

BOUNDARY SETTING OF MENTAL HEALTH PROFESSIONALS:  
ITS RELATIONSHIP TO SELF-CARE, BURNOUT, AND WELL-BEING

A Dissertation

by

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Submitted to the Graduate and Professional School of  
Texas A&M University  
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

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August 2022

Major Subject: Counseling Psychology

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## ABSTRACT

Setting boundaries between personal and professional life is a common piece of advice given to many professionals due to an assumption that it can positively impact one's life. From a mental health perspective, though, there is a lack of empirical research studying how boundary setting relates to constructs like self-care, burnout, or well-being. Furthermore, there are few psychometrically validated measures to measure boundary setting. This study seeks to address both gaps in the literature. First, a new survey was created, the Personal-Professional Life Boundary Setting Survey, and its psychometric properties were examined using exploratory factor analysis. This process resulted in a final three factor structure of Segm, PersInt, and ProfInt. Second, this study examined the relationship of boundary setting with self-care, burnout, and well-being, using the Self-Care Assessment for Psychologists, the Maslach Burnout Inventory, the Satisfaction With Life Scale, and the Flourishing Scale. Structural equation modeling (SEM) analyses were used to examine the relationship between the multiple factors in each measure. Overall, segmentation was found to relate positively with all aspects of self-care and well-being. Professional interference on personal life was found to relate negatively with self-care and well-being but positively relate with burnout. Personal interference on professional life was related with diminished feelings of personal accomplishment.

## ACKNOWLEDGEMENTS

Looking back on this journey to a PhD, there is more to acknowledge than I can adequately express. After all, where did my journey truly begin? Was it the first official day of class, or when I was admitted to this program, or when I began applying for graduate schools? Or was it the innumerable formative moments, experiences, nurture, guidance, and history that established the foundation for this milestone that I'd like to consider "mine"?

When I think back on all the intertwined personal decisions, internal and external voices, relationships, cultural considerations, and opportunities that have influenced my journey, I'm humbled and awed. I must thank God first and foremost that He is the Author of this story. He is the one overseeing the overwhelming number of strands that are interwoven in my story, many of which I may never even know. At every point, He has been my constant companion and the friend that sticks closer than a brother. So many times, I didn't know where I was going and felt discouraged, intimidated, exhausted, or overwhelmed. But if there were only one lesson I have learned through this process, it is to trust Him day-by-day. He has reminded me repeatedly not to worry about tomorrow because there are already enough troubles for today, because He knows what I need, because He gives me daily bread, and because He knows His plan for me. I was not particularly good at learning this lesson, but He sure has been diligent about teaching it to me for all 5 years of this PhD.

Humanly speaking, one of the key influencers throughout my program has been my advisor and Chair, Dr. Charles Ridley. I am tremendously thankful for him. In fact, he was the reason I chose Texas A&M over the other graduate schools that had offered me admission. I could see myself being mentored well by him even on interview day, and he has more than surpassed my expectations. Throughout these years, he has helped me in so many ways, whether

that be launching me into research projects & presentations, talking with me through important decisions, writing references for various applications, connecting me to other professionals, or providing a critical eye for this dissertation. I am so blessed that he took me under his wing, and I can't emphasize enough how much of a positive influence he's been.

Other program-specific influences that I want to acknowledge include my entering PhD cohort, the research team led by Dr. Ridley (affectionately known as the Multicultural Mafia), many former graduates of our program, several of my clinical supervisors, my assistantship employers, my stats consultant (thank you SO much, Katie), and the Committee overseeing this dissertation. Each of you has contributed something uniquely valuable to my journey, and I hope I have expressed that personally and directly to you even though I couldn't write it all out here.

Both in the program and in my life in general, my parents are two people who have tremendously influenced my journey. I still remember them believing in me enough to push me to apply to graduate school at the end of my college degree, despite my hysterical tears over not feeling good enough. Looking back, I see several times in my life where that impostor syndrome could have seriously deterred me from seizing key moments, but thankfully my parents insisted that I make a full effort to take the leap of faith. Through their own lives, they show me an example of continually learning new things, problem-solving instead of complaining, and embarking on yet another adventure.

Outside of the program, I think of several close friends from college who I see as family. Despite the geographical distance between us, we've found our ways to stay connected, and I feel so incredibly blessed by that. You guys have seen me through so many transitions over the years, and I'm truly so thankful for your consistency. You know who you are.

Locally, I want to acknowledge the fantastic community I've found through Grace Bible Church. In particular, the two main groups I've gotten connected with are the young adults' ministry (Junction) and my intergenerational home group. I've met so many incredible people who have been so welcoming, generous, and servant hearted. The support I've received through you has been a consistent reminder that God always provides. That's ranged from a place to live during a snowpocalypse, solutions for several car troubles, transitioning between different leases, and just general tips on living in the area. Aside from the practical help you've been, you've also been such as source of encouragement, laughter, wisdom, and honesty. You've made my life so much richer than just a nose-to-the-grind PhD experience, and I don't take that for granted. I am so deeply thankful for the way God's used you to shape me and for the opportunities you've also given me to serve you. Thank you for the diverse gifts, passions, and personalities you bring together in my life and in the lives of so many others.

Finally, I must acknowledge the almost 400 participants in this study, as well as the numerous people who distributed recruitment announcements on my behalf. I don't know who you all were, and most of you probably did not know me, but I honestly am so grateful to you. I can't thank you enough for taking time out of your busy schedules to complete yet another survey for no guaranteed compensation. You must have done it out of the goodness of your heart (or maybe out of a passion for generating empirical data?), and I'm just blown away in surprise. Some of you even proactively contacted me to offer help, provide feedback, or suggest some ideas. I literally could not have conducted this study without you, and the help you've given me throughout data collection has given me a much brighter view of the network/community within our mental health profession.

## CONTRIBUTORS AND FUNDING SOURCES

### **Contributors**

This work was supervised by a dissertation committee consisting of Professors Charles R. Ridley [Chair], Timothy Elliott, and Jeffrey Gagne of the Department of Educational Psychology and Professor Beverly Irby of the Department of Educational Administration and Human Resource Development.

As the investigator, I gathered the data analyzed for Chapter III. With assistance from Katherine (Katie) Fletcher, a graduate assistant within the Department of Educational Psychology, I also analyzed the data in Chapter IV. For the structural equation modeling analyses, Katie conducted the steps and drafted the initial tables of their results. I drafted the final SEM tables and the other results depicted in Chapter IV. The analyses have not been previously published. I independently completed all other work for this dissertation.

### **Funding Sources**

Graduate study was supported by several graduate assistantships within the College of Education and Human Development at Texas A&M University.

This work received some voluntary financial support from my grant-funded practicum placement at the Texas A&M Telebehavioral Care (TBC). The financial support was used solely for participant compensation. The practicum program was called the Integration of Telehealth in Regions Underserved for Student Training (iTRUST), and it received Grant #: D40HP33362-01-00T from the U.S. Health Resources & Services Administration (HRSA). The contents of this work are solely the responsibility of the authors and do not necessarily represent the official views of the HRSA or the TBC.

This work also received some voluntary financial support from the Dissertation Chair, Dr. Charles Ridley. This financial support was used solely to hire the statistical consultant to conduct the structural equation modeling analyses in this study.

## NOMENCLATURE

Boundary Setting – 3 factors from (Personal-Professional Life Boundary Setting Survey):

PersInt	Personal life interference with professional life
ProfInt	Professional life interference with personal life
Segm	Segmentation approach

Self-Care – 5 factors from SCAP (Self-Care Assessment for Psychologists):

ProfSup	Professional support
ProfDev	Professional development
LifeBal	Life balance
CogAw	Cognitive awareness
DayBal	Daily balance

Burnout – 3 factors from MBI (Maslach Burnout Inventory):

EE	Emotional exhaustion
DP	Depersonalization
PA	Personal accomplishment

Well-Being – 2 measures:

SWLS	Satisfaction With Life Scale
Flourish	Flourishing Scale

## TABLE OF CONTENTS

	Page
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
CONTRIBUTORS AND FUNDING SOURCES .....	vi
NOMENCLATURE .....	viii
TABLE OF CONTENTS.....	ix
LIST OF FIGURES .....	xi
LIST OF TABLES .....	xii
CHAPTER I INTRODUCTION.....	1
Purpose Statement.....	3
Other Variables .....	3
Research Questions (RQs) .....	5
CHAPTER II LITERATURE REVIEW .....	7
Boundaries and Boundary Setting.....	7
Self-Care .....	24
Burnout .....	31
Well-Being.....	37
Mental Health Professionals .....	42
CHAPTER III METHODS .....	45
Procedures.....	45
Participants.....	48
Measures .....	51
Data Analysis .....	55
CHAPTER IV RESULTS.....	64
Preparatory Statistical Analyses.....	64
RQ-Specific Analyses.....	96
CHAPTER V SUMMARY AND CONCLUSIONS .....	104
RQ1: Boundary Setting & Self-Care .....	104
RQ2: Boundary Setting & Burnout.....	109
RQ3: Boundary Setting & Well-Being .....	113

RQ4: Boundary Setting & Self-Care, Burnout, Well-Being.....	117
Novelty.....	120
Future Directions for Research .....	123
Limitations .....	125
REFERENCES .....	129
APPENDIX A: ELECTRONIC RECRUITMENT .....	150
APPENDIX B: INFORMED CONSENT FORM.....	157
APPENDIX C: SCREENING QUESTIONS.....	160
APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE.....	161
APPENDIX E: PERSONAL-PROFESSIONAL LIFE BOUNDARY SETTING.....	163
APPENDIX F: SELF-CARE ASSESSMENT FOR PSYCHOLOGISTS.....	166
APPENDIX G: FLOURISHING SCALE.....	169
APPENDIX H: SATISFACTION WITH LIFE SCALE.....	170
APPENDIX I: PARTICIPANT COMPENSATION NOTIFICATION.....	171

## LIST OF FIGURES

	Page
Figure 1. Three Factors Correlated Model of Boundary Setting .....	66
Figure 2. Three Factors with 2 <sup>nd</sup> -Order Latent Variable Model of Boundary Setting.....	68
Figure 3. Full Structural Equation Model.....	83

## LIST OF TABLES

	Page
Table 1. Excerpts from the APA Ethical Principles and Code of Conduct .....	27
Table 2. Excerpts from the ACA Code of Ethics and the NASW Code of Ethics .....	28
Table 3. Demographic Characteristics of Participants.....	49
Table 4. Professional Demographics of Participants .....	50
Table 5. EFA Assessment of Model Fit.....	65
Table 6. Boundary Setting Items with CFA and SEM Factor Loadings .....	66
Table 7. Reliability of Measures .....	69
Table 8. Goodness-of-Fit Statistics for Each Measure .....	71
Table 9. Correlations Among Self-Care Factors.....	73
Table 10. Correlations Among Burnout Factors.....	74
Table 11. Correlations Among Boundary Setting Factors.....	75
Table 12. Correlations of Boundary Setting Factors with Other Factors .....	76
Table 13. Linear Regression Model Fit Statistics: Boundary Setting & Self-Care Factors .....	79
Table 14. Linear Regression Model Fit Statistics: Boundary Setting & Burnout Factors.....	79
Table 15. Linear Regression Model Fit Statistics: Boundary Setting & Well-Being Measures...	80
Table 16. Boundary Setting - Pattern Coefficients and Residuals.....	85
Table 17. Self-Care - Pattern Coefficients and Residuals.....	87
Table 18. Burnout - Pattern Coefficients and Residuals.....	89
Table 19. Well-Being - Pattern Coefficients and Residuals .....	90
Table 20. Residual Variances for Factors in the SEM Model .....	92
Table 21. Factor Covariances in the SEM Model.....	93
Table 22. Residual Covariances in the SEM Model .....	95
Table 23. Self-Care Factor Loadings.....	97

Table 24. Burnout Factor Loadings .....	99
Table 25. Well-Being Factor Loadings.....	100
Table 26. Statistically Significant Factor Loadings.....	102

## CHAPTER I

### INTRODUCTION

Boundary setting between personal and professional life is a concept that is frequently mentioned in a variety of contexts, including casual, academic, and professional ones. Across disciplines, there are implicit and explicit messages about the importance of setting boundaries and the variation in the quality of a person's boundaries (Cloud & Townsend, 2017; Harrison & Westwood, 2009; Hellman et al., 1987; Matheson & Rosen, 2012; Morris, 2018; Norcross & Guy, 2007). Boundaries are even mentioned colloquially and informally, such as in conversations, social media, websites, YouTube videos, or blog posts. Although statements about the importance of setting boundaries are common, they often do not offer clear explanations about why boundaries matter. Furthermore, concrete operationalizations of boundary setting in practice are also lacking.

In the psychological literature for mental health professionals, the construct of "boundaries" typically does not refer to a differentiation between personal and professional life. Instead, it is most associated with the construct of professional boundaries, also known as professional ethics. Professional boundaries/ethics refer to the standards of ethical and professional behavior expected of mental health professionals, especially towards their clients, colleagues, or supervisees (Gutheil & Gabbard, 1993; Sawyer & Prescott, 2011; Smith & Fitzpatrick, 1995). This aspect of boundaries is highly important and has received extensive psychological research attention. However, the personal-professional life aspect of boundary setting has been insufficiently studied and conceptualized. There is little scholarly consensus on a definition of boundary setting, few validated measures for this construct, and few studies examining it from a mental health perspective. Therefore, an important future direction for the

psychological literature is to expand the scholarly discussion beyond professional ethical behavior to personal-professional life boundary setting.

In the organizational/occupational health literature, boundary setting between personal and professional life has received somewhat more attention than it has in more clinically oriented psychological literature. This discipline has produced some definitions, theories, and measures of personal-professional life boundaries that could be relevant to a mental health perspective (Ashforth et al., 2000; Bulger et al., 2007; Clark, 2000; Dumas & Sanchez-Burks, 2015; Matthews & Barnes-Farrell, 2010; Voydanoff, 2005). For instance, boundary setting could be related to the person's self-care, well-being, or burnout. However, clinically oriented psychological literature rarely references the organizational/occupational health literature on boundary setting between personal and professional life. Therefore, another opportune way to expand the psychological knowledge on boundary setting is to draw upon the existing knowledge from the organizational/occupational health discipline.

While the psychological literature for mental health professionals speaks markedly less about personal-professional life boundaries than about professional ethical boundaries, this aspect of boundary setting is no less important. The mental health profession places many demands on individual professionals, which, if not managed well, can diminish their well-being and lead to burnout (Allen et al., 2000; Barnett et al., 2007; Bulger et al., 2007; Hellman et al., 1987; Matheson & Rosen, 2012). Some of these demands include the emotional and psychological demands of their work, additional administrative demands, perceived expectations for their own well-being, and ethical standards for their professional behavior (Bettney, 2017; Morris, 2018; Rupert et al., 2015). Boundary setting may be one way that mental health professionals can positively cope with the professional demands and their personal life. The

potential benefit of boundary setting for the individual's self-care, burnout, and well-being makes it even more important to form a clear, operationalized understanding of what boundary setting between personal and professional life means in practice

### **Purpose Statement**

The purpose of this study was to investigate the relationship between personal-professional life boundary setting to self-care, burnout, and well-being in mental health professionals. In this study, boundary setting was defined as active, purposeful behaviors and choices that individuals make to set a demarcation between their personal and professional life. I hypothesized that boundary setting relates significantly to the constructs of well-being, burnout, and self-care. However, there is a paucity of research studying these relationships. Although there is research on the relationships between self-care, burnout, and well-being (Dorociak et al., 2017; Lee et al., 2020; Posluns & Gall, 2019; Salloum et al., 2015; Skovholt et al., 2001), there is no research on the relationships of these constructs to boundary setting.

### **Other Variables**

In addition to boundary setting, this study examined three other variables: self-care, burnout, and well-being. Each of these constructs are common concerns for mental health professionals, regardless of their specializations. In this study, the operationalizations of boundary setting and self-care were active, purposeful behaviors, which are objective and observable. Meanwhile, the operationalization of burnout and well-being was more subjective, representing the internal experience of the mental health professional.

### ***Self-Care***

I used Lee and Miller's (2013) definition of self-care:

Personal self-care is defined as a process of purposeful engagement in practices that promote holistic health and well-being of the self, whereas professional self-care is understood as the process of purposeful engagement in practices that promote effective and appropriate use of the self in the professional role within the context of sustaining holistic health and well-being. (p. 98)

Several aspects of this definition are important to note. First, this definition emphasizes that self-care is *purposeful*. It is not passive, such as just allowing something to happen or having something. Instead, it emphasizes the behaviors and choices that the individual actively makes. This emphasis is consistent with this study's operationalization of boundary setting as active and purposeful. Second, this definition emphasizes *engagement in practices*. Practices are more likely to be observable, objective, and measurable, which provides a better comparison for studying this new operationalization of boundary setting. Third, this definition distinguishes between personal and professional self-care, which is consistent with this study's purpose of studying boundary setting between the personal and professional life. Finally, this definition serves as the conceptual underpinning of the measure of self-care in this study.

### ***Burnout***

In this study, the definition of burnout aligns with the original description from Maslach and Jackson (1996): "Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p. 4). They further elaborated that it is "...a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's capacity to perform" (p. 20).

Two aspects of this definition are important to note for this study. First, the conceptualization of burnout is tridimensional, as opposed to a one-dimensional view of it as

merely exhaustion. Second, the dimensions of burnout are in reference to occupation/work. Although the term, “burnout,” is sometimes used in generic and context-free ways (Schaufeli et al., 2009), for the purposes of this study, general experiences of one or all three dimensions that are unrelated to professional work do not qualify as burnout.

### ***Well-Being***

In this study, I used the definition of well-being offered by Stewart-Brown & Janmohamed (2008):

Mental well-being is now largely accepted as covering two perspectives: (1) the subjective experience of happiness (affect) and life satisfaction (the hedonic perspective); and (2) positive psychological functioning, good relationships with others and self realisation (the eudaimonic perspective). (p. 2)

It is important to note that this definition acknowledges two major theoretical conceptualizations of well-being. To represent both the hedonic and the eudaimonic perspectives of well-being, two measures of well-being were used in this study.

### **Research Questions (RQs)**

This study addressed the following four research questions:

***RQ1: What is the relationship between boundary setting and self-care in mental health professionals?***

- Hypothesis 1: Increased boundary setting relates with increased self-care in mental health professionals.

***RQ2: What is the relationship between boundary setting and burnout in mental health professionals?***

- Hypothesis 2: Increased boundary setting relates with decreased burnout in mental health professionals.

***RQ3: What is the relationship between boundary setting and well-being in mental health professionals?***

- Hypothesis 3: Increased boundary setting relates with increased well-being in mental health professionals.

***RQ4: What is the relationship between boundary setting, self-care, burnout, and well-being in mental health professionals?***

- Hypothesis 4: Increased boundary setting relates with increased self-care and increased well-being but with decreased burnout in mental health professionals.

## CHAPTER II

### LITERATURE REVIEW

This Chapter is a critical review of the scientific knowledge of the constructs of interest in this study. The psychological literature and organizational/occupational health literature on “boundaries” and “boundary setting” are reviewed first, including a review of existing measures of this construct. The Chapter then continues with a review of the psychological literature on self-care, burnout, and well-being. The final section includes a review of the specific population of mental health professionals and the relevance of these constructs to them.

#### **Boundaries and Boundary Setting**

The term, “boundaries,” is used extensively in scientific literature across many disciplines and fields of study (Cloud & Townsend, 2017; Harrison & Westwood, 2009; Hellman et al., 1987; Matheson & Rosen, 2012; Morris, 2018; Norcross & Guy, 2007). Therefore, the term also represents a variety of ideas across the various domains of knowledge. As Ashforth et al. (2000) noted,

Political scientists use boundaries to define geopolitical areas, organization theorists speak of system boundaries, engineers use boundaries to demarcate physical properties, marketing scholars speak of boundary-spanning individuals and activities, and psychologists use boundaries to explain where the self begins and ends and to diagnose the health of interpersonal relationships. (p. 474)

Given the plethora of meanings attributed to the construct of boundaries, it is essential to specify that this study focused on the conceptualization of boundaries from a psychological perspective and from an organizational/occupational health perspective. This review is organized

by discussing the scientific literature from these two disciplines, followed by a critique of the current research measures for the construct of boundaries.

### ***A Mental Health Perspective***

In the psychological literature, clear definitions of the term, “boundaries,” are difficult to find. When the term is used, it is often mentioned without an explicit definition (Dumas & Sanchez-Burks, 2015; Höge, 2009; Kreiner, 2006; Matheson & Rosen, 2012; Russell & Peterson, 1998). Many authors have mentioned the term, “boundaries,” along with a citation to past landmark articles, particularly those from the organizational/occupational health literature. For instance, two of the most referenced works are from Ashforth et al. (2000)’s landmark article, “All in a day’s work: Boundaries and micro role transitions,” and Nippert-Eng (1996)’s foundational book, *Home and work: Negotiating boundaries through everyday life*. These past works, though, often provided simplistic statements about boundaries that provide minimal clarity about their operationalization in practice. Ashforth et al. (2000), for example, defined boundaries as “physical, temporal, emotional, cognitive, and/or relational limits” (p. 474). Few pieces of psychological literature have expanded on or further clarified this definition.

For mental health professionals, one of the few explicit statements about boundaries comes from an influential book titled, *Leaving it at the office, second edition: A guide to psychotherapist self-care* (Norcross & VandenBos, 2018). In a chapter dedicated to “Setting Boundaries,” the authors stated:

In a general sense, “boundary” implies a marking point between two domains. In a psychotherapeutic sense, boundary means a line or limit that should not be crossed or violated. For psychotherapists, boundary demarcates separation in at least three senses: between yourself/therapist and others/clients; between your professional life and your

personal life; and between effective or ethical practices and the ineffective or unethical.  
(pp. 99-100)

This explanation acknowledges three different aspects to boundaries for mental health professionals: (a) interpersonal boundaries; (b) personal-professional boundaries; and (c) professional (ethical) boundaries. This section of the review is organized into the three categories. It is important to note that they have not all received equal research attention in the psychological literature. This can be seen not only from the volume of articles identifiable for each category but also from an examination of the official “American Psychological Association [APA] Thesaurus of Psychological Index Terms” in the database APA PsycInfo. Each index term is accompanied by an official scope note, which uses one to two sentences to delineate the chosen meaning of the index within this database.

A search for the term “boundar\*” in this official “APA Thesaurus of Psychological Index Terms” yielded five results. Only three of these five results overtly include the phrase “boundar\*” in their name: (a) boundaries (psychological); (b) boundary crossings; (c) boundary violations. In addition to these three index terms, the two other results are: (d) professional client sexual relations and (e) fuzzy set theory. The scope notes of these indexes reveal further insight into the significance of these results.

The first index, *boundaries (psychological)*, has a scope note description of, “Psychological barriers that separate or divide, and, in some cases, protect the integrity of individuals or groups.” This demarcation between self and others falls under the first sense of boundaries that Norcross and VandenBos (2018) identified, which my review categorizes as “interpersonal boundaries.” Meanwhile, the second and third indexes, *boundary crossings* and

*boundary violations*, both clearly fall under the third sense of boundaries, which I called “professional (ethical) boundaries.” Their scope notes, respectively, are:

In clinical practice, any deviation from normal patient-therapist boundary protocols. Examples of crossings that can potentially help the patient include self-disclosure, home visits, non-sexual touching, and the giving of gifts.

In clinical practice, any unethical deviation from traditional forms of therapy. A common example is the sexual exploitation of current clients.

In addition to these three indexes, there were two other search results that did not include the word “boundar\*” in the index name. One of these was *professional client sexual relations*, which was recommended in lieu of “boundary violations (sexual).” Its scope note reads: “Sexual relations, intimacy, or affectionate behavior between a professional (e.g., therapist, lawyer, religious personnel, or educator) and his or her clients or patients.” This description clearly indicates that this index is categorized under “professional (ethical) boundaries.” The final index term was *fuzzy set theory*. Its scope note reveals an entirely unrelated understanding of boundaries: “Mathematical theory of sets in which membership is a matter of degree and boundaries are indistinct.”

Of these five official index terms in APA PsycInfo for “boundar\*”, one can be classified as “interpersonal boundaries,” three can be classified as “professional (ethical) boundaries,” and the final one has a miscellaneous classification. However, it is striking that there is no official index for the second aspect of boundaries, “personal-professional life boundaries.” This lack of an official index term is noteworthy because of the implications it holds for the accessibility and organization of the existing literature base for this second aspect of boundaries.

This review now summarizes the psychological literature for these three aspects of boundaries: (a) interpersonal boundaries; (b) personal-professional boundaries; and (c) professional (ethical) boundaries.

**Interpersonal Boundaries.** For helping professionals, interpersonal boundaries can be defined as “the rules that establish the professional relationships as primary and as separate from other relationships” (Owen & Zwahr-Castro, 2007, p. 17). Concepts like connection, autonomy, identity, communication, privacy, and identity are frequently discussed in relation to interpersonal boundaries (Derlega & Chaikin, 1977; Petronio et al., 1998). Additionally, interpersonal boundaries can be conceptualized at multiple levels including individual, family, group, and organizational (Schneider, 1987).

At the individual level, there are both intrapersonal and interpersonal boundaries. Intrapersonal boundaries sometimes use concepts from psychoanalytic theory like the id, ego, and superego. They are necessary for differentiating and integrating the person’s own psyche. Examples include knowing the difference between fantasy and reality, knowing the difference between yourself and the external world, or being able to exercise self-control over one’s own impulses (Schneider, 1987).

Interpersonal boundaries are those between the self and other people. Establishing interpersonal boundaries is a process that begins in early childhood. Developmental psychology asserts that even as early as age two, children become aware of how they are separate from others (Mahler et al., 1975). Key developmental tasks include learning to say no, learning to control their own behaviors, and learning to exert mastery over their environment. Establishing boundaries is key to these life tasks, as children must learn how to develop their autonomous self while still meeting a need for relatedness. Future developmental tasks —like establishing identity

or developing intimacy— depend on being able to establish boundaries (Freud, 1923; Greene, 1982; Mahler et al., 1975; Schneider, 1987). Identity requires people to be able to distinguish themselves from others, impressions of others, or fantasies about themselves (Greene, 1982; Kernberg, 1976).

At the family level, interpersonal boundaries primarily center on role and generational boundaries. Family systems theories provide further insights on the need for distinct roles, tasks, and identities while still preserving a sense of connection and relatedness. Family dysfunction can often be described in terms of overly diffuse or overly rigid boundaries (Schneider, 1987).

At the group level, two kinds of boundaries exist: (a) between the individual and the group and (b) between the group and other groups. These boundaries are formed through a process that involves the members negotiating their individual boundaries, testing group rules, struggling with others for power, defining their group identity, and distinguishing their group from other groups. Group boundaries can be established through a variety of means such as induction ceremonies, retirement rituals, identifying internal scapegoats, identifying external enemies, or sharing common goals for the purpose of the group (Schneider, 1987).

At the organizational level, boundaries differentiate the organization from its environment. Organizations can create these boundaries by buffering or isolating their operations, creating niches in distinctive competence, controlling the flow of inputs and outputs, and responding proactively or reactively to environmental change. Organizational problems often reflect either excessive or insufficient boundaries or a combination of both (Schneider, 1987).

Across the various levels of interpersonal boundaries, there are several shared commonalities. The purpose of establishing boundaries is to meet both the need to differentiate

from others and connect with others. Establishing and managing boundaries is a dynamic process that changes based on the stage of development. Finally, to preserve the entity's identity, the boundaries must be firm yet also flexible.

**Personal-Professional Life Boundaries.** Compared to the other two aspects of boundaries, the demarcation between personal and professional life for mental health professionals has received much less attention in the psychological literature. Although no official index to organize the literature on personal-professional life boundaries exists in APA PsycInfo, there are some individual pieces of psychological literature that discuss this aspect of boundaries. Some studies on psychotherapists' well-being and burnout have included the term boundaries in their discussions of results. For instance, Hellman et al. (1987) found that "effective boundary management" is important for managing the stresses and conflicts in psychotherapeutic work. Matheson and Rosen (2012) found that among marriage and family therapists, those who had poor boundaries were at risk for poor work, poor life balance, and burnout. Their study described several indicators of poor work boundaries such as taking work home almost every night; accepting an overabundance of tasks, responsibilities, and roles; feeling that the amount of work was intrusive/problematic. In contrast, healthy boundaries consisted of saying no and speaking up for oneself (Matheson & Rosen, 2012). Some reasons participating therapists had poor work boundaries were that work felt *boundaryless*, that they had few interpersonal reasons to go home, and they enjoyed their job.

Although some examples of psychological literature acknowledging the concept of the personal-professional life boundary do exist, overall, purposeful, and explicit studies of this aspect of boundaries are still lacking. This is unfortunately unsurprising, considering the lack of clear definitions of this conceptualization. Furthermore, few measures of boundary setting

between personal and professional life exist. A critique of the existing research measures for personal-professional life boundary setting is forthcoming.

**Professional (Ethical) Boundaries.** Considerable psychological literature discusses a broad category that is often termed professional ethics or professional boundaries. As mentioned earlier, a perusal of the official indexes available in the APA Thesaurus of Psychological Index supports that in the database APA PsycInfo, the most common association for “boundar\*” are terms referring to professional boundaries or professional ethics. From an ethical perspective, boundaries are the limits of what is appropriate in each situation (Gutheil & Gabbard, 1993). In other words, professional boundaries are demarcations of what behavior is ethical, appropriate, and effective for mental health professionals when they are working in their professional roles. Common aspects of professional boundaries to consider include role, time, place and space, money, gifts, clothing, language, self-disclosure, and physical contact (Sawyer & Prescott, 2011). Several important concepts to understand are boundary crossings, boundary violations, and the slippery slope hypothesis.

Boundary crossings refer to therapist behavior that deviates from commonly accepted practice but does not harm the client (Black, 2017; Gutheil & Gabbard, 1993). Some common examples of boundary crossings include gift acceptance and self-disclosure. Some warning signs of boundary crossings include the following: giving/receiving gifts, personal information disclosure, special treatment/appointment times, and social contact and/or dual relationships (Sawyer & Prescott, 2011). Various professional ethics codes strongly discourage multiple relationships because of their potential to impair the professional’s objectivity or competence or to risk exploitation/harm to the client (ACA, 2014; APA, 2017; NASW, 1999).

In contrast to boundary crossings, boundary violations are deviations from commonly accepted practice that harm or exploit the client, which can be either sexual or non-sexual (Black, 2017; Gutheil & Gabbard, 1993). Currently, all romantic or sexual contact with current clients is considered a serious boundary violation and clearly unethical. Romantic or sexual contact with former clients is not automatically a boundary violation, but it is a boundary crossing that is highly likely to be a boundary violation and is therefore highly discouraged. The APA Ethics Code states that psychologists should not engage in romantic or sexual relationships with former clients “except in the most unusual circumstances” (APA, 2017). Because of the high potential for harming the client, the APA Ethics Code requires the psychologist to thoroughly consider and document their ethical reasoning before crossing this boundary. Considerations for documentation would include the amount of time since post-termination, the intensity of former therapeutic relationship, circumstances of termination, current mental health of the client, client’s personal history, likelihood of harm to the client, and any behaviors of the therapist during therapy suggesting the possibility of a post-termination relationship with the client.

The slippery slope is a term coined by Gutheil and Gabbard (1993), which refers to the hypothesis that “seemingly minor boundary crossings lead to a cascade of increasingly larger boundary crossings, non-sexual boundary violations and eventually sexual boundary violations” (Black, 2017). The slippery slope hypothesis has become more widely debated since its original debut, with some scholars asserting that there is no conclusive evidence that boundary crossings *inevitably* lead to boundary violations (Gottlieb & Younggren, 2009; Lazarus & Zur, 2002). In fact, some researchers argue that rigid, dogmatic adherence to avoiding boundary crossings can harm clients (Barnett et al., 2007; Campbell & Gordon, 2003; Osborn, 2012; Zur, 2007).

Examples where rigid boundaries can harm clients include not extending session for a client in crisis (Barnett et al., 2007); rejecting a small holiday gift from a child (Barnett, 2014); shaming diverse clients by refusing an ethnic greeting ritual that involves touching (Barnett et al., 2007); or denying services to rural clients because of multiple relationships (Osborn, 2012).

Psychological literature extensively discusses professional boundaries in terms of the professional, ethical limits of the therapist-client relationship. Although this is an important framework for professional boundaries, it is not the only context where ethical conduct is important. Mental health professionals must navigate other professional relationships as well, such as with supervisors, supervisees, and other professionals. There are still standards for professional boundaries in these relationships as well, although many of these have received much less attention in the literature. Furthermore, this aspect of boundaries in the psychological literature differs from the aspect of interest in this study.

### ***An Organizational and Occupational Health Perspective***

Although the personal-professional life aspect of boundaries is overlooked in the psychological literature, it has received more attention in the organizational and occupational health literature. In this body of work, there are a few different boundary-related terms, which are often discussed alongside constructs such as “work-life balance” and “work-family conflict”. Although a review of these other terms is beyond the scope of this study, these constructs do have a substantial literature base of their own. This review now provides an overview of the foundational concepts in three relevant theories: boundary theory, border theory, and role theory. Following a summary of these theories, the research measures developed from these works will be reviewed.

**Boundary Theory.** Nippert-Eng (1996), Michaelsen and Johnson (1997), and Zerubavel (1991) posited that people create boundaries to order and simplify their environments. Boundaries were loosely defined as “mental fences” (Zerubavel, 1991, p. 2) to designate social domains like “home,” “work,” or “church” (Nippert-Eng, 1996). Two broad approaches to boundaries between different domains were posited: (a) segmentation and (b) integration. Segmentation refers to creating more separation between the domains, which reinforces the boundary. Integration refers to creating more overlap between the two domains, which blurs the boundary.

Ashforth et al. (2000) expanded on these concepts by introducing an organized boundary theory. In their theory, boundary work refers to actions that foster greater segmentation or greater integration of domains. Boundaries can be characterized based on their flexibility and permeability. A flexible boundary is one that can be easily moved (e.g., working at other times or in other locations). A permeable boundary allows the person to be physically present in one domain but to respond behaviorally to the other, such as by taking personal phone calls during work (Bulger et al., 2007). The domains themselves can be characterized by their level of contrast, which is another important term in boundary theory. Contrast refers to the perceived differences/similarities between the norms and demands in each domain (Ashforth et al., 2000). Roles with greater contrast are more difficult to transition between. Strong boundaries tend to increase the contrast between domains. Strong boundaries are characterized by less flexibility and permeability (Dumas & Sanchez-Burks, 2015; Matthews et al., 2010).

Matthews and Barnes-Farrell (2010) expanded the concept of flexibility into two further subcomponents: flexibility-ability and flexibility-willingness. Flexibility-ability refers to the individual’s perception of how easily they can move between domains. Flexibility-willingness

refers to how much an individual wants to take advantage of options to segment or integrate domains.

**Border Theory.** Although named slightly differently, border theory is closely related to boundary theory and includes several related concepts. Clark (2000) created border theory to explain how individuals navigate and reduce the conflict between different roles, purposes, and cultures at work and at home. This theory asserts that people shape their environments, and their environments shape them as they transition between the domains of work and home. Key concepts in this theory include borders, border-crossers, and border-keepers.

Borders are “lines of demarcation between domains, defining the point at which domain-relevant behavior begins or ends” (Clark, 2000, p. 756). Borders can be physical, temporal, and/or psychological. They vary in their flexibility, permeability, blending, and strength. Flexibility and permeability are defined similarly to their definitions in boundary theory. Blending occurs when the border is so permeable and flexible that it is unclear whether the domain is work or family (Clark, 2000). Strong borders do not allow blending and are more impermeable and inflexible.

Border-crossers are those who transition between the two domains (Clark, 2000). They can either be peripheral or central participants in either one. Border-keepers are members of one domain that are influential in defining the border of that domain. In border theory, the relationship between border strength and work/family balance depends on other factors such as domain contrast and the communication between the border-crosser and the border-keepers.

**Role Theory.** Role theory is a classic perspective on how people manage the responsibilities of various roles within social structures (Goode, 1960; Kahn et al., 1964; Katz & Kahn, 1978; Merton, 1968). In this theory, boundary work is conceptualized as how people

participate in their work or non-work roles. Role conflict occurs when the expectations of one role interfere with the person's ability to meet the expectations of another role (Kahn et al., 1964; Katz & Kahn, 1978). Boundary work is a way that a person can reduce role conflict by keeping the roles separate. This theory is a prominent reason that boundary-related constructs are often discussed alongside terms like *work-family conflict* and *work-life balance*, as mentioned before.

**Segmentation vs. Integration.** For over a century, segmentation has been the prevailing ideology for boundary management. Segmentation has been hypothesized to reduce role conflict, enhance concentration and focus, improve performance, reduce the number of transitions between domains, and allow the person to be fully present in each role/domain. The conceptualization of strong boundaries also reflects this leaning towards segmentation. Strong boundaries are those that allow few cognitive or behavioral transitions from one life domain to another (Matthews et al., 2010). Some empirical findings do indicate that weak boundaries at home are related to work interference in home life and that weak boundaries at work are related to home interference in work life (Bulger et al., 2007). It is important to note that this study acknowledged that boundary strength can vary by direction. Other findings corroborate that boundary strength is not necessarily equal both ways. In fact, many employees have been found to have stronger boundaries at work than at home (Spieler et al., 2017). Boundary strength has also been found to have some degree of daily variation (Sonnentag, 2012).

Although segmentation has been prominent, there have been significant changes in technology, the nature of work, and workforce demographics that may warrant a reexamination of the segmentation approach (Dumas & Sanchez-Burks, 2015). Scholars have argued that segmentation is artificial and problematic (Kanter, 1977) and that integration is a more realistic way to navigate the demands of different domains (Bailyn, 2011; Bailyn et al., 2001). Integration

has been hypothesized to simplify transitions between domains, facilitate efficient use of time, and allow expression of diverse identities (Dumas & Sanchez-Burks, 2015).

Attempts to study whether segmentation or integration is the better strategy have yielded mixed results. Rothbard et al., (2005) found that individuals were more satisfied if their organizations' policies for segmentation or integration fit with their personal desires for segmentation or integration. Dumas & Sanchez-Burks (2015) found that neither segmentation nor integration necessarily yielded better outcomes (role responsibility management or identity & relationship management). Instead, it was more important for the worker's preferences to fit the organization's policies.

### *Measures and Questionnaires*

Within the psychological and organizational/occupational health literature, there are a few measures that explicitly include the term, "boundary," in their name. There are also some surveys and questionnaires for boundary-related concepts. This section provides a brief overview of seven of these measures: (a) the Boundary Questionnaire (Hartmann, 1991; R. H. Harrison et al., 2006); (b) the Boundary Personality Questionnaire (Schredl et al., 2009); (c) a survey for boundary permeability (Clark, 2002); (d) a survey for boundary flexibility (Matthews & Barnes-Farrell, 2010); (e) the Boundary Violations Scale (Madden-Derdich et al., 2002); (f) a questionnaire on segmentation (Kreiner, 2006); and (g) The Work-Family Integration-Blurring Scale (Desrochers et al., 2005). After this overview, a brief discussion of the usefulness of these measures for this study follows.

First, the Boundary Questionnaire (Hartmann, 1991; R. H. Harrison et al., 2006) is a 138-item measure that assesses various conceptualizations of boundaries. These include boundaries regarding the person's conscious and subconscious, their approach to work, their organization of

their physical environment, and indications of psychopathology. Many of the items in this questionnaire are tangential to personal-professional life boundaries. The number of items also makes this measure unwieldy and impractical for use. Examples of items are as follows: (a) “I have dreams and daydreams or nightmares in which I see isolated body parts --arms, legs, heads, etc.”; (b) Sometimes I meet someone and trust him or her so completely that I can share just about everything about myself at the first meeting”; (c) “I have had ‘out of body’ experiences during which my mind seems to or actually has, left my body.”

Second, the Boundary Personality Questionnaire (Schredl et al., 2009) was developed as an attempt to refine the Boundary Questionnaire (R. H. Harrison et al., 2006; Hartmann, 1991). Schredl et al. (2009) shortened the Boundary Questionnaire by removing items that were biased towards a psychoanalytic theoretical orientation or that indicated more severe psychopathology. Their revisions resulted in a final Boundary Personality Questionnaire of 20 items. Despite significant revisions, the items of the Boundary Personality Questionnaire are still scattered across several domains and are not specific to boundaries between professional and personal life. Examples of items in this measure are: (a) “I keep my desk and worktable always neat and tidy”; (b) “When I read something, I get so involved it can be difficult to get back to reality”; (c) “I cannot fall in love with someone if circumstances do not match.”

Third, Clark (2002) created a questionnaire to assess the concept of boundary permeability. The items were categorized in three main themes, with 10-11 questions each. Then, each item was slightly reworded for the domain of work-life and for the domain of home-life. This resulted in a total of 62 final items. Although the questions did focus on similarities, differences, or interaction between the domains of work and life, few of them asked about active and purposeful choices that the individual makes to set boundaries. The number of items make

this questionnaire unwieldy, and the psychometric support for this measure is unclear. Examples of items on Clark's questionnaire include: (a) "My relationships at work are very close, perhaps even intimate/My relationships at home are very close, perhaps even intimate"; (b) "I share unpleasant things that happened at work with family/I share unpleasant things that happened at home with others at work"; (c) "I take care of family business while I am at work/I take care of work-related business while I am at home."

Fourth, Matthews and Barnes-Farrell (2010) developed an enhanced survey of boundary flexibility that expanded the concept of flexibility to include subcomponents: flexibility-ability and flexibility-willingness. Their survey contained 18 questions for each domain (home and work), resulting in a total of 36 items. Items in this survey focused more on willingness or ability to be flexible but did not emphasize the behaviors that the individual chose to set boundaries. Examples of items are as follows: (a) "My family and personal life responsibilities would not prevent me from going into work early if the need arose;" (b) "I am willing to take an extended lunch break so that I can deal with responsibilities relating to my family and personal life;" (c) "My family contacts me while I am at work".

Fifth, the Boundary Violations Scale (Madden-Derdich et al., 2002) is a 12-item measure designed to assess the existence of unhealthy dynamics between parents and their children. This measure focuses on the interpersonal aspect of boundaries rather than the personal-professional life aspect of boundaries, so it is ill-suited for this study. Examples of items are as follows: (a) Mom tells child secrets; (b) Dad talks like a close friend; (c) Child pressured to take mom's side.

Sixth, Kreiner (2006) developed a questionnaire on segmentation preferences and supplies. It assesses the individual's desire for segmentation and the extent to which their work domain allows segmentation. This questionnaire consists of 4 items for segmentation preferences

and 4 items for segmentation supplies, for a total of 8 items. This measure assesses flexibility-willingness but not flexibility-ability. Examples of items are as follows: (a) I don't like to think about work while I'm at home; (b) My workplace lets people forget about work when they're at home; (c) I prefer to keep work life at work.

Seventh, the Work-Family Integration-Blurring Scale (WFIBS; Desrochers et al., 2005) is a summative index that assesses whether the domains of work and family are blurred. This measure consists of only these three items: (a) "It is often difficult to tell where my work life ends and my family life begins"; (b) "I tend to integrate my work and family duties when I work at home"; and (c) "In my life, there is a clear boundary between my career and my role as a parent." The WFIBS is useful in measuring perceptions of the independence between work and family domains, and it does report some psychometric properties. However, it does not measure the characteristics of the boundaries themselves, does not focus on the active choices of the individual, and consists of only three relevant items.

Of the seven measures and questionnaires reviewed, there are several common issues that limit their usefulness for this study. First, several of these instruments are not psychometrically validated measures. This was often the case when they originated from the occupational and organizational health literature, possibly due to different standards for validation in the organizational/occupational health discipline versus the psychological/behavioral health discipline. Second, even when the measure had been psychometrically validated, it often conceptualized boundaries differently from the perspective intended in this study. Finally, none of these measures or questionnaires consistently evaluated the active, purposeful choices that the participant makes to set boundaries.

Active, purposeful, involvement is an important aspect of the operationalized definition of boundary setting in this study. Since the existing research measures did not adequately capture this aspect of personal-professional life boundary setting, it became necessary to create an instrument to use in this study.

### **Self-Care**

The term self-care originated in the medical field and initially focused primarily on physical behaviors and outcomes (J. J. Miller et al., 2019). In its historical context, the goal of self-care was for medical patients to take actions on their own that could mitigate the negative outcomes of their medical issues even when not actively being overseen or treated by a medical professional (J. J. Miller et al., 2019). Although its inception began with a focus on physical health, self-care has since expanded to include psychological, social, spiritual, and other components of health. Additionally, self-care has also shifted from simply mitigating negative outcomes to promoting positive ones (Lee et al., 2019), in part due to the increasing prominence of the positive psychology movement (Seligman, 2002; Seligman & Csikszentmihalyi, 2000).

Although discussions and research on self-care have increased in the recent years, there is no uniform consensus about its conceptualization or definition (Dorociak et al., 2017; Morris, 2018). Instead, a variety of perspectives have been offered about the nature of self-care. Self-care has been variously described as a process, a set of behaviors, strategies to employ; guiding principles, an approach, and an art and a science (Dorociak et al., 2017; Rupert et al., 2015; Skovholt et al., 2001; Wise et al., 2012).

Along with debate about the nature of self-care, there is also variety in the dimensions of self-care that have been proposed. The most theorized components are physical, emotional, relational, and spiritual self-care (Dorociak et al., 2017; Morris, 2018; Santana & Fouad, 2017;

Skovholt et al., 2001). There is also disagreement about whether personal self-care and professional self-care should be distinguished as separate components. Some scholars have asserted that professional self-care is a separate construct from personal self-care and that professional self-care has received insufficient attention (Dorociak et al., 2017; Lee & Miller, 2013). Based on this perspective, attempts have been made to create self-care measures that include a professional self-care component (Dorociak et al., 2017; Lee & Miller, 2013). Other scholars insist that professional self-care and personal self-care are indistinguishable. Proponents of this view have argued that attempts to separate the two are unhealthy, that seeing them as separate entities that need to be protected from each other is outdated, and that they naturally influence one another (Bressi & Vanden, 2017; B. Miller & Sprang, 2017).

Regarding measures of self-care, there is no specific theoretical basis guiding their development, including the structure of the measure or the components of self-care (Jiang et al., 2020). Several authors have noted this lack of consensus (Dorociak et al., 2017; Lee et al., 2019; Posluns & Gall, 2019; Salloum et al., 2015), and some have made efforts to review the existing research (Morris, 2018; Jiang et al., 2020; Posluns & Gall, 2019). Efforts to review the research or propose new measures have noted that despite the divergence of ideas about self-care, there is some broad agreement. First, the construct is multi-faceted, consisting of a variety of components (Dorociak et al., 2017; Godfrey et al., 2011; Jiang et al., 2020). Second, self-care differs between professionals, perhaps particularly depending on whether it is applied to the personal self or to the professional self (Dorociak et al., 2017; Goncher et al., 2013; Pipes et al., 2005). Third, self-care efforts can occur beyond an individual level to a program or organizational level as well (Goncher et al., 2013; Jiang et al., 2020; Salloum et al., 2015). Fourth, self-care plays a positive role in promoting the professional's functioning and well-being

and in reducing burnout (Colman et al., 2016; Dorociak et al., 2017; Salloum et al., 2018; Santana et al., 2017; Wise et al., 2012).

### ***Importance***

Self-care is important for all people because it is a way to promote positive outcomes and well-being (Lee & Miller, 2013; Skovholt et al., 2001; Wise et al., 2012) and to prevent negative outcomes (Rupert et al., 2015; Skovholt et al., 2001). Along these lines, people can use self-care preventatively and diagnostically. For instance, they can engage in purposeful practices to replenish themselves before becoming exhausted, or people can begin practicing self-care in response to noticing feelings of exhaustion.

Mental-health professionals experience many professional challenges and stressors that increase their risk of “experiencing distress, burnout, vicarious traumatization, and eventually impaired professional competence” (Barnett et al., 2007, p. 603). Self-care is a way for them to manage these demands effectively. For this reason, some scholars have even asserted that self-care is an ethical imperative for mental health professionals (Barnett et al., 2007). For psychologists, this claim is often based on sections from the *APA Ethical Principles of Psychologists and Code of Conduct* (APA, 2017). Several specific sections of the APA Ethics Code are important to note because they are commonly used to build the argument that self-care is an ethical imperative. These excerpts can be found in Table 1.

**Table 1.**

*Excerpts from the APA Ethical Principles and Code of Conduct*

APA Ethical Principles of Psychologists and Code of Conduct	
Principle A - Beneficence and Nonmaleficence	“Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (APA, 2017, p. 3).
Standard 2.03 - Maintaining Competence	“Psychologists undertake ongoing efforts to develop and maintain their competence” (APA, 2017, p. 5).
Standard 2.06 - Personal Problems and Conflicts	(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.  (b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (APA, 2017, p. 5)

Based on these principles and standards, scholars have insisted that self-care is a way that psychologists can maintain their professional functioning and competence to ensure quality care for their clients (Barnett et al., 2006; Barnett et al., 2007). Self-care is also a way for them to prevent their personal problems from interfering in performing their professional responsibilities adequately. Self-care is not an indulgence or a privilege but essential to the professional identity (Barnett et al., 2006). When mental health professionals neglect to take care of themselves, their personal experience of stress, distress, burnout, and mental health issues can compromise their ability to serve clients (Barnett et al., 2007; Jiang et al., 2020). Lack of self-care can harm clients as the professional’s functioning deteriorates (Brady et al., 1995; Collins, 2005; Wise & Reuman, 2019). Insufficient self-care can lead to emotional depletion, exhaustion, impaired

clinical judgment, modeling unhealthy behaviors, and mental health issues in the professional themselves (Barnett et al., 2006; Wise & Reuman, 2019).

These ethical standards are not just limited to psychologists, though. Counselors and social workers find similar guidance in their respective codes of ethics. Similar statements are found in the American Counseling Association’s (ACA) Code of Ethics (ACA, 2014) and the National Association of Social Worker’s (NASW) Code of Ethics (NASW, 1999). See Table 2.

**Table 2.**

*Excerpts from the ACA Code of Ethics and the NASW Code of Ethics*

ACA Code of Ethics	
Section C.2.g. - Impairment	Counselors monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when impaired. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until it is determined that they may safely resume their work. (ACA, 2014, p. 9)
NASW Code of Ethics	
Standard 4.05 - Impairment	<p>(a) Social workers should not allow their own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have a professional responsibility.</p> <p>(b) Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and performance should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others. (NASW, 1999, p. 7)</p>

In addition to the ethical rationales, self-care is also important for mental health professionals in a few other ways. For example, mental health professionals can empower themselves through self-care (Lee & Miller, 2013). This can benefit them on a personal level,

such as by increasing their sense of self-efficacy, competence, and confidence in their personal lives. Empowerment can also increase these qualities in their professional lives. Furthermore, engaging in self-care can be a way for mental health professionals to model healthy self-respect, balance, and compassion for their clients (Thompson, 1990). Considering the many professional challenges that providers in this field face, self-care is important for the survival and growth of the mental health profession.

### ***Relationship to Boundaries***

There are many proposed components, aspects, principles, or guidelines for self-care. However, boundary setting is not regularly included among them. Many theories and frameworks about self-care may allude to the concept of boundary setting, though, through the concept of “balance” (Baker, 2003; Barnett et al., 2006; Dorociak et al., 2017; Morris, 2018; Skovholt & Trotter-Mathison, 2011). For instance, Dorociak et al. (2017) includes both the concepts of “Daily Balance” and “Life Balance” in their Self-Care Assessment for Psychologists. In their scale, “Life Balance” refers to ways that people maintain a personal identity alongside a professional identity through spending time with friends/family or pursuing comforting activities whereas “Daily Balance” are “smaller-scale, microfocused strategies that can be incorporated throughout the workday to manage demands while maintaining awareness and replenishing resources” (p. 331). These descriptions imply some similarities between balance and boundary setting. However, the possible connection between these constructs is not explicitly stated.

Although boundary setting has not been regularly included in theories or studies on self-care, some authors have mentioned the concept of boundary setting in the discussions of their studies (Morris, 2018; Norcross & VandenBos, 2018; Posluns & Gall, 2019). For instance, Posluns & Gall (2019) states, “Other strategies to achieve life balance include: ... maintaining

good work and personal life boundaries...” (p. 6). Although boundary setting is stated as contributing to life balance, which is considered an aspect of self-care in this article, no further explanation is given about what qualifies as “good” boundaries or how to maintain them. Furthermore, no other studies are cited as empirical support for this assertion.

Some publications on self-care also reference the concept of boundaries in their writing. For instance, in the book, *Leaving It at the Office, Second Edition: A Guide to Psychotherapist Self-Care* by Norcross and VandenBos (2018), there is a chapter that is explicitly titled “Setting Boundaries.” Within this chapter is this surprising statement: “Setting boundaries consistently emerges in the research as one of the most frequently used and one of the most highly effective self-care principles” (p. 100). However, this assertion was not followed by any parenthetical citations. An email inquiry to the authors about this statement resulted in an explanation that the statement referred to a survey the authors had issued to some “master therapists,” which asked them to rate how often they used the self-care principles on the survey (J. C. Norcross; personal communication, March 5, 2020). One of these survey items was “setting boundaries at the office,” which was chosen the most frequently by their survey participants. However, the authors said they had not published this survey or its results anywhere else (J. C. Norcross; personal communication, March 10, 2020).

Even when the term, “boundaries,” is explicitly stated within discussions or publications on self-care, no empirical research is provided to substantiate any such statements. Therefore, even seemingly bold statements about the relevance of boundary setting and self-care to each other are little more than speculation or opinion. This indicates a prominent gap in scientific knowledge. Few scholars seem to have considered or studied how self-care and boundary setting

could be related, suggesting that the paucity of the empirical research on this connection is a fertile ground for investigation.

## **Burnout**

Herbert Freudenberger (1974, 1975) coined the term, “burnout,” to describe the physical and behavioral changes observed in staff workers at a free clinic serving people with drug addictions and/or who were homeless. His definition is “a depletion or exhaustion of a person’s mental and physical resources attributed to his or her prolonged, yet unsuccessful striving toward unrealistic expectations, internally or externally derived” (Freudenberger, 1984, p. 223). Other definitions have subsequently emerged in the literature. However, the term’s reference to a state of stress and exhaustion in response to job-related occupational and interpersonal demands continues to persist (Simionato et al., 2019).

Maslach and Jackson (1996) proposed a conceptualization of burnout as consisting of three dimensions: emotional exhaustion, depersonalization, and diminished personal accomplishment. Emotional exhaustion (EE) refers to feeling physically and/or emotionally depleted; depersonalization (DP) refers to feeling disconnected from one’s job role; and diminished personal accomplishment (PA) refers to difficulty feeling satisfied or accomplished in response to one’s work. Maslach and Jackson (1996) also created a measure, the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), that quickly became the “gold standard” for measuring burnout in research (Rupert et al., 2015; Schaufeli et al., 2009). Indeed, by the end of the 1990’s, the MBI was used in 93% of journal articles and dissertations (Schaufeli et al., 2009) and continues to be “used in nearly all research” (Rupert et al., 2015, p. 168).

Some critics of burnout and the MBI have argued that burnout is equivalent to exhaustion, meaning that it is not a multidimensional phenomenon (Pines & Aronson, 1981;

Kristensen et al., 2005; Shirom & Melamed, 2005). Furthermore, they argued that since burnout was derived inductively from factor analyses, it is inferior to a construct derived from a theoretical framework. In response to these critiques, Schaufeli et al. (2009) asserted that the MBI was created through an iterative process of extensive, in-depth interviews, which yielded a statistically confirmed three-dimensional construct. Therefore, while burnout does include exhaustion, they insist that “there is no scientific reason to use the term, burnout, when referring to exhaustion only” (Schaufeli et al., 2009, p. 212).

Overall, further work on burnout continues to accept the base three components, although there have been shifts in the use of the term and theories about the phenomenon. For instance, burnout originally described a range of mild to severe symptoms but has shifted to describe the end-stage process of exhaustion (Baker, 2003). This shift partly results from burnout’s acceptance as a formal medical diagnosis in some countries, allowing this diagnosis to receive monetary compensation or medical treatment (Schaufeli et al., 2009). Other shifts include viewing it as the product of rapid social change from an industrial society to a service economy, seeing it as the erosion of engagement in work, or seeing it as the erosion of positive psychological state (Schaufeli et al., 2009).

New models for classifying types and contributors to burnout have also been proposed. Montero-Marín and García-Campayo (2010) classified burnout into different subtypes: frenetic, underchallenged, and worn-out. Stressors contributing to burnout have been classified into three main domains: job, organizational, and individual (Bakker et al., 2014). Numerous models have been proposed to explain the development of burnout, such as the Job Demands-Control Model (Karasek, 1979), which was expanded on by the Job Demands-Control-Support Model (J. V. Johnson & Hall, 1988) and the Job Demands-Resources Model (Demerouti et al, 2001). Another

conceptual model that focuses more on resources rather than job demands is the Conservation of Resources Model of Stress (Hobfoll, 1989; Hobfoll & Freedy, 1993). Although a review of each of these models is beyond the scope of this study, each model has generated “a substantial body of research in the general occupational health literature” (Rupert et al., 2015, p. 169).

### ***Among Mental Health Professionals***

Burnout is a serious and common issue among mental health professionals (Rupert et al., 2015; Simionato et al., 2019). This population faces a myriad of challenges and stressors due to occupational demands. If not properly addressed, chronic stress from these demands can lead to burnout (Rupert et al., 2015), which has been described as the “terminal phase of therapist distress” (Baker, 2003, p. 21). Burnout in mental health professionals poses multi-level threats for the individual, their clients, the overall institution, and the overall profession.

For the individual professional, burnout negatively affects their quality of life (Rupert et al., 2015). It has been linked to many physical and psychological health issues including sleep disturbances, back pain, headaches, flu-like symptoms, memory impairments, and gastrointestinal symptoms (Posluns & Gall, 2019; Simionato et al., 2019; Maslach et al., 2001). Burnout also increases the risk of for psychological distress, as manifested through depression, anxiety, or posttraumatic stress disorder (Simionato et al., 2019). The professional may experience less openness to new experiences, reduced capacity to benefit from support, social withdrawal, and interpersonal difficulties (Maslach & Leiter, 2016; Sandström et al., 2011).

Beyond the effect on the individual level, burnout can negatively affect the professional’s quality of services, which threatens their clients and their larger institution. The professional may emotionally disengage more from clients or avoid exploring emotionally charged topics due to emotional exhaustion (Rupert et al., 2015). They may become less committed to therapeutic

outcomes and put less effort into their work as they experience more diminished personal accomplishment, which can result in poorer client outcomes. This can create a self-reinforcing cycle where poorer client outcomes then further reduce the professional's feelings of personal accomplishment, increasing their burnout (Baker, 2003; Barnett & Hillard, 2001).

Burnout has even become an ethical issue for the profession. APA Ethics Code Standard 2.06 explicitly states that psychologists need to be aware of personal problems that can negatively impact their competence and take appropriate action about those problems (APA, 2017). Burnout has been found to be “a common feature of unintentional misconduct among psychotherapists” (Simionato et al., 2019, p. 478). It is a term that can be used to describe therapists who no longer function effectively. When mental health professionals act unethically, this not only has personal consequences but threatens the reputation and credibility of their overall profession (Barnett, 2014; Barnett & Hillard, 2001; McNulty et al., 2013).

Considering how serious and common burnout can be, much attention has been given to identifying both the risk and protective factors for burnout (Bakker et al., 2014; Maslach et al., 2001; Rupert & Kent, 2007; Rupert & Morgan, 2005; Rupert et al., 2015). Protective factors are those factors that help prevent, diminish, or treat burnout. Self-care is a proposed method for mitigating burnout (Salloum et al., 2015). Risk factors are those factors that increase the likelihood, severity, or duration of burnout. The risk factors of burnout can be categorized in three main domains: job, organizational, and individual (Bakker et al., 2014).

At the job level, the demands of work and job resources have been identified as “the main causes” of burnout and work engagement, respectively (Bakker et al., 2014, p. 399). In the work demands category, several factors are associated with increased risk of burnout. These include working longer hours, spending more time on administrative tasks, stressful client behaviors, and

feeling over-involved with clients (Morris, 2018; Rupert et al., 2015). In the job resources category, two factors are commonly associated with reduced risk of burnout: feeling a sense of control and having personal support (Morris, 2018). The job resource of control has received considerable research attention. Rupert et al. (2015) indicated that numerous researchers have found that greater control is associated with less EE, less DP, and more PA. However, there is less clarity about the meaning of control, as items used represent various aspects including control over work schedule, activities at work, treatment, or even case management. It is worth noting that this conceptualization of “control” could have some overlap with this study’s conceptualization of boundary setting. For instance, boundary setting could be an operationalization of control, or it could create a greater sense of control.

At the organizational level, burnout can be influenced by systemic factors like “excessive workload, lack of control, an inadequate reward structure, interpersonal tensions, unfairness, and value conflicts” (Baker, 2003, p. 22). These factors create pressure upon psychotherapists that can lead to burnout and directly impact client work (Simionato et al., 2019). Social support is a particularly protective systemic measure that can be implemented through means such as “supervision, peer consultation groups, opportunities for informal support, and mentoring relationships (Skovholt, 2001)” (Simionato et al., 2019, p. 475). Other systemic models to intervene in burnout have included compassionate health-care models, person-centered models, and communication models (Chambers & Ryder, 2018; Johnson et al., 2012, 2013; Wise & Reuman, 2019, as cited in Simionato et al., 2019).

At the individual level, factors include personality variables like locus of control, self-esteem, achievement motivation, and emotional stability (Bakker et al., 2014). Of the three dimensions of burnout, emotional exhaustion appears to be most representative in

psychotherapists (Di Benedetto & Swadling, 2014; Rupert & Kent, 2007; Rupert & Morgan, 2005). In the personal resources category, there is less clarity in the definition of this category and less conclusive results. Some suggested examples with research support include social support, recreational activities, cognitive coping skills, self-care activities, problem-solving coping instead of avoidant-coping, having a family, and practicing self-awareness (Ben-Zur & Michael, 2007; Emery et al., 2009; Thornton, 1992). Overall, two broad aspects of personal resources included self-care and cognitive coping (Rupert et al., 2015). Ironically, many of the examples of self-care strategies overlapped with the examples of cognitive strategies. These included maintaining a sense of control, reflecting on satisfying experiences of work, balancing personal and professional lives, and maintaining self-awareness/self-monitoring (Rupert & Kent, 2007).

### ***Relationship to Boundaries***

There is limited research that explicitly links the construct of burnout to the construct of boundaries. In the database APA PsycInfo, burnout is even not listed as an official search index. Instead, the term “occupational stress” is frequently suggested.

Among the few articles that discuss either burnout or occupational stress alongside the term boundaries, the conceptual meaning of the term, “boundaries,” varies. Some articles discussed boundaries using the first sense of the term that Norcross and VandenBos (2018) identified: a demarcation between the therapist and their clients. For instance, H. Johnson et al. (2016) studied how client behaviors that violate the client-professional boundary could be associated with increased risk for burnout in the mental health professional. They found that the frequency of client boundary violations was associated with less trust among the mental health professional staff team, which was linked to higher emotional exhaustion and depersonalization.

Ministry of Justice (2011) asserted that developing and maintaining professional boundaries is a key strategy for preventing burnout, especially when working with challenging clients who violate professionals' boundaries.

A few works mention work-life boundaries in their discussion of the relationship between burnout and other constructs. These mentions, though, are frequently in the discussion or introduction sections. For instance, Höge (2009) stated that a future research direction would be to investigate how concepts from border theory (Clark, 2000), such as segmentation or integration, could be related to the constructs in his study. Matheson and Rosen (2012) interviewed 16 marriage and family therapy faculty to understand how they pursued balance in both their personal and professional lives. In their findings, they explicitly discussed "poor boundaries" as a factor within their "Balance Reducers" section (Matheson & Rosen, 2012, p. 407).

However, no studies were found that directly and explicitly focus on the relationship between burnout and work-life boundaries. Instead, all existing studies either included only one of the constructs explicitly or made speculative remarks about these two constructs (Dlugos & Friedlander, 2001; Salloum et al., 2015; Simionato et al., 2019; Rupert et al., 2015). Some studies discussed related constructs, such as work-life balance, work-family conflict, occupational stress, or perceived stress (Haar et al., 2014; Kinnunen et al., 2016; Matthews et al., 2010; Voydanoff, 2005), but these other constructs still differ from burnout and personal-professional life boundary setting.

## **Well-Being**

Well-being literature extends back almost a century and has a long history in counseling and psychology (Flugel, 1925; Lent, 2004; Roscoe, 2009). Although well-being originated

before the onset of the positive psychology and health psychology movements, it has become a central concept within those specialties and been greatly aided by their increased prominence (Roscoe, 2009). Positive psychology and health psychology focus on what is healthy, strong, or positive in human functioning rather than on psychopathology (Seligman, 2002; Seligman & Csikszentmihalyi, 2000). Proponents of these perspectives assert that preventing or treating negative symptoms is insufficient for the promotion of positive outcomes, especially since positive and negative outcomes may be somewhat independent of each other (Ryff & Singer, 1998; Frisch et al., 1992; Keyes, 2002).

Historically, a focus on strengths and positive potentials has been one way that counseling psychology sought to differentiate itself from other mental health specialties (Gelso & Fassinger, 1992; Lent, 2004). However, this emphasis is not exclusive to counseling psychology. For instance, the World Health Organization's (1948) definition of health as "a state of complete physical, mental, and social well-being" is commonly referenced in discussions of well-being's origins. Furthermore, the positive psychology and health psychology movements have also influenced other health professions to incorporate considerations of strengths and positives.

Well-being does not have a uniform definition in the literature. It is used inconsistently with various conceptualizations and sometimes alongside other terms such as wellness and quality of life (Cooke et al., 2016; Lent, 2004; Roscoe, 2009). Many measures of well-being exist, but there is no gold standard for measuring it, partly due to the lack of consensus of its definition (Cooke et al., 2016; Lui & Fernando, 2018; Roscoe, 2009).

Among the many definitions of well-being, there is broad agreement that well-being is different from the mere absence of disease and represents the presence of something positive

(Adams et al., 1997; Lent, 2004; Roscoe, 2009). This consensus is consistent with the general premises of the positive psychology and health psychology movements. Furthermore, the various ways of conceptualizing well-being can be categorized into four broad approaches: (a) hedonic, (b) eudaimonic, (c) quality-of-life, and (d) wellness.

### ***Hedonic***

Hedonic approaches to well-being focus on pleasure and happiness, with the most prominent model being a tripartite model of (a) satisfaction with life, (b) absence of negative affect, and (c) presence of positive affect (Cooke et al., 2016; Diener et al., 1985; Ryan & Deci, 2001). Many proponents of this perspective tend to conceptualize well-being with these three components, although some researchers simply focus on life satisfaction alone (Cooke et al., 2016). Compared to the other approaches, the hedonic approach to well-being is relatively more straightforward to operationalize. The operationalized measures can query about positive affect, negative affect, and/or life satisfaction (Lent, 2004; Watson et al., 1988). This hedonic approach aligns more naturally with the medical model of treatment, which has historically focused on reducing negative symptoms (Cooke et al., 2016; Ryff & Singer, 1998). The hedonic approach to well-being broadens this mentality by including two additional goals for well-being: increasing positive affect and increasing life satisfaction.

### ***Eudaimonic***

Eudaimonic approaches to well-being conceptualize the construct as fulfilling one's potential, functioning optimally, or realizing one's true nature (Cooke et al., 2016; Lent, 2004). This perspective tends to focus on more life domains than does the hedonic perspective, although there is considerable variation in the elements fundamental to determining well-being. Two prominent eudaimonic models are the psychological well-being model (Ryff, 1989; Ryff &

Keyes, 1995) and the eudaimonic model (Ryan & Deci, 2001). The first model proposes six elements of self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. The second model proposes three psychological needs of autonomy, competence, and relatedness.

Eudaimonic approaches to well-being tend to emphasize that positive health is linked to philosophical questions such as what constitutes the good life, how people find purpose, or what constitutes thriving and flourishing (Lent, 2004). Proponents of this approach emphasize a multifaceted view of well-being, often because they view a hedonic approach as limited, incomplete, or even misguided.

### ***Quality-of-life***

The term quality-of-life is sometimes used interchangeably with well-being, as well as with other terms like subjective well-being and life satisfaction (Frisch et al., 1992). However, there does not appear to be broad consensus about the definition of quality of life (Lent, 2004). It tends to represent a broader approach to well-being than either the hedonic or the eudaimonic approaches (Cooke et al., 2016). Quality of life has been described as a “conceptual umbrella” that encompasses many aspects of functioning, including physical, psychological, and social, with well-being as just one of its indicators (Lent, 2004, p. 483). Its eclectic mix of constructs and measures may be due to its multidisciplinary roots in various disciplines including medicine, sociology, and psychology (Lent, 2004).

### ***Wellness***

Wellness approaches to well-being are rooted in counseling literature but tend to be broader and less clearly defined than any of the previous approaches (Cooke et al., 2016; Roscoe, 2009). There is generally agreement that wellness is multidimensional, lies on a continuum, and

is more than the absence of illness (Ardell, 1977; Teague, 1987). However, there are many differences in what specific elements or components are included (Roscoe, 2009). Some definitions include a focus on optimal functioning; others differentiate intellectual wellness; and still others include environmental wellness (Roscoe, 2009). Some authors even use the term wellness interchangeably with well-being (Cooke et al., 2016).

### ***Relationship to Boundaries***

There is very limited research on the relationship between well-being and boundaries. Within the database APA PsycInfo, only 16 results included variations of these two terms either in their title or subjects. Within these few results, the conceptual meaning of “boundaries” varied between scholarly publications.

One study found an association between blurred boundaries and reduced well-being (T. D. Allen et al., 2000). Another paper noted how most of the research on boundary-creation between work and life has primarily been at the organizational level, which corresponds to few measures for boundary-creation at the individual level (Rexroth et al., 2016). Spieler et al. (2017) found that stronger boundaries between work and nonwork were positively associated with affective well-being in a sample of German employees. In their study, stronger boundaries meant that the employee made fewer cognitive or behavioral interdomain transitions. They observed the importance of distinguishing boundaries based on direction. A strong boundary at home appears to be more crucial for well-being than a strong boundary at work although both were associated with better affective well-being (Spieler et al., 2017). Another study found that a strong boundary at home appears to be more crucial for well-being than a strong boundary at work, and that boundary strength was not equivalent to work-home interference or enhancement (Hecht & N. J. Allen, 2009).

## **Mental Health Professionals**

Mental health professionals are a population that seeks to help others improve their mental health. In the process of doing so, they face many profession-specific challenges that can challenge their own well-being (Morris, 2018). A common concern is burnout, which can negatively impact both personal and professional functioning. Self-care is frequently promoted to mitigate this outcome and its precipitating stressors. Boundary setting between personal and professional life may be another way for mental health professionals to navigate the challenges specific to their own population.

The first of the profession-specific challenges is the emotional and psychological nature of therapeutic work, which can be draining (Morris, 2018). Most approaches to therapy require some degree of emotional engagement and almost all require cognitive engagement to effectively serve clients. Therapists must engage and disengage meaningfully with numerous clients, often within the same day and certainly across their careers. Psychotherapeutic work can also disrupt therapists' meaning of the world, particularly when therapists are working with clients on trauma (Matheson & Rosen, 2012; R. L. Harrison & Westwood, 2009; Pearlman, 1995). Even when content is not diagnostically traumatic, it can still be intense and draining. This inherent aspect of therapy can understandably lead to feelings of emotional or mental exhaustion, which is one of the first components of burnout.

In addition to the emotional and mental demands of the therapeutic work itself, there are extensive administrative demands on mental health professionals. These include documentation, case management, billing, scheduling, referrals, and organizational policies (Bettney, 2017; Rupert et al., 2015). These multiple responsibilities form another layer of professional challenge that the mental health professional needs to manage. Otherwise, ineffective handling of these

challenges can lead to diminished well-being and burnout. Self-care is a commonly suggested practice to mitigate these risks and cope in a healthy manner (Colman et al., 2016; Dorociak et al., 2017; Posluns & Gall, 2019; Rupert & Kent, 2007). Similarly, boundary setting is another common colloquial piece of advice to various kinds of professionals. Although boundary setting is not a novel concept, what is lacking in the psychological literature is clear, concrete, empirically supported guidance on how a mental health professional can set healthy boundaries.

In addition to the psychological and administrative challenges of the profession, mental health professionals are no less likely to experience their own personal life challenges or mental health concerns (Barnett et al., 2007; Morris, 2018; Thoreson et al., 1989). These could include depression, anxiety, relationship dissatisfaction, recurrent physical illness, or substance abuse (Thoreson et al., 1989). Many psychotherapists have experienced personal history of trauma or abuse (Morris, 2018). In a 2010 study by the American Psychological Association, 51% of participants reported current challenges that “impacted their professional functioning” (APA Practice Research & Policy Staff, 2010). Surveys of psychology trainees also have found rates of anxiety and depression at clinically significant levels that have been higher than the general population and even medical students (Rummell, 2015). Furthermore, mental health professionals are not immune to other unexpected stressful life events such as personal or family illness, serious injury, natural disaster, etc. (Thoreson et al., 1989).

When facing challenges, whether personal or professional, mental health professionals may also be hesitant to seek out support (Barnett & Hillard, 2001; Bettney, 2017). They may fear the effect that disclosing their struggles may have on their professional reputation, particularly if their struggles relate to their professional functioning. Mental health professionals may also feel the need to be mentally and emotionally “strong” since they are supposed to be service providers

who help others improve their well-being (Barnett & Hillard, 2001; Morris, 2018). There is even evidence that professionals push themselves to continue practicing, despite acknowledging that they “were too stressed to be effective” (Pope et al., 1987, p. 1000). They may feel shame, guilt, or fear that their struggles with their own well-being and mental health are indicators of professional incompetence. These barriers to seeking social support augment the vulnerability of mental health professionals for burnout or diminished well-being.

Finding balance between caring for themselves and caring for others is a common challenge among mental health professionals. Furthermore, compared to other professionals, mental health professionals may be particularly prone to imbalance for several reasons (Matheson & Rosen, 2012). First, mental health professionals may be caring, talented, and motivated to use their resources to help others (Underwood, 1991). They may naturally be concerned about others’ mental health and seek to help others. Second, professional training further teaches the individual how to promote the well-being of other people, which reinforces those natural tendencies to help others. Caring for the self, though, may have been less taught, practiced, or modeled through professional training. Although the importance of self-care has gained increasing recognition in the overall mental health profession, professional training may still inherently emphasize caring for others over caring for the self (Posluns & Gall, 2019; Pakenham & Stafford-Brown, 2012; Sapienza & Bugental, 2000; Wise et al., 2012). Third, mental health professionals may become imbalanced when they neglect their own needs. The professional’s individual needs will shift as their workload and environment evolves over time, meaning that neglect of their own needs can happen inconspicuously. Pursuing balance requires intentionality and attentiveness to their own shifting needs, making it a dynamic phenomenon rather than a static one.

## CHAPTER III

### METHODS

This Chapter describes the process taken to conduct this study. First, the Procedures section explains the steps taken to implement the study and complete data collection. Second, the Participants section describes the demographic and professional characteristics of the subjects in this study. Third, the Measures section lists the measures administered in this study. Finally, the Data Analysis section explains the statistical analyses and theoretical reasoning used to analyze the data in this study.

#### **Procedures**

Following approval by the Dissertation Committee on January 27, 2021, the Protocol Director began the process to propose the study to the Institutional Review Board (IRB) at Texas A&M University on February 3, 2021. This process included obtaining permission to use all measures in the study, purchasing licenses for administration, creating the full survey over Qualtrics, drafting all recruitment announcements, and submitting a detailed description of the study to the Texas A&M University IRB. The IRB requested some minor edits, which were completed within a week. After resubmitting the proposal with edits, the IRB gave official approval to commence the study on February 10, 2021.

Following IRB approval, participation recruitment began by email on February 10, 2021. This process initially began by identifying the contact information of various professional organizations for mental health professionals and requesting permission to send a recruitment email to their formal list-serv. Examples of professional organizations contacted include: multiple Divisions of American Psychological Association (APA); Texas Psychological Association (TPA); American Arab, Middle Eastern, and North African Psychological

Association (AMENAPSY); Asian American Psychological Association (AAPA); National Latinx Psychological Association (NLPA); Association of Black Psychologists (ABPsi).

Of the two dozen professional organizations contacted, only a handful of them responded to agree to distribute a participation recruitment announcement. Response rate also plateaued at about 30 responses after a few weeks. The Protocol Director recognized the need to modify the recruitment strategy. The following modifications were submitted as an amendment to the IRB, approved on March 16, 2021, and then enacted that same day. First, the investigator emailed clinical practices with mental health professionals to request that they forward a recruitment announcement. These clinical practices were identified through a google search of “email counseling clinic in [STATE]”. Second, colleagues in the professional network of the investigator or Dissertation Chair were contacted. Requests to distribute recruitment announcements were accompanied with a particular emphasis that participation would be voluntary, and all data be anonymous and de-identified. Some colleagues volunteered to distribute an announcement about the study through social media platforms, to which the investigator agreed. Finally, participant compensation was increased from one of six \$20 Amazon gift cards to one of ten \$50 Amazon gift cards. Both the survey and all further recruitment emails noted this updated compensation amount. Both clarified that people who had already participated would automatically be included in the drawing for the updated compensation amount.

Initial contact was attempted through email or website webform requests. The initial message included a brief explanation of the study, a request for the recipient to forward a separate recruitment email to their list-serv or contacts, and the informed consent form. Any organizations or individuals that responded to this contact with agreement were thanked and then

sent the formal recruitment email along with the informed consent form attached. These recruitment emails included a brief explanation of the study, description of participation, potential compensation, contact information, and a link to the survey (see Appendix A). Two to four weeks after the initial recruitment email, one follow-up reminder to forward was sent to the same recipients who had agreed to help with participant recruitment.

To be eligible to participate in this study, participants had to: (a) be at least 18 years old; (b) have maintained a permanent residence in the U.S. for the last 6 months; (c) have been a licensed mental health professional in the U.S. within the last 6 months; (d) have provided direct clinical services to clients within the last 6 months. These examples of licensed mental health professionals were provided in the recruitment materials: LP, LSSP, LPC, LCSW, LMSW, LMFT, etc. The following examples of direct clinical services were provided in recruitment materials: intakes, individual counseling, couples counseling, family counseling, group counseling, career counseling, crisis intervention, psychological assessment.

Participants could participate in the study by clicking on the survey link provided in the recruitment email. The survey began with the informed consent form, which participants had to confirm that they had read, understood, and agreed to before being allowed to proceed. The next page of the survey consisted of a brief set of screening questions to determine participant eligibility (see Appendix C). Only participants who met all eligibility criteria were allowed to proceed. Eligible participants were then directed to answer a demographic questionnaire (see Appendix D) and then the various measures used in this study (see Appendices E, F, G, and H). After participants completed all measures, the final page of the survey confirmed their completion along with an optional separate link to enter a drawing for one of ten \$50 Amazon

gift cards. Participants were assured that emails entered through this separate link would not be connected to their survey responses in any way.

Data collection lasted approximately 13 weeks. When sufficient sample size was reached, the Qualtrics survey links were closed on May 4, 2021. Using the link for the gift card drawing, ten emails were randomly selected to receive the compensation prize. On May 17, 2021, these recipients were emailed a link to their Amazon gift card along with a message containing the IRB approval number and investigators' contact info (see Appendix I).

## **Participants**

A total of 378 responses were recorded. Of the 378 responses, 45 responses were incomplete and did not contain ample information for analysis. Therefore, 333 participants were included in the study. This study had originally aimed to recruit 300 participants to have sufficient sample size for statistical power analyses.

Participants ranged in age from 25 to 85 ( $M=42.35$ ;  $SD = 11.92$ ).

Most participants identified as a Woman (81.9%,  $n=273$ ), with a smaller proportion identifying as a Man (16.8%,  $n=56$ ) or Other (1.2%,  $n=4$ ).

Ethnically, the sample consisted primarily of people of White/European Origin (79.28%,  $n=264$ ), followed by Latino-a/Hispanic (6.66%,  $n=22$ ), Asian American/Asian Origin/Pacific Islander (6.66%,  $n=22$ ), African American/Black/African Origin (5.7%,  $n=19$ ), Arab/Middle Eastern (1.5%,  $n=5$ ), and American Indian/Alaska Native/Aboriginal Canadian/Indigenous (0.6%,  $n=2$ ). These percentages sum to  $>100\%$  because there were 27 participants (4.5%) who identified either as Biracial/Multiracial or selected several ethnicities.

Participants' highest education level was almost evenly divided: 53.8% ( $n=179$ ) Doctorate/Professional and 46.2% ( $n=154$ ) Master's.

A summary of participants' demographic information can be found in Table 3.

**Table 3.**

*Demographic Characteristics of Participants*

<b>Demographic Variable</b>	<b>N</b>	<b>%</b>
<b>Age</b>		
21-30	50	15.0
31-40	132	39.6
41-50	73	21.9
51-60	42	12.6
≥61	36	10.8
<b>Gender</b>		
Woman	273	81.9
Man	56	16.8
Transgender Woman	0	0
Transgender Man	2	0.6
Other		
Genderqueer	1	0.3
Nonbinary	1	0.3
<b>Ethnicity<sup>1</sup></b>		
White/European Origin	264	79.28
Latino-a/Hispanic	22	6.66
Asian American/Asian Origin/Pacific Islander	22	6.66
African American/Black/African Origin	19	5.7
Arab/Middle Eastern	5	1.5
American Indian/Alaska Native/Aboriginal Canadian/Indigenous	2	0.6
Biracial/Multiracial	27	4.5
<b>Highest Education Level</b>		
Master's	154	46.2
Doctorate/Professional	179	53.8

<sup>1</sup>Participants had the option to select more than one ethnicity, which is why percentages sum to >100%. The n-values and percentages of the Biracial/Multicultural identifier include those who explicitly selected this option and those who selected more than 1 ethnic identifier.

In terms of mental health profession, participants held the following licenses: Licensed Psychologist (47.4%, n=158), Licensed Professional Counselor (22.8%, n=76); Licensed Clinical Social Worker (14.7%, n=49); Licensed Marriage and Family Therapist (4.5%, n=15); Licensed Mental Health Counselor (3.3%, n=11); Licensed Masters Social Worker (2.7%, n=9); Licensed

Clinical Alcohol & Drug Counselor (2.4%, n=8). Additionally, 10.8% (n=36) selected Other as their licensure. These percentages sum to >100% because 29 participants held more than one kind of professional licensure.

Participants worked in a variety of treatment settings: Private Practice (42.3%, n=141); University/College Counseling Center (18.3%, n=61); Community Mental Health (16.2%, n=54); Hospital/Medical Facility (9.0%, n=30); Veterans Administration/Department of Veterans Affairs (2.4%, n=8); Jail/Criminal Justice System (2.1%, n=7). Additionally, 9.6% (n=32) of participants indicated Other as their treatment setting.

A summary of participants' professional demographics can be found in Table 4.

**Table 4.**

*Professional Demographics of Participants*

<b>Professional Demographic Variable</b>	<b>N</b>	<b>%</b>
<b>Licensure</b>		
Licensed Psychologist	158	47.4
Licensed Professional Counselor	76	22.8
Licensed Clinical Social Worker	49	14.7
Licensed Marriage and Family Therapist	15	4.5
Licensed Mental Health Counselor	11	3.3
Licensed Masters Social Worker	9	2.7
Licensed Clinical Alcohol & Drug Counselor	8	2.4
Other	36	10.8
<b>Treatment Setting</b>		
Private Practice	141	42.3
University/College Counseling Center	61	18.3
Community Mental Health	54	16.2
Hospital/Medical Facility	30	9.0
Veterans Administration/Department of Veterans Affairs	8	2.4
Jail/Criminal Justice System	7	2.1
Other	32	9.6

## **Measures**

All measures in this study were administered through Qualtrics, a web-based data collection tool. At the beginning of the study, participants were presented with the informed consent form (see Appendix B), which they had to confirm that they had read, understood, and agreed to. Then, participants were asked a set of screening questions (see Appendix C). Eligible participants were then directed to complete a demographic questionnaire (see Appendix D).

After signing the informed consent form, passing the screening questions, and completing the demographic questionnaire, participants completed several measures. These measures were administered to obtain data on the four variables of boundary setting, self-care, burnout, and well-being. These measures were: (a) the Personal-Professional Life Boundary Setting Survey; (b) the Self-Care Assessment for Psychologists (SCAP); (c) the Maslach Burnout Inventory-Human Services Survey (MBI-HSS); (d) the Satisfaction With Life Scale (SWLS); and (e) the Flourishing Scale. The following subsections describe these measures in greater depth.

### ***Personal-Professional Life Boundary Setting Survey***

An appropriate psychometrically validated instrument for the construct of boundary setting was not available. Existing instruments with “boundary” in their name or intention conceptualized the term from a distinctly different perspective than the meaning used in this study. See Chapter II – Boundaries & Boundary Setting: Measures and Questionnaires for further explanation.

Since no existing measures for boundaries were appropriate for this study, the investigator created a survey instrument called the Personal-Professional Life Boundary Setting Survey. Survey instruments differ from scales in that scales require validation and psychometric studies for use. Although using scales for research is ideal, when appropriate scales are not

available, it is common to use survey instruments instead in psychological research. The survey in this study was created to evaluate the purposeful actions or choices mental health professionals make at an individual level to set boundaries between their personal and professional lives.

The Personal-Professional Life Boundary Setting Survey consisted of two parts, both of which employed a 7-point Likert scale. The first part asked participants to indicate their level of agreement with 14 items. The second part asked participants to indicate how frequently another 14 items was true for them. The entire Personal-Professional Life Boundary Setting Survey that was administered consisted of 28 items (see Appendix E). A 7-point Likert scale was employed because 7 points offer greater sensitivity than a lower-point scale without affecting reliability (Dawes, 2008; Leung, 2011). Additionally, collapsing responses into narrower categories would be more feasible than expanding responses into wider categories (E. Allen & Seaman, 2007; Leung, 2011). Finally, the other measures in this study all used 7-point scales, so using a 7-point Likert scale for this survey facilitates analyzing the relationship between various scores.

### ***Self-Care Assessment for Psychologists (SCAP)***

The SCAP (Dorociak et al., 2017) is a 21 item, self-administered assessment designed to measure how often psychologists and other professionals engage in self-care behaviors that are relevant to their personal and professional functioning. Each item describes a self-care behavior, and participants indicate how frequently they engage in it on a scale of 1 (*never*) to 7 (*always*). The measure also categorizes the items into five components: professional support, professional development, life balance, cognitive awareness, and daily balance.

The SCAP was initially validated on a sample of 374 psychologists, with good support for its factorial structure, concurrent validity, and content validity. All subscales had Cronbach's

alphas in the range of .70-.83 (Dorociak et al., 2017). An adaptation of the scale for clinical psychology doctoral students produced further support for this scale's reliability (Zahniser et al., 2017). Additionally, a recent systematic review of existing self-care measures definitively recommended this measure as one of the two best-supported measures for assessing self-care behaviors at an individual level (Jiang et al., 2020).

The SCAP is a non-commercial instrument that requires permission from the original authors before it can be used for other research purposes. The investigator contacted the first author, Katherine E. Dorociak, PhD, to request permission to use the scale in this study. Permission was granted along with an official letter indicating approval. See Appendix F.

### ***Maslach Burnout Inventory–Human Services Survey (MBI-HSS)***

The MBI-HSS (Maslach & Jackson, 1996) is a 22-item measure that assesses burnout, using three components: emotional exhaustion (EE), depersonalization (DP), and a reduced sense of personal accomplishment (PA). Participants rate how often they experience each item on a scale of 0 (*never*) to 6 (*daily*). The MBI-HSS has repeatedly been shown to have sound psychometric properties, rendering it now the “gold standard” in burnout research among helping professions (Schaufeli et al., 2009).

The MBI-HSS is a commercial instrument published by Mind Garden, Inc. A purchase license is required for each reproduction or administration of the MBI. Researchers can purchase one of three kinds of licenses: (a) paper/pen administration; (b) online administration through their platform; (c) remote online administration using one's own platform. For this study, the Protocol Director purchased the license for remote online administration through a separate platform. To comply with copyright restrictions, this document will not reproduce the specific items of the MBI that were administered.

### ***Satisfaction With Life Scale (SWLS)***

The SWLS (Diener et al., 1985) is a 5-item measure that assesses life satisfaction from a hedonic approach to well-being. Participants indicate their agreement with each item on a scale from 1 (*completely disagree*) to 7 (*completely agree*). The measure has been extensively used and has well-established support for its psychometric properties, including reliability and construct validity (Diener et al., 1985; Pavot et al., 1998). Cronbach's alpha has ranged from  $r=.79$  to  $.89$  (Pavot & Diener, 2008). The SWLS positive correlates with a range of life outcomes, including mental/physical health and is commonly used as part of validation for new measures of well-being.

The SWLS has a Creative Commons license, meaning the authors have given people permission to use this measure freely if proper citation is included. It is not necessary to contact the author or publisher to obtain permission for use.

### ***Flourishing Scale***

The Flourishing Scale (Diener et al., 2010) is an 8-item measure that assesses well-being using a eudaimonic approach. Participants consider their past 4 weeks and indicate their agreement with each item on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*). The measure has demonstrated construct validity through unidimensionality and convergence with similar short scales (Diener et al., 2010). The measure was developed based on the theory that individuals have a need for competence, engagement, and purpose. Cronbach's alpha has ranged from  $0.81$  to  $0.87$  (Cooke et al., 2016; Diener et al., 2010).

At the end of their seminal paper, Diener et al. (2010) explicitly state that others may use the Flourishing Scale freely without contacting the authors if proper citation of the measure is included.

## **Data Analysis**

To address the Research Questions (RQs) of this study, linear regression analyses were originally proposed as the methodology for analyzing the data. After attempting all linear regressions, though, the investigator and statistical consultant determined that this statistical methodology would not be sufficient for the complexity of the data. Instead, structural equation modeling (SEM) was deemed more suitable for addressing the research questions of this study.

Several steps were taken to prepare the data for RQ-specific analyses. First, the data was cleaned and coded. Second, the Personal-Professional Life Boundary Setting Survey was examined to identify a suitable factor structure. Third, the reliability and validity of all the measures were verified. Fourth, correlation analyses were conducted to identify which relationships to focus on for linear regression analysis. Fifth, linear regressions were conducted on those relationships. Finally, structural equation modeling was conducted to address the research questions of this study. The following subsections will describe each of these steps in further detail.

### ***Cleaning & Coding***

After all data was gathered, it was prepared for analysis by first removing any survey responses where >10% items were missing. Then, the data was recoded to convert text responses into numeric values. Based on theoretical reasoning, some items within the boundary setting survey were selected to be reverse scored. These items were reviewed to ensure that reverse-scoring was done accurately. The researchers then used Excel 2016 to calculate the average scores for the factors within each measure. Excel 2016 was also used to calculate the descriptive statistics of the data and demographic characteristics of participants.

### *Factor Structure for Boundary Setting*

Having cleaned and summarized the overall data, the investigator then examined the Personal-Professional Life Boundary Setting Survey. This instrument was specifically created for this study, so its preliminary psychometric properties needed to be established first. This required investigating the potential factor structure of the survey. Based on the theoretical reasoning about the survey items, the investigator proposed several potential models, which were then tested by the software STATA/SE 16.1 using confirmatory factor analysis and a maximum-likelihood estimation.

The first model that was hypothesized was a one factor, unidimensional model that included all 28 administered items. Goodness-of-fit indices indicated that the model fit was very poor (RMSEA = 0.149; SRMR = 0.149; CFI = 0.436). Therefore, the investigator decided to hypothesize about potential factors within the model.

The second model to be tested split the 28 items into four different factors, which were correlated with each other. This four-factor correlated model also had poor initial fit (RMSEA= 0.142; SRMR= 0.150; CFI= 0.498). Therefore, steps were taken to try to improve model fit by removing items individually. This began by examining the standardized coefficients for individual items. If an item had a non-significant p-value for its standardized coefficient, this indicated that it was not represented well by its hypothesized factor grouping. This item would be deleted, and then the goodness-of-fit tests were re-rerun. Then the next item with a non-significant p-value for its standard coefficient was removed. This process was repeated, resulting in a final four-factor model with 16 items. However, this final four factor correlated model still did not reach acceptable fit (RMSEA= 0.129; SRMR= 0.100; CFI= 0.778).

The third model hypothesized was a modification based on the previous four-factor model. Based on theoretical reasoning, two items from the initial four factor model were rearranged into the other factors, and then the remaining items in the fourth factor were deleted. These changes resulted in an initial three factors correlated model with 21 items. An overall goodness-of-fit test showed that this third model had improved fit (RMSEA=0.145; SRMR=0.141; CFI=0.571) compared to the initial four factors correlated model, although it still did not meet criteria for acceptable fit. Again, individual items were removed from the model to improve model fit. First, items that had standardized coefficients with non-significant p-values were deleted. One item was identified for deletion, and then the overall goodness-of-fit indices were recalculated. No other items had non-significant standardized coefficients. Therefore, equation-level goodness-of-fit tests were conducted, which yielded  $r^2$  values for each item that indicate its fit with the model. The item with the lowest  $r^2$  value was deleted first, and then the overall goodness-of-fit indices were recalculated to see if the model had reached acceptable fit. If the model had not, equation-level goodness-of-fit indices were calculated again, and the next item with the lowest  $r^2$  value was deleted. This process resulted in deleting an additional 8 items.

Deleting these 8 additional items resulted in a refined model with acceptable goodness-of-fit indices (RMSEA = 0.093; SRMR = 0.050; CFI = 0.908). This refined model was a three-factors-correlated model of 12 items total. Since this model reached acceptable fit, whereas the other hypothesized models had not, it was expected to be used for further analyses on the variable of boundary setting. Based on theoretical reasoning, its three factors were named: (a) PersInt–personal life interfering with professional life; (b) ProfInt–professional life interfering with personal life; and (c) Segm–segmentation approach.

One final model for boundary setting was proposed, which was a slight modification to the previous three-factors-correlated model of 12 items. Instead of correlating the three factors of PersInt, ProfInt, and Segm, a second-order latent variable of boundary setting was hypothesized to connect the three factors. This second-order three-factor model had acceptable goodness-of-fit indices (RMSEA = 0.094; SRMR = 0.060; CFI = 0.906) that were closely comparable to the three-factors-correlated model. However, the model did not reach convergence. Therefore, the three correlated factors model was used in all further analyses on the variable of boundary setting.

### ***Reliability***

To evaluate the quality of the measures included in this study, reliability tests were conducted on all five of the measures in this study. Using STATA/SE 16.1, reliability was determined through Cronbach's alpha. Based on guidelines from George & Mallery (2001, p. 217),  $\alpha > 0.7$  was considered acceptable,  $\alpha > 0.8$  was considered good, and  $\alpha > 0.9$  was considered excellent. Alpha values in this study were also compared to alpha values from the original study for the variables of self-care, burnout, and well-being. For the variable of boundary setting, this is the original study on its reliability and other psychometric properties.

### ***Validity***

Along with reliability tests, validity tests were also necessary to determine the quality of the measures used in this study. Validity tests were conducted using STATA/SE 16.1, beginning with the model building and estimation function. The three variables of self-care, burnout, and well-being already had existing factor structures published in their original studies. Therefore, for those three variables, the researcher reconstructed the existing model structure and then conducted a confirmatory factor analysis with a maximum-likelihood estimation. For the fourth

variable of boundary setting, the researcher followed the steps described in the previous subsection “Factor Structure for Boundary Setting.”

All the models for each variable were assessed based on their overall goodness-of-fit indices. The following guidelines were used to determine acceptable model fit: RMSEA < .08 (Browne & Cudeck, 1993); SRMR < .08 (Hu & Bentler, 1998); CFI > .90 (Marsh, Hau, & Wen, 2004). Although  $\chi^2$  values were also reported, they were not used as the primary index of model fit because this statistical test of fit is considered “too strong to be realistic” (Hu & Bentler, 1998, p. 425). Meeting the other criteria for overall fit was considered sufficient to indicate that the proposed factor structure was a valid depiction of the data.

### ***Correlations***

After verifying the reliability and validity of the measures used in this study, the investigator conducted correlation analyses to acquire preliminary information about potentially meaningful relationships in the data. Correlation analyses produce r-values that can range from -1.0 to +1.0. Positive r-values indicate that as one variable increases, the other variable also increases. The absolute value of the r-value indicates the strength of the relationship between the variables with  $|r| = 0.10$  considered a small effect size,  $|r| = 0.30$  considered a medium effect size, and  $|r| = 0.50$  considered a large effect size (Cohen, 1992).

Correlations analyses were conducted in two parts, using the software STATA/SE 16.1. First, correlations between factors for the same variable were calculated. Several variables (e.g., self-care, burnout, and boundary setting) were assessed through measures that consisted of multiple factor scores. For these variables, correlations between its own factors were calculated first.

Second, based on the Research Questions of this study, correlations between the three factors of boundary setting (PersInt, ProfInt, and Segm) and the other factors were calculated. These correlations served as a guideline for which relationships to further investigate through linear regression analyses. Correlations with  $|r| \geq 0.30$  were noted because they indicated at least a medium effect size.

While considering the positive/negative directionality of the  $r$  values, the investigator realized that the results would be more intuitive if the reverse-scored items were not reversed. All reverse-scored items were therefore revised to become forward-scored. Then, all previous calculations were redone, and tables recreated. All reported values in the Results section reflect this change.

### ***Linear Regressions***

Based on the results of the correlation analyses, several relationships were noted for linear regression analysis. In particular, the boundary setting factor, PersInt, did not have any correlations with  $|r| \geq 0.30$ , so it was excluded from being a predictor in any of the linear regression analyses. The remaining correlations frequently indicated that both ProfInt and Segm had at least a medium effect size relationship with the other factors. Therefore, the investigator decided to initially include both ProfInt and Segm as predictors in the linear regression analyses. If the results showed that either of these factors was not a statistically significant predictor at  $\alpha=0.05$  level, then a simple linear regression was re-calculated using only the remaining factor as a predictor.

Linear regressions were originally expected to be sufficient for addressing Research Questions 1, 2, and 3 since these RQs examine the relationship of boundary setting with one outcome variable individually. Simple linear regressions compare one predictor variable with

one outcome variable, while multiple linear regressions compare multiple predictor variables with one outcome variable. However, neither form of linear regression can analyze multiple outcome variables simultaneously. Unfortunately, upon further examining the data, the investigator realized that the outcome variables of self-care and burnout both consisted of multiple factor scores rather than one comprehensive total score. Therefore, linear regressions would only be able to analyze the relationship between boundary setting and an individual subfactor of self-care or of burnout. This statistical approach would not be able to examine all subfactors together.

After consulting with a statistician and a committee member about this issue, the investigator decided to first try conducting individual linear regressions through STATA/SE 16.1. As previously explained, the relationships between ProfInt and Segm with the individual factors were studied first. After attempting these individual regression analyses, the investigator sought further consultation and feedback from the Committee and statistician. It was decided that linear regressions were an insufficient approach for the complexity of the data set and the research questions. Instead, a statistical procedure that could simultaneously analyze multiple predictors and multiple outcomes was needed. For this reason, structural equation modeling (SEM) was chosen. Some tables that summarize the attempted linear regression models will still be reported in the Results section, but they will not be the primary basis for addressing the Research Questions of this study.

### ***Structural Equation Modeling (SEM)***

Since it was determined that linear regressions were insufficient for the complexity of the data, structural equation modeling (SEM) was chosen as the next step in data analysis. SEM is a methodology that can analyze multiple predictors and multiple outcomes together by first

depicting them graphically. A statistical consultant was hired to assist with SEM, including model hypothesis, estimation, and interpretation. SEM was conducted using STATA/SE 16.1.

Several potential models were proposed, based on different theoretical considerations. All the models included a predictor side and an outcome side. On the predictor side, all three factors of boundary setting (e.g., PersInt, ProfInt, and Segm) as predictors. These factors could either be correlated with each other or be modeled with a 2<sup>nd</sup> order latent variable for boundary setting. Since the 2<sup>nd</sup> order latent variable model for boundary setting did not converge on its own (see previous subsection, “Factor Structure for Boundary Setting”), the latter approach was attempted with caution.

On the outcome side, several variations for modeling were proposed. First, each outcome variable could be modeled separately from the others, which would result in the three different SEM models for self-care, burnout, and well-being, respectively. Alternatively, all outcome variables could be modeled simultaneously within the same model. This would be advantageous because it would provide one set of model coefficients instead of three different sets, which facilitates parsimony. Additionally, this model would provide information about potential overlap between outcome variables. Therefore, this approach was chosen over the previous option of three separate models.

Even after choosing to model all outcomes in the same model, there were additional possibilities. Outcome variable factors could be correlated with each other or be connected to a 2<sup>nd</sup> order latent variable. Both approaches were tested. Since the outcome variable of well-being consisted of two different measures, these scores could either be represented as separate outcomes or combined under a 2<sup>nd</sup> order latent variable of well-being. Both alternatives were attempted. Finally, another statistical consultant suggested the possibility of a path model

approach on the outcome side, where only summed factor scores (rather than individual items) would be modeled. This approach was attempted as well.

Several variations in modeling the predictors and outcomes were attempted, but most of the models did not reach convergence. Lack of model convergence means that the model is not a valid representation of the actual data, and the specific paths cannot be estimated. Only models that converge are interpretable. Four of the hypothesized SEM models did converge. These four models were: (a) correlated predictors model with no 2<sup>nd</sup> order latent variables; (b) correlated predictors model with no 2<sup>nd</sup> order latent variables plus covaried residuals in the outcomes; (c) 2<sup>nd</sup> order latent variables for all variables; (d) 2<sup>nd</sup> order latent variables except for well-being. The Results section will depict the models that did converge, along with their goodness-of-fit indices.

Of the models that converged, the second model with correlated predictors and covaried residuals in the outcomes was chosen to address the Research Questions in this study. This model was the most parsimonious of the four remaining models, still had adequate model fit, and had strong theoretical justification. Since the model depicted all outcome variables in one model, each part of the model can be examined by itself as well as in the context of the whole. Using the model estimation function in STATA/SE 16.1 yielded estimates of the pattern coefficients, residual variances, factor covariances, residual covariances, and factor loadings for the SEM model. To address the Research Questions of this study, the factor loadings from the model were specifically examined. Chapter IV will present these results and then Chapter V will discuss their implications.

## CHAPTER IV

### RESULTS

This Chapter presents the results of the statistical analyses described in the previous Chapter. These results are split into two main sections: (a) Preparatory Statistical Analyses; and (b) RQ-Specific Analyses. The first section, Preparatory Statistical Analyses, presents the results that lay the foundation needed to address the research questions of this study. The second section, RQ-Specific Analyses, focuses only on the results that directly relate to the research questions of this study.

#### **Preparatory Statistical Analyses**

Before the Research Questions of this study could be addressed, several statistical analyses had to be conducted first. This section lays out the results of those foundational steps, which are organized into subsections that align with those from Chapter III – Methods: Data Analysis: (a) Factor Structure for Boundary Setting; (b) Reliability; (c) Validity; (d) Correlations; (e) Linear Regressions; and (f) Structural Equation Modeling (SEM).

#### ***Factor Structure for Boundary Setting***

Exploratory factor analysis (EFA) was conducted to examine the dimensionality of the variable, boundary setting. Several possible models were hypothesized and tested, including a one factor, unidimensional model, a four correlated factors model, and a three correlated factors model. See Table 5 for a comparison of the fit statistics of these hypothesized models.

**Table 5.***EFA Assessment of Model Fit*

<b>Model</b>	<b># Items</b>	<b>ML <math>\chi^2</math></b>	<b>RMSEA*</b>	<b>SRMR*</b>	<b>CFI**</b>
One factor, unidimensional model	28	2919.560 (p <0.001)	0.149	0.149	0.436
Four factors correlated, initial model	28	2633.198 (p <0.001)	0.142	0.150	0.498
Four factors correlated, final model	16	635.701 (p <0.001)	0.129	0.100	0.778
Three factors correlated, initial hypothesis	21	1484.296 (p <0.001)	0.145	0.141	0.571
Three factors correlated, final model	12	196.157 (p <0.001)	0.093	0.050	0.908
Three factors with a second-order latent variable	12	199.643 (p <0.001)	0.094	0.060	0.906

Note: ML  $\chi^2$  = maximum likelihood chi-square value; RMSEA = root mean square error of approximation; SRMR = standardized root mean residual; CFI = comparative fit index

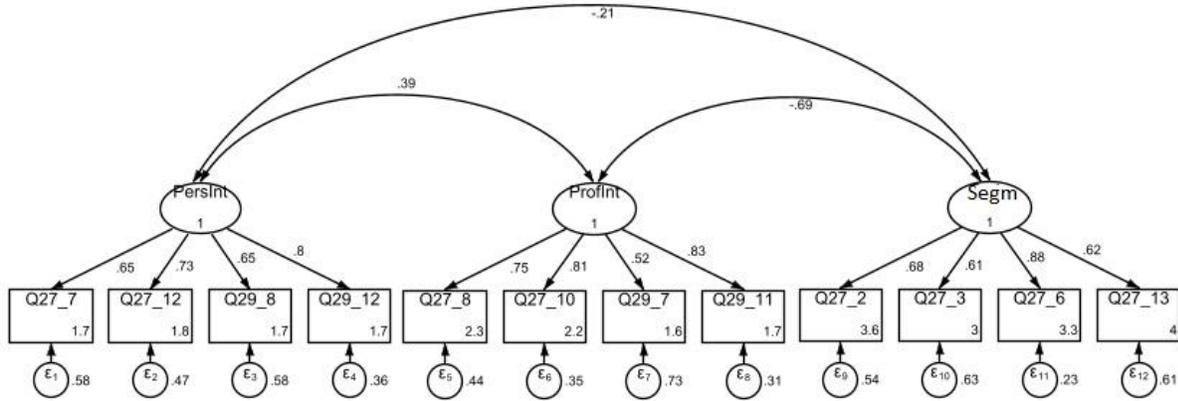
\*RMSEA and SRMR values <0.08 are acceptable.

\*\*CFI values >0.90 are acceptable.

Since the initial goodness-of-fit statistics for these hypothesized models was poor, steps were taken to improve the fit of the models. Items were individually deleted based on their goodness-of-fit and equation-level goodness-of-fit indices, as previously described in the Methods section. These steps eventually resulted in a three correlated factors model of 12 items that had acceptable model fit (RMSEA = 0.093; SRMR = 0.050; CFI = 0.908). See Figure 1.

**Figure 1.**

*Three Factors Correlated Model of Boundary Setting*



The specific boundary-setting items in the three-factor correlated model are displayed in Table 6, along with their factor loadings. Later in this study, SEM analyses also yielded factor loading values, which are presented in Table 6 too for comparison.

**Table 6.**

*Boundary Setting Items with CFA and SEM Factor Loadings*

Item		CFA	SEM
<b>Personal Interference on Professional Life (PersInt)</b>			
Q27_7	I do not complete some of my professional responsibilities because of personal life demands.	.646	.655
Q27_12	I do not have enough energy for my professional life because of personal life demands.	.731	.735
Q29_8	I miss professional advancement opportunities because of personal life demands.	.649	.652
Q29_12	My professional life is struggling because of excessive personal life demands.	.798	.796

**Table 6 (continued).***Boundary Setting Items with CFA and SEM Factor Loadings*

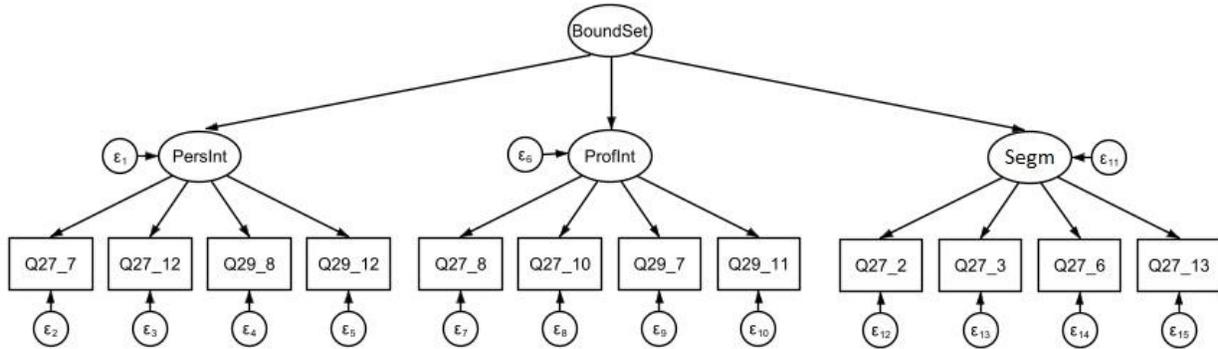
<b>Professional Interference on Personal Life (ProfInt)</b>			
Q27_8	I do not complete some of my personal life responsibilities because of professional demands.	.749	.708
Q27_10	I do not have enough energy for my personal life because of professional demands.	.808	.829
Q29_7	I miss important events with my friends/family because of professional responsibilities.	.523	.510
Q29_11	My personal life is struggling because of excessive professional life demands.	.828	.850
<b>Segmentation Approach (Segm)</b>			
Q27_2	I set certain hours for my professional responsibilities.	.676	.664
Q27_3	I set certain hours for my personal life responsibilities.	.606	.610
Q27_6	I balance competing demands in my personal life and my professional life.	.877	.852
Q27_13	I purposefully create some separation between my personal life and my professional life.	.624	.620

From Table 6 above, the CFA factor loading coefficients were very close in value to the SEM factor loading coefficients. This result provides further evidence that the fit of this CFA validation model for boundary setting is replicable in the SEM model created later in the data analysis process. In other words, the fit of the boundary setting survey in the larger SEM model was comparable to the fit of the boundary setting survey on its own.

After testing the fit of the three-factor correlated model in Figure 1, a modification was made by adding a second-order latent variable of boundary setting. See Figure 2.

**Figure 2.**

*Three Factors with 2<sup>nd</sup>-Order Latent Variable Model of Boundary Setting*



Note: This hypothesized model of boundary setting did not converge, so model estimations could not be generated.

The fit of this second-order three factor model was tested. This model failed to converge, meaning that the model is not a valid representation of the available data. Even though overall goodness-of-fit indices were able to be generated (RMSEA = 0.094; SRMR = 0.060; CFI = 0.906), their values do not compensate for the model's lack of convergence. Models that do not converge require the model to be restructured in some way. In this case, the 2<sup>nd</sup> order latent variable was removed, and correlations between the three latent factors were reinstated to return to the model in Figure 1. This three-factors-correlated model was used for all further analyses on the variable of boundary setting.

### **Reliability**

Reliability tests were conducted on the factors within each measure to verify their consistency. STATA/SE 16.1 was used to calculate Cronbach's alpha. As a rule-of-thumb,  $\alpha > 0.7$  was considered acceptable,  $\alpha > 0.8$  was considered good, and  $\alpha > 0.9$  was considered

excellent (George & Mallery, 2001, p. 217). Alpha values from this study were also compared to those from the original study. See Table 7.

**Table 7.**

*Reliability of Measures*

<b>Measure Factor</b>	<b>Original study's <math>\alpha</math></b>	<b>Cronbach's <math>\alpha</math> in this study</b>	<b>Average Inter-item covariance</b>	<b># Items in factor</b>
Flourishing Scale	0.81 to 0.87	0.9128	0.5564368	8
Satisfaction With Life Scale (SWLS)	0.79 to 0.89	0.8825	1.012216	5
Self-Care Assessment for Psychologists (SCAP)				
ProfSup	0.85	0.8674	1.501398	5
ProfDev	0.79	0.7909	1.052701	5
LifeBal	0.80	0.8248	1.094074	4
CogAw	0.71	0.7995	0.6858982	4
DayBal	0.69	0.7322	1.461097	3
Personal-Professional Life Boundary Setting Survey				
PersInt	-	0.7876	1.029805	4
ProfInt	-	0.8158	1.601351	4
Segm	-	0.7908	1.078215	4
Maslach Burnout Inventory (MBI)				
EE	0.84	0.9233	1.69863	9
DP	0.79	0.7556	0.6720381	5
PA	0.87	0.7111	0.273217	8

All Cronbach's  $\alpha$ -values in this study met criteria for acceptable reliability ( $\alpha > 0.70$ ). Two of them –EE and Flourishing– had excellent reliability. Four of them –SWLS, ProfSup, LifeBal, and ProfInt– had good reliability.

Considering the  $\alpha$ 's from the original studies, all  $\alpha$ 's in this study were comparable. In fact, most  $\alpha$ 's in this study exceeded those in the original study (e.g., Flourishing, ProfSup, LifeBal, CogAw, DayBal, EE). A few  $\alpha$ 's in this study were almost identical to those of the

original study (e.g., SWLS and ProfDev). Only two  $\alpha$ 's in this study were smaller than those of the original study (e.g., DP and PA), although these two values are still within acceptable range.

Having reliability scores within acceptable, good, or excellent range is a positive indicator about the factors that were tested. Higher reliability scores indicate that the items are measuring a similar latent construct, which are named as a factor. Since most of these factors came from previously validated measures, this provides support for the item groupings used in the original measures. For the Personal-Professional Life Boundary Setting Survey, it is particularly noteworthy that all three factors had acceptable (or better) reliabilities. The three boundary setting factors even had better reliability scores than some of the factors from published measures.

### ***Validity***

Validity was calculated by using the model building and estimation function within STATA/SE 16.1. Goodness-of-fit tests were run on each of the models to evaluate how well the proposed factor structure fit the collected data. These guidelines were used to evaluate fit: RMSEA < .08 (Browne & Cudeck, 1993); SRMR < .08 (Hu & Bentler, 1998); CFI > .90 (Marsh, Hau, & Wen, 2004). See Table 8 for the fit of each of the models.

**Table 8.***Goodness-of-Fit Statistics for Each Measure*

<b>Measure</b>	<b>ML <math>\chi^2</math></b>	<b>RMSEA</b>	<b>SRMR</b>	<b>CFI</b>
Self-Care Assessment for Psychologists	493.297 (p <0.001)	0.073	0.060	0.898
Maslach Burnout Inventory	404.484 (p <0.001)	0.136	0.117	0.706
Satisfaction With Life Scale	45.375 (p <0.001)	0.156	0.047	0.960
Flourishing Scale	109.883 (p <0.001)	0.117	0.037	0.944
Personal- Professional Life Boundary Setting Survey	196.157 (p <0.001)	0.093	0.050	0.908

Note: ML  $\chi^2$  = maximum likelihood chi-square value; RMSEA = root mean square error of approximation; SRMR = standardized root mean residual; CFI = comparative fit index

Using the above guidelines, none of the models completely met all criteria for good fit. However, the SCAP met two of the criteria (RMSEA < 0.08 and SRMR < 0.08) and was very close to meeting the third (CFI > 0.90). Of the measures administered in this study, the SCAP had the best goodness-of-fit indices for this data set.

Three of the other measures, the SWLS, Flourishing Scale, and the Boundary Setting survey, also met two out of three of the criteria (SRMR < 0.08 and CFI > 0.90). Of these, the Boundary Setting Survey was also close to meeting the third criteria (RMSEA < 0.08) and had the next best goodness-of-fit indices for this data set.

The MBI did not meet any of the criteria for model fit. However, its goodness-of-fit indices were still comparable to the guidelines.

Although the chi-square  $\chi^2$  values were reported for all five of these models, they were not used to evaluate model fit because this statistical test of fit is considered “too strong to be

realistic” (Hu & Bentler, 1998, p. 425). All chi-square  $\chi^2$  values reported would have indicated that the models did not perfectly fit the collected data.

Although none of the measures met all three criteria for model fit, most of them met at least two criteria. Two of the measures, the SCAP and the Boundary Setting Survey, were close to meeting the third criteria. This strongly indicates that the factor structure for the measure’s items was fitting. The MBI did not meet any goodness-of-fit criteria, but it is already established as the “gold standard” for research on burnout (Schaufeli et al., 2009). Therefore, all five measures in this study were still accepted as valid measures for their latent constructs and their factor structures were considered validated.

The Personal-Professional Life Boundary Setting Survey had the second-best goodness-of-fit indices of the five measures in this study. This is particularly noteworthy because it had better validity than several published measures like the MBI or the SCAP. This is an excellent result for a survey that was created specifically for this study and that did not have any previous psychometric properties. The reliability and validity scores reported here can now be considered the preliminary psychometric properties of the Personal-Professional Life Boundary Setting Survey. Both the reliability and validity scores were at least acceptable, which strongly indicates that this survey has potential to become a validated measure of boundary setting for use in future research.

### ***Correlations***

Correlation analyses were conducted in two parts. For both parts, the following guidelines from Cohen (1992) were used to evaluate effect size: (a)  $r = 0.10$  for a small effect size; (b)  $r = 0.30$  for a medium effect size; and (c)  $r = 0.50$  for a large effect size.

First, correlation analyses began by calculating correlations within models that consisted of multiple factors. Three variables —self-care, burnout, and boundary setting— used measures with multiple-factor models. The correlations within factors of each of these variables are shown in Tables 9, 10, and 11, respectively.

**Table 9.**

*Correlations Among Self-Care Factors*

Self-Care Factors	ProfSup	ProfDev	LifeBal	CogAw	DayBal
ProfSup	–				
ProfDev	0.6601**	–			
LifeBal	0.4605**	0.4340**	–		
CogAw	0.4622**	0.4628**	0.4674**	–	
DayBal	0.2445**	0.2911**	0.3813**	0.4731**	–

Note: ProfSup = professional support; ProfDev = professional development; LifeBal = life

balance; CogAw = cognitive awareness; DayBal = daily balance

\*\*p < 0.01

Table 9 above indicates that all possible correlations between two self-care factors were significant at a p < 0.01 level. All correlations were positive. All-but-two correlations had medium effect sizes ( $r \geq 0.3$ ). The two correlations that did not were DayBal & ProfSup and DayBal & ProfDev.

These correlations' directionality was as expected based on theoretical reasoning and prior research. All five factors represent different dimensions of self-care. Therefore, the positive directionality between the factors was expected. The medium effect sizes indicate that the factors are related to each other, but the effect sizes are not so large that the factors may be better to combine with each other. The moderate size correlation values indicate that it is better to categorize these items into these separate factors and that these factors do represent different aspects of the same latent variable.

**Table 10.**

*Correlations Among Burnout Factors*

Burnout Factors	EE	DP	PA
EE	–		
DP	0.5279**	–	
PA	-0.3865**	-0.4175**	–

Note: EE = emotional exhaustion; DP = depersonalization; PA = personal accomplishment.

\*\*p < 0.01

Table 10 above indicates that all three pairings of the burnout factors was significant at a  $p < 0.01$  level. All three correlations had a medium effect size of  $|r| \geq 0.3$ . From highest-to-lowest  $|r|$  values, the order of correlations was: (a) EE and DP; (b) PA and DP; (c) PA and EE. A positive relationship was found between EE and DP whereas a negative relationship was found for PA and DP and for PA and EE.

These correlations' directionality was all as expected based on theoretical reasoning and prior research. EE (emotional exhaustion) and DP (depersonalization) both represent the negative symptoms that indicate burnout's presence, so it was expected for them to be positively correlated. PA (personal accomplishment) represents positive symptoms that indicate the absence of burnout, so it was expected that it would negatively correlate with both EE and DP. Again, the effect sizes were all medium. This indicates that it is better to represent the burnout items through these three factors rather than as one singular factor.

**Table 11.**

*Correlations Among Boundary Setting Factors*

Boundary Setting Factors	PersInt	ProfInt	Segm
PersInt	–		
ProfInt	0.3090**	–	
Segm	-0.1472**	-0.5512**	–

Note: PersInt = personal life interfering with professional life; ProfInt = professional life interfering with personal life; Segm = segmentation approach.

\*\*p < 0.01

Table 11 above indicates that all three pairings of the boundary setting factors was significant at a p < 0.01 level. Considering the r-values themselves, ProfInt and PersInt were positively correlated with  $\geq 0.3$ , while ProfInt and Segm were negatively correlated with  $|r| \geq 0.3$ . PersInt and Segm did not have  $|r| \geq 0.3$ .

These correlations' directionality was all as expected based on theoretical reasoning and prior research. Segm (segmentation approach) represents the active, purposeful behaviors that an individual chooses to set boundaries that segment personal and professional life. ProfInt (professional interference on personal life) and PersInt (personal interference on professional life) represent one life domain interfering with the other. It was expected that Segm would be negatively related with both ProfInt and PersInt. It also was expected that ProfInt and PersInt would positively relate with each other. Again, all three of these correlations had a medium effect size. This provides strong support for categorizing the boundary setting items into these three factors rather than in one singular factor. It also indicates provides further support for creating this three-factor structure for the Personal-Professional Life Boundary Setting Survey.

After calculating the correlations within factors of the same variable, the second part of correlation analyses consisted of calculating the correlations between factors of different variables. In particular, the three factors of boundary setting —PersInt, ProfInt, Segm— were correlated with the factors of other variables. These correlations are shown in Table 12.

Correlations with  $r \geq 0.3$  are highlighted.

**Table 12.**

*Correlations of Boundary Setting Factors with Other Factors*

	ProfSup	ProfDev	LifeBal	CogAw	DayBal
PersInt	-0.0742	-0.0666	-0.1141*	-0.1882**	-0.1176*
ProfInt	-0.1091*	-0.1704**	-0.4082**	-0.3322**	-0.5607**
Segm	0.1555**	0.2195**	0.4294**	0.3806**	0.5685**
	EE	DP	PA	SWLS	Flourish
PersInt	0.1250*	0.0928	-0.1793**	-0.0578	-0.1683**
ProfInt	0.6676**	0.2789**	-0.2746**	-0.4398**	-0.3202**
Segm	-0.4234**	-0.1816**	0.2566**	0.4411*	0.2672**

Note: SWLS = Satisfaction With Life Scale

\* $p < 0.05$ . \*\* $p < 0.01$

Table 12 above indicates that of the three boundary setting factors, PersInt had the lowest correlation with the factors from other variables. None of its  $r$ -values were  $\geq 0.3$  even though some did have significance at a  $p=0.05$  or  $p < 0.01$  level. This suggests that PersInt may not be strongly related to the other outcome factors in this study.

In contrast, ProfInt was significantly correlated with all-but-one factors at a  $p < 0.01$  level (only  $\text{corr}(\text{ProfInt}, \text{ProfSup})$  had  $p = 0.047$ ). ProfInt also had  $r$ -values  $\geq 0.3$  for most factors, meaning it had moderately strong correlation that was statistically significant. For two of the factors, DayBal and EE, ProfInt even had a large effect size ( $\text{corr}(\text{ProfInt}, \text{DayBal}) = -0.5607$ ,  $p < 0.01$ ; and  $\text{corr}(\text{ProfInt}, \text{EE}) = 0.6676$ ,  $p < 0.01$ ). The directionality of all correlations was as

expected. ProfInt was negatively correlated with all self-care factors and with both measures of well-being, which makes sense since ProfInt represents professional interference on personal life. ProfInt was positively correlated with the two factors of burnout, EE and DP, that indicate the presence of negative burnout symptoms.

(a)  $r = 0.10$  for a small effect size; (b)  $r = 0.30$  for a medium effect size; and (c)  $r = 0.50$  for a large effect size.

The boundary setting factor, Segm, was significantly correlated with all factors at a  $p < 0.01$  level. Segm also had  $r$ -values  $\geq 0.3$  for many factors, meaning its correlations were all at least moderately strong. Segm was strongly correlated with DayBal ( $\text{corr}(\text{Segm}, \text{DayBal}) = 0.5685, p < 0.01$ ). The directionality of Segm's correlations with the other factors were all as expected. Segm was positively correlated with all self-factors and with both measures of well-being. This is consistent with the Hypotheses about how boundary setting would relate with self-care and well-being. Segm was negatively correlated with the factors of burnout, EE and DP, that indicate the presence of negative burnout symptoms. This is also consistent with the Hypothesis about how boundary setting would relate with burnout.

The directionality of Segm's correlations with the outcome variables was exactly opposite to the directionality of ProfInt's correlations with the outcome variables. This is logically consistent with Segm and ProfInt being negatively correlated with each other. This provides further support for conceptualizing Segm as the presence of active, purposeful behaviors to set boundaries and ProfInt as professional life interfering with personal life, which is an indicator of boundary strength.

### ***Linear Regressions***

Simple and multiple linear regressions were originally attempted to address Research Questions 1, 2, and 3 separately. These Hypotheses theorize about the relationship between boundary setting with self-care, burnout, and well-being, respectively. Separate linear regression models had to be conducted for each outcome since multiple linear regressions cannot analyze multiple outcome variables simultaneously. Two of the outcome variables, self-care and burnout, did not have one overall total score but were represented by numerous subscale scores. Therefore, a separate linear regression model was attempted for each subscale score within these variables.

In all the linear regression models, the boundary setting factors ProfInt and Segm were first tested together as predictors in all of the models. If the resulting linear regression model showed that one of those two factors was not statistically significant at  $\alpha=0.05$  level, then the model was re-run with only the other factor as a predictor. The boundary setting factor, PersInt, was not included as a predictor since none of its correlations with any of the outcome factors had  $r \geq 0.30$ .

Tables 13 and 14 summarize the fit of each of these models for the factors of self-care and burnout, respectively. Table 15 summarizes the fit of the linear regression models for the two separate measures of well-being.

**Table 13.***Linear Regression Model Fit Statistics: Boundary Setting & Self-Care Factors*

	<b>ProfSup</b>	<b>ProfDev</b>	<b>LifeBal</b>	<b>CogAw</b>	<b>DayBal</b>
<b>Predictor(s)</b>	Segm	Segm	ProfInt Segm	ProfInt Segm	<i>ProfInt</i> <i>Segm</i>
<b>Overall r<sup>2</sup></b>	0.0242	0.0482	0.2265	0.1664	0.4111
<b>F(,)=</b>	F(1,331)= 8.20	F(1,331)= 16.75	F(2,330)= 48.32	F(2,330)= 32.93	F(2,330)= 115.19
<b>p-value</b>	p=0.0045	p=0.0001	p <0.001	p <0.001	p <0.001
<b>Adjusted r<sup>2</sup></b>	0.0212	0.0453	0.2218	0.1613	0.4076
<b>Average prediction error</b>	1.3024	1.127	1.016	0.848	1.087

Note: Refer to Nomenclature (p. vii) or to previous tables for full names of these factors.

**Table 14.***Linear Regression Model Fit Statistics: Boundary Setting & Burnout Factors*

	<b>EE</b>	<b>DP</b>	<b>PA</b>
<b>Predictor(s)</b>	ProfInt	ProfInt	ProfInt Segm
<b>Overall r<sup>2</sup></b>	0.4457	0.0778	0.0913
<b>F(,)=</b>	F(1,331)= 266.12	F(1,331)= 27.91	F(2,330)= 16.58
<b>p-value</b>	p <0.001	p <0.001	p <0.001
<b>Adjusted r<sup>2</sup></b>	0.4440	0.0750	0.0858
<b>Average prediction error</b>	1.011	0.907	0.624

Note: Refer to Nomenclature (p. vii) or to previous tables for full names of these factors.

**Table 15.***Linear Regression Model Fit Statistics: Boundary Setting & Well-Being Measures*

	<b>SWLS</b>	<b>Flourishing Scale</b>
<b>Predictor(s)</b>	ProfInt Segm	ProfInt Segm
<b>Overall r<sup>2</sup></b>	0.2501	0.1144
<b>F(,)=</b>	F(2,330)= 55.03	F(2,330)= 21.31
<b>p-value</b>	p <0.001	p <0.001
<b>Adjusted r<sup>2</sup></b>	0.2456	0.1090
<b>Average prediction error</b>	0.930	0.737

Note: Refer to Nomenclature (p. vii) or to previous tables for full names of these factors.

Although these linear regression models were still attempted and their results reported, this statistical procedure was deemed insufficient for the data set. After consulting further with the statistician and the Committee, the investigator decided that each individual subscale score was not sufficient to make inferences about its overall latent construct. Therefore, it was vital to turn to a statistical procedure that could simultaneously analyze multiple outcomes.

### ***Structural Equation Modeling (SEM)***

Structural equation modeling (SEM) was chosen as the statistical procedure necessary to address the research questions of this study. SEM is advantageous because of its ability to analyze multiple predictors and multiple outcomes together. Several SEM models had been hypothesized, but only three of the tested models converged. This subsection will describe the one that was chosen to address the research questions of this study. This section will provide an overview of the SEM model, followed by a breakdown of the main statistical outputs about the

model. However, the SEM results that are specific to the research questions will be presented separately in the next section of this Chapter.

**Overview of the SEM Model.** The SEM model chosen for analysis consisted of a predictor side and an outcome side. The predictor side is represented on the left, with the three factors of boundary setting (ProfInt, PersInt, and Segm) modeled as the circular latent factors. These three exogenous variables were directly covaried with each other, as seen through the rounded two-way arrows. This covariance structure was chosen to be consistent with the factor structure used to validate the boundary setting survey (see previous subsection “Factor Structure for Boundary Setting”). All individual items were included on the predictor side to highlight the measurement properties of this new survey for boundary setting. Individual items were represented by rectangular measurement variables, which emanated from their latent factor by linear one-way arrows.

On the outcome side, a total of ten endogenous variables were predicted. Five of these were the factors of self-care (ProfSup, ProfDev, LifeBal, CogAw, and DayBal), three of these were the factors of burnout (EE, DP, and PA), and two of these were the two measures for well-being (Flourish and SWLS). Refer to Nomenclature (p. vii) for the full names of these factors. A path model that only included these latent factors without the individual items did not converge. Therefore, all individual measurement items were included on the outcome side.

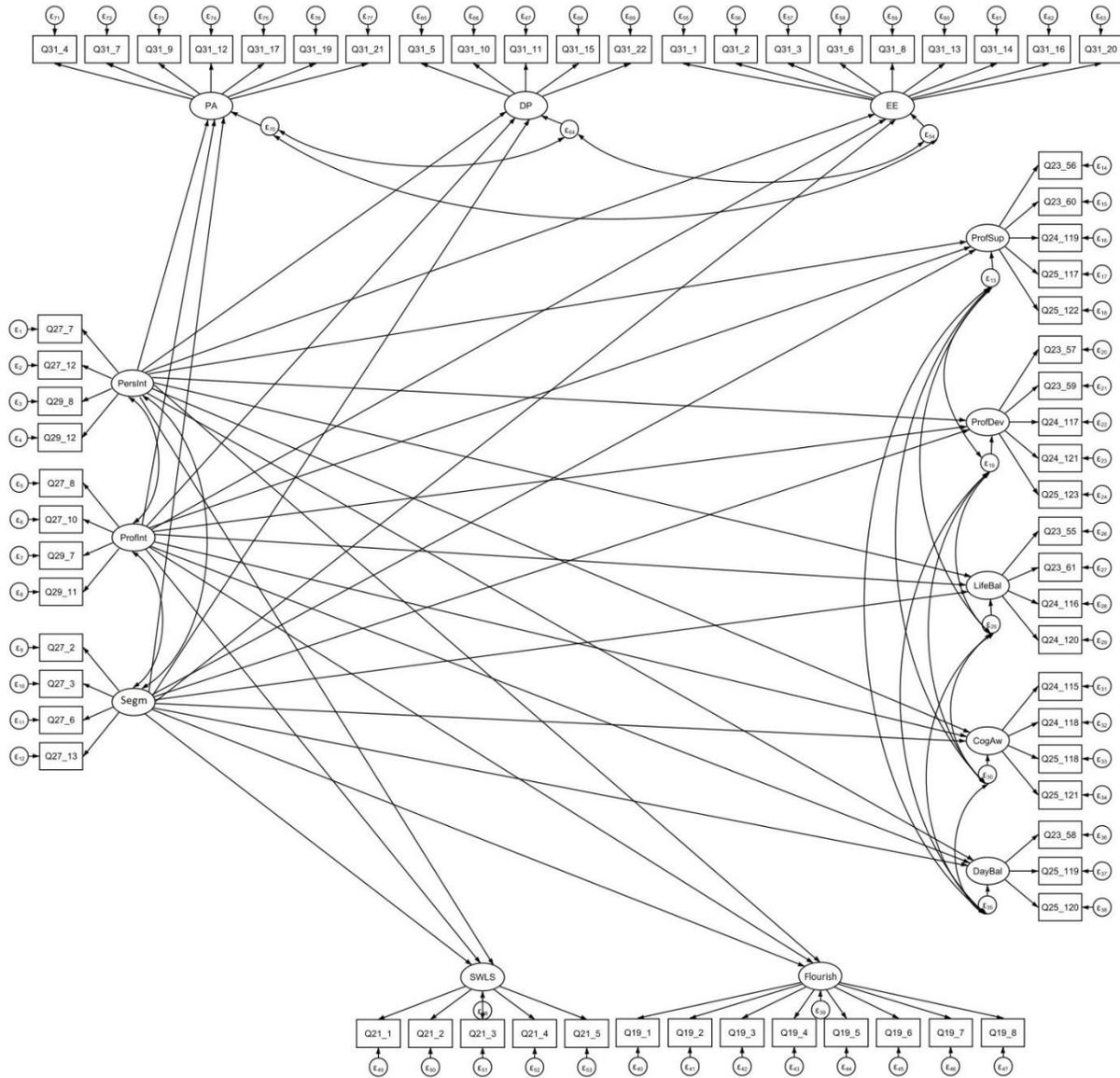
Covariances were modeled between the residuals of the five factors of self-care and between the residuals of the three factors of burnout. These residual covariances were necessary to reflect the five-factor structure and three-factor structure that were supported during the validity tests. SEM modeling does not allow endogenous variables to be covaried directly, which is why these latent factors had to be covaried through their residuals. Without these residual

covariances, the model would imply that the burnout factors and self-care factors were all independent factors that were only connected through the predictor variables. For the two measures of well-being, their items were modeled using separate latent constructs, SWLS and Flourish. The residuals of these two latent variables were not covaried because these were two separate measures rather than two factors within the same model of well-being.

See Figure 3 for a depiction of this SEM model. Overall, it had an adequate global fit with a  $\chi^2(2111)=4358.001$  ( $p < .001$ ), RMSEA = .058, CFI = .815, and SRMR = 0.092.

**Figure 3.**

*Full Structural Equation Model*



Note: On the left are the three covaried factors of boundary-setting, the exogenous variables. On the top, right, and bottom are the factors of burnout, self-care, and well-being, respectively. Factors from the same model have their residual variances covaried with each other.

Running the model estimation function within STATA/SE 16.1 yields several statistical characteristics of the SEM model. These include pattern coefficients, factor variances, factor covariances, and residual covariances. Each of these characteristics will be briefly explained and then presented in the following subsections.

**Pattern Coefficients.** Pattern coefficients indicate how much of the measurement item is due to its latent factor. In Figure 3, they are represented as the linear one-way arrows pointing from the circular latent factors to the rectangular measurement items.

To interpret pattern coefficients, first their p-values are examined to see if they indicate a statistically significant relationship at an  $\alpha = 0.05$  level. Then, the standardized pattern coefficients value itself is noted. These values can range from 0 to 1. Higher values indicate that the item is represented well by its latent factor, but there are no concrete cut-off scores for determining the strength of pattern coefficient values. Standardized pattern coefficient values can be understood as corresponding to the relationship between the standard deviations of the measurement item and its latent factor. In other words, when the measurement item increases by 1 standard deviation, the latent factor increases in standard deviation by the value of the pattern coefficient.

For the variable of boundary setting, the maximum likelihood estimates of the pattern coefficients and residuals are displayed in Table 16.

**Table 16.***Boundary Setting - Pattern Coefficients and Residuals*

Indicator	Pattern Coefficients (standardized)			Residual Variances (standardized)		
	Est.	SE	P	Est.	SE	
<u>Personal-Professional Life Boundary Setting Survey</u>						
PersInt						
Q27_7	I do not complete some of my professional responsibilities because of personal life demands.	0.655	0.040	< .001	0.571	0.052
Q27_12	I do not have enough energy for my professional life because of personal life demands.	0.735	0.035	< .001	0.460	0.051
Q29_8	I miss professional advancement opportunities because of personal life demands.	0.652	0.040	< .001	0.574	0.052
Q29_12	My professional life is struggling because of excessive personal life demands.	0.796	0.032	< .001	0.366	0.051
ProfInt						
Q27_8	I do not complete some of my personal life responsibilities because of professional demands.	0.708	0.032	< .001	0.499	0.045
Q27_10	I do not have enough energy for my personal life because of professional demands.	0.829	0.023	< .001	0.312	0.037
Q29_7	I miss important events with my friends/family because of professional responsibilities.	0.510	0.045	< .001	0.740	0.045
Q29_11	My personal life is struggling because of excessive professional life demands.	0.850	0.021	< .001	0.278	0.036
Segm						
Q27_2	I set certain hours for my professional responsibilities.	0.664	0.037	< .001	0.559	0.049
Q27_3	I set certain hours for my personal life responsibilities.	0.610	0.040	< .001	0.627	0.049
Q27_6	I balance competing demands in my personal life and my professional life.	0.852	0.027	< .001	0.273	0.045
Q27_13	I purposefully create some separation between my personal life and my professional life.	0.620	0.039	< .001	0.615	0.049

From Table 16 above, all items were statistically significant measures of their latent variable, which was one of the three boundary setting factors. Since all items had statistically significant pattern coefficients, it is fitting to organize the items among these three factors. Of the twelve boundary-setting items, Q27\_6 had the largest pattern coefficient of 0.852 ( $p < 0.001$ ), meaning that it is the item that is best represented by its latent factor, Segm. In contrast, Q29\_7 had the smallest pattern coefficient of 0.510 ( $p < 0.001$ ), meaning it is the item that is least represented by its latent factor, ProfInt.

For the variable of self-care, the maximum likelihood estimates of the pattern coefficients and residuals are displayed in Table 17.

**Table 17.***Self-Care - Pattern Coefficients and Residuals*

Indicator	Item	Pattern Coefficients (standardized)			Residual Variances (standardized)	
		Est.	SE	<i>p</i>	Est.	SE
<b>Self-Care Assessment for Psychologists</b>						
<b>ProfSup</b>						
Q23_56	I maintain a professional support system.	0.798	0.024	< .001	0.363	0.038
Q23_60	I cultivate professional relationships with my colleagues.	0.866	0.019	< .001	0.251	0.032
Q24_119	I avoid workplace isolation.	0.653	0.035	< .001	0.574	0.046
Q25_117	I share positive work experiences with colleagues.	0.791	0.025	< .001	0.374	0.039
Q25_122	I share work-related stressors with trusted colleagues.	0.705	0.032	< .001	0.503	0.044
<b>ProfDev</b>						
Q23_57	I take part in work-related social and community events.	0.668	0.037	< .001	0.553	0.050
Q23_59	I participate in activities that promote my professional development.	0.677	0.037	< .001	0.542	0.050
Q24_117	I connect with organizations in my professional community that are important to me.	0.675	0.037	< .001	0.545	0.050
Q24_121	I find ways to stay current in professional knowledge.	0.571	0.044	< .001	0.674	0.050
Q25_123	I maximize time in professional activities I enjoy.	0.697	0.035	< .001	0.514	0.049
<b>LifeBal</b>						
Q23_55	I spend time with people whose company I enjoy.	0.677	0.036	< .001	0.541	0.049
Q23_61	I find ways to foster a sense of social connection and belonging in my life.	0.797	0.028	< .001	0.365	0.044
Q24_116	I seek out activities or people that are comforting to me.	0.737	0.032	< .001	0.457	0.047
Q24_120	I spend time with family or friends.	0.755	0.031	< .001	0.430	0.047

**Table 17 (continued).***Self-Care - Pattern Coefficients and Residuals*

Indicator	Item	Pattern Coefficients (standardized)			Residual Variances (standardized)	
		Est.	SE	<i>p</i>	Est.	SE
<u>Self-Care Assessment for Psychologists</u>						
CogAw						
Q24_115	I am mindful of triggers that increase professional stress.	0.686	0.036	< .001	0.529	0.050
Q24_118	I make a proactive effort to manage the challenges of my professional work.	0.749	0.033	< .001	0.438	0.049
Q25_118	I try to be aware of my feelings and needs.	0.760	0.032	< .001	0.423	0.048
Q25_121	I monitor my feelings and reactions to clients.	0.643	0.039	< .001	0.586	0.050
DayBal						
Q23_58	I take breaks throughout the workday.	0.600	0.044	< .001	0.640	0.053
Q25_119	I take some time for relaxation each day.	0.709	0.037	< .001	0.497	0.053
Q25_120	I avoid over-commitment to work responsibilities.	0.729	0.035	< .001	0.468	0.051

From Table 17 above, all items were statistically significant measures of their latent variable, which was one of the five self-care factors. Q23\_60 had the largest pattern coefficient of 0.866 ( $p < 0.001$ ), meaning it is the item that is best represented by its latent factor, ProfSup. In contrast, Q24\_121 had the smallest pattern coefficient of 0.571 ( $p < 0.001$ ), meaning it is the item that is least represented by its latent factor, ProfDev.

For the variable of burnout, the maximum likelihood estimates of the pattern coefficients and residuals are displayed in Table 18.

**Table 18.***Burnout - Pattern Coefficients and Residuals*

Indicator	Pattern Coefficients (standardized)			Residual Variances (standardized)	
	Est.	SE	<i>p</i>	Est.	SE
<u>Maslach Burnout Inventory</u>					
EE					
Q31_1	0.849	0.018	< .001	0.279	0.030
Q31_2	0.820	0.021	< .001	0.328	0.033
Q31_3	0.806	0.021	< .001	0.350	0.034
Q31_6	0.679	0.032	< .001	0.539	0.043
Q31_8	0.876	0.015	< .001	0.233	0.027
Q31_13	0.728	0.028	< .001	0.471	0.041
Q31_14	0.727	0.029	< .001	0.471	0.041
Q31_16	0.625	0.037	< .001	0.609	0.045
Q31_20	0.721	0.029	< .001	0.480	0.041
DP					
Q31_5	0.524	0.045	< .001	0.725	0.047
Q31_10	0.827	0.024	< .001	0.317	0.039
Q31_11	0.902	0.021	< .001	0.187	0.037
Q31_15	0.521	0.045	< .001	0.729	0.047
Q31_22	0.320	0.053	< .001	0.897	0.034
PA					
Q31_4	0.285	0.059	< .001	0.919	0.034
Q31_7	0.630	0.044	< .001	0.603	0.056
Q31_9	0.566	0.047	< .001	0.680	0.053
Q31_12	0.413	0.056	< .001	0.829	0.046
Q31_17	0.585	0.046	< .001	0.658	0.054
Q31_19	0.636	0.044	< .001	0.596	0.055
Q31_21	0.572	0.047	< .001	0.673	0.054

From Table 18 above, all items were statistically significant measures of their latent variable, one of the three factors of burnout. Q31\_11 had the largest pattern coefficient of 0.902 ( $p < 0.001$ ), meaning it is the item that is best represented by its latent factor, DP. In contrast, Q31\_4 had the smallest pattern coefficient of 0.285 ( $p < 0.001$ ), meaning it is the item that is least represented by its latent factor, PA. To comply with copyright restrictions on the MBI, the specific items corresponding to each burnout factor will not be listed anywhere in this document.

For the variable of well-being, the maximum likelihood estimates of the pattern coefficients and residuals are displayed in Table 19 below.

**Table 19.**

*Well-Being - Pattern Coefficients and Residuals*

Indicator	Item	Pattern Coefficients (standardized)			Residual Variances (standardized)	
		Est.	SE	<i>p</i>	Est.	SE
<u>Flourishing Scale</u>						
Flourish						
Q19_1	I lead a purposeful and meaningful life.	0.831	0.020	< .001	0.310	0.034
Q19_2	My social relationships are supportive and rewarding.	0.627	0.036	< .001	0.607	0.045
Q19_3	I am engaged and interested in my daily activities.	0.764	0.026	< .001	0.415	0.039
Q19_4	I actively contribute to the happiness and well-being of others.	0.794	0.023	< .001	0.370	0.037
Q19_5	I am competent and capable in the activities that are important to me.	0.801	0.023	< .001	0.358	0.036
Q19_6	I am a good person and live a good life.	0.825	0.021	< .001	0.320	0.034
Q19_7	I am optimistic about my future.	0.762	0.026	< .001	0.419	0.040
Q19_8	People respect me.	0.689	0.032	< .001	0.525	0.044
<u>Satisfaction With Life Scale</u>						
SWLS						
Q21_1	In most ways my life is close to my ideal.	0.886	0.016	< .001	0.215	0.028
Q21_2	The conditions of my life are excellent.	0.854	0.018	< .001	0.271	0.032
Q21_3	I am satisfied with my life.	0.869	0.017	< .001	0.244	0.030
Q21_4	So far I have gotten the important things I want in life.	0.714	0.030	< .001	0.491	0.043
Q21_5	If I could live my life over, I would change almost nothing.	0.592	0.039	< .001	0.650	0.046

From Table 19 above, all items from the Flourishing Scale were statistically significant measures of their latent variable, well-being. Q19\_1 had the largest pattern coefficient of 0.831 ( $p < 0.001$ ), meaning it is the item that is best represented by the measure. In contrast, whereas

Q19\_2 had the smallest pattern coefficient of 0.627 ( $p < 0.001$ ), meaning it is the item least represented by the measure.

From Table 19 above, it can also be seen that all items from the Satisfaction With Life Scale were statistically significant measures of their latent variable, well-being. Q21\_1 had the largest pattern coefficient of 0.886 ( $p < 0.001$ ), whereas Q21\_5 had the smallest pattern coefficient of 0.592 ( $p < 0.001$ ).

**Residual Variances for Latent Factors.** Residual variances are the proportion of variance in the measurement that is not measured by its respective latent variable (StataCorp, 2013). In other words, they are the variance that is unique to the variable rather than due to the relationships in the model. In Figure 3, residual variances for factors are represented as the small circles that are pointing to each of the elliptical latent factors.

Factor residual variances are interpreted by first examining their p-values to see which relationships are statistically significant at an  $\alpha = 0.05$  level. Standardized residual variance values can range from 0 to 1, but their specific numeric values are not guided by rules-of-thumb and are not directly interpretable. Instead, residual variances are compared to each other to see which are high and which are low. A high factor residual variance indicates that most of the variance in the factor is due to things not represented in the model. A low factor residual variance indicates that most of the variance in the factor can be explained by the factors and relationships overtly modeled.

**Table 20.***Residual Variances for Factors in the SEM Model*

	Standardized		<i>p</i>
	Est.	<i>SE</i>	
Factor variances, <i>var</i> (X)			
e.ProfSup	0.934	0.032	-
e.ProfDev	0.876	0.042	-
e.LifeBal	0.644	0.056	-
e.CogAw	0.708	0.057	-
e.DayBal	0.343	0.057	-
e.Flourish	0.836	0.044	-
e.SWLS	0.643	0.051	-
e.EE	0.369	0.047	-
e.DP	0.874	0.041	-
e.PA	0.864	0.050	-
e.PersInt	1.000	-	-
e.ProfInt	1.000	-	-
e.Segm	1.000	-	-

Note: Some cells were purposely left blank because those calculations were not available.

From Table 20 above, the factors EE and DayBal have the lowest residual variances (0.343 and 0.369, respectively). Most of the variance in these two factors can be explained by the model. This indicates that EE and DayBal are likely to be better explained by the boundary setting predictors than are the other outcome factors. In contrast, the factors ProfSup and ProfDev have the highest residual variances (0.934 and 0.876, respectively). Most of the variance in these factors are unique to themselves. This indicates that ProfSup and ProfDev are not explained well by any other aspects of the model, such as the boundary setting predictors or the residual covariance with other self-care factors.

**Factor Covariances.** Factor covariances indicate the extent to which two factors change in concert with each other. Standardized covariance values are equivalent to correlation coefficients. In Figure 3, factor covariances are represented as the curved two-way arrows that connect the three boundary-setting latent factors.

To interpret factor covariances, first their p-values are examined to identify which relationships are statistically significant at an  $\alpha = 0.05$  level. Standardized factor covariance values can range from -1.0 to 1.0. Positive values indicate that the two variables increase or decrease together. Negative values indicate an inverse relationship between the two variables. Standardized covariance values indicate the fraction of the variance of one factor that is explained by the other.

**Table 21.**

*Factor Covariances in the SEM Model*

	Standardized		
	Est.	SE	p
Factor covariances, $cov(X,Y)$			
PersInt, ProfInt	0.375	0.059	< .001
PersInt, Segm	-0.206	0.066	.002
ProfInt, Segm	-0.690	0.042	< .001

Table 21 above shows that all three covariances between the boundary setting factors have statistically significant relationships. This supports modeling the three factors as separate pieces that are still related to each other. Segm and ProfInt have the strongest relationship, where Segm increases while ProfInt decreases ( $cov(\text{Segm}, \text{ProfInt}) = -0.690$ ,  $p < 0.001$ ). The next strongest relationship is between PersInt and ProfInt, which are positive related to each other. As PersInt increases, ProfInt also increases ( $cov(\text{PersInt}, \text{ProfInt}) = 0.375$ ,  $p < 0.001$ ). Finally, Segm is also negatively related with PersInt. As Segm increases, PersInt decreases ( $cov(\text{Segm}, \text{PersInt}) = -0.206$ ,  $p = 0.002$ ).

Factor covariances can only exist for exogenous variables in an SEM model because endogenous variables are not allowed to be directly covaried. Instead, to indicate that endogenous variables belong to the same factor structure, their residual errors are covaried

together. Therefore, on the outcome side, SEM modeling and estimation yield residual covariance values rather than factor covariances.

**Residual Covariances.** Residual covariances represent the unexplained covariance between variables that the hypothesized model does not depict. In Figure 3, residual covariances are represented as the curved two-way arrows between the residuals of the burnout factors and the curved two-way arrows between the residuals of the self-care factors.

Interpreting residual covariances begins with examining their p-values. Only those variables with  $p < 0.05$  have a significant relationship with each other. Then, the actual residual covariance value itself is examined. These values can range from -1.0 to 1.0, with positive values indicating that as one variable's residual increases, the other variable's residual also increases. Larger absolute values for residual covariances indicate a stronger relationship between the two variables. However, there are no rules-of-thumb for the strength of the numeric values themselves since residuals are defined as the unknown contributors to a value.

**Table 22.***Residual Covariances in the SEM Model*

	Standardized		
	Est.	SE	p
Residual covariances, $cov(X, Y)$			
e.ProfSup, e.ProfDev	0.791	0.035	< .001
e.ProfSup, e.LifeBal	0.481	0.058	< .001
e.ProfSup, e.CogAw	0.516	0.056	< .001
e.ProfSup, e.DayBal	0.149	0.089	.094
e.ProfDev, e.LifeBal	0.432	0.065	< .001
e.ProfDev, e.CogAw	0.514	0.062	< .001
e.ProfDev, e.DayBal	0.167	0.095	.079
e.LifeBal, e.CogAw	0.407	0.069	< .001
e.LifeBal, e.DayBal	0.018	0.099	.856
e.CogAw, e.DayBal	0.452	0.089	< .001
e.EE, e.DP	0.528	0.059	< .001
e.EE, e.PA	-0.354	0.082	< .001
e.DP, e.PA	-0.460	0.061	< .001

Table 22 above depicts three residual covariances between the burnout factors of EE, DP, and PA. All these relationships were statistically significant at an  $\alpha = 0.05$  level. EE and DP were positively related and had the strongest relationship ( $cov(e.EE, e.DP) = 0.528, p < 0.001$ ). EE and PA were negatively related ( $cov(e.EE, e.PA) = -0.354, p < 0.001$ ), as were DP and PA ( $cov(e.DP, e.PA) = -0.460, p < 0.001$ ).

Table 22 also depicts ten residual covariances between the self-care factors of ProfSup, ProfDev, LifeBal, CogAw, and DayBal. All of the self-care factors were positively related with each other. All but three of these relationships were statistically significant at an  $\alpha = 0.05$  level. Of the statistically significant relationships, the strongest relationship was between ProfSup and Prof Dev ( $cov(e.ProfSup, e.ProfDev) = 0.791, p < .001$ ), followed by the relationship between ProfSup and CogAw ( $cov(e.ProfSup, e.CogAw) = 0.516, p < .001$ ). The three non-significant

relationships all included the self-care factor of DayBal. These relationships were DayBal & LifeBal ( $p = 0.856$ ), DayBal & ProfSup ( $p = 0.094$ ), and DayBal & ProfDev ( $p = 0.079$ ).

### **RQ-Specific Analyses**

Although several preparatory statistical analyses were foundational for data analysis, structural equation modeling (SEM) was the specific statistical procedure used to address the research questions analyses of this study. This section will focus only on the statistical characteristics of the SEM model that directly address the Research Questions (RQs) of this study. These were the factor loadings, which were represented in Figure 3 as the linear one-way arrows pointing from the boundary setting factors to each of the endogenous latent variables.

Factor loadings indicate the strength of relationship between a variable and a factor. Standardized factor loadings can be interpreted like standardized regression coefficients in multiple regression. Their values range from -1 to +1, with higher absolute values indicating that the variable is more relevant to its factor. As a rule of thumb, an absolute value of 0.7 or higher indicates a sufficiently strong relationship. Negative factor loadings indicate an inverse relationship between the variable and factor. In these results, standardized factor loadings will be reported as  $\beta$ .

#### ***RQ1: Boundary Setting & Self-Care***

Research Question 1 focused on the relationship between boundary setting and self-care, hypothesizing that there would be a positive relationship between the two variables. In Figure 3, this relationship was depicted as one-way linear arrows from the boundary setting factors to each of the self-care factors. Using STATA/SE 16.1, the model estimation function then yielded estimates for each of these paths. These estimates are called factor loadings and are presented in Table 23.

To answer RQ1, the factor loadings in Table 23 will be examined to understand the strength of relationship between the boundary setting factors and the self-care factors.

**Table 23.**

*Self-Care Factor Loadings*

Parameter	Est.	Standardized	
		<i>SE</i>	<i>p</i>
ProfSup by			
PersInt	-0.060	0.072	.400
ProfInt	0.025	0.110	.821
Segm	0.256	0.104	.014
ProfDev by			
PersInt	0.015	0.075	.847
ProfInt	-0.122	0.115	.290
Segm	0.261	0.109	.017
LifeBal by			
PersInt	0.011	0.066	.863
ProfInt	-0.204	0.105	.052
Segm	0.441	0.099	< .001
CogAw by			
PersInt	-0.122	0.070	.079
ProfInt	-0.046	0.109	.677
Segm	0.467	0.100	< .001
DayBal by			
PersInt	0.055	0.062	.377
ProfInt	-0.409	0.087	< .001
Segm	0.489	0.081	< .001

The boundary setting factor of Segm was significantly related to all five factors of self-care. Furthermore, all these relationships were positive. On average, a one standard deviation increase in the boundary setting factor of Segm would result in a 0.256 standard deviation increase in ProfSup ( $\beta = 0.256$ ,  $p = .014$ ), all other relationships staying constant. A one standard deviation increase in Segm on average resulted in 0.261 standard deviation increase in ProfDev ( $\beta = 0.261$ ,  $p = .017$ ), a 0.441 standard deviation increase in LifeBal ( $\beta = 0.441$ ,  $p < 0.001$ ), a

0.467 standard deviation increase in CogAw ( $\beta = 0.467, p < 0.001$ ), and a 0.489 standard deviation increase in DayBal ( $\beta = 0.489, p < 0.001$ ).

In contrast, the boundary setting factor of PersInt was not significantly related with any of the five factors of self-care. This is consistent with the linear regression analyses conducted earlier. This statistical nonsignificance indicates that the factor of PersInt is not an effective predictor of any of the self-care factors in this data set.

The boundary setting factor of ProfInt was only a significant predictor of two self-care factors, DayBal and LifeBal. Both relationships were negative. A one standard deviation increase in ProfInt would result in a 0.409 standard deviation decrease in DayBal ( $\beta = 0.409, p < 0.001$ ). ProfInt was related to the self-care factor of LifeBal, where one standard deviation increase in ProfInt would result in a 0.204 standard deviation decrease in LifeBal ( $\beta = 0.204, p = 0.052$ ). ProfInt was not significantly related with ProfSup ( $p = 0.821$ ), ProfDev ( $p = 0.290$ ), or CogAw ( $p = 0.677$ ), indicating that it is not an effective predictor of these self-care factors.

### ***RQ2: Boundary Setting & Burnout***

Research Question (RQ) 2 focused on the relationship between boundary setting and burnout, hypothesizing that there would be a negative relationship between the two variables. In Figure 3, this relationship was depicted as one-way linear arrows from the boundary setting factors to each of the burnout factors. The model estimation function then yielded estimates for each of these paths. These estimates are called factor loadings and are presented in Table 24.

To answer RQ2, the factor loadings in Table 24 are examined to understand the strength of relationship between the boundary setting factors and the burnout factors.

**Table 24.***Burnout Factor Loadings*

Parameter	Standardized		
	Est.	SE	p
EE by			
PersInt	-0.131	0.053	.013
ProfInt	0.879	0.071	< .001
Segm	0.066	0.076	.387
DP by			
PersInt	-0.030	0.071	.677
ProfInt	0.345	0.112	.002
Segm	-0.028	0.108	.794
PA by			
PersInt	-0.168	0.079	.034
ProfInt	0.030	0.137	.828
Segm	0.319	0.126	.012

The boundary setting factor of PersInt was significantly related with two of the factors of burnout, EE and PA. Both relationships were negative. One average, a one standard deviation increase in PersInt would result in a 0.131 standard deviation decrease in EE ( $\beta = 0.131$ ,  $p = 0.013$ ), assuming all other relationships stay constant. In addition, a one standard deviation increase in PersInt would result in a 0.168 decrease in PA ( $\beta = 0.168$ ,  $p = 0.034$ ). PersInt was not significantly related to DP.

The boundary setting factor of ProfInt was also significantly related two of the factors of burnout, EE and DP. Both relationships were positive. On average, a one standard deviation increase in ProfInt would result in a 0.879 standard deviation increase in EE ( $\beta = 0.879$ ,  $p < 0.001$ ), assuming all other variables were held constant. Additionally, a one standard deviation increase in ProfInt would result in a 0.345 standard deviation increase in DP ( $\beta = 0.345$ ,  $p = 0.002$ ). ProfInt was not significantly related to PA.

The boundary setting factor of Segm was significantly related with only one factor of burnout, PA. This relationship was positive. On average, one standard deviation increase in Segm would result in a 0.319 standard deviation increase in PA ( $\beta = 0.319$ ,  $p = 0.012$ ). Segm was not an effective predictor of EE or DP for this data set.

***RQ3: Boundary Setting & Well-Being***

Research Question (RQ) 3 focused on the relationship between boundary setting and well-being, hypothesizing that there would be a positive relationship between the two variables. In Figure 3, this relationship was depicted as one-way linear arrows from the boundary setting factors to the two well-being measures. The model estimation function then yielded estimates for each of these paths. These estimates are called factor loadings and are presented in Table 25.

To answer RQ3, the factor loadings in Table 25 are examined to understand the strength of relationship between the boundary setting factors and the well-being measures.

**Table 25.**

*Well-Being Factor Loadings*

Parameter	Est.	Standardized <i>SE</i>	<i>p</i>
Flourish by			
PersInt	-0.093	0.070	.183
ProfInt	-0.108	0.123	.378
Segm	0.287	0.118	.015
SWLS by			
PersInt	0.060	0.064	.342
ProfInt	-0.242	0.108	.024
Segm	0.419	0.101	< .001

Only the boundary setting factor of Segm was significantly related with both measures of well-being. Both relationships were positive. On average, one standard deviation increase in Segm would result in a 0.419 standard deviation increase in SWLS ( $\beta = 0.419$ ,  $p < 0.001$ ),

assuming all other variables stayed constant. A one standard deviation increase in Segm could also result in a 0.287 standard deviation increase in Flourish ( $\beta = 0.287$ ,  $p = 0.015$ ), assuming all other variables stayed constant.

The boundary setting factor of ProfInt was significantly related with the SWLS, and this relationship was negative. A one standard deviation increase in ProfInt would result in a 0.242 standard deviation decrease in SWLS ( $\beta = 0.242$ ,  $p = 0.024$ ). ProfInt was not significantly related with Flourish, indicating that it was not an effective predictor of this well-being measure for this data set.

The boundary setting factor of PersInt was not significantly related to either measure of well-being. This indicates that it was not an effective predictor of either well-being measure for this data set.

#### ***RQ4: Boundary Setting & Self-Care, Burnout, Well-Being***

Research Question (RQ) 4 considered the relationship between boundary setting with self-care, burnout, and well-being together. It was hypothesized that boundary setting would have a positive relationship with self-care and well-being but a negative relationship with burnout. To answer RQ4, all three of these outcome variables were depicted in the same model in Figure 3, rather than in three separate models. Therefore, the factor loadings from before are intended to be used to address RQ4 as well. Those factor loading values were estimated based on considering all three variables as outcomes for the boundary setting factors.

To answer RQ4, the statistically significant factor loadings from the first three research questions are presented in Table 26. These will be examined in context of each other to understand how boundary setting relates to self-care, burnout, and well-being.

**Table 26.***Statistically Significant Factor Loadings*

Parameter	Standardized		
	Est.	SE	p
Segm by			
ProfSup	0.256	0.104	.014
ProfDev	0.261	0.109	.017
LifeBal	0.441	0.099	< .001
CogAw	0.467	0.100	< .001
DayBal	0.489	0.081	< .001
PA	0.319	0.126	.012
Flourish	0.287	0.118	.015
SWLS	0.419	0.101	< .001
ProfInt by			
LifeBal	-0.204	0.105	.052
DayBal	-0.409	0.087	< .001
EE	0.879	0.071	< .001
DP	0.345	0.112	.002
SWLS	-0.242	0.108	.024
PersInt by			
EE	-0.131	0.053	.013
PA	-0.168	0.079	.034

Note: Table 26 presents the factors from all three outcome variables —self-care, burnout, and well-being— that had statistically significant factor loadings.

The boundary setting factor of Segm was significantly related to all five factors of self-care: ProfSup, ProfDev, LifeBal, CogAw, and DayBal. Segm was only significantly related to one factor of burnout: PA. It was also significantly related to both measures of well-being: Flourish and SWLS. Furthermore, all these relationships were positive. In summary, Segm was significantly positively related to all outcome factors except for two of the burnout factors: EE and DP.

The boundary setting factor of ProfInt was significantly related to two factors of self-care: DayBal and LifeBal. Both relationships were negative. ProfInt was also significantly

related two of the factors of burnout: EE and DP. Both relationships were positive. ProfInt was significantly related with one measure of well-being: SWLS. This relationship was negative. In summary, ProfInt was significantly related with some factors of self-care, burnout, and well-being

The boundary setting factor of PersInt was not significantly related with any of the five factors of self-care. PersInt was significantly related with two of the factors of burnout: EE and PA. Both relationships were negative. PersInt was not significantly related to either measure of well-being. In contrast with the previous two factors of boundary setting, PersInt was only significantly related with two factors of burnout but not with any factors of self-care or of well-being. This indicates that PersInt is not an effective predictor of self-care or of well-being for this data set.

## CHAPTER V

### SUMMARY AND CONCLUSIONS

This Chapter summarizes the overall study and discusses an interpretation of the results presented in Chapter IV. This Chapter begins by discussing the results according to each original Research Question. After considering the implications of these results, the novelty of the overall study is discussed. Then, several future directions for research are identified. Finally, this Chapter concludes by acknowledging some limitations of this study.

Boundary setting was measured using the Personal-Professional Life Boundary Setting Survey, which used a three-factor structure of Segm, PersInt, and ProfInt. The specific measurement items within each of these three factors can be found in Table 6.

#### **RQ1: Boundary Setting & Self-Care**

Research Question 1 focused on the relationship between boundary setting and self-care. To answer this question, the factor loadings for the paths from the boundary setting factors to the self-care factors were examined (see Table 23). The implications of these results are inferred based on the specific items that constituted each factor.

Self-care was measured using the Self-Care Assessment for Psychologists, which consisted of a five-factor structure. The five factors were ProfSup, ProfDev, DayBal, CogAw, and LifeBal. The specific measurement items within each of these five factors can be found in Table 17.

#### ***Theoretical Interpretations***

The positive significant relationships between Segm and all five factors of self-care strongly support Hypothesis 1, which proposed that boundary setting positively relates with self-care. Setting certain hours for each set of life responsibilities can help a variety of aspects of self-

care, as opposed to only a few. Designating specific times for the tasks of each domain is a practical way to pursue segmentation even when physical separation between personal and professional life is less feasible. This method of segmentation helps professionals care for themselves in ways such as by spending time in meaningful relationships, staying current in the literature, participating in professional organizations, tuning into their own internal experience, or relaxing during the workday.

The negative relationships between ProfInt and two factors of self-care –DayBal and LifeBal– indicate that professional interference on personal life has noticeable associations with some aspects of self-care but not others. The negative relationship between DayBal and ProfInt indicates that when one has poorer daily balance (e.g., not taking breaks, not making time to relax, not preventing over-commitment), one also experiences more difficulty completing personal life tasks or spending time with friends/family. This may be because overworking in the workday saps one of the energy and motivation to engage with personal tasks and relationships. Additionally, when one experiences more professional life interference, one may try to cope by working more incessantly during the workday to accomplish more, even though this reduces one's overall self-care. Similarly, there was a negative relationship between LifeBal and ProfInt. This relationship further indicates that professionals may be prone to sacrifice their personal life to cope with increased professional life demands. Poor life balance was represented as not spending time with people one enjoys, not pursuing comforting activities, and not fostering a sense of belonging/connection. Professional life demands may cause professionals to feel too drained to engage in social pursuits or in personal hobbies, which causes this aspect of their self-care to decline. In contrast to DayBal and LifeBal, the remaining self-care factors of ProfSup, ProfDev, and CogAw were not significantly related to ProfInt. This indicates that professional

life interference on personal life is not clearly related to seeking connectedness with colleagues, pursuing professional development, or being aware of one's personal feelings & needs.

The nonsignificant results between PersInt and all the self-care factors indicate that personal life interfering with professional life is not positively or negatively related to self-care behaviors. Personal life interference into professional life may have a mixed directionality of impact depending on situation. In some cases, greater attention to personal life matters may facilitate greater self-care, whereas in other cases, personal life demands may drain one of time and energy for self-care or for professional life demands. Personal life interference may also be less common than professional life interference for most professionals surveyed.

### ***Summary of Interpretations in Context***

Overall, these results strongly support Hypothesis 1, which proposed that boundary setting relates positively with self-care. Segm was positively related to all five factors of self-care, which is the strongest direct support possible for Hypothesis 1. Furthermore, ProfInt was also negatively related with two of the self-care factors, DayBal and LifeBal.

These results expand well beyond the existing literature base for self-care or for boundary setting, as there is a paucity of research that studies the two in connection with each other. Self-care literature rarely explicitly includes boundary setting in its conceptualization, definitions, or studies. Instead, it is more common to include the concept of “balance” as an aspect of self-care (Backman, 2004, Lee et al., 2009, Skovholt & Trotter-Mathison, 2011, as cited in Posluns & Gall, 2019). This is directly evident even in the conceptualization of self-care used in the study by Dorociak et al. (2017), which included two forms of “balance” (DayBal and LifeBal) but no explicit reference to boundary setting. These pieces of literature imply that there is some connection between self-care and boundary setting through the concept of balance, although the

nature of this relationship is neither explicitly stated nor clarified. For instance, Posluns & Gall (2019) provided a list of strategies to achieve life balance, one of which was “maintaining good work and personal life boundaries” (p. 6).

A select few pieces of self-care literature assert that boundary setting is important. For instance, Harrison and Westwood (2009) reported that “maintaining clear boundaries” was one of the nine salient themes for how “master therapists” pursue self-care to enhance their well-being. Norcross and Guy (2007) suggested that “setting boundaries” was a key principle of self-care for therapists. Morris (2018) identified “being boundaried” as a key theme in self-care for psychologists and high intensity therapists. However, even in mentions like these, the statements about the importance of boundary setting are brief. They also rarely are supported by citations to other empirical studies. Therefore, these seemingly bold statements about the significance of boundary setting are little more than speculation or opinion. This study begins to rectify these significant gaps by providing empirical evidence that can support theoretical inferences.

In addition to the lack of empirical studies supporting the statements about the importance of boundary setting to self-care, another limitation in the literature base is the lack of clarity about the operationalization of boundary setting or about how boundary setting relates to self-care. This is an example of a wider-spread problem within the psychological literature, which has been called “Descriptive but not Prescriptive” (Ridley et al., 2001; Ridley et al., 2021). “Descriptive” statements are those that assert something (e.g., the existence of various dimensions within a model, the ethical responsibility for clinicians to practice self-care, the importance of boundary setting, etc.) but do not provide clarity or specificity about the application of their assertion. In contrast, “prescriptive” statements both assert something and provide actionable guidelines for the implementation of their assertion. Prescription does not

refer to strict manualization; instead, it refers to fluid guidance on the operationalization of ideas (Ridley et al., 2021). Prescription is necessary for there to be clarity about the practical implementation of otherwise abstract assertions.

This study begins to rectify the lack of prescription about the construct of boundary setting and its relationship to self-care. This study offers a clear definition of boundary setting and then operationalizes that definition through the items of Segm. Then, Segm is explicitly studied in relationship with various aspects of self-care, which provides empirical evidence to support any theoretical inferences about boundary setting's relationship to self-care. In this study, Segm's positive relationships with all aspects of self-care indicate that purposefully designating specific hours for each life domain is a practical way to help one engage more fully in various aspects of self-care. Some of these self-care pursuits can include taking breaks during the workday, enjoying meaningful relationships, engaging in personal hobbies, participating in professional organizations, or sharing positive work experiences with colleagues. Other practical ways to set boundaries between personal and professional life include establishing a designated space for professional tasks, limiting notifications from the other life domain, and practicing a routine to help one transition between domains.

In addition to Segm's positive relationship with all aspects of self-care, ProfInt was negatively related with both daily balance and life balance. This indicates that when professional life is able to interfere with personal life, this noticeably harms one's balance at a daily level and a broader life level. Purposeful boundary setting is an important way to diminish professional life's interference with personal life. Some practical ways to facilitate better balance and stronger boundaries include designating specific time for work tasks, taking purposeful breaks from work tasks, making time to relax during the workday, pursuing enjoyable hobbies during one's

personal time, and spending time with meaningful personal relationships. Although it may feel tempting to skip breaks, take on more tasks, and not relax during the workday to cope with increased professional demands, this approach does not truly help one accomplish more. Instead, it only drains one's energy, diminishes one's self-care, and then harms one's personal life functioning.

## **RQ2: Boundary Setting & Burnout**

Research Question 2 focused on the relationship between boundary setting and burnout. To answer this question, the factor loadings for the paths from the boundary setting factors to the burnout factors were examined (see Table 24). The implications of these results are inferred based on the item content of each factor, although the specific items are not listed to comply with copyright restrictions.

Burnout was measured using the Maslach Burnout Inventory, which used a three-factor structure of emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). The questions for EE asked about feeling frustrated, drained, used up, burnt out, at the end of one's rope, or like one is working too hard. The questions for DP asked about feeling impersonal, hardened, callous, uncaring, or blamed in one's professional life. The questions for PA asked about feeling effective, energetic, relaxed, exhilarated, accomplished, calm, and positive. High scores of EE and DP indicate the presence of burnout while high scores of PA suggest its absence.

### ***Theoretical Interpretations***

The results of the SEM paths from the boundary setting factors to the burnout factors provided mixed support for Hypothesis 2, which hypothesized that boundary setting and burnout were negatively related. On the one hand, the relationships between Segm & EE and Segm & DP

were nonsignificant. On the other hand, there were positive significant relationships between Segm & PA, ProfInt & EE, and ProfInt & DP. These latter relationships provide support that boundary setting negatively relates with burnout in some aspects.

The positive significant relationship between Segm and PA indicates that as professionals delineate certain hours for each domain of personal and professional life, their feelings of personal accomplishment about their work also increase. Boundary setting may make it easier to perform at work at a level with which one feels satisfied. One way that boundary setting may facilitate increased PA is through reducing personal life interference into professional life. This is corroborated by the negative significant relationship between PersInt and PA and the negative correlation between Segm and PersInt. When one's personal life interferes with one's ability to complete professional tasks or pursue professional advancement, one is less likely to feel satisfied, competent, energized, or positive about one's professional functioning. Therefore, boundary setting that decreases PersInt can facilitate increased PA. Since higher PA scores indicate less burnout, these relationships indirectly support the hypothesis that stronger boundaries are associated with less burnout.

Two other results that indirectly support Hypothesis 2 are the positive significant relationships between ProfInt & EE and ProfInt & DP. ProfInt represents the interference of professional life onto personal life while EE and DP both represent the negative symptomology that characterizes burnout. Therefore, the positive relationships between ProfInt & EE and ProfInt & DP both indicate that professional life interference on personal life increases in concert with burnout. When professional responsibilities impair one's time or energy for one's personal life, one is more likely to feel exhausted, depersonalized, drained, overworked, callous, or hardened. These results indicate that one way to decrease burnout is to decrease professional life

interference into personal life. The negative correlation between Segm and ProfInt indicates that boundary setting is one way to decrease professional life interference into personal life.

Therefore, these relationships provide indirect support for the hypothesis that boundary setting is negatively associated with burnout.

In contrast to the positive significant relationships of ProfInt with both EE and DP, PersInt was not clearly related to the negative symptomology that characterizes burnout. PersInt was negatively related with EE, nonsignificantly related with DP, and negatively related with PA. The negative relationship between PersInt & EE is illuminated by considering it in contrast with the positive relationship between ProfInt & EE. Together, these results indicate that when one is emotionally exhausted, it is more likely for professional life to be interfering in personal life than for personal life to be interfering in professional life. ProfInt is likely a greater and more common contributor to burnout than is PersInt, although PersInt can decrease one's sense of accomplishment at work.

### ***Summary of Interpretations in Context***

Overall, the results of this study indirectly support Hypothesis 2, which proposed that boundary setting would relate negatively with burnout. Segm was significantly related to bolstering positive emotions (PA) but not significantly related to reducing the negative experiences that characterize burnout (EE or DP). This indicates that boundary setting has a noticeable impact on enhancing feelings of accomplishment at work but a less noticeable impact on reducing negative symptomology. Boundary setting's relationship with personal accomplishment can be better understood in context of the Effort-Recovery Model (Meijman & Mulder, 1998), which hypothesizes that recovery from work stress occurs when an individual is no longer confronted with work demands. Based on this model, Kinnunen et al. (2016)

hypothesized that boundary management can be an effective way for an individual to facilitate work stress recovery. Their results confirmed that segmentation was more helpful than integration for facilitating recovery experiences like psychological detachment, relaxation, and control. Boundary setting's ability to facilitate recovery experiences explains the positive significant relationship between Segm and PA in this study. By limiting one's exposure to work demands outside of working hours, one is better able to replenish one's resources, which also facilitates feelings of vigor, mastery, energy, or accomplishment about one's work.

Further support for Hypothesis 2 comes from the positive significant relationships between ProfInt & EE and ProfInt & DP. These relationships indicate that professional life interference on personal life increases in concert with burnout. This is consistent with several studies that have found that work-to-family conflict is related to increased stress-related outcomes (Aryee, 1993; Bacharach et al., 1991; R. J. Burke, 1988; Drory & Shamir, 1988; Greenglass & Burke, 1988; Izraeli, 1988; Kinnunen & Mauno, 1998; Netemeyer et al., 1996, as cited in Allen et al., 2000). The results of this study expand beyond these prior studies, though, by specifically focusing on burnout. Burnout is a more precise construct than the general cluster of stress-related outcomes. Burnout has a definition based on agreement among scholars and researchers and a gold standard measure of the construct. Therefore, using burnout in this study provides greater clarity and specificity that progresses the body of literature about burnout, boundary setting, or professional life interference. Furthermore, this study is one of the first to explicitly investigate the relationship of these three constructs. Previous works have hypothesized about potential relationships between boundary setting, burnout, and professional life interference but have not included them as the focus of their studies (Dlugos & Friedlander, 2001; Höge, 2009; Salloum et al., 2015; Simionato et al., 2019; Rupert et al., 2015). Therefore,

this study provides novel empirical data for relationships that previously were only speculated about.

Considering all three boundary setting factors and all three burnout factors together, the results suggest the following. When one sets stronger boundaries between personal and professional life, one will feel more accomplished and effective at one's work. When one's personal life boundaries are weak, indicating professional life can interfere with personal life, one's experience of burnout will increase, indicating one will feel more emotionally exhausted and depersonalized. When one's professional life boundaries are weak, indicating personal life can interfere with professional life, one will feel less satisfied with one's work performance but not necessary emotionally exhausted or depersonalized overall.

### **RQ3: Boundary Setting & Well-Being**

Research Question 3 focused on the relationship between boundary setting and well-being. To answer this question, the factor loadings for the paths from the boundary setting factors to the two well-being measures were examined (see Table 25). The practical implications of these results are inferred based on the specific items that constituted each factor.

As a reminder, well-being was assessed using two measures, the Satisfaction With Life Scale (SWLS) and the Flourishing Scale. The specific questions corresponding to both measures can be found in Table 19.

### ***Theoretical Implications***

The positive significant relationships between Segm and both measures of well-being strongly support Hypothesis 3, which proposed that boundary setting relates positively with well-being. Creating separation between personal and professional life is associated with one's subjective happiness and one's self-realization. Setting certain hours for the responsibilities of

each life domain is a practical way to facilitate pursuing the activities one considers important, helping others, building social support, or making meaningful decisions. Creating some separation between personal and professional life seems to help one feel satisfied about one's life, feel that one's life does not need to be changed too much, and that one's life conditions are excellent. Alternatively, a greater sense of well-being may also strengthen one's ability to set boundaries between personal and professional life. This could be because pursuits like helping others, building social support, or daily activities keep personal life rich, which motivates one to devote attention to one's personal life instead of allowing one's professional life to dominate.

Indirect support for Hypothesis 3 can also be found in the negative relationship between the boundary setting factor ProfInt and the well-being measure SWLS. As professional life interferes more with personal life, one's well-being diminishes. When one lacks energy or time for one's personal life, misses important events with friends/family, or struggles with excessive professional life demands, one is more likely to feel dissatisfied with one's life. This finding is consistent with previous research about how work-family conflict is one of the leading sources of occupational stress and negatively impacts life satisfaction (Bulger et al., 2007). In fact, a comprehensive review of work-to-family conflict and its related outcomes found that "Life satisfaction is the variable most often associated with WFC in the nonwork domain" (Allen et al., 2000, p. 289). The results of this study further corroborate this existing trend, but this study investigates the relationship between more specific constructs using more specific measures.

The boundary setting factor, PersInt, was not significantly related to either measure of well-being. Personal life interference into professional life is not clearly related with well-being. One possible interpretation of this finding is that personal life interference into professional life is a less relevant concern for these participants. Perhaps personal life interference occurs only in

specific incidents and is transient, whereas professional life interference into personal life is a chronic challenge. Another interpretation is that personal life interference into professional life may have effects on well-being that have mixed directionality. In some cases, it could be associated with poorer well-being if dissatisfaction with one's professional functioning affects one's overall satisfaction with life. In other cases, shifting attention to one's personal life could improve one's overall well-being, even if that redirection of energy causes some professional tasks to be left undone.

### *Summary of Interpretations in Context*

Overall, these results directly support Hypothesis 3, which proposed that boundary setting positively relates with well-being. One important way that boundary setting can promote well-being is through reducing professional life interference into personal life. Several authors have speculated about this relationship when discussing their results about other constructs, but they have not directly studied this relationship (Bulger et al., 2007; Haar et al., 2014). Other authors have also theorized that boundary setting may facilitate work-life balance (Harrison & Westwood, 2009; Morris, 2018, Norcross & Guy, 2007). For instance, Haar et al. (2014) asserted that work-life balance was positively associated with life satisfaction across seven distinct cultures, and they speculated that boundary setting could be a strategy for facilitating WLB.

This study expands beyond these conceptual arguments by explicitly studying boundary setting as a construct. In this study, Segm was a separate factor from ProfInt, which is consistent with the assertion that work-life balance is distinct from work-to-family conflict (Haar et al., 2014). The results of this study provide empirical support for conceptual assertions that weak boundaries are associated with work interference into professional life (Bulger et al., 2007). Segm was negatively correlated with ProfInt, and ProfInt was negatively correlated with SWLS.

This indicates that stronger boundary setting was associated with diminished professional life interference into personal life, and less professional life interference into personal life was associated with greater life satisfaction. This is consistent with existing research indicating that work-to-family conflict negatively impacts life satisfaction (Allen et al., 2000; Bulger et al., 2007). Therefore, these results provide support that boundary setting can help diminish professional life interference into personal life, which then increases well-being.

Boundary setting can also directly help increase well-being. Previous research has found that stronger boundaries between work and nonwork were positively associated with affective well-being, especially when the boundary around home life is strong (Spieler et al., 2017). This is consistent with the results in this study, which found that Segm was positively associated with both SWLS and with Flourish. One mechanism through which boundary setting can increase well-being is through promoting work stress recovery. As explained earlier, the Effort-Recovery Model (Meijman & Mulder, 1998) hypothesizes that when individuals are no longer confronted with work demands, they are more able to experience work stress recovery. Based on this Model, Kinnunen et al. (2016) found that a segmentation approach to boundary setting was more helpful than an integration approach for facilitating recovery experiences like psychological detachment, relaxation, and control. The results of this study further corroborate these findings, as a higher score on Segm was indicative of a segmentation approach to boundary setting. Segm's positive relationships with both measures of well-being indicate that boundary setting can help a professional create purposeful time and space for activities that promote their well-being, including those that facilitate work stress recovery.

#### **RQ4: Boundary Setting & Self-Care, Burnout, Well-Being**

Research Question 4 focused on the relationship between boundary setting with self-care, burnout, and well-being. To answer this question, all three of the outcome variables were modeled together in one single SEM model rather than in three separate SEM models. Paths were depicted from the boundary setting factors to self-care factors, burnout factors, and well-being measures. Model estimation yielded factor loading estimates for each of these paths, which were presented in distinct tables for each outcome variable. A compilation of the statistically significant factor loadings was presented in Table 26. The previous sections discussed the practical implications by outcome variable. This section now discusses the implications of all the results in context of each other and the whole model.

The boundary setting factor, Segm was a significant predictor for all five self-care factors and for both well-being measures. All these relationships were positive, which aligned with the original Hypotheses 1 and 3. Segm was also a significant predictor for one burnout factor, personal accomplishment (PA). This relationship was also positive, which is as expected, since a high score on the PA factor represents low burnout. There were only two factors that Segm was not significantly related to, which were the two factors of burnout —EE and DP—both of which characterize the negative symptomology of burnout. Taken all together, these results suggest that boundary setting is effective as a proactive strategy to enhance desirable outcomes like well-being and self-care and personal accomplishment. It can be considered as a protective factor against negative outcomes like burnout, but as an intervention, it may not immediately reduce negative symptomology like emotional exhaustion or depersonalization. This does not mean that boundary setting is useless for those already experiencing burnout, but rather that the effects of boundary work may be more readily observable through the enhancement of positive outcomes

rather than through the reduction of negative symptoms. Furthermore, the effects of boundary setting may be better understood through considering it in context with ProfInt and PersInt.

The boundary setting factor, ProfInt, was significantly related to at least one factor of each of the outcome variables of self-care, burnout, and well-being. This strongly indicates that professional interference on personal life is associated with some aspects of each outcome. In fact, ProfInt was the only boundary setting factor that was significantly related with both burnout factors of EE and DP in directionalities that supported the original Hypothesis. ProfInt was positively related with both EE and DP, which indicates that when one's personal life suffers, one experiences more burnout. Professional life interference was also associated with diminished satisfaction with one's life, diminished daily balance, and diminished life balance. This manifests as not spending time with people one enjoys, not participating in activities one finds comforting, not taking breaks throughout the day, over-committing, and not feeling that one's life is close to one's ideal. Taken together, these results indicate that professional life interference directly impacts one's self-care, well-being, and burnout.

Considering both the boundary setting factors ProfInt and Segm together, their relationships with self-care, burnout, and well-being gain greater clarity. ProfInt and Segm were negatively correlated, indicating that when boundary setting is stronger, professional life interference into personal life is less. Therefore, purposeful boundary setting can indirectly decrease burnout through decreasing professional life interference. When one is able make time for personal life tasks, have energy for personal life, and attend important events with friends/family, one is less likely to feel drained, frustrated, overworked, callous, impersonal, or uncaring at work. Creating some separation between personal and professional life helps one manage the competing the demands of each domain instead of allowing professional life to

interfere into personal life, which leads to burnout. Boundary setting can also both directly and indirectly increase self-care and well-being. Setting boundaries can directly help one feel more satisfied & accomplished, delegate time for meaningful activities, participate in professional organizations, spend time relaxing, or stay socially connected. Setting boundaries can also prevent professional life from sapping one's energy or time, which indirectly helps one pursue daily balance, promote life balance, and feel satisfied with one's life.

In contrast with the Segm and ProfInt, the boundary setting factor of PersInt was not significantly related with most outcome variables. PersInt was not significant predictor of any factors of self-care or either measure of well-being. It was only significantly related with two of the factors of burnout, EE and PA, both of which had negative coefficients. These two statistically significant relationships indicate that personal life interference could be associated with less emotional exhaustion and less feelings of personal accomplishment. Taken in context, the nonsignificant relationships with PersInt indicate that personal life interference is not as impactful on self-care, burnout, or well-being, compared to professional life interference or a segmentation approach. In practical terms, this means that it is more important to focus boundary setting efforts on preventing professional life from interfering in one's personal life than the other way around. When one's personal life suffers, this has direct implications for one's experience of burnout or well-being. However, making efforts to focus on personal life, such as by setting boundaries or by engaging in self-care does not necessarily harm one's professional life functioning. In other words, taking care of one's personal self does not have to come at the expense of one's professional life.

## **Novelty**

This study offers several new contributions to the existing body of psychological literature. First, this study more clearly defines and operationalizes the construct of boundary setting. Second, a new survey was created for this study, which was refined into a potential measure: the Personal-Professional Life Boundary Setting Survey. Third, this study studies a novel set of relationships: boundary setting with self-care, burnout, and well-being. Finally, this study begins the process of integrating findings from two different bodies of scholarly thought: mental health literature and organization/occupational health literature.

In the preexisting mental health literature, there was a lack of prescription about the construct of boundary setting, and this study begins to rectify that gap. “Descriptive but not Prescriptive” statements are a wide-spread problem for a variety of psychological constructs (Ridley et al., 2001; Ridley et al., 2021), including boundary setting. “Descriptive” statements assert something but do not provide clarity about the application of their assertion, while “prescriptive” statements both assert something and provide actionable guidelines for the assertion. Previous literature on boundary setting often asserted the importance of personal-professional life boundaries but offered limited explanation on how to establish them in practice. This study offers greater prescription by clarifying a definition of boundary setting: “active, purposeful behaviors and choices that individuals make to set a demarcation between their personal and professional life” (Yin, 2022, p. 3). Then, survey items were created to operationalize this definition. Examples of practical ways to set boundaries included establishing a designated space for professional tasks, limiting notifications from the other life domain, and practicing a routine to help one transition between domains. This survey and its results were then refined into a measure that further operationalizes the construct of boundary setting.

In addition to further operationalizing the construct of boundary setting, creating a new measure also redresses the lack of pre-existing psychometrically validated instruments for this construct. The Personal-Professional Life Boundary Setting Survey shows strong psychometric properties, as seen through its reliability and validity scores and through comparison with the psychometric properties of the other measures used in this study. The measure began as a survey that the investigator created to assess boundary setting. Then, the survey was refined through exploratory factor analysis to create the Personal-Professional Life Boundary Setting Survey. The refined measure consists of 12 items, which are grouped into three factors: (a) Segm, (b) ProfInt, and (c) ProfInt. The reliability scores of all three factors are at least acceptable, with  $\alpha > 0.7$  (George & Mallery, 2001). In fact, these three factors have higher reliability scores than do some of the burnout factors or the self-care factors.

Further support for the psychometric strength of the Personal-Professional Life Boundary Setting Survey are seen through the validity scores that exploratory and confirmatory factor analysis yielded. When the boundary setting survey was modeled, the resulting fit statistics met criteria for acceptable fit. In fact, the Personal-Professional Life Boundary Setting Survey has the second best fit statistics of any of the measures administered in this study. Its validity scores exceed those of the Maslach Burnout Inventory, the Satisfaction With Life Scale, and the Flourishing Scale in this study. This is noteworthy since all three of these other measures are widely used in research for their respective constructs, with the Maslach Burnout Inventory even being considered a gold standard measure (Schaufeli et al., 2009). Surpassing the validity scores of other existing measures is excellent for a survey that was created specifically for this protocol. Together, the reliability and validity scores from this study are preliminary support for the potential of the Personal-Professional Life Boundary Setting Survey to become a

psychometrically validated measure of boundary setting. This new measure can then serve as a steppingstone to advance consistent and systematic research on personal-professional life boundary setting.

In addition to creating a new measure with acceptable psychometric properties, this study studies a novel set of relationships. Boundary setting has not been previously examined in relationship to self-care, burnout, or well-being. Although some studies speculate about some potential relationships in their discussion sections, no studies have explicitly chosen these relationships as the focus of their research. An extensive literature review found only a handful of studies that include boundary setting with one of these three outcome variables. This is a significant gap in the literature, especially considering how common advice about boundary setting is given to working professionals. Therefore, this study provides seminal empirical data on how boundary setting can relate to a professional's self-care, burnout, and well-being. It also sheds light on what "setting healthy boundaries" truly means in practice.

Finally, by studying this set of relationships, this study also identifies some untapped potential to integrate findings from two different bodies of scholarly thought. Boundary setting-related concepts and theories primarily stem from the organizational/occupational health literature. Meanwhile, concepts and theories on self-care, burnout, and well-being primarily stem from the mental health literature. However, the two bodies of work on these constructs have rarely cross-referenced each other. This is a surprising gap that could be highly beneficial to address. Integrating boundary theory and its practical implementation into a mental health perspective could strengthen the psychological knowledge base, benefiting mental health professionals, their clients, the overall profession, and other professionals in general.

## **Future Directions for Research**

These results indicate several future directions for research. These include revision of the Personal-Professional Life Boundary Setting Survey, inclusion of slightly different constructs with boundary setting, focused investigation of boundary setting with burnout, and extension of this research to other professionals.

The Personal-Professional Life Boundary Setting Survey would benefit from further refinement of its items and factors. More items could be introduced for the factor of Segm to represent the intended definition of “active, purposeful behaviors and choices,” since this definition motivated the creation of this measure. The original 28 administered items did include more items that fit this definition, but many of them were removed in the exploratory factor analysis (EFA) process to create a refined factor structure with acceptable model fit. A future revision of the Personal-Professional Life Boundary Setting Survey would benefit from more specific items about how the participant sets boundaries in practice. Another potentially helpful revision to the boundary setting survey would be to create another factor with items representing integration, since this is the opposite approach of segmentation in boundary theory (Ashforth et al., 2000). In the original 28 administered items of the boundary setting survey, there were some items that represented integration, but again, these were removed in the EFA process to enhance model fit. Finally, it may be worthwhile to consider distinguishing the factors ProfInt and PersInt by separating them into another measure, particularly if an Integration factor were introduced. ProfInt and PersInt are more representative of the outcomes of boundary setting, rather than the purposeful actions of boundary setting. For each of these suggested changes, further investigation of the psychometric properties of the changed measure would also be critical.

In addition to revising the Personal-Professional Life Boundary Setting Survey, it would also be worthwhile to study slightly different relationships with boundary setting. Constructs like work-family conflict (WFC) or work-life balance (WLB) could be important to include, especially since previous scholars have asserted that these constructs are distinct from each other (Haar et al., 2014). Furthermore, WFC represents a similar idea to the factors of ProfInt and PersInt that were included in this study. Including WFC as an explicit factor would align well with the previous suggestion of refining the boundary setting survey by removing ProfInt and PersInt as factors while still acknowledging their potential relationship with boundary setting itself. In fact, the data in this study may indicate that ProfInt and PersInt represent a related but distinct construct from Segm since ProfInt and PersInt were both significantly correlated with Segm, but all three factors did not converge into a 2<sup>nd</sup> order latent variable of boundary setting. Therefore, inclusion of constructs like WFC and WLB allows for the underlying construct to still be acknowledged while also allowing the Personal-Professional Life Boundary Setting Survey to be refined.

Another worthwhile direction for future study is to focus on how boundary setting relates to burnout. This focused study could also include the addition of variables like WFC and WLB. In the current study, the boundary setting factor of Segm was only significantly related with PA, which represents positive symptoms that indicate the absence of burnout. It was not significantly related with either of the factors that represent the negative characteristics of burnout, EE or DP. Only the boundary setting factor of ProfInt had significant relationships with both burnout factors of EE and DP. This was a surprising result that warrants further investigation of boundary setting and burnout. Perhaps a refined version of the Personal-Professional Life Boundary Setting Survey that includes more items for Segm, removes ProfInt, and removes PersInt would

yield clearer results on the relationship between boundary setting and burnout. Furthermore, including variables like WFC and WLB allows for the underlying idea of ProfInt to still be represented while still allowing the construct of boundary setting to be refined.

A final worthwhile future direction is to extend this research beyond mental health professionals to other professional populations. While mental health professionals face some profession-specific challenges (Morris, 2018) that motivated a focus on them in this study, many other professionals also face challenges that could potentially be mitigated by personal-professional life boundary setting. This study was one of the first to purposefully study the relationship between boundary setting with self-care, burnout, and well-being, and the results indicated several significant relationships. Therefore, it would be intriguing to investigate how these constructs relate for people who work in other professions. This could begin through extension to other helping professionals (e.g. nursing, teaching, medical professionals) since these workers are often at high risk for experiencing burnout or distress (Lee et al., 2011; Matheson & Rosen, 2012; Salloum et al., 2015). Even for working professionals at large, though, the operationalization of boundary setting has strong potential to be helpful at a practical level. Therefore, it would be worthwhile to examine how boundary setting impacts other professional groups, such as through their self-care, burnout, and well-being.

### **Limitations**

This study contains a few limitations that are worth noting. First, while creating the entire survey through Qualtrics, one item (Question 18) in the Maslach Burnout Inventory was accidentally omitted. This omission was discovered after about 270 usable responses had already been collected. The mistake was corrected, and about 50 more responses were collected that included a response for item 18. Unfortunately, however, this mistake in survey design directly

resulted in missing data. Item 18 falls under the PA factor of burnout, which may explain why the PA reliability score in this study ( $\alpha = 0.711$ ) was low compared to the PA reliability score of the original study ( $\alpha = 0.87$ ). Furthermore, there was a noticeable difference in the goodness-of-fit indices for the burnout factor structure when confirmatory factor analysis was conducted using a maximum likelihood estimation with missing estimates ( $\chi^2(206)=641.390$  ( $p < .001$ ); RMSEA = .080; SRMR = not calculable; CFI = .866) versus a regular maximum likelihood estimation ( $\chi^2(206)=404.484$  ( $p < .001$ ); RMSEA = .136; SRMR = 0.117; CFI = .706).

A second limitation of this study was that the measure for boundary setting, the Personal-Professional Life Boundary Setting Survey, has no preexisting psychometric properties. The survey was created for this study, so this is the original study on its reliability, validity, and factor structure. Verifying these psychometric properties also required rearrangement of the items in the survey. In particular, the original survey consisted of 28 total items where 14 items were answered by agreement, and 14 items were answered by frequency. The final three-factor model consisted of 12 total items where 8 items were answered by agreement and 4 were answered by frequency. Recombining the items together could have affected the true latent meaning, as some items' scores were in response to a slightly different prompt. Furthermore, the remaining 12 items may not have embodied the definition of boundary setting as "active, purposeful behaviors and choices" as well as intended. The original 28 items may have aligned more explicitly with this definition, but many of those items had to be deleted to reach adequate model fit.

Another limitation of the study is the limited diversity of the sample. Although the sample size is reasonable for a dissertation ( $N=333$ ), participants had limited diversity in terms of gender or ethnicity. In terms of gender, 81% of the participants identified as a "Woman."

Ethnically, 79% of participants identified as “White/European Origin”. These statistics reflect the current composition of the mental health profession as mostly female and mostly White (American Psychological Association, 2016). While the demographic composition of this study’s sample is consistent with the overall profession, this can make it difficult to determine how well these results can be generalized to other groups.

One final limitation of note is that the data for this study was collected during the COVID-19 pandemic. This is very likely to have been a confounding variable that affected participants’ responses on this survey. In fact, several participants proactively contacted the investigator to express this very sentiment, saying that their responses on the survey were significantly different than if they had participated before COVID-19. Since the protocol for this study gathered data anonymously, further questions were not asked regarding participants’ responses, even if they had proactively offered feedback. Based on theoretical reasoning, though, it is hypothesized that the pandemic likely weakened many people’s boundary setting between personal and professional life by requiring them to work from home. Furthermore, the pandemic likely decreased participants’ access to some forms of self-care, increased their level of burnout, and decreased their sense of well-being. Despite this massive confounding variable, the results of this study still have practical relevance and generalizability because the pandemic is a variable that continues to be influencing people both personally and professionally.

Each of the limitations noted above are important to consider. Nevertheless, this study contributes new and valuable findings to the psychological literature. This study introduces a new measure for evaluating the construct of boundary setting, which has comparable reliability and validity to existing validated measures. It also sheds light on how boundary setting may be related to self-care, burnout, and well-being, which is a previously unstudied set of relationships.

This study also draws connections between aspects of mental health literature and the organizational/occupational health literature that have been minimally explored up until now. Therefore, this study serves as a first step towards multiple future avenues of research that can benefit not only the mental health profession, but other professions in general.

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## APPENDIX A: ELECTRONIC RECRUITMENT

Updated: 03/15/2021

### Contacting Professional Organizations

Subject Line: Request to Distribute Survey Research Opportunity

Dear [PROFESSIONAL ORGANIZATION NAME],

My name is Caroliina Ying, and I am a doctoral candidate in the PhD in Counseling Psychology program at Texas A&M University. Would you be willing to help me recruit some participation for my dissertation study?

I am seeking licensed mental health professionals (e.g., LCSW, LMSW, LMFT, LPC, LP) to complete a 20-minute online survey. My dissertation studies the relationship between personal-professional life boundary setting, self-care, burnout, and well-being. This study has been approved by the Texas A&M University IRB (IRB2021-0076M) and is chaired by Charles R. Ridley, PhD. The survey can be accessed at the following link:  
[https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtaI8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtaI8)  
Participants can also save and continue their progress on the survey within 1 week of their last response.

At the end of this study, there will be a random drawing for ten \$50 Amazon gift cards. Participants can enter the drawing for one of these gift cards by entering their email address in a separate link. Emails entered will not be connected to their survey responses in any way.

Would you be willing to allow me to distribute a recruitment email through the [PROFESSIONAL ORGANIZATION NAME] list-serv? Or would you be willing to distribute the recruitment emails on my behalf? I would greatly appreciate it, if so.

Thank you for your consideration, and please let me know if there is anything else you need from me!

Respectfully,  
**Caroliina Ying, MEd** (she/her/hers)  
Doctoral Candidate in Counseling Psychology  
Department of Educational Psychology  
Texas A&M University

## Contacting Individual Professionals

Subject Line: Request to Distribute Survey Research Opportunity

Dear [NAME],

I hope you are well. My name is Caroliina Ying, and I am a doctoral candidate in the PhD in Counseling Psychology program at Texas A&M University. Would you be willing to help me recruit some participation for my dissertation study?

I am seeking licensed mental health professionals (e.g., LCSW, LMSW, LMFT, LPC, LP) to complete a 20-minute online survey. My dissertation studies the relationship between personal-professional life boundary setting, self-care, burnout, and well-being. This study has been approved by the Texas A&M University IRB (IRB2021-0076M) and is chaired by Charles R. Ridley, PhD. The survey can be accessed at the following link:

[https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtaI8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtaI8)

Participants can also save and continue their progress on the survey within 1 week of their last response.

At the end of this study, there will be a random drawing for ten \$50 Amazon gift cards. Participants can enter the drawing for one of these gift cards by entering their email address in a separate link. Emails entered will not be connected to their survey responses in any way.

If you know any practicing colleagues (or agencies with practicing licensed mental health professionals) that you'd feel comfortable sharing this with, I could send you a separate email to forward to them.

I really appreciate your consideration, and please let me know if there is anything else you need from me!

Respectfully,

**Caroliina Ying, MEd** (she/her/hers)  
Doctoral Candidate in Counseling Psychology  
Department of Educational Psychology  
Texas A&M University

### Initial Email to Participants\*

\*Adapted from Terrebonne (2019) with permission. \*

Terrebonne, T. M. B. (2019). *Use of social support in therapy as a function of clinicians' theoretical orientation, treatment setting, and self-perceived social support* [Doctoral dissertation, Texas A&M University]. OakTrust. <https://hdl.handle.net/1969.1/186284>

Subject Line: Request for Survey Research Participation

Dear Prospective Participant:

I hope that this email finds you well. My name is Caroliina Ying, and I am a doctoral candidate in the Counseling Psychology PhD program at Texas A&M University. I am seeking licensed mental health professionals (e.g., LCSW, LMSW, LMFT, LPC, LP) to participate in a brief survey for my doctoral dissertation.

My dissertation studies the relationship between personal-professional life boundary setting, self-care, burnout, and well-being. This study is chaired by Charles R. Ridley, PhD, and has been approved by the Texas A&M University IRB (IRB2021-0076M). You can access the survey at [https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtaI8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtaI8). You can also save and continue your progress on the survey within 1 week of your last response.

Your participation in this study is voluntary, and you may withdraw from the study at any time without penalty. Participation in this study will take approximately **20 minutes** and will involve the completion of an online survey. All of your responses will be kept anonymous and will only be available to the researchers of this study. At the end of the survey, you will have the option to submit your email address through a separate link to be entered in a drawing for one of ten \$50 Amazon gift cards. Your email will not be connected to your survey responses in any way.

To be eligible for this study:

- You must be at least 18 years old
- You must have maintained a permanent residence in the U.S. for the last 6 months
- You must have provided direct clinical services to clients during the last 6 months
- You must be a licensed mental health professional (e.g., LCSW, LMSW, LMFT, LMHC, LPC, LP) within the U.S. for the last 6 months

If you would like to participate in this study, here is the survey link again:

[https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtaI8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtaI8)

You can save your responses and return to this survey within 1 week of your last response.

If you have any questions or concerns about this study, you may contact the Principal Investigator (Charles Ridley, PhD | [cridley@tamu.edu](mailto:cridley@tamu.edu)) or the Protocol Director (Caroliina Ying, MEd | [cying@tamu.edu](mailto:cying@tamu.edu)). You can also contact the Texas A&M University Human Research Protection Program (1-979-458-4067 | 1-855-795-8636 | [irb@tamu.edu](mailto:irb@tamu.edu)).

Thank you so much for your time and consideration. We sincerely hope to have you as a part of this study.

Respectfully,  
**Carolina Ying, MEd** (she/her/hers)  
Doctoral Candidate in Counseling Psychology  
Department of Educational Psychology  
Texas A&M University

## Follow-Up Email to Participants\*

\*Adapted from Terrebonne (2019) with permission. \*

Terrebonne, T. M. B. (2019). *Use of social support in therapy as a function of clinicians' theoretical orientation, treatment setting, and self-perceived social support* [Doctoral dissertation, Texas A&M University]. OakTrust. <https://hdl.handle.net/1969.1/186284>

Subject Line: Follow-Up Request for Survey Research Participation

Dear Prospective Participant:

This email is a **follow-up request** for licensed mental health professionals to participate in our research study. My name is Caroliina Ying, and I am a doctoral candidate in the Counseling Psychology PhD program at Texas A&M University. My doctoral dissertation studies the relationship between personal-professional life boundary setting, self-care, burnout, and well-being. This study is chaired by Charles R. Ridley, PhD, and has been approved by the Texas A&M University IRB (IRB2021-0076M).

If you have already participated in this study, we sincerely thank you for your time. We also note that we have increased the compensation for our study, and those who have already participated will automatically be included in the random drawing for this greater amount.

If you have not yet participated in this study, we ask that you please consider contributing to this study.

Your participation in this study is voluntary, and you may withdraw from the study at any time without penalty. Participation in this study will take approximately **20 minutes** and will involve the completion of an online survey. All of your responses will be kept anonymous and will only be available to the researchers of this study. At the end of the survey, you will have the option to submit your email address through a separate link to be entered in a drawing for one of ten \$50 Amazon gift cards. Your email will not be connected to your survey responses in any way.

To be eligible for this study:

- You must be at least 18 years old
- You must have maintained a permanent residence in the U.S. for the last 6 months
- You must have provided direct clinical services to clients during the last 6 months
- You must be a licensed mental health professional (e.g., LCSW, LMSW, LMFT, LMHC, LPC, LP) within the U.S. for the last 6 months

If you would like to participate in this study, you can access the survey at

[https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtalr8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtalr8)

You can also save and continue your progress on the survey within 1 week of your last response.

If you have any questions or concerns about this study, you may contact the Principal Investigator (Charles Ridley, PhD | [cridley@tamu.edu](mailto:cridley@tamu.edu)) or the Protocol Director (Caroliina Yin(g), MEd | [cying@tamu.edu](mailto:cying@tamu.edu)). You can also contact the Texas A&M University Human Research Protection Program (1-979-458-4067 | 1-855-795-8636 | [irb@tamu.edu](mailto:irb@tamu.edu)).

Thank you so much for your time and consideration. We sincerely hope to have you as a part of this study.

Respectfully,

**Caroliina Yin(g), MEd** (she/her/hers)  
Doctoral Candidate in Counseling Psychology  
Department of Educational Psychology  
Texas A&M University

## Social Media Post

Dear Licensed Mental Health Professionals,

My name is Caroliina Ying, and I am a doctoral candidate in the PhD in Counseling Psychology program at Texas A&M University. I am seeking licensed mental health professionals (e.g., LCSW, LMSW, LMFT, LPC, LP) to complete a 15–20-minute online survey for my doctoral dissertation.

My dissertation studies the relationship between personal-professional life boundary setting, self-care, burnout, and well-being. This study is chaired by Charles R. Ridley, PhD and has been approved by the Texas A&M University IRB (IRB2021-0076M).

You can access the survey at [https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtAlr8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtAlr8). You can also save and continue your progress on the survey within 1 week of your last response.

At the end of this study, there will be a random drawing for ten \$50 Amazon gift cards. You can enter the drawing for one of these gift cards by entering your email address in a separate link. Your email will not be connected to your survey responses in any way.

If you have any questions or concerns about this study, you may contact the Principal Investigator (Charles Ridley, PhD | [cridley@tamu.edu](mailto:cridley@tamu.edu)) or the Protocol Director (Caroliina Yin(g), MEd | [cying@tamu.edu](mailto:cying@tamu.edu)). You can also contact the Texas A&M University Human Research Protection Program (1-979-458-4067 | 1-855-795-8636 | [irb@tamu.edu](mailto:irb@tamu.edu)).

Thank you so much for your time and consideration! We sincerely hope to have you as a part of this study.

## APPENDIX B: INFORMED CONSENT FORM

\*Updated: 03/15/2021

**Project Title:** Boundary Setting of Mental Health Professionals: Its Relationship to Self-Care, Burnout, and Well-Being

You are invited to participate in a research study conducted by Caroliina Ying, MEd and Charles Ridley, PhD, researchers in the Department of Educational Psychology at Texas A&M University. This study is approved by the Texas A&M University IRB and has been assigned the following IRB number: IRB2021-0076M.

This form provides information to help you decide whether to take part. If you decide to participate in the study, you must sign this consent form. You may choose to stop participating at any time without penalty. If you choose not to participate, there will be no penalty to you.

### **Why Is This Study Being Done?**

The purpose of this study is to explore the relationship between personal-professional life boundary setting and self-care, burnout, and well-being in mental health professionals. This study aims to deepen the knowledge base about the relationship among these variables and to better operationalize the meaning of personal-professional life boundary setting in practice.

### **Who Is Eligible for This Study?**

To be eligible for this study:

- You must be at least 18 years old
- You must have maintained a permanent residence in the U.S. for the last 6 months
- You must have provided direct clinical services (e.g., intakes, individual/couples/family/group/career counseling, crisis intervention, psychological assessment) to clients during the last 6 months
- You must be a licensed mental health professional (e.g., LCSW, LMSW, LMFT, LMHC, LPC, LMFT, LP) within the U.S. for the last 6 months

Prospective participants must also select “Agree to participate” on the survey, which indicates that you have read and understood the information on this form, before they will be allowed to begin the study.

### **How Many Participants Will Be in This Study?**

This study aims to recruit approximately 300 participants.

### **What Will I Be Asked to Do in This Study?**

This research will be conducted online and take approximately 20 minutes to complete. You will be asked to answer a few screening questions to verify your eligibility to participate. If you meet all eligibility criteria, you will be asked to complete a demographic questionnaire and several questions about your boundary setting behaviors, self-care, burnout, and well-being. The survey will conclude with a final page that confirms your completion. You will also have the option to

click on a separate link where you can provide your email to enter a drawing for potential compensation for your participation.

You can access the survey here: [https://tamucehd.qualtrics.com/jfe/form/SV\\_74fkvZWJOPtAr8](https://tamucehd.qualtrics.com/jfe/form/SV_74fkvZWJOPtAr8)  
You can also save and continue your progress on this survey within 1 week of your last response.

### **Are There Any Risks to Me?**

There is minimal risk in this study. Participants are unlikely to encounter any greater risks than those of everyday life. Some individuals may feel uncomfortable, challenged, or bored by the questions in this survey. You may stop participating at any time with no penalty.

### **Is There Any Cost to Me?**

Aside from your time, there is no cost for participating in this study.

### **Will I Be Paid for My Participation?**

There is no guaranteed payment for participation in this study. However, we will randomly select ten participants to receive a \$50 Amazon gift card. You will be able to enter this drawing by clicking on a separate link on the final page of the study. You can enter your email on this separate link, which will not be connected in any way to your survey responses. We will email the randomly selected participants to receive their prize. If you are not selected or if you decline, there will be no compensation for participating.

### **What Are the Alternatives to Being in This Study?**

The alternative to being in the study is not to participate.

### **Will Information from This Study Be Kept Private?**

The records of this study will be kept private. No identifiers linking you to this study will be included in any sort of report that might be published. All information will be collected via the internet. Any information stored in computer files will be secured and protected with a password.

People who have access to your information include the Principal Investigator (Charles Ridley, PhD) and Protocol Director (Caroliina Ying, MEd). Representatives of regulatory agencies such as the Office of Human Research Protections (OHRP) and entities such as the Texas A&M University Human Research Protection Program may access your records to make sure the study is being run correctly and that information is collected properly. Information about you related to this study will be kept confidential to the extent permitted or required by law.

### **Whom May I Contact for More Information?**

You may contact the Principal Investigator (Charles Ridley, PhD | [cridley@tamu.edu](mailto:cridley@tamu.edu)) or the Protocol Director (Caroliina Ying, MEd | [cying@tamu.edu](mailto:cying@tamu.edu)) with any questions, concerns, or complaints about this research.

For questions about your rights as a research participant, input regarding research, or complaints or concerns about the research, you may call the Texas A&M University Human Research Protection Program (HRPP) by phone at 1-979-458-4067, toll free at 1-855-795-8636, or by email at [irb@tamu.edu](mailto:irb@tamu.edu).

**What If I Change My Mind About Participating?**

Your participation in this research is voluntary. You may choose whether or not to participate in this research study. You may decide not to begin or to stop participating at any time. If you choose not to be in this study or to leave the study, there will be no effect on your relationship with the investigators or with Texas A&M University.

**SIGNATURE AND ACKNOWLEDGMENT: By selecting “Agree to participate”, you are electronically signing this form and agreeing to participate in this research study. You are also indicating that you have read the above information and agree to participate in the study until you decide otherwise.**

\*Adapted from Terrebonne (2019) with permission

Terrebonne, T. M. B. (2019). *Use of social support in therapy as a function of clinicians' theoretical orientation, treatment setting, and self-perceived social support* [Doctoral dissertation, Texas A&M University]. OakTrust. <https://hdl.handle.net/1969.1/186284>

## APPENDIX C: SCREENING QUESTIONS

Updated: 03/16/2021

Are you 18 years old or older?

- Yes
- No

In the last 6 months, have you continuously maintained a permanent residence within the United States of America?

- Yes
- No

In the last 6 months, were you continuously licensed as a mental health provider in the United States of America?

- Yes
- No

In the last 6 months, which of these licenses did you continuously hold? (Please select all that apply.)

- Licensed Clinical Social Worker
- Licensed Masters Social Worker
- Licensed Clinical Alcohol & Drug Counselor
- Licensed Marriage and Family Therapist
- Licensed Mental Health Counselor
- Licensed Professional Counselor
- Licensed Psychologist
- Other: \_\_\_\_\_
- None of the above

In the last 6 months, have you provided any of these direct clinical services to any clients?

- Intakes/Triages
- Individual counseling
- Couples counseling
- Family counseling
- Group counseling
- Career counseling
- Crisis intervention
- Psychological assessment

- Yes
- No

APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE

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Updated: 03/16/2021

Age: \_\_\_\_\_

Gender:

Man

Woman

Transgender Man

Transgender Woman

Other: \_\_\_\_\_

Ethnicity: (Please select all that apply.)

African American/Black/African Origin

American Indian/Alaska Native/Aboriginal Canadian/Indigenous

Arab/Middle Eastern

Asian American/Asian Origin/Pacific Islander

Latino-a/Hispanic

White/European Origin

Biracial/Multiracial

Highest Degree Earned:

Associate

Bachelor

Master's

Doctorate/Professional

Current Living Situation: (Please select all that apply.)

Living alone

Living w/ partner

Living w/ dependent(s) <18 in the home

Living w/ relative(s)

Living w/ non-relative(s)

Living w/ pet(s)

Over the last 6 months, where did you primarily provide direct clinical services?

Community Mental Health

Hospital/Medical Facility

Jail/Criminal Justice System

Private Practice

Universities/College Counseling Clinic

Veterans Administration/Department of Veterans Affairs

Other: \_\_\_\_\_

Over the last 6 months, how many hours have you typically spent *per week* on direct clinical services? (0 to 168) \_\_\_\_\_

Examples of direct clinical services include:

- Intakes/Triages
- Individual counseling
- Couples counseling
- Family counseling
- Group counseling
- Career counseling
- Crisis intervention
- Psychological assessment

Over the last 6 months, how many hours have you typically spent *per week* on all professional responsibilities, including direct clinical services? (0 to 168) \_\_\_\_\_

Over the last 6 months, how many hours have you typically spent *per week* on personal life responsibilities? (0 to 168) \_\_\_\_\_

## APPENDIX E: PERSONAL-PROFESSIONAL LIFE BOUNDARY SETTING SURVEY

© 2022 Caroliina Yin

*Participant Instructions:* Please read each of the following statements and indicate the degree to which you agree or disagree.

*Response Scale:*

- 7 = Strongly agree
- 6 = Agree
- 5 = Slightly agree
- 4 = Neither agree nor disagree
- 3 = Slightly disagree
- 2 = Disagree
- 1 = Strongly disagree

*Survey Items (Agreement):*

1. I designate a physical space for my professional work.
- 2. I set certain hours for my professional responsibilities.**
- 3. I set certain hours for my personal life responsibilities.**
4. I recognize when my work interferes with my personal life.
5. I recognize when my personal life interferes with my work.
- 6. I balance competing demands in my personal life and my professional life.**
- 7. I do not complete some of my professional responsibilities because of personal life demands.**
- 8. I do not complete some of my personal life responsibilities because of professional demands.**
9. I cannot give enough time to my personal life because of professional demands.
- 10. I do not have enough energy for my personal life because of professional demands.**
11. I cannot give enough time to my professional life because of personal life demands.
- 12. I do not have enough energy for my professional life because of personal life demands.**
- 13. I purposefully create some separation between my personal life and my professional life.**
14. I purposefully create some overlap between my personal life and my professional life.

*Additional Participant Instructions:* Now read each of the following statements and indicate how frequently each statement has been true for you in the past 6 months.

*Response Scale:*

- 7 = Every day
- 6 = A few times a week
- 5 = Once a week
- 4 = A few times a month
- 3 = Once a month or less

2 = A few times a year or less  
1 = Never

*Survey Items (Frequency):*

1. I change my working hours to take care of personal life responsibilities.
2. I change my personal plans to take care of professional responsibilities.
3. During my non-working hours, I address professional responsibilities.
4. During my working hours, I address personal life responsibilities.
5. I change my personal life plans to meet my professional responsibilities.
6. I change my work schedule to meet my personal life responsibilities.
- 7. I miss important events with my friends/family because of professional responsibilities.**
- 8. I miss professional advancement opportunities because of personal life demands.**
9. I make changes when my personal life interferes with my work.
10. I make changes when my work interferes with my personal life.
- 11. My personal life is struggling because of excessive professional life demands.**
- 12. My professional life is struggling because of excessive personal life demands.**
13. My personal responsibilities dominate my life.
14. My professional responsibilities dominate my life.

Note: Bolded items are those that were retained in the final three-factor structure for this survey. See scoring instructions below.

Reference:

Yin, C. (2022). *Boundary Setting of Mental Health Professionals: Its Relationship to Self-Care, Burnout, and Well-Being* [Unpublished doctoral dissertation]. Texas A&M University.

*Personal-Professional Life Boundary Setting Survey Scoring*

*Scoring Instructions:*

Each factor consists of the items listed below them. Items can either be summed for a total factor score or averaged for an average factor score. These three factors were correlated together rather than connected through a 2<sup>nd</sup> order latent factor.

*Factors:*

---

Personal Life Interference on Professional Life (PersInt)	
Agr7	I do not complete some of my professional responsibilities because of personal life demands.
Agr12	I do not have enough energy for my professional life because of personal life demands.
Frq8	I miss professional advancement opportunities because of personal life demands.
Frq12	My professional life is struggling because of excessive personal life demands.

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Professional Life Interference on Personal Life (ProfInt)	
Agr8	I do not complete some of my personal life responsibilities because of professional demands.
Agr10	I do not have enough energy for my personal life because of professional demands.
Frq7	I miss important events with my friends/family because of professional responsibilities.
Frq11	My personal life is struggling because of excessive professional life demands.

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Segmentation Approach (Segm)	
Agr2	I set certain hours for my professional responsibilities.
Agr3	I set certain hours for my personal life responsibilities.
Agr6	I balance competing demands in my personal life and my professional life.
Agr13	I purposefully create some separation between my personal life and my professional life.

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Reference:

Yin, C. (2022). *Boundary Setting of Mental Health Professionals: Its Relationship to Self-Care, Burnout, and Well-Being* [Unpublished doctoral dissertation]. Texas A&M University.

## APPENDIX F: SELF-CARE ASSESSMENT FOR PSYCHOLOGISTS



### Department of Psychology

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Dear Colleague:

Enclosed please find a copy of the Self-Care Assessment (SCAP). The citation for the measure is as follows:

Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of a self-care assessment for psychologists. *Journal of Counseling Psychology*, 64(3), 325-334.

Please do not hesitate to contact me (941-284-9648, [kdorociak@luc.edu](mailto:kdorociak@luc.edu)) if I can be of any further assistance to you.

Sincerely,

Katherine Dorociak, M.A.  
Department of Psychology  
Loyola University Chicago

**Self-Care Assessment for Psychologists (SCAP)**

(Dorociak et al., 2017)

**Instructions: The items below contain statements about your personal and professional activities. Please use the following scale to indicate how often you engage in each activity.**

How Often: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_ 6 \_\_\_\_\_ 7 \_\_\_\_\_  
Never Always

1. I spend time with people whose company I enjoy. \_\_\_\_\_
2. I maintain a professional support system. \_\_\_\_\_
3. I take part in work-related social and community events. \_\_\_\_\_
4. I take breaks throughout the workday. \_\_\_\_\_
5. I participate in activities that promote my professional development. \_\_\_\_\_
6. I cultivate professional relationships with my colleagues. \_\_\_\_\_
7. I find ways to foster a sense of social connection and belonging in my life. \_\_\_\_\_
8. I am mindful of triggers that increase professional stress. \_\_\_\_\_
9. I seek out activities or people that are comforting to me. \_\_\_\_\_
10. I connect with organizations in my professional community that are important to me. \_\_\_\_\_
11. I make a proactive effort to manage the challenges of my professional work. \_\_\_\_\_
12. I avoid workplace isolation. \_\_\_\_\_
13. I spend time with family or friends. \_\_\_\_\_
14. I find ways to stay current in professional knowledge. \_\_\_\_\_
15. I share positive work experiences with colleagues. \_\_\_\_\_
16. I try to be aware of my feelings and needs. \_\_\_\_\_
17. I take some time for relaxation each day. \_\_\_\_\_
18. I avoid over-commitment to work responsibilities. \_\_\_\_\_
19. I monitor my feelings and reactions to clients. \_\_\_\_\_
20. I share work-related stressors with trusted colleagues. \_\_\_\_\_
21. I maximize time in professional activities I enjoy. \_\_\_\_\_

Reference:

Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of a self-care assessment for psychologists. *Journal of Counseling Psychology, 64*(3), 325-334.

## **SCAP Scoring**

### **Scoring of the five SCAP sub-scales:**

#### **Professional Support**

Total Items: 2, 6, 12, 15, 20

#### **Professional Development**

Total Items: 3, 5, 10, 14, 21

#### **Life Balance**

Total Items: 1, 7, 9, 13

#### **Cognitive Awareness**

Total Items: 8, 11, 16, 19

#### **Daily Balance**

Total Items: 4, 17, 18

#### Reference:

Dorociak, K. E., Rupert, P. A., Bryant, F. B., & Zahniser, E. (2017). Development of a self-care assessment for psychologists. *Journal of Counseling Psychology, 64*(3), 325-334.

## APPENDIX G: FLOURISHING SCALE

(Diener et al., 2010)

Below are eight statements with which you may agree or disagree. Using the 1-7 scale below, indicate your agreement with each item by indicating the response for each statement.

- 7 = Strongly agree
- 6 = Agree
- 5 = Slightly agree
- 4 = Neither agree nor disagree
- 3 = Slightly disagree
- 2 = Disagree
- 1 = Strongly disagree

- \_\_\_\_\_ I lead a purposeful and meaningful life.
- \_\_\_\_\_ My social relationships are supportive and rewarding.
- \_\_\_\_\_ I am engaged and interested in my daily activities.
- \_\_\_\_\_ I actively contribute to the happiness and well-being of others.
- \_\_\_\_\_ I am competent and capable in the activities that are important to me.
- \_\_\_\_\_ I am a good person and live a good life.
- \_\_\_\_\_ I am optimistic about my future.
- \_\_\_\_\_ People respect me.

### Reference:

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D., Oishi, S., & Biswas-Diener, R. (2010). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research*, 97(2), 143-156. <https://doi.org/10.1007/s11205-009-9493-y>

## APPENDIX H: SATISFACTION WITH LIFE SCALE

(Diener et al., 1985)

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

7 = Strongly agree

6 = Agree

5 = Slightly agree

4 = Neither agree nor disagree

3 = Slightly disagree

2 = Disagree

1 = Strongly disagree

\_\_\_\_\_ In most ways my life is close to my ideal.

\_\_\_\_\_ The conditions of my life are excellent.

\_\_\_\_\_ I am satisfied with my life.

\_\_\_\_\_ So far I have gotten the important things I want in life.

\_\_\_\_\_ If I could live my life over, I would change almost nothing.

### Reference:

Diener, E. D., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction With Life Scale. *Journal of Personality Assessment*, 49(1), 71-75.  
[https://doi.org/10.1207/s15327752jpa4901\\_13](https://doi.org/10.1207/s15327752jpa4901_13)

## APPENDIX I: PARTICIPANT COMPENSATION NOTIFICATION

Congratulations! You are one of ten participants who have been randomly selected to receive a \$50 Amazon gift card. Thank you for participating in the research study conducted by Caroliina Ying, MEd, and Charles Ridley, PhD, researchers at Texas A&M University.

This study was approved by the Texas A&M University IRB and assigned the following IRB number: IRB2021-0076M. If you have any questions, concerns, or complaints about this research, you may contact the Principal Investigator (Charles Ridley, PhD | [cr Ridley@tam u.edu](mailto:cr Ridley@tam u.edu)) or the Protocol Director (Caroliina Ying, MEd | [cying@tam u.edu](mailto:cying@tam u.edu)).

Thank you again!