Walden University

College of Social and Behavioral Sciences

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Shane T. Spiker

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Walden University
2019

Abstract

Understanding Self-Care Techniques Among Currently Practicing Behavior Analysts

By

Shane T. Spiker

MS, University of Phoenix, 2012

BS, University of Phoenix, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements of the Degree of

Doctor of Philosophy

Psychology

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Abstract

Board Certified Behavior Analysts (BCBAs) serve as the primary practitioners within this field, providing direct services to individuals with socially significant problem behaviors. The purpose of this study was to expand research on the behavior analytic practitioner regarding their self-care practices and develop an understanding of their lived experience using Orem's theory of self-care. Data were collected from 10 BCBAs via face-to-face interviews derived of questions regarding self-care practices. The interview questions included discussions around self-care behaviors as well as beneficial and problematic effects regarding individual self-care practices. Interpretive phenomenological analysis was used to gather information regarding practices and interpret the lived experience of current practitioners. It was found that BCBAs have informal exposure to self-care and share effects like burnout with other helping professions. Some practitioners indicated that lack of self-care resulted in diminished relationships, lowered quality of care for clients, and poor quality of life outcomes. This research indicated social change implications that include using the results to improve self-care practices among BCBAs could result in less burnout and improved care for patients. If improvements to self-care repertoires are made, client outcomes may also improve, reducing the need for behavior analysis services long term.

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Dedication

I would like to dedicate this study to anyone actively pursuing the preservation and development of scientific literacy in our education, communities, and public policies. To the scientists, the dreamers, and the change-makers; “However, I continue to try and I continue, indefatigably, to reach out. There is no way I can single-handedly save the world or, perhaps, even make a perceptible difference – but how ashamed I would be to let a day pass without making one more effort.” – Isaac Asimov.

Acknowledgements

I would like to take a moment to say thank you to everyone who has helped me reach this point along the way. Thank you to all of my behavior analyst peers, colleagues, and friends who have shared their knowledge and continue to make changes in the world. Thank you to all of my role models; Dr. Greg Graffin, Dr. Dan Yemin, and other staples in the punk rock community that showed me you can be loud and obnoxious while being calculated, thoughtful, and active in making meaningful and humane differences in our communities, even if it's only for a single moment.

I would also like to take some time to say thank you to Dr. Arcella Trimble, Dr. Leanne Parker, and Dr. Sharon Xuereb for being active on my dissertation committee. It means the world to me to share this experience with you and to have your guidance and support. Your presence has been impactful beyond words.

Finally, and most importantly, I want and need to thank my friends and family. Callista, my wife, you have been an incredible rock for me, tolerating my nonsense and giving me an unwavering and immeasurable level of support that I certainly haven't deserved. To my children, Riley and Ethan, I hope that I live up to your expectations. You mean the world to me and are the reason I strive to be the man you see in me. To my parents, P-Nut and Tom, who continue to show me what kindness, compassion, strength, and dedications means. You are the exemplars for humanity. To Sam and Margarita, thank you for having faith in me during this journey, which has seemed never-ending. I hope I can make you proud. To Mikey, Chris, and Emelia, thank you for always being the

best support I could have ever asked for and for adding levity to all of my trying circumstances. And to Jesse, my brother; it's whatever, no big deal.

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Chapter 1: Introduction to the Study

Introduction

Applied behavior analysis is a newer discipline in terms of subsets of psychology. Initially developed by Skinner (1938) and based on operant conditioning, behavior analysis branched off into two distinct areas of practice: the experimental analysis of behavior (EAB) and applied behavior analysis (ABA) (Cooper, Heron, & Heward, 2007). Since the inception of applied behavior analysis, research has been focused directly on the behavior of organisms, with increased focus on animal behavior, problematic behavior, and behavior related to language, which Skinner defined as verbal behavior. As research continues to develop, fields like organizational behavior management (OBM) and school-based behavior analysis continue to grow in terms of understanding and implementation (Shook & Favel, 2008). Today, applied behavior analysis is growing as the foremost treatment for children and adults with autism spectrum disorder and behavior problems in general (Cebula, 2012). There are over 10,000 practitioners currently certified to practice behavior analysis worldwide (Behavior Analysis Certification Board, 2014).

In the current body of literature, there is little research on the behavior analyst as a professional and variables surrounding practice for behavior analysts. Behavior analysts are expected to practice in a collaborative environment, engaging in treatment programs with mental health counselors, psychiatrists, medical doctors, and other health care providers. Similarly, behavior analysts practice in comparable settings to mental health counselors in terms of client interaction, job requirements, and patient outcomes.

Exposure to challenging clients, dangerous behavioral episodes, rigorous documentation requirements, and increasing demand for ABA service all contribute to daily stressors of the behavior analytic practitioner (Mills & Rose, 2011; Vollmer, Iwata, Smith, & Rodgers, 1992). Ultimately, there are clear deficits in research regarding self-care techniques among most practitioners in helping professions, including behavior analysts (Cebula, 2012; Figley, 2001; Richards, Campenni, & Muse-Burke, 2010). Behavior analytic professionals are exposed to intensive therapy sessions that can include violent outbursts from clients, injury to caregivers, the use of restraints for clients in crisis, and life-threatening situations that can harm the client (Bailey & Burch, 2013; Vollmer et al., 1992) These events may serve as stressors to the behavior analyst, sometimes resulting in trauma to the professional (Shook & Favell, 2008). The intensity of behavioral analysts' work environments makes it vital to understand self-care techniques to determine how behavior analysts use these skills.

Background

Self-care is often difficult to define for practitioners. Many times, definitions of self-care are reduced to a set of behavioral repertoires with outcomes related to health outcomes (Orem, 2001; Sundberg, 2016; Vollmer et al, 1992). However, it is suggested that across practices, self-care remains difficult to define in terms of identifying behaviors, caregivers, or outcomes related to self-care practices (Godfrey et al., 2011). Among medical and psychological practitioners, there seems to be some disparity regarding what self-care is, but there appears to be agreement regarding the impact of the lack of self-care. Increased burnout, compassion fatigue, diminished caregiver

repertoires, and breakdowns in healthy behaviors are listed among some of the more significant impacts related to lack of self-care (Figley, 2002; Hunter, 2012; Pearlman, & Caringi, 2009).

Many studies can be found on self-care in different aspects, including literature related to Orem's (1985) theory of self-care. The focus of many of these studies include the therapist, medical professional, or direct care service provider as the primary subject for self-care repertoires (Kemper, 1980; Kissel, Whitman, & Reid, 1983; Queiros, Vidinha, & Filho, 2014). These researchers regularly evaluate the variety of caregivers who may engage in self-care behavioral repertoires. However, despite this varied population, behavior analytic practitioners are neglected. This is particularly concerning due to the nature of caregiving practitioners working with special needs populations where the impact of problem behavior increases rates of burnout (Mills & Rose, 2011). With constant exposure to challenging behavior remaining a consistent element of behavior analytic practice, an exploration of self-care repertoires is necessary for behavior analytic practitioners.

Over the course of this chapter, I will begin exploring the problem of caregiving and self-care practices among current behavior analytic certificants. Additionally, there will be discussion of the current research proposed for the study, the design of the study, and some of the assumptions and limitations related to this design.

Problem Statement

Skinner, Pavlov, and Wundt began helping to set the foundation for behaviorism in practice as early researchers investigating behavioral sciences as observable and

measurable phenomena (Cooper et al., 2007). As a newer field of practice, however, behavior analysis is rife with research gaps (Carr et al., 2002; Friman, Hayes, & Wilson, 1998; McIntyre, Gresham, DiGennaro, & Reed, 2007). Scope limitations in research specific to observable and measurable phenomena have prevented research expansion to areas related to psychological disorders, socioeconomic issues, and internal research on practitioners themselves. Ultimately, the limit to behavioral mechanisms presents a unique challenge to effectively evaluating qualitative phenomena from a behavior analytic perspective.

This scope limitation impacts research on the practitioner specifically, where the effects of continued clinical practice are not clearly evaluated among behavior analysts. Whereas research on issues such as vicarious traumatization, burnout, and caregiver fatigue often include medical, psychological, or caregiver professionals, the literature has no mention of behavior analytic practitioner among this group. In turn, researchers and practitioners alike cannot answer whether behavior analysts currently engage in self-care behavioral repertoires, nor have they been able to explore the impact of these repertoires. The problem with this gap is that as practitioners who are exposed to intense and possibly traumatic events during practice, a self-care routine deficit could be potentially harmful to the practitioner as well as to the individual receiving behavior analytic services (Mills & Rose, 2011; Orem, 2001; Pearlman & Caringi, 2009; Richards, Campenni, & Muse-Burke, 2010).

Purpose of the Study

The purpose of this phenomenological study was to explore the self-care practices among currently certified behavior analysts through their experiences. The semistructured interview design allowed me to explore the varying experiences of multiple practitioners in the field of behavior analysis. This research specifically explored if and how current behavior analytic certificants engage in self-care behavioral repertoires. This type of information may lead to a better understanding of how self-care is perceived among behavior analytic practitioners whose primary practice is rooted in behaviorism. This study is justified because of the nature of behavior analytic work. Behavior analytic practitioners are exposed to intense problem behavior, challenging family dynamics, and may experience adverse effects related to treatment settings, like those described in Mills and Rose (2011). Exposure to high levels of problem behavior can result in compassion fatigue, traumatization, or burnout among caregivers. These effects, such as compassion fatigue, can result in a caregiver's lack motivation to engage in high quality care for those in their charge. This can also include diminished quality of life for the caregiver, resulting in deteriorating personal relationships as well as poor job satisfaction.

Research Questions

Because this area of research is largely unexplored, I reviewed several research questions that may have brought further understanding into the self-care practices of behavior analysts. However, literature in this specific topic is scarcer than previously anticipated, which prompted me to broaden the scope of the question to explore how behavior analysts engage in self-care. Simply put, the scientific community understands

little about this population in practice. There is a need for developing an understanding about the practices of these professionals before further research can be explored. Speaking to this deficit in research, there was one main research question for this project:

RQ1 – Qualitative: How do currently certified behavior analysts engage in self-care practices?

Conceptual Framework for the Study

Theory of Self-Care

This study is primarily based on Orem's (1959) theory of self-care, a medical model of self-care originally designed to impact nurses and other healthcare professionals working in the medical field. The original goal of this theory was to introduce a means of teaching behavioral repertoires to caregivers, resulting in a reduction in burnout among those caring for others. This theory shares some elements of behaviorism and Maslow's hierarchy of needs, whereas the caregiver must have their basic needs met to maintain individual health (Queiros et al, 2014). Over time, this theory has been applied to those maintaining caregiving roles, including psychology rooted practitioners. This specific theory provides the main framework for this specific study. With the goal of understanding self-care practices among behavior analysts, Orem's theory of self-care sets the occasion for understanding what self-care looks like to behavior analytic practitioners specifically.

According to Orem's (2001) theory of self-care, each person is a specific individual and requires engagement in some kind of self-care behaviors. This includes assumptions about the carer and how self-care should be initiated:

- The individual should be self-reliant and ultimately responsible for their own care. Additionally, the individual is responsible for the care of others, including family and individuals who need care.
- Each person is a unique individual.
- Nursing and caring are behaviors that include interactions between two people.
- Primary care requires meeting basic universal needs as well as developmentally appropriate self-care requirements. This is critical to prevention care and illness prevention.
- Knowledge regarding the health risks and potential problems is required to promote self-care behaviors.
- Self-care behaviors as well as dependent behaviors are learned behaviors through socio-cultural contexts.

Theory of self-care domains. Along with these assumptions, the theory itself is comprised of three specific elements: theory of self-care, theory of self-care deficit, and theory of nursing system. Essentially, these components encompass major problems within self-caring environments and account for needs, deficits, and how needs and deficits are addressed comprehensively.

Within the theory of self-care, Orem (2001) discussed universal healthcare needs for the organism in question. This is an extensive list that overlaps with some of Maslow's (1943) hierarchy of needs. Everyone requires food, water, sleep, and oxygen. This level of needs analysis continues through to the inclusion of the urinary/bowel elimination process, balance between activities and rest, and maintaining individual

safety. The final goal of this specific theory element is the improvement and promotion of individual functioning. This goal highlights one of the primary purposes of the theory and practice, which is for the individual to develop and maintain normal, independent, and healthy functioning (Orem, 2001).

Regarding the theory of self-care deficit, Orem (2001) continued to describe when care is needed, not necessarily what happens to the individual when care is absent. As part of this theory element, Orem described several actions that the individual engaging in care behavior can engage in to initiate and maintain caregiving behaviors: (a) acting for and doing for others, (b) guiding others, (c) supporting another, (d) providing an environment prompting personal development to meet future demands, and (e) teaching another. These five actions outline an informal action plan by which nursing practitioners can evaluate next steps when discovering self-care deficits within a specific workspace.

The third element of this theory includes the theory of nursing systems. Orem (2001) described the theory of nursing systems as the global self-care environment and all of the necessary resources that enable the most efficient and effective caring environment. By accounting for the carer, the individual in need of self-care, and the environment in which self-care is taking place, Orem highlighted that self-care does not occur in isolation and may not be entirely behavioral. As such, the goal of the carer is to determine where there may be deficits in the nursing system and to act to correct future errors.

Behaviorism

In addition to Orem's theory of self-care, behaviorism provides an additional framework for this study. With self-care practices rooted in behavioral repertoires, the researcher aims to identify and define self-care practices among behavior analytic practitioners. The theory of behaviorism was originally founded through Pavlov's work with respondent behavior but gained additional support and development through Skinner's research on operant behavior. This further development of behaviorism posited that learned behavior is a result of a stimulus-response-stimulus (S-R-S) relationship, where antecedents and consequences occasion behavior, resulting in either increases or decreases in specific repertoires. This S-R-S relationship serves as a primary mechanism of behavior analytic practice and remains a foundational element of behaviorism theory. Skinner's (1938) discussion of operant behavior and general behaviorist concepts help to provide observable and measurable behavioral elements to this study. In using this theory as an additional framework, a researcher can easily define repertoires that will allow future researchers to identify behavioral topographies of self-care among practitioners. This theory will be discussed further in Chapter 2.

Nature of the Study

The nature of this phenomenological qualitative study focused on exploring self-care in the frame of behavior analytic practice. Qualitative research is consistent with exploring the nature of a research area to develop a better understanding of underlying issues within a particular field. The primary focus of this dissertation was to better understand self-care in behavior analytic practice. The research question above was to

explore current practice of behavior analysts regarding self-care. Through the specific information identified in the research question above, I was able to better understand the nature of self-care practices among behavior analysts.

This particular study was a phenomenological study because there was insufficient literature exploring the lived experience of behavior analytic professionals (Creswell & Creswell, 2017). The research question designed for this study aimed to explore behavior analysts and their self-care practices. Using an IPA, I was able to gather information about practitioners' experience and add further depth to the current knowledge base regarding self-care practices among behavior analysts (Smith, Flowers, & Larkin, 2012). Information was gathered on the day-to-day experience of the analysts as it pertains to the use of self-care tactics. Through examining the lived experience of the practitioner, I was be able to better understand the nature and depth of self-care practices among professionals. In using IPA strategies for this study, I was able to identify and understand recurring themes on an individual and group level, which ultimately provided a deeper and more concise understanding of the experience of behavior analysts (Smith et al., 2012).

Definitions

Applied Behavior Analysis (ABA): Applied behavior analysis (ABA) specifically refers to the evidence-based practice of behavior analysis in applied settings using applied research. This practice specifically aims to treat socially significant behaviors for change (Cooper, Heron, & Heward, 2007).

Behavior Analyst: The term behavior analyst refers to individuals receiving a certain level of training and passing the board exam. This term commonly supplants the complete term board certified behavior analyst.

Board Certified Behavior Analyst (BCBA): The term board certified behavior analyst is often shorted to the initials BCBA. This term refers specifically to those individuals who have met the qualifications to practice in behavior analysis. This training includes at least a master's level degree, specific coursework in behavior analysis, and a minimum of 1,500 hours of fieldwork. Those who have met this requirement must then pass an exam to receive their certification. These requirements are governed through the behavior analyst certification board (BACB, 2017).

Caregiver: Godfrey et al. (2011) share several definitions for the term caregiver, with no indication of a single definition for further research purposes. For the purposes of this study, the caregiver refers specifically to the BCBA participating in this study. These participants hold caregiving roles in that they deliver ongoing services to individuals in need of behavior analysis services.

Self-Care Repertoire: Self-care repertoires may include a variety of behaviors. For the purposes of this study, a self-care repertoire would be defined as any behavior or set of behaviors that are engaged in for the purposes of care (see citation). Specific topographies of behavior were defined by the researcher following the interviews using guidelines outlined by Cooper, et al. (2007). The specific criterion for defining behavior is describing the shape of the behavior in terms that a second observer may be able to clearly observe and measure. These behavioral repertoires would be outside of standard

work routines for the practitioner and directed at the caregiver themselves. Some examples may include getting a massage, reading a book, or having a glass of wine following a work day. Examples that would not be considered self-care may include behaviors linked to daily work routines or necessary errands important for sustaining a current living situation.

Assumptions and Limitations

Assumptions

The phenomenological approach to this particular question allowed for an exploratory approach to a topic largely unexplored in self-care literature. With the selection of this design, assumptions consistent with phenomenological research were applied. The nature of this study was to explore the concepts of self-care highlighted in Orem's (2001) theory of self-care as it applied to behavior analytic professionals. I did not attempt to analyze or evaluate self-care deficits, but rather explore the nature of self-care as it may or may not exist within behavior analytic professional practice. The assumption regarding self-care among behavior analysts was that behavior analysts do not formally engage in self-care practices as defined by other practices. Instead, it is possible and likely that behavior analysts engage in activities that may be self-caring in nature but are not directly recognized as self-care by behavior analysts due to discrepancies among behavior analytic and psychological language.

An additional assumption in this study was that the group of participants share similar training in regard to theoretical orientation. This was assumed due to the requirements of behavior analytic certification outlined by the BACB (2016), wherein

behavior analysts are required to complete specific training and in-field supervisory work. However, due to the individual professional experience of each analyst, it was unknown how similar their practical experience may be, which in turn may have yielded unique experiences unknown to the researcher.

A third assumption for this study was that participants would be open and truthful about the information they present. The interview questions, specifically those centered around client care, may be uncomfortable for some practitioners, and as a result, details may be omitted or hidden regarding their experience. This assumption may be directly influenced by the current BACB (2016) ethics code regarding client care and practice, which includes elements of discussion regarding practitioner and client therapeutic relationships. If the current code emphasizes ethical violations due to diminishing client care, the assumption is that some participants may be hesitant to provide detailed information regarding self-care outcomes. However, I did not ask for information through which participants' clients may be identified.

Scope and Delimitations

This study explored the extent to which behavior analysts actively practice self-care behaviors while currently certified. Data was gathered through interviews with current professionals and through stories shared by focus groups. Within the field of behavior analytic practice, self-care as defined by Godfrey et al. (2011) is not currently addressed. Rather, the term is often redefined as behaviors related to independent hygiene tasks. I explored self-care as defined in psychological literature among current behavior analysts in practice.

Regarding boundaries, this study was specifically limited to master's level practitioners, which eliminates other practitioner levels. Master's level practitioners make up most of the board certificants, however there is a second majority of title holders within the BACB pool. Registered behavior technicians (RBTs) serve as the majority of certification holders through the board at this time. Despite this new certification, this group holds less responsibility than BCBA's currently practicing.

A specific delimitation was the credentials of the practitioners. Practitioners outside the field of behavior analysis were not included in this study, as the focus is primarily on behavior analysts. The scope of the study limited outside practitioners as their experience is not directly relevant to the lived experience of the behavior analysts, but future research may include this population for comparative studies.

Limitations

One of the primary limitations of this study was directly related to the language used when describing self-care. This specific limitation was highlighted in the literature review, where research such as Godfrey et al. (2011) and Vollmer et al. (1992) showed significant differences in how self-care is defined. It was my goal to reduce the impact of this limitation using the semistructured interview as an opportunity to clarify terminology to practitioners as well as having behavioral definitions for self-care available prior to the interview.

A potential bias that may have arisen as part of the study was related to the framework. I was a participant observer, with much of my primary practical training aligning with Skinner's behaviorism. This bias may have prompted more behaviorally-

based responses and may have limited the amount of inquiry into answers that share language with cognition or emotion. It is not likely that this bias interfered with the study itself, however it is worth noting due to the framework, definitions, and participants within the study. To reduce this bias, I advised the interviewee that this study was based on the experience of the practitioner, with behavioral repertoires serving as a small portion of the total experience being investigated.

Significance

This study was unique in that behavior analysis as a field strives to be wholly objective, thus, concepts like self-care are often ignored as they are linked to mentalistic terminology like stress, anxiety, and burnout. To discuss self-care in behavior analysis presents a crossing over of theoretical perspectives, which can be challenging for some practitioners. However, there were important similarities between behavior analytic practice and other helping professions with a focus on therapy. While the perspective of behavior analytic practice is different in theory compared to other areas of therapeutic practice, the daily routine includes client care, treatment design, ongoing evaluation, and exposure to traumatic events. With a large body of research showing the importance of self-care skills among other types of practitioners (Cebula, 2012; Figley, 2001; Godfrey et al., 2011), there was a deficit in the understanding of self-care among behavior analytic professionals. By better understanding self-care in behavior analytic practice, it might have been possible to improve the experiences for both practitioners and patients.

Specific to the behavior analytic community, a better understanding of self-care practices could have informed various components of the field in terms of supervision,

training, and applied practice. Specifically, understanding the extent to which self-care is or is not practiced can serve to prioritize discussions on self-care and self-care training, resulting in improved educational programs for upcoming behavior analysts. More importantly than the training aspect, the implementation of self-care within the realm of behavior analytic practice could greatly impact the clients being served. Better cared for practitioners do not suffer the same experiences with diminished caregiving, caregiver burnout, or treatment fidelity issues as those who are lacking self-care repertoires (Figley, 2002; Orem, 2001). Understanding the nature of self-care among behavior analysts could serve to improve treatment outcomes as a result of more focused and less burned-out practitioners.

Summary

In sum, this specific study was designed to explore the lived experience of behavior analytic practitioners. Understanding behavioral repertoires of caregivers is evident among some of the literature outlined here, however there was not much discussion regarding behavior analysts despite similar practices with medical and psychological professionals. This phenomenological study used Orem's (1959) theory of self-care as well as elements of Skinner's (1938) behaviorism theory to create a framework with which to explore these specific phenomena. With expansive research on effects of self-care, it seems that behavior analysts have yet to be studied. The overarching aim of this research was to be able to explore and understand how behavior analysts engage in self-care behavioral repertoires.

Chapter 2 included the literature review for the study, which highlighted theoretical orientation for the study, literature on qualitative research designs and data collection, a synthesis of the current literature, and a discussion on the current gaps in behavior analytic research. Chapter 3 outlineed the design of the study itself, including the sampling strategy, interview questions, and data collection methods.

Chapter 2: Literature Review

Introduction

As stated in the previous chapter, the current problem surrounding self-care and behavior analytic practitioners was a unique challenge that is currently unexplored. The lived experience of the behavior analyst regarding self-care had been discussed informally, but formal research in this area was significantly lacking. Add to this concerns related to self-care deficits in other fields of practice, and the gap in research about self-care deficits among behavior analysts was magnified. The following chapter reviewed the current body of literature related to the theory of self-care as well as the current state of behavior analytic practice regarding self-care.

A review of the literature highlights the current problem of limited self-care research further. Much of the psychological and nursing research discuss self-care in several different aspects, including engagement and effects of self-care as well as chronic lack of self-care. The overall body of literature referring to self-care indicated that self-care is a necessity among carers who currently work in a helping profession, while lack of self-care can result in diminished care for clients, deteriorating quality of life for the carer, and burnout among those working in a variety of fields. The following chapter discussed this in greater length, including (a) literature search strategy, (b) conceptual framework, (c) literature review related to key variables, and (d) summary of findings.

Literature Search Strategy

Journal articles were searched for online through several databases within the Walden University library. These databases include PsychINFO, PsycARTICLES, and

PsychEXTRA. Additionally, the EBSCO data base was used to find general articles as well as articles in the nursing and caregiving areas of practice. Behavior analytic journals were searched for through the above-mentioned data bases, however, few articles were found through these data bases. I also included ProQuest searches available through the BACB.com. This used the ERIC Searchable Research Database as well as online availability of Wiley publications *Journal of Applied Behavior Analysis, Journal of the Experimental Analysis of Behavior,* and *Behavioral Interventions.*

Along with online searches, I had access to several hardcopy journals identified as flagship journals for the field of behavior analytic practice. I evaluated articles published within the *Journal of Applied Behavior Analysis, Journal of the Experimental Analysis of Behavior, The Behavior Analyst, Journal of Organizational Behavior Management,* and *The Analysis of Verbal Behavior,* none of which yielded relevant articles. No year-based limitations were included in these searches.

Conceptual Framework

In order to best address the concept of self-care, I aimed to investigate several elements of the practitioner in terms of behavior, perception, and motivation. Each of these concepts needed to be framed in a way that would address how self-care practices occur or how these same practices are neglected. The primary and overarching theory that shaped the framework for this research is Orem's theory of self-care (Orem, 1959). The original theory identified nursing staff as primary candidates for chronic self-care deficits, citing challenges related to patient need and job requirements among issues with motivation and support. According to Orem (1959), self-care is a function of demands

that existed when the care of a family member or patient cannot be met thoroughly and support is required to overcome human limitations. More recent definitions of self-care include areas of self-care such as physical, emotional, and mental self-care (Chen, Chien, Kang, Jeng, & Chang, 2014).

Orem's (1959) theory consists of three separate categories related to self-care: theory of self-care, theory of self-care deficit, and theory of nursing systems. The structure of this theory allows for the framework to account for both individual and systems surrounding the individual, with the individual defined as the person of focus within the caregiving relationship. The individual is identified as the primary beneficiary for self-care and the target of problems related to self-care deficits. The theory highlights that the individual actively engages or has deficits in self-care, and that there is an uneven balance between the two. Behaviors related to self-care should increase, whereas behaviors targeted as barriers causing deficits should be actively diminished (Orem, 1959). The system surrounding said barriers must also be addressed, though system is defined loosely within the theory, and relegated to nursing focus.

Throughout much of the psychological literature, systems were mostly defined as either groups of people within a family (Combrinck-Graham, 2014), an organization with individuals in their employ (Mueller & Mueller, 2007; Peirson, Boydell, Furguson, & Ferris, 2011), or a community that may serve as support (Peirson, et al., 2011; Shensul, 2009). Ultimately, the definition of system has overarching implications beyond Orem's (1959) definition of system and is highlighted by the changing definition of system in the current literature. However, Orem's original theory served to expand upon self-care as a

tool for caregivers in other practices. Queiros et al. (2014) outlined the importance of this contribution to the study of self-care, citing the identification of the individual within the system and the system itself as needing self-care. Thus, there is an overarching theme of caregiver preservation as a primer for caring for others in need. In having identified self-care as an important element of caregiver health, there is a need to define self-care as a set of behaviors used by the caregiver to maintain healthy qualify of life. Because the purpose of this study focused on the individual experience of the behavior analyst, a definition of systems was not be necessary at the time.

In addition to the original theory, the 2001 extension of the theory also notes aspects of self-care deficits. Within Orem's self-care deficit nursing theory, 10 factors were identified that impacted or interrupted the engagement of self-care. These factors are conceptualized as basic conditional factors (BCFs), and attribute contextual variables to concerns related to self-care engagement. These factors include (a) age, (b) gender, (c) developmental status, (d) health status, (e) socio-cultural orientation, (f) healthcare system, (g) family system, (h) patterns of living, (i) environmental factors, and (j) resource availability and adequacy (Orem, 2001). This specific aspect of the theory is seen more directly applied to understanding contextual issues around self-care. Kim and Dee (2017) specifically cited aspects related to age, sociocultural orientation, developmental status, health status, and patterns of living in evaluating self-care behavior among women with postpartum depression. These factors are also apparent in studies like Trahan et al. (2011), where researchers informally considered factors related to developmental status, environmental factors, and resources availability and adequacy in

relation to dementia patients. Both studies showcase the flexibility of practical applications in the use of Orem's theory as well as the application of the BCFs.

Overview of Self-Care

Orem's theory of self-care explicitly outlined the nature of self-care among caregivers while highlighting the potential problems with deficits in self-care skills (Orem, 1959). This phenomenon is further outlined by Figley (2001), where evaluations of caregivers with little to no self-care practice experience a variety of emotional, physical, and mental stressors that impact the clinician's quality of care for clients. The implications of self-care deficits are severe enough to warrant investigation into the experience of behavior analysts as a helping profession. Behavior analysts share many characteristics with other helping professions, including exposure to trauma and vicarious trauma, which suggests self-care practice is necessary to maintain quality service.

Self-care is a loosely defined concept within several fields of practice. Generally, this concept refers to an identified caregiver practicing behaviors to ensure that they are well-cared for when they are charged with the care of another individual (Orem, 2001). This can be applied within several fields of practice, including psychology, organizational management, and nursing, where it originated. The development of self-care practice was through necessity, as the nature of caregiving began to show intense strains on the caregivers themselves, resulting in a diminished level of care for those in their charge (Orem, 2001).

Much of the literature found on self-care is often paired with a result of self-care deficits. For example, Figley (2002) specifically addressed compassion fatigue, a

caregiving issue that results in a lack of care for the individual receiving treatment. Pearlman and Caringi (2009) addressed the concept of vicarious traumatization to the caregiver, and how self-care deficits can increase the likelihood of traumatization overall. Furthermore, Mills and Rose (2011) cited problem behavior as it relates to caregiver burnout and demonstrates that those individuals with limited self-care repertoires may display higher rates of burnout in caregiving roles.

However, because self-care is poorly defined within a wide body of literature, there are incomplete or distinctly different definitions across practices. For instance, Vollmer et al. (1992) defines self-care skills as behaviors related to cleanliness and hygiene. This refers to the individual as the caregiver but does little to compare to other definitions of self-care within other practices. The concern with this is that there is a lack of a formal, operational definition for self-care. Godfrey et al. (2011) showcased this clearly, with a meta-analysis that demonstrated significant incongruences among researchers of self-care.

With the literature reflecting the dire need for self-care practice among helping professionals, there was no mention of behavior analytic practitioners within the literature (Babatunde, 2013; Bai, Chiou, & Chang, 2009; Figley, 2002; Godfrey et al., 2011; Richards, Campenni, & Muse-Burke, 2010). Cooper et al. (2007) authored what is considered the seminal textbook for training behavior analysts toward practice and certification but makes no mention of self-care practices. Similarly, there were no ethical standards outlined in Bailey and Burch (2005) nor in the ethics code used by the BACB

(2016). This suggests that language related to self-care is nearly nonexistent in behavior analytic practice.

Despite that concern, self-care is widely discussed as an important behavioral repertoire for practitioners in caregiving roles. Whether there are incongruent definitions or not, the literature that highlights chronic lack of self-care illustrates significant caregiver problems. Through burnout, vicarious traumatization, and compassion fatigue, the need for self-care among caregivers is apparent regardless of definitions. What was even more apparent is that medical and psychology fields recognize this concern and are active in researching this concept. Behavior analytic research has not reached this conclusion, nor has it sought to define self-care outside of activities of daily living, which is the primary motivation behind this study.

Literature Review Related to Key Variables

In order to provide a complete picture of the study in the context, it was critical to understand the practice in which the research was conducted. While the following section included research pertaining specifically to the theory of self-care and implications of self-care deficits, there will be some additional discussion and research regarding the current culture of behavior analytic practice. This addition served to highlight some core deficits in the applications of self-care within the behavior analytic community.

Overview of Behavior Analytic Practice

Behavior analysis describes a wide scope of practice heavily rooted in Skinner's (year) conceptualization of behaviorism. Through Skinner's many works developing a theoretical framework of behavior analytic practice, the application of behavior analysis

in meaningful, socially significant practice has developed into a unique field of practice that incorporates elements of education, psychology, social work, and medical aspects into a global iteration of service. This specific practice involves the science of behavior and can be applied in any scenario where behavior respondent or operant behavior may be present. Historically, the focus of this practice has been the behavior of organisms, which has been reflected within the body of literature. Over the past several years, however, the field has since branched into other areas of practice that include artificial intelligence and robotics, thus further showcasing the large scope of behavior analytic practice.

The common experience of the behavior analytic practitioner focuses on socially significant problem behavior (Baer, Wolf, & Risley, 1968). The goal of behavior analytic practice is to identify and treat problem behaviors that diminish the quality of life for individuals (Cooper, Heron, & Heward, 2007). These behaviors may be deemed socially significant if they impact the community in a negative way, put the person or someone else at risk of health or safety, or result in a restriction of any domain of life (i.e. residential, financial, social, medical; citation). The practitioner is charged with developing interventions to change these problematic behaviors while developing and teaching replacement behaviors to develop a more socially appropriate repertoire.

The environment in which the behavior analytic practice can vary as well. Per the ethical code, service should be rendered where problem behaviors are actively occurring (BACB, 2016; Bailey & Burch, 2013;). This means a behavior analyst can work in the home, community, clinical based settings, school environments, organizational settings,

or even forensic settings. The intervention of the practitioner would be individualized within that setting and focus on the behaviors requiring active treatment. Within the environment, interventions are designed and taught to caregivers for direct instruction to the client receiving services. For example, in Michael (1959), nurses were trained as behavioral engineers to implement behavior treatment within a medical environment. This same treatment model has been adopted for current practice, though the behavioral technician (formerly behavioral engineers) can include any number of caregivers or interventionists. Add summary and synthesis to fully conclude the paragraph.

Along with active treatment and wide scope of practice, a primary characteristic of behavior analytic practice is the use of evidence-based practice and data driven decision making (Cooper et al., 2007). Behavior analytic practice hinges most treatment decisions on data collected within the environment. These data provide a visual display of behavioral trends over the course of treatment, which in turn highlight the effectiveness of interventions as they are implemented. This defining feature of behavior analytic practice allows the practitioner to make real-time decisions based on specific behavioral trends or behavioral responses to medical interventions or life events. For example, changes in medication can result in steep behavioral changes. Close analysis of behavioral data can help behavior analytic practitioners collaborate with prescribing physicians to adjust medication doses to more effectively impact behavior.

Despite the broad scope of behavior analytic practice demonstrated here, there are significant deficits in the theoretical framework that yield itself to other practical challenges. Skinner (1938) set a foundation of practice that focuses solely on behavior as

a central measure for practice. This definition of practice removes concepts related to emotion, cognition, or other more advanced psychological concepts. What this meant for behavior analytic literature is limited in scope related to these more complex and nebulous concepts. While the current behavior analytic culture recognized emotions and cognition as private events, the limit remained in the conceptualization of behavior as a foundational element of practice. This conceptualization rules out complex human psychology to some degree, thus resulting in a limit to study on mental health. This specific issue is what led me to the topic of self-care among behavior analytic practitioners, which is discussed in more depth further on.

Overall, behavior analytic practice is like that of other fields in terms of purpose and environment. Ultimately, the focus on behavior change clearly demonstrates a specific theoretical framework with which behavior analytic services are rendered. It is this specific focus on behavior that both expands the scope of active practice but limits conceptualization regarding emotion or cognition. With firm roots in behaviorism, there is a clear foundation of intervention, with goals of treatment specific to socially significant problem behavior. Data analysis serves as a foundational characteristic of the practice and defines behavior analytic practice as a separate field compared to psychology, medical, or educational fields. Despite an extensive body of literature for the effectiveness of interventions and a clearly defined practice, there is a large gap related to self-care practices among the behavior analyst. This gap demonstrates how behavior analytic practice has not yet begun to conceptualize more complex psychological concepts within the behavior analytic framework.

Review of the Research Literature

Current literature regarding self-care skills among practicing therapists was limited compared to other areas of research, such as intervention or measurement literature. Additionally, research on self-care was often closely paired with either effects of self-care deficits (Figley, 2002; Richards, Campenni, & Muse-Burke, 2010) or as a co-topic with vicarious traumatization (Hunter, 2012; Pearlman & Caringi, 2009). Other articles also highlighted self-care skills among caregivers, though the subjects of the studies actively practice in nursing settings as a primary career rather than psychological practice (Babatunde, 2013; Guidetti & Tham, 2002). Abundant research was found regarding nursing staff and direct caregivers that showed effects of maladaptive self-care behaviors (Babatunde, 2013; Filey, 2002; Mills & Rose, 2011; Orem, 2001) However, little was found on behavior analysts in terms of self-care practice, nor was much research found regarding the actual self-care practices of therapists within psychological practice. This presented a challenge finding articles solely focused on self-care techniques and training among therapists working in psychological practice. Furthermore, research extended into behavior analytic practice was sparse in regard to self-care skills among therapists.

A major challenge to identifying self-care skills among behavior analytic professionals in the literature had been the objective definition of self-care. While Orem's (2001) theory clearly defines self-care skills in caregivers, behavior analytic literature identifies self-care skills as skills related to daily living or hygiene of the client (Remington, 1998; Trahan, Kahng, Fisher, & Hausman, 2011; Vollmer, Iwata, Smith, &

Rodgers, 1992). This confusion was also apparent in some research as self-care behavior is often studied in terms relation to a skill deficit in individuals with chronic illness or injury resulting in an increased need for self-care in the absence of caregivers (Bai, Chiou, & Chang, 2009; Trahan et al. 2011).

There are discrepancies in the self-care literature when analyzing the current body of research in different subject areas such as psychology, healthcare, and behavior analysis (Bai, Chiou, & Chang, 2009; Orem, 2001; Vollmer et al., 1992). Based on the subject matter of the literature, there are three basic descriptions of self-care skills determined by the subject of the self-care practice: those who engage in self-care, motivations of self-care, and self-care among healthcare providers (Godfrey et al., 2011). Godfrey et al., (2011) outlined several distinct factors found within self-care research that included content related to seven distinct aspects of self-care. Overall, there appear to be some definitions that focused on general outcomes, while others focused on either ability or health. Some research focused on the performer of self-care and included caregivers as well as health care professionals, while other research focused on the action itself. For example, Mills and Rose (2011) focused on the impact of chronic self-care deficits among caregivers working with individuals with special needs and significant problem behavior. The goals here focused primarily on how to improve rates of burnout among caregivers in working with this population. Kim and Dee (2017) included focused goals on improving symptoms of post-partum depression among an underserved population, while Guidetti and Tham (2002) oriented goals toward occupational therapists and how they engage in self-care practices within the realm of their own practical experience.

Regarding self-care outcomes, there does not appear to be a consistent consensus on outcomes, but rather outcomes are driven based on the need of the targeted caregiver.

In addition to these factors, some research focused on the healthcare system as a whole, with focus on training and practice within an entire field. Overall, a total of 139 separate studies published between 1976 and 2009 included distinctly separate definitions of self-care skills (Godfrey et al., 2011). Of these studies, the World Health Organization (2009) published a total of seven reports that each included different aspects of self-care.

There are also some definitions provided by the World Health Organization that specify levels at which self-care occurs: individual, family, and community levels (World Health Organization, 2009). Within the definition of these levels, there were notations of physical fitness and mental health on the individual level, support on the familial level, and minor mention of community resources to enable self-care in the community. Similar definitions can be found in operational definitions across self-care research. This was overtly highlighted in the Godfrey et al.'s (2011) meta-analysis that highlights varying definitions. Orem's (2001) theory specifically describes self-care in terms of community resources as part of the nursing systems element, whereas Vollmer et al. (1992) define self-care using a more molecular analysis of behavior rather than total task descriptions or systems change discussions.

Specific to the Topic or Research Question: Definitions of Self-Care

The current literature regarding self-care includes multiple definitions without a formally agreed upon operational definition. Godfrey et al. (2011) reviewed 139 separate definitions of self-care across several decades. Within these definitions, however, general

themes of care emerged and were expressed. Based on the definitions reviewed, the following aspects of self-care were described:

1. *Aspects related to health*: Some definitions included specific information about the health of the caregiver, though the definition changed from health promotion to risk prevention, which shifted the primary focus of self-care practices. Definitions with this characteristic accounted for 48% of the total definitions. Some examples of this can be found in Chen et al. (2014) and Bai et al. (2009). In these studies, the primary focus is related to health related behaviors centralized around caring for type 2 diabetes.
2. *Aspects related to illness or disability*: Definitions that included this aspect would include mention of the illness, diagnosis, or symptoms being cared for by the caregiver. Definitions with this characteristic accounted for 51% of the total definitions. Regarding this aspect, there are many studies that reference self-care to a specific illness (Chen et al., 2014; Reimers & Vance, 1995; Rivas et al., 2014). Other studies also reference specific disabilities (Mills & Rose, 2011; Vollmer et al., 1992) The discrepancy here is that while the illness or disability are noted, there is no designation as to whether the carer is the one engaging in the behavior, or if the caregiver of the individual is engaging in self-care. This is apparent in the Mills and Rose (2011) where the focus is care for individuals with disabilities, but the subject is the direct care staff and not the individual

with the disability. In contrast, Chen et al. (2014) focuses on the individual with the illness engaging in care behaviors related to their own care.

3. *Aspects related to general outcomes*: Within this aspect, definitions included an overview of the purpose of self-care, though many of the definitions included in this area were considered to be vaguer than others due to generalization. Definitions with this characteristic accounted for 4% of the total definitions. Many of the studies found with this aspect refer to concerns with caregiver outcomes (Mills & Rose, 2011), outcomes of the organization from training (Kissel et al., 1983), or outcomes from the client (Dean et al., 1986; Kemper, 1980; Reimers & Vance, 1995). Furthermore, some studies focus on the outcomes within the organization in general (Mueller & Mueller, 2007; Peirson et al., 2011). As mentioned above, there is not a formal consensus on general outcomes of self-care, but rather a focus on the caregiver's specific needs. For instance, some studies focus on the how burnout can be reduced with self-care among caregivers (Mills & Rose, 2011), while others focus on engagement of self-care following training (Kissel et al., 1983). Common outcomes include how well a client is taken care of or how well they can implement necessary self-care practices regarding specific medical procedures) Dean et al., 1986, Kemper, 1980, Reimers & Vance, 1995; Vollmer et al., 1992). Regarding general outcomes, it appears that many of the goals related to self-care are individualized to the target of care.

4. *Aspects related to the performer of self-care*: These definitions included specific information regarding who engages in the behaviors labeled as self-care as well as responsibility of the self-carer and the self-carer as the target of care. Definitions with this characteristic accounted for 38% of the total definitions. This specific aspect varies based on the role of the self-carer, which makes this aspect somewhat complex. For instance, Guidetti and Tham (2002) highlights how occupational therapists engage in self-care and conduct training in this arena. The primary focus here is the professional as a self-care performer. In this study, occupational therapists were interviewed and asked to describe their experience teaching self-care skills to clients who had suffered significant injuries or medical trauma. The focus was not the occupational therapist regarding self-care, but rather how they taught self-care to the individual in need. Some studies primarily focus on the outcome of therapists in relation to vicarious traumatization and self-care (Hunter, 2012; Pearlman & Caringi, 2009). Hunter (2012) explores the concerns related to how practitioners can reduce the impact of vicarious traumatization by improving therapeutic bonds with individuals in their care. Pearlman and Carinigi (2009) focused more on mindfulness and self-awareness as a tool to reduce the adverse effects of vicarious traumatization. In both studies, the focus is on tools the practitioner can use as a type of self-care intervention to reduce problematic effects related to exposure of considerably adverse treatment variables. The primary

participants here are, again, professionals, but the study itself is framed differently. A third example here includes Vollmer et al. (1992), which focuses on the patient as the performer. The goal of this article was to demonstrate how a treatment package could impact the behavior of a client in the practitioner's care. The goal was to reduce problem behaviors related to aggression and self-injury while simultaneously improving behaviors related to activities of daily living. However, the definition of self-care in this article reflects activities of daily living and not commonly cited definitions of self-care found in the Godfrey et al. (2011) study. Finally, the example of Shore (2001) note individuals who do not identify as professionals caring for others, which adds another sub-aspect of who the carer is regarding this specific aspect. The goal of this study was to focus on those individuals who are in need of care, but may need to develop independent self-caring skills to reduce the impact on available resources and improve independence.

5. *Aspects related to the action of self-care:* Definitions in this group were specific to behaviors of self-care rather than focusing on outcomes, targets, or performers themselves. Instead, information was specific to what self-care behaviors look like. Definitions with this characteristic accounted for 41% of the total definitions. Within these studies, there appears to be some overlap with determine who is engaging in the behavior. Literature pertaining to this aspect focus specifically on defining

behaviors related to illness/disability, therapist actions, organizational changes, or carer behaviors directed at individual care (Chen et al., 2014; Mueller & Mueller, 2007; Pearlman & Caringi, 2009; Vollmer et al. 1992). For example, Chen et al. (2014) specifically focuses on behavioral outcomes related to self-care behaviors in outpatient clients with type II diabetes and comorbid diagnose. Using self-efficacy measures, the study found that individuals with comorbid diagnoses struggled with maintain adequate self-care routines, showing that there is a possible link between comorbidity and deficient self-care skills. Mueller and Mueller (2007) focused on a recovery model that eliminated systems based approaches and incorporated client and patient self-care focus to improve outcomes within an organization as well as for therapists and clients. This focus included individualized outcomes of self-care among those providing and receiving treatment. These articles are both similar to the Vollmer et al. (1992) study that demonstrates individualized behavioral focuses for the caregiver and client alike. As mentioned above, this article focuses primarily on behavior-based outcomes specific to client needs rather than generalized self-care outcomes.

6. *Aspects related to healthcare professionals*: This particular section of definitions included the performer, but designated definitions based on the role of the performer as well. Since self-care can include family caregivers as well as professionals, these definitions were specific to the healthcare

provider. Definitions with this characteristic accounted for 28% of the total definitions. Where this aspect is unique relates specifically to the subject matter, and serves to highlight the significant deficit at the core of this study. The majority of studies that focus on the healthcare processional also tend to focus on a specific problem rather than the actual engagement of self-care behaviors (Figley, 2002; Mills & Rose, 2011; Pearlman & Caringi, 2009; Richards et al., 2010). For example, Figley (2002) frames the engagement of self-care around psychotherapists, effectively meeting the aspect listed here. However, the focus of the psychotherapist is secondary to the overall problem, which would be compassion fatigue as a result of self-care deficits. This same concern can be seen in the Babatunde (2013) article, which focuses on occupational stress among individuals within the workforce. Pearlman and Carinigi (2009), as mentioned above, specifically notes that mindfulness and self-reflection has the potential to diminish adverse variables related to caregiving, and ultimately improve self-care repertoires. Overall, research in this specific aspect of self-care remains grounded elements of the practitioner related to the tools used within practice and deficient caregiving skills as well as effects of self-care engagement and deficit. While this overlaps with the aspect related to action, behavioral definitions remain secondary compared to the focus on the caregiver and effects of self-care practices related to the caregiver.

7. *Aspects related to the healthcare system*: Of the definitions included in the analysis, few included any information about how self-care impacted or operated within a healthcare system. While these definitions referenced the provider, the provider was framed within the context of the system. Definitions with this characteristic accounted for 5% of the total definitions. Mueller and Mueller (2007) highlights this aspect specifically, but adds the therapist and client layer into the organizational change, though the focus is still individualized. The overarching goal of this article is how using recovery models of practice can impact the care outcomes of the organization and residual effects of other participants within the organization through individualized self-care practices. Kissel et al. (1983) also focuses on how the organization can impact self-care for staff, and specifically cite client and professional impact within the organization. Peirson et al. (2011) includes an overview of a systems change approach, with a focus on ecological variables that may drive outcomes for organizational change. With a focus on psychological factors that impact the community, the ecological change proposal was designed to incorporate self-care practices among those the organizational change would impact directly. This specific aspect is not as well researched with specific regard to self-care due to the individual nature of self-care practices. Because this aspect is less accounted for per Godfrey et al. (2011) as it pertains to self-care, more of the research in this area focuses

> on organizational outcomes and overall burnout. Babatunde (2013) highlights this aspect and frames the research in a way that relates the individual to the organization, specifically regarding occupational satisfaction and occupational burnout.

In discussing the aspects of the definitions further, the research had found that the current operational definitions of self-care include only some of the above aspects rather than all of the aspects. No articles within Godfrey et al. (2011) were found to include each aspect listed above, though many of the definitions included more than one aspect.

Additional Research on Self-Care

As highlighted in Godfrey et al. (2011), one of the major challenges with researching self-care was in the definition itself. Despite the discrepancies in self-care literature, there appears to be an overarching concern with results of diminished self-care. The current body of literature consistently outlined definitive results of little to no self-care practices among psychology professionals and caregivers (Figley, 2002; Mills & Rose, 2011; Pearlman & Caringi, 2009). Additionally, previous literature on self-care indicated definitions specific to caregiving roles rather than roles related to psychological practice (Dean, Hickey, & Holstein, 1986; Gantz, 1990; Kember, 1980; Orem, 1985).

Much of the empirical discussion on self-care revolved around the impact of self-care deficits among caregivers, specifically citing occupational stress (Babatunde, 2013), compassion fatigue (Figley, 2002), vicarious traumatization (Pearlman & Carinigi, 2009), and burnout (Mills & Rose, 2011). These concerns appeared in literature across professions, with Orem's (2001) theory of self-care citing these challenges within the

nursing profession and multiple articles found within psychological research (Chen et al, 2015; Godfrey et al., 2011; Guidetti & Tham, 2002; Pearlman & Caringi, 2009). Ultimately, the concern with diminished self-care repertoires was directly related to well-being of the caregivers in practice regardless of profession (Godfrey et al., 2011; Levin, 1976; Shore, 2001).

In addition to research on self-care deficits, there was significant research on developing and maintaining self-care repertoires to enhance practice and prevent the previously discussed concerns (Chen et al., 2014; Guidetti & Tham, 2002; Mueller & Mueller, 2007; Queiros et al., 2014; Richards et al., 2011). In several different studies, the outcome of teaching self-care skills with varying definitions resulted in desired outcomes for those in care. For instance, increased training of self-care behavior in older patients with type II diabetes resulted in less medical oversight (Bai et al., 2009). Among occupational therapists, training in self-care resulted in less burnout and maintained self-care skills across different therapists (Guidettie & Tram, 2002). Among those diagnosed with intellectual disabilities, caregivers continued training self-care repertoires to improve daily health and wellness behaviors (Kissel, Whitman, & Reid, 1983). Within psychological practice, active work on developing self-care behaviors resulted in maintaining effective work among psychological professionals working with victims of trauma (Pearlman & Caringi, 2009). The driving outcome behind self-care practices was to continue effective care for those who are seeking help across a variety of different professional services and to ultimately maintain the health and wellness of the caregiver.

This may be fairly evident in the varietal body of literature on self-care despite the inability of the scientific community to clearly define self-care behavioral repertoires.

Self-Care in Practice

The general impact of self-care had been discussed at length and studied regularly. In evaluating the concept of self-care, it is clear that there are multiple facets to highlight to formulate an adequate understanding of the topic. As discussed in Godfrey et al. (2011), defining self-care is difficult at best. However, there are some clear examples of how self-care was used in practice. Practical self-care and its utility can be highlighted in many of the articles evaluated on the topic.

For instance, Kim and Dee (2017) illustrated the utility of understanding developing self-care practices regarding health in a specific vulnerable group. This study noted that this is the first study using Orem's theory of self-care among rural Hispanic women suffering from postpartum depression. Rather than studying the impact of self-care, this study focused primarily on what factors contribute to self-care and self-care deficits, finding specifically that using BCFs as a framework for determining self-care barriers can be an effective evaluative protocol.

Other articles, such as Mueller and Mueller (2007) indicated that self-care is less about the carers but more about systematic organizational change. Through discussing important systems changes, Mueller and Mueller (2007) demonstrated where self-care roles can be improved for patients and therapists alike, which in turn impacts the organization at large.

Godfrey et al. (2011) was thorough in the description of self-care in practice, with a meta-analysis that covers 139 studies regarding self-care. This study alone showcased the strength of self-care language within the nursing and psychology practice, and demonstrates how descriptive self-care practices can be. Additionally, this study went on to describe multiple aspects of self-care outlined earlier in the chapter. these definitions specified different elements of self-care, including who should engage in self-care and what self-care practices entail. Throughout the research, caregivers were designated as therapists, nurses, family members, and even organizations. Despite these broad and inconsistent definitions, however, behavior analytic practitioners were not included. In the current body of literature, there are clear discrepancies between how self-care is defined, and behavior analytic practice makes no mention of self-care in the same regard as psychological research. Of the definitions highlighted in Godfrey et al. (2011), there were no mention of behavior analytic practice or the behavior analyst in a helping profession capacity. This appeared to be a glaring gap in the research regarding the behavior analyst and self-care practices.

Effects of Self-Care Deficits in Among Caregivers

Throughout the literature, there appeared to be a larger theme regarding the impact of self-care and self-care deficits specifically. Where Godfrey et al. (2011) showed the discrepancies across definitions and aspects of self-care, many of the articles reviewed here highlighted the clinical concerns related to a breakdown in self-care repertoires.

Studies that focus on caregivers with individuals with special needs highlight high rates of caregiver burnout and illustrate the varying effects of chronic self-care deficits (Cebula, 2012; Mills & Rose, 2011). Cebula (2012) presented unique information about caregiver burnout present in siblings in treatment with children with autism. In this article specifically, there was no reference to self-care behaviors, but rather that treatment outcomes in the home, including negative emotional effects related to sibling interaction. Similar findings in Mills and Rose (2011) showed a trend regarding problem behavior and caregiver burnout, where caregivers within this setting who are regularly exposed to aberrant behavior have higher rates of burnout.

This trend was apparent in other clinical experiences as well, where practitioners who are exposed to high need care for individuals may experience compassion fatigue or burnout (Babatunde, 2013; Figley, 2001; Hunter, 2012; Pearlman & Caringi, 2009). Figley (2001) specifically referenced compassion fatigue where self-care is lacking. Some of the impacts noted in this study include a diminished quality of care for clients in the care of the suffering therapist, ethical impetus to change self-care practices, and potentially dangerous clinical errors. In Hunter (2012), findings indicated that self-care plays a role in improved therapeutic relationships. More specifically, Hunter (2012) noted aspects of the therapeutic alliance that are improved as a result of better therapist caregivers, including increased empathic responses and role importance.

The impact of this literature highlighted the problem of deficient self-care practices among caregivers. Ultimately, a missing or deficient self-care repertoire has resounding impacts for the caregiver, relations to the caregiver, individuals within the

caregivers' care, and the organization in which the caregiver practices. Many of the articles here highlight individual impacts, but demonstrate how self-care deficits do not impact the caregiver alone. While the primary effect of self-care is specific to the individual lacking self-care behaviors, the secondary effects of self-care deficits are often interlaced with other individuals, most of those individuals being someone in the care of the practitioner.

Self-Care in Behavior Analysis

There were glaring discrepancies in discussions of self-care regarding behavior analysts and behavior analytic practice. Godfrey et al. (2011) discussed seven unique aspects of self-care, with the aspect of the action of self-care noted as one of these aspects. Where behavior analytic research is concerned, the action of self-care is paramount. This was consistent with behavior analytic training, where the focus of behavior and environmental factors play roles in how behavior is changed. The effects of self-care behavior analysis are typically measured in terms of observable and measurable events within the environment. Similarly, the self-care aspect of behavior analysis framed the client as the caregiver, which ultimately leaves gaps in research regarding the practitioner themselves.

Vollmer et al. (1992) focused specifically on procedures to impact behavior in two specific ways. A primary effect of the procedure was to reduce problem behavior, whereas the secondary effect is to improve self-care behaviors. The use of differential reinforcement in this study is a useful treatment protocol in practice, and self-care skills

for the participant are directly impacted. To elaborate, there was a clear increase in self-care behaviors such as tooth brushing or hygiene maintenance.

Trahan et al. (2011) was another example of self-care in behavior analytic research where self-care is specific to activities of daily living related to client outcomes. As with the Vollmer et al. (1992) article, the same themes were apparent. Client engagement of activities of daily living serve as the only reference to self-care within the research. This particular study was a meta-analysis that references self-care techniques, but does not overtly research self-care in dementia patients.

In line with the theme of self-care among practitioners, an article referencing self-care among behavior analytic practitioners was written by Sundberg (2016). This publication served as a call to action to behavior analysts to evaluate stress in the workplace, but does not formally address self-care behaviors among behavior analytic practitioners.

In regard to this literature, there was a clear distinction on how self-care is perceived in behavior analytic practice. Whereas Orem's theory is specific to caregiver repertoires, the behavior analytic literature here most often references activities of daily living, which serve as a small portion of the self-care repertoires. This focus on activities related to daily living highlighted two important elements of the behavior analytic perspective on self-care. First, the focus on behavior was limited to narrowly defined repertoires of behavior, primarily those related to socially significant behavior. This focus, while important in the treatment setting, showed where practitioner resources are often delegated in daily practice. The second element here was that the behavior analytic

literature was not practitioner focused regarding self-care behavior. In each of the studies, the focus had been an individual in care. While there was a distinct need for this type of research, there was an inherent gap within the studies as they are written. The subjects of the studies were individuals in care, but the interventions require caregivers to implement these procedures, behavior analysts to implement or train these procedures, and researchers to evaluate these procedures. However, the focus did not fall on the practitioner or caregiver within these contexts. This last implication provided a clear perspective on the focus and definition of self-care repertoires within behavior analytic publications.

Behavior Analyst Training and Ethics

As mentioned in the beginning of the chapter, a critical element to this study was understanding self-care in the context of behavior analysis. Since the current study was designed to explore the behavior analytic practitioner, context about the state of practice, training within the field, and ethical considerations regarding behavior analytic practice add an important dimension to this study.

With the current body of self-care literature including a variety of caregiver roles across several areas of practice, there appeared to be a lack of self-care discussion within the behavior analytic realm. This was evidenced by evaluating the training and ethics within behavior analytic practice as well as the term “self-care” within the behavior analytic context.

Beginning with the *Professional and Ethical Compliance Code for Behavior Analysts,* there was an extensive discussion on how behavior analytic practice should

occur (BACB, 2016). Within this document, there are ten distinct areas of professional and ethical competence with which the behavior analyst should conduct themselves. Per the BACB (2016), these areas are broken down as follows:

1. Responsible Conduct of Behavior Analysts
2. Behavior Analysts' Responsibility to Clients
3. Assessing Behavior
4. Behavior Analysts and the Behavior-Change Program
5. Behavior Analysts as Supervisors
6. Behavior Analysts' Ethical Responsibility to the Profession of Behavior Analysts
7. Behavior Analysts' Ethical Responsibility to Colleagues
8. Public Statements
9. Behavior Analysts and Research
10. Behavior Analysts' Ethical Responsibility to the BACB

Within this specific code of conduct, there was no overt discussion of self-care practices as a behavior analytic professional. While some codes speak to ethical responsibilities, others speak to legal areas of consideration and principles of behavior analytic practice. Throughout the brief document, there was no discussion regarding self-care. In lieu of discussion of behavior analysts' responsibilities to their well-being, the code discussed assurances for client care and maintaining empirically supported practice. Additionally, several codes explicitly stated ethical responsibilities for reporting ethical violations and specific reporting measures.

A second framework that highlights behavior analytic training can be found in the *Fourth Edition Task List*, which established the areas of professional competence a behavior analyst should develop during their training and supervisory periods. This current task list included three specific areas of practice, which are then broken into sub-sections. These sections included Basic Behavior-Analytic Skills, Client-Centered Responsibilities, and Foundational Knowledge. Within each section, there is a list of specific competencies related to the primary section, totaling 173 minimum competences for the current behavior analyst (BACB, 2016). As with the conduct code, however, there was no discussion of self-care among any of the listed subcategories.

To further illustrate the lack of self-care discussion within behavior analytic practice, references were made to the current ethics handbook. Baily and Burch (2013) was currently the primary ethics reference for behavior analytic professional practice in terms of guidance for specific ethics scenarios. Within this book, specific situations were described and ethical outcomes are discussed as a means to illustrate several potential outcomes for ethical dilemmas that may arise within the field. However, this reference did not specifically account for self-care, nor did it reference burnout among behavior analysts. Instead, the scenarios were often tied back to task list items or to the professional behavior code, both of which lack self-care verbiage.

Finally, training for behavior analysts was determined and accredited by the BACB in order to ensure uniform training across global programs. The BACB determines the specific type of training and hours required for certification prior to certification exams, and accredits university programs based on specific content areas.

According to the most recent course content allocation from the BACB (2016), a master's level BCBA will complete a total of 270 classroom hours of graduate level instruction with coursework in the following content areas:

1. Ethical and Professional Content: 45 hours
2. Concepts and Principles of Behavior Analysis: 45 hours
3. Research Methods in Behavior Analysis:
    a. Measurement (including Data Analysis): 25 hours
    b. Experimental Design: 20 hours
4. Applied Behavior Analysis:
    a. Fundamental Elements of Behavior Change & Specific Behavior Change Procedures: 45 hours
    b. Identification of the Problem & Assessment: 30 hours
    c. Intervention & Behavior Chance Considerations: 10 hours
    d. Behavior Chance Systems: 10 hours
    e. Implementation, Management and Supervision: 10 hours
5. Discretionary: 30 hours

Based on the allotment above, behavior analytic coursework may allow self-care training to occur during the discretionary hour allotment. This is not a requirement, however, and because the field remains characterized by empirical support and influence, the lack of behavior analytic research on self-care may limit any potential training in self-care. Similarly, the limited amount of discussion regarding stress or burnout under the behavior analytic modality may limit the scope of behavior analytic research. Sundberg

(2016) commented on stress in an online article, noting that behavior analysts may be susceptible to common workplace stressors, however, the article itself only cites two references, both of which come from non-behavior analytic journals.

Research on Methodology

To further support the selection of the research methodology here, I have included several studies regarding phenomenological studies and IPA. In particular, the primary structure of this study is designed based on the methodology used by Cacciatori (2017). This study focused on exploring the experience of men attracted to minors and how they specifically sought therapy behaviors. This study paralleed the study described here in that a small group of participants are selected to understand their experience regarding a specific set of behaviors. The design of the study was a semi-structured interview, which can be described in Chenail (2011) as an effective method for gathering nuanced variables related to experience.

The IPA method of data analysis is described in several studies, which demonstrates the utility of the data analysis method. Omari, Razeq, and Fooladi (2016) applied this methodology to understanding the experience of rites of passage among Jordanian adolescent females with specific contexts surrounding menstruation. Conversely, Krause-Parello and Morales (2018) used IPA as a means to understand the experience of veterans with trained military dogs and their experience as it relates to this specific relationship. These examples highlight the utility of this method across age groups, cultural considerations, and specific behaviors.

Synthesis of the Research Findings

Following an extensive review of the literature on self-care, there were several themes that were apparent specific to those working in helping professions. Similarly, there was a specific emerging theme related to behavior analysts as practitioners. First, there was no consistent definition of self-care within the research. Godfrey et al. (2011) conducted a meta-analysis that showed a total of 139 distinct definitions of self-care across several decades. The inconsistent definition of self-care presents specific challenges, however, there is a general theme of self-care. Typically, definitions of self-care included previously mentioned aspects of self-care involving daily living skills, emotional well-being, or general descriptors of care, but each definition included a mixture of the aforementioned characteristics. This ultimately eliminated any formal consistency (Dean, Hickey, & Holstein, 1986; Dean & Kickbusch, 1995; Godfrey et al. 2011; Orem, 2001)

A second trend found was that there is sufficient evidence that self-care deficits lead to more serious concerns with practice long-term. Research on chronic lack of self-care indicated several specific effects related to the quality of care, mistakes made during care for individuals receiving services, diminished compassion among practitioners, and diminished quality of life for the practitioner themselves. There was ample documentation on how lack of self-care is a chronic problem among healthcare practitioners (Godfrey et al., 2011).

A third trend was that there is some research on the performer of the behavior, with specific definitions that included the healthcare provider as a performer of self-care.

However, within the literature, there was no mention of the behavior analyst as a professional, a performer of self-care, or even specific, objective definitions of self-care behavior. Instead, mentions of caregivers included practicing nursing staff, psychological practitioners that include counselors, and family members caring for loved ones (Figley, 2002; Godfrey et al., 2011; Hunter, 2012).

Throughout the review of current literature, there was a significant deficit in discussions related to the behavior analyst as a professional. The closest approximation to the behavior analyst described in the literature was the psychological practitioner, which does not accurately represent behavior analytic practice. A close analysis of the current literature also suggested that there is no consistent definition of self-care. This is a significant barrier to future research in the field of self-care. With varying definitions of both self-care practice and caregivers, the current body of literature in self-care was inconsistent at best. Despite this inconsistency, there was a large supporting body of literature that shows chronic problems with self-care deficits. The implications of diminished self-care practices show critical need in developing self-care behavioral repertoires across caregivers as a general rule. The behavior analyst as a professional easily fell within the loose definitions of caregiver within the literature, and as such, self-care practices apply accordingly. However, there was a distinct gap within the current body of literature that applies directly to the behavior analyst as a professional.

Summary

There appeared to be significant discrepancies in defining the nature of self-care (Godfrey et al., 2011). The primary finding in the literature was that there was no

agreement on what self-care means in terms of who is engaging in self-care or what behaviors are present in self-care practices. As stated in Godfrey et al., (2011), there were 139 distinct definitions of self-care that include the patient, the caregiver, and the organization, among other participants. These discrepancies showcase the lack of focused self-care definitions and practice across disciplines.

The second finding from the literature was that despite the extensive though incongruent literature on self-care in psychological research, there is no definition of self-care practices that clearly falls in line with psychological definitions. Indeed, definitions of self-care in behavior analytic practice reflected behaviors related to hygiene, daily living, or medical care (Kissel et al., 1983; Reimers & Vance, 1995; Rivas et al., 2014)., It appeared that self-care practices as defined in Godfrey et al. (2011) are non-existent within behavior analytic practice.

The most critical concern found in the literature specifically encompassed the glaring lack of research in the behavior analytic arena regarding self-care. Godfrey et al. (2011) showed extensive research on the definitions of self-care, which did not include behavior analytic practice. Several articles in this review cited concerns related to lack of self-care practices within therapeutic practice (Babatunde, 2013; Hunter, 2012; Richards et al., 2010). In the following chapter, I outlined the research methodology that was used to explore the experience of behavior analytic practitioners regarding self-care.

Chapter 3: Research Method

Introduction

The purpose of this phenomenological qualitative study was to explore the self-care practices among certified behavior analytic professionals. It was my aim to better understand behavior analysts in regard to self-care practices, especially in light of the intense, day-to-day experiences of the typical behavior analyst. Chapters 1 and 2 provide an overview of the study, while the literature review spans the seminal research along with current literature to showcase the need for this study. The self-care experience among behavior analysts is unknown currently, presenting a unique research opportunity. Because behavior analysts experience intense problem behavior within their own practice on a regular basis, there is cause for exploration regarding self-care practices. The current research suggested that individuals who work with individuals with special needs or those who practice with a high level of care need are more likely to display chronic self-care deficits, resulting in adverse effects on their own quality of life, job satisfaction, and well-being.

This chapter will expand on the methodology by covering (a) purpose of the study, (b) assumptions and rationale for qualitative design, (c) target population and participant selection, (d) procedures, (e) instruments, (f) research questions and hypotheses, (g) data analysis, (h) ethical considerations, and (i) expected findings.

Research Design and Rationale

Phenomenological designs are used with the intent of developing a better understanding of specific phenomena through the lived experience of the phenomena's

participants (Moustakas, 1994). Essentially, this type of study is used to develop further knowledge about unknown or minimally understood phenomena of the human experience. Because the research question informing this study is designed to explore the experience of the behavior analyst's self-care practices, a phenomenological study was the most appropriate design.

The design of this study yielded narratives from practicing behavior analysts about the perception and practice of self-care within the behavior analytic field. Through collected stories, shared insights, and collaborative discussions about behavior analytic practice, I was able to establish a better understanding of the nature of self-care among behavior analysts. The singular research question of "how do currently certified behavior analysts engage in self-care practices?" is inherently expansive. The exploratory nature of phenomenological research designs is the best fit for the research question and to discover more about this particular concern within the field of behavior analysis.

For this study, I used the IPA to explore the experience of the behavior analyst in practice. Smith et al. (2012) described this type of analysis as a means by which a researcher can better understand the participants experience through exploration and interpretation of lived experience. IPA focuses on the individual's specific experience, rather than generalized experiences, thus providing a deeper exploration of the perception of the participant. It is understood that the complete experience may not be synthesized through this type of analysis, though a more complex picture of the experience may be developed through individual analysis and comparison to group norms.

Role of the Researcher

For this study, I was the only researcher. This established me as the singular data collection instrument included within this research. As the only instrument for collecting data, I was also the sole interviewer for participants in the study as well as the only data interpreter. As stated earlier in the study, the interviews are designed to be semistructured.

I did not have personal or professional relationships with participants within this study, which eliminates any concerns with dual or multiple relationships. This aligned with the BACB (2017) ethics code for research. Additionally, I had no history in the research environment. Incentives were not established for this study, so participants were not reimbursed for their participation.

Based on the design of the study, there was an expectation of lengthy interactions with the participants. As a participant observer, there was an inherent bias and potential shared experience with the participants, which may impact the role of the researcher as an instrument for data collection. I recognized my personal and professional biases as well as my lived experience regarding self-care. As a practitioner who currently works in crisis-level behavior management, the need for self-care is high. My experience as a behavior analyst is uncommon among the field, with a limited amount of behavior analysts actively working in crisis management regularly. Additionally, with exposure to self-care practices as part of this study, there was a bias toward active engagement in self-care. Steps to address these biases and remain balanced in this research were established

in the discussion of trustworthiness. Reflexive journaling was used to maintain a record of personal and professional biases through the duration of the study.

Methodology

Participant Selection Logic

The target population for this study consisted of individuals who meet the criteria as currently certified master's level behavior analysts working within the United States. These individuals were currently certified through the BACB as a BCBA. Given the design of the research and the nature of the research question, purposive sampling with a focus on a homogenous group was used to gather participants. By using purposive sampling, I gathered a specific group of individuals who met the inclusion criteria for the research and likely shared similar professional training. This sampling method also lended itself to data that are more consistent with the aim of the research, which would be to understand how self-care practices occur within this population (Bitsika & Sharpley, 2012; Olson, Leko, & Roberts, 2016).

I reviewed all applicants who submitted to participate through the BACB email invitation to ensure that they meet inclusion criteria. The review process included a verbal confirmation of the applicant's certification and work history. I sent via email to inform the applicants who did not meet the inclusion criteria that they were not be asked to participate in the study. This form can be found in Appendix A.

Inclusion criteria for participants within the research include these primary characteristics:

- Participants in the study must be currently designated as a BCBA through the BACB.
- Participants must have at least three years of experience practicing as a BCBA in the field.
- Participants must be active and currently practicing in an applied behavior analysis treatment setting. This can include home, community, or clinic-based services for individuals with problem behavior.
- Participants must be certified at the BCBA level. RBT, Board Certified assistant Behavior Analysts (BCaBA), and Board Certified Behavior Analyst-Doctoral (BCBA-D) level certificants were not be included in this study.

I targeted BCBA level practitioners based on several factors. The largest certificant pool provided by the BACB is the master's level BCBA certification, with nearly 15,000 BCBA's certified worldwide (BACB, 2016). This particular certification role included direct therapy, administrative work, supervisory duties, legal challenges, and several other professional responsibilities within its professional scope. This specific population made up most practicing professionals within the field of behavior analysis.

Due to the broad application of behavior analytic practice, members of the population were excluded from the study if their primary practice in behavior analysis did not include direct therapeutic applications working with problem behavior. Branches of behavior analysis can include organizational behavior management (OBM), academia, and research among therapeutic practices. Participants who primarily work outside of

direct service were excluded from the study to maintain a more homogeneous sample of a maximum of 12 participants.

Regarding saturation and sample size, saturation occurs once general patterns emerge during the data collection period (Creswell & Creswell, 2017). Oversaturation refers to a phenomenon when the data set is so large, emergent patterns are discovered, but no new data patterns are discovered after a certain amount of data is collected. With a maximum of 12 participants set for this study, it was not likely that oversaturation will occur.

Instrumentation

In this phenomenological study, I was the interviewer and the primary instrument. Data for this instrument was be compiled through interviews conducted by the interviewer. Englander (2012) cited the interview as a primary source of data collection for phenomenological research. Semistructured interviews may yield additional content with some prompting, whereas structured interviews may yield limited information comparatively. Interviews were conducted with a sample of 10 currently practicing behavior analysts that meet the current inclusion criteria for the study. I used semistructured interviews during one-on-one interviews. This interview was made up of 10 interview questions with follow-up questions for clarification if necessary. These questions can be found in Appendix B.

Englander (2012) used the interview as an effective means of data collection in phenomenological studies, where the interview was used to gather variables difficult to measure traditionally. Additionally, the interview itself, as well as the interviewer, served

as valuable interpretive measures that allow for guided questioning, exploration, and clarification that more rigid data collection methods may not be able to capture. Content validity was established as each of the interview questions is a direct subset of the original research question. Questions about the self-care experience served as the overarching interview questions, with clarification questions answered only following initial interview questions. The interviewer as a data collection instrument along with the semistructured interview and audio recording capabilities establishes a sufficient data recording method. This method allows for direct observation and data collection as well as records review of collected data. The ability to review previously collected data allows for repeated review and interpretation of collected data.

Procedures for Recruitment, Participation, and Data Collection

For this research, a sample was gathered using the user directory through the BACB. Potential participants were emailed through the BACB, where a mass email was sent to the entire BCBA registrant pool. The sample was selected by me based on participant criteria and order of response to participant request. Bitsika and Sharpley (2012) indicated the benefit of using a homogenous sample in that targeted information about a population was easily gathered. Through sampling of behavior analytic practitioners, I was able to ask follow-up questions for clarification to obtain specific and thematic information about self-care practices.

A request for participation was administered through the current certificant pool provided by the BACB. This email can be found in Appendix A. Participants were recruited via email if they voluntarily responded to the email and were selected based on

availability to interview. This email was sent out through the BACB, the professional organization that manages certification. I reviewed the consent form provided via email in a digital PDF file and again at the start of the scheduled interview. Participants who meet the inclusion criteria will complete the informed consent form. This consent form also includes consent for digital audio recording of the interview only. This form was signed in person prior to the start of the interview. If the interviewee declined participation after reviewing the consent form, the interview did not continue and a new participant was identified for the study based on the inclusion criteria.

Interviews were conducted in a live format via Skype using semistructured interview questions and follow-up questions for clarification if necessary. Interviewees did not need to travel to a mutually agreed upon interview site determined before the scheduled interview, but did need to coordinate with the me to determine a mutually agreed upon time... I conducted interviews with the participants via Skype from my private office. Participants could choose the location of their site with recommendations that their site be chosen to ensure privacy.

During the interviews, the researcher asked for clarification regarding the interview questions. Interviews lasted approximately 60 minutes to allow for time to ask clarifying questions as additional information or questions may arise during the interviews. The interviewer used a digital recorder to record audio from the interview.

Audio recording was used for interviews. Recordings were analyzed following interviews. The researcher personally transcribed all audio recordings into written format. All recording files and written documents will be stored securely for a minimum of seven

years following collection. At the end of the seven-year period, all records and data will be deleted or otherwise destroyed.

Data Analysis Plan

I selected IPA as a means to identify themes within recorded data. Smith et al. (2012) outlined IPA as a means to investigate individual experience with a bit more depth compared to other types of content analysis. Pietkiewicz and Smith (2012) highlighted some flexibility in determining a data analysis plan within this type of framework, allowing the researcher to be creative in their analysis and interpretive steps. Following the IPA model, I used the following steps as my primary data analysis plan.

Multiple Reading and Making Notes

Step one in my data analysis process included rigorous review of the interviews and transcripts once collected. The goal with this step was to fully immerse myself in the data as a means to uncover further meaning than identified in the original interviews. This step allowed me to make additional notes about nuances within the interview, including capturing variables regarding tone and atmosphere that may be easily missed during initial reviews.

Transforming Notes into Emergent Themes

For step two, I took reviewed data and categorizing the information into common themes. If the goal was to understand the lived experience of a single practitioner as well as the common lived experience of behavior analytic practitioners, the use of emergent themes allowed me to further understand commonalities across practitioners with varying backgrounds. This particular type of data analysis also allowed me to analyze this data in

regard to the hermeneutic circle, where a single part of the data is analyzed in relation to the whole, and vice versa (Pietkiewicz & Smith, 2012).

Seeking Relationships and Clustering Themes

The third step in analyzing the available data set was to begin conceptualizing the reoccurring themes and organizing data based on common characteristics. The ability to cluster themes and identify significant relationships between these themes allowed me to further conceptualize the experience of the practitioner in broader terms, while still allowing for richness of detail within the overarching themes.

Repeat and Note

The final step in my data analysis plan was to repeat steps one through three to determine any potential missed variables of note. The goal with this specific step was to add an additional layer of analysis and interpretation as a means to verify potential themes and identify significant variables that may either be missed during the initial analysis or may not be categorized in the recurring themes. Through this step, outliers were also be identified and noted as part of the analysis.

No software was used for the above outlined data analysis process. Any outlying concerns or variables that do not fit emergent themes will be noted within Chapter 4.

Issues of Trustworthiness

Trustworthiness refers to specific qualities of qualitative research that demonstrate data validity and reliability. Specifically, issues of trustworthiness include evaluative criteria outlined by Lincoln and Guba (1985) These criteria include credibility, transferability, dependability, and confirmability. In order to confirm trustworthiness

within this study, I verified trustworthiness using a variety of methods based on the four evaluative criteria listed below.

Credibility

Credibility specifically refers to the extent to which participants can report and recognize their own experiences as true and accurate. The goal of credibility is to establish that participants can confirm information about their lived experience as a persistent truth (Lincoln & Guba, 1985). For this study, I planned to use prolonged engagement, persistent observation, peer debriefing, and member checking.

Prolonged engagement. Prolonged engagement is a technique that requires extended time engaged with participants to account for variables that may impact data collected. The purpose of prolonged engagement is to detect and remove bias as much as possible from data collected, and is often used as a means to reduce reactivity to researchers not belonging to specific studied populations (Lincoln & Guba, 1985). In this particular context, I remained the interviewer, so reactivity was not be as much of a concern. As the researcher, my primary purpose in selecting this technique was to reduce bias during the interview process.

Peer debriefing. Also known as analytic triangulation, peer debriefing is a technique that would benefit this research due to my participant observer status. In peer debriefing, I as the researcher involved a disinterested or uninvolved peer to probe for inherent biases or missing inquiries in the research process (Lincoln & Guba, 1985). The goal of this technique would aim to refine the inquiry process with participants prior to

beginning the inquiry process and allow the researcher to more objectively frame ongoing inquiry with participants.

Member checking. Member checking is a more current technique that allows the researcher to follow-up with the participants to ensure their responses are represented accurately following data analysis (Brit et al., n.d.; Merriam & Tisdell, 2015). Using this technique, I was able to follow up with the participants following interviews and verify how representative the transcription and interpretation are regarding their lived experience.

Transferability

Transferability refers to how well the results can apply to other context or scenarios (Lincoln & Guba, 1985). In order to improve transferability within this research, I plan to use thick description as a means to deliberately enhance the detail provided by participants in the study. Lincoln and Guba (1985) describe thick description as a means by which the researcher can gather more detailed descriptions of the experiences described during the interview process. By gathering clear, concise, and descriptive data during the interviews, transferability was be enhanced and emergent themes may be evaluated in other contexts.

Dependability

Dependability serves as a reliability counterpart in qualitative research, citing the overall stability of the research. More specifically, this refers how dependable the data and the data gathering processes in the context of the research. This process begins with the design of the study through the presentation of the results, which prompts the

researcher to develop continuity and consistency throughout the inquiry process (Lincoln & Guba, 1985). In order to ensure that dependability is maintained throughout the duration of the study, an audit trail was used to account for each step of the process. This was included detailed descriptions of gathering and coding data, such as moving from raw data to condensed data.

Confirmability

Regarding confirmability, I took steps to ensure the data collected, the results, and the interpretations of the data are accurate. This effort was established in part by the audit trail discussed in the previous section. By utilizing an audit trail, I was held accountable for the study from design to presentation of results. The maintenance of records throughout the process will allow for secondary interpretation and can account for original sources of data within the study (Lincoln & Guba, 1985).

Reflexivity and reflexive journaling. Another technique to ensure confirmability in the study is specific to reflexivity and reflexive journaling. Reflexivity refers to the researcher's attendance to specific biases throughout the research process (Lincoln & Guba, 1985). Through the use of reflexive journaling, I maintained an active journal that accounts for particular attitudes and biases that may arise throughout the inquiry process.

Ethical Procedures

Ethical issues in the behavior analytic arena are similar to those within the clinical practice of psychology. The *BACB Professional and Ethical Compliance Code for Behavior Analysts* includes specific ethical considerations for the practitioner, however, there are no guidelines for self-care practices (BACB, 2016). This same code outlines

specific code breaches and reportable incidents that may occur as a result of ethical violations. The primary ethical consideration for this study was that the population described above is required to adhere to this code of ethics.

There were minimal ethical concerns that might have arisen as part of this research. It was not likely that problematic disclosures will occur as a result of interviews as the focus of the interviews will be practitioner self-care behavior. Participants in this study practiced under a specific ethics code outlined by the BACB, while this study explored the self-care practices among these practitioners. The possible occurrence of BACB code violations during the course of this study remained highly unlikely. In the event that any ethical violations did arise, I planned to take the appropriate steps to remediate the concerns per the BACB ethics standard. This included addressing the concern with the behavior analyst and providing reasonable resources to prevent further violations. Major violations of the BACB ethics code would have resulted in reports to the board directly. These violations could include significant client harm or illegal activities engaged in by the behavior analyst.

In the event that problematic disclosures did occur during the session (i.e. concerns with abuse/neglect), the researcher would query the participants further to determine if the incidents had been properly reported to authorities. If these incidents had not been reported and fall within mandated reporting guidelines under reporting laws, the researcher would have provided further information to the participant regarding their responsibilities to report under current laws.

To protect confidentiality, names, certification numbers, and locations of practice was coded. All data collected will be stored in digitally encrypted files under password protection for a minimum of seven years. This includes any interview recordings, transcripts of recordings, process notes collected during interviews, and any other types of datum that may be collected throughout the course of the research.

Summary

This chapter reviewed the design of this study as well as protocols for interviews with behavior analytic certificants who were actively practicing in the field. This included why the interview protocols are the best fit for the subject area. As described throughout the chapter, specific documents were developed to recruit potential candidates for the study as well as consent forms. Interview questions were developed for the interviews, and follow-up questions were determined based on responses from interviewees throughout the interview process. The goal of the semi-structured interview design was to further explore the nuances of self-care in behavior analytic practice. Ultimately, this type of design aligned well with the purpose of the study, which was to explore how self-care occurs with behavior analytic practitioners.

Based on the design, it was not likely that there is a major ethical concern. The study was exploratory in nature and does not require intervention nor does it target a vulnerable population. Participants here were behavior analytic practitioners who remain in good standing with the certification board, so participant vulnerability is at a minimum. Overall, the design yielded data and themes related to self-care that had not

previously been researched through this type of study with this population. Chapter 4 goes on to discuss data collection and analysis.

Chapter 4: Results

Introduction to the Current Study

Self-care practices are discussed often within the social sciences and medical fields of practice, with research conducted on self-care among caregivers, providers, licensed professionals, within organizations, and with individuals actively practicing self-care (Godfrey et al., 2011). The concept of self-care seems to be limited within the behavior analytic field of practice, with research in this area focusing on aspects of hygiene related tasks (Trahan et al., 2011). In relation to current studies on self-care, there does not appear to be a focus on the experience of the behavior analyst in relation to self-care repertoires (Trahan et al., 2011; Vollmer et al., 1992). Furthermore, there is little discussion surrounding the lived experience of the behavior analyst in practice.

Because of the nature of this study and the limited amount of research regarding the behavior analytic practitioner, as well as the limited scope of self-care research in the behavior analytic research, only one research question was selected for this study. The research question or this study was as follows: How do currently certified behavior analysts engage in self-care practices?

The purpose of this chapter is to discuss the results of the current study. This chapter will also include the setting where the study took place, participant demographics, and the data collected throughout the study. This chapter will also discuss the data analysis process and a discussion on the results.

Setting

Face to face interviews to gather data were conducted with participants who met the inclusion criteria for the study. Participants were selected based on order of response to the recruitment email send out through the BACB. Interviews were conducted over the internet via Skype over the course of several weeks. This took place in a synchronous format, with live, face-to-face interactions for the duration of the interviews. I remained within a private office setting with a closed door. Participants appeared to be in a variety of settings, some noting their home office while others appeared to be at a work-setting. In all instances, participants remained within the noted settings and were not interrupted by others. Each participant remained in front of their computer on camera through the duration of the interview. Interruptions did not occur during the interviews.

Incentives were not provided for participation. To date, there were no known conditions that may have influenced participants in their experiences during interviews. At this time, there are no environmental factors that are relevant to note.

Demographics

During recruitment, 200 potential participants that met the inclusion criteria responded with interest to participate. Participants that were included in this study consisted of 10 adults (N=10) who are currently certified behavior analysts in a variety of practice settings. The group comprised nine female analysts and one male behavior analyst. This group is representative of current certificant demographics per the BACB (2018). Table 1 below illustrates some of the participant demographics identified during the interviews.

Table 1

Participant Demographics

Participant	Gender	Age	Geographic Region	Years Certified	Primary Role
1	Female	30-40	Florida, United States	6 years	Instructor
2	Female	30-40	California, United States	10 years	Clinical Director
3	Female	30-40	United Kingdom	3 years	Contractor
4	Female	30-40	Illinois, United States	8 years	Crisis Intervention
5	Female	30-40	Utah, United States	3 years	Researcher
6	Female	30-40	Utah, United States	3 years	Clinical Director
7	Male	30-40	Florida, United States	4 years	Trainer
8	Female	30-40	Florida, United States	4 years	Practitioner
9	Female	30-40	Florida, United States	5 years	OBM
10	Female	30-40	Florida, United States	8 years	School Intervention

Data Collection

Data collection occurred across all participants for the study (N=10). These data were collected via internet-based video conferencing through a semi-structured interview. Participant consent was given and documented and verified at the beginning of each interview. Questions to this interview can be found in Appendix B. Interviews were conducted over the course of several weeks, and only included one interview per participant. These interviews lasted between 30 to 60 minutes per each interview and were audio recorded. This varied length of interview time is based on the answers from respondents. Interviews were recorded using a Phillips VoiceTracer 1100 audio recording device. This device was used to record each interview for further data analysis. There were no variations to the data collection method mentioned in Chapter 3 of this study. Additionally, there were no unusual circumstances noted during the data collection process that would be of note or would impact the results of the study to my knowledge.

There is no video recording of these interviews. Audio recording of each interview was made and transcribed, to support data analysis.

Data Analysis

During the data analysis process, I realized that saturation was reached at the 10th participant. It was determined that the data from this group would provide the basis for understanding the self-care practices among currently certified behavior analysts. Overall, the analysis of the data resulted in a total of five primary themes with 12 separate subthemes.

Data collected in this study was analyzed and coded based on interpretive phenomenological methods outlined by Smith et al. (2012), as presented in Chapter 3 of this dissertation. Each interview was recorded, and each transcript was analyzed independent of the other collected interviews. Following each individual interview analysis, all transcripts were analyzed together. This analysis was used to determine potential relationships between each data set.

First, I immersed myself in the data, where transcripts of the interviews were reviewed multiple times. This was to ensure that the participant was the focus of the individual analysis. Next, notes were made on the transcripts to begin identifying specific commentary or potential themes within the interviews that began to emerge. Notes were handwritten and consolidated into emergent themes identified in the data interpretation process.

Following the completion of notes reviews, the notes were compared to transcripts from the interview to further confirm emergent themes within the interviews.

Descriptive notes made during this component of the analysis were based on common terminology used among participants and include specific framing regarding the terminology surrounding self-care practices. According to Smith et al. (2012), this level of analysis helps to further determine potential emergent themes within the collected data.

After this level of data analysis was completed, emergent themes were identified, and notes were reviewed. This level of analysis was used to identify major themes as well as potential subthemes within the collected data. At this point, I began to interpret the data across data sets to further determine emergent themes across participants. Connections were found as a result of commonly used terminology and context of discussions surrounding experiences.

Once this portion was completed, I reviewed each interview transcript in relation to the interpreted data set, comparing each interview transcript to one another. This step was used to identify potential patterns across each participant and the interview data. Two of the interviews were completed at a shorter duration than others, lasting slightly beyond the 30-minute mark. However, due to the succinct answers provided by participants, and comparable experiences among the participants when analyzing data, the shorter duration did not appear to impact the results or data analysis. These themes were analyzed to determine potential connections regarding their lived experiences.

Themes Identified

As a result of the data analysis process, this researcher was able to identify five major themes emerged from the analysis of the interview transcripts. These themes

comprised: (a) limited exposure; (b) variable definitions; (c) high-stress work; and (d) impact of practice. During data analysis, 12 subthemes emerged in relation to these major themes (see Table 2).

Table 2

Themes and sub-themes

Discovering Self-Care	**Personal Experiences with Self-Care Behavior**	**High-Stress Work**	**Personal Impact of Self-Care Practice/Practice Deficits**
Self-Care by Happenstance	Personal Definitions/Perspectives	High-Risk or High-Need Clients	Diminished Effectiveness at Work
Beginning with ACT	Unique Practices/ Experiences	Transient	Quality Client Care
	ACT vs. Traditional Experience	Personal History and Practice	Effect on Relationships
		Isolation from Support Network	

There were no discrepant findings in the participant's comments here, despite each of the participants working in uniquely different areas of practice within the field. The details of the findings in this table are detailed later within this chapter.

Evidence of Trustworthiness

Trustworthiness was verified using a variety of methods discussed earlier in this study. These methods included prolonged engagement, peer debriefing, member checking, and reflexive journaling. These methods helped to demonstrate credibility, dependability, transferability, and confirmability, which is illustrated in the following section.

Credibility

Credibility was demonstrated throughout the interviews and following completion of scheduled interviews through multiple methods. This was further demonstrated when participants were able to identify the findings as their own experiences regarding the current topic of self-care through member checking. Participants were provided a transcript of their interviews to review and confirm accuracy of their reporting.

Through prolonged engagement, I was able to identify and record potential distortions that may have been displayed due to my position as an individual outside of the participant's lived experience (Lincoln & Guba, 1985). This was done at the start of the interviews, where I spent some time building rapport with the participants.

Member checking was included in this study to help determine the accuracy of the participant representation in the findings and interpretation of the data collected. Following the completion of the interviews, participants each received a transcribed version of the interview via email. This was done to confirm that the interviews accurately depicted their views and experiences on self-care practices.

Reflexive journaling was implemented throughout the interview process. This journaling technique helped to document any initial thoughts during the interview sessions, potential patterns that began to arise, and emerging themes as the interviews continued.

Transferability

Transferability refers to the degree to which the results of a study can be generalized to other observable contexts. In this regard, transferability helps to provide

readers of the study some parallels between the study and their lived experiences (Shenton, 2004). Through thick description, transferability can be improved or enhanced (Lincoln & Guba, 1985). During interviews, I asked additional clarifying questions to gather more specific examples of experiences from the interviewees. Silence was used during interviews to allow interviewees to provide additional description of experiences they had encountered in practice. In this regard, transferability was enhanced through a clear, concise, and detailed description of the participants lived experience with self-care.

Dependability

Dependability in qualitative research specifically refers to how stable the data analysis and collection process. As a result of the process identified within this study, dependability can be demonstrated. These processes include maintenance of the interview transcripts and audio files, journal entries, and notes related to this specific research process (Smith et al 2012). In relation to this study, dependability is demonstrated through confirmation that I was consistent throughout the entire research and data analysis process.

Confirmability

Finally, confirmability was demonstrated through the audit trail, which includes records that were generated throughout the study. This includes the raw audio files and transcripts of interviews and is further demonstrated through notes and journaling completed during the study.

Results

Either at the start of each interview, or in preliminary discussions regarding the interviews, participants as well as potential participants noted the need for this type of study regarding the subject of self-care. The overall discussion around the was one that indicated that there is a current need to understand self-care and its impact within this field.

Of the statements of need that were made, many participants paired the statement of need with discussions around importance. During more informal discussions before and after direct interviews, participants thanked me and noted that this subject was important to help improve services and impact on clients. This discussion of importance was consistent across participants as well as potential participants interested in participating in the study. This is further bolstered by noting that the initial interest in participating in the study garnered 200 eligible participants.

Participant 7 noted at the end of the interview that they were glad someone was doing this research as it is not commonly discussed among behavior analytic practitioners. Participant 5 shared a similar line of commentary, stating the following:

> I'm glad that you're doing this, and I think it's really important for us to think about as a human services field. We really are expecting a lot of BCBA's or graduate students and of course nobody said graduate school was going to be easy or that behavior analysis is an easy field to practice in or to do research in. But I am glad someone is explicitly talking about this because that's what I really do think it's going to take for us to do a little bit better.

In addition to the discussions around need and importance, participants continued to ask about the results. At the end of two interviews, participants asked what kind of results were being seen at this stage of the interviews. Those who were identified as potential participants have asked to see the completed study and results as soon as possible. This line of inquiry has been consistent within discussions around the topic of self-care and in particularly, the results of this study.

Toward the end of the interview, Participant 6 asked me about the results of the study so far. They presented the following line of questioning regarding the study up until that point:

> Have you found anything or anyone that's specifically identified great ways for self-care or things that work, or you know? Like you said, there isn't a lot of training out there, so to be able to pass that on to other people in the field, is it just all about finding what works for you or is there already ideas out there?

This commentary appeared to be a more minor theme and was ultimately not identified as a primary theme for the study but seemed to reflect the overall view of participants involved in the study as well as those who showed interest in participation. Throughout the interviews as well as prior to interviews, participants and potential participants seemed to demonstrate some level of enthusiasm for the subject. Lines of inquiry were opened among participants regarding the preliminary findings, and commentary regarding the study's importance were found among those who participated as well as those who had expressed interest in participating. Among those who participated in the interviews, there appeared to be a heightened enthusiasm when

discussing the potential findings, and gratitude to the researcher for taking steps to conduct the research.

The goal of this study was to explore the experience of the behavior analyst and self-care practices. These interviews included a total of eight questions developed to respond to one research question: How do currently certified behavior analysts engage in self-care practices?

How do currently certified behavior analysts engage in self-care practices?

Theme 1: Discovering self-care. When asked questions regarding the concept of self-care, all participants identified that there was no formal training in the concept, and that in their behavior analytic work, this was not discussed as a need. Participant 9 described their exposure generally as "happenstance" or as coming across the material/concept by accident. Of the six participants, none of them noted a prior exposure to self-care before entering the field of behavior analysis or in their behavior analytic training. However, some participants noted that they had been exposed to the concept of self-care within some interdisciplinary literature, and more specifically, students surrounding Accepting and Commitment Therapy (ACT), a current trending topic among some behavior analytic practitioners.

In response to questions about previous exposure, participant 1 noted that self-care "…wasn't something that my supervisors even mentioned." Participant 2 provided further insight on this specific theme, stating that they had not been exposed to self-care prior to the interview. "Not in school. Certainly not at my other company." During the interview with participant 2, they elaborated further, stating "I don't feel like I was

exposed very much, if any, during my supervision." Similar quotes can be found from other participants, including participant 4, stating that in regard to their exposure to the concept; "Not formally as a concept, but I mean, I think self-care is something that we all engage in to an extent, whether or not we know the concept."

Subtheme 1.1: Self-care by happenstance. All 10 participants indicated that they had not been trained on the subject of self-care within the field of behavior analysis in either their supervision or their coursework. However, three of the participants indicated that they had sought training outside of the field. Across all participants, it was noted that despite their limited training or exposure, there had been some direct exposure from some other areas of practice or discussion. Only one participant could identify the origin of their self-care practices, citing their supervisor modeling self-care practices. Otherwise, participants had not had formal exposure to the concept in training, supervision, or education settings.

Regarding this particular topic, very little was noted regarding outside exposure from participants other than continuing education or study on ACT, which will be included for further exploration as a sub-theme in the following section. Participant 4 specifically notes that their exposure and outside training was "self-guided," and that any training came from independent research. Their training was "Just the continuing education stuff, which was all done within the last, as a concept really, within the last couple of years, to be honest."

Participant 2 further adds to this discussion, noting that their experience with self-care began with independent training and research rather than formal training. When

asked about formal exposure or training, participant 2 elaborated: “No, I didn’t. Well, not really. Not in school. Certainly not at my other company.”

Participant 3’s discussion around training or exposure indicated that their first experience with the literature was a professional choice rather than required training:

> And now, I’m supervising [people] myself, so I made it a priority on my list for my supervisees to read about self-care, about ACT. It’s something that is missing from supervision, and something I was missing myself, which I needed.

Subtheme 1.2: Beginning with ACT. For those who sought training, these participants noted that they were actively seeking training in Acceptance and Commitment Therapy (ACT). This field focuses on a variety of conceptual and psychological research surrounding suffering, stress, and mindfulness. Ultimately, there is some debate on the behavior analytic nature of this new line of research, though it is noted to be a newly emerging field of research that behavior analytic practitioners are interested in. Participants that noted they had exposure to this or were actively practicing this were less stressed on a general basis, and they were clearer in their definitions of self-care practices.

Throughout the interviews, it appeared that those who had previous exposure to ACT in either their independent research or through formal training had an enhanced understanding of self-care as a concept: “I’m very into ACT at the moment so I try to bring ACT and the science toward what ACT says about self-care and how important it is.”

Participant 4 shared a similar viewpoint regarding ACT and utilizing some of the concepts, but within a higher education setting specific to behavior analysis and behavior analytic research:

> I personally got a little bit into ACT and I think most behavior analysts, at some point, break it in and try to read some ACT stuff, which was really helpful for me in stressful times in my master's program.

Participant 2 notes that ACT is practiced among their organization, noting that they have "not mastered ACT as a company," but are actively building in policies within the organization to include some of the techniques available through the modality.

Based on the data gathered that aligns with this theme, it appears that the experience of these participants is one of limited exposure to self-care outside of a small but growing branch of behavior analytic research in ACT. The topic of self-care is one that is not consistent among behavior analytic practitioners unless behavior analysts independently seek this information. This is further demonstrated by the experiences of participants 2 and 4, who either independently sought experience in ACT and contacted self-care, or began working at an agency where self-care concepts derived from ACT were part of an organizational culture.

However, the concept itself does not appear to be foreign to behavior analytic practitioners. Rather, the concept of self-care is one that is described through layperson experiences as opposed to formal training. Theme 1 highlights clear deficits in formal exposure to self-care in training and supervision practices, and demonstrates that self-care

as a concept is one that does not receive extensive attention in current behavior analytic training programs.

Theme 2: Personal experiences with self-care behavior. Regarding definitions of self-care, it was clear that each participant had a unique definition and practice. There appeared to be a slight uniformity in that the participants continually noted their own behaviors and care repertoires, however definitions varied at both the conceptual level of self-care and the practical applications. For example, participant 3 noted the following in regard to their view on self-care: "It's to understand when I need to disengage myself from my work and commit to it [self-care]. Basically, say enough is enough, now this is my time no matter what."

Following this theme, participant 5 had the following to say in regard to defining self-care: "You do all those things that you've been putting off for too long, and I would say that in general, if you were to maintain that really well throughout the semester, that would be the ideal self-care to me."

Some definitions were more succinct, as was the case with Participant 1: "I'd say it is engaging in behaviors that promote physical and mental psycho-emotional well-being." In contrast, Participant 6 had a more complex definition regarding self-care:

> For me, that means making sure that I don't lose my mind, basically, and how I make that work. Because you understand. It's a balancing act. You have to be there professionally, but you also have to balance your home life and being a parent, and then also being able to take care of yourself. And so, for me, self-care

> is making sure that I don't skirt the responsibilities I have and finding the time for things that I need to take care of me as well.

Subtheme 2.1: Personal definitions/perspectives. Definitions of self-care across participants were highly individualized. While some participants would note their self-care repertoires to be in line with some of the behavior analytic definitions highlighting activities of daily living, others would note that they were engaging in activities that "they enjoyed doing," as noted by participant 1. Some cited recreational activities such as surfing or paddle-boarding, while others noted home-based activities around reading or watching television. In each instance, the participants were able to share an individualized version of their self-care practices.

While most definitions included some kind of health and wellness component, each definition included highly varying discussions around what self-care formally means. Participant 1 went so far as to ask whether an operational definition was necessary, and noted that they were not aware of a formal operational definition that aligned with behavior analytic practice.

Participant 5 offered a definition that included some insight on common behavior analytic practices for those who are providing home and community-based services:

> Basically, you do all of those things that you've been putting off for too long, and I would say that in general, if you were to maintain that really well throughout the semester, that this would be the ideal self-care to me. But that's like… you've got your exercise routine and you're doing it pretty regular, you're cooking at home most of the time and prepping your own meals as opposed to

> eating out or eating things on the run. And, you know, you're able to go get a haircut and get your eyebrows done, those things that often times in the semester, as it goes on, you kind of let go.

Participant 1, who had asked if an operational definition was necessary, noted that self-care "is engaging in behaviors that promote physical and mental, psycho-emotional well-being." While these two definitions share similar qualities, participant 2 noted that self-care was about "balance and autonomy," while participant 4 cites self-care as "anything that you're doing for yourself that helps you feel less stress or that you can manage the things in your life a little bit easier."

Further illustrating the lack of consistency among definitions for self-care in behavior analytic practice, participant 4 shared their definition:

> For me that means making sure that I don't lose my mind, basically, and how I make that work. Because you understand. It's a balancing act. You have to be there professionally, but you also have to balance your home life and being a parent, and then also being able to take care of yourself. And so, for me, self-care is making sure that I don't skirt responsibilities I have and finding time for things that I need to take care of me as well."

Subtheme 2.2: Unique practices and experiences. Each participant also highlighted varying practices of self-care in regard to how they practice. Aligning with the sub-theme of individualization, the participants noted how their self-care practices were applied. Some participants noted that they are limited in their time practicing self-care, while others actively make time for these activities. Variables that contributed to

this inconsistency included a variety of life obligations, intensity of work, or participation in graduate programs.

In describing their day to day work, each practitioner noted holding a variety of roles within their position and within the field of behavior analysis. For example, participant 1 noted that they were currently an instructor at a college and a PhD student with a history of formal applied practice in a hospital setting and home and community based interventions. Participant 2 noted that they currently worked in a clinic based setting as well as home and community based setting. Participant 3 demonstrated a slight difference in this, as they maintained a consultant position as well as a trainer within their community.

Additionally, the areas of expertise among practitioners varied, showcasing the flexibility of behavior analytic work comparable to the variety found within psychological practice. Participant 1 previously worked with individuals who suffered from traumatic brain injury, and participants 4 and 7 noted that they specialized with individuals who exhibited crisis behaviors. Participant 2 noted that they served individuals through early intervention, as did participant 8. Participant 9 noted that they served individuals considered "at risk" within a school setting. Across all participants in the study, the age range of individuals receiving behavior analytic services ranged from 15 months to an elderly woman in her early 90s.

Subtheme 2.3: ACT versus traditional experience. In reviewing transcripts across participants, a fairly consistent sub-theme was the effect of those who were engaged in ACT practices versus those who did not discuss this. Consistently, those who

were engaged in ACT practices appeared to be more relaxed during the interviews, and appeared to have a more consistent management of their personal and work related activities. For those who were not engaged in ACT, they cited more stressful work environments, more difficulty completing necessary tasks, and a higher level of burnout within their current roles.

In alignment with theme 1 in terms of outcomes, theme 2 seems to demonstrate a similar experience among participants. Each participant provided a definition of self-care that varied and appeared to be based on their individual learning history. For those with more formal training in self-care, they appeared to receive this training and information directly from literature on ACT, a growing area of research within the behavior analysis community. Along with varying definitions, each participant interviewed shared information regarding their professional experience. For example, participants 1 and 3 both did not directly experience self-care training, but engaged in preferred activities regularly, whereas participants such as 2 and 4 were directly exposed to ACT and described their experiences as having clearer boundaries and recognizing signs of burnout fairly easy. While the overall nature of behavior analytic work remained consistent, their exposure to different types of problem behavior, skill deficits, and populations varied greatly. Each participant held a different role within their respective work environments, and their training experience varied greatly. Overall, the experience of the behavior analyst in practice can vary widely across multiple aspects of practice, which results in high variability among their professional learning histories.

Theme 3: High-stress work. A consistent theme among those practitioners interviewed was that of a high stress work environment. Participants included in this study included independent contractors, university instructors, clinic-based providers, and state employed personnel. In each interview, participants noted a high level of stress relating to the care of those in their charge, whether it was a direct beneficiary of services or students who were learning new principles and concepts. Each participant noted a high level of passion for their roles as well.

Participant 4 noted that their position required being available at all hours due to the intensity of some behaviors that were occurring. Participant 7 noted a similar experience, demonstrating work within a highly dangerous setting that required constant supervision of clients who resided at the site. Several participants in this study noted challenges with organization, paperwork, managing a caseload, travel to clients, managing staff, and collaborative efforts as stressors specific to their roles. Participant 6 specifically noted:

> I am also the director, so it can get a little bit crazy. So, I kind of have to balance between the administrative side and the direct work with clients. Then I'm also the reviewer for our reports for reassessments and initial assessments for our entire company. It can get…for me it looks like a lot of documentation I'm reviewing. I'm reviewing a lot of other reports and programming. I'm also the board supervisor for several of my interns down here. And so, I'm supporting them, making sure they're following the ethics of it, understanding what that means.

Of specific note, participant 6 further clarifies that they are a constant support for staff at the site, providing ongoing support for mental health needs for individuals who might be struggling with their cases:

> I know when I'm not taking care of myself and I can't get my stuff organized, then I tend not to be a great supervisor in the sense of I haven't done supervision in 3 weeks, the parents are struggling. They don't feel like they're supported.

Subtheme 3.1: High-risk or high need clients. Some participants noted that, either in their current practice or their previous places of employment, a major contributor to stress in the workplace was working with high risk clients. Dangerous clients that place practitioners or their client's high-risk situations are often common in practice, and participants noted struggles with this particular population directly. Some effects of working with clients at this level include injury to the practitioner, liability challenges, loss of life for the client, loss of sleep, diminished relationships at home or in the community for the practitioner, etc. These effects were discussed but warrant further research.

Participant 4 specifically notes the challenges of working with intense clients and the types of clients receiving their services. The discussion below alludes to working with high risk clients who might be medically fragile or dangerous based on the environments where intervention may be occurring:

> We're not technically a mobile crisis team in the sense that we don't respond in the moment, per se, but we handle the toughest folks in the state, so we never know what we're going to get into when we walk in the door that day. We work

> in multiple environments, and most of our clients are adults, so we'll work in whatever group home situation or family home they're living in. We will also work in the state institutions for mental health needs or those for specifically developmentally disabled adults. Schools, nursing homes, jails, you name it. We're everywhere.

Participant 7 does not directly work with clients who have severe needs, but they note that the training they provide is a crisis level training and requires extensive knowledge and exposure to clients with critical and dangerous needs. Participant 1 notes that previous work prior to the college setting presented unique and high-risk situations, including working with impulsive clients due to symptoms of traumatic brain injury.

Regarding high-risk clients, participant 2 noted that working with younger children with special needs tends to be fairly risky due to challenging behavior and safety concerns, but that working with problem behavior among this population presents the risk of being harmed, office supplies being broken, or injuries to the child as a result of self-injurious behavior. This discussion is similar to participants 6, 8,9, and 10, who currently provides a similar type of service working with at-risk youth in a variety of settings. Some participants such as participant 5, indicated that they felt exhausted, stressed out, or at risk of doing a poor job due to burnout, which placed some of the individuals they served at a higher risk due to diminished care. This seemed to cause significant worry in this participant.

Subtheme 3.2: Transient. For participants who were currently working in the home and community settings, or those who had noted their work in this setting, travel

was identified as a contributing factor to stress. Some participants noted traveling up to 60-90 minutes to see a single individual to render services. One participant noted that they sought new places of employment due to the amount of travel required at their previous agency.

Participant 4 indicated that some consultations require anywhere between one to three hours for a single trip. These consultations often include highly aggressive individuals who are dangerous to family members and place the practitioner in danger when they arrive. For participant 6, they identified that they "only live about 25 minutes away" from their clinic, which indicates a normalcy for lengthier drives to a specific location for work.

Participant 5 noted the extensive travel required of their job, which added a different layer of stress to the role. They indicated that extensive travel could "take its toll" and result in an additional stressor that may not be present in clinic based settings. Participant 2 shared a similar experience, noting that much of their travel required public transit and took up extensive time during the days where services or consultation were rendered. Both participants indicated that even though this was not a direct part of providing services to clients, it was part of a complex work week and took time away from self-care practices.

Subtheme 3.3: Personal history and practice. During the interviews, it was clear that each participant had a unique experience in the field, as noted previously. This appears to be a theme not only among participants, but among the general population of the field itself. Within this study, it is noted that the participants included instructors and those

providing services in home, community, and school based settings. Additionally, some participants were actively providing services within clinic settings. Participant 3 is currently providing services in the United Kingdom, which currently has limited access to behavior analysis services for those who are in need. Each interview highlighted unique and individualized experiences within the field as well as with their exposure to self-care.

This varied experience is further highlighted in discussions around organizational practices. Participant 7 notes that a large portion of their work requires traveling to a variety of states and countries for week-long, physical training of staff members. They indicated that this travel is challenging in itself, and that there are some difficulties maintaining healthy self-care routines. This is in stark contrast of participant 2, who practices within a clinic setting throughout the week providing direct services. Participants 1 and 5 both attend school throughout the week in conjunction with their behavior analytic practice, which provides exposure to research labs and experimental analysis of behavior, which is not present with other participants.

While each practitioner experienced a varied work experience, they all noted specific stressors related to their role. Varying from care of clients in home and community settings, ensuring students were succeeding in university-based programs, managing research teams, or leading trainings related to care, the varying roles seemed to compete directly with self-care practices. Most participants noted rigors and expectations related to their current practice roles directly competed and prevented additional time allotted for necessary self-care skills.

Subtheme 3.4: Isolation from support network. One sub-theme that was highlighted by the participants was an issue with isolation. Participants who are actively working in a clinic or university setting are able to connect with colleagues on site and noted they had a sense of comradery. However, it was noted that those working or those who had previously worked in individual practitioner settings experienced heightened levels of isolation, which contributed to high levels of stress for them. Some noted that working in that type of environment was not desirable and sought employment changes as a result. Others noted that they adapt and take steps to reduce the impact of this particular concern.

Participant 1 discussed this concern in further detail than others in the study, noting the following:

> A lot of things I should have been doing, I wasn't. I was sacrificing going to the gym. I was sacrificing healthy meals. I was sacrificing socialization, which was difficult anyway because my schedule changed week to week. It was almost impossible to plan something. So, it was something that even if I didn't want to, or was willing to give it up, I didn't have it. I was very isolated.

Participant 3 notes a similar experience working as a consultant in a country with limited behavior analytic support: "It's very different here. We don't have agencies. We don't have scholars yet. We work differently. It's sometimes here, so that's why it's very important to reach to other people."

Participant 7 follows a similar concern regarding isolation, noting their consistent travel schedule:

> When I'm gone, I'm gone for weeks at a time. I communicate with my family, which is important, but otherwise, I rarely get to spend time with others who understand what I do. It's challenging, and can be pretty isolating.

Theme 3 provides a more thorough look into the regular life of a behavior analytic practitioner. Exposure to high-stress situations can vary across each practitioner, but there are some consistent experiences among those who have practice. There are clear experiences working with dangerous clients with severe or intense problem behavior among the participants here. This experience, paired with the daily challenges of administrative work and isolating environments, further adds to the overall level of stress that practitioners are exposed to. Another variable to account for in regard to those working in home and community based settings is the amount of travel to clients. Some participants who are actively working within this type of practice noted the amount of time spent traveling to their appointments. For those who no longer worked in this particular environment, their commentary on travel indicated that this was not a preferred aspect of their work and may have added to their daily stressors.

Theme 4: Personal impact of self-care practice/practice deficits. A common discussion in the interviews conducted included how self-care impacts practice. Despite the varied experiences and practices of the participants, each participant noted a clear impact on their practice during times of stress or limited self-care practice.

Subtheme 4.1: Diminished effectiveness at work. A critical sub-theme identified in the interviews was that during periods of diminished self-care, participants were not as effective or had some struggles with their work. One participant noted that when they

were lacking in self-care, they were “less on point.” Participants did not note any ethical concerns regarding this in terms of reportable incidents, but did note that they immediately needed to make changes to avoid harmful treatment effects as a result of being burned out. One participant indicated that they felt “highly ineffective” during these periods, which demonstrates a potential impact to clients being served.

Participant 6 notes that their tolerance to attend to the daily challenges of work lessens, and can result in less effective work and a breakdown in team support:“I feel like the people under me really struggle because I’m not being an effective leader. I can’t get my own crap together and so it’s kind of just waterfalls down.”

A similar sentiment can be found with participant 3, who discusses their impact on clients directly:

> I’m not present. I just want to leave. I just don’t want to be there. The treatment is not effective, I’m not effective. Then the client, they don’t want to be with you and it’s more likely that you’re going to put the punishment procedures in play.

Participant 5 discussed their experience working in a university setting in regard to diminished effect:

> It’s probably not the same work quality that it would be if I’m fully rested, I’m ready to go. I think that’s true of anyone though, right? That the quality of your work kind of declines as you’re more physically spent.

Following this line of questioning, participant 5 provides further elaboration on the quality of work discussion noted here:

> I'm teaching a class and it just doesn't go as smoothly as it otherwise might have, or you know, I'm working with some folks at the school and I'm doing some training and maybe I'm not as thrilled as I otherwise would be as far as thinking of examples and non-examples.

Subtheme 4.2: Quality client care. Conversely, participants also noted that when they were taking good care of themselves, they felt like they were able to do better work. One participant noted that they felt "like everything was operating smoothly" during these periods, and team members seemed to be able to achieve more complex job tasks during these periods. This theme was apparent as some of the participants also held administrative roles and noted that these "good" periods seemed to be the most efficient for their team members. This, in turn, seemed to have a more positive impact on clients being served.

Regarding better care, many participants noted that they were more aware of their surroundings, and more likely to make measured decisions in relation to treatment concerns. Participant 4 briefly discussed a circumstance where a training had gone poorly during a time, they were not caring for themselves. The following references this particular scenario in the frame of good self-care: "Life is just a lot better for myself and everyone else. I think my patience skyrockets, certainly. Those same situations I just described, I could totally handle a different way."

Participant 1 added further to this discussion, noting that when they are taking good care of themselves, they notice specific qualities that are important parts of their quality of life:

> I was more creative. I was more energetic. I was better able to collaborate and do some perspective taking. Because I think when you are collaborating and, we as a field, aren't good at that, it was way easier to be tactful and think of ways to incorporate other disciplines.

Further adding to this theme, participant 3 noted that they were more likely to interact regularly with their clients and focus on interventions that were being implemented. Of note, participant 3 stated "I want to be with my little clients." Participant 2 shared a similar perspective regarding their own self-care:

> I try to walk around the clinic and connect with people. That connection feeds both of us. It does take time to go out there and have a conversation with somebody about their weekend or about a kid that they're working with or how I can support you more, but it's such a good investment for everyone…And not just with the clinical team, with everybody, right? I'm more likely to do that during good times.

Subtheme 4.3: Effect on relationships. One of the more unique themes that emerged during the interviews indicated that participants tended to have better relationships and better interactions during periods where they were taking better care of themselves. One participant noted that there was no tension at work among colleagues when they were taking better care of themselves. Some participants noted that when they were taking poor care of themselves, they appeared more "cranky" or "irritable" and would "snap" more frequently at staff they were working with. It appeared that there may

be a loose correlation between the level of care and stress the practitioner is experiencing at the time and their current relationship quality.

It was clear that in the discussion impact, commentary and context around relationships began to emerge. Of note, when participants discussed lack of self-care, they often framed the impact of their self-care deficits around how they interacted with others. Participant 6 shared some insight regarding their experience around self-care deficits:

> I'm really grumpy, and honestly I start to lose my ability to connect with where I'm at in the sense of I start looking for a different job. I'm like, I don't want to do this anymore. I'm not happy with the people I work with, I'm not happy with this. And I just start to lose myself and look for change rather than being content with my stability. I feel like I've got to change everything else in order to find that happiness instead of just finding my peaceful spot and know that everything's ok.

Participant 6 would go on to further elaborate, noting that they would have to "fake" their demeanor, and "put on a show for [my client] to make sure he had a positive session."

Similar tones around being irritable were noted as well. Participant 2 noted that they had a "short fuse" and would get "easily agitated." Others, such as participants 1, 3, and 7 would note that they would be less likely to spend time with others, isolate themselves, and engage in "experiential avoidance" so as to avoid any social contact that may be considered aversive for them during these more difficult periods.

Based on the experiences of the participants in this study, there appears to be some anecdotal evidence of some consequences related to self-care practices as well as self-care deficits. Overall, some participants indicated that when they are taking better care of themselves, their work is improved, their relationships are stable, and that they generally feel better. Conversely, when self-care is neglected, there appears to be a problematic impact on varying aspects of the practitioner's personal and professional lives. They appear to be more irritable, care less about the quality of their work, or see some marked deterioration in their daily performance. This type of report was consistent across participants in the study, noting that when there was a lack of self-care, the quality of work provided was diminished.

Summary

This study included a total of 10 currently certified behavior analysts. No other information was gathered regarding these participants prior to their participation in the study to avoid potential skewing the results and to prevent biases. These participants were recruited through the BACB via a group email. After consent was received from the participants, semi-structured interviews were completed via Skype.

Multiple themes emerged during the interviews and subsequent data analysis. These practitioners seemed to have encountered a variety of experiences regarding self-care that include themes such as limited exposure, variable definitions, high-stress work, impacted practice, and general statements of need. Based on the data collected for this study, there appears to be a few major findings regarding self-care and behavior analysts. Overall, there appears to be no formal training in self-care among behavior analysts, and

experience with self-care is largely one of independent research and findings. Exposure to self-care appears to be of a similar nature, where the concept was found as either a layperson or out of necessity from another area of practice, such as psychology or nursing.

Other findings include information regarding practitioner experience. Experiences in training, coursework, supervision, and practice varied widely, as each practitioner held unique roles in their organizations, trained in specific areas of behavior analysis, and continued to practice in a specialized area of the field. Similarly, exposure to a variety of behavior deficits and client populations provided further insight to the complex and variable nature of behavior analytic work. With each participant having worked in a differing area of practice, the experience of the behavior analyst seems to be one that warrants further exploration.

In addition to the above findings, there is some anecdotal evidence of an impact on the professional regarding self-care skills. Noted during the interviews, good self-care lead to better outcomes among those who were able to identify and practice self-care repertoires. For those who were able to identify poor self-care skills, there were noted consequences related to those deficits, including impacts on practice and relationships. Furthermore, there was a clear emphasis on the importance of the subject among participants in the study. Throughout each interview and among those who were interested in participating, there were regular comments regarding the subject and its current relevance in the field as well as ongoing inquiry regarding the findings.

Chapter 5 provides further discussion and interpretation of the results of this study, as well as limitations and potential future research in this area. Furthermore, I will discuss some implications of social change and final conclusions for this study.

Chapter 5: Discussion

Introduction

This study was conducted to explore self-care practices among currently certified behavior analysts. The primary goal of this study was to gather information to identify and understand how self-care may occur within behavior analysis as told by those who are actively practicing in the field. This study targeted master's level BCBAs who are actively practicing as a behavior analyst in some capacity. The results of this study help to provide a unique understanding of the practicing behavior analyst in relation to their work demands, as well how the concept of self-care is discussed and perceived.

The ten participants in the study are all actively practicing in some capacity of behavior analytic work, and each demonstrated the variability of work in the field as well as common stressors regarding practice. This study identified five main themes and 12 distinct subthemes related to participants' lived experiences. The following chapter will provide a summary of the results, further discuss limitations of the study, provide additional recommendations for future research, and discuss some potential social implications.

Overview

Self-care as a concept that has a widely variable operational definition within the current body of research (Godfrey et al., 2011). Despite Orem's (2001) theory defining the varying aspects of the concept, researchers still struggle with defining exactly what self-care is. However, the impact of self-care and self-care deficits has been widely studied, with a clear focus on helping professions or individuals engaging in self-care

practices. For example, compassion fatigue has resulted in diminished care for clients or quality of work among psychotherapists (Figley, 2002), while vicarious traumatization has resulted in emotional and mental harm among therapists (Hunter, 2012). For self-carers, engagement in active medical care has helped to reduce the amount of medical attention needed among older populations with diabetes (Bai, Chiou, & Chang, 2009). Even more diverse populations such as pregnant Hispanic women have been studied as part of the self-care literature (Kim & Dee, 2017).

Prior to this study, the behavior analyst was not the focus of self-care studies. Furthermore, the concept of self-care was studied as a behavioral skill for activities of daily living. For instance, Trahan et al. (2011) focused on improving self-care repertoires among older adults with dementia, focusing on improving skills centered around hygiene or necessary tasks for daily living. Vollmer et al. (1992) focused on reducing problem behaviors while improving self-care skills among individuals with special needs. This study also focused on the concept of self-care as a hygiene based set of behavioral repertoires, further demonstrating the conceptualization of self-care within behavior analytic literature. In both studies, the population of focus was the client receiving care and not the behavior analyst as a provider.

Interpretation of the Findings

While conducting an initial review of the current literature regarding self-care, many studies were found on self-care and more directly, effects of chronic self-care deficits (Babatunde, 2013; Figley, 2002; Kim & Dee, 2017; Mills & Rose, 2011; Pearlman & Caringi, 2009). There are distinct concerns within the literature with

concepts like compassion fatigue and caregiver burnout, and diminished care is described in many of these studies. This part of the literature review adds further credence to the Orem's theory of self-care and how it applies to caregivers working with those in need.

In addition to focus on deficits and outcomes, some of the literature also focused on the more positive outcomes of health self-care repertoires. Studies focused on improving caregiver outcomes and demonstrating helpful training in self-care help to illustrate that the concept of self-care can be applied to those in caregiving roles (Dean & Kickbusch, 1995; Kemper, 1980; Richards, Campenni, & Muse-Burke, 2010; Shore, 2001). This body of research helps to provide the other perspective regarding self-care, which focuses on training repertoires and diminishing poor outcomes of self-care deficit. Aligning with Orem's (2001) theory, these studies add support to the domain of self-care that is housed within the self-care model.

Another defining feature of self-care within the literature that crosses the nursing and behavior analytic research is the definition of self-care as it pertains to defining activities of daily living for those in the caregiver's charge. In the nursing and medical fields, this is more clearly highlighted by demonstrating patient behavior and how the individual may actively partake in their own care (Bai et al., 2009; Chen et al., 2014; Gantz, 1990). The concept of the individual receiving care as the subject for self-care behavior is further expanded upon in some behavior analytic literature. Studies regarding activities of daily living among those receiving services operational define self-care behavior through the lens of hygiene related activities (Trahan et al., 2011; Vollmer et al.,

1992). This set of literature in the self-care realm seems to be the only formal bridge between the behavior analysis and other fields studying self-care.

The original research question for this study asked how behavior analysts engage in self-care practices. Throughout the interview processes, I was able to gather further insight as to the lived experience of the behavior analyst, including why they may engage in self-care practices and how they may engage in self-care practices. As the original research indicated among self-care practices, defining self-care repertoires often included a nebulous definition of self-care that allowed for interpretation and flexibility (Godfrey et al., 2011; Orem, 2001). The results of this research are no different in that the concept of self-care is not clearly defined. Each participant provided a unique definition of self-care, some definitions being more variable than others. This directly aligns with trends within the current body of literature and demonstrates a consistent perspective on self-care among helping professions despite limited practitioner-focused research in behavior analysis.

Exposure to self-care and descriptions of self-care repertoires were individualized across participants, which also aligned with the current body of literature regarding how self-care may be defined (see Godfrey et al., 2011). This variability in definition also followed behavior analytic training in that operational definitions are defined based on individual repertoires rather than overgeneralized definitions of behavior (Cooper et al., 2007). While the varying definitions of self-care aligned with the trend in self-care literature, the outcome of defining self-care behaviors from a behavior analytic perspective aligned clearly with behavior analytic training. For example, participants

often described their self-care routines as behaviors that they engaged in. Participant one went so far as to describe self-care as contacting reinforcing activities or stimuli, which appears to be heavily influenced by behavior analytic training. Overall, a clear and concise definition could not be gleaned from the participants, but a general definition of self-care describing behavioral repertoires could be established as a result of the interviews.

Self-care as a concept in behavior analytic practice is at its infancy and has not been a focus of behavior analytic analysis. The concept has been studied, as evidenced by Vollmer et al. (1992) and Trahan et al. (2016), though the findings here do not align with that previous research. This is likely due to differences in the varying definitions of self-care and some of the discrepancies regarding the topic. For instance, the studies mentioned here focus on activities of daily living, identifying self-care as practical hygiene skills like hand-washing or completing laundry tasks. In the current study, the discussion centered around self-care as defined by Orem (2001) and behaviors that result in outcomes such as burnout prevention and improved occupational satisfaction. What was discovered in this research is that self-care has been studied minimally and primarily focuses on hygiene within the behavior analytic context. Instead, what was found is that the practice of self-care exists, and it varies among practitioners, though self-care nor its outcomes have been formally studied or defined outside of hygiene tasks in the literature.

Behavior analysts are actively practicing self-care skills, though there have not been formal definitions or formal training on the concept. It is unclear what this suggests in terms of learning among behavior analytic practitioners or the concept of self-care;

however, there is a clear indication that behavior analysts actively participate in some capacity of self-care. This currently does not contradict the literature as there is no formal literature on self-care practices among behavior analysts, as demonstrated by Trahan et al. (2011) and Vollmer et al. (1992). Rather, this indicates that this phenomenon is occurring presently among behavior analysts and has gone unnoticed by researchers.

The original literature review and summary discussed here provides context for the results of the study. Of the 10 participants, no participant had formal training regarding self-care. When asked questions about their previous experience, each participant noted that they had heard the term or had discussions about the concept, but not in any formal capacity or within their training. Some commented that they had read about self-care within psychology articles, but this further demonstrated that the concept was fairly alien to the practitioners. This is consistent with the behavior analytic research on self-care, which routinely focused on hygiene-based tasks (see Trahan et al., 2011; Vollmer, et al., 1992).

However, each of the practitioners noted that they actively engaged in some kind of self-care routine without prior training, consistent with some descriptions found in literature outside of behavior analytic practice. This was highlighted further when discussing some of the current research regarding accepting and commitment therapy (ACT) within the behavior analysis field. Of the 10 participants, four were actively practicing concepts regarding ACT as well as mindfulness practices. While ACT may not explicitly direct practitioners to engage in self-care practices, it does focus active

behavioral repertoires on the practitioner. Further research on the impact of ACT and self-care would be necessary to identify salient variables regarding this application.

What makes these findings significant is that there was previously little understanding on whether self-care existed within the realm of behavior analysis. Definitions in Godfrey et al. (2011) lacked any inclusion of a behavior analyst within their descriptions of caregivers, though the role of a behavior analyst can be likened to some counseling and treatment professions. The findings of this study indicate that behavior analysts share similar barriers and concerns with those discussed in Chapter 2, where caregiver burnout and compassion fatigue may be present in the behavior analytic community (Figley, 2002; Mills & Rose, 2007; Pearlman, 2009). In sum, behavior analysts share may share more than a few qualities with other helping professions, though the profession is limited in available research on the topic.

With practitioners lacking formal training in self-care, or some practitioners noting deficits in this behavioral repertoire, participants noted specific effects of self-care deficits consistent with the current literature. Some participants noted that they would see challenges with coworkers or personal relationships, while others would note that their services for clients in their care would suffer as a result. Similarly, it was noted that when participants were actively taking care of themselves, their relationships seemed to improve, and services rendered during these periods were more consistent and effective. This also aligns with some of the research found within self-care outside of behavior analytic practice (see Figley, 2002, Kemper, 1980; Kim & Dee, 2017). This is a crucial finding as it identifies links between behavior analytic practitioners and other caring

professions. Parallels with similar professions may be found regarding caregiver burnout, vicarious traumatization, or compassion fatigue. Understanding this experience and the implications regarding these concepts can help to improve the experience of the behavior analyst and prevent potentially problematic outcomes among those practicing behavior analysis.

While there are many parallels discussed here, there are some stark differences in the experience of those practicing behavior analysis compared to other helping professions. Behavior analysts may have a smaller caseload, work longer hours or extended sessions lasting anywhere between 1-5 hours per client per session in a single week. Behavior analysts are often directly exposed to circumstances where problem behavior may occur and may be victims of aggression from clients directly. Vicarious traumatization may occur, but it is more likely that direct traumatization may be occurring as a result of immediate exposure to crisis events occurring with the client. The experience of behavior analysts may vary based on setting and population, similar to those practicing in other helping professions; however, the majority of behavior analysts are often exposed to individuals with special needs requiring support and services due to intense problem behavior, resulting in direct contact with situations that result in a health or safety risk on a daily basis (BACB, 2016).

The original research question for this study sought to answer whether behavior analysts engaged in self-care practices. Consistently, participants indicated that they do, which is a promising result. However, there are clear discrepancies in how self-care is defined among practitioners, and furthermore, how practitioners recognize what self-care

repertoires might look like. Some participants identified activities of daily living, which aligns clearly with their behavior analytic training. Others sought to answer the question by discussing their experiences with literature that aligns with behavioral approaches but is considered more conceptual at this time.

Furthermore, it appeared that much of the discussion regarding self-care took place around the impact of self-care and the current state of behavior analysis as practitioners. While this did not fall within the scope of the research question directly, this information provides a clearer picture of the lived experience of the behavior analyst in practice. Extensive travel, long work days, direct care of clients when providing direct services, and unpaid work were all noted variables that contribute to work stressors. Some participants working in clinic settings seemed to weigh some of these variables over others, such as putting more of an emphasis on unpaid work than on travel. Those working as instructors at colleges cited similar stressors in the academic environment but would note direct care variables from previous experiences.

The clearest analysis of the data provided is that behavior analysts may unknowingly participate in self-care activities as part of their routines. Discussion regarding their experiences seem to illustrate that behavior analysts are susceptible to the same variables related to burnout as those working in psychological or medical fields. This further highlights the gap in self-care research in behavior analysis despite all the parallels among behavior analytic practitioners and other fields where caregivers serve in the primary service provision role.

In sum, the results from the interviews conducted in this study indicate that behavior analysts have some exposure to self-care, but that there is no formal training outside of those skills related to hygiene and activities of daily living for others (Trahan et al., 2011; Vollmer et al., 1992). It is likely that behavior analysts informally complete self-care practices as a result of layperson exposure such as social media discussions or organizational cultures, however nothing formal was identified during the process. There seems to be some recognition as to the impact of self-care and self-care deficits, but again, this appears to come less from a behavior analytic scope and more from a self-monitoring, layperson viewpoint in relation to the concept of self-care. Behavior analysts who are currently practicing do engage in self-care behaviors, though it is inconsistent, informal, and potentially ineffective in addressing concerns around caregiver burnout or compassion fatigue.

The findings from the interviews closely align with Godfrey et al. (2011) in that the perspective and definitions of what self-care behaviors are and who engages in self-care are ill-defined. While Orem (2001) strives to define the behaviors, practitioners who engage in these behaviors still appear naïve to the concept in full, only engaging in the behavior in a cursory way. The behavior analysts in this study demonstrate an understanding of the concept as defined by Orem's (2001) theory and provided some examples of how they may regularly engage in self-care, such as reading or watching television in an attempt to remove themselves from a work environment. The behavior analysts interviewed here indicated that self-care activities do occur within the repertoires of behavior analysts, though this occurs as more of a casual practice rather than

intentional. Participants also noted some challenges regarding self-care, including availability of time or limited understanding of formal self-care practices.

Ultimately, it was discovered that behavior analysts do engage in self-care, but not as a result of formal training, exposure, or research. Instead, self-care behaviors are individualized and recognized through informal discussions around the topic, increasing interest in self-care as part of the behavior analytic culture, and from individual needs based on personal and professional experiences. Self-care is recognized among those in the community, though not from a clinical or academic perspective.

Limitations of the Study

Several limitations can be attributed to the nature of the study due to the subjective nature of the topic of self-care. Concepts like reliability and validity, which are found within qualitative research, limit the potential for quantitative results (Smith et al., 2012). This limitation also includes concerns with generalizability, which would be less of a concern in a quantitative study. With a focus on trustworthiness, however, the qualitative nature of this study can be considered reliable. The themes found within this study may be transferable, which helps to address issues with generalizability. While this may not address larger generalized claims of the consistency of the research, this does provide those reading the study to identify potential connections to the themes and sub-themes regarding their own lived experience.

A second limitation may be regarding the demographics of the participants in the study. Of the 10 participants, nine identified as female and one identified as male. They spanned in age between 30 and 40 years old and reported practicing between 3-10 years.

Most participants identified as white, while one participant identified as Latino and another as black. While saturation was reached at 10 participants, there may be unique lived experiences among male analysts, or those analysts that identify with minority populations in the United States. It is unknown whether differing demographics would highlight unique lived experiences within the field.

An additional limitation to the study could be the length of interviews conducted. Original interview times were slated between 60-90 minutes long, but the interviews conducted here lasted between 30-60 minutes consistently. With longer interviews, more information could be gathered regarding the lived experience of these practitioners. However, due to concise and literal nature of behavior analytic language among practitioners, it is possible that longer interviews might also become tedious and limit participant responses.

Over the course of each interview, I as the researcher attempted to remain unbiased. The researcher as a data collection instrument is a cornerstone of interpretative phenomenological research. It is understood that biases may exist due to learning history and perspectives on the subject being studied. It should also be understood that there is the possibility of an inherent bias toward self-care among behavior analytic practitioners. Because of the subjective nature of the focal point of the study, some questions or discussions regarding the topic may not yield a clear picture of the lived experience being studied here. There is the possibility that another researcher attempting to complete a replication of this study may find additional themes based on additional practice sites or exposure to unique populations outside of developmental disabilities.

Recommendations for Future Research

Despite research spanning nearly 100 years and including practical application, experimental analysis, and ongoing conceptualization, the field of behavior analysis is far from mature. In the past several decades, further expansions in research have broadened applications of the science, though there still seems to be a gap regarding research on the behavior analyst directly. Research focusing on the behavior analyst as the subject matter has been limited, and publications regarding ethics or supervision seemingly work to explore best practices in these subjects. Where the limitation is clearer is in the fact that the experience of the behavior analyst is not explored directly. While this study does not answer every question regarding the experience of behavior analysts, it could serve as a starting point to begin exploring the nuances of behavior analytic practitioners in a variety of settings.

Studies exploring the experience of behavior analysts in areas with limited resources, whether they are rural United States or countries with limited access to behavior analysts, would provide an opportunity to compare the experience of those working in more resource rich areas. An example of this would be with participant three, who worked in a community with limited access to publicly funded services and a minimal number of behavior analysts within their community. During interviews, such as with participant four, the experience of the behavior analyst working in a rural area may limit the number of collaborative opportunities with colleagues in person. In contrast, those working in clinic-based settings had multiple opportunities to connect with peers regarding case consultation. Another study could explore the impact of self-care and self-

care deficits among practitioners in different settings (i.e. home and community-based services vs. clinic-based services). In describing the experiences of the participants in the study, there are clear differences between working in a home-based setting vs. a community-based setting. Exposure to family dynamics or community experiences may be hindered in a clinic setting, which may alter the experience of the practicing behavior analyst.

Ultimately, the next step would be to take the time to further explore the experience of the behavior analyst in practice and continue to build a body of literature dedicated to studying the practitioner across a variety of settings. After interviewing practitioners from a variety of settings, it may be important to demonstrate clear differences in the lived experience of those practicing with various populations or in different treatment settings due to specific, practice specific variables that may not occur in another setting. It is recommended that additional studies include a more varied demographic among behavior analytic practitioners.

An additional recommendation would be to focus on behavior analytic practitioners within specialties, such as those working in early intervention, crisis management, organizational behavior management, or another area in which behavior analysts may work. For instance, contextual variables found in behavioral gerontology may provide a contrast to those working in early intervention. Crisis management treatment settings present a specific set of contingencies that may not be considerations working in a home-based treatment environment.

Another potential study would be a quantitative study that would evaluate the overall effectiveness of self-care routines on the behavior analytic practitioner. For example, it may be worth considering whether an intervention impacts self-care repertoire and what those effects might entail. This study only discusses whether self-care exists in the behavior analytic community, not whether self-care interventions have a specific treatment effect.

Implications and Social Change

This study offers some valuable implications for social change in relation to the behavior analytic community. Participants consistently reported that they had limited exposure to self-care practices or repertoires in their training. Similarly, participants reported feelings of burnout, loss of effective skills in practice, and repeatedly noted that colleagues shared these sentiments. This presents a concern with the care that is being provided to those seeking services as well as those who are receiving supervision as part of their training and development. The impact of self-care deficits has been discussed previously, and appeared to be no different among behavior analysts compared to other helping professions. Understanding this experience among behavior analysts is the first step to changing the perspective of self-care in the behavior analytic community.

This research also aims to offer a new perspective regarding behavior analytic practice and may serve to demonstrate that despite behavior analysis' designation as a natural science, practitioners in the role share many job characteristics of those working in social sciences, specifically human services. This parallel may serve to allow exploration into improve the quality of life of practitioners serving vulnerable

populations, prevent burnout among those in practice, and ultimately improve quality of services rendered. This, in turn, would serve to improve outcomes for vulnerable families in need of support.

With these findings, it is the hope of the researcher that the field of behavior analysis begin to explore the behavior analyst and their experiences in the field. Skinner's work on human behavior and the multitude of extensions that have been developed in the past decades lends itself to further conceptualization of human behavior and, in turn, the human experience. By exploring the lived experience of the behavior analytic practitioner and further conceptualize self-care within the behavior analytic context, behavior analysts can continue to improve their own practice repertoires.

Regarding these findings, behavior analysts need to be aware that self-care is not a topic that is commonly discussed but has been recognized as an important element of human services (Godfrey et al., 2011). Practicing behavior analysts should take steps to improve their self-care repertoires, seek formal study on the topic, and begin to develop individual interventions regarding their own self-care practices. Similarly, supervisors may benefit from identifying concerns with self-care and steps to begin practicing self-care within their current organizational settings. Ultimately, behavior analysts would begin to review self-care as an observable and measurable phenomenon, and as such, begin to focus on treating self-care deficits among those service individuals in need.

Researcher's Reflections

Completing this study was important to me for several reasons. While it was critical for me to complete the requirements of my doctorate, I strongly felt that this topic

was one of great importance in my field of practice. I have been practicing as a behavior analyst for nearly a decade, and I have seen the level of care and concern that practitioners exhibit. There is a level of care that I have not experienced in any other profession that I have spent time in, but I noticed patterns of avoidance and burnout that were not being openly discussed.

During this process, I pushed myself outside of my general competence and training so that I could learn more about what it means to be a behavior analyst. I believed that there was more to our profession then objective definitions and measurable results. Human services fields are not easy to understand fully, but it seems to be that behavior analysts are far behind in turning the research view on ourselves and taking the time to study the phenomena that we experience.

The behavior analyst is a newer profession, and in a field that is exponentially growing, I believe it's time to look at the practitioner themselves. I think that studying the experience of the behavior analyst is an area that will only further enhance our understanding of what behavior analysts cope with on a near daily basis. Self-care is merely a spoke in the wheel when discussing the overall practitioner experience.

This qualitative study is not a definitive account of the behavior analyst's experience in the field. In fact, it may only be the start of further exploration of the behavior analyst profession. There is much to learn about what a behavior analyst does day in and day out. There is more to explore regarding the perspective of the behavior analyst and how they perceive the world. I am satisfied with the results of this study,

though I know this is just the start of a deeper understanding of our field and the people that comprise it.

Conclusion

The focus of this study was to provide an extension to the self-care literature to include behavior analytic practitioners. The goal of this study was to be able to provide a picture of the lived experience of those behavior analysts currently certified and practicing regularly. The structure of this study allowed for the researcher to be able to gather specific and unique information from those who are currently immersed in the field. Five themes were identified in this study; limited exposure, variable definitions, high-stress work, impact of practice, and statements of need. These emergent themes provide an additional line of inquiry for future studies that focus on behavior analysts as the subject. It is the hope of this researcher that this line of research will help to focus the lens of scientific inquiry on the behavior analyst as a subject of scientific scrutiny and to help better understand this maturing profession.

After completing this study, further inquiry is necessary. However, this study provides a deeper understanding of the lived experience of the behavior analytic practitioner. Through this study, the behavior analyst role is one that is varied in daily practice as well as specialty. While some practitioners work to provide direct services, others focus on continuing education. While some work in clinics, others work in home and community-based settings. Each behavior analyst serves a unique population and set of challenging behaviors.

It was also made clear that self-care is not a core concept that behavior analysts directly experience in their training and academics. Some behavior analysts may have learned importance self-care concepts through independent professional development rather than formal academic training, and as a result, a more layperson approach to the concept of self-care has been adopted. However, the impact of self-care and self-care deficits can be noted and compared to the experience of other human services professions. Compassion fatigue and caregiver burnout may not be explicitly discussed here, but there is some cause for a new line of inquiry regarding these specific concepts.

Self-care as a concept is new to behavior analytic practice, though the literature does not describe this term in the same way as psychological research. Through this study, the need for ongoing exploration of self-care within the behavior analyst community is evident. The impact of self-care and self-care deficits among behavior analysts has only been briefly discussed through this study, and studies that can expand on the direct impact of this concept within the community may be beneficial to improving the quality of behavior analyst development in a rapidly growing field.

As we move forward in behavior analysis, the need for understanding the behavior analyst as a helping profession continues to grow. In the last decade since beginning to work in the field, behavior analysts have continued to grow exponentially, reaching over 30,000 certificants in 2018. Behavior analysts impact individuals with special needs, organizations, geriatric populations, and other populations that exhibit challenging behavior or skill deficits. As the field continues to grow, the need to care for

ourselves continues to become a pressing issue that will ultimately impact our profession and the communities we serve.

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Appendix A: Recruitment Email

Dear BACB Certificant,

We are inviting you to participate in a study about your experiences with self-care as a behavior analytic practitioner. **We are interested in exploring the self-care practices among currently certified BCBAs working in the field of behavior analysis.** Our hope is that the results of this research will help us to shed light on the nature of self-care skills among those who are currently certified and working within the field.

<u>The current inclusion criteria for this study is as follows:</u>

In order to participate in this study, potential participants must meet the following criteria:

- Must be a currently certified Board Certified Behavior Analyst (BCBA)
- Must have at least 3 years of experience practicing within the field of behavior analysis

Currently, BCaBAs and BCBA-Ds will not be included in this study.

Please know that your participation will remain confidential. Your participation is entirely voluntary. We will be conducting interviews as part of this research using a semi-structured interview style with 8 primary questions and some potential follow-up questions. These interviews should take approximately 60 minutes.

This study has been reviewed and approved by the Institutional Review Board of Walden University. If you have any questions or would like to participate, please email Shane Spiker at _____.

Thank you for your time and consideration.

Sincerely,

Shane Spiker, MS, BCBA

Appendix B: Open-Ended Interview Questions

The following questions have been developed for the semistructured interview design as part of this study:

Open-Ended Conversational Interviews

The following open-ended interview questions will be used:

1. What does a typical week of behavior analytic work look like for you?

2. What is your definition of self-care?

3. What do you do to take care of yourself after a difficult day of work?

4. What was your experience with self-care during your supervision toward board certification?

5: What was your previous exposure to self-care before this interview?

6. What happens to you when you aren't able to take care of yourself?

7. What kind of impact do you see on your professional practice when you are not taking care of yourself?

8. What kind of impact do you see on your professional practice when you are taking good care of yourself?