in burnout among police officers.

Louw (2014) conducted a quantitative, cross-sectional survey of South African police officers to measure the impact of personality dimensions and social support on burnout. The data analysis revealed that neuroticism is consistently related to all three burnout dimensions (Louw, 2014). Costa and McCrae (2008) posited that individuals with neurotic tendencies experience negative affectivity and expect the worst from situations. Additionally, neurotic individuals tend to underestimate self-performance. Further, neuroticism positively correlated with physical fatigue, emotional exhaustion, and cognitive weariness. Additional findings revealed that neuroticism negatively correlated with perceived social support, including friends, family, and significant others in the test group (Louw, 2014). Finally, Louw confirmed that neuroticism is positively related to all dimensions of burnout among law enforcement officers. Therefore, officers with neurotic tendencies are at increased risk of burnout due to the frequency and variety of stressors in the law enforcement profession.

Conversely, extraversion was negatively related to cognitive weariness and produced no statistically significant relationships with physical fatigue or exhaustion (Louw, 2014). Extraverts in the study showed a significant positive relationship with family, friends, and significant others. Further, extroverts showed

a predisposition to sociability and tended to anticipate experiencing positive emotions more often than other personality types. Individuals who scored high on extraversion tended to engage in social activities more often and tended to ask for help when seeking difficulties strengthening them against burnout. Individuals exhibiting personality traits such as openness to experiences, agreeableness, emotional stability, and conscientiousness are less prone to burnout (Larsen et al., 2005). Therefore, personality dimensions such as extraversion, conscientiousness, openness, agreeableness, and emotional stability foster resiliency and healthy relationships, protecting against burnout. Conversely, officers with neurotic tendencies are more susceptible to burnout, hindering personal well-being and productivity.

Administration. Police officers experience stress from life-threatening events, but such events are rare (Hickman et al., 2011). In contrast, law enforcement officers face significant and consistent organizational pressure throughout their careers and often daily (Morash et al., 2006). Many researchers have posited that organizational stressors affect law enforcement officers more strongly than inherent stressors, potentially leading to burnout and decreased job performance (Violanti & Paton, 1999). Shane (2010) posited that common organizational factors deserved equal—if not more—attention than environmental concerns when evaluating problematic behaviors among law enforcement officers. Blau (1985) found that law enforcement agencies' organizational and administrative structures predisposed supervisors and managers to be somewhat insensitive to the stresses endured by patrol officers. Kalliath and Kalliath (2015) suggested that job stress and job dissatisfaction are the most common causes of employees' negative perceptions of the workplace. Additional studies determined that burnout, job stress, and job dissatisfaction positively correlated to turnover intention among workers (Harrison et al., 2006; Nisar & Rasheed, 2020). McCarty et al. (2019) discovered that officers who supported the organizational leadership and the department's strategic direction experienced less dissatisfaction and reduced their risk of burnout. In summary, organizational stressors contributed to officer stress

and how the management team responds can facilitate or decrease burnout, influencing an officer's intent to leave the organization.

Adding to the rule-intensive nature of police work, state and federal laws work in conjunction with city and agency rules to circumscribe officer behavior, thus exacerbating officer stress (Bishopp et al., 2018). While performing their duties, police officers operate under significant scrutiny for their actions and their adherence to policies and procedures by law enforcement administration, the public, and the media (Brown, 2016). Wolfe and Nix (2016) posited that continuous media exposure and coverage of law enforcement incidents worsened police officer's perception to the general public, exacerbating the stressors already experienced by those working in policing. Therefore, officers face significant stress due to their necessary adherence to administrative policies while under increased organizational and public scrutiny.

Johnson et al. (2005) compared the stress-related outcomes of policing to 26 other occupations finding that, on average, police officers scored among the lowest on measures of physical health, mental well-being, and job satisfaction. A consistent theme associated with the lowest scoring occupations in the study was the requirement for in-person or verbal interaction with clients or victims requiring strict adherence to organizational policies and procedures, thereby increasing employee stress. In summary, police officers face significant stressors within their organizational structures to adhere to policies and procedures, exacerbating burnout, decreasing officer well-being, and facilitating job dissatisfaction.

The Effects of Burnout on Law Enforcement Officers

Mental Health Challenges. According to Kilpatrick et al. (2013), upwards of 89.7% of the general population will encounter a traumatic event in their lifetime; however, only 8.3% of those exposed to trauma develop PTSD. According to Patterson (2001), law enforcement officers experienced more than three traumatic events every 6 months of service, placing them at increased risk for developing mental health challenges such as PTSD or depression. Researchers studying PTSD and depression among active law enforcement officers have suggested that between 19% and 35% of those analyzed showed symptoms of

mental health challenges (Heyman et al., 2018; Yuan et al., 2011). A study in Great Britain on the mental health of police officers by Houdmont and Elliot-Davies (2016) discovered that 80% of the respondents indicated high levels of stress and poor mental health, with 92% of the respondents citing their workplace intensifying the issues. Further, among all of England's public health services, law enforcement registered the highest levels of mental health problems. Berger et al. (2012) discovered that repeated exposure to trauma placed officers at higher risk for suicide than the general population. Therefore, the typical challenges of police work, combined with the anti-police climate and the COVID-19 pandemic, facilitate an environment that places officers at significant risk for developing mental health challenges.

A national study of active-duty police officers in the United States measured their mental health during the COVID-19 pandemic and the existent socio-political environment (Lilly & Curry, 2020). Participants identified as 84% male, 85% White, and had an average length of service of 16 years (Lilly & Curry, 2020). Participants worked in diverse geographic settings with 44% urban, 42% suburban, and 14% rural. The findings of the study measured mental health functioning experienced by respondents within the past month and included the following:

- 47% of the sample screened positive for PTSD using the Primary Care PTSD Screen for the DSM-5, a measure developed by the National Center for PTSD. The findings are nine to 10 times greater than the prevalence of PTSD in the general population.
- 29% of the sample scored in the moderate to the very severe range for anxiety. The findings show that officers suffered from anxiety two times greater than the general population.
- 37% of the sample scored in the moderate to the very severe range for depression. These findings are approximately five times greater than those found in the general population.
- When grouped by years of service, officers with 5–10 years of service were at greater risk for PTSD and depression when compared with officers with

0–4 years, 11–20 years, or 20+ years of service. Officers with less than 5 years scored significantly and statistically lower than all other groups.

- Officers who consider quitting their job "always" or "often" reported significantly greater symptoms of stress, depression, anxiety, and PTSD.
- 59% of the sample reported feeling trapped or hopeless about their job in law enforcement daily or weekly. Feeling trapped or hopeless about the job is associated with stress, depression, anxiety, and PTSD.
- Female officers reported more significant levels of PTSD and anxiety than their male counterparts (Lilly & Curry, 2020, p. 5).

Trauma-focused researchers have identified betrayal as an emotion frequently implicated in trauma-based reactions (Lilly & Curry, 2020). When individuals feel betrayed by the institutions that they serve, they are at an increased risk for PTSD, suicide, and depression (Smith & Freyd, 2013). Further, when officers feel denigrated or maligned by those they serve, a sense of betrayal and mistrust can be developed, potentially leading to mental health concerns or burnout (Lilly & Curry, 2020).

Suicide is an epidemic among police officers (O'Hara et al., 2013), and hopelessness is a leading predictor of the phenomenon, putting officers at increased risk of taking their lives (Ribeiro et al., 2018). Lilly and Curry (2020) predicted that the rate of officer suicides would increase dramatically due to the stressors placed on law enforcement officers precipitated by the current socio-political crisis and the COVID-19 pandemic. Therefore, the high levels of stress typical of the law enforcement profession combined with the civil and social unrest aimed at police officers and the COVID-19 pandemic combine to form a climate exacerbating officer stress and burnout, leading to increased mental health concerns.

Work Productivity. Duty-related stress and the accompanying mental health challenges associated with law enforcement significantly impacted the work productivity of officers. A nationwide study of law enforcement officers in the United States by Lilly and Curry (2020) measured the impact of duty-related stressors on work performance and work perceptions.

- 63% of the sample reported that recent events impacted their work productivity daily or weekly.
- 59% of the sample reported feeling trapped or hopeless about their job in law enforcement daily or weekly.
- 55% of the sample reported that they consider quitting their job in law enforcement daily or weekly.
- 69% of the sample stated that they would be somewhat unlikely or very unlikely to recommend a job in law enforcement as a career choice. Only 16% reported that they would be somewhat likely or very likely to recommend a job in law enforcement.
- 38% of the sample reported that their department does not provide adequate mental health services, with an additional 8% indicating that they would prefer not to respond (Lilly & Curry, 2020, p. 4).

In a national study of U.S. police officers by McCarty et al. (2019), burnout positively correlated with increased work-family conflict and decreased productivity in law enforcement officers. Martinussen et al. (2007) discovered that burnout is positively associated with an officers' intention to quit law enforcement. Therefore, burnout and work-related stressors correlated with decreased productivity and intention to leave among police officers.

Barriers to Assistance

A variety of barriers inhibit officers from seeking or receiving help regarding burnout or other mental health concerns. Johnson (2016) found that while officers understand the need for help, stigma contributed to their unwillingness to seek treatment. Further, officers expressed concern about job demotion, job loss, and loss of trust from supervisors and fellow officers if they sought professional help (McGhee, 2014). Lilly and Curry (2020) discovered that 28% of the officers in their study cited job loss or department repercussions as barriers against seeking assistance. Additionally, being deemed unfit for duty or reassignment contributed to the officer's unwillingness to seek help. Lilly and Curry (2020) discovered that "loss of reputation" among officers and peers was the number one barrier (31%) to

seeking professional help (p. 6). Additionally, 38% of the study reported that their department did not provide adequate mental health services, with an additional 8% refusing to respond to the question. Therefore, significant barriers exist for officers seeking assistance in dealing with burnout and mental health concerns.

Recommended Solutions for Law Enforcement Burnout

Workload Restructuring. McCarty et al. (2019) discovered that the strongest predictor of officer burnout was work overload contributing to work-life conflict. McCarty et al. (2019) found that officers who expressed the most significant difficulty in balancing work and life responsibilities displayed the highest levels of burnout. Paoline (2003) noted that the prevailing police organizational culture promoted heavy officer workloads exacerbating the challenge and requiring organizational restructuring to address the issue. Burger and Nachreiner (2017) examined the effects of flexibility in patrol officers' work schedules to enhance officer performance and wellness, finding that respondents indicated enhanced job satisfaction and improved work-life balance. Rabe-Hemp (2008) recommended incremental workload changes to officers seeking to balance their work and home lives. Reducing occupational stress and trauma by rotating staff to less stressful roles facilitated officer well-being in a study conducted by Foley and Massey (2020). Therefore, providing officers with the ability to adjust their schedules to enhance work-family balance increased officer well-being and provided resilience against burnout.

Communication and Organizational Engagement. Communicating consistently with employees and involving them in organizational direction strongly correlates with burnout prevention. Leiter and Maslach (2009) found that creating organizational values is one of the most robust defenses against burnout. Therefore, building and communicating a shared vision that permeates policies and procedures is a primary consideration for law enforcement leadership (McCarty et al., 2019). Further, providing officers input into policies and procedures and communicating changes in organizational strategy can mitigate feelings of burnout and improve officer well-being and buy-in (Crank, 2010). Rosenbaum and McCarty (2017) discovered that providing officers with a platform to make

suggestions and recommendations to departmental direction and policies reduced burnout, created trust, and fostered job satisfaction. Therefore, law enforcement administrators should encourage officer participation in establishing strategic direction and initiatives to facilitate officer buy-in, decrease burnout, and reinforce their intention to stay with the department.

Emotional Support and Professional Counseling. Griffin and Sun (2018) recommended incorporating policies and programs designed to enhance supervisory support and constructive coping for officers to reduce work and family-related conflicts and improve officer well-being. Family support is consistently and negatively related to reducing all three burnout dimensions; therefore, facilitating family support enhances officer burnout resiliency and well-being (Louw, 2014). Furthermore, family support is positively associated with increased emotional energy and improved cognitive liveliness. Supervisor support from within the department is also critical and forms a buffer against prolonged stressors. In summary, social and peer interaction, combined with family support, facilitated relationships, provided relational support, and enhanced officer resiliency against burnout.

Addressing the mental health concerns of law enforcement officers garner benefits for officers and their departments. Access to mental health counselors can reduce officer turnover, burnout, medical retirements, and decrease disciplinary issues (Christopher et al., 2016; Finn et al., 2000). Additionally, early intervention can lessen treatment costs and speed the recovery of officers experiencing trauma or crisis (Kureczka, 1996). Law enforcement administrators can facilitate an increase in officer mental health by clarifying and systematizing departmental mental health policies and mandating counseling as a tool to bypass officer concerns regarding stigma (Hofer & Savell, 2021). Further, police administrators can facilitate resilience among their officers by creating a culture of positive mental health and providing training, resources, and programs promoting and encouraging wellness and resilience. Finally, law enforcement leaders need to ensure confidential access to professional counseling services trained in the nuances of police work to assist officers in maintaining mental health. Therefore, it is the

responsibility of the law enforcement administration to reduce any stigma associated with mental health improvement and create a culture that encourages officer well-being through positive mental health practices.

According to Lilly and Curry (2020), less than 38% of law enforcement departments provide officers access to mental health services. Additionally, officers may refuse to seek personal or professional assistance due to the stigma associated with seeking professional help exacerbating the risk of burnout and other mental health issues. Therefore, departments should provide mental health services and encourage officers to seek mental health treatment to protect against burnout and improve personal and professional well-being.

Training. Officer training designed to strengthen skills in identifying burnout and related dimensions can improve officer well-being and create resiliency against the phenomenon. Police administrators can facilitate resilience among their officers by providing training, resources, and programs promoting and encouraging wellness and resilience (Hofer & Savell, 2021). Louw (2014) recommended officer training on burnout prevention and identification as a recommended solution to emotional fatigue, a dimension of burnout. Schaufeli and Enzmann (1998) discovered that practical training sessions reduced burnout and improved officer well-being. Therefore, law enforcement officials should consider implementing training programs for their officers to help identify burnout and its dimensions, improving officer productivity, job satisfaction, and intent to stay.

Examining Officer Personality Dimensions. Analyzing personality profiles during the hiring process and throughout an officer's career helps identify potential personality issues that could lead to burnout and other mental health challenges impacting officer productivity and well-being. Specific personality characteristics such as extraversion created resiliency against burnout and other mental health risks (Louw, 2014). Larsen et al. (2005) discovered that individuals exhibiting personality traits such as openness to experiences, agreeableness, emotional stability, and conscientiousness displayed resiliency against burnout and other mental health challenges. Conversely, officers with neurotic tendencies were at higher risk of burnout (Costa & McCrae, 2008). Therefore, individuals scoring

high in neuroticism should perhaps be excluded from high-risk positions due to their inclination towards burnout.

Eastburg et al. (1994) found that extroverts need more work-related peer support than introverts indicating that most personality profiles require a level of support to operate at peak proficiency. Therefore, while some personality dimensions increased resiliency against burnout, each personality type required support to bolster against the phenomenon. In summary, personality dimensions provided insight into officers' psychological and emotional resiliency, enhancing law enforcement administrators' awareness of individual officer suitability for police work and resiliency against burnout and other mental health challenges.

Summary of Law Enforcement Burnout

Law enforcement officers face a myriad of challenges to their physical, emotional, and mental health in their mission to provide public safety and security for their communities. Law enforcement is a dangerous profession and an inherently stressful career. Officers face trauma and stressors based on their interactions externally with the general public and internally from their departments and administrative systems (Violanti & Paton, 1999). The challenges to law enforcement officers to meet higher standards of transparency, accountability, and effectiveness while dealing with the adverse effects of the COVID-19 pandemic, calls for national police reform, and increased violence against officers created additional stressors to an already stressful profession. Burnout and the accompanying side effects created by trauma and stress reduce officer health, effectiveness, and overall well-being, placing them, their families, and the communities they serve at risk.

Further, burnout is positively associated with an officers' intentions to quit law enforcement (Martinussen et al., 2007). It is impossible to remove stress and trauma from police work; however, organizations are responsible for supporting law enforcement officers doing this challenging work (Foley & Massey, 2020). Therefore, law enforcement administrators should promote officer well-being by reducing controllable stressors and providing officers with resources, education,

and opportunities to increase personal well-being, thereby improving job performance, reducing intention to leave, and lessening burnout.

The Impact of Burnout on Clergy

Burnout among clergy is a significant problem with widespread implications for ministers, their families, congregations, and the community. Researchers have indicated that being a part of a faith-based community can be a protective component for psychological health following a disaster or crisis (Milstein, 2019). According to Muse et al. (2016), clergy burnout and stress have garnered growing attention from researchers. The clergy serve an essential role in contributing to the welfare of their congregants and the communities they serve. The COVID-19 crisis and its impact on helping professionals, a resurgence in racism and hostile rhetoric, the anti-police movement, and political instability created significant stressors for ministers and other helping professionals. The culmination of these sustained incidents drastically impacts ministers as they seek to deal with the trauma of those they serve while processing their emotional and psychological challenges within the events (Greene et al., 2020). According to Visker et al. (2017), clergy members fulfill spiritual responsibilities for their congregations. They frequently function in other capacities to serve the general public's well-being, placing them at increased risk of burnout. Additionally, researchers have shown that stress-related burnout is prevalent in other-focused industries such as pastoral ministry (Diaconescu, 2015; Hendron et al., 2014). Therefore, burnout and related stressors pose a significant threat to the well-being and productivity of clergy.

In previous studies on clergy burnout, scholars have noted the tendency of ministers to face work overload, suffer from emotional isolation, and neglect self-care exacerbating the phenomenon (Jackson-Jordan, 2013). A Duke University study linked burnout and frustration to clergy leaving the ministry, with 20% of respondents referencing the phenomenon as the main factor in their departure (Hoge & Wenger, 2003). Visker et al. (2017) conducted a study on Assemblies of God ministers, finding that 65% of the participants were either suffering from burnout or on the verge of burnout. Francis et al. (2008) found that clergy (60%)

rated job satisfaction high yet also found that a significant number (40%) of the participants indicated being depressed most of the time and (40%) indicated a desire to leave the ministry as a profession.

A study conducted by Duke University showed that 85% of seminary students leave their initial pastoral roles within 5 years (Barton, 2015; Kanipe, 2007). Up to 90% do not stay in the ministry long enough to retire as ministers. Significantly, researchers have indicated that the number of pastors leaving ministry would potentially be higher if ministers felt they had opportunities for jobs outside of the church (Sherman, 2014). In summary, burnout negatively affects a minister's ability to serve their congregations and community effectively and contributes to early departure from their roles.

Contributors to Clergy Burnout

Various issues contribute to burnout among clergy members, with most of the triggers divided into two main categories: external and internal factors. External factors included occupational or organizational demands and job-specific stressors (Fee, 2018). Internal factors identified personality traits and characteristics that contributed to or protected from burnout. Early research by Malony (1988) examined the role of stress in the clergy who experienced burnout primarily due to role ambiguity, role overload, and significant responsibilities. As interest in clergy burnout has expanded, researchers discovered similarities with the phenomenon comparable with other professions (Fee, 2018). Four distinct external aspects surfaced related to clergy burnout: role ambiguity, role conflict, work-family conflict, and personal conflict.

External Factors: Role Ambiguity. The clergy's job expectations are diverse and include leadership functions that involve constant engagement with others (Adams et al., 2017). Milstein et al. (2005) divided ministerial responsibilities into six main categories: (a) preacher, (b) deliverer of rituals and sacraments, (c) pastor, (d) teacher, (e) organizer, and (f) administrator. Significantly, of the people in the United States seeking help for a severe mental condition, one fourth approach their clergy person before seeking outside support, adding additional responsibility to the minister’s role (Wang et al., 2003).

Therefore, providing pastoral care to congregants can be a vitally important function for ministers adding additional responsibilities to their workload (Adams et al., 2017).

Role ambiguity occurs when workers lack the necessary information to understand the specific role they are to perform (Ghorpade et al., 2011). Hoge et al. (1993) described role ambiguity as a lack of daily structure, uncertainty about authority, unclear goals and objectives, and uncertainty about others' expectations. Due to the diversity of their various roles, ministers frequently transition between responsibilities, sometimes many times a day, resulting in potential role overload, which can facilitate burnout (DeShon, 2012). According to Hang-Yue et al. (2005), because the role of a minister is often limitless and unclear, it is consequently beset with role ambiguity. Further, because there are no clear standards for defining effective or exceptional pastoral work, gauging ministry success is problematic (Fee, 2018).

In a study of clergy by Faucett et al. (2013), the researchers discovered that role ambiguity and role conflict explained 41.7% of the variance in overall ministry job satisfaction. Findings attributed role ambiguity to 20.9% of the variance. Additionally, role ambiguity accounted for a 22.6% variance concerning intrinsic job satisfaction for clergy. Conversely, when role ambiguity and the stress associated with the phenomenon decreased, clergy job satisfaction increased. Therefore, reducing role ambiguity decreases the stressors contributing to burnout and increases ministers' job satisfaction.

Role ambiguity for clergy can have positive effects given the right circumstances. According to Kemery (2006), role ambiguity accords ministers the decision latitude necessary to address unexpected occurrences (e.g., creative ministry approaches, counseling, illness, and accident visitation) and encourages and nurtures innovative ministry methods to pursue their ministry calling. When conflicts arose within the church, role ambiguity resulted in decreased ministerial satisfaction. Therefore, role ambiguity can foster creative problem solving, increasing role satisfaction for some clergy; however, the phenomenon typically leads to burnout and decreases job satisfaction.

External Factors: Role Conflict. Katz and Kahn (1978) defined role conflict as "the simultaneous occurrence of two or more role expectations such that compliance with one would make compliance with the other more difficult" (p. 204). Clergy can be particularly susceptible to the stresses of role conflict due to the frequently conflicting expectations of their congregations, denominational superiors, and family members while attempting to consistently follow their ministry calling (Faucett et al., 2013). Stewart (2003) summarized the complexity and conflict of the pastoral role as follows:

> No other profession demands competency in such a variety of roles as the ordained ministry. Ministers are expected to be administrators, spiritual advisors, caregivers, healers, preachers, teachers, conflict negotiators, arbiters, lawyers, biblical scholars, church and denominational historians, visionaries, fathers, mothers, sisters, brothers, confidants, psychologists, sociologists, economists, fundraisers, prophets, priests, advocates for social justice, defenders of the poor and oppressed, evangelists, spiritual warriors, truth-tellers, armor bearers, and leaders of workshops, worship services, Bible studies, and church retreats. (p. 79)

In a study on role conflict, Schaefer and Jacobsen (2009) found that role conflicts have significant negative ramifications for clergy and regularly lead to burnout. Church boards often judge clergy by their ability to support and maintain the organization's financial needs and increase membership. In this role, the clergy operate as business leaders. Simultaneously, they are expected to take solid moral positions and make decisions that may alienate influential members or cause consternation, potentially negatively impacting the church's finances, member retention, and creating role conflict. Therefore, when clergy feel pressure to make decisions that conflict with their integrity, they may experience work-related stress, leading to burnout.

The strategies that clergy use to lead their congregations can impact the amount of role conflict they encounter. Kemery (2006) noted three different general strategic models that pastors use to influence their members: charismatic strategies, traditional authoritative models, and legal-rational authority. Charismatic strategies

derive their power from the notion that clergy receive their authority and calling from God. Manifestations of this strategy include "demonstrating the gift of God's grace and showing people good nature and sincerity" (Kemery, 2006, p. 567). The "traditional authority" model comes from the position held by the minister manifested by conducting religious services appropriately and officiating marriages, funerals, and baptisms. The third model is the legal-rational authority, which involves planning and goal setting and implementing church programs. Falbo et al. (1989) proposed that charismatic authority is at the top of the hierarchy of ministerial influence strategies. Kemery (2006) determined that role conflict can occur when clergy deal with administrative or congregational issues with little training or experience. Therefore, when clergy experience role conflict for which they have little training or is outside of their preferred model of congregational influence, burnout can increase, leading to lower job satisfaction and decreased productivity.

External Factors: Work-Family Conflict. Work-family conflict occurs when a profession's roles seem discordant or incongruent with the roles of family life (Fee, 2018). According to Hang-Yue et al. (2005), work-family conflict among clergy families surfaces when one role conflicts with participation in another role. Further, a popular cultural trend is a traditional notion that to be a "true" priest or rabbi, you must "give your entire life" to others (Schaefer & Jacobsen, 2009, p. 40). "This way of thinking and living—residually operative in the minds of many clergy and congregants—can become arduous for clergy and their families who put themselves last and their congregations first" (Schaefer & Jacobsen, 2009, p. 40). A cross-denominational Duke University study by Hoge and Wenger (2003) found that 9% of the surveyed ministers who exited church pastoral ministry left due to family issues correlating to work-family conflict. Therefore, work-family conflict is a significant challenge for clergy and can lead to burnout and leaving ministry.

Wells et al. (2012) measured clergy members' cross-denominationally and observed that work-family conflict occurred due to two stressors: work-related stress and boundary-related stress. Work-related stress in the study comprised and measured stresses related to conflict, criticism, role ambiguity, critical members,

congregational challenges, and staff relations issues. Boundary-related stress measured congregational demands, experienced isolation, problems having private time, and difficulty having time for recreation. Their findings showed that clergy with children indicated higher levels of work stress (2.89) and boundary stress (3.29) than those without children (2.76). Further, married clergy reported higher levels of boundary stress (3.28) but lower levels of work stress (2.79) than unmarried clergy (3.09 and 2.94). A strong correlation and association between boundary stress and organization stress existed in the study. As work stress increased, boundary stress increased, the relationship remained strong, even when personal characteristics and other variables were introduced. Therefore, there is a correlation between work-related stress and boundary-related stress, both factors in clergy burnout and work-family conflict.

A contributing factor to work-family conflict and burnout among the clergy was the substantial volume of work described as role overload. Berry et al. (2012) showed that the constant pressure from everyday pastoral responsibilities that never seem to find completion significantly contributed to role overload, leading to burnout. Many pastors remain available at a moment's notice to deal with emotional trauma or a personal crisis among congregants and the community, which facilitated burnout and exacerbated stress contributing to work-family conflict (Hendron et al., 2012). Stewart (2003) argued that congregations typically expect their pastors to always be on call, exacting a heavy toll on their time and energy. This prolonged stress can significantly impact a clergy's family, in that children can also experience burnout-related symptoms similar to their parent's (Salmela-Aro et al., 2011). Therefore, role overload among clergy is related to increased stress and burnout, facilitating work-family conflict and leading to potential burnout among clergy and their family members.

External Factors: Personal Conflict. Personal conflict occurs for various reasons in the life of a minister. It can be a significant source of stress and frustration, potentially leading to burnout, job dissatisfaction, and a departure from pastoral ministry. Moore (2014) found that conflict occurs in all relationships; however, leaders are expected to develop procedures and processes to create

positive approaches to problems and change structure to reduce conflict among partners and participants. Breen and Matusitz (2012) found that conflict in a church can derive from many sources and can be caused by significant events, social differences, spiritual reasons, and interpersonal conflict within the organization. Significantly, according to Earls (2020), the conflict and disunity created in church congregations by the enormous effect of the COVID-19 pandemic was the top concern for pastors during the crisis. Therefore, personal conflict and its associated stressors are significant sources of burnout for ministers.

In a cross-denominational study for Duke University, Hoge and Wenger (2003) identified six common factors among pastors who left their churches. Of the six factors, 50% related to some dispute, including disagreements with denominational officials, disputes with church members, and doctrinal conflicts over specific issues. Significantly, of the six common factors, conflict was the most prominent reason ministers left their church. The third most common issue for ministry departure was minister burnout, discouragement, stress, or being overworked. Therefore, ministers experiencing persistent conflict risk burnout, job dissatisfaction, and potential departure from pastoral ministry.

Interpersonal conflicts with parishioners are a significant source of conflict stress for clergy. Jinkins (2002) found that clergy regularly experience conflicts with church members over congregational procedures, rules, and ministry goals. Additionally, interpersonal conflicts arose between the pastor and congregants due to gossip, lies, betrayals of trust, harmful comments, or subversive behavior from church members. The pastors in the study reported that due to the excessive amount of time and energy allocated to conflict resolution, they were exhausted physically and emotionally, lacked enthusiasm, became frustrated, felt trapped, and felt less love for their congregants. Therefore, personal conflict experienced by clergy can lead to a reduction in personal satisfaction, pastoral care, lessened compassion for congregants, and burnout.

Internal Factors: Personality Considerations. Although various external factors contributed to clergy burnout, increasing interest in personality traits as predictors of burnout gained the attention of researchers (Bakker et al., 2006).

Findings have indicated that some ministers thrive when confronted with situational considerations and working conditions while others burn out, leading researchers to consider personality factors as indicators of burnout resilience (Joseph et al., 2011). Jung's definitive model of psychological personality type has been developed and operationalized through a set of psychometric instruments, including the Myers-Briggs Type Indicator (Myers et al., 1985), the Keirsey Temperament Sorter (Keirsey & Bates, 1984), and the Francis Psychological Type Scales (Francis, 2005). Building on that personality research, Barnard and Curry (2012) examined the internal impact of personality dimensions on burnout, categorizing four aspects of a minister's personality in the study, including their desire to please others, guilt or shame proneness, self-compassion, and differentiation of self from the role.

A minister's desire to please others manifests in fear of letting parishioners down or not living up to their expectations (Barnard & Curry, 2012). Guilt or shame proneness manifests in each of the distinct emotions as a measurement to which a person construes their behavior as bad (i.e., guilt) or themselves as bad (i.e., shame). Self-compassion arises from Eastern philosophical thought and comprises three main components (Neff, 2003); offering kindness, patience, and understanding to oneself, recognition that others experience similar pain and feel connectedness instead of isolation, and neither ignore nor ruminate on their shortcomings. Clergy who can differentiate who they are and what they value apart from their role tend to experience decreased levels of burnout (Beebe, 2007).

Barnard and Curry (2012) found that clergy who were higher in self-compassion experienced more significant satisfaction in ministry and lower levels of emotional exhaustion in ministry. Further, these researchers found that lower shame, higher self-compassion, and higher differentiation of self from role were significantly associated with more satisfaction and less emotional exhaustion. Additionally, a higher desire to please significantly correlated with higher emotional exhaustion. Results indicated that clergy exhibited high levels of satisfaction and high levels of emotional exhaustion simultaneously, with 15%–20% expressing fatigue, lack of enthusiasm, and irritation as part of their daily

experience. Therefore, while many ministers express great personal satisfaction in their roles, they simultaneously function with burnout symptoms. In summary, developing positive personality dimensions such as self-compassion can reduce burnout symptoms and increase job satisfaction in the clergy.

In the years following Sanford's (1992) groundbreaking clergy burnout research, scholars and researchers have examined other personality and institutional factors that correlate with and help predict burnout among ministers. Negative correlates such as extraversion (Francis et al., 2008), spiritual exercises such as prayer (Turton & Francis, 2007), applying a collaborative conflict management style (Beebe, 2007), and utilizing mentors (Doolittle, 2010) provided a defense against burnout. Positive correlates to burnout included neuroticism (Hills et al., 2004), psychoticism, openness to change one's beliefs (Miner, 2007), and dissatisfaction with spiritual life (Doolittle, 2010). The personality profiles are organized primarily in two orientations (extrovert and introvert), two perceiving processes (sensory and intuition), two judging processes (thinking and feeling), and two approaches toward the outer world (judging and perceiving; Fee, 2018). While some personality traits such as extraversion may be challenging to change, changes in personal characteristics or practices could lead to greater clergy resilience against burnout and its effects.

Miner et al. (2010) examined the association between ministers and burnout using the basic orientations of internal motivation and external motivation. The researchers developed a three-dimensional factor structure including a sense of spiritual relatedness, a sense of ministry competence based on training and skills, and a perceived capacity to function in ministry without direct congregational support, indicative of personal autonomy. Researchers have indicated that internally motivated ministers exhibited personal qualities and skills as sources of ministry legitimation. In contrast, externally oriented ministers relied on congregational support and encouragement for legitimation. There is evidence of a partially mediated role of burnout on ministry satisfaction evident for autonomy but directly impacted spiritual relatedness and competence. Therefore, directly and indirectly, higher levels of internality render clergy less vulnerable to burnout.

Additionally, scholars have reported that the internal dimensions of autonomy and spiritual relatedness protected clergy from burnout. Autonomy is also related to lower emotional exhaustion and depersonalization and higher levels of personal accomplishment, further protecting ministers from burnout. In summary, the three internal dimensions of internal orientation directly or indirectly led to greater ministry satisfaction and reduced burnout.

Joseph et al. (2011) examined the impact of the Big Five personality characteristics on burnout and engagement among the clergy. These traits include extraversion, agreeableness, openness, conscientiousness, and neuroticism (Costa & McCrae, 2008). The results indicated a positive association with neuroticism and burnout and a negative association with engagement, complementing findings from previous research studies (Joseph et al., 2011). The clergy who scored lower on neuroticism tended to be calm, emotionally balanced, and free from persistent negative feelings. Finally, those with neurotic characteristics in their life and ministry tended to burn out. Therefore, analyzing a minister's personality can provide insight into how they may react to stressors that contribute to burnout.

In contrast, ministers who scored high in extraversion were negatively associated with burnout and indicated a positive association with engagement (Joseph et al., 2011). Agreeableness is negatively associated with the two burnout dimensions of emotional exhaustion and depersonalization. Conscientiousness was negatively associated with burnout in the clergy, who did not plan well, organize, or systematically operate their church. The findings of Joseph et al. indicated that the personality characteristics of ministers play a significant role in their ability to be effective in their ministry calling and avoid burnout. Therefore, ministers scoring high on neuroticism and low on extraversion, agreeableness, and conscientiousness may need assistance and training to offset the impact of their personality limitations.

In summary, internal factors play a significant role in a minister's ability to reduce or enhance the effects of burnout. According to Hills et al. (2004), internal or personal factors may significantly impact burnout more than external factors. Therefore, analyzing ministers' personality profiles and characteristics and

providing training and resources to augment or offset their backgrounds can enhance their ability to resist or reduce the harmful effects of burnout and increase job satisfaction.

Internal Factors: Age. Researchers have indicated that clergy age and burnout shared a significant negative correlation in the burnout dimensions of emotional exhaustion and depersonalization (Randall, 2007). Additionally, the findings of a study of clergy in the United Kingdom revealed that chronological age correlated with maturation and made a person less prone to burnout. Francis et al. (2013) found that older clergy showed higher levels of satisfaction and lowered emotional exhaustion compared to their younger counterparts. Muse et al. (2016) observed that younger clergy tend to exert large amounts of time and energy to solve people's problems while neglecting their self-care, contributing to burnout and compassion fatigue. Therefore, the chronologically younger an individual is, the more likely they are prone to burnout (Randall, 2007). The highest scores for emotional exhaustion and depersonalization occurred for clergy in their forties.

Randall (2007) discovered that ministers under 50 had a more diminished sense of personal accomplishment than those over 50 years old; however, there was not a proneness to burnout symptoms in those older than 50. Therefore, when chronologically younger candidates enter the ministry, individual-centered and organizational-centered solutions, including mentorship and supervision, can assist in burnout prevention.

Hybels et al. (2020) conducted a 66-month longitudinal study of clergy measuring burnout, depressive symptoms, and anxiety among the test group. Their findings indicated that the older participants scored lower on depressive symptoms, anxiety, emotional exhaustion, and depersonalization but scored higher than younger adults in personal accomplishment. Additionally, depersonalization scores decreased over time among those 55 years and older but increased among those 54 years and younger. Therefore, older adult clergy may have higher levels of resilience, display better work-life balance, and engage in behaviors that increase spiritual well-being and decrease burnout compared to younger clergy.

Internal Factors: Spiritual Formation and Spiritual Disciplines. When challenged with extreme difficulty or stress, clergy often find strength and purpose through connecting with a higher power through spiritual disciplines and spiritual formation. Spiritual formation created by spiritual disciplines is vital to minister burnout prevention, effectiveness, and well-being (Gemignani, 2002; Nelson, 2012). Meek et al. (2003) found that the development of spiritual disciplines is one of the critical components necessary to maintain resiliency in pastoral work. According to McNeal (2011), spiritual formation is the foundation of a pastor's personal and professional success. In the Christian tradition, spiritual disciplines that lead to spiritual formation include prayer, fasting, solitude, reading Scripture, and journaling (Meek et al., 2003). Therefore, experiencing the love of God through life patterns and practices enhances spiritual formation, creating a connection with God's transformative work that provides clergy with a protective barrier against burnout.

In a study of Christian ministers in the United States, Meek et al. (2003) found that 66% of the respondents, identified as exemplars of clergy health and learning, practiced spiritual disciplines to maintain spiritual health, combat stress, and increase personal effectiveness. While analyzing spiritual disciplines, "psychologists have unfairly maligned these Christian beliefs in years past, but they now appear to be a growing recognition that these beliefs can be healthy" (Meek et al., 2003, para. 30). Additionally, pastors practicing spiritual disciplines tended to trust in the character and provision of God rather than their self-efficacy, thereby acknowledging their weakness in dealing with difficult situations and transferring their reliance on God and His capability to guide their actions. Further, through the application of spiritual disciplines, the exemplars in the study became keenly aware of their weaknesses and limitations but more confident in the power and provision of God to fulfill their responsibilities. This awareness allowed them to transfer anxiety to a higher power, thereby reducing their stress. In summary, ministers practicing spiritual formation through spiritual disciplines tend to be less stressed and more resilient to burnout and its dimensions.

Spiritual formation and spiritual disciplines facilitate the rise of self-compassion in the life of the minister. Self-compassion arises from Eastern philosophical thought and includes three main components (Neff, 2006). First is offering kindness, patience, and understanding to oneself during times of failure and disappointment. The second recognizes that others go through similar experiences; therefore, the individual should feel connected to others rather than isolated during times of pain. Third, "individuals operating in self-compassion neither ignore nor ruminate about their shortcomings" (Neff, 2006, p. 152). Barnard and Curry (2012) discovered that ministers with higher self-compassion levels reported increased job satisfaction and lower exhaustion levels while facing various stressors. Researchers have further suggested that pastors who are patient and forgiving of personal failure or disappointment are more resilient and able to overcome emotional exhaustion, and less likely to experience ministry burnout (Muse et al., 2016). Therefore, ministers who cultivate self-compassion created through spiritual formation experience more significant job satisfaction and lower levels of emotional exhaustion.

The spiritual discipline of taking a sabbath rest impacted the clergy's productivity and resiliency to burnout. London and Wiseman (2003) discovered that 21% of ministers do not take 1 day off per week to rest, reinforcing the presupposition among many pastors that compulsive overextension of time and energy is an affirmation of godliness. Vaccarino and Gerritsen (2013) found that rest deprivation reduces an individual's productivity physically, mentally, emotionally, and spiritually. Further, lack of rest can lead to poor concentration and mood swings, negatively impacting productivity. Diddams et al. (2004) stated, "practicing rest bolsters psychological resiliency and personal agency" (p. 317), which serves as an essential element in stress management (Carver, 1998). Therefore, a minister's decision to take periods of rest and refreshment can impact their productivity and susceptibility to burnout.

In the study by Chandler (2009), the author identified spiritual dryness as the primary predictor of emotional exhaustion leading to burnout in the life of a minister. Oswald (1991) defined spiritual dryness as spiritual lethargy, a lack of

vibrant spiritual encounters with God, and an absence of spiritual resources. Chandler (2009) examined the relationship between a pastor's rest-taking habits, spiritual renewal processes, and support system practices with the three dimensions of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. Researchers have confirmed that spiritual dryness (29%) and lack of rest (4%) correlated with emotional exhaustion. Further, ministry involvement prevented rest, leading to emotional exhaustion. No correlation existed between system practices and rest related to burnout in the study. Therefore, not taking rest correlates with reduced productivity and can lead to burnout for clergy.

In summary, spiritual formation and disciplines form the basis of a healthy minister's lifestyle and concurrently provide a defense against burnout. Chandler (2009) indicated that no specific spiritual renewal practice emerged as a deterrent to burnout. Applying multiple dimensions of spiritual renewal—including rest-taking, praying, fasting, solitude, and mentoring relationships—nurtures an ongoing relationship with God and helps maintain work-life balance, reduce stress, and deter burnout among the clergy.

Clergy Burnout Interventions

The impact of burnout among clergy is considerable, and scholars have collectively demonstrated various solutions to combat the phenomenon. Strategies include establishing and maintaining healthy relationships (Scott & Lovell, 2015), engaging in spiritual formation through spiritual disciplines (Gemignani, 2002; Nelson, 2012), practicing self-care (Vaccarino & Gerritsen, 2013), denominational and organizational support (Chandler, 2009), establishing healthy boundaries (Schaefer & Jacobsen, 2009), and training in conflict resolution (Hoge & Wenger, 2003). In the following section, I review recommendations and solutions to reduce or eliminate the impact of burnout among the clergy.

Establishing and Maintaining Healthy Relationships. According to Scott and Lovell (2015), loneliness remains the most robust explanatory variable in pastor burnout; therefore, healthy intimate relationships remain critical to minister health and productivity. According to Headington (1997), 70% of pastors reported not having a close friendship to provide support and edification. Consequently,

fostering healthy close relationships for ministers can significantly reduce the effects of burnout and compassion fatigue and is an essential component of creating and maintaining minister well-being (Meek et al., 2003). These relationships may include, but are not limited to, family, friends, mentors, and peers.

Family and friend relationships for clergy provide a central support system for ministers to resist burnout and isolation. In a study of American Protestant ministers, Meek et al. (2003) found that 62% of clergy members considered exemplars of ministry success referenced their family unit as an essential element of their emotional and spiritual health. Further, ministers cited their spouse as a critical factor in their psychological and emotional support as friends, prayer partners, and honest confidants. Extra-familial friendships for clergy provided a crucial element of support for ministers, with 42% identifying these relationships as critical to maintaining well-being. In summary, clergy families and friends provided positive connectedness that remedies social isolation and alleviates pastoral ministry stresses.

In a study of clergy burnout and psychological health in the United States, the researchers found that ministers with a mentor (26%) reported higher ministry satisfaction scores than their counterparts (Francis et al., 2013). Out of the variety of support strategies investigated in the study, only mentoring relationships and education sabbaticals positively impacted ministry satisfaction prompting researchers to recommend mentoring relationships as a positive deterrent to burnout. Meek et al. (2003) found that 45% of clergy in their study referenced mentorship as a critical factor in reducing burnout. In summary, familial, peer-to-peer relationships and mentors can bolster ministers' health, reduce isolation, and provide support against burnout (Greene et al., 2020).

Engaging in Spiritual Renewal through Spiritual Disciplines and Spiritual Formation. Spiritual renewal is vital to pastor effectiveness, burnout prevention, and minister restoration (Gemignani, 2002; Nelson, 2012). According to McNeal (2011), spiritual renewal is the foundation of a pastor's personal and professional effectiveness. Historically, Christ-followers practiced specific spiritual disciplines or practices that deepened their faith (Foster, 1988). Chandler (2009)

discovered that experiencing the love of God through life patterns and practices fostered spiritual renewal and created a connection with God's transformative work reducing the adverse effects of burnout.

Disciplines are defined as “any activity within our power which brings us to a point where we can do what we at present cannot do by direct effort” (Willard, 1998, p. 106). The spiritual disciplines transform the entire state of the soul by a renewal of the whole person from the inside involving thought, feeling, and character that manifests in outward behavioral changes. In Christian discipleship, spiritual formation is the outgrowth of the application of spiritual disciplines, facilitating the transformation of a Christ-follower into Christlikeness. The general spiritual disciplines include solitude and silence, fasting, scripture memorization, and regular, corporate, and individual praise and worship.

In a study on clergy effectiveness, Chandler (2009) discovered that spiritual dryness positively and significantly contributed to burnout and was the single most significant predictor of burnout for ministers. Of the clergy in the study, 29% referenced spiritual dryness as the primary source of burnout in their ministry demonstrated through the dimension of emotional exhaustion. Further, the researchers determined that an ongoing relationship with God expanded primarily through spiritual formation provided the most significant deterrent to burnout in the life of a minister. Therefore, engaging in spiritual formation through spiritual disciplines protects ministers against burnout and increases ministry effectiveness.

Self-Care. Frequently, religious leaders can neglect themselves, leading to job dissatisfaction, decreased effectiveness, and burnout. In a U.S. study of clergy, the researchers found that many ministers perceive their work negatively impacts their health (Proeschold-Bell & LeGrand, 2012). Therefore, to prevent burnout and increase resiliency and productivity, ministers need to take care of themselves by balancing concern for others with a concern for one’s well-being, doing those things that nurture both the body and soul (Vaccarino & Gerritsen, 2013). Self-care practices can include, but are not limited to, rest, exercise, differentiating between self and role, and practicing self-compassion.

Sabbath Rest. Researchers have indicated that lack of rest can reduce a minister's physical, mental, emotional, and spiritual well-being (Vaccarino & Gerritsen, 2013). Further, lack of rest can cause mood swings and lead to poor concentration impacting individual productivity and effectiveness. Most importantly, a minister can care for others and neglect their self-care, ultimately preventing them from fulfilling their mission due to burnout (Melander & Eppley, 2002). Diddams et al. (2004) stated, "practicing rest bolsters psychological resiliency and personal agency" (p. 317), which serves as an essential element in stress management (Carver, 1998). Shrier (2009) asserted that the Sabbath rest "is not just a rest from the business of life, it is a rejuvenation of the soul" (p. 13). Therefore, a minister's decision to take periods of rest and refreshment can impact their productivity and reduce susceptibility to burnout.

Hough et al. (2019) researched clergy in the United States and correlated rest taking with increased overall well-being. Those who reported keeping a Sabbath rest three to four times per month, including sleep, vacation, and relaxing activities ($p < 0.001$ for each kind of rest), reported lower life chaos scores ($p < 0.001$) and experienced less high demand by congregants on their time ($p = 0.001$). Additionally, participants who kept the Sabbath rest three to four times per month reported higher spiritual well-being scores ($p < 0.001$) and quality of life scores ($p < 0.001$). Finally, clergy who kept the Sabbath rest three to four times per month were significantly likely to report low depression scores ($p < 0.001$) and less likely to experience burnout ($p = 0.001$). In conclusion, Sabbath-keeping correlated with a higher quality of life measured as relational satisfaction, creativity, and encouraging others and lower levels of burnout than non-Sabbath-keeping respondents.

Exercise. In a cross-denominational study, Terry and Cunningham (2021) linked exercise to increased clergy physical health, resiliency, and reduced burnout. Participants in the study (62.4%) indicated that work interfered with their health either consistently or sometimes. Almost one fourth of the ministers (23.4%) cited exercise as a strategy to reduce stress, maintain health, and function at an optimum

level in their ministerial role. Therefore, exercising increases overall health and well-being and reduces stress for ministers.

Gerber et al. (2013) conducted a 12-week exercise program study measuring the effect of exercise on burnout and its symptoms utilizing guidelines from the American College of Sports Medicine. Participants exercised 2 to 3 days per week for a minimum of 1 hour per session to measure its effect on burnout. Participants significantly reduced their burnout symptoms after the 12-week program indicating reduced burnout and increased positive mood states (d =- 0.60 and d = -2.00) attributed to the exercise program (Gerber et al., 2013, para. 25). Cox et al. (2004) found that high-intensity and moderate-intensity exercise contributed to cardiorespiratory and metabolism benefits, positively impacting mood and well-being changes. Gerber et al. (2013) linked regular cardiovascular exercise to significantly reducing burnout and perceived stress among participants. In summary, regular exercise can reduce burnout symptoms, stress, and depression among specific individuals in high-stress environments.

Differentiating Self and Role. According to Beebe (2007), clergy who can differentiate who they are and what they value from their role as a minister and their effectiveness tend to experience lower levels of burnout. Grosch and Olsen (2000) discovered that ministers could struggle with differentiation between self and role because others typically view them as "the pastor," resulting in the clergy member being more likely to merge their self-concept with their role concept facilitating burnout. Barnard and Curry (2012) discovered that pastors who differentiated self from role displayed greater professional satisfaction and experienced less emotional exhaustion than those who could not. Therefore, clergy who effectively differentiate themselves from what they do as ministers experience higher personal and professional satisfaction levels and are resilient to burnout.

Self-Compassion. A function of self-care expressed through self-compassion provides a barrier against clergy burnout. Self-compassion arises from Eastern philosophical thought and comprises three main components (Neff, 2006). The first recommendation is offering kindness, patience, and understanding to oneself during times of failure and disappointment. The second recognizes that

others go through similar experiences and feel connected rather than isolated during times of pain. Third, "individuals operating in self-compassion neither ignore nor ruminate about their shortcomings" (Neff, 2006, p. 152). Barnard and Curry (2012) discovered that ministers with higher self-compassion levels reported increased job satisfaction points and lower exhaustion levels while facing various stressors. Researchers have further suggested that pastors who are patient and forgiving of personal failure or disappointment are more resilient and able to overcome emotional exhaustion, and less likely experience ministry burnout (Muse et al., 2016). In summary, self-care bolsters minister resistance to burnout by the minister being kind towards themselves during stressful periods, increasing job satisfaction, and reducing emotional exhaustion.

Organizational Interventions. According to Chandler (2009), intervention and training regarding burnout, its effects, and prevention at the denominational level could significantly and positively impact ministers. Unfortunately, many pastors experience a lack of organizational support and believe that their primary value to the denomination comes through church growth (Meek et al., 2003). "Pastors are asking their organizations to set the stage by first rethinking basic job requirements and then educating congregations and support staff about the many responsibilities and needs of the pastor" (Meek et al., 2003, para. 34). As pastors traditionally train in Bible schools and seminaries, ministry training centers can assist clergy to develop healthy personal practices to reduce stress and burnout through focused curricular consideration. Additionally, providing holistic self-care within ministry training contexts can contribute to personal self-care and foster positive engagement with self, church, family, and others, potentially reducing burnout (Wuellner, 2005). In summary, denominations, ministry organizations, and seminaries can contribute to burnout prevention and reduction for ministers through education and training, potentially leading to healthier life balance, improved performance, overall well-being, and reduced early departure from ministry.

Establishing Healthy Boundaries. Clergy must manage their time and responsibilities by establishing and maintaining clear boundaries between their ministry and personal lives (Oswald, 1991). Weems and Arnold (2009) emphasized

that "How the boundary between home and congregational life is drawn is of vital importance to the health of individual clergy and the health of clergy families" (p. 3). In the study by Vaccarino and Gerritsen (2013), the researchers found that 50.9% of their clergy respondents maintained clear and appropriate boundaries most of the time with their congregations. Due to the nature of ministry life, including dealing with crisis and other unforeseen situations, prohibited establishing certain boundaries, "keeping no boundaries creates burnout" (Vaccarino & Gerritsen, 2013, p. 75). Therefore, ministers must establish clear boundaries to restrict unnecessary intrusion from their work-life into their family life, mitigate work-family conflict, maintain a healthy balance, and avoid burnout.

Conflict Resolution Training. The results of Hoge and Wenger's (2003) cross-denominational study revealed that 26% of the ministers who left full-time ministry referenced conflicts with congregants or the denominational leadership as significant factors in their departure. Compounding the issue, in many congregations, the pastor is the primary conflict manager. According to Earls (2020), the conflict generated in church congregations by the enormous effect of the COVID-19 pandemic was the top concern for pastors during the crisis. The findings from a study on conflicts that led to a minister's employment termination showed that without proper training, or when pastors felt they did not have the skills to deal with conflict, they resorted to evasive actions or behaviors that avoided addressing the conflict, leaving the situation unresolved (Earls, 2020). Beebe (2007) found that ministers who exhibited a collaborative conflict management style demonstrated less burnout and enjoyed higher job satisfaction than their counterparts. Therefore, training ministers in conflict management and resolution is of significant importance, potentially increasing job performance and lessening the effects of burnout.

Summary of Clergy Burnout

Increased interest in the phenomenon of clergy burnout and compassion fatigue is encouraging, principally because the health of clergy impacts a large segment of society (Little et al., 2007). While 80% of clergy report enjoying their profession, about 30% deal with emotional exhaustion, a significant component of

burnout (Francis et al., 2008), supporting the view that most ministers are "happy but exhausted" (p. 168). Further, a significant portion of clergy expressed an interest in leaving the ministry (26%), with 12% citing burnout as a significant factor in that decision (Hoge & Wenger, 2003). According to Jackson-Jordan (2013), "more systemic change is needed to promote clergy resilience and to foster healthy, long-term tenure in ministry professions" (p. 4). Although burnout and the stressors of caring for congregants exist, understanding the factors related to clergy burnout can help equip ministers, their families, congregations, denominational leaders, and seminaries to reduce the phenomenon's effects and create a healthy balance between the professional expectations and personal well-being.

Chapter 3 – Methodology

In this chapter, the researcher details the methods and resources utilized in this quantitative research survey study to examine the correlations between the three factors of burnout and its impact on career commitment during the COVID-19 crisis among physicians, law enforcement, and clergy. The purpose of survey research is to produce quantitative descriptions of some aspects of the population under study (Pinsonneault & Kraemer, 1993). According to Hair et al. (2012), understanding complex information requires applying multivariate statistical methods to convert data into useful information. Thus, in this study, I examined quantitative data among three helping professional groups, which, according to Creswell (2009), allows for understanding the relationships between independent and dependent variables.

Research Questions and Hypotheses

In this study, I explored the impact of burnout on career commitment during the COVID-19 pandemic among physicians, law enforcement officers, and clergy. Further, I compared the findings between these three groups of helping professionals. I employed a survey research method to examine the correlations between the three factors of burnout and their impact on career commitment. The three primary research questions that guided the study were as follows:

Research Question 1

The first research question asked: What is the level of burnout among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How does the level of burnout compare between the three groups?

H1a: There is a high level of burnout among physicians, law enforcement officers, and clergy.

H1b: There is a difference in levels of burnout between physicians, law enforcement officers, and clergy.

Research Question 2

The second research question was: What is the level of career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How do the levels of career commitment compare between the three groups?

H2a: There is a low level of career commitment among physicians, law enforcement officers, and clergy.

H2b: There is a difference in levels of career commitment in physicians, law enforcement, and clergy.

Research Question 3

The third research question asked: What is the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy? How do the correlations between burnout and career commitment compare between the three groups?

H3a: There is a negative correlation between burnout and career commitment.

H3b: There is a negative correlation between burnout and career commitment in physicians.

H3c: There is a negative correlation between burnout and career commitment in law enforcement officers.

H3d: There is a negative relationship between burnout and career commitment in the clergy.

H3e: There is a difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy.

I distributed a voluntary, online anonymous survey instrument through the partnering organizations to participants. Comparative data were gathered via voluntary, anonymous online surveys using the MBI-HSS (Maslach et al., 1996) and career commitment utilizing the BCCM (Blau, 1988).

Research Design

I selected a quantitative methodology with a correlational design to guide this examination of whether a relationship existed between burnout and career commitment among physicians, law enforcement officers, and clergy. According to Creswell (2008), a correlational research design enables the identification of relationships between variables and predictive patterns within the samples. ANOVAs and linear regression analysis provided these comparisons. Based on the outcomes of the ANOVAs, I conducted a post hoc test to analyze the data. Regression analysis is an analytical method used to "predict the changes in the dependent variable response to change in the independent variables" (Hair et al., 2012, p. 16). In the study, multiple regression analyses were used to examine the predicted continuous or noncontinuous effect of the independent variables on the dependent variable (see Girden & Kabacoff, 2010).

Variables

The BCCM, developed by Blau (1985), was used to examine the respondents' self-reported attitudes toward their profession and served as the dependent variable in the study. The MBI-HSS (Blau, 1985) provided feedback on the burnout factors of emotional exhaustion, depersonalization, and personal accomplishment. These three burnout factors served as the independent variables in the study. Finally, the three professions of physicians, law enforcement officers, and clergy served as the control variables.

Missing Data

The data were screened for missing variables and outliers in the survey responses by running descriptive statistical techniques. Additionally, the dataset was screened for any additional missing data and outliers. To improve the strength of multiple regression results, Missing Values Analysis (MVA) was utilized to manage missing data in the dataset. I handled missing data in the dataset > 5% of the sample size with casewise deletion. Missing data levels of 5% or less were considered inconsequential for subsequent analytic procedures. I deleted 75 cases with missing values utilizing listwise deletion.

Outliers

After establishing how missing data were handled, I screened the data to check univariate and multivariate outliers. To screen for univariate outliers, all variables were transformed into standardized *z* scores. Mertler and Vannatta (2010) recommended that a dataset with more than 100 cases, as a sample size may benefit from a more liberal guideline for identifying and eliminating outliers therefore excluding any case with z score of +/- 4.0 is recommended. No variables in the study met this criterion for exclusion. To screen for multivariate outliers, linear regression was used to check for Mahalanobis distances. A chi square table was used to determine the value at which outliers were removed at a significance level of $p < .001$. Based on the $df = 3$ (variables in the study), I deleted values greater than the recommended degrees of freedom in the chi square table, resulting in 27 deletions. After all missing data and outliers were addressed, the final *N* was 484.

Normality

I analyzed all intervals and scale variables for assumptions of normality and checked for skewness and kurtosis. No variables required transformation due to skewness. Box plots were utilized to confirm the assumption of homoscedasticity.

Data Analysis

The data in the study was analyzed and reported using the 28th version of IBM's Statistical Package for the Social Sciences (SPSS). After the dataset was cleaned, to answer RQ1, the levels of burnout for the aggregate sample were tested by an examination of the statistical mean in relation to each burnout dimension. Then three separate one-way between subjects ANOVAs were utilized for the three independent variables of burnout to determine whether professional job type was related to a respondent's level of burnout. Post hoc Tukey HSD tests were used to test the sample means for statistical significance. To answer RQ2, the aggregate sample was tested by an examination of the statistical mean in relation to the measure of career commitment. A one-way between-subjects ANOVA was then conducted for the dependent variable of career commitment to determine whether professional job type was related to a respondent's level of career commitment.

Post hoc Tukey HSD tests were used to test the sample means for statistical significance. To test RQ3, I conducted a series of MLR tests were used for the aggregate sample and then again for the disaggregate sample. Additionally, the predictor variables of burnout were analyzed for the aggregate sample, then analyzed for the disaggregate sample. The split cases functions in SPSS were used for the disaggregate sample.

Summary

In this chapter, I presented and justified the methods and resources that I selected to examine the correlations between the three factors of burnout and its impact on career commitment during the COVID-19 crisis among physicians, law enforcement, and clergy. The study produced quantitative descriptions of some aspects of the population studied. Further, I employed quantitative data research principles and methods to examine burnout and career commitment among the three helping professional groups, which, according to Creswell (2009), allows for understanding relationships between independent and dependent variables. According to Hair et al. (2012), understanding complex information requires applying multivariate statistical methods to convert data into useful information. Therefore, the methods and statistical instruments selected for this study provided the appropriate framework to examine the correlations between the three factors of burnout on career commitment during the COVID-19 crisis among physicians, law enforcement officers, and clergy.

Chapter 4 – Results

In this study, I administered surveys to 484 respondents working in three helping professions, including physicians (*N* = 71), clergy (*N* = 275), and law enforcement officers (*N* = 138). As shown in Table 1, the participants were from two southwestern states and of different genders and racial/ethnic backgrounds. Eighty-one percent of the respondents were male (*N* = 394) and 18.6% were female. (*N* = 90). Respondents self-reported their racial/ethnic background as follows: 86% White (*N* = 416), 3.5% African American (*N* = 17), 6.8% Hispanic (*N* = 33), and 3.7% Other (*N* = 18). Each participant self-reported their current levels in three dimensions of burnout—emotional exhaustion, depersonalization, and personal accomplishment—and their current level of career commitment.

Table 1

Descriptive Statistics for Dependent, Independent, and Control Variables

	N	%
Profession		
Physician	71	14.7
Pastor	275	56.8
Law Enforcement Officer	138	28.5
Gender		
Males	394	81.4
Females	90	18.6
Race		
White (Non-Hispanic)	416	86
African American (Non-Hispanic)	17	3.5
Hispanic	33	6.8
Other	18	3.7

Note. *N* = 484.

To ensure the reliability of the dependent scaled variable of interest, career commitment, and the three independent scaled variables of burnout (i.e., emotional exhaustion, depersonalization, and personal accomplishment) utilized in the current study, a Cronbach's alpha (α) statistical technique was conducted. The Cronbach's alpha statistic is a well-recognized technique, expressed between 0 and 1, that is commonly used in survey research for determining the internal consistency of a set

scale (Tavakol & Dennick, 2011). Pallant (2005) indicated that a Cronbach's alpha of .70 or higher is necessary for establishing reliability. Prior findings from early burnout studies utilizing the MBI-HSS yielded Cronbach's alpha scale estimates of .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment as displayed in Table 2.

Table 2

Cronbach's Alpha (α) Values for Dependent Variable and All Independent Variables

Scale	No. of Items	Cronbach's Alpha (α)
Career Commitment	7	.90
Burnout: Emotional Exhaustion	9	.93
Burnout: Depersonalization	5	.85
Burnout: Personal Accomplishment	8	.81

Levels of Burnout by Profession

Burnout for this study was measured by utilizing the MBI-HSS. The MBI-HSS Burnout Inventory, developed by Maslach and Jackson (1981), is a 22-item inventory that is commonly used in burnout literature to measure the constructs of emotional exhaustion, depersonalization (cynicism), and personal accomplishment (personal efficacy) among professionals in the public service field (i.e., physicians, health aides, social workers, therapists, law enforcement officers, clergy, etc.).

Scoring for the MBI-HSS utilizes a mean scoring system along with the survey instruments' 7-point Likert-type scale. Burnout classification scores range from three levels: low, moderate, and high (Maslach & Jackson, 1981). For example, an Emotional Exhaustion (EE) mean scale score of 3.5 would be interpreted as indicating that the respondent felt emotionally exhausted several times each month on average, but not every week; an EE score of 5.5 would indicate the respondent felt emotionally exhausted several times per week on average, but not every day (Maslach & Leiter, 2016). The mean score values on the Likert-type scale for emotional exhaustion and depersonalization range from low ($M \leq 2.33$) to moderate ($M = 2.34$ to 4.66) to high ($M \geq 4.67$). Conversely, lower scores for personal accomplishment indicate higher degrees of burnout. "Using this

method, judgments about whether the experience of each aspect of burnout is sufficiently frequent to be of concern and worth taking seriously are left to the respondent and/or others who are in a position to take corrective steps" (Maslach & Leiter, 2016, p. 24).

To examine differences in levels of burnout among the three professional job types (physician, clergy, and law enforcement officers), I conducted a series of one-way ANOVAs with Tukey's (HSD) post hoc tests. According to Creswell (2014), one-way ANOVAs are utilized to determine whether there are statistically significant differences between the means of two or more groups on an outcome variable of interest. Further, once statistically significant mean differences have been established utilizing an ANOVA technique, it is necessary to conduct a Tukey's HSD post hoc test to investigate between-group differences. Specifically, Tukey's HSD post hoc test allows for the precise determination of which specific group's mean differs in a sample (Creswell, 2014).

Research Question 1

The first research question asked: What is the level of burnout among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How does the level of burnout compare between the three groups? The first hypothesis (H1a) that I tested stated: There is a high level of burnout among physicians, law enforcement officers, and clergy.

To test the levels of burnout for the aggregate sample, H1a required an examination of the statistical mean in relation to each burnout dimension (emotional exhaustion, depersonalization, and personal accomplishment). The mean scores for emotional exhaustion were: physicians (M = 2.76), law enforcement officers (M = 2.61), and clergy (M = 2.41). Therefore, all three groups of helping professions exhibited moderate feelings of emotional exhaustion (M = 2.34 to 4.66) once per month to less than a few times per month on average. The mean scores for depersonalization among the three groups were: physicians (M = 1.77), law enforcement officers (M = 2.68), and clergy (M = 1.40). The mean scores for physicians and clergy were low ($M \leq 2.33$), indicating depersonalization a few times per year or less. The mean score for law enforcement officers was

moderate (M = 2.34 to 4.66), indicating depersonalization from once per month to a few times per month. The mean scores for personal accomplishment were: physicians (M = 4.77), law enforcement officers (M = 4.20). and clergy (M = 4.25). The mean score for physicians was high ($M \geq 4.67$), and the mean scores for law enforcement officers and clergy were moderate (M = 2.34 to 4.66). Given that lower scores in personal accomplishment indicate higher levels of burnout, physicians reported low levels of personal accomplishment while law enforcement officers and clergy reported moderate levels of personal accomplishment. In summary, physicians, law enforcement officers, and clergy reported low and moderate levels of burnout on all three dimensions of the MBI-HSS. Therefore, H1a was rejected.

H1b stated: There is a difference in levels of burnout between physicians, law enforcement officers, and clergy. To test H1b, three separate one-way between-subjects ANOVAs were conducted for the three independent variables of burnout (emotional exhaustion, depersonalization, and personal accomplishment) to determine whether professional job type (physician, clergy, and law enforcement officers) was related to a respondents' level of burnout. The ANOVA on emotional exhaustion yielded statistically significant variations related to a respondent's professional job type ($F(2, 481) = 6.43$, $p \leq 0.001$). The effect size ($\eta^2 = .02$) indicated that 2% of the variance in emotional exhaustion can be explained by professional job type. As shown in Table 3, a post hoc Tukey HSD test showed that emotional exhaustion for law enforcement officers (M = 2.61) was significantly different than clergy professionals (M = 2.41, $p \leq 0.001$). Regarding emotional exhaustion, physician scores were not statistically different from the other professional groups.

Table 3

ANOVA Results for Emotional Exhaustion Among Professional Job Type

Professional Job Type	*n*	*M*	*SD*	*F* (2, 481)
Physician	71	2.76	1.79	6.43
Clergy	275	2.41*	1.39	
Law Enforcement Officer	138	2.61	1.43	

Note. * $p \leq .001$ for law enforcement officer.

As shown in Table 4, the ANOVA on depersonalization yielded statistically significant difference to a respondent's professional job type ($F(2, 481) = 38.88$, $p \leq 0.001$). The effect size ($\eta^2 = .13$) indicated that 13% of the variance in depersonalization can be explained by professional job type. A post hoc Tukey HSD test found that depersonalization for law enforcement officers ($M = 2.68$) was significantly different than clergy professionals ($M = 1.41$, $p \leq 0.001$) and physicians ($M = 1.77$, $p \leq 0.001$). Regarding depersonalization, physicians' scores were not statistically different from those of clergy.

Table 4

ANOVA Results for Depersonalization Among Professional Job Type

Professional Job Type	*n*	*M*	*SD*	*F* (2, 481)
Physician	71	1.77*	1.79	38.88
Clergy	275	1.40*	1.39	
Law Enforcement Officer	138	2.68	1.43	

Note. * $p \leq .001$ for law enforcement officer

As shown in Table 5, the ANOVA on personal accomplishment demonstrated that there was a significant difference to a respondent's job type ($F(2, 481) = 9.45$, $p \leq 0.001$). The effect size ($\eta^2 = .13$) indicated that 13% of the variance in personal accomplishment can be explained by professional job type. A post hoc Tukey HSD test found that personal accomplishment for physician scores ($M = 4.77$) was statistically different than that of both law enforcement officers ($M = 4.20$, $p \leq 0.001$) and clergy ($M = 4.25$, $p \leq 0.001$). Regarding personal accomplishment, clergy scores were not statistically different from law enforcement officers. There is a statistically significant difference in levels of burnout between physicians, law enforcement officers, and clergy; therefore, H1b was retained.

Table 5

ANOVA Results for Personal Accomplishment among Professional Job Type

Professional Job Type	*n*	*M*	*SD*	*F* (2, 481)

Physician	71	4.77	1.79	9.45
Clergy	275	4.25*	1.39	
Law Enforcement Officer	138	4.20*	1.43	

Note. * $p \leq .001$ for physician.

Levels of Career Commitment by Profession

Career commitment was measured using the BCCM ($\alpha = .90$). This instrument, developed by Blau (1985), is a seven-item inventory that is commonly used to examine individuals' perceptions or attitudes towards their level of career commitment (Cohen, 1995; Katz et al., 2019; Reilly & Orsak, 1991; Somers & Birnbaum, 1998). Specifically, each of the items focus on measuring an individual's level of commitment to their occupation and career orientation utilizing a 5-point scale (1 = *Strongly Agree*, 2 = *Agree*, 3 = *Unsure*, 4 = *Disagree*, 5 = *Strongly Disagree*; Blau, 1988). Scoring for the BCCM utilized a mean scoring system along with the survey instruments 5-point Likert-type scale. Seven items were used to measure career commitment and items were linearly summed to create the scale score (Blau, 1985). Lower scores on the survey scale indicate stronger degrees of career commitment, and higher scores indicate weaker degrees of career commitment. Following Blau's instructions on calculating the mean score values of the Likert-type scale for career commitment, the mean scores range from *Strongly Agree* (M = 1.00 to 1.80), *Agree* (M = 1.81 to 2.60), *Unsure* (M = 2.61 to 3.40), *Disagree* (M = 3.41 to 4.20), and *Strongly Disagree* (M = 4.21 to 5.00). As lower mean scores relate to high levels of career commitment, a mean score of M = 1.27 would be interpreted as respondents exhibiting strong feelings of career commitment, whereas a mean score of M = 2.5 would indicate moderately strong feelings of career commitment. Respondents scoring M = 3.15 would be interpreted as unsure of their career commitment. A mean score of M = 4.00 indicates that respondents have moderately weak feelings of career commitment, whereas a mean score of M = 4.50 indicates solidly weak feelings of career commitment. To examine differences in levels of career commitment among the three professional job types (physician, clergy, and law enforcement officers), I conducted a one-way

between-subjects ANOVA with a post hoc Tukey HSD test for the dependent variable of career commitment.

Research Question 2

The second research question was: What is the level of career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How do the levels of career commitment compare between the three groups? The first hypothesis under this research question (H2a) posited: There is a low level of career commitment among physicians, law enforcement officers, and clergy.

To test the levels of career commitment for the aggregate sample, H2a required an examination of the statistical mean in relation to the BCCM. Lower scores on the BCCM indicate higher degrees of career commitment (Blau, 1988). As demonstrated in Table 6, the mean scores for career commitment were as follows: physicians (M = 2.27), law enforcement officers (M = 2.81), and clergy (M = 1.76). The mean scores for physicians (M = 2.27) indicated moderately strong feelings of career commitment (M = 1.81 to 2.60), whereas the mean scores of law enforcement officers (M = 2.81) indicated unsure feelings of career commitment (M = 2.61 to 3.40). The mean scores of clergy (M = 1.76) indicated that the respondents exhibited strong feelings of career commitment (M = 1.00 to 1.80). In summary, physicians exhibited moderate feelings of career commitment, law enforcement officers exhibited unsure feelings of career commitment, and clergy displayed strong feelings of career commitment toward their profession; therefore, H2a was rejected.

H2b stated: There is a difference in levels of career commitment in physicians, law enforcement officers, and clergy. To test H2b, a one-way between-subjects ANOVA was conducted for the dependent variable of career commitment to determine whether professional job type (physician, law enforcement officers, and clergy) was related to a respondent's level of career commitment (see Table 6). The ANOVA on career commitment yielded a statistically significant variation related to a respondent's professional job type ($F(2,481) = 71.10$, $p \leq 0.001$). The effect size ($\eta^2 = .22$) indicated that 22% of the variance in low career commitment

can be explained by professional job type. The results from a post hoc Tukey HSD test found that the level of career commitment for physicians ($M = 2.27$) was statistically different than that of law enforcement officers ($M = 2.81$, $p \leq 0.001$) and clergy ($M = 1.76$, $p \leq 0.001$). Additionally, the results also indicated that the level of career commitment for clergy ($M = 1.76$) was statistically different than that of law enforcement officers ($M = 2.81$, $p \leq 0.001$). In summary, all three professions displayed statistically significant differences from each other; therefore, H2b was retained.

Table 6

ANOVA Results for Career Commitment Among Professional Job Type

Professional Job Type	*n*	*M*	*SD*	*F* (2, 481)
Physician	71	2.27	1.79	71.10
Clergy	275	1.76[a]	1.39	
Law Enforcement Officer	138	2.81[ab]	1.43	

Note. [a] $p \leq .001$ with physician, [b] $p \leq .001$ with clergy

Relationship Between Burnout and Career Commitment by Profession

To answer Research Question 3 and test Hypotheses 3a through 3e, I ran a series of MLRs that examined the main effects of each factor of burnout (emotional exhaustion, depersonalization, and personal accomplishment) on the dependent variable career commitment. Analyses were conducted for the aggregate sample and then the disaggregated sample by professional job type to determine whether differences were present in the outcome of career commitment between physicians, clergy, and law enforcement officers.

Research Question 3

The third research question asked: What is the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy? How do the correlations between burnout and career commitment compare between the three groups? This research question was answered by testing five hypotheses:

H3a: There is a negative correlation between burnout and career commitment.

H3b: There is a negative correlation between burnout and career commitment among physicians.

H3c: There is a negative correlation between burnout and career commitment among law enforcement officers.

H3d: There is a negative correlation between burnout and career commitment among clergy.

H3e: There is a difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy.

Aggregated Sample Multiple Linear Regression

To test H3a, I conducted a MLR to examine the main effects of each type of burnout on the dependent variable career commitment for the aggregated sample (n = 484). As shown in Table 7, for the aggregated sample (n = 484), the model analyzing the influence of burnout (emotional exhaustion, depersonalization, and personal accomplishment) significantly correlated levels of burnout to levels of career commitment ($F(4, 479) = 118.49$, $p < 0.001$), and accounted for 49.7% (R^2 = .497) of the variation in career commitment. For the aggregate model, emotional exhaustion displayed a significant positive relationship with career commitment for helping professionals (β = .34, $p < .001$). Similarly, depersonalization also displayed a significant positive relationship to levels of career commitment (β = .26, $p < .001$). Personal accomplishment had a significant negative relationship to levels of career commitment (β = -.19, $p < .001$). Therefore, based on the response indicated in the multiple linear regression for the aggregate sample, H3a was partially accepted.

Table 7

Multiple Linear Regression Model Examining the Main Effects of Burnout on Career Commitment for the Aggregate Sample (n = 484)

	Model		
Career Commitment	*B*	*β*	*SE*
Constant	1.79		.19
Emotional Exhaustion	.22	.34*	.03

Depersonalization	.16	.26*	.03
Personal Accomplishment	-.19	-.19*	.03
Professional Job Type [a]	.23	.15*	.05
R^2	.49		
ΔF	118.49		
df1	4		
df2	479		
ΔR^2	.497		
Adjusted R^2	.493		

Note. $N = 484$, * $p < .001$.

[a] Physician = 0, Clergy = 1, Law enforcement officers = 2

Disaggregate Model Professional Job Type MLR Regression

To test H3b through H3e, a series of MLR models were conducted to examine the effects of each type of burnout on the dependent variable career commitment disaggregated by professional job type. The multiple linear regression models for physicians ($n = 71$), law enforcement officers ($n = 138$), and clergy ($n = 275$) examined the effects of the three independent variables of burnout (emotional exhaustion, depersonalization, and personal accomplishment) on the dependent variable career commitment as demonstrated in Table 8.

To test H3b, the disaggregated sample model for physicians ($n = 71$) examining the influence burnout on career commitment correlated levels of burnout with levels of career commitment ($F(3,67) = 38.31$, $p < .001$) and accounted for 63% ($R^2 = .63$) of the variance. For physicians, emotional exhaustion displayed a significant positive relationship with career commitment ($\beta = .50$, $p < .001$), depersonalization had no significant correlation to career commitment, and personal accomplishment had a significant negative relationship to levels of career commitment ($\beta = -.32$, $p < .001$). Therefore, H3b was partially accepted.

To test H3c, the disaggregated sample model for law enforcement ($n = 138$) examining the influence of burnout on career commitment correlated levels of burnout with levels of career commitment ($F(3,134) = 30.57$, $p < .001$) and accounted for 41% ($R^2 = .41$) of the variance. For law enforcement, emotional exhaustion displayed a significant positive relationship with career commitment ($\beta = .49$, $p < .001$), depersonalization had no significant correlation to career commitment, and personal accomplishment had a significant negative relationship

to levels of career commitment (β = -.27, p < .001). Therefore, H3c was partially accepted.

To test H3d, the disaggregated sample model for clergy (n = 275) examining the influence of burnout on career commitment correlated levels of burnout with levels of career commitment (F(3,271) = 82.52, p < .001) and accounted for 48% (R^2 = .48) of the variance. For clergy, emotional exhaustion displayed a significant positive relationship with career commitment (β = .18, p < .001), depersonalization had a significant positive relationship with career commitment (β = .13, p < .001), and personal accomplishment had a significant negative relationship to levels of career commitment (β = -.24, p < .001). Therefore, H3d was partially accepted.

H3e posited that there is a statistically significant difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy. The three disaggregate MLR models testing differences in the correlation between the three helping professions confirmed that there was a statistically significant difference between the physicians (F(3,67) = 38.31, p ,< .001), law enforcement (F(3,134) = 30.57, p < .001), and clergy (F(3,271) = 82.52, p < .001) regarding burnout and levels of career commitment.

For the disaggregate models, the first factor of burnout, emotional exhaustion, displayed a significant and positive relationship with career commitment for all three professions: physicians (β = .50, p < .001), law enforcement (β = .49 p < .001), and clergy (β = .33, p < .001). Emotional exhaustion (p < .001) contributed to a .50 increase in the levels of career commitment among physicians, a .49 increase in the levels of career commitment among law enforcement officers, and a .17 increase in the levels of career commitment among the clergy. For depersonalization, only the disaggregated model for clergy (n = 275) displayed a significant and positive relationship with career commitment (β = .13, p < .001). Thus, depersonalization (p < .001) contributed to a .13 ($p \leq .01$) increase in the levels of career commitment among clergy professionals. For personal accomplishment, the disaggregated sample MLR models by professional job type displayed a significant and negative correlation

with levels of career commitment for all three professions: physicians (β = -.32, p < .001), law enforcement (β = -.28, p < .001), and clergy (β = -.31, p < .001). Personal accomplishment (p < .001) contributed to a .32 decrease in the levels of career commitment among physicians, a .28 decrease in the levels of career commitment among law enforcement, and a .31 decrease in the levels of career commitment among clergy. Based on the results, statistically significant differences in the effect of each factor of burnout by the three professional job types were found; therefore, H3e was retained.

Table 8

Multiple Linear Regression Model Examining the Main Effects of Burnout on Career Commitment for Physicians (n = 71), Law Enforcement Officers (n = 138), and Clergy (n = 275)

Career Commitment	Model 1			Model 2			Model 3		
	B	*β*	*SE*	*B*	*β*	*SE*	*B*	*β*	*SE*
Constant	1.90		.48	2.01		.38	2.18		.19
Emotional Exhaustion	.28	.50*	.07	.32	.49*	.06	.18	.33*	.04
Depersonalization	.07	.11	.08	.002	.003	.06	.13	.21*	.04
Personal Accomplishment	-.32	-.32*	.08	-.27	-.28*	.07	-.24	-.31*	.04
R^2	.63			.41			.48		
ΔF	38.31			30.60			82.52		
df1	3			3			3		
df2	67			134			271		
ΔR²	.63			.39			.48		
Adjusted R^2	.62			.39			.47		

Note. $N = 484$. Model 1 examined outcomes for physicians ($n = 71$), Model 2 examined outcomes for law enforcement ($n = 138$), and Model 3 examined outcomes for clergy ($n = 275$).

* $p < .001$.

Summary of Results

In this dissertation, I examined the impact of burnout on career commitment during the COVID-19 pandemic among 484 helping professionals, including physicians (N = 71), clergy (N = 275), and law enforcement officers (N = 138). Burnout in the study was measured by utilizing the MBI-HSS. Career commitment was measured using the BCCM. Three research questions and nine hypothesis statements provided the framework for the study. The first question posed: What is the level of burnout among physicians, clergy, and law enforcement officers during the COVID-19 pandemic? Additionally, how does the level of burnout compare between the three groups? To address Research Question 1, H1a posited there is a high level of burnout among physicians, clergy, and law enforcement officers. Physicians, clergy, and law enforcement officers reported low and moderate levels of burnout on the three dimensions of the MBI-HSS; therefore, H1a was rejected. H1b posited: There is a difference in levels of burnout between physicians, clergy, and law enforcement. Three separate ANOVAs were conducted for the three independent variables of burnout determining that there is a statistically significant difference in levels of burnout between physicians, law enforcement officers, and clergy; therefore, H1b was retained.

The second research question posed: What is the level of career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic? How do the levels of career commitment compare between the three groups? To address RQ2, H2a required an examination of the statistical mean between the three groups of helping professionals in relation to the BCCM. I discovered that physicians exhibited moderate feelings of career commitment, law enforcement officers exhibited unsure feelings of career commitment, and clergy displayed strong feelings of career commitment; therefore, H2a was rejected. H2b stated: There is a difference in levels of career commitment in physicians, law enforcement officers, and clergy. A one-way ANOVA was conducted among the three groups, and the results revealed that all three professions displayed statistically significant differences from each other; therefore, H2b was retained.

Research Question 3 posed: What is the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy? How do the correlations between burnout and career commitment compare between the three groups? To address the questions, I ran a series of MLRs that examined the main effects of each factor of burnout (emotional exhaustion, depersonalization, and personal accomplishment) on the dependent variable of career commitment. To address the research question, H3a stated: There is a negative correlation between burnout and career commitment. After running MLRs for the aggregated sample, H3a was partially accepted. To test H3b through H3e, a series of MLR models were conducted to examine the effects of each type of burnout on the dependent variable of career commitment disaggregated by professional type. H3b stated: There is a negative correlation between burnout and career commitment among physicians. Emotional exhaustion displayed a positive relationship with career commitment, depersonalization had no significant correlation to career commitment, and personal accomplishment displayed a significant negative relationship with career commitment among physicians. Therefore, H3b was partially accepted. H3c posited: There is a negative correlation between burnout and career commitment among law enforcement officers. Emotional exhaustion demonstrated a significant positive relationship with career commitment, depersonalization had no significant correlation to career commitment, and personal accomplishment had a significant negative relationship to levels of career commitment. Therefore, H3c was partially accepted. H3d stated: There is a negative correlation between burnout and career commitment among clergy. Emotional exhaustion displayed a significant positive relationship with career commitment, depersonalization had a significant positive relationship with career commitment, and personal accomplishment had a significant negative relationship to career commitment. Therefore, H3d was partially accepted. H3e posited that there is a difference in the correlation between burnout and career commitment among physicians, law enforcement, and clergy. I utilized three disaggregate MLR models to test the differences in the correlation between the three helping professions and confirmed that there was a statistically significant difference

between the three groups of helping professions (physicians, law enforcement, and clergy) regarding the levels of career commitment. Further, I examined the three factors of burnout, confirming that there were statistically significant differences in the effect of each burnout factor by the three helping professional job categories; therefore, H3e was retained.

Chapter 5 – Discussion

Through the current study, I sought to fill a gap in current leadership literature by examining burnout and career commitment during the COVID-19 pandemic among physicians, law enforcement, and clergy. Prior to the COVID-19 crisis, significant stress was considered a normal part of the three helping profession occupations (Jackson-Jordan, 2013; Queirós et al., 2020; West et al., 2018). I found, however, that the increased emotional, psychological, and sometimes physical strain experienced by these groups during the COVID-19 pandemic significantly increased their levels of stress, potentially leading to personal burnout (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020).

In this study, I examined three research questions and tested nine hypotheses related to the three groups of helping professionals. I conducted a quantitative, cross-sectional, correlational study focused on levels of burnout and career commitment among those working in Texas and Arkansas during the pandemic. I distributed an anonymous single report online survey via email by internal organizational managers and administered it online through Survey Monkey. Respondents had between September 2021 and the end of January 2022 to complete the survey. The survey instrument involved a self-report measure in which respondents reflected on their current perception of three burnout factors (emotional exhaustion, depersonalization, and personal accomplishment) and their career commitment during the COVID-19 pandemic. To assess burnout and career commitment, I administered two proven measurement instruments: the MBI-HSS (Maslach & Jackson, 1981) and the BCCM (Blau, 1985).

The MBI-HSS, developed by Maslach and Jackson (1981), provided feedback on the burnout factors of emotional exhaustion, depersonalization, and personal accomplishment, which served as the independent variables. The BCCM developed by Blau (1985) was used to examine respondents' self-reported attitudes toward their profession and served as the dependent variable. The three professions served as the control variable to identify differences within and between professions.

Probability sampling, followed by convenience sampling, was used to recruit survey participants from the three helping professions. A total of 484 statistically valid responses were received. A series of four one-way ANOVAs and two MLR models (aggregate and disaggregate sample models) were run in SPSS to test the nine hypotheses necessary to answer the three research questions. Of the 484 respondents, 71 identified as physicians, 275 identified as clergy, and 138 identified as law enforcement officers. Additionally, 394 of the sample were male and 90 were female respondents. As it relates to ethnicity, 416 identified as White, 17 African American (Non-Hispanic), 33 Hispanic, and 18 Other. The research findings produced Cronbach's Alpha of burnout dimensions ranging from .80 to .90 (emotional exhaustion ($\alpha = .93$), depersonalization ($\alpha = .85$), and professional accomplishment ($\alpha = .81$) and a career commitment score of .90 (α).

The following section is a review of the research questions and the theoretical implications of burnout and career commitment among three helping professions during the COVID-19 pandemic. In addition, practical implications, limitations, and recommendations for future research are discussed. The chapter ends with a conclusion and summary of the research project.

RQ1: Description and Findings

Research Question 1 asked: What is the level of burnout among physicians, law enforcement officers, and clergy during the COVID-19 pandemic, and how does the level of burnout compare between the three groups of helping professionals? Two hypothesis statements provided the framework, and H1a posited that there is a high level of burnout among physicians, law enforcement officers, and clergy. H1b hypothesized that there is a difference in levels of burnout between physicians, law enforcement officers, and clergy.

The findings did not affirm H1a, which predicted that helping professionals would display high levels of burnout (emotional exhaustion, depersonalization, and personal accomplishment) during the COVID-19 pandemic. This contradicted the findings of recent scholars who raised concern regarding the added stress and strain placed on helping professionals during the COVID-19 pandemic leading to increased burnout (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020).

This concern was merited because physicians encounter burnout throughout their careers, and the challenge of burnout within the profession was already becoming more prevalent before the pandemic (Gold, 2019). At the beginning of the COVID-19 pandemic, law enforcement officers were held in high esteem, along with other helping professionals who risk their lives to serve the community (Lilly & Curry, 2020). Following the death of George Floyd, public perception rapidly shifted, and officers encountered increased verbal, psychological, and physical assaults from the public, creating a more stressful work environment. The extra stress on clergy was also merited, as they play a critical role in supporting individuals, families, and communities coping with crises and traumatic situations, while dealing with their own emotional and psychological challenges (Greene et al., 2020).

Surprisingly, I found low to moderate levels of burnout in all three groups of helping professionals. As a result, the resiliency against burnout exhibited by these groups during an ongoing crisis is noteworthy and merits further exploration. H1b posited that there is a difference in the levels of burnout between physicians, law enforcement officers, and clergy. To address the scarcity of information within current literature regarding this situation, I addressed the aggregate sample regarding burnout levels and found that physicians and clergy displayed moderately strong feelings of career commitment and law enforcement officers indicated uncertain feelings of career commitment. As a result of differences identified between the respondents in the study, H1b was supported.

RQ2: Description and Findings

Research Question 2 posed: What is the level of career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic and how do the levels of career commitment compare between the three groups? Two hypotheses provided the framework for RQ2. H2a posited that there is a low level of career commitment among physicians, law enforcement officers, and clergy. H2b predicted that there is a difference in levels of career commitment in physicians, law enforcement officers, and clergy.

The prolonged and stressful nature of the COVID-19 pandemic on the career commitment among helping professionals was of concern because of the essential contributions these groups make to overall societal welfare. As a result, researchers have highlighted the influence of burnout on career commitment, especially as it relates to turnover intentions, job performance, work satisfaction, and early dropout rates (Aryee & Tan, 1992; Berlin, 2021; Blau, 1988; Chang, 1999). Perez et al. (2010) found that continued exposure to stressors positively impacted burnout and turnover intentions among law enforcement officers as well. Finally, the findings of pre-COVID research among clergy indicated that up to 40% experienced fatigue and depression, as well as a desire to leave the profession entirely (Francis et al., 2008; Jackson-Jordan, 2013).

During this dissertation research, physicians indicated moderately strong feelings of career commitment, law enforcement officers exhibited unsure feelings of career commitment, and clergy exhibited strong feelings of career commitment during the pandemic. The findings of H2a did not support the statement that the helping professionals in the study had a low level of career commitment; therefore, H2a was rejected. Law enforcement officers faced stressors beyond the current pandemic in the form of socio-political calls for police reform, increased scrutiny, distrust, and hostility from the public, while clergy expressed a strong commitment toward their careers as helping professionals during the pandemic.

H2b suggested that there is a difference in levels of career commitment in physicians, law enforcement officers, and clergy. The collected data indicated that 22% of the variance in career commitment could be explained by professional job type. Specifically, all three professions displayed statistically different responses from each other in relation to career commitment; therefore, H2b was supported and retained.

RQ3: Description and Findings

Research Question 3 asked: What is the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy and how do the correlations between burnout and career commitment compare between the three groups? The five hypotheses under this research question provided the

framework to address RQ3. H3a hypothesized that there is a negative correlation between burnout and career commitment. H3b stated that there is a negative correlation between burnout and career commitment among physicians. H3c predicted that there is a negative correlation between burnout and career commitment among law enforcement officers. H3d posited that there is a negative correlation between burnout and career commitment among clergy. Finally, H3e predicted a difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy.

H3a suggested that there is a negative correlation between burnout and career commitment. The existing literature linked burnout directly to job dissatisfaction and absenteeism in the workplace among all three groups (Lizano & Barak, 2015; Roelen et al., 2015). Salvagioni et al. (2017) found that individuals who displayed high burnout symptoms averaged 13.6 days absent annually, compared to an average of 5.4 days for those with low burnout scores. Therefore, without appropriate action to counter the effects of burnout, helping professionals may choose to leave the occupation or organization much sooner than expected (Ciftcioglu., 2011). In this part of the dissertation research, I examined the main factors of burnout (emotional exhaustion, depersonalization, and career commitment) for the aggregated sample and found that burnout levels significantly correlated to levels of career commitment. Emotional exhaustion and depersonalization displayed significant relationships to career commitment, while personal accomplishment had a significant negative relationship to career commitment among the aggregate sample; as a result, H3a was only partially accepted.

H3b stated: There is a negative correlation between burnout and career commitment among physicians. Shanafelt et al. (2014) found that physicians experiencing burnout noted decreased productivity, increased job dissatisfaction, and displayed the intent to leave their current practice for reasons other than retirement. Further, their findings indicated that 18% of physicians that planned to leave their current position in the next 24 months often cited burnout and conflict with work-life balance as the dominating factors. As a result, physician burnout

increased a medical professional's intent to leave their practice, negatively impacting the healthcare workforce and potentially reducing quality patient care. In this study, however, measuring the influence of burnout on career commitment indicated that burnout accounted for 63% of the variance. Emotional exhaustion represented a significant positive relationship with career commitment, and personal accomplishment had a significant negative relationship to levels of career commitment. Depersonalization among the physician respondents in this study did not reflect a significant correlation to career commitment, so H3b was partially accepted.

H3c suggested that there is a negative correlation between burnout and career commitment among law enforcement officers. Malach-Pines and Keinan (2006) found that law enforcement officers experiencing burnout also displayed low job satisfaction and an increased desire to leave police work. Martinussen et al. (2007) confirmed that burnout is positively associated with police officers' intention to quit law enforcement, and burnout and work-related stressors directly correlated with decreased productivity and intention to leave their profession.

This dissertation research found that the influence of burnout on career commitment levels among law enforcement participants accounted for 41% of the variance. As anticipated, emotional exhaustion displayed a significant positive relationship with career commitment and personal accomplishment had a significant negative relationship with career commitment. Law enforcement officers' feelings of depersonalization as specified by their responses indicated no significant correlation to career commitment so H3c was only partially accepted.

H3d posited that there is a negative correlation between burnout and career commitment among clergy. According to Francis et al. (2008), 80% of clergy say they enjoy their profession; however, about 30% deal with emotional exhaustion, a significant component of burnout. Francis et al. (2008) found that many clergy (60%) rated their job satisfaction as high, and yet found a significant number (40%) of the participants indicated depression most of the time and (40%), as well as a desire to leave the ministry as a profession. The scholars in a Duke University study linked burnout and frustration directly to clergy leaving the ministry, with

20% of respondents referencing the phenomenon as the main factor in their departure (Hoge & Wenger, 2003).

In examining the influence of burnout on career commitment levels among clergy respondents, I found a 48% variance. Respondents displayed a significant positive relationship between emotional exhaustion and depersonalization with career commitment. Personal accomplishment had a significant negative relationship to levels of career commitment. Clergy respondents were the only group that indicated a significant and positive relationship with career commitment; therefore, H3d was partially accepted.

Finally, H3e posited that there is a difference in the correlation between burnout and career commitment among physicians, law enforcement officers, and clergy. My findings confirmed that there were statistically significant differences between physicians ($p < .001$), law enforcement officers ($p < .001$), and clergy ($p < .001$) regarding burnout and levels of career commitment; therefore, H3e was retained.

Implications

The results of this dissertation study did not validate the hypothesis that helping professionals would display high levels of burnout and low career commitment during the COVID-19 pandemic. The results of the ANOVA revealed that there are statistically significant differences in levels of burnout and career commitment between the three professions of physicians, clergy, and law enforcement. The MLR for Research Question 3 (H3a) examining the relationship between burnout and low career commitment for the aggregate sample did, however, reveal that the three factors of burnout significantly predicted scores of low career commitment. Therefore, the three independent variables of burnout in the aggregate MLR regression model scored as follows: emotional exhaustion ($p \leq 0.001$), depersonalization ($p \leq 0.001$), and personal accomplishment ($p \leq 0.001$). In the following section, I discuss the specific implications of burnout and its impact on career commitment during the COVID-19 pandemic among three groups of helping professionals that I examined in this study.

Physicians

Physicians encounter burnout and its effects early in their vocational experience. Scholars have indicated that approximately 50% of physicians suffer from this phenomenon at various points during their professional careers (Shanafelt, Hasan et al., 2015). Further, researchers have reported that 28% to 75% of physicians struggle with various factors of burnout as early as medical school (Dyrbye, West et al., 2014). As physicians move into practice, those in certain specialties are at a greater risk of burnout, including family medicine practitioners, internal medicine specialists, and emergency medicine physicians (Shanafelt et al., 2014). The AMA found that middle career physicians (11–20 years of practice) exhibited higher levels of burnout, characterized by emotional exhaustion and depersonalization than early-career physicians (10 years or less) and late-career physicians (21 years or more; Dyrbye et al., 2013). According to Benham et al. (2020), widespread medical events such as the COVID-19 pandemic serve as accelerants that intensify the factors that put medical professionals at risk of burnout.

In this study, the physician respondents exhibited a moderate (2.76) level of burnout when indicating feelings of emotional exhaustion on an average of once per month to less than a few times per month during the COVID-19 pandemic. They also indicated low feelings of depersonalization (1.77), experiencing feelings of depersonalization toward patients a few times per year or less. This contradicts the AMA findings, which suggested that physicians experienced high feelings of emotional exhaustion and high feelings of depersonalization (Dyrbye et al., 2013). The physicians participating in this study also expressed high or strong feelings of personal accomplishment (4.77) a few times per week in spite of the pandemic stressors.

The AMA study (Dyrbye et al., 2013) found that physicians who experienced emotional exhaustion and frustration were more likely to leave their practice and pursue a career outside of medicine. Physicians in this study, however, exhibited moderately strong feelings of career commitment (2.27) and indicated positive feelings toward their vocation overall. As a result, physicians displayed

moderate to moderately high degrees of resiliency against burnout and its factors during the pandemic, while maintaining strong feelings of career commitment toward their professions.

As physicians experience burnout early and throughout their careers, they may be more conditioned to higher levels of stress than other professions. A physician's personal and relational well-being suffers when dealing with burnout, placing them, their families, and their patients at risk (Oreskovich et al., 2012; Van der Heijden et al., 2008; West et al., 2012). Further, the conservative estimated financial impact of burnout among physicians is a staggering $4.6 billion annually in the United States alone (Han et al., 2019), suggesting that additional research into the underlying causes of physician burnout during high stress events are clearly needed. In summary, while physicians in the study appeared to have resiliency against the effects of burnout, healthcare organizations and the individual physicians who are part of those systems should work together to find strategies to reduce the negative effects of the phenomena.

Law Enforcement

Historically, law enforcement has been consistently ranked among the most stressful occupations worldwide, and researchers have indicated that the stress of the profession can negatively impact mental, emotional, and physical health, adversely impacting job performance and well-being (Dantzer, 1987; Queirós et al., 2020). In 2020, law enforcement officers in the United States experienced a dramatic shift in public perception. Initially, the public celebrated law enforcement officers alongside other helping professionals risking their lives during the COVID-19 pandemic (Lilly & Curry, 2020). Public perception quickly shifted following the death of George Floyd, as negative stressors such as verbal, psychological, and physical assaults increased. Calls for defunding the police and radical law enforcement reform have exacerbated the adverse effects of the pandemic by forcing officers to perform under increased public scrutiny, distrust, and hostility. While officers faced significant external and internal pressures before the COVID-19, the combination of pandemic and shift in public perception amplified negative

stressors causing a higher risk for burnout, decreased productivity, and desire to leave the profession (Lilly & Curry, 2020).

In this study, I measured the level of burnout (emotional exhaustion, depersonalization, and personal accomplishment) of law enforcement respondents in Texas and Arkansas to determine their level of burnout during the COVID-19 pandemic. The emotional exhaustion level of law enforcement officers was moderate (2.61), indicating that officers felt emotionally exhausted on average once per month to less than a few times per month. In comparison, in a nationwide study by McCarty et al. (2019), the researchers found that respondents scored 3.40 on the MBI-HSS modified emotional exhaustion scale. Therefore, the officers in this study were less emotionally exhausted than in the nationwide study. Additionally, law enforcement officers in this study experienced moderate levels of depersonalization (2.68) towards people from once per month to a few times a month, while officers in the McCarty et al. study averaged slightly higher for depersonalization (2.84).

Lilly and Curry (2020) noted that officers are leaving law enforcement at higher-than-normal rates due to the increased pressure and strain placed on them by the current crisis environment. The respondents of this dissertation research, however, reported moderate (4.20) levels of personal accomplishment indicated less pressure and strain to leave the profession. In relation to career commitment, respondents were unsure of their feelings towards their profession (2.81), suggesting a degree of uncertainty towards continuing in their vocation. Law enforcement officers in the current study indicated moderate degrees of depersonalization (emotional exhaustion, depersonalization, and personal accomplishment) and were unsure about their commitment to their vocation. As a result, law enforcement officers in the study expressed a level of resiliency against burnout slightly higher than the national average.

While it is impossible to remove stress and trauma from law enforcement, organizations and the communities they serve are ultimately responsible for supporting law enforcement officers doing this challenging and essential public service (Foley & Massey, 2020). Both administrative stressors and externally

generated challenges affect law enforcement officers (Shane, 2010). Further, workload stressors were the leading predictor of work-life conflict which led to increased burnout among law enforcement officers (McCarty et al., 2019), so administrators could improve officer well-being by reducing controllable stressors such as workload scheduling, proper resource allocation, additional education, and mental health services that increase professional and personal well-being.

Clergy

The social upheaval caused by the COVID-19 pandemic had a significant negative impact on religious expression and the role of clergy in the United States. Church members and attenders were suddenly deprived of their typical avenues of religious expression as churches across the United States canceled public meetings to avoid spreading the contagion. Although online worship quickly replaced traditional in-person services for many churches, the loss of shared rituals and direct contact among faith communities resulted in a sense of isolation (Village & Francis, 2021). While physicians and law enforcement officers had to continue interacting with patients and citizens, clergy were suddenly limited in how they could interact with congregants and forced to find new ways to conduct public events and pastoral care without physical contact. This included worship services, funerals, weddings, hospital visitations, in-home visitations, Holy Communion, and other traditional or sacramental practices.

In this study, clergy exhibited moderate levels of emotional exhaustion (2.41) on average of once per month to less than a few times a month. Depersonalization scores for clergy were low (1.40), indicating that they felt disconnected from their congregants a few times per year or less. Clergy indicated feelings of personal accomplishment (4.25) from once per month to a few times a month. Regarding depersonalization, only the disaggregated model for clergy displayed a significant and positive relationship to career commitment ($p < .001$). Therefore, depersonalization contributed to an increase in the levels of career commitment among clergy professionals. Even though clergy were disconnected from congregants physically, their career commitment did not appear to be

diminished, and in fact increased. This resiliency could be related to increased feelings of closeness to God during the COVID-19 pandemic.

In a study of clergy in England during the COVID-19 lockdown, the researchers found that respondents indicated increased exhaustion (48%), anxiety (38%), and stress (37%), but also felt closer to God (43%) and experienced an increase (50%) in their prayer life (Village & Francis, 2021). This phenomenon could explain why clergy in this study experienced moderate levels of emotional exhaustion and personal accomplishment, while staying connected, encouraged, and motivated in their profession through a stronger spiritual connection to God through prayer.

In summary, the findings of this study regarding physicians indicate that they were moderately committed to their profession during the pandemic, while law enforcement officers were unsure. Clergy, however, expressed a strong level of resiliency against burnout, as well as a strong, positive feeling toward their career commitment. These results align with the assessment of Francis et al. (2008) that while clergy often face significant challenges in their profession, "pastors are happy but exhausted" (p. 168).

Limitations

While the results of this dissertation provided new insight into the impact of burnout and career commitment among physicians, law enforcement officers, and clergy during the COVID-19 pandemic, it is important to identify its limitations. First, I used convenience sampling, which according to Creswell and Creswell (2018), can be a limitation to the research. Next, participants voluntarily selected whether to participate in the study, allowing for participant self-selection biases (Creswell, 2014; Creswell & Creswell, 2018), which can also be a significant limitation. Finally, the surveys were self-reported which could potentially lead to unintentional biases, especially if there is a difference between those who responded and those who did not respond, leaving a gap in the overall findings.

The research involved a cross-sectional study, which can be a potential limitation because of errors related to common method variance (CMV) and causal inference (CI). The impact the validity of survey-based cross-sectional studies

(Lindell & Brandt, 2000; Podsakoff et al., 2003) is a common problem but can't always be avoided. Therefore, collecting longitudinal data as a means of reducing CMV and CI is desirable when the temporal nature of a phenomena is clear, when it is unlikely that intervening events could confound a follow-up study, or when alternative explanations are likely and cannot be controlled with a cross-sectional approach (Rindfleisch et al., 2008). Finally, the cross-sectional nature of the study only allowed for the identification of statistical relationships between the independent and dependent variables, leaving any claims of causality beyond the scope of this study unknown.

An additional limitation may be linked to the demographic sample. Specifically, the socio-political environment of the geographical region of the respondents was limited to parts of Texas and Arkansas. The sampled region is politically conservative, and the respondents may or may not share cultural and political similarities that influence burnout and career commitment in other parts of the country. I also did not differentiate between rural and metropolitan (nonrural) settings, which could result in participants with different views or experiences. Finally, respondents were primarily male (81.4%) and ethnically White (86%), which could also be a limitation when trying to draw conclusions from the findings.

Physician Study Limitations

Another limitation of the study was the lack of response from physicians (*N* = 71). Two separate group managers from each participating state separately commented on the challenges that they encountered getting physicians to respond to any type of communication during the pandemic. One manager stated, "They [physicians] know they are burned out and they don't want to talk about it" (A. Driggs, personal communication, November 18, 2021). Therefore, it is possible that the physicians experiencing the most acute burnout because of the COVID-19 pandemic might be least inclined to participate in a survey on burnout, thereby skewing the results.

Law Enforcement Study Limitations

The contextual variables included in this study are for the entire law enforcement agencies involved and did not account for different ranks or positions (e.g., patrolman, corporal, captain, sheriff, etc.), which could have limited the findings. I also did not differentiate between the type of agency (e.g., town, city, sheriff's office, university police, wildlife officer, highway patrol, etc.), which could have influenced the outcomes if differences were significant. I recognized the different dynamics that could potentially occur due to these factors and identified many of them on the front end of the study.

Clergy Study Limitations

This study was based on a large convenience sample within two states: Texas and Arkansas. The study group also came primarily from the Assemblies of God evangelical denomination located in the Arkansas and North Texas Districts, rather than a broader range of Christian groups. As a result, it was not possible to tell accurately how representative the effects of burnout and its impact on career commitment were among other clergy groups during the COVID-19 pandemic. Finally, there was no comparable measure of well-being prior to the pandemic among these groups, which would have helped broaden my knowledge and understanding of how clergy might respond to such a study.

Suggestions for Future Research

The findings of this study offer new knowledge and insights into the impact of burnout and career commitment among helping professionals during a global crisis. The findings also raise additional questions for research opportunities regarding burnout among other groups of helping professionals. As a result, initial recommendations for further research include the need for a longitudinal research initiative providing supplementary insights into the effect of burnout on career commitment among the same or similar sample groups. Studies centering on the effects of pandemics or other broad range crisis events on helping professionals would also add additional knowledge to leadership literature, especially because so

little is known about how helping professionals deal with burnout and career commitment before, during, and after a major crisis.

Considering the purposive sampling technique utilized in the current study, only three helping professional groups were examined; thus, it would be beneficial for future researchers to replicate the study among different helping professional groups such as nurses, social workers, therapists, teachers, firefighters, and others. This would help further clarify differences in the relationship between burnout and career commitment among helping professionals overall. Research examining other helping profession groups from different socio-political and geographical locations could also prove valuable for gathering comparative information. In addition, research on groups outside of the helping professions (e.g., business, transportation, service industries, entertainment, etc.) could provide insights into how to better understand burnout and career commitment during a crisis among professional workers overall.

Finally, future studies could benefit from a broader sample of gender and racial variability. Considering the impact of age, gender, tenure, race, and income could provide valuable insights into how professionals deal with and respond to burnout and career commitment when these factors differ. A qualitative study among similar groups of helping professionals to complement the quantitative findings within the current study may also hold valuable insights into the topic of burnout on career commitment as well. Further, applying a qualitative study approach to helping professionals who exited their careers could provide additional insights into the phenomenon of burnout and retention. Finally, conducting a mixed-methods study within a single department or organization examining the impact of burnout on career commitment could reveal valuable insight into the effect of the phenomenon.

Suggestions for Future Research – Physicians

Due to the limited responses by physicians in this study, the findings cannot be generalized to physicians nationwide; therefore, having a larger response to analyze the findings is highly recommended. Certain physician specialties are at greater risk for burnout than others, specifically family medicine practitioners,

internal medicine specialists, and emergency medical physicians (Shanafelt et al., 2016). As a result, studying the effects of burnout among different physician specialty groups during and after the COVID-19 crisis could prove helpful to those responsible for training and management. Examining the effects of burnout and career commitment among physicians in rural versus metropolitan areas could also prove enlightening for professional agencies and higher education. Further, the findings of qualitative studies among physician respondents could prove valuable.

Researchers have indicated a strong link between personality characteristics and burnout, with some profiles providing resilience and others being susceptible to the phenomenon (Louw, 2014). Holland (1997) posited that matching personality types with corresponding work environments could prove useful in increased job satisfaction. Therefore, research studies that examined physician personality types and the impact on their organizational environments could provide insight into burnout resiliency and job satisfaction.

Suggestions for Future Research – Law Enforcement

A broad comparative study among various law enforcement agencies (e.g., town, city, county agencies, university campus police, wildlife officers, highway patrol, etc.) regarding burnout and career commitment could prove helpful for both individuals and agencies who support and employ these individuals. Measuring additional control variables such as rank, race, age, gender, tenure, and compensation could prove invaluable for both the individuals and those who oversee their work. The majority of sworn law enforcement officers in the United States are employed in jurisdictions of 100,000 or more residents (Reaves, 2015); thus, specific studies of these groups could also be valuable for human resource offices and administrators.

Suggestions for Future Research – Clergy

In this study, I analyzed burnout and career commitment among clergy in one denomination, the Assemblies of God, in Texas and Arkansas. A similar study comparing the results of burnout and career commitment on an entire denomination could provide useful information regarding the effects of burnout on different

regions. A comparative study between denominational clergy would help determine whether the findings of this study are the same or similar results given cultural, organizational, and theological differences. A research project analyzing the effects of burnout and career commitment among staff members other than senior or lead pastors (e.g., associate pastor, youth pastor, children's pastor, worship pastor, administrative staff) could also be useful when educating and training these individuals for service in volunteer or professional ministry settings. Examining variables such as age, race, gender, tenure, compensation, and level of ordination could provide data that inform practical recommendations for both training and management.

Summary

The long-term impact of the COVID-19 crisis among helping professionals such as physicians, law enforcement officers, and clergy remains primarily unknown, partly because of the recent timing of the event. The personal and professional impact on these groups is profound and certainly merits further discussion and formal research (Benham et al., 2020; Greene et al., 2020; Stogner et al., 2020). In this study, I sought to explore the effects of burnout on career commitment among helping professionals including physicians, law enforcement officers, and clergy during the COVID-19 pandemic and offers some insight into what occurred. I did not, however, validate the hypothesis predicting that helping professionals would display high levels of burnout (emotional exhaustion, depersonalization, personal accomplishment) and low career commitment during the pandemic, which was surprising.

The findings contribute to the body of literature confirming a relationship between burnout and low career commitment for the aggregate sample, and by confirming that the three factors of burnout significantly predicted scores of low career commitment. In this study, I also identified specific organizational and individual interventions, as well as the need for increased awareness and greater relational and public support for those who take on the responsibility of keeping the larger public healthy, safe, and spiritually strong. Finally, the results confirmed the resiliency of the respondents of this study against the negative impacts of burnout

during the COVID-19 pandemic and is a testimony to their professionalism and tenacity in serving their communities, even in the face of adversity.

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Appendix A

Blau Career Commitment Measure

Career Commitment

1. I like this career too well to give it up.
2. If I could go into a different profession which is paid the same, I would probably take it.
3. If I could do it all over again, I would not choose to work in this profession.
4. I definitely want a career for myself in this profession.
5. If I had all the money, I needed without working, I would probably still continue to work in this profession.
6. I am disappointed that I ever entered this profession.
7. This is the ideal profession for a life's work.

Appendix B

Maslach Burnout Inventory Human Services Survey

Emotional Exhaustion Survey Questions

Emotional Exhaustion

I feel emotionally drained.

I feel used up at the end of the day

I feel fatigued when I get up in the morning and have to face another day on the job.

Working with people all day is really a strain for me.

I feel burnt out from my work.

I feel frustrated about my job.

I feel I'm working too hard on my job.

I don't really care what happens to some patients/clients/congregants.

Working with people directly puts too much stress on me.

Appendix C

Maslach Burnout Inventory Human Services Survey

Depersonalization Survey Questions

Depersonalization

I feel I treat some patients/clients/congregants as if they were impersonal objects.

I've become more callous toward people since I took this job.

I worry that this job is hardening me emotionally.

I don't really care what happens to some patients/clients/congregants.

I feel patients/clients/congregants blame me for some of their problems.

Appendix D

Maslach Burnout Inventory Human Services Survey

Personal Accomplishment Survey Questions

Personal Accomplishment

I can easily understand how my patients/clients/congregants feel about things.

I deal very effectively with the problems of my patients/clients/congregants.

I feel I'm positively influencing other people's lives through my work.

I feel very energetic.

I can easily create a relaxed atmosphere with my patients/clients/congregants.

I feel exhilarated after working closely with my patients/clients/congregants.

I have accomplished many worthwhile things in this job.

In my work, I deal with emotional problems very calmly

Appendix E

IRB Approval

SOUTHEASTERN UNIVERSITY

NOTICE OF EXEMPTION FOR HUMAN RESEARCH

DATE:	September 17th, 2021
TO:	Joshua Henson, Christopher Clem
FROM:	SEU IRB
PROTOCOL TITLE:	The Impact of Burnout on Career Commitment during COVID-19
FUNDING SOURCE:	NONE
PROTOCOL NUMBER:	21 BE 02
APPROVAL PERIOD:	Approval Date: September 17th, 2021, Expiration Date: September 16th, 2022

Dear Investigator(s),

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the protocol entitled, The Impact of Burnout on Career Commitment during COVID-19. The project has been approved for the procedures and subjects described in the protocol.

Any changes require approval before they can be implemented as part of your study. If your study requires any changes, the proposed modifications will need to be submitted in the form of an amendment request to the IRB to include the following:

- Description of proposed revisions;
- *If applicable,* any new or revised materials;
- *If applicable,* updated letters of approval from cooperating institutions

If there are any adverse events and/or any unanticipated problems during your study, you must notify the IRB within 24 hours of the event or problem.

At present time, there is no need for further action on your part with the IRB. This approval is issued under Southeastern University's Federal Wide Assurance 00006943 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the IRB's Assurance, please do not hesitate to contact us.

Sincerely,

Rustin Lloyd
Chair, Institutional Review Board
irb@seu.edu

Appendix F

Survey Invitation Sample Email to Physicians

Dear Member,

One of our main priorities is to help facilitate the wellness and resilience of our members as we navigate through and beyond the current Covid-19 crisis. As part of our ongoing commitment to you, we are partnering in a study on burnout/moral injury and career commitment and its impact on helping professionals during the crisis.

The information gathered will help us measure and evaluate these factors and assist our organization and others in providing resources and support to you. It should take no more than 5-10 minutes to complete the survey, and you can use any portable electronic device or computer.

Finally, this survey is entirely secure, and all participants will be completely anonymous. We would appreciate you taking a few moments to complete the survey by clicking the link below.

https://www.surveymonkey.com/r/H9HNVWG

We are here for you and appreciate your commitment to your patients and our community.

Sincerely,

Appendix G

Survey Invitation Sample Email to Law Enforcement

The last 18 months have been some of the hardest months many of us have experienced in our careers. Many of our brothers and sisters have simply walked away from law enforcement as a profession. Although the causes are varied, the most commonly stated reason is burnout.

This devastating trend must be changed.

A fellow officer is researching the level of burnout experienced by LEOs in Texas and Arkansas. This research will benefit those of us presently in law enforcement, as well as those that follow in our steps. Your input, experience, and perspective would greatly impact this important research.

Attached is a link to a completely anonymous Burnout Survey. I completed the survey in less than 5 minutes on my phone. I encourage you to carve out 5 minutes to complete the survey too. Your responses will be compiled with others to shed light on this alarming trend.

Here is the Burnout Survey link: https://www.surveymonkey.com/r/H9HNVWG

Appendix H

Survey Invitation Sample Email to Clergy

I know you've heard the statistics from the Barna Group. Monthly over 1,500 ministers nationwide forsake their calling. The toll on one's emotional, spiritual, relational and financial resources drive ministers like us to simply walk away from ministry. Although the causes are varied, the most commonly stated reason is burnout.

This devastating trend must be changed.

One of our Assemblies of God ministers is researching the level of burnout experienced by North Texas ministers. This research will benefit those of us presently in ministry, as well as those that follow in our steps. Your input, experience and perspective would greatly impact this important research.

Attached is a link to a completely anonymous Burnout Survey. I completed the survey in less than 5 minutes this morning on my phone. I encourage you to carve out 5 minutes to complete the survey too. Your responses will be compiled with others to shed light on this alarming trend.

Here is the Burnout Survey link: https://www.surveymonkey.com/r/H9HNVWG

Blessings,