The Role of Self-Care and Hardiness in Moderating Burnout in Mental Health Counselors

Traci Danielle Richards
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THE ROLE OF SELF-CARE AND HARDINESS IN MODERATING BURNOUT IN
MENTAL HEALTH COUNSELORS

by

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Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELOR EDUCATION AND SUPERVISION

OLD DOMINION UNIVERSITY
May 2017

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ABSTRACT

THE ROLE OF SELF-CARE AND HARDINESS IN MODERATING BURNOUT IN
MENTAL HEALTH COUNSELORS

Traci Danielle Richards
Old Dominion University, 2017
Chair: Dr. Jeffery Moe

Due to the emotional intensity of the occupation, mental health counselors are highly susceptible to burnout, which can cause significant impairment (Lawson & Venart, 2005). For this reason, the profession emphasizes the use of self-care as an ethical imperative. Previous studies have verified self-care’s buffering effect on burnout (Collins & Long, 2003; Kraus, 2005; Stamm, 2002). However, personal factors, such as hardiness, may also be playing a role in this relationship. The main hypothesis of this study is that hardiness would serve as a buffer against the negative impacts of burnout, over and above self-care. Results of a hierarchical multiple regression indicated that hardiness accounts for more of the variance in predicting burnout than self-care. Results of a Pearson’s correlation and factorial MANOVA explored the relationships between counselor demographics and hardiness, with insignificant results. Data collected for this study has implications for self-care and resiliency curriculum and effective training programs for preventing and reducing burnout and enhancing wellness.
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This dissertation is dedicated to my dad, Ronald Brent Hickman.
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Chapter 1

Statement of the Problem

This chapter provides an introduction to the study and will review the background of the problem and the limitations of past research. This chapter will also review the purpose of the study, study significance, and the research questions. This chapter will conclude with definitions specific to this dissertation.

Introduction

Mental health counselors are particularly vulnerable to burnout, a term coined in the 70s to describe workers’ reactions to chronic stress common in occupations involving numerous interactions with people (Freudenberg, 1974). Mental health counselors face constant exposure to unique and emotionally charged working hazards, with burnout estimated as high as 67% for those in the mental health profession (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012, p. 2). The repercussions of burnout are far-reaching beyond just the physical, mental, and emotional impacts on the individual; there are also negative consequences for the organization and the clients who receive services (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012).

Due to the environmental facets that contribute to burnout symptoms, many studies have emphasized the power of modifying organizational-level factors (Burk & Richardsen, 1993; Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter, 2001; Stalker & Harvey, 2002). Skovholt and Trotter-Mathison (2011) emphasize that when the professional focuses on what he or she cannot control, job stress is intensified. Mental health counselors are not often able to control the organizational-environmental factors. For this reason, interventions and trainings do not address environmental factors, but rather internal factors (Skovholt & Trotter-Mathison, 2011). Additionally, even if some organizational-environmental aspects are modified,
occupational hazards such as normative failure, constant empathy, constant interpersonal
sensitivity, one-way caring, ambiguous loss, and the covert nature of the job – to name a few—
cannot be modified (Skovholt & Trotter-Mathison, 2011). For this reason, this study focused on
the individual in order to better inform mental health counselor wellness trainings and
educational courses and programs.

Currently, counselor ethical codes and educational programs emphasize the obligation to
refrain from practicing while impaired. The American Counseling Association (ACA) places
emphasis on maintaining competency and protecting clients from one’s personal problems that
interfere (ACA, 2014). Specifically, Section C of the ACA Code of Ethics (ACA, 2014) states
counselors should “refrain from offering or providing professional services when such
impairment is likely to harm a client or others” (C. 2 g.) and “continually monitor their
effectiveness as professionals” (C.2.d). The broad interpretation of this standard is to attend to
one’s own care in order to adequately help others and prevent harm (Barnett, 2007). The Council
for the Accreditation of Counseling and Related Educational Programs (CACREP; 2016)
includes standards for self-care in Section II. F. 1. L: “self-care strategies appropriate to the
counselor role.” The ACA ethical code also explicitly includes self-care as part of professional
responsibility, stating counselors should “engage in self-care activities to maintain and promote
their own emotional, physical, mental, and spiritual well-being to best meet their professional
responsibilities” (Section C, p. 8). In sum, self-care is an ethical necessity (Carroll, Gilroy, &
Mura, 1999).

Self-care as an ethical imperative has support in the research: it has been identified as a
protective factor against burnout (Stamm, 2002). Self-care and coping skills for stress are
without a doubt important, but there may be another variable such as personal factors, that is
aiding these strategies in buffering against burnout. Morse et al., (2012) emphasize the need for increasing “other human qualities and abilities” to add to burnout prevention research (p. 8). Research supports hardiness, a personality construct known as dispositional resilience, has shown promise in reducing burnout. Hardiness has been identified as a personality factor that buffers against job dissatisfaction (Maddi, 1999a), diminished well-being (Bartone, Ursano, Wright, & Ingraham, 1989; Lambert, Lambert, Klipple, & Mewshaw 1989; Nathawat & Joshi, 1997; Nathawat & Rathore, 1996; Robitschek & Kashubeck, 1999), and burnout (Chan, 2003; Collins, 1996; Keane, Ducette, & Adler, 1985; McCranie, Lambert, & Lambert, 1987; Simoni & Paterson, 1997).

**Purpose of the Study**

The purpose of this study is to investigate the relationship between select demographic variables such as gender, time in the counseling field, and specialty area on counselor hardiness. Secondly, this study seeks to determine how hardiness is related to burnout and self-care to ascertain if these variables are predictors for burnout. Thirdly, this research seeks to identify if hardiness is a moderator for burnout, over and above self-care strategies.

**Significance of the Study**

As mentioned above, counselors have an ethical imperative to remain effective by avoiding burnout and other occupational hazards. This study contributes valuable insight into the resiliency of counselors, identifies possible factors to buffer against the negative impact of burnout, and will build upon gaps in previous research using a direct measure for hardiness and sampling from the counseling profession. Data collected for the study may guide curriculum for self-care and resiliency within the counseling field and inform effective training programs for preventing and reducing burnout and enhancing wellness.
Limitations of Past Research

While it is recognized that burnout is detrimental, research continues to be limited with many gaps in understanding the specific preventative factors and effective interventions (Paris & Hoge, 2010; Morse et al., 2012). Certain job characteristics have been shown to impact and reduce burnout, however, these are outside of a professional’s control, reinforcing the need to maintain the focus on the internal aspects of burnout. Pick and Leiter (1991) further support this assertion, stating that despite organizational predictors, researchers need to consider personality differences particularly when it is unclear which specific individual differences contribute to burnout. Furthermore, the influence of personality traits needs to be considered when exploring burnout; what may be exhilarating to one person may be overtaxing to another (Jennings, 2008). The hardy personality has been identified as a moderator for burnout, though the focus has been on the nursing profession and several empirical discrepancies are noted. First and foremost, these studies did not include counselors. Secondly, is the problem of the measurement: these studies used Kobasa’s (1981) initial hardness instrumentation, which had several flaws. Younkin and Betz (1996) identified four major problems with the Kobasa instruments, to include (a) they lacked stability, (b) they utilized three traits already identified as important in stress resistance to measure a supposedly uni-dimensional trait of hardiness, (c) the differential relationship of the dimensions to criterion variables, and (d) the use of negative indicators. Despite these problems, the authors acknowledged that the concept of hardiness has “logical merit and face validity” (p. 163) and emphasized the need for a direct (rather than indirect) measure for hardiness. With the early instrumentation available, there were inconsistent methods of measurement across the studies mentioned above; it is possible that the hardiness construct was conceptually flawed or something other than hardiness was being measured in these studies. This created a need for a
study using a third generation, direct measure of hardiness with a focus specifically on those within the mental health profession. This study does just that: it extends hardiness research to mental health counselors and utilizes an instrument that offers a direct measurement of this construct.

**Research Questions and Hypotheses**

Motivated by a desire to address specific gaps in prior studies and improve the effectiveness of mental health counselors’ self-care and preparation for high-stress environments and the occupational hazard of burnout, mental health counselors were asked to answer the following questions:

**Research Question One**

What is the relationship between mental health counselors’ hardiness levels and select demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area)?

**Null Hypothesis One**

There will be no significant ($p \leq .05$) difference in mental health counselors’ hardiness based on select demographic variables.

**Research Hypothesis One**

There will be a significant ($p \leq .05$) difference in mental health counselors’ hardiness based on select demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area).
Research Question Two

What is the relationship between burnout, hardiness, and self-care in a sample of mental health counselors, adjusting for demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area)?

Null Hypothesis Two

There will be no significant ($p \leq .05$) relationship between burnout, hardiness, and self-care, after adjusting for demographic variables.

Research Hypothesis Two

Mental health counselors’ hardiness and self-care will predict ($p \leq .05$) burnout, adjusting for demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area).

Research Question Three

Does mental health counselors’ hardiness account for a significant amount of the variance in predicting self-reported burnout, over and above that accounted for by self-care and other demographic variables?

Null Hypothesis Three

Hardiness does not account for a significant amount of the variance in self-reported burnout, over and above that accounted for by self-care and other demographic variables.

Research Hypothesis Three

Mental health counselors’ hardiness will account for a significant amount of the variance in self-reported burnout over and above that accounted for by self-care and other demographic variables.
Study Specific Definitions of Terms

Mental Health Counselor

Mental health counselors are those who have earned a master’s degree in counseling and specialized in mental health (AMHCA, 2016). For the specific purpose of this study, a mental health counselor is one that selects the response ‘yes’ to the survey question “Are you a mental health counselor?”

Gender

Gender refers to the “attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex” (American Psychological Association, 2012). For the purposes of the present study participants indicated their gender as female/female-identified, male/male-identified, transgender, or ‘other’ with the option to write in their gender identity.

Ethnocultural Identity

This term refers to the racial or cultural group(s) an individual identifies with; for the purposes of this study categories were based on the U.S. Census (2013) categories: Black or African American, White or European-American, Native American /Alaska Native, Asian or Asian-American, Hispanic or Latina/Latino, Multiple Heritage, Native Hawaiian/Pacific Islander, or Other.

Job Satisfaction

Job satisfaction is how content an individual is with his or her job. For the specific purpose of this study, job satisfaction is the response ‘yes’ to the survey question “Are you satisfied (contented, pleased) with where you work?”
**Burnout**

Burnout is defined as “a psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job” (Leiter & Maslach, 2004, p. 93). For this study, burnout was demonstrated upon the summation of the three dimensions on the Maslach Burnout Inventory (MBI): emotional exhaustion, depersonalization, and personal accomplishment (reverse coded).

**Hardiness**

Hardiness has been defined as a “pattern of attitudes and skills that facilitates turning adversity into opportunity, thereby enhancing performance and health” (Khoshaba & Maddi, 2005, p. 43). For this reason, hardiness is called “dispositional resilience” (Bartone, 2006, 2007). For this study, hardiness was determined using the Dispositional Resilience Scale-15 (DSR-15). A respondent will be considered hardy if the score on the DSR-15 is 33 or above.

**Self-Care**

Self-care is any intentional actions an individual takes to care for oneself. Individuals choose different strategies and activities, all toward the goal of finding a state of optimal physical, mental, and emotional health.

**Physical Self-Care**

Physical self-care was defined as “incorporating physical activity (e.g. exercise, sports, household activities, etc.)” (Richards, Campenni, & Muse-Burke, 2010).

**Psychological Self-Care**

This term refers to “one’s own personal therapy (psychological treatment, in any form, for psychological distress or impairment experienced” (Richards, Campenni, & Muse-Burke, 2010).
**Spiritual Self-Care**

Spiritual self-care is defined as “activities and behaviors to enhance one’s sense of purpose and meaning of life; deep thoughts or contemplation resulting in introspection (e.g., attending worship, praying, attending retreats, meditation, etc.)” (Richards, Campenni, & Muse-Burke, 2010).

**Support Self-Care**

This term refers to “relationships and interactions developed and maintained as professional and personal support systems (e.g., consultation and supervision from peers, colleagues, and supervisors; continuation of professional education; quality time with spouse, companion, friends, family, etc.)” (Richards, Campenni, & Muse-Burke, 2010).

**Self-Care Frequency**

Self-care frequency is how often one engages in actions to take care for oneself. Replicating a previous study by Richards, Campenni, and Muse-Burke (2010), participants were given a broad definition of self-care and its main components: physical, psychological, spiritual, and support and indicated on a Likert scale the frequency of each. For purposes of this study, items were totaled to produce final scores of zero to 24, with higher scores indicating greater propensity for self-care.

**Self-Care Importance**

Self-care importance is how much one values the components of caring for oneself. Replicating a previous study by Richards, Campenni, and Muse-Burke (2010), participants were given a broad definition of self-care and its main components: physical, psychological, spiritual, and support and indicated on a Likert scale the importance of each. For purposes of this study,
items were totaled to produce final scores of zero to 24, with higher scores indicating agreement with self-care importance.
Chapter 2

Literature Review

Burnout is defined as “a psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job” (Leiter & Maslach, 2004, p. 93). Research has long supported that burnout negatively impacts the individual, organization, and the clients who receive services (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). The field of mental health involves working conditions and therapeutic encounters that are stressful for the workers, making them particularly vulnerable to burnout. Paris and Hoge (2009) emphasize the need to “build a more robust knowledge base about the prevalence, causes, and effects of burnout in this field” (p. 526). Morse et al. (2012) identified “ironically, the mental health field has paid relatively little attention to the health and well-being of its workers…there is a pressing need for additional, basic research on mental health and burnout” (p. 10). This dissertation sought to identify a moderating agent that buffers against the effects of burnout, namely: the personality characteristic of hardiness. Understanding hardiness could guide future intervention studies and effective training programs for preventing and reducing burnout and enhancing wellness.

Burnout

Freudenberger (1974) introduced the term ‘burnout’ related to worker stress in the 70s. It has been estimated that over 6,000 articles, chapters, dissertations, and books have been written on the subject in the 35 years after its introduction with over 300 articles published within the first 5 years (Skovholt & Trotter-Mathison, 2011). With this extensive popularity have come several definitions and conceptualizations. Burnout affects every profession, but mental health professionals are particularly susceptible. Kottler (2003) identifies burnout as “the single most common personal consequence of practicing therapy” (p. 158).
**Burnout Construct**

Burnout is a distinct construct, empirically separate from a general stress reaction (Awa, Plaumann, & Walter, 2010) or a mental health disorder such as depression (Bakker et al., 2000), or from job dissatisfaction (Maslach, Schaufeli, & Leiter, 2001). As a construct, it is also distinct from secondary traumatization (Figley, 1995), vicarious traumatization (Dunkley & Whelan, 2006), and compassion fatigue (Canfield, 2005), although these are often referred to as types of burnout (Figley, 1995). Burnout can be measured as a continuous variable. Maslach, Jackson, and Leiter (1996) presented ranges to conceptualize low, average, and high levels of burnout. Burnout can also be conceptualized as a multidimensional syndrome characterized by emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment (Lawson, 2007; Maslach, Jackson, & Leiter, 1996; Soderfeldt, Solderfelt, & Warg, 1995). This three-factor model has been supported through confirmatory factor analyses in numerous studies (Belcastro, Gold, & Hays 1983; Green & Walkey, 1988; Lee & Ashforth, 1990; Pierce & Molloy, 1989). These three factors are described further below.

**Emotional Exhaustion**

This dimension measures feelings of being emotionally overextended and exhausted by one’s work (Maslach & Jackson, 1981). Emotional exhaustion corresponds with the concept of strain and linked to anxiety and physiological symptoms such as tension, physical fatigue, and insomnia (Maslach & Jackson, 1981). Further, it is a reflection of stress symptoms, with a focus on physiological and affective-cognitive strain (Perlman & Hartman, 1982) Maslach and Jackson (1981) link emotional exhaustion to the ambiguity and frustration of continually working with clients for whom solutions are not always obvious or easily obtained. This chronic stress can
cause emotional resources to feel depleted, giving a sense that the helper has nothing left to give (Maslach & Jackson, 1981).

**Depersonalization**

This dimension measures an unfeeling and impersonal response toward recipients of one’s service, treatment, or instruction (Maslach & Jackson, 1981). Depersonalization corresponds to the notion of defensive behavior and self-appraisal of performance (Ashforth & Lee, 1990) and treating others as objects or numbers rather than as people (Kahill, 1988; Maslach, 1982). This dimension is a reflection of the behavioral stress symptoms (Perlman & Hartman, 1982). Maslach and Jackson (1981) associate depersonalization with cynicism and negative attitudes and feelings about one’s clients. Ryan (1971) identified that the dehumanized perception of clients can lead the worker to believe the client is deserving of his or her troubles.

**Personal Accomplishment**

This dimension measures feelings of competence and successful achievement of one’s work. Personal accomplishment corresponds to self-efficacy and is linked to adjustment to demanding situations (Bandura, 1986; Lee & Ashford, 1990). Thus, personal accomplishment, similar to self-efficacy, represents the perception of control (Gecas, 1989), but also motivation to be in control (Lee & Ashford, 1990). Lee and Ashford (1990) confirmed the strong association between personal accomplishment with perceptions of performance and the use of control, which the researchers link to cognitive and behavioral aspects of efficacy expectations. Maslach and Jackson (1981) link this dimension of the helper’s tendency to negatively evaluate their performance and feel dissatisfied with job accomplishments. In a survey to establish external validity of the Maslach Burnout Inventory, police wives indicated frequency of their husband’s behaviors. The wives that rated their husbands as having a cheerful mood and as doing work that
was a source of pride and prestige for their family had husbands that scored higher on Personal Accomplishment (Maslach & Jackson, 1981).

**Burnout Prevalence**

Due to the significant impact on personal and professional life, mental health counselors need to be concerned about burnout (Lawson, 2007). Several studies have attempted to ascertain the scope of burnout within the mental health field (Oddie & Ousley, 2007; Rohland, 2000; Siebert, 2005; Webster & Hackett, 1999;). In these studies, the prevalence of high levels of burnout among mental health workers has been found to be between 21% and 67% (Morse et al, 2012, p. 2). Morse et al. (2012) point out that although methodological problems are common in these prevalence studies, the rates across studies indicate that burnout is “widespread” and “will continue to increase” (p. 4). Though burnout has been explored within and among professions and disciplines, burnout has been found higher among community social workers compared to nurses and psychiatrists (Priebe, Fakhoury, Hoffman, & Powell, 2005). Mental health counselors are particularly susceptible to burnout due to the intense proximity to the struggles of others and the exhausting pace of the workload. Skovholt (2001) explained burnout occurs “when the calling of caring for others and giving to others in an area such as emotional development, intellectual growth, or physical wellness no longer gives sufficient meaning and purpose in one’s life” (p. 111). Morse et al. (2012) stated

Despite its prevalence and association with a number of negative outcomes, little has been directed toward reducing or preventing burnout among mental health professionals. The need for burnout prevention and interventions for mental health providers has been highlighted by researchers for decades (p. 6).
Contributing Environmental Factors

Many environmental factors of the mental health profession contribute to burnout. Maslach & Leiter (2008) identify seven of these factors within the general workplace that include: work overload, control, reward, fairness, community, value, and job-person incongruity. Solderfeldt, Solderfelt, and Warg (1995) identified several work related factors specific to the mental health profession associated with burnout that include low work autonomy, lack of challenge on the job, low degrees of support, role ambiguity, work in public sector, low professional self-esteem, low salary, and bad agency functioning. Work setting may play a role as evidenced by findings from Prosser et al. (1997) in which inpatient staff experienced lower levels of burnout than community based staff. Rupert and Kent (2007) found higher levels of personal accomplishment in psychologists working independently or in group practices compared to those working in agency settings. Many studies have emphasized the power of modifying these organizational-level factors (Burk & Richardsen, 1993; Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter, 2001; Stalker & Harvey, 2002). However, as Skovholt and Trotter-Mathison (2011) emphasize: when the professional focuses on what he or she cannot control, job stress is intensified. Mental health counselors are not often able to control the organizational-environmental factors. For this reason, interventions and trainings do not address environmental factors, but rather internal factors (Skovholt & Trotter-Mathison, 2011). Additionally, even if some organizational-environmental aspects are modified, occupational hazards such as normative failure, constant empathy, interpersonal sensitivity and one-way caring, ambiguous loss, and the covert nature of the job – to name a few—cannot be modified (Skovholt & Trotter-Mathison, 2011).
Impacts of Burnout

Personal Impacts

The burned out professional is described as “disenchanted, discouraged, irritated, frustrated, and confused” (Burke, 1981, p. 52) and faces serious risks-- burnout symptoms have mental and physical health implications. Regarding mental health symptoms, Schonfeld and Bianchi (2016) found that previous studies have under-estimated the burnout-depression overlap and suggest that burnout is likely a form of depression (Shonfeld & Bianchi, 2016). Ahola et al. (2005) found that those with mild burnout were at 3.3 times more risk of having major depressive disorder. Burnout is also correlated with anxiety symptoms (Corrigan, Holmes, & Luchins, 1995; Jansson-Fromjark, & Lindblom, 2010; Rossler, Hengartner, Ajdacic-Gross & Angst, 2015; Shirom & Ezrachi, 2003), nightmares (Clark & Gioro, 1998), grief (Clark & Gioro, 1998), sleep disturbances (Bride, 2004), and relational conflicts (Steed & Downing, 1998). Burnout is associated with increased alcohol consumption, substance use (Peterson et al. 2008; Rohland, 2000) and a diminished sense of well-being (Stalker & Harvey, 2002). Regarding the health implications, burnout is associated with higher rates of physical illness to include greater reports of flu-like symptoms and gastroenteritis (Acker, 2010). Burnout is associated with increased use of sick leave (Austin, Goble, Leier, & Byrne, 2009; White, 2006) and physical complaints (Bride, 2004; Steed & Downing, 1998). Burnout is also linked with impaired memory and neck and back pain (Peterson et al. 2008).

Professional Impacts

Burnout impacts the workplace as well. Burnout is associated with higher turnover rates (Austin, Goble, Leier, & Byrne, 2009; Stalker & Harvey, 2002; White 2006), lower morale and productivity (Stamm, Varra, Pearlman, & Giller, 2002; White, 2006), low energy and fatigue,
(Lambie, 2006), and being late or absent from work (Schwab, Jackson, & Schuler, 1986; Smoot & Gonzolas, 1995; Stalker & Harvey, 2002). These behaviors can disrupt continuity of care (Boyer & Bond, 1999) and impact quality of services (Carney, Donovan, Yurdin, & Starr, 1993; Hoge et al., 2007; Maslach & Pines, 1979). Rollins, Salyers, Tsai, and Lydick (2010) found a correlation between staff absences and turnover and reduced use of evidenced based practice. In a study of psychologist effectiveness, almost 60% admitted to having worked when impaired (Pope, Tabachnick, & Keith-Spiegel, 1987). In an ACA survey, 63.5% of mental health professionals reported knowing an impaired colleague and 75.7% identified impaired professionals as a threat to the profession (APA, 2010). Kottler (2003) found that counselors are often reluctant to report burnout, thus remaining on the job while too distressed to be effective. Research confirms clients report lower satisfaction with services when the counselor is impaired (Austin, Goble, Leier, & Byrne, 2009; Phelps, Lloyd, Creamer, & Forbes, 2009; White, 2006), which follows the fact that burnout is associated with cynicism and distant, rejecting attitudes towards clients (Holmqvist & Jeanneau, 2006). Failing to address burnout could lead to counselor impairment and potentially result in reduced quality of services and unethical behaviors (Lawson & Venart, 2005).

**Preventing Burnout**

**Environmental Factors**

Research has attempted to identify strategies and factors to prevent burnout. As mentioned, the most effective approach has been to identify organizational strategies to prevent burnout. Pines (1993) identified that developmentally supportive environments reduce the likelihood of burnout. In this way, supportive environmental strategies such as increasing promotion opportunities (Abu-Bader, 2000), competitive salaries, increased staffing levels, and
flexible work schedules (Paris & Hoge, 2009), have been found to reduce the impact of burnout. Despite the impact and implication of this research to the administrative realm, the individual or training institutions cannot control these environmental factors.

**Personal Factors**

The degree to which a person is a match or a mismatch with the mental health profession is correlated to burnout (Maslach, Schaufeli, & Leiter, 2001) and some personal factors may play a role in preventing burnout, including one’s attitude and meaning making abilities. For instance, job satisfaction (Schulz, Greenley, & Brown, 1995), compassion satisfaction (Stamm, 2002), and affective commitment to the work (Rhoades, Eisenberger, & Armeli, 2001) have been found to moderate levels of burnout, though none with a specific focus on mental health counselors. An individual’s use of self-care has also been identified as a protective factor that offsets burnout. Stamm (2002) found that those who had sustained relationships and conducted self-care tasks were less at risk for burnout. Collins and Long (2003) identified active coping as the most common coping strategies used by counselors to cope with work related stress. Active coping includes activities that promote physical health and well-being, spiritually-oriented activities, various leisure activities, and seeking both emotional and instrumental support (Kraus, 2005). Much of the intervention strategies focus on cognitive and behavioral aspects of coping, though some have endeavored to explore emotional coping, with mixed results. Wilkerson and Bellini (2006) found emotion-oriented coping was predictive of burnout, meaning that focusing on feelings associated with the stressors were predictive of higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment. However, this is contrary to the findings that escape-avoidance strategies and turning away from these emotions are related to symptoms of burnout (Venart, Vassos, & Pitcher-Heft, 2007). Morse et al. (2012) acknowledge
the importance of coping skills in reducing burnout, yet emphasize the need for studies to explore and identify “other positive human qualities and abilities” (p. 8).

**The Big Five Factors of Personality**

The risk of burnout differs among work stressors, but may also differ across individuals. Gaining an understanding of the role personality in burnout could clarify burnout as related more to individual variability than a social phenomenon (Bakker, Van Der Zee, Lewing, & Dollard, 2006). Extensive research has explored the relationship between burnout and the Big Five factors of personality, with consistent findings of Neuroticism and Conscientiousness as predictors of burnout (Armon, Shirom, & Melamed, 2012). In a sample of 80 volunteer counselors, Bakker, Van Der Zee, Lewig, and Dollard (2006) found that emotional exhaustion was predicted by emotional stability; extraversion, autonomy, and emotional stability predicted depersonalization; and personal accomplishment was predicted by extraversion and emotional stability. These findings suggest personality protects against the risk of developing burnout in counseling (Bakker, Van Der Zee, Lewing, & Dollard, 2006). An additional finding from this study was a positive relationship between neuroticism and burnout only in volunteers with many negative experiences as opposed to those with few negative experiences (Bakker, Van Der Zee, Lewing, & Dollard, 2006). The researchers surmised that individual differences in relation to burnout reflect differential reactions to stressful situations; certain individuals may be more capable of adapting to stressful conditions and returning quickly to their well-being baseline (Bakker, Van Der Zee, Lewig, & Dollard, 2006).

**Positive Psychology and Resiliency**

Borrowing from the positive psychology movement, this study sought to identify a personal factor to buffer against burnout. The three pillars of positive psychology, as described
by Seligman (2002), include the study of positive emotions, the study of positive human traits, and the study of positive institutions. Positive psychology research focuses on building strengths and personal resources and finding variables that enable the individual to thrive in the face of adversity (Seligman & Csikszentmihalyi, 2000). One such positive psychology variable that has been able to promote wellbeing in helping professions is resilience.

According to Everly, Welzant, & Jacobson (2008) resiliency is one’s ability to recover from adversity without experiencing significant distress. The personality trait that promotes resiliency is called hardiness (Barton, 2006; Maddi, 2007). For this reason, hardiness is called “dispositional resilience” (Bartone, 2006, 2007) and considered a pathway to resilience (Bonanno, 2004). The hardness dimensions are “the core individual-level qualities that affect resilience” (Escolas, Pitts, Safer, & Bartone, 2013, p. 117). Maddi (2002), who originally conceptualized hardiness as ‘existential courage,’ explains that the hardiness attitudes “facilitate awareness that you formulate life’s meaning for yourself by the decisions you make and that choosing the future regularly, despite the anxiety of uncertainty, leads to the most vibrant life” (Maddi, 2002, p. 175).

**Hardiness**

Selye (1956) is credited with discovering “stress” when he observed that patients suffering from different diseases often exhibited identical signs and symptoms (Kobasa, 1979b). Selye emphasized individual differences in the stress reaction and the personality as the distinctive way in which individuals deflect the negative impact of stressful life events (Collins, 1996; Kobasa, 1979b; Selye, 1956). It was from this angle of determining which personality could protect the individual from stress that Kobasa (1979b) sought to identify factors of those who remained healthy under life stress. Kobasa (1979a) hypothesized that individuals who
remain healthy after experiencing stress exhibit “a constellation of attitudes, beliefs, and behavioral tendencies” (p. 1). Kobasa labeled this constellation *hardiness* and it serves as a model of individual resiliency to stress. Overtime, it has been defined not as a single personality style, but rather a combination of personality factors that decrease illness-causing effects in the face of stressful life situations (Funk & Houston, 1997; Ganellen & Blaney, 1984, Kobasa, Maddi, & Kahn, 1982; Wagnild & Young, 1991). It has been established as distinct from constitutional predisposition (Kobasa, Maddi, & Courington, 1981), exercise, social support (Kobasa, Maddi, Puccetti, & Zola, 1985, type A behavior, and health practices (Maddi & Kobasa, 1984). Hardiness has convergent properties with locus of control (Rotter, 1990), optimism (Scheier, Carver, & Bridges, 2001), and self-efficacy (Bandura, 1997).

Hardiness is conceptualized as “a source of resistance to the negative effects of stressful life events” (Kobasa & Pucetti, 1983, p.840) or simply put: “a stress-resistance resource” (Kobasa, 1983, p. 840). Hardiness has been defined as a “pattern of attitudes and skills that facilitates turning adversity into opportunity, thereby enhancing performance and health” (Khoshaba & Maddi, 2005, p. 43). Hardiness is a set of personality variables that promote resiliency (Bartone, 2006; Maddi, 2007). Maddi (1967) identifies the hardy person as the “ideal identity” in which the person has a sense of purpose and belief in their own effectiveness. Gentry and Kobasa (1984) explain that the conceptual framework for hardiness theory is that hardy individuals reduce stress through reappraisal of stressors through the use of adaptive coping behaviors. The implication of hardiness is that it may be learned, which has practical implications for training programs and interventions (Kardum, Hudek-Knezevic, & Krapic, 2012; Walton, 1990).
According to the hardiness model, the hardy individual transforms stress into advantage through hardy coping, hardy social interaction, and hardy self-care (Maddi, 2013). Hardiness has been associated with active, transformational and problem-focused coping and less emotion-focused coping (Williams, Wiebe, & Smith, 1992). These coping strategies are those that reframe stress into a benign experience. Individuals low in hardiness have been found to use cognitive and behavioral avoidance and denial strategies, which is suspected to compound the emotional stress and maladjustment (Williams, Wiebe, & Smith, 1992). Hardy self-care is identified as putting forth effort to promote bodily functioning such as engaging in relaxation, having a balanced and moderate diet, and maintaining a moderate level of physical activity (Maddi, 2013).

**Hardiness Dimensions**

Kobasa initially identified three general characteristics of the hardy person:

a) The belief that they can control or influence the events of their experience,

b) An ability to feel deeply involved in or committed to the activities of their lives, and

c) The anticipation of change as an exciting challenge to further development (Kobasa, 1979b, p. 3).

These factors are described further below.

**Control**

Kobasa built on the model proposed by Averill (1973) in which some organisms maintained their health despite being highly stressed. Averill’s model proposed that the highly stressed, but healthy person maintains decisional control, cognitive control, and effective coping skills (Kobasa, 1979a). Persons high in hardiness believe they have personal influence over events, rather than feeling powerless (Kobasa, 1979b). This perception enhances stress resistance
as the individual assesses the experience as one of normal, everyday occurrences rather than out of the ordinary (Kobasa, 1979b; Kobasa, Maddi, & Kahn, 1982). As such, the individual views the situation as within his or her capabilities for managing and is not therefore overwhelmed (Bowsher & Keep, 1995; Kobasa, 1979b; Kobasa, Maddi, & Kahn, 1982). This dimension may overlap with Benight and Bandura’s (2004) construct of Coping Self-Efficacy (CSE), which has also been utilized as a predictor for resilience and recovery (Benight et al., 2000; Benight, Harding-Taylor, Midboe, & Durham, 2004; Cieslack, Benight, & Lehman, 2008; Hirschel & Schulenberg, 2009; Solomon, Benbenishty, & Mikulincer, 1991). Distinguishing between these two traits is beyond the scope of this dissertation.

**Commitment**

Kobasa hypothesized that committed persons have a belief system that mitigates the threat inherent in stressful life events (Kobasa, 1979b). Committed persons have a sense of purpose and an involvement with others, therefore having both a reason and an ability to seek social support when encountering stressful environments (Kobasa, 1979b). In this way, they commit themselves to what they are doing rather than having feelings of alienation and are more likely to become active in the process of change (Kobasa, 1982; Kobasa & Puccetti, 1983).

**Challenge**

For the third dimension, Kobasa hypothesized individuals under stress that view the change as a challenge would remain healthier than those who view it as a threat (Kobasa, 1979b, p. 4). These individuals were described as “cognitively flexible” and “change seekers” (Kobasa, 1979, p. 4). Having cognitive flexibility allows the individual to appraise and integrate new situations, engage in decision-making, confirm life’s priorities, set new goals, and engage in other complex activities (Kobasa, 1979b; Kobasa 1983). Being receptive to change allows for a
life filled with interesting experiences (Kobasa, 1979b). Thus, coping for the hardy individual resides in their ability to turn stressful life events into possibilities and opportunities for personal development, allowing for openness to change and adaptation (Bowsher & Keep, 1995; Kobasa, 1982; Kobasa, Maddi, & Kahn, 1982; Kobasa & Puccetti, 1983). This dimension may overlap with Hope Theory, which posits that hope is what underlies one’s ability and motivation for seeking and obtaining goals as well as drives one’s emotions and well-being (Snyder, Rand, & Sigmon, 2002). Distinguishing between the personality of the highly hopeful and the hardy individual is beyond the scope of this dissertation.

**Hardiness as A Buffer**

**Buffer Against Illness**

Hardiness was initially explored for its buffering effect on health and illness prevention (Kobasa, Maddi, & Courington, 1981; Kobasa, Maddi, & Kahn, 1982; Kobasa & Puccetti, 1983; Kobasa, Maddi, Puccetti, & Zola, 1985). These studies consistently showed hardiness had moderating effects on illness. Hystad, Eid, and Brevik (2011) found that hardiness predicted both the likelihood of having any sickness absence and the number of absence spells. Additionally, these researchers found an interaction between hardiness, job control, and psychological demands. Specifically, when demands were high, high job control was associated with more absence among employees with low levels of hardiness. Mental health counselors often face high psychological demands and have low job control. Increasing a mental health counselor’s hardiness may serve as a buffer to these two factors. As previously mentioned, burnout contributes to mental health symptoms among professionals (Ahola et al., 2005; Corrigan, Holmes, & Luchins, 1995; Jansson-Fromjark, & Lindblom, 2010; Rossler, Hengartner, Ajdacic-Gross, & Angst, 2015; Shirom & Ezrachi, 2003; Shonfeld & Bianchi, 2016). Maddi and
Khoshaba (1994) sought to identify hardiness as a quick index of mental health. The researchers related hardiness to the Minnesota Multiphasic Personality Inventory (MMPI) and the results suggested hardiness as a general measure of mental health, controlling for negative affectivity.

**Buffer Against Job Dissatisfaction**

Hardiness was also explored for its impact on performance (Maddi & Hess, 1992; Manning, Williams, & Wolfe, 1988; Nowack & Hanson, 1983; Westman, 1990). These studies showed hardiness as positively related to performance outcomes. Further, and important for this dissertation, hardiness has been identified as a personality factor that improves performance through increased satisfaction with one’s work, feelings of control over the work situation, and the increased use of a coping style in which one believes he or she is becoming a better person by being exposed to the stressful situation (Maddi, 1999a). Hardiness may help explain the phenomenon in which mental health professionals score high in the burnout dimension of emotional exhaustion as well as high in personal accomplishment (Paris & Hoge, 2009, p. 526).

**Buffer Against A Diminished Well-Being**

Hardiness has been recognized as having impact on subjective well-being (SWB), which refers to one’s judgment of his or her life as happy and filled with satisfaction (Costa & McCrae, 1985; King & Napa, 1998; Lightsey, 1997). Subjective Well Being studies have linked life satisfaction or happiness to greater job satisfaction (Fielding, Li, & Tang, 1995; George & Jones, 1996; Judge & Lock, 1993) and to increased adaptation to change and adverse life conditions (Headey, Kelley, & Waring, 1992; Headey & Waring, 1989; Myers & Diener, 1995). Hardy individuals tend to be higher in SWB than individuals low in hardiness (Bartone, Ursano, Wright, & Ingraham, 1989; Lambert, Lambert, Kipple, & Mewshaw, 1989; Nathawat & Joshi,
found that employees who experience burnout also experience a diminished sense of well-being.

**Hardiness as Moderator for Burnout**

Due to the practical implications of hardiness in planning stress management programs, numerous authors have explored the effects of hardiness on work-related outcomes, with the majority on burnout. The generated research suggests that hardiness is negatively related to burnout, though the focus has been in the professions of nursing and education (Chan, 2003; Simoni & Paterson, 1997).

Pollock (1989) was perhaps the first to emphasize the importance of the hardiness characteristic to the nursing field and proposed that due to “stressful jobs and the associated burnout” nurses may benefit from hardiness instruction (p. 61). Keane, Ducette, and Adler (1985) were the first to present data supporting hardiness as a resistance resource for preventing burnout among hospital nurses. Hardiness was found to be significantly associated with burnout among ICU nurses (Keane, Ducette, & Adler, 1985). Replicating the Keane study for validity and generalizability and including a different sample of nurses, McCranie, Lambert, and Lambert (1987) included job stress as a variable, exploring whether hardiness moderated the impact of perceived job stress on level of burnout. Hardiness had beneficial main effects in reducing burnout, but did not appear to prevent high levels of stress from leading to high levels of burnout. The sample included 107 nurses from different departments within the same hospital. Collins (1996) utilized a convenience sample of 113 nurses at one hospital and different scales from the preceding research to include the Personal Views Survey as an instrument to assess hardiness and examined the relationship between hardiness and job stress and hardiness and burnout. The hypotheses were supported: nurses who possessed higher levels of personality trait
hardiness were most likely to have less work stress and less burnout (Collins, 1996). Since these studies are specific to the field of nursing it cannot be assumed the results will generalize to mental health counselors. Morse et al. (2012) stated:

There is little reason to believe that burnout would affect mental health workers differently than nurses, teachers or other professional groups where additional research describes strong relationships between burnout and a range of associated problems. Nonetheless, future research should include mental health workers and use larger samples …to better examine the relationship between burnout and associated problems (p. 6).”

Other than not including other mental health professionals, these studies had several methodological weaknesses. Foremost is the use of measurement in these studies as initial hardiness instrumentation was utilized. Younkin and Betz (1996) identified four major problems with the Kobasa instruments utilized in the above studies, and they are: (a) they lacked stability, (b) they utilized three traits already identified as important in stress resistance to measure a supposedly uni-dimensional trait of hardiness, (c) the differential relationship of the dimensions to criterion variables, and (d) the use of negative indicators. Despite these problems, the authors acknowledged that the concept of hardiness has “logical merit and face validity” (p. 163) and emphasized the need for a direct (rather than indirect) measure for hardiness. With the early instrumentation available, there were inconsistent methods of measurement across the studies mentioned above; it is possible that the hardiness construct was conceptually flawed or something other than hardiness was being measured in these studies. These problems led to a need for a study using a third generation, direct measure of hardiness with a focus specifically on those within the mental health profession such as counselors.
Summary

Mental health counselors are exposed to unique and emotionally charged working hazards that have contributed to a high level of burnout within the field, with some estimates as high as 67% (Morse et al., 2012, p. 2). While it is recognized that burnout is detrimental, research continues to be limited with many gaps in understanding the specific preventative factors and effective interventions (Paris & Hoge, 2010; Morse et al., 2012). Certain job characteristics have been shown to impact and reduce burnout, however, these are often outside of a professional’s control. Pick and Leiter (1991) assert that despite organizational predictors, researchers need to consider personality differences. Particularly when it is unclear which specific individual differences contribute to burnout.

The American Counseling Association (ACA) places emphasis on counselor well-being and self-care (ACA, 2014). Specifically, Section C of the ACA Code of Ethics (ACA, 2014) states counselors should “engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities.” Self-care has been identified as a protective factor (Stamm, 2002), with effectiveness shown for action-oriented coping strategies to reduce work related stress (Collins & Long, 2003). Self-care and coping skills for stress are without a doubt important; however, Morse et al., (2012) emphasize the need for increasing “other human qualities and abilities” to add to burnout prevention research (p. 8).

One such personal factor that has shown promise in reducing burnout is hardiness. Hardiness has been identified as a personality factor that buffers against job dissatisfaction (Maddie, 1999a) and against diminished well-being (Bartone, Ursano, Wright, & Ingraham, 1989; Lambert, Lambert, Klipple, & Mewshaw, 1989; Nathawat & Joshi, 1997; Nathawat &
Rathore, 1996; Robitschek & Kashubeck, 1999). Hardiness has been identified as a moderator for burnout, though the focus has been mainly on the nursing profession. Additionally, these nursing studies had several empirical discrepancies. Hardiness research should be extended to the mental health profession and utilize an instrument that offers a direct measurement of this construct. This study will seek to explore the relationship between hardiness, self-care, and burnout using a direct measure for hardiness and sampling from mental health counselors. Additionally, this research will seek to identify if hardiness is a moderator for burnout, over and above self-care strategies.
Chapter 3
Methodology

The primary goal of this study is to explore the relationships between burnout, self-care, and hardiness, with separate instruments to measure each variable. This chapter will address the specific methodology conducted to address the research questions related to these relationships. The methodology is organized into several parts to include the research design, selection of participants, sampling procedures, instrumentation, data collection procedures, data analysis, and limitations.

Research Paradigm and Design

The paradigm for this study is postpositivism. Within this paradigm, a study seeks to verify theory and describe constructs with the understanding that the universal reality can only be known probabilistically. Stemming from the importance of scientific inquiry and experimental methodology, postpositivism places emphasis on validity, reliability, and alternative hypotheses (Hays & Singh, 2012). Accordingly, a theory should not only be verified, but also falsified (Hays & Singh, 2012). Since reality can only be known probabilistically, errors and alternative hypotheses should be explored in order to strengthen theory (Patton, 2002). For this study, the constructs of burnout and hardiness are likely universal truths, although from a postpositive approach, it is understood these constructs cannot be fully measured. Thus, the research will not prove these constructs, but perhaps strengthen or weaken them. This research will pursue objectivity, whilst recognizing the possible effects of biases (Robson, 2002). This researcher acknowledges research is a social process that influences the researcher and those being researched.
An ex post facto survey design will be utilized for this dissertation. Survey research is the “collection of quantified data” (Sapsford, 2007) and the purpose of survey research is to make planned comparisons, to generalize from a sample to a population so that inferences can be made about some characteristic, attitude, or behavior of this population (Creswell, 2014). Snapford (2007) states that survey research allows for the identification of “covariation between variables that may point to causal relationships or predictive patterns of influence” (p. 8). Therefore, a survey is the preferred type of data collection procedure for this study as the researcher is interested in exploring the relationships and predictive patterns of influence between the variables. Additionally, a survey allows for rapid turnaround in data collection and economy of the design (Creswell, 2014). Surveys involve systematic interviewing, dictating what questions and range of answers that may be given (Snapford, 2007). This standardization will allow this researcher to obtain consistent answers to consistent questions (Snapford, 2007). The survey will be cross-sectional and will be implemented using an online survey distributor, Qualtrics. This procedure was selected in order to reach a national sample quickly and affordably.

**Selection of Participants**

The target population of this study will be mental health counselors in the United States. This population includes only those with experience in the mental health field. Green (1991) has two rules of thumb for the minimum acceptable sample size when using multiple regression, dependent on whether one wants to test the overall fit of the model or whether one wants to test the individual predictors within the model. Green (1991) recommends that both be calculated and use the one that has the largest value. Accordingly, to test the overall fit of the regression (i.e. testing the $R^2$), the following calculation is suggested: $50 + 8k$, where $k$ is the number of predictors. For this study, with 7 predictors, 106 participants would be needed. To test the
individual predictors (i.e. testing the \( b \)-values of the model), the minimum suggested sample is calculated by \( 104 + k \). Again, having 7 predictors, this study would need 111 participants. However, the sample size required depends on the size of the effect and how much statistical power is needed to detect these effects. A power analysis has been conducted as set forth in the guidelines provided by Cohen (1988, 1992) and Olejnik (1984). To this end, the G-Power software was utilized to calculate power and to determine effect size (Faul, Erdfelder, Lang, & Buchner, 2007). For a linear multiple regression: fixed model, \( R^2 \) increase, based on an alpha of .05, a power level of .80, and seven predictors (time in field, hardiness score, self-care score, two for gender, two for ethnicities), the calculation revealed that 103 participants are required to detect a moderate effect size (.15).

The survey asked if participants are a licensed mental health counselor with an active, direct-client role in the profession; a response of yes is required for inclusion in this study. Participants were asked to indicate their age in years. Participants were asked to specific Female/Female-identified, Male/Male-identified, Transgender, or Other gender identities. The survey asked participants to identify ethnicity (and Census-based race categories) and provided the following options to select from: Black or African American, Asian or Asian-American, Native American/Alaska Native, Hispanic or Latino/Latina, White or European American, Native Hawaiian/Pacific Islander, Multiple Heritage, and Other. Participants were asked to indicate their total time, in years, of experience within the mental health field. Participants were asked to indicate their primary setting, with selections listed as Outpatient, Inpatient/Residential, Acute Care/Crisis Stabilization, In-Home, Prison/jail, or Other (please specify). Participants were asked to indicate their population and/or specialty from a checklist that includes substance use treatment, sex offender treatment, and trauma. A single-item measure for job satisfaction was
included; participants were asked to indicate yes or no to the question: “Are you satisfied (contented, pleased) with where you work?”

**Sampling Procedures**

Purposive, convenience, and snowball sampling were utilized to achieve the desired sample size. Though not highly recommended, non-probability sampling allowed this researcher to gain access to data when other sampling strategies are not pragmatic or permitted. Other sampling strategies required the researcher to have formal access, which this researcher did not have. Using purposive sampling, this researcher recruited participants via email to state branches of ACA, AMHCA, and VA Clinical Counselors Alliance and with specific use of listservs (e.g. CESNET, COUNSGRADS, and ACA Connect).

**Instrumentation**

Participants were emailed a link to the survey containing several components: an informed consent, demographic survey, the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), the Dispositional Resilience Scale (DRS; Bartone, 2007), and questions regarding self-care frequency and importance. The informed consent document was the first page of the survey, followed by the demographic questions, the MBI, the DRS, and concluded with the self-care questions.

**Maslach Burnout Inventory- Human Services Survey**

The MBI-HSS is the original measure and the most commonly used tool to self-assess the risk of burnout for professionals in the human services and health care (Maslach, Schaufeli, & Leiter, 2001). Burnout is defined as “a psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job” (Leiter & Maslach, 2004, p. 93). The MBI-HSS consists of 22 statements of job-related feelings. Each statement is followed by a 7-
point scale to indicate frequency, the selection includes: never, a few times a year or less, once a month or less, a few times a month, once a week, a few times a week, or every day. There are three subscales of the MBI to measure exhaustion, depersonalization, and personal accomplishment. The three-factor structure has been validated across occupations and national contexts (Schaufeli & Enzmann, 1998). Burnout is the summation of the three dimensions and indicated when exhaustion and depersonalization are high and personal accomplishment is low.

Convergent validity, discriminant validity, and reliability were established for the MBI through several studies. For convergent validity, MBI scores were correlated with behavioral ratings made independently by spouses and co-workers (Maslach, Jackson, & Leiter, 1996). For example, co-workers rated those that scored high on Depersonalization as having more frequent client complaints and wives rated those that scored high on Personal Accomplishment as coming home in a cheerful mood. Another method for convergent validity involved correlating MBI scores with the presence of job characteristics, such as caseload and working hours, which were expected to contribute to burnout (Maslach, Jackson, & Leiter, 1996). Additionally, MBI scores were correlated with measures of various outcomes related to burnout to include insomnia, relationship difficulties, and alcohol and drugs (Maslach, Jackson, & Leiter, 1996). Discriminant validity was established by distinguishing it from constructs such as job dissatisfaction and depression, thought to be confounds for burnout (Maslach, Jackson, & Leiter, 1996). Further, the MBI was not influenced by a social desirability response set (Maslach, Jackson, & Leiter, 1996). Test-retest reliability has been conducted with time periods spanning a few weeks, 3 months, and 1 year. The test-retest coefficients ranged between .54 and .82; higher coefficients were found for the few week range (Maslach, Jackson, & Leiter, 1996).
The Emotional exhaustion subscale, consisting of 9 items, measures feelings of being emotionally overextended and exhausted by one’s work (Maslach & Jackson, 1981). Emotional exhaustion is assessed with statements such as “working with people all day long requires a great deal of effort” and “I feel I work too hard at my job.” A total of 17 or less indicates low-level exhaustion and between 18 and 29 is indicative of moderate emotional exhaustion. High-level emotional exhaustion is indicated with a total of over 30. However, for mental health workers, high levels of burnout include scores of at least 21 on emotional exhaustion (Maslach, Jackson, & Leiter 1996). Lee and Ashforth (1990) reported Cronbach alpha ratings of .93 for Emotional Exhaustion. Earlier ratings reported by Iwanicki and Schwab (1982) were .90 for Emotional Exhaustion. Gold (1984) reported similar Cronbach alpha ratings.

The Depersonalization subscale consists of 5 items and measures an impersonal response toward recipients of one’s service, care treatment, or instruction (Maslach & Jackson, 1981). Items such as “I am afraid this job is making me uncaring” and “I really don’t care about what happens to some of my clients” are utilized to assess depersonalization. Low-level depersonalization is indicated with a total of 5 or less; between 6 and 11 indicates moderate level, and a total of 12 or greater indicates high level. High levels of burnout include depersonalization scores of at least 8 for mental health workers (Maslach, Jackson, & Leiter 1996). Lee and Ashforth (1990) reported Cronbach alpha ratings of .81 for Depersonalization. Earlier ratings reported by Iwanicki and Schwab (1981) were .76 for Depersonalization. Gold (1984) reported similar Cronbach alpha ratings.

The third subscale of Personal Accomplishment consists of 8 items and measures one’s ability to feel successful and competent about one’s work (Maslach & Jackson, 1981). Personal accomplishment is assessed with statements such as ‘I feel full of energy” and “I accomplish
many worthwhile things in this job.” A total of 39 or more indicates high-level; between 32 and 38 indicates moderate-level, and a total lower than 31 indicates low-levels of personal accomplishment. High levels of burnout include personal accomplishment scores of 28 or higher for mental health workers (Maslach, Jackson, & Leiter 1996). Lee and Ashforth (1990) reported Cronbach alpha ratings of .85 for Personal Accomplishment. Earlier ratings reported by Iwanicki and Schwab (1981) were .76 for Personal Accomplishment. Gold (1984) reported similar Chronbach alpha ratings.

**Dispositional Resilience Scale**

The Dispositional Resilience Scale (DSR-15) is of the third-generation instrumentation that measures for the presence of hardiness, rather than its absence. Hardiness has been defined as a “pattern of attitudes and skills that facilitates turning adversity into opportunity, thereby enhancing performance and health” (Khoshaba & Maddi, 2005, p. 43). The DSR contains 15 statements and a 4-point scale of not at all true, a little true, quite true, and completely true. This dissertation utilized the sum score for the 15 items, though scores can be grouped into categories. For instance, scores of 39 and above can be used to indicate very high hardiness; scores between 34 and 38 indicative of high hardiness; scores between 28 and 33 indicative of average hardiness; low hardiness indicated when scores are between 22 and 27; scores below 21 indicative of very low hardiness. In a review of hardiness research, Funk (1992), identified the DRS as the most sound hardiness measure available, both conceptually and psychometrically.

Predictive validity for the DRS-15 has been established using a large group of Army Reservists (N = 787) and Army Special Forces candidates (Bartone, Roland, Picano, & Williams 2008). Specifically, hardiness measure was predictive of illness and health behaviors in a large sample of Army Reservists exposed to combat stress during the Gulf War (Bartone, 1995).
Additionally, hardiness measure was predictive of performance under high-stress; Army Special Forces candidates scored high on hardiness were more likely to succeed in the extremely demanding selection course (Bartone, Roland, Picano, & Williams 2008). Bartone (2007) established criterion-related validity across multiple samples. For the overall 15-item measure, Cronbach’s alpha coefficient was .82, indicating good internal consistency (Bartone, 2007). However, since Cronbach alpha can underestimate reliability, a test-retest reliability approach was conducted. The test-retest coefficient was .78, indicating high reliability for the short form scale (Bartone, 2007).

There are three subscales: control, commitment, and challenge. The Control subscale, consisting of 5 items, measures the belief that one can control or influence events (Bartone, 2005). Items to assess this dimension include “How things go in my life depends on my own actions” and “I don’t think there is much I can do to influence my own future.” Bartone (1995) reported the Cronbach alpha of .70 for control. The Commitment subscale, consisting of 5 items, measures one’s tendency to see life as interesting and meaningful (Bartone, 2007). Items used to assess this dimension include “I feel that my life is somewhat empty of meaning” and “most days, life is really interesting and exciting for me.” Bartone (2007) reported the Cronbach alpha of .77 for commitment. The Challenge subscale, consisting of 5 items, measures one’s preference to explore and try new things (Bartone, 2007). Items used to assess this dimension include “I don’t like changes in my regular activities” and “I enjoy the challenge when I have to do more than one thing at a time.” Bartone (1995) reported the Cronbach alpha of .71 for challenge.

Self Care

To assess self-care, researchers often use a self-care inventory, which is a list of possible activities divided into categories such as physical, psychological, or spiritual. Individuals identify
the frequency of every item on the list and the results are then summed. However, research indicates that frequency of participation in any one self-care strategy and view of the importance of self-care are the variables significantly associated with general well-being (Richards, Campenni, & Muse-Burke, 2010). Therefore, this dissertation replicated the method utilized by Richards, Campenni, and Muse-Burke (2010) to assess for self-care frequency and importance. Participants were given a broad definition of self-care and its main components: physical, psychological, spiritual, and support. Participants indicated frequency of use from each category of self-care behaviors using a 7-point Likert scale. Participants were asked to indicate on a Likert scale the extent to which they agree with four statements pertaining to the importance of self-care.

Data Collection Procedure

The Old Dominion University Human Subjects Review Board approved this study before data collection began. License agreements were obtained to utilize the MBI and DRS instruments. Additionally, permission was obtained for remote online use of the MBI and to alter the wording from “recipient” to “client.” Richards, Campenni, and Muse-Burke provided permission to replicate and copies of the questionnaires. An informed consent document, demographic survey, and three assessments were distributed to participants using a Qualtrics electronic survey. Participants were asked to complete the informed consent first; the survey did not continue until agreement was provided. Participation was voluntary and withdrawal was permitted at any point in the survey. Data was stored in a password-protected spreadsheet only accessible to the researcher. Risks were actively minimized through confidentiality and anonymity.
Data Analysis

Data Cleaning

Once the dataset has been collected and uploaded into statistical software, in this case, SPSS, the data was cleaned. The researcher searched for values that were missing or not valid, for example, entry errors or nonsensical data. Variables were checked to ensure they were properly labeled and have accurate levels of measurements. Empty records, consisting of no data, will be eliminated. Outliers were removed; they have an “especially large influence on the correlation” (Aron, Coups, & Aron, 2013, p. 468).

Assumption Checks

After the dataset had been cleaned, the researcher commenced assumption checking. Data met all assumptions to complete correlational and regression analyses as set forth by Berry (1993). Firstly, all predictor variables (self-care, hardiness, time in field) must be quantitative or categorical with only two categories. The outcome variable (burnout) must be quantitative, continuous and unbounded (Field, 2009). Secondly, the predictors should have some variation in value with no variances of 0. Thirdly, the predictor variables should not correlate too highly. Meaning that there should be no perfect linear relationship between two or more of the predictors. Fourthly, external variables, which are variables that haven’t been included in the regression model and influence the outcome variable, should not correlate with any of the variables included in the regression model. If the external variables do correlate with the predictors, then the conclusions drawn from the model become unreliable. Fifthly, is the assumption of homoscedasticity, meaning that the residuals at each level of the predictors should have the same variance. At each level of the predictor variable, the variance of the residual terms should be constant. The sixth assumption is that the residual terms should be independent. This
assumption can be tested with the Durbin-Watson test, which test for serial correlations between errors and whether adjacent residuals are correlated. The seventh assumption is that the differences between the model and the observed data are most frequently zero or very close to zero, and that differences greater than zero happen only occasionally. The predictors do not need to be normally distributed, but rather the residuals in the model be random, normally distributed variables with a mean of 0. The eighth assumption for multiple regressions is that all of the values on the outcome variable (burnout) are independent, meaning they come from a separate entity. Lastly, is the assumption of linearity; that is, it is assumed that the relationship being modeled is a linear one.

Analysis

Data was input into and analyzed using SPSS. First, a Pearson’s Correlation and factorial MANOVA were conducted to ascertain the relationship between hardiness and the demographic variables and to determine if mental health professionals differed in their burnout, levels of hardiness, and effectiveness of self care based on the demographic variables. These analyses were followed by a hierarchical multiple regression to determine if burnout, the dependent variable, could be predicted based on the independent variables and if hardiness predicts burnout over these variables (demographic variables, job characteristics, and self-care). Aron, Coups, and Aron (2013) identify that multiple regression can be utilized for a number of possible hypothesis tests. It can be used to test the significance of the multiple correlations to see if the variables as a whole are associated with the criterion variable. Additionally, it can be utilized to test whether the predictor variable adds more than 0 to the prediction over and above what the other predictor variables already predict. For this purpose, the hierarchical multiple regression, as opposed to the step-wise or forced-entry regression, was the best analysis match based on the variables and the
hypotheses. Descriptive statistics will also be conducted to analyze the means, standard deviations, frequencies, and other descriptive statistics to gain a better understanding of the sample.

**Study Limitations**

The limitations of this study include that it was not an experimental design. Therefore participants were not randomly selected or randomly assigned to a group. Additionally, there was not a control group. Instead, a survey method was used. While the survey method allows for the gathering of large amounts of data efficiently, the survey itself (instrumentation) may pose a threat to the internal and external validity if the instrument is not valid and reliable. The validity refers to the extent the survey actually measures what it is supposed to measure. For instance, this researcher hopes the instrument selected to measure burnout, actually measures burnout, as opposed to job dissatisfaction, cynicism, or weariness. The reliability refers to the extent the survey is consistent and repeatable. This researcher attempted to utilize reliable and valid instruments for assessing burnout and hardiness.

Despite using valid and reliable instruments when using self-report survey methods the response styles of the participants as well as the self-report nature can create limitations. These styles include willingness to answer, position preferences, and yea-saying and nay-saying. These response styles could negatively impact the generalizability of the findings. The surveys selected attempt to control for these response styles. The MBI and the DSR-15 have reverse scoring for select items and utilize a Lickert scale to aid in the countering of these possibilities.

When utilizing a survey method, the sample poses many possible threats to the external validity of the study. The researcher attempted to select a sample that was representative of the population to allow for generalizability of the results. However, since non-random sampling
techniques have a selection bias, caution must be taken to generalize the findings of this sample to the whole population.
Chapter 4

Results

This chapter describes the results of data analyzed from participants who completed the survey for this study, which included measures for hardiness and burnout, demographic questions, and self-care items. The research questions and hypotheses, data cleaning, description of participant demographics, correlations between variables of interest, and descriptions of the results of main statistical analyses are included. Burnout was assessed using the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981). Dispositional Resilience, or Hardiness, was assessed using the Dispositional Resiliency Scale (DRS; Bartone, 2007). Two short questionnaires were utilized to assess Self-Care frequency and importance and a demographic questionnaire was included to measure participant identity variables such as age, gender, ethnocultural identity, job satisfaction, counseling specialty, and setting. A factorial MANOVA and a hierarchical multiple regression were conducted to analyze the data.

Research Questions and Hypotheses

The first research question was answered using Pearson’s correlation matrix and a factorial MANOVA. The second and third research questions were answered with a hierarchical multiple regression analyzing participant MBI scores, DRS scores, self-care frequency and importance, and demographic variables.

Research Question One

What is the relationship between mental health counselors’ hardiness and select demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area)?
Null Hypothesis One

There will be no significant ($p \leq .05$) difference in mental health counselors’ hardiness based on select demographic variables.

Research Hypothesis One

There will be a significant ($p \leq .05$) difference in mental health counselors’ hardiness based on select demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area).

Research Question Two

What is the relationship between burnout, hardiness, and self-care in a sample of mental health counselors, adjusting for demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area)?

Null Hypothesis Two

There will be no significant ($p \leq .05$) relationship between burnout, hardiness, and self-care, after adjusting for demographic variables.

Research Hypothesis Two

Mental Health counselors’ hardiness and self-care will predict ($p \leq .05$) burnout, adjusting for demographic variables (i.e. age, gender, ethnocultural identity, time in field, primary setting, and specialty area).

Research Question Three

Does mental health counselors’ hardiness account for a significant amount of the variance in predicting self-reported burnout, over and above that accounted for by self-care and other demographic variables?
**Null Hypothesis Three**

Hardiness does not account for a significant amount of the variance in self-reported burnout, over and above that accounted for by self-care and other demographic variables.

**Research Hypothesis Three**

Mental health counselors’ hardiness will account for a significant amount of the variance in self-reported burnout over and above that accounted for by self-care and other demographic variables.

**Description of Data and Sample**

Data were collected over the course of four weeks using Qualtrics survey software. A link to the survey was emailed to American Mental Health Counselors Association (AMHCA) leadership and each of the state chapters for dissemination. Additionally, a link was emailed to the American Counseling Association (ACA) Research and Knowledge Committee and Virginia Counseling Association (VCA) division presidents. A link was also emailed to listservs of CESNET, ACA connect, Counsgrads, and 1,802 members of the AMHCA listserv.

**Data Cleaning**

Data were screened and cleaned for missing values and outliers. Data were entered into SPSS 22 for analysis. Incomplete surveys and surveys that did not meet inclusion criteria were deleted from the sample, yielding 154 complete surveys. For example, surveys that completed the demographic information, but did not complete the other assessments, were not included in this survey. This sample size is sufficient for statistical power in the hierarchical multiple regression and factorial MANOVA analyses (Cohen, 1988; Granello & Wheaton, 2011; Tabachnick & Fidell, 2013). Fourteen missing values were replaced with mean values. A
missing age was replaced with the mode age. The MBI and DRS subscale and total raw scores were computed. Demographic variables were dummy coded for regression analysis.

The third step in the data cleaning process was screening for outliers using descriptive statistics. Hierarchical multiple regression and factorial MANOVA are sensitive to outliers in the data and outliers could influence the relationship of research variables in any results (Tabachnick & Fidell, 2013). Outliers were screened for using boxplots. No outliers were identified in the data. The next step in data cleaning was to ensure the normality of the continuous variables of interest. The MBI scores, DRS scores, and Self-care scores were all normally distributed, falling within acceptable values of skewness and kurtosis (Tabachnick & Fidell, 2013).

**Description of Participant Demographic Characteristics**

As a part of the online survey participants were asked to complete a short demographic questionnaire. This information was collected in order to describe the sample and to establish the level of generalizability of this study. The demographic information collected included participants’ counseling specialty, age, gender, ethnocultural identity, primary setting, job satisfaction, specialty area(s), professional counseling experience, and total experience within the mental health field.

Participants (N=154) identified as mental health counselors who engage in direct client services and were either licensed or in residency. Of the mental health counselors sampled, participants reported having a Master’s degree (n=137, 89%) or a doctorate degree (n=17, 11%) and were either in residency (n=24, 15.6%) or licensed (n=130, 84.4%). The sample included counselors from multiple mental health specialties: adult mental health (n=131, 81.37%), child and adolescent mental health (n=74, 45.96%), Other (n=23, 14.29%), marriage and family (n=70, 43.48%), court ordered clients (n=37, 22.98%), severe, persistently mentally ill (n=32, 19.88%),
phase of life issues \((n=70, 43.48\%)\), trauma issues \((n=93, 57.76\%)\), crisis intervention \((n=46, 28.56\%)\), and substance-use and addictive disorders \((n=23, 14.29\%)\). Counselors who selected the “Other” specialty specified grief and loss/bereavement, and geriatric/senior adult mental health. The sample identified their primary setting, including outpatient \((n=112, 72.7\%)\), acute care/crisis stabilization \((n=4, 2.6\%)\), inpatient/residential \((n=9, 5.8\%)\), in-home \((n=3, 1.9\%)\), community agency \((n=16, 10.4\%)\), prison/jail \((n=2, 1.3\%)\), and other \((n=8, 5.2\%)\). Counselors who selected “Other” specified college and military counseling.

Participants’ ages ranged from 19 to 75 years \((M=50.31, SD=14.48)\). Regarding gender, 115 participants identified as female \((74.7\%)\), 38 as male \((24.7\%)\), and one as transgender, male-identified \((0.6\%)\). Ethnoculturally, 129 participants identified as White or European American \((83.8\%)\), 11 as Black or African American \((7.1\%)\), 8 as multiple heritage \((5.2\%)\), 3 as Hispanic/Latino/a \((1.9\%)\), one as Asian or Asian American \((0.6\%)\), one as Native Hawaiian/Pacific Islander \((0.6\%)\), and one as Arab American \((0.6\%)\). In terms of job satisfaction, 143 \((92.9\%)\) reported yes and 11 \((7.1\%)\) reported no. Regarding total years experience within the mental health field, experience ranged from 0 to 48 years \((M=17.71, SD=12.34)\). Regarding years of experience as a counselor, experience ranged from 0 to 45 years \((M=13.29, SD=11.37)\). The difference between total experience and years of experience as a counselor ranged from 0 to 37 years \((M=4.31, SD=6.11)\).

**Burnout**

The Maslach Burnout Inventory was utilized to measure burnout (Maslach & Jackson, 1981). This measure includes three subscales: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. The 9 items of the Emotional Exhaustion subscale describes exhaustion and being emotionally overextended (Maslach & Jackson, 1981). The
Depersonalization subscale contains 5 items and describes an impersonal response towards clients (Maslach & Jackson, 1981). The subscale of Personal Accomplishment contains 8 items that describe achievement and competence (Maslach & Jackson, 1981). In the present sample subscale scores were: Emotional Exhaustion ($M = 13.15$, $SD = 9.57$); Depersonalization ($M = 3.08$, $SD = 3.4$); and Personal Accomplishment ($M = 41.87$, $SD = 5.09$). For both Emotional Exhaustion and Depersonalization subscales, higher mean scores correspond to higher degrees of experienced burnout (Maslach & Jackson, 1981). Lower mean scores on Personal Accomplishment correspond to higher degrees of experienced burnout (Maslach & Jackson, 1981).

For purposes of this study, burnout was measured as a continuous variable by calculating the average total score. Descriptives of MBI average in the present sample, used for analyses, is presented below in Table 1. The MBI variable was normally distributed (skewness and kurtosis less than ±2) (Tabachnick & Fidell, 2013). The MBI variable has a skewness of .825 and kurtosis of .480, within parameters of normality (Tabachnick & Fidell, 2013).

Table 1

<table>
<thead>
<tr>
<th>MBI Descriptives</th>
<th>$M$</th>
<th>$SD$</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>MBI Average</td>
<td>1.0162</td>
<td>.647</td>
<td>.00</td>
<td>3.18</td>
</tr>
<tr>
<td>Emotional Exhaustion</td>
<td>13.15</td>
<td>9.57</td>
<td>.00</td>
<td>49.00</td>
</tr>
<tr>
<td>Depersonalization</td>
<td>3.08</td>
<td>3.4</td>
<td>.00</td>
<td>21.00</td>
</tr>
<tr>
<td>Personal Accomplishment</td>
<td>41.87</td>
<td>5.09</td>
<td>22.00</td>
<td>48.00</td>
</tr>
</tbody>
</table>

*Note. MBI= Maslach Burnout Inventory (Maslach, Jackson, & Leiter, 1996). MBI scores are reported as averages.*
Hardiness

The DRS assessed participants’ hardiness, or dispositional resilience (Bartone, 2007). This scale includes three subscales indicating individual resiliency to stress: Control (the belief that they can influence events in their experience), Challenge (the anticipation of change as an exciting challenge to further development), and Commitment (an ability to feel deeply involved and committed to the activities of their lives) (Bartone, 2007). In the present sample subscale scores were: Control ($M= 11.90$, $SD= 2.1$); Commitment ($M= 11.90$, $SD= 2.1$); and Challenge ($M= 9.08$, $SD= 2.72$). Correlations of DRS subscale scores indicate significant correlation between the subscales. The Commitment subscales were significantly correlated with both Control ($r= .515$, $p< .001$) and Challenge ($r= .320$, $p< .001$). The Control subscale score was significantly correlated with Challenge ($r= .324$, $p< .001$).

For purposes of this study, hardiness was measured as a continuous variable by calculating the total score. Descriptives of DRS in the present sample, used for analyses, is presented below in Table 2. The DRS variable was normally distributed (skewness and kurtosis less than ±2) (Tabachnick & Fidell, 2013). The DRS variable has a skewness of -.488 and kurtosis of 1.34, within parameters of normality (Tabachnick & Fidell, 2013).
Table 2

**DRS Descriptives**

<table>
<thead>
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<th></th>
<th>M</th>
<th>SD</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRS Total</td>
<td>32.89</td>
<td>5.29</td>
<td>12.00</td>
<td>45.00</td>
</tr>
<tr>
<td>Control</td>
<td>11.90</td>
<td>2.1</td>
<td>3.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Commitment</td>
<td>11.90</td>
<td>2.1</td>
<td>5.00</td>
<td>15.00</td>
</tr>
<tr>
<td>Challenge</td>
<td>9.08</td>
<td>2.72</td>
<td>.00</td>
<td>15.00</td>
</tr>
</tbody>
</table>

*Note.* DRS = Dispositional Resiliency Scale (Bartone, 2007). DRS scores are reported as the total sum of all scores.

**Self-Care**

Self-care frequency and importance were assessed, replicating a previous study (Richards, Campenni, & Muse-Burke, 2010). Participants were given a broad definition of self-care and its main components: physical, psychological, spiritual, and support and indicated on a Likert scale the frequency and importance of each.

**Frequency**

Participants indicated frequency of use from each category of self-care behaviors.

**Physical.** Participants reported frequency of physical self-care: One or more times daily (*n*=43, 22.1%); Multiple times weekly (*n*=75, 48.7%); Once weekly (*n*=18, 11.7%); Multiple times monthly (*n*=15, 9.7%); Once monthly (*n*=7, 4.5%); and Rarely (*n*=5, 3.2%).

**Psychological.** Participants reported frequency of psychological self-care: One or more times daily (*n*=17, 11%); Multiple times weekly (*n*=22, 14.3%); Once weekly (*n*=17, 11%); Multiple times monthly (*n*=18, 11.7%); Once monthly (*n*=31, 20.1%); and Rarely (*n*=49, 31.8%).

**Spiritual.** Participants reported frequency of spiritual self-care: One or more times daily (*n*=58,
37.7%; Multiple times weekly \((n=33, 21.4\%);\) Once weekly \((n=16, 10.4\%);\) Multiple times monthly \((n=16, 10.4\%);\) Once monthly \((n=12, 7.8\%);\) and Rarely \((n=19, 12.3\%).\)

**Support.** Participants reported frequency of Support as self-care: One or more times daily \((n=68, 44.2\%);\) Multiple times weekly \((n=52, 33.8\%);\) Once weekly \((n=11, 7.1\%);\) Multiple times monthly \((n=12, 8.4\%);\) Once monthly \((n=5, 3.2\%);\) and Rarely \((n=5, 3.2\%).\)

**Total.** For purposes of this study, items were totaled to produce final scores of zero to 24, with higher scores indicating greater propensity for self-care. The Frequency Total Score \((M=7.16, SD=3.63)\) met normality assumptions with a skewness of .510 and a kurtosis of .160.

**Importance**

Participants also indicated the extent to which they agreed with four statements pertaining to the importance of self-care \(\text{(Richards, Campenni, & Muse-Burke, 2010).}\)

**Physical.** Participants reported importance of physical self-care: Disagree strongly \((n=1, .6\%);\) Disagree slightly \((n=1, .6\%);\) Neither agree nor disagree \((n=4, 2.6\%);\) Agree slightly \((n=14, 9.1\%);\) Agree \((n=61, 39.6\%);\) and Agree Strongly \((n=73, 47.4\%).\)

**Psychological.** Participants reported importance of psychological self-care: Neither agree nor disagree \((n=2, 1.3\%);\) Agree slightly \((n=2, 1.3\%);\) Agree \((n=53, 34.4\%);\) and Agree Strongly \((n=97, 63\%).\)

**Spiritual.** Participants reported importance of spiritual self-care: Disagree strongly \((n=1, .6\%);\) Disagree slightly \((n=3, 1.9\%);\) Neither agree nor disagree \((n=7, 4.5\%);\) Agree slightly \((n=10, 6.5\%);\) Agree \((n=39, 25.3\%);\) and Agree Strongly \((n=94, 61\%).\)

**Support.** Participants reported importance of support as self-care: Neither agree nor disagree \((n=3, 1.9\%);\) Agree slightly \((n=4, 2.6\%);\) Agree \((n=55, 35.7\%);\) and Agree Strongly \((n=92, 59.7\%).\)
Total. For purposes of this study, items were totaled to produce final scores of zero to 24, with higher scores indicating agreement with self-care importance. The Importance Total Score ($M=21.75$, $SD=2.22$) did not meet normality assumptions with a skewness of -1.34 and a kurtosis of 2.97. This distribution shape was anticipated and considered ‘normal’ for this construct, given that self-care is highly regarded as important and necessary within the field of mental health.

Demographic Variables

The variables gender, age, ethnocultural identity, education, licensure status, job satisfaction, specialty, and experience within the field were used as independent variables in the factorial MANOVA and hierarchical multiple regression model. These variables were measured using a demographic questionnaire that was included in the electronic survey. All participants ($N=154$) indicated their counseling specialty, gender, age, ethnocultural identity, licensure status, education level, years of experience, and job satisfaction; there were no missing values following data cleaning. The categorical variables (counseling specialty, gender, ethnocultural identity, education, licensure, and job satisfaction) were dummy coded for use in the regression model, as described below in the description of the regression analyses. As these variables were categorical, they were not screened for normality. The continuous variables, age (skewness=$-.216$, kurtosis=$-1.17$), and experience (skewness=$.574$, kurtosis=$-.762$), met standards for normality as both skewness and kurtosis were less than ±2 (Tabachnick & Fidell, 2013).

Research Question One

A Pearson’s correlation and factorial MANOVA were conducted in attempts to explore the relationship between mental health counselors’ hardiness and select demographic variables such as age, gender, ethnocultural identity, experience in the field, education, licensure status, and job satisfaction.
Pearson’s correlation

For the purposes of exploring the relationship between paired variables, only continuous variables of the study met the assumption requirement of a Pearson’s correlation. Only age, time in field, hardiness subscale scores, and the hardiness total score were included in this analysis. Preliminary analyses showed the relationship to be linear with variables meeting normality assumptions based on visual inspection of the Q-Q plots; there were no outliers.

Age. There was not a statistically significant correlation between age and the DRS subscales of Commitment ($r=.216, p=.007$), Control ($r=.002 p=.980$), Challenge ($r=.054, p=.506$), or DRS total score ($r=.114, p=.160$).

Experience. There was not a statistically significant correlation between total experience in the field and the DRS subscales of Commitment ($r=.200, p=.013$), Control ($r=-.002 p=.981$), Challenge ($r=-.074, p=.366$), or DRS total score ($r=.039, p=.630$). There was not a statistically significant correlation between time in the field, specifically as a counselor, and the DRS subscales of Commitment ($r=.199, p=.013$), Control ($r=-.001 p=.987$), Challenge ($r=-.055, p=.498$), or DRS total score ($r=.050, p=.538$).

Table 3

Correlations: Variables of Interest

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<td>1. DRS Total Score</td>
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<td>.766**</td>
<td>.763**</td>
<td>.769**</td>
<td>.114</td>
<td>.039</td>
</tr>
<tr>
<td>2. DRS Control</td>
<td>--</td>
<td>--</td>
<td>.515**</td>
<td>.324**</td>
<td>.002</td>
<td>.002</td>
</tr>
<tr>
<td>3. DRS Commitment</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.320**</td>
<td>.216</td>
<td>.200</td>
</tr>
<tr>
<td>4. DRS Challenge</td>
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<td>--</td>
<td>--</td>
<td>--</td>
<td>.054</td>
<td>-.074</td>
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<td>5. Age</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.722**</td>
</tr>
<tr>
<td>6. Experience</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
MANOVA

To explore the differences in hardiness in counselors across counseling specialty, gender, ethnocultural identity, job satisfaction, licensure status, education, and experience were included in a factorial multivariate analysis of variance (MANOVA). Variables of interest in this model included participants’ DRS subscale scores (Challenge, Commitment, and Control) and select demographic variables (i.e., counseling specialty, gender, ethnocultural identity, job satisfaction, education, licensure status, and experience in the field).

The assumptions of factorial MANOVA include independence, the absence of outliers, normality, homogeneity of variance, multicollinearity, and linearity. Additionally, dependent variables are continuous (DRS Challenge, Commitment, and Control subscale scores) and independent variables (exposure variables) are categorical; this assumption is met in this sample. Independence is met in this sample; participants were not members of multiple groups in the same category (i.e. participants were not members of multiple ethnocultural identity groups).

No outliers were present in this sample, meeting that assumption of factorial MANOVA. Homogeneity of variance can be assumed in the present sample, as indicated by the insignificant Box’s M statistic (Box’s M = 93.22, p = .06). The assumption of multicollinearity is also met in this sample; no correlations between dependent variables (DRS Challenge, Commitment, and Control subscale scores) are greater than .90. There was a relationship between select demographic variables (gender, counseling specialty, ethnocultural identity, poverty counseling experience and personal poverty exposure) and DRS subscale scores, as assessed by scatterplot; linearity can be assumed in this sample. The DRS subscale scores met the normality assumption.
with skewness and/or kurtosis being less than ±2 (Tabachnick & Fidell, 2013). The factorial MANOVA was conducted using a Bonferroni correction to minimize family-wise error.

The factorial MANOVA found no statistical differences in hardiness subscales in select demographic groups: education, \((F[3,124]=1.140, p= .336, \text{ Wilks’ } \lambda = .973, \text{ partial } \eta^2 = .01)\); licensure, \((F[3,124]= .8852, p= .468, \text{ Wilks’ } \lambda = .98, \text{ partial } \eta^2 = .01)\); gender, \((F[3,124]= 1.507, p= .216, \text{ Wilks’ } \lambda = .965, \text{ partial } \eta^2 = .02)\); ethnocultural identity, \((F[3,124]= .089, p= .996, \text{ Wilks’ } \lambda = .998, \text{ partial } \eta^2 = .020)\); counseling specialty, \((F[3,124]= .600, p= .616, \text{ Wilks’ } \lambda = .986, \text{ partial } \eta^2 = .06)\); and job satisfaction \((F[3,124]= 4.211, p= .007, \text{ Wilks’ } \lambda = .908, \text{ partial } \eta^2 = .01)\). As the IVs had no effect on the DVs at the pre-set alpha level, the null hypothesis for question 1 was accepted and the research hypothesis rejected.

**Research Questions Two and Three**

A hierarchical multiple regression was conducted to analyze the predictive capabilities of identity demographics, job characteristics, self-care variables, and dispositional resilience as they related to burnout. Additionally, the hierarchical multiple regression was utilized to determine if the addition of dispositional resilience improved the prediction of burnout over and above self-care frequency and importance, job characteristics, and identity demographics such as ethnocultural identity, gender, and age.

Assumptions of hierarchical multiple regression include linearity, homoscedasticity, multicollinearity, the absence of outliers, and normality. There was linearity as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.886. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by
tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.25, and values for Cook's distance above 1. There assumption of normality was met, as assessed by Q-Q Plot.

Categorical variables were dummy coded and entered into the regression model congruent with the causal priority of the variables (Petrocelli, 2003). Cisgender females were coded as 0 and all other genders, which included cisgender males and transgender-identified people, were coded as (1). Ethnocultural identity was coded as White (0) and non-White (1). Counseling specialty was coded as Trauma primary (0), Trauma not primary (1). Job satisfaction was coded as “satisfied” (0) and “not satisfied” (1). Education and licensure status were already dichotomous variables. The variables of years of experience, self-care frequency, self-care importance, age, and dispositional resilience were continuous level variables. Variables were entered according to causal priority (Petrocelli, 2003). The first model included identity demographics to include age, ethnicity, and gender. The second model included job characteristics to include time in field, education level, licensure status, and job satisfaction. Self-care frequency and importance were included in the third model, followed by hardiness.

**Regression Results**

A hierarchical multiple regression was conducted to analyze the predictive capabilities of the independent variables (research question 2) as well as to analyze the predictive capabilities of dispositional resilience over and above self-care and demographic variables (research question 3). The dependent variable, burnout, was represented by participants’ MBI scores. Variables were entered into the model according to their causal priority (Petrocelli, 2003). The first step (model 1) included participants’ identity demographics: ethnocultural identity, age, and gender. The second step (model 2) included job characteristics: job satisfaction, experience in the field,
education, licensure status, and trauma as a primary specialty. The third step included self-care frequency and self-care importance into the model. Dispositional resilience, measured by the DRS score, was included in the fourth step.

The hierarchical multiple regression revealed that at Model 1, identity demographics contributed significantly to the regression model, $F(3, 149) = 7.279, p < .001$, and accounted for 12.8% of the variation in Burnout. Introducing job characteristics explained an additional 12.1% of the variance and this $R^2$ was significant, $F(5, 144) = 5.970, p = .001$. Adding Self-Care factors to the regression model explained an additional 6.1% of the variation in Burnout and this change in $R^2$ was significant, $F(2, 142) = 6.367, p = .003$. Finally, the addition of Hardiness to the regression model explained an additional 12.8% of the variation in Burnout, this $R^2$ was statistically significant, $R^2 = .438, F(1, 141) = 9.971, p < .001$, indicating that the final model significantly improves the ability to predict Burnout. Together, the full model of identity demographics, job characteristics, self-care variables, and dispositional resilience accounted for 43% of variance in Burnout.

When all of the independent variables were included in model 4 of the regression, only Age, Job Satisfaction, Frequency of Self-Care, and Hardiness were contributing significantly as predictors of Burnout (see Table 6). These standardized beta values indicate that Hardiness has the most impact in the model, followed by Job-Satisfaction, Age, then Frequency of Self-Care. Hardiness and Age have a negative relationship with Burnout; that is, as these factors increase, burnout decreases. Due to the dummy coding of Job-Satisfaction ($0 =$ satisfaction; $1 =$ no satisfaction), the results require modification to interpret. As one’s job satisfaction decreases, burnout increases. Interestingly, as self-care frequency increases, so does burnout; for a one-standard deviation increment on Frequency of Self Care, burnout increases by .154. As the IVs
predicted the DV at the pre-set alpha level, the null hypotheses for questions 2 and 3 were rejected and the research hypotheses affirmed.

Table 4

Summary of the Hierarchical Multiple Regression Analysis for Variables Predicting Burnout

\( (N= 154) \)

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>( R^2 )</th>
<th>Adj ( R^2 )</th>
<th>Std. Error</th>
<th>( \Delta R^2 )</th>
<th>( \Delta F )</th>
<th>df1</th>
<th>df2</th>
<th>Sig ( \Delta F )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.36</td>
<td>.13</td>
<td>.110</td>
<td>.61</td>
<td>.128</td>
<td>7.279</td>
<td>3</td>
<td>149</td>
<td>.000</td>
</tr>
<tr>
<td>2</td>
<td>.50</td>
<td>.25</td>
<td>.207</td>
<td>.58</td>
<td>.121</td>
<td>4.65</td>
<td>5</td>
<td>144</td>
<td>.001</td>
</tr>
<tr>
<td>3</td>
<td>.56</td>
<td>.31</td>
<td>.261</td>
<td>.56</td>
<td>.061</td>
<td>6.333</td>
<td>2</td>
<td>142</td>
<td>.003</td>
</tr>
<tr>
<td>4</td>
<td>.66</td>
<td>.44</td>
<td>.394</td>
<td>.51</td>
<td>.128</td>
<td>32.078</td>
<td>1</td>
<td>144</td>
<td>.000</td>
</tr>
</tbody>
</table>

*Note.* Model 1 represents the variables ethnocultural identity, age, and gender. Model 2 includes the Model 1 variables, job satisfaction, counseling specialty, education, licensure status, and experience in the field. Model 3 includes all previous variables and self-care frequency and importance scores. Model 4 includes all previous variables and DRS score.

Table 5

ANOVA Table for Hierarchical Multiple Regression, Predicting Burnout \( (N= 154) \)

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Regression</td>
<td>28.01</td>
<td>11</td>
<td>2.546</td>
<td>9.97</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>36.01</td>
<td>141</td>
<td>.255</td>
<td>--</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>64.02</td>
<td>152</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Note.* Model 4 represents the variables ethnocultural identity, age, gender, counseling specialty, years of experience, job satisfaction, education, licensure status, self-care importance, self-care frequency, and DRS score.
### Table 6

*Hierarchical Multiple Regression Predicting Burnout*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>1.737</td>
<td>1.507</td>
<td>2.017</td>
<td>3.244</td>
</tr>
<tr>
<td>Age</td>
<td>-.015**</td>
<td>-.33**</td>
<td>-.016*</td>
<td>-.348*</td>
</tr>
<tr>
<td>Gender</td>
<td>.003</td>
<td>0.115</td>
<td>-.02</td>
<td>-.013</td>
</tr>
<tr>
<td>Ethnocultural</td>
<td>.122</td>
<td>.14</td>
<td>.141</td>
<td>.081</td>
</tr>
<tr>
<td>Experience</td>
<td>.001</td>
<td>.012</td>
<td>-.001</td>
<td>-.014</td>
</tr>
<tr>
<td>Trauma</td>
<td>-.132</td>
<td>-.01</td>
<td>-.151</td>
<td>-.115</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>.804**</td>
<td>.321**</td>
<td>.838**</td>
<td>.335**</td>
</tr>
<tr>
<td>Education</td>
<td>.104*</td>
<td>.051*</td>
<td>.062</td>
<td>.03</td>
</tr>
<tr>
<td>Licensure Status</td>
<td>.29</td>
<td>.163</td>
<td>.338*</td>
<td>.19*</td>
</tr>
<tr>
<td>SC Importance</td>
<td></td>
<td>-.040</td>
<td>-.137</td>
<td>-.022</td>
</tr>
<tr>
<td>SC Frequency</td>
<td>.030*</td>
<td>.167*</td>
<td>.028*</td>
<td>.154*</td>
</tr>
<tr>
<td>Hardiness (DRS)</td>
<td></td>
<td>-.049**</td>
<td>-.39**</td>
<td></td>
</tr>
</tbody>
</table>

*Note: **= (p<.001); *= (p<.05)*

**Summary**

The results of the three research questions above provide varying levels of support for research hypotheses. The first research question, which explored the differences in hardiness and select participant demographics of education, licensure status, counseling specialty, ethnocultural identity, gender, experience in the field, and job satisfaction were not significant; therefore, the null hypothesis was not disproven. The second research question, exploring the relationship...
between hardiness, self-care, and burnout, the null hypothesis was disproven, providing support for the research hypothesis. This indicates that hardiness and self-care impact burnout. Self-care frequency, self-care importance, and hardiness decrease burnout risk. The third research question, to determine if the addition of dispositional resilience improved the prediction of burnout over and above self-care frequency and importance, job characteristics, and identity demographics, provided support for the research hypothesis. Hardiness accounted for a significant amount of the variance in self-reported burnout over and above that accounted for by self-care and other demographic variables.
Chapter 5

Discussion

Chapter one provided an introduction and overview of this study and included the rationale for the study, statement of the problem, significance of this research, study related research questions, and study specific term definitions. Chapter two presented literature relevant to this study that included the burnout construct and dimensions; the impact and prevention of burnout; the hardness construct and dimensions; and the use of hardness as a buffer. The third chapter outlined the methodology that was implemented in this research to successfully answer the three research questions posed in this study. Chapter three also included descriptions of participant selection and sampling, instrumentation, and data collection and analysis procedures. Results of this study were presented in chapter four, which included research question specific analyses, tables to organize the data, and descriptive statistics of participants. Chapter five will discuss the results of this study presented in chapter four; this will include implications of results, implications for future research, and limitations of this study.

Review of Study

The aim of this study was to explore the relationship between burnout, self-care, and hardness among mental health counselors. The purpose of this study was to contribute to the literature related to the constructs of hardness and burnout while also exploring the buffering abilities of hardness against burnout. This study was conducted using electronic survey methods participants were recruited through AMCHA, ACA, and VCA leadership and various professional counseling listservs to include CESNET, COUNSGRADS, and the AMHCA listserv. Participants were recruited over a four-week period during December 2016 and January 2017. Due to the exploratory nature of this study, survey methodology is appropriate and
supported by the literature (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Paris & Hoge, 2009).

The sample in the present study included 154 professional counselors from various professional counseling specialties, ethnocultural identities, genders, and ages. Participants also reported on their years of experience within the field and if they did or did not feel satisfied with their work. The research questions outlined below were addressed using a Pearson’s correlation, factorial MANOVA, and a hierarchical multiple regression in SPSS 22.

**Major Findings**

**Research Question One**

A Pearson’s correlation and factorial MANOVA were conducted to answer the first research question, which explored the relationship between mental health counselors’ hardiness and select demographic variables such as age, gender, ethnocultural identity, experience in the field, education, licensure status, and job satisfaction.

The Pearson’s correlation showed no significant correlations between age and the subscales of hardiness to include Commitment, Control, and Challenge or experience and these subscales. The results indicate that an individual’s hardiness level was not related to experience or age. This finding was true for the other categorical variables as well using the factorial MANOVA. The factorial MANOVA was not significant and indicates there are no significant differences in hardiness subscales based on a counselor’s gender, ethnocultural identity, education, specialty, licensure status, and job satisfaction. This result suggests identity demographics and job characteristics do not significantly affect the outcome variable: hardiness. That is, hardiness levels are not dependent on one’s gender, ethnocultural identity, education, specialty, licensure, or job satisfaction. This finding is consistent with the literature on hardiness,
which identifies it as a personality trait (Funk, 1992). The results support a rationale for further sampling from a more robust data set.

The results indicate one’s hardiness levels are consistent no matter how long one works in the field or whether they have chosen to work with trauma. That is to say, hardy counselors can be found in both areas of trauma and non-trauma specialties and at varying experience levels. Previous literature has warned of the long-term effects of working in the counseling field with most literature focusing on the impact of continual exposure to trauma clients (Adams, Boscarino, & Figley, 2006; Bride, 2004, 2007). If hardiness is indeed a personality trait that is helpful in promoting wellness despite environmental exposures, then counselors with higher hardiness levels may be relatively unaffected by the additive stressors associated with longevity in the field or with such career-specific hazards like secondary traumatic stress, vicarious traumatization, and compassion fatigue.

**Research Question Two**

The second research question used a hierarchical multiple regression to analyze the predictive capabilities of identity demographics, job characteristics, self-care variables, and dispositional resilience as they related to burnout. The identity demographics were entered first, followed by job characteristics, then self-care variables, with dispositional resilience entered lastly.

The results were significant with each step indicating that burnout scores are impacted by each set of variables. Job satisfaction has been found to moderate levels of burnout, though no literature has had a specific focus on mental health counselors (Schulz, Greenley, & Brown, 1995). This current study corroborates this finding within the field of counseling and supports the need for organizational-level changes (Burke & Richardsen, 1993; Halbesleben & Buckley,
That is, modifying work characteristics can reduce burnout (Awa, Plaumann, & Walter, 2010). Affective commitment, one’s identification with, involvement in, and emotional attachment to one’s own organization, has also been a significant buffer against burnout (Schmidt, 2007; Setti, Lourel, & Argentero, 2016). This construct may overlap with hardiness and explain how counselors are able to work in an emotionally demanding environment without succumbing to burnout.

The finding that self-care factors account for the variance in burnout scores supports the ACA ethical guidelines and CACREPS’ emphasis on self-care. This finding is also consistent with Stamm’s (2003) finding that engaging in self-care can reduce the risk of burnout. Surprisingly, frequency of self-care was identified as a significant predictor more so than self-care importance and has a direct relationship with burnout. Those that engage in self-care more frequently are more at risk for burnout. It may be that frequency is not synonymous with effectiveness. Engaging in self-care that is effective, albeit infrequently conducted, may be better than engaging in frequent self-care.

**Research Question Three**

The third research question utilized the same hierarchical multiple regression to determine if the addition of hardiness, operationalized for the present study as dispositional resilience (Bartone, 2007), improved the prediction of burnout over and above self-care frequency and importance, job characteristics, and identity demographics such as ethnocultural identity, gender, and age.

The results of this regression were significant, indicating that while controlling for demographic and work variables, hardiness, as measured by the DRS, does predict burnout over and above self-care. The model with Hardiness statistically explained 44% of the variability in
burnout scores; with Hardiness alone accounting for 12.8% of the variance. With regard to predicting Burnout, the Hardiness variable carries the most impact, the most significant predictor across all the models. This result is consistent with the research of hardiness as a moderator for burnout in nursing professionals (McCranie et al., 1987; Rich & Rich, 1987; Topf, 1989). Additionally, this result is consistent with research that found hardiness to be the most important predictor of burnout amongst nursing professionals (Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995; Simoni & Paterson, 1997). The underlying mechanisms of hardiness lend insight into potential explanations for the findings of this study. According to the hardiness model, the hardy individual converts stress into advantage through hardy coping, hardy social interaction, and hardy self-care (Maddi, 2013). Hardiness has convergent properties with locus of control (Rotter, 1990), optimism (Scheier, Carver, & Bridges, 2001), and self-efficacy (Bandura, 1997). Hardy self-care is identified as putting forth effort to promote bodily functioning such as engaging in relaxation, having a balanced and moderate diet, and maintaining a moderate level of physical activity (Maddi, 2013). Hardiness promotes resiliency in combat veterans through active problem solving (Maddi, 1999a; Maddi & Hightower, 1999), positive cognitive appraisal (Allred & Smith, 1989), using optimistic and active coping strategies (Kobasa, 1982; Maddi & kobasa, 1984) and seeking a support network (King, King, Fairbank, Keane, & Adams, 1998). Individuals with higher hardiness scores report fewer symptoms of depression and PTSD (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). It seems logical to conclude hardy counselors are more likely to use an active problem solving approach, transformational coping styles, positive cognitive appraisal, and have a better support network to reduce the risk of burnout.
Study Implications

Results of this study suggest hardiness may enable counselors to engage in more effective self-care and coping strategies such as utilizing more problem-solving, maintaining a positive attitude, and improving likeliness of seeking support. These strategies allow high-hardy counselors to have a strong awareness of and commitment to their values, goals, and capabilities, a greater sense that they control what occurs in their lives, and a perception of stressors as challenges that will make them stronger.

Implications for Counselor Education and Supervision

Concerned about impairment in students and potential harm to clients, CACREP standards, ACA guidelines, and counseling literature place emphasis on wellness and self-care (ACA, 2014; CACREP, 2016; Corey, Corey, & Callanan, 1993). Towards this end, counselor research, educators, and supervisors have attempted to find ways to reduce impairment and enhance wellness. In fact, literature has failed to support the effectiveness of a wellness course in counselor education and the requirement of personal counseling for each student (Roach & Young, 2007). Whether students had a wellness course or attended counseling, students still demonstrated higher levels of wellness than the general population (Roach & Young, 2007). It was noted that in this current study, participants placed a high level of importance on self-care, though reported a low frequency for actually engaging in self-care behaviors. This is an interesting finding that suggests counselors know that self-care is important, but they reported a low frequency self-care practices or not in need of a high frequency of self-care. Regardless, hardy counselors appear to be buffered against the harmful effects of refraining from self-care.

Counseling programs teach that self-care is not an option, but a necessity or a requirement. This study does support the efficacy of self-care in moderating the effects of
burnout, however, hardiness was a better predictor in the regression model, suggesting hardiness may be a more powerful tool in the fight against burnout. Counseling programs may benefit from identifying students’ hardiness levels. Counselors with low-hardy levels could then be monitored and perhaps even targeted trainings could bolster this attribute. The previous research on hardiness suggests and supports that leadership, such as a counseling supervisor or educator, may be able to foster cognitions and behaviors of the hardy counselor (Bartone, 2006). The military has long acknowledged the power of resilience and has sought to foster this trait through leadership influence. The leaders are encouraged to assist their subordinates with interpreting and making sense of their experiences by the policies and priorities that get set, the directives given, advice and counsel offered, and the stories and examples provided (Bartone, 2006). Once identified, counselor educators and supervisors could influence a student with low-hardiness’ meaning making process by encouraging students to have a strong awareness of and commitment to their values, goals and capabilities, a greater sense that they control their lives, and a perception of stressors as challenges that will make them stronger.

Wellness has been offered before as a gatekeeping strategy for counseling education programs (Roach & Young, 2007). Knowing the preservative impact of hardiness against occupational stressors, it seems reasonable to consider measuring applicants’ levels. Several studies have criticized counseling programs’ current admissions procedures, which consists of Graduate Record Examination scores, undergraduate grade point average, letters of recommendation, and interviews. All of these criteria were found to have low-positive correlations with academic success and attainment of counseling skills (Hosford, Johnson, & Atkinson, 1984; Market & Monke, 1990; McKee, Harris, & Swanson, 1979). Counselor education programs recognize the danger of impairment among students; hence, the current
ethical and program standards on self-care. Though research suggests hardiness may protect counselors from burnout and other hazards that cause impairment, additional research is required prior to implementing hardiness as a criterion for admissions.

**Implications for Counseling Practice and Theory**

The results of this study have implications for counseling practice and theory. Resiliency is a trait to be fostered not only within counseling students, but also within clients. The construct of resiliency is aligned with the wellness-model and the principles of Positive Psychology (Seligman, Ernst, Gillham, Reivich, & Linkins, 2009). From these perspectives, health is not the absence of a disease, but the presence of wellness (Fava & Sonino, 2008). Counselors can work with clients to enhance resilience, a set of attributes and resources that prevent illness following adverse environmental circumstances and prevent relapse after remission.

Resiliency can be promoted through therapies such as Narrative therapy, Post-traumatic Growth, and Wellness Therapy. The therapeutic modality of Narrative therapy inherently incorporates the dimensions of hardiness through the incorporation of meaning making around the trauma (Brown & Augusta-Scott, 2006; Foa, Molnar, & Cashman, 1995). Posttraumatic growth programs are also designed to incorporate resiliency in processing of PTSD-related negative emotions through meaning making and inner strength (Zoellner & Maercher, 2006). Wellness therapy focuses on positive emotional health rather than on decreasing negative affective symptoms (Fava & Tomba, 2009). This therapy is based on the theory of resiliency and postulates that deficits in wellbeing are due to lack of capacity to sustain states of well-being and inattention to positive experiences (Fava & Tomba, 2009). The focus of treatment is to lead clients from an impaired level to an optimal level in six dimensions of psychological wellbeing:
environmental master, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others (Fava & Tomba, 2009).

**Strengths and Limitations**

A strength of the study is its relevance to the counseling profession. First, this study adds to the empirical support for self-care within the field. Second, the findings contribute to the existing literature on burnout prevention, addressing the limitations of previous studies by sampling from the counseling profession. Third, a thorough review of the literature indicates this is the first study of measured resilience among counselors. Many conceptual articles have been written to discuss the importance of resilience and to develop models and theories of it and wellness, but none have measured the construct. The data obtained on hardiness may foster a better understanding of the personality of counselors and support the need for resiliency training as opposed to merely emphasizing self-care in our educational programs. A fourth strength was in the selection of instrumentation. The MBI is the most commonly utilized instrument for measuring burnout and was developed exclusively for use in human services professions (Maslach et al, 1996). Further, research supports both the validity and the reliability of the instrument (Maslach, Jackson, & Leiter, 1997; Sabbah, Sabbah, Sabbah, Akoum, & Droubi, 2012). Addressing the limitations of previous studies, the DRS was selected to improve the reliability and validity of measuring the hardiness construct (Funk, 1992).

Nevertheless, the present study has multiple limitations, which should be considered when interpreting the results. In addition to the many limitations presented previously in chapter 3, methodological issues and sampling are also limitations of this study. The measurement of counselor self-care represents a study limitation. Personal definitions and understandings of self-care vary between individuals and may have not been adequately captured in the definitions
provided. This study replicated the Richards, Campenni, and Muse-Burke (2010) methods to ascertain self-care frequency and importance, the two variables identified as most indicative of overall self-care. Lastly, the results of the present study are also limited by the composition of the sample. The majority of the participants were white (83.8%) females (74.7%). Nonwhite (16%) and non-female identified (25.3%) participants were a minority of this sample. This study therefore lacked gender and ethnocultural diversity, though arguably, this sample is comparable to the overall gender and ethnocultural distribution of the counseling profession. The sample size itself (N= 154), although sufficient for statistical analysis, inhibits generalizability to all mental health counselors and could benefit from replication with a larger sample.

**Recommendations for Future Research**

The results of this study highlight the need for continued assessment of burnout and its associated factors within the counseling profession. Further research is needed to assess factors that bolster hardiness and sustain healthy attitudes and beliefs. Counseling programs and the profession as a whole recognize the importance of wellness and reducing impairment. Furthering research on hardiness and assessing the effectiveness of hardiness training could be beneficial to the profession.

This study was exploratory research into the relationships between self-care, burnout, and hardiness. This research could be replicated, continued, and expanded upon. An important extension to this research would be to include a more diverse sample to more fully understand if hardiness varies between the demographic variables. Some studies have suggested individuals with multiple minority identities may be hardier due to a more complex self-concept and varied experience (Consolacion, Russell, & Sue, 2004). It is unknown how hardiness is related to minority stress, more fully understanding this relationship could ensure promoting hardiness is
intersectional. Replicating within other counseling specialties (i.e. substance use treatment, sex-offender treatment) or within other counseling tracks, such as school counseling or career counseling could also be beneficial to understanding hardiness. To improve upon the study, research could utilize other methods for measuring self-care and coping mechanisms. More exploration could be conducted to better understand the causal pathways between self-care, coping mechanisms, and hardiness. Future research could explore the role of time through a longitudinal study. The current study has measured burnout at only one point in time; research that explores the impact of self-care on burnout at different points within a counselor’s career could prove useful in better understanding self-care’s role. Additionally, research could extend beyond burnout to ascertain hardiness’ ability buffer against more nuanced working hazards such as secondary traumatic stress, compassion fatigue, and vicarious traumatization. Including the Adjective Check List Success Factors at Work (ACL-SFW), which assesses personality traits and the factors that are important to success at work, into the study design could assist with insight into the personalities of the participants. Including the Areas of Worklife Survey (AWS), which assesses an individual’s areas of strength and weakness within their organizational settings, would be a better method for assessing work satisfaction than the one-item question utilized in this study. Qualitative research could be utilized to gain a more in-depth understanding of the hardy counselor’s attitudes and coping strategies. Qualitative methods may also allow for more in-depth exploration of the phenomenon of counselors having high emotional exhaustion, but also high personal accomplishment.

**Conclusions**

The results of this study support the hypothesis that there is a significant relationship between hardiness, self-care, and burnout. Moreover, the study seems to support the hypothesis
that hardiness plays a larger role than self-care in buffering against burnout. This finding seems to indicate that students and supervisees could benefit not just from understanding the importance of self-care, but also bolstering hardiness. If hardiness trainings are developed and implemented, counselor’s well-being could be fostered and bolstered. With the organizational and emotional stressors inherent in the profession, students could benefit from learning to transform this stress into advantage through hardy coping, hardy social interaction, and hardy self-care.
The Role of Self-Care and Hardiness in Moderating Burnout in Mental Health Counselors

Traci D. Richards, Jeffery Moe, Jill Krahwinkel, Christine Berger, Mark Rehfuss

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Abstract

This study explored the relationship between hardiness, identity characteristics, and job factors using a Pearson’s correlation and factorial MANOVA. Additionally, this study examined the relationship between self-care, hardiness, and burnout in a sample of mental health counselors using a hierarchical multiple regression. The researcher sampled participants through email using a Qualtrics survey. The study used valid and reliable instruments: the Maslach Burnout Inventory (MBI) was used to assess burnout and the Dispositional Resilience Scale (DRS) was used to assess hardiness. Self-care frequency and importance along with job satisfaction were also assessed. Findings showed that significant predictors of burnout amongst the variables in the model include age, job satisfaction, self-care frequency, and hardiness. Hardiness carried the most significant impact in predicting burnout.

Keywords: resilience, hardiness, mental health counselors, burnout, self-care, job satisfaction, Maslach Burnout Inventory, Dispositional Resilience Scale
The Role of Self-Care and Hardiness in Moderating Burnout in Mental Health Counselors

Mental health counselors are particularly vulnerable to burnout, a term coined in the 70s to describe workers’ reactions to chronic stress common in occupations involving numerous interactions with people (Freudenberg, 1974). Mental health counselors face constant exposure to unique and emotionally charged working hazards, with burnout estimated as high as 67% for those in the mental health profession (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012, p. 2). The repercussions of burnout are far-reaching beyond just the physical, mental, and emotional impacts on the individual; there are also negative consequences for the organization and the clients who receive services (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012).

Due to the environmental facets that contribute to burnout symptoms, many studies have emphasized the power of modifying organizational-level factors (Burk & Richardsen, 1993; Halbesleben & Buckley, 2004; Maslach, Schaufeli, & Leiter, 2001; Stalker & Harvey, 2002). Skovholt and Trotter-Mathison (2011) emphasize that when the professional focuses on what he or she cannot control, job stress is intensified. Mental health counselors are not often able to control the organizational-environmental factors. For this reason, interventions and trainings do not address environmental factors, but rather internal factors (Skovholt & Trotter-Mathison, 2011). Additionally, even if some organizational-environmental aspects are modified, occupational hazards such as normative failure, constant empathy, constant interpersonal sensitivity, one-way caring, ambiguous loss, and the covert nature of the job – to name a few—cannot be modified (Skovholt & Trotter-Mathison, 2011). For this reason, this study focused on the individual in order to better inform mental health counselor wellness trainings and educational courses and programs.
Freudenberger (1974) introduced the term ‘burnout’ related to worker stress in the 70s. It has been estimated that over 6,000 articles, chapters, dissertations, and books have been written on the subject in the 35 years after its introduction with over 300 articles published within the first 5 years (Skovholt & Trotter-Mathison, 2011). With this extensive popularity have come several definitions and conceptualizations. Burnout affects every profession, but mental health professionals are particularly susceptible. Kottler (2003) identifies burnout as “the single most common personal consequence of practicing therapy” (p. 158).

Due to the significant impact on personal and professional life, mental health counselors need to be concerned about burnout (Lawson, 2007). Though burnout has been explored within and among professions and disciplines, burnout has been found higher among community social workers compared to nurses and psychiatrists (Priebe, Fakhoury, Hoffman, & Powell, 2005). Mental health counselors are particularly susceptible to burnout due to the intense proximity to the struggles of others and the exhausting pace of the workload. Morse et al. (2012) stated

Despite its prevalence and association with a number of negative outcomes, little has been directed toward reducing or preventing burnout among mental health professionals. The need for burnout prevention and interventions for mental health providers has been highlighted by researchers for decades (p. 6)

Research has attempted to identify strategies and factors to prevent burnout. As mentioned, the most effective approach has been to identify organizational strategies to prevent burnout. Pines (1993) identified that developmentally supportive environments reduce the likelihood of burnout. In this way, supportive environmental strategies such as increasing promotion opportunities (Abu-Bader, 2000), competitive salaries, increased staffing levels, and
flexible work schedules (Paris & Hoge, 2009), have been found to reduce the impact of burnout. Despite the impact and implication of this research to the administrative realm, the individual or training institutions cannot control these environmental factors.

The degree to which a person is a match or a mismatch with the mental health profession is correlated to burnout (Maslach, Schaufeli, & Leiter, 2001) and some personal factors may play a role in preventing burnout, including one’s attitude and meaning making abilities. For instance, job satisfaction (Schulz, Greenley, & Brown, 1995), compassion satisfaction (Stamm, 2002), and affective commitment to the work (Rhoades, Eisenberger, & Armeli, 2001) have been found to moderate levels of burnout, though none with a specific focus on mental health counselors. An individual’s use of self-care has also been identified as a protective factor that offsets burnout. Stamm (2002) found that those who had sustained relationships and conducted self-care tasks were less at risk for burnout. Collins and Long (2003) identified active coping as the most common coping strategies used by counselors to cope with work related stress. Active coping includes activities that promote physical health and well-being, spiritually-oriented activities, various leisure activities, and seeking both emotional and instrumental support (Kraus, 2005). Much of the intervention strategies focus on cognitive and behavioral aspects of coping, though some have endeavored to explore emotional coping, with mixed results. Wilkerson and Bellini (2006) found emotion-oriented coping was predictive of burnout, meaning that focusing on feelings associated with the stressors were predictive of higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment. However, this is contrary to the findings that escape-avoidance strategies and turning away from these emotions are related to symptoms of burnout (Venart, Vassos, & Pitcher-Heft, 2007).
Self-Care

Currently, counselor ethical codes and educational programs emphasize the obligation to refrain from practicing while impaired. The American Counseling Association (ACA) places emphasis on maintaining competency and protecting clients from one’s personal problems that interfere (ACA, 2014). Specifically, Section C of the ACA *Code of Ethics* (ACA, 2014) states counselors should “refrain from offering or providing professional services when such impairment is likely to harm a client or others” (C. 2 g.) and “continually monitor their effectiveness as professionals” (C.2.d). The broad interpretation of this standard is to attend to one’s own care in order to adequately help others and prevent harm (Barnett, 2007). The Council for the Accreditation of Counseling and Related Educational Programs (CACREP; 2016) includes standards for self-care in Section II. F. 1. L: “self-care strategies appropriate to the counselor role.” The ACA ethical code also explicitly includes self-care as part of professional responsibility, stating counselors should “engage in self-care activities to maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities” (Section C, p. 8). In sum, self-care is an ethical necessity (Carroll, Gilroy, & Mura, 1999).

Self-care as an ethical imperative has support in the research: it has been identified as a protective factor against burnout (Stamm, 2002). Self-care and coping skills for stress are without a doubt important, but there may be another variable such as personal factors, that is aiding these strategies in buffering against burnout. Morse et al. (2012) emphasize the need for studies to explore and identify “other positive human qualities and abilities” (p. 8).

Borrowing from the positive psychology movement, this study sought to identify a personal factor to buffer against burnout. One such positive psychology variable that has been
able to promote wellbeing in helping professions is resilience. According to Everly, Welzant, & Jacobson (2008) resiliency is one’s ability to recover from adversity without experiencing significant distress. The personality trait that promotes resiliency is called hardiness (Barton, 2006; Maddi, 2007). For this reason, hardiness is called “dispositional resilience” (Bartone, 2006, 2007) and considered a pathway to resilience (Bonanno, 2004). The hardiness dimensions are “the core individual-level qualities that affect resilience” (Escolas, Pitts, Safer, & Bartone, 2013, p. 117).

**Hardiness**

Selye (1956) is credited with discovering “stress” when he observed that patients suffering from different diseases often exhibited identical signs and symptoms (Kobasa, 1979b). Selye emphasized individual differences in the stress reaction and the personality as the distinctive way in which individuals deflect the negative impact of stressful life events (Collins, 1996; Kobasa, 1979b; Selye, 1956). It was from this angle of determining which personality could protect the individual from stress that Kobasa (1979b) sought to identify factors of those who remained healthy under life stress. Kobasa (1979a) hypothesized that individuals who remain healthy after experiencing stress exhibit “a constellation of attitudes, beliefs, and behavioral tendencies” (p. 1). Kobasa labeled this constellation hardiness and it serves as a model of individual resiliency to stress. Overtime, it has been defined not as a single personality style, but rather a combination of personality factors that decrease illness-causing effects in the face of stressful life situations (Funk & Houston, 1997; Ganellen & Blaney, 1984, Kobasa, Maddi, & Kahn, 1982; Wagnild & Young, 1991). It has been established as distinct from constitutional predisposition (Kobasa, Maddi, & Courington, 1981), exercise, social support (Kobasa, Maddi, Puccetti, & Zola, 1985, type A behavior, and health practices (Maddi &
Kobasa, 1984). Hardiness has convergent properties with locus of control (Rotter, 1990), optimism (Scheier, Carver, & Bridges, 2001), and self-efficacy (Bandura, 1997).

According to the hardiness model, the hardy individual transforms stress into advantage through hardy coping, hardy social interaction, and hardy self-care (Maddi, 2013). Hardiness has been associated with active, transformational and problem-focused coping and less emotion-focused coping (Williams, Wiebe, & Smith, 1992). These coping strategies are those that reframe stress into a benign experience. Individuals low in hardiness have been found to use cognitive and behavioral avoidance and denial strategies, which is suspected to compound the emotional stress and maladjustment (Williams, Wiebe, & Smith, 1992).

Due to the practical implications of hardiness in planning stress management programs, numerous authors have explored the effects of hardiness on work-related outcomes, with the majority on burnout. The generated research suggests that hardiness is negatively related to burnout, though the focus has been in the professions of nursing and education (Chan, 2003; Simoni & Paterson, 1997).

Pollock (1989) was perhaps the first to emphasize the importance of the hardiness characteristic to the nursing field and proposed that due to “stressful jobs and the associated burnout” nurses may benefit from hardiness instruction (p. 61). Keane, Ducette, and Adler (1985) were the first to present data supporting hardiness as a resistance resource for preventing burnout among hospital nurses. Hardiness was found to be significantly associated with burnout among ICU nurses (Keane, Ducette, & Adler, 1985). Replicating the Keane study for validity and generalizability and including a different sample of nurses, McCranie, Lambert, and Lambert (1987) included job stress as a variable, exploring whether hardiness moderated the impact of perceived job stress on level of burnout. Hardiness had beneficial main effects in reducing
burnout, but did not appear to prevent high levels of stress from leading to high levels of burnout. The sample included 107 nurses from different departments within the same hospital. Collins (1996) utilized a convenience sample of 113 nurses at one hospital and different scales from the preceding research to include the Personal Views Survey as an instrument to assess hardiness and examined the relationship between hardiness and job stress and hardiness and burnout. The hypotheses were supported: nurses who possessed higher levels of personality trait hardiness were most likely to have less work stress and less burnout (Collins, 1996). Since these studies are specific to the field of nursing it cannot be assumed the results will generalize to mental health counselors. Morse et al. (2012) stated:

There is little reason to believe that burnout would affect mental health workers differently than nurses, teachers or other professional groups where additional research describes strong relationships between burnout and a range of associated problems. Nonetheless, future research should include mental health workers and use larger samples …to better examine the relationship between burnout and associated problems (p. 6).”

Other than not including other mental health professionals, these studies had several methodological weaknesses. Foremost is the use of measurement in these studies as initial hardiness instrumentation was utilized. Younkin and Betz (1996) identified four major problems with the Kobasa instruments utilized in the above studies, and they are: (a) they lacked stability, (b) they utilized three traits already identified as important in stress resistance to measure a supposedly uni-dimensional trait of hardiness, (c) the differential relationship of the dimensions to criterion variables, and (d) the use of negative indicators. Despite these problems, the authors acknowledged that the concept of hardiness has “logical merit and face validity” (p. 163) and emphasized the need for a direct (rather than indirect) measure for hardiness. With the early
instrumentation available, there were inconsistent methods of measurement across the studies mentioned above; it is possible that the hardiness construct was conceptually flawed or something other than hardiness was being measured in these studies. These problems led to a need for a study using a third generation, direct measure of hardiness with a focus specifically on those within the mental health profession such as counselors.

**Method**

Purposive, convenience, and snowball sampling were utilized to achieve the desired sample size. Participants were emailed a link to the survey containing several components: an informed consent, demographic survey, the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), the Dispositional Resilience Scale (DRS; Bartone, 2007), and questions regarding self-care frequency and importance. The informed consent document was the first page of the survey, followed by the demographic questions, the MBI, the DRS, and concluded with the self-care questions.

A Pearson’s Correlation and factorial MANOVA were conducted to ascertain the relationship between hardiness and the demographic and job variables. These analyses were followed by a hierarchical multiple regression to determine if burnout, the dependent variable, could be predicted based on the independent variables and if hardiness predicts burnout over these variables (demographic variables, job characteristics, and self-care).

**Participants**

Participants (N=154) identified as mental health counselors who engage in direct client services and were either licensed or in residency. Of the mental health counselors sampled, the 89% of participants reported having a Master’s degree (n=137) and 84.4% were licensed (n=130). Within the sample, 57.8% specialized in trauma issues (n=93). The majority of the
participants were female (74.7%) and white (83.8%). Participants’ ages ranged from 19 to 75 years \((M= 50.31, SD= 14.48)\). Experience within the mental health field ranged from 0 to 48 years \((M= 17.71, SD= 12.34)\).

**Instrumentation**

Two valid and reliable instruments were used in the study in order to measure Burnout and Hardiness. A demographic questionnaire gathered demographic information and specific information about participants’ job characteristics to include licensure status, education level, and job satisfaction. To assess self-care frequency and importance, the methods utilized by Richards, Campenni, and Muse-Burke (2010) were replicated. Participants were given a broad definition of self-care and its main components: physical, psychological, spiritual, and support. Participants indicated frequency of use from each category of self-care behaviors using a 7-point Likert scale. Participants were asked to indicate on a Likert scale the extent to which they agree with four statements pertaining to the importance of self-care.

**The MBI-HSS.** The original measure and the most commonly used tool to self-assess the risk of burnout for professionals in the human services and health care (Maslach, Schaufeli, & Leiter, 2001). The MBI-HSS consists of 22 statements of job-related feelings. Each statement is followed by a 7-point scale to indicate frequency, the selection includes: never, a few times a year or less, once a month or less, a few times a month, once a week, a few times a week, or every day. There are three subscales of the MBI to measure exhaustion, depersonalization, and personal accomplishment. The three-factor structure has been validated across occupations and national contexts (Schaufeli & Enzmann, 1998). Burnout is the summation of the three dimensions and indicated when exhaustion and depersonalization are high and personal accomplishment is low.
The **DRS** The Dispositional Resilience Scale (DSR-15) is of the third-generation instrumentation that measures for the presence of hardiness, rather than its absence. The DSR contains 15 statements and a 4-point scale of not at all true, a little true, quite true, and completely true. In a review of hardiness research, Funk (1992), identified the DRS as the most sound hardiness measure available, both conceptually and psychometrically.

**Procedure**

Data were collected over the course of four weeks using Qualtrics survey software. A link to the survey was emailed to American Mental Health Counselors Association (AMHCA) leadership and each of the state chapters for dissemination. Additionally, a link was emailed to the American Counseling Association (ACA) Research and Knowledge Committee and Virginia Counseling Association (VCA) division presidents. A link was also emailed to listservs of CESNET, ACA connect, Counsgrads, and 1,802 members of the AMHCA listserv.

**Results**

A Pearson’s correlation and factorial MANOVA were conducted to answer the first research question, which explored the relationship between mental health counselors’ hardiness and select demographic variables such as age, gender, ethnocultural identity, experience in the field, education, licensure status, and job satisfaction. There was not a statistically significant correlation between age and the DRS subscales of Commitment \(r = .216, p = .007\), Control \(r = .002, p = .980\), Challenge \(r = .054, p = .506\), or DRS total score \(r = .114, p = .160\). There was not a statistically significant correlation between total experience in the field and the DRS subscales of Commitment \(r = .200, p = .013\), Control \(r = -.002, p = .981\), Challenge \(r = -.074, p = .366\), or DRS total score \(r = .039, p = .630\).
To explore the differences in hardness in counselors across counseling specialty, gender, ethnocultural identity, job satisfaction, licensure status, education, and experience were included in a factorial multivariate analysis of variance (MANOVA). Variables of interest in this model included participants’ DRS subscale scores (Challenge, Commitment, and Control) and select demographic variables (i.e., counseling specialty, gender, ethnocultural identity, job satisfaction, education, licensure status, and experience in the field).

The factorial MANOVA found no statistical differences in hardness subscales in select demographic groups: education, \( F[3, 124] = 1.140, p = .336, \text{ Wilks' } \lambda = .973, \text{ partial } \eta^2 = .01 \); licensure, \( F[3, 124] = .8852, p = .468, \text{ Wilks' } \lambda = .98, \text{ partial } \eta^2 = .01 \); gender, \( F[3, 124] = 1.507, p = .216, \text{ Wilks' } \lambda = .965, \text{ partial } \eta^2 = .02 \); ethnocultural identity, \( F[3, 124] = .089, p = .996, \text{ Wilks' } \lambda = .998, \text{ partial } \eta^2 = .020 \); counseling specialty, \( F[3, 124] = .600, p = .616, \text{ Wilks' } \lambda = .986, \text{ partial } \eta^2 = .06 \); and job satisfaction \( F[3, 124] = 4.211, p = .007, \text{ Wilks' } \lambda = .908, \text{ partial } \eta^2 = .06 \).
\( \eta^2 = .01 \). As the IVs had no effect on the DVs at the pre-set alpha level, the null hypothesis for question 1 was accepted and the research hypothesis rejected.

A hierarchical multiple regression was conducted to analyze the predictive capabilities of the independent variables (research question 2) as well as to analyze the predictive capabilities of dispositional resilience over and above self-care and demographic. The dependent variable, burnout, was represented by participants’ MBI scores. Variables were entered into the model according to their causal priority (Petrocelli, 2003). The first step (model 1) included participants’ identity demographics: ethnocultural identity, age, and gender. The second step (model 2) included job characteristics: job satisfaction, experience in the field, education, licensure status, and trauma as a primary specialty. The third step included self-care frequency and self-care importance into the model. Dispositional resilience, measured by the DRS score, was included in the fourth step.

The hierarchical multiple regression revealed that at Model 1, identity demographics contributed significantly to the regression model, \( F(3, 149) = 7.279, p < .001 \), and accounted for 12.8% of the variation in Burnout. Introducing job characteristics explained an additional 12.1% of the variance and this \( R^2 \) was significant, \( F(5, 144) = 5.970, p = .001 \). Adding Self-Care factors to the regression model explained an additional 6.1% of the variation in Burnout and this change in \( R^2 \) was significant, \( F(2, 142) = 6.367, p = .003 \). Finally, the addition of Hardiness to the regression model explained an additional 12.8% of the variation in Burnout, this \( R^2 \) was statistically significant, \( R^2 = .438, F(1, 141) = 9.971, p < .001 \), indicating that the final model significantly improves the ability to predict Burnout. Together, the full model of identity demographics, job characteristics, self-care variables, and dispositional resilience accounted for 43% of variance in Burnout.
When all of the independent variables were included in model 4 of the regression, only Age, Job Satisfaction, Frequency of Self-Care, and Hardiness were contributing significantly as predictors of Burnout (see Table 6). These standardized beta values indicate that Hardiness has the most impact in the model, followed by Job-Satisfaction, Age, then Frequency of Self-Care. Hardiness and Age have a negative relationship with Burnout; that is, as these factors increase, burnout decreases. Due to the dummy coding of Job-Satisfaction (0 = satisfaction; 1 = no satisfaction), the results require modification to interpret. As one’s job satisfaction decreases, burnout increases. Interestingly, as self-care frequency increases, so does burnout; for a one-standard deviation increment on Frequency of Self Care, burnout increases by .154. As the IVs predicted the DV at the pre-set alpha level, the null hypotheses for questions 2 and 3 were rejected and the research hypotheses affirmed.

Table 4

Summary of the Hierarchical Multiple Regression Analysis for Variables Predicting Burnout

\( (N=154) \)

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R^2</th>
<th>Adj R^2</th>
<th>Std. Error</th>
<th>( \Delta R^2 )</th>
<th>( \Delta F )</th>
<th>df1</th>
<th>df2</th>
<th>Sig ( \Delta F )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.36</td>
<td>.13</td>
<td>.110</td>
<td>.61</td>
<td>.128</td>
<td>7.279</td>
<td>3</td>
<td>149</td>
<td>.000</td>
</tr>
<tr>
<td>2</td>
<td>.50</td>
<td>.25</td>
<td>.207</td>
<td>.58</td>
<td>.121</td>
<td>4.65</td>
<td>5</td>
<td>144</td>
<td>.001</td>
</tr>
<tr>
<td>3</td>
<td>.56</td>
<td>.31</td>
<td>.261</td>
<td>.56</td>
<td>.061</td>
<td>6.333</td>
<td>2</td>
<td>142</td>
<td>.003</td>
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<tr>
<td>4</td>
<td>.66</td>
<td>.44</td>
<td>.394</td>
<td>.51</td>
<td>.128</td>
<td>32.078</td>
<td>1</td>
<td>144</td>
<td>.000</td>
</tr>
</tbody>
</table>

Note. Model 1 represents the variables ethnocultural identity, age, and gender. Model 2 includes the Model 1 variables, job satisfaction, counseling specialty, education, licensure status, and experience in the field. Model 3 includes all previous variables and self-care frequency and importance scores. Model 4 includes all previous variables and DRS score.
Table 5

**ANOVA Table for Hierarchical Multiple Regression, Predicting Burnout (N= 154)**

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Regression</td>
<td>28.01</td>
<td>11</td>
<td>2.546</td>
<td>9.97</td>
<td>.000</td>
</tr>
<tr>
<td>Residual</td>
<td>36.01</td>
<td>141</td>
<td>.255</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Total</td>
<td>64.02</td>
<td>152</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

*Note.* Model 4 represents the variables ethnocultural identity, age, gender, counseling specialty, years of experience, job satisfaction, education, licensure status, self-care importance, self-care frequency, and DRS score.

Table 6

**Hierarchical Multiple Regression Predicting Burnout**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>B 1.737</td>
<td>B 1.507</td>
<td>B 2.017</td>
<td>B 3.244</td>
</tr>
<tr>
<td>Age</td>
<td>-015**</td>
<td>-033**</td>
<td>-016*</td>
<td>-034*</td>
</tr>
<tr>
<td>Gender</td>
<td>0.003</td>
<td>0.115</td>
<td>-0.02</td>
<td>-0.013</td>
</tr>
<tr>
<td>Ethnocultural</td>
<td>0.122</td>
<td>0.141</td>
<td>0.081</td>
<td>0.174</td>
</tr>
<tr>
<td>Experience</td>
<td>0.001</td>
<td>0.012</td>
<td>-0.001</td>
<td>-0.014</td>
</tr>
<tr>
<td>Trauma</td>
<td>-0.132</td>
<td>-0.1</td>
<td>-0.151</td>
<td>-0.115</td>
</tr>
<tr>
<td>Job Satisfaction</td>
<td>0.804**</td>
<td>0.321**</td>
<td>0.838**</td>
<td>0.335**</td>
</tr>
<tr>
<td>Education</td>
<td>0.104*</td>
<td>0.051*</td>
<td>0.062</td>
<td>0.03</td>
</tr>
<tr>
<td>Licensure Status</td>
<td>0.29</td>
<td>0.163</td>
<td>0.338*</td>
<td>0.19*</td>
</tr>
<tr>
<td>SC Importance</td>
<td>0.040</td>
<td>0.137</td>
<td>-0.022</td>
<td>-0.075</td>
</tr>
<tr>
<td>SC Frequency</td>
<td>0.030*</td>
<td>0.167*</td>
<td>0.028*</td>
<td>0.154*</td>
</tr>
<tr>
<td>Hardiness (DRS)</td>
<td>0.049**</td>
<td>0.39**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: **= (p<.001); * = (p<.05)*
Discussion

The Pearson’s correlation showed no significant correlations between age and the subscales of hardiness to include Commitment, Control, and Challenge or experience and these subscales. The results indicate that an individual’s hardiness level was not related to experience or age. This finding was true for the other categorical variables as well using the factorial MANOVA. The factorial MANOVA was not significant and indicates there are no significant differences in hardiness subscales based on a counselor’s gender, ethnocultural identity, education, specialty, licensure status, and job satisfaction. This result suggests identity demographics and job characteristics do not significantly affect the outcome variable: hardiness. That is, hardiness levels are not dependent on one’s gender, ethnocultural identity, education, specialty, licensure, or job satisfaction. This finding is consistent with the literature on hardiness, which identifies it as a personality trait (Funk, 1992). The results support a rationale for further sampling from a more robust data set.

The results indicate one’s hardiness levels are consistent no matter how long one works in the field or whether they have chosen to work with trauma. That is to say, hardy counselors can be found in both areas of trauma and non-trauma specialties and at varying experience levels. Previous literature has warned of the long-term effects of working in the counseling field with most literature focusing on the impact of continual exposure to trauma clients (Adams, Boscarino, & Figley, 2006; Bride, 2004, 2007). If hardiness is indeed a personality trait that is helpful in promoting wellness despite environmental exposures, then counselors with higher hardiness levels may be relatively unaffected by the additive stressors associated with longevity
in the field or with such career-specific hazards like secondary traumatic stress, vicarious traumatization, and compassion fatigue.

The results of the hierarchical multiple regression were significant with each step indicating that burnout scores are impacted by each set of variables. Job satisfaction has been found to moderate levels of burnout, though no literature has had a specific focus on mental health counselors (Schulz, Greenley, & Brown, 1995). This current study corroborates this finding within the field of counseling and supports the need for organizational-level changes (Burke & Richardsen, 1993; Halbesleben & Buckley, 2004). That is, modifying work characteristics can reduce burnout (Awa, Plaumann, & Walter, 2010). Affective commitment, one’s identification with, involvement in, and emotional attachment to one’s own organization, has also been a significant buffer against burnout (Schmidt, 2007; Setti, Lourel, & Argentero, 2016). This construct may overlap with hardiness and explain how counselors are able to work in an emotionally demanding environment without succumbing to burnout.

The finding that self-care factors account for the variance in burnout scores supports the ACA ethical guidelines and CACREPS’ emphasis on self-care. This finding is also consistent with Stamm’s (2003) finding that engaging in self-care can reduce the risk of burnout. Surprisingly, frequency of self-care was identified as a significant predictor more so than self-care importance and has a direct relationship with burnout. Those that engage in self-care more frequently are more at risk for burnout. It may be that frequency is not synonymous with effectiveness. Engaging in self-care that is effective, albeit infrequently conducted, may be better than engaging in frequent self-care.

The results of the regression also indicated that hardiness, as measured by the DRS, does predict burnout over and above self-care. The model with Hardiness statistically explained 44%
of the variability in burnout scores; with Hardiness alone accounting for 12.8% of the variance. With regard to predicting Burnout, the Hardiness variable carries the most impact, the most significant predictor across all the models. This result is consistent with the research of hardiness as a moderator for burnout in nursing professionals (McCranie et al., 1987; Rich & Rich, 1987; Topf, 1989). Additionally, this result is consistent with research that found hardiness to be the most important predictor of burnout amongst nursing professionals (Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995; Simoni & Paterson, 1997). The underlying mechanisms of hardiness lend insight into potential explanations for the findings of this study. According to the hardiness model, the hardy individual converts stress into advantage through hardy coping, hardy social interaction, and hardy self-care (Maddi, 2013). Hardiness has convergent properties with locus of control (Rotter, 1990), optimism (Scheier, Carver, & Bridges, 2001), and self-efficacy (Bandura, 1997). Hardy self-care is identified as putting forth effort to promote bodily functioning such as engaging in relaxation, having a balanced and moderate diet, and maintaining a moderate level of physical activity (Maddi, 2013). Hardiness promotes resiliency in combat veterans through active problem solving (Maddi, 1999a; Maddi & Hightower, 1999), positive cognitive appraisal (Allred & Smith, 1989), using optimistic and active coping strategies (Kobasa, 1982; Maddi & Kobasa, 1984) and seeking a support network (King, King, Fairbank, Keane, & Adams, 1998). Individuals with higher hardiness scores report fewer symptoms of depression and PTSD (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009). It seems logical to conclude hardy counselors are more likely to use an active problem solving approach, transformational coping styles, positive cognitive appraisal, and have a better support network to reduce the risk of burnout.
Limitations

The limitations of this study include that it was not an experimental design. Therefore participants were not randomly selected or randomly assigned to a group. Additionally, there was not a control group. Instead, a survey method was used. While the survey method allows for the gathering of large amounts of data efficiently, the survey itself (instrumentation) may pose a threat to the internal and external validity if the instrument is not valid and reliable. Despite using valid and reliable instruments when using self-report survey methods the response styles of the participants as well as the self-report nature can create limitations. These response styles could negatively impact the generalizability of the findings. The surveys selected attempt to control for these response styles. The MBI and the DSR-15 have reverse scoring for select items and utilize a Lickert scale to aid in the countering of these possibilities.

When utilizing a survey method, the sample poses many possible threats to the external validity of the study. The researcher attempted to select a sample that was representative of the population to allow for generalizability of the results. However, since non-random sampling techniques have a selection bias, caution must be taken to generalize the findings of this sample to the whole population. The results of the present study are also limited by the composition of the sample. The majority of the participants were white (83.8%) females (74.7%). Nonwhite (16%) and non-female identified (25.3%) participants were a minority of this sample. This study therefore lacked gender and ethnocultural diversity, though arguably, this sample is comparable to the overall gender and ethnocultural distribution of the counseling profession. The sample size itself (N= 154), although sufficient for statistical analysis, inhibits generalizability to all mental health counselors and could benefit from replication with a larger sample.
The measurement of counselor self-care represents a study limitation. Personal definitions and understandings of self-care vary between individuals and may have not been adequately captured in the definitions provided. This study replicated the Richards, Campenni, and Muse-Burke (2010) methods to ascertain self-care frequency and importance, the two variables identified as most indicative of overall self-care.

Recommendations for Future Research

The results of this study highlight the need for continued assessment of burnout and its associated factors within the counseling profession. Further, research is needed to assess factors that bolster hardiness and sustain healthy attitudes and beliefs. Counseling programs and the profession as a whole recognize the importance of wellness and reducing impairment. Furthering research on hardiness and assessing the effectiveness of hardiness training could be beneficial to the profession.

This study was exploratory research into the relationships between self-care, burnout, and hardiness. This research could be replicated, continued, and expanded upon. An important extension to this research would be to include a more diverse sample to more fully understand if hardiness varies between the demographic variables. Some studies have suggested individuals with multiple minority identities may be hardier due to a more complex self-concept and varied experience (Consolacion, Russell, & Sue, 2004). It is unknown how hardiness is related to minority stress, more fully understanding this relationship could ensure promoting hardiness is intersectional. Replicating within other counseling specialties (i.e. substance use treatment, sex-offender treatment) or within other counseling tracks, such as school counseling or career counseling could also be beneficial to understanding hardiness. To improve upon the study, research could utilize other methods for measuring self-care and coping mechanisms. More
exploration could be conducted to better understand the causal pathways between self-care, coping mechanisms, and hardiness. Future research could explore the role of time through a longitudinal study. The current study has measured burnout at only one point in time; research that explores the impact of self-care on burnout at different points within a counselor’s career could prove useful in better understanding self-care’s role. Additionally, research could extend beyond burnout to ascertain hardiness’ ability buffer against more nuanced working hazards such as secondary traumatic stress, compassion fatigue, and vicarious traumatization. Including the Adjective Check List Success Factors at Work (ACL-SFW), which assesses personality traits and the factors that are important to success at work, into the study design could assist with insight into the personalities of the participants. Including the Areas of Worklife Survey (AWS), which assesses an individual’s areas of strength and weakness within their organizational settings, would be a better method for assessing work satisfaction than the one-item question utilized in this study. Qualitative research could be utilized to gain a more in-depth understanding of the hardy counselor’s attitudes and coping strategies. Qualitative methods may also allow for more in-depth exploration of the phenomenon of counselors having high emotional exhaustion, but also high personal accomplishment.
References


References


Funk, S. C. & Houston, B. K. (1987). A critical analysis of the hardiness scale's validity and


APPENDIX A: SAMPLE ITEMS FROM MASLACH BURNOUT INVENTORY-
HUMAN SERVICES SURVEY

For each question, indicate the score that corresponds to your response.

<table>
<thead>
<tr>
<th></th>
<th>Never (1)</th>
<th>A few times per year (2)</th>
<th>Once a month (3)</th>
<th>A few times per month (4)</th>
<th>Once a week (5)</th>
<th>A few times per week (6)</th>
<th>Every day (7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel emotionally drained in my work. (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel used up at the end of the day. (2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am fatigued when I get up in the morning and have to face another day on the job. (3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX B: DISPOSITIONAL RESILIENCY SCALE-15

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all true (1)</th>
<th>A little true (2)</th>
<th>Quite True (3)</th>
<th>Completely true (4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most of my life gets spent doing thing that are meaningful. (1)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>By working hard you can nearly always achieve your goals. (2)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I don’t like to make changes in my regular activities. (3)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I feel that my life is somewhat empty of meaning. (4)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Changes in routine are interesting to me. (5)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>How things go in my life depends on my own actions. (6)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I really look forward to my daily activities. (7)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>I don’t think there is much I can do to influence my own future. (8)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Click to write Statement 9 (9)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Click to write Statement 10 (10)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Click to write Statement 11 (11)</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Click to write Statement 12 (12)</td>
<td></td>
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<td>----------------------------------</td>
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</tr>
<tr>
<td>Click to write Statement 13 (13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Click to write Statement 14 (14)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Click to write Statement 15 (15)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
APPENDIX C: SELF-CARE FREQUENCY ITEMS

Self-care refers to any activity that one does to feel good about oneself. It can be categorized into four groups, which include: physical, psychological, spiritual, and support. Please identify how often you participate in the following activities. Note that there are no right or wrong responses, simply the answers that reflect the frequency that you are involved with such activities. Please be sure to respond to each statement and to select only one answer for each item.

<table>
<thead>
<tr>
<th></th>
<th>One or more times daily</th>
<th>Multiple times weekly</th>
<th>Once weekly</th>
<th>Multiple times monthly</th>
<th>Once monthly</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical--incorporating physical activity (e.g. exercise, sports, household activities, etc.)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Psychological--one's own personal therapy (psychological treatment, in any form, for psychological distress or impairment experienced)</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
</tr>
<tr>
<td>Spiritual--activities and behaviors to enhance one's sense of purpose and meaning of life; deep thoughts or contemplation resulting in introspection (e.g. attending worship, praying, attending</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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</tbody>
</table>
retreats, meditation, etc.) (3)

Support--relationships and interactions developed and maintained as professional and personal support systems (e.g., consultation and supervision from peers, colleagues, and supervisors; continuation of professional education; quality time with partner, companion, friend, family, etc.) (4)

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<td></td>
</tr>
</tbody>
</table>
APPENDIX D: SELF-CARE IMPORTANCE ITEMS

Q14 Please read each statement and circle the number that best fits for you. Note that there are no right or wrong responses, simply the answers that reflect your own opinion. Please be sure to respond to each statement and to select only one answer for each item.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Disagree Strongly (1)</th>
<th>Disagree (2)</th>
<th>Disagree Slightly (3)</th>
<th>Neither Agree nor Disagree (4)</th>
<th>Agree Slightly (5)</th>
<th>Agree (6)</th>
<th>Agree Strongly (7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The physical aspect of self-care is important to me. (1)</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
</tr>
<tr>
<td>The psychological aspect of self-care is important to me. (2)</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
</tr>
<tr>
<td>The spiritual aspect of self-care is important to me. (3)</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
</tr>
<tr>
<td>The support aspect of self-care is important to me. (4)</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
<td>![Not applicable]</td>
</tr>
</tbody>
</table>

Q24 To indicate the relative importance of each category, please distribute 100 points across the four categories to reflect the importance each has in your life. Be sure that the numbers you have placed in each category total 100 points when you have finished.

_____ Physical (1)
_____ Psychological (2)
_____ Spiritual (3)
_____ Support (4)
APPENDIX E: INFORMED CONSENT AND DEMOGRAPHIC ITEMS

PROJECT TITLE: The Role of Self-Care and Hardiness in Moderating Burnout in Mental Health Counselors.

INTRODUCTION
The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. The research involves the completion of a survey that should take approximately 10 minutes. This survey will ask you to self-assess your burnout risk, your perception of your psychological hardiness, and the frequency and importance of your self-care habits, along with your demographic information.

RESEARCHERS
Primary Researcher:
Traci Richards, LPC
Old Dominion University, College of Education, Department of Counseling & Human Services

Responsible Project Investigator: Jeffry Moe, PhD, Old Dominion University, College of Education, Department of Counseling & Human Services

DESCRIPTION OF RESEARCH STUDY
It is known that the psychological construct of hardiness and self-care components play a role in buffering stress, though it is unknown which plays a larger role in moderating the effects of burnout. This study aims to explore the relationship between helper burnout, the construct of hardiness, and the frequency and importance of self-care habits.

RISKS AND BENEFITS
RISKS: With participation in any research there are risks of discomfort in reporting beliefs. Data will remain confidential and anonymous. The researchers will reduce risks by removing any linking identifying information when reporting on results. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: There are no benefits for your participation in this study.

COSTS AND PAYMENTS
None.

NEW INFORMATION
If the researchers find new information during this study that would reasonably change your decision about participating, then they will inform you.

CONFIDENTIALITY
All information obtained about you in this study is strictly confidential unless disclosure is required by law. The results of this study may be used in reports, presentations and publications,
but the researcher will not identify you personally.

**VOLUNTARY CONSENT AND WITHDRAWAL PRIVILEGE**
It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

**QUESTIONS**
In the event that you have questions or concerns as a result of participation in any research project, you may contact Dr. Jeffry Moe at jmoe@odu.edu or Dr. Ed Gomez, Chair of the Darden College of Education Human Subjects Review Committee, Old Dominion University, at egomez@odu.edu, who will be glad to review the matter with you.

By clicking the "YES" button below, you are telling the researcher that you consent to participate in this study.

☐ Yes, I consent to participate (1)
☐ No, I do not consent to participate (2)

If No, I do not consent to par... Is Selected, Then Skip To End of Survey

Please respond to the following demographic questions about yourself.

D1 Are you a mental health counselor who engages in direct client care as your primary professional role, and are either in residency or already licensed?
☐ Yes (1)
☐ No (2)

If No Is Selected, Then Skip To End of Survey

D2 Highest level of education completed:
☐ Master’s (1)
☐ Doctorate (2)

D3 Please indicate licensure status:
☐ Residency (1)
☐ Licensed (2)

D4 Gender (check all that apply):
☐ Female/Female-identified (1)
☐ Male/Male-identified (2)
☐ Transgender (3)
☐ Other (please specify): (4) ________________
D5 Please indicate your exact age (in years):

D6 Please indicate your ethnicity or racial identity (check all that apply):
- Black or African American (1)
- White or European American (2)
- Hispanic or Latino/Latina (3)
- Asian or Asian American (4)
- Native American/Alaska Native (5)
- Native Hawaiian/Pacific Islander (6)
- Multiple Heritage (7)
- Other (please specify): (8) ____________________

D7 Indicate your time, in years, of experience within the mental health field (including pre-Master’s work):

D8 Indicate your time, in years, of experience specifically as a professional mental health counselor:

D9 Please tell us your primary setting:
- Outpatient (1)
- Acute care/Crisis Stabilization (2)
- Inpatient/Residential (3)
- In-home (4)
- Community Agency (5)
- Prison/jail (6)
- Other (please specify): (7) ______________

D10 Please indicate your primary specialty area (s). Check all that apply.
- Adult mental health (1)
- Child and adolescent mental health (2)
- Marriage and family (3)
- Court ordered clients (4)
- Severe, persistent mentally Ill (5)
- Phase of life issues (6)
- Trauma issues (7)
- Crisis intervention (8)
- Substance-use and addictive disorders (9)
- Other (please specify): (10) ______________
D11 Are you satisfied (contented, pleased) with where you work?
- Yes (1)
- No (2)
APPENDIX F: LETTER OF DETERMINATION FOR EXEMPT STATUS

OFFICE OF THE VICE PRESIDENT FOR RESEARCH

Physical Address
4111 Monarch Way, Suite 203
Norfolk, Virginia 23508

Mailing Address
Office of Research
1 Old Dominion University
Norfolk, Virginia 23529
Phone (757) 683-3460
Fax (757) 683-5902

DATE: December 15, 2016
TO: Jeff Moe, PhD
FROM: Old Dominion University Education Human Subjects Review Committee
PROJECT TITLE: [995522-1] The Role of Self-Care and Hardiness in Moderating Burnout in Mental Health Counselors.
REFERENCE #: 
SUBMISSION TYPE: New Project
ACTION: DETERMINATION OF EXEMPT STATUS
DECISION DATE: December 15, 2016
REVIEW CATEGORY: Exemption category # [6.2]

Thank you for your submission of New Project materials for this project. The Old Dominion University Education Human Subjects Review Committee has determined this project is EXEMPT FROM IRB REVIEW according to federal regulations.

We will retain a copy of this correspondence within our records.

If you have any questions, please contact Petros Katsioloudis at (757) 683-5323 or pkatsiol@odu.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Old Dominion University Education Human Subjects Review Committee's records.
APPENDIX G: LICENSE AGREEMENT FOR MASLACH BURNOUT INVENTORY

For use by Traci Richards only. Received from Mind Garden, Inc. on November 27, 2016

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her thesis or dissertation research:

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

Copyrights:

MBI-General Survey (MBI-GS): Copyright ©1996 Wilm B. Schaufeli, Michael P. Leiter, Christina Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

MBI-General Survey - Students (MBI-GS (S)): Copyright ©1996, 2016 Wilm B. Schaufeli, Michael P. Leiter, Christiana Maslach & Susan E. Jackson. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

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MBI-Educators Survey (MBI-ES): Copyright ©1986 Christina Maslach, Susan E. Jackson & Richard L. Schwab. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

Three sample items from a single form of this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published material.

Sincerely,

[Signature]

Robert Most
Mind Garden, Inc.,
www.mindgarden.com
APPENDIX H: ALTERATION AGREEMENT FOR MBI

Traci Richards

Conditions of Use for Altering a Mind Garden Instrument

Before conducting your research:

1) You will register your intent to make an alteration of a Mind Garden instrument by describing the type of alteration(s), the details of the alteration(s), and the rationale behind the alteration(s). (You have fulfilled this condition. The information you provided is included below).

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instrument Name:</td>
<td>Maslach Burnout Inventory - Human Services Survey</td>
</tr>
<tr>
<td>Specific Alterations:</td>
<td>Change terms (e.g., &quot;leader&quot; to &quot;orchestra leader&quot;)</td>
</tr>
<tr>
<td>Alteration Details:</td>
<td>The term &quot;recipients&quot; would be changed to &quot;clients&quot;</td>
</tr>
<tr>
<td>Reason for Alterations:</td>
<td>My population of study are Mental Health Counselors who use the specific term &quot;clients&quot; as opposed to &quot;recipients&quot; or &quot;patients.&quot; Using the term &quot;clients&quot; would be for ease of reading and a match to the specific term used within the profession.</td>
</tr>
</tbody>
</table>

2) You will assign all rights to the altered instrument to the copyright holder. (You agreed to this condition by electronically signing and submitting the form).

3) You will put the instrument copyright, including the notification that the instrument was modified, on every page containing question items from this instrument. Add the following text to the end of the copyright:

"This instrument was modified -- by: [insert your name] -- from the original."
APPENDIX I: APPROVAL FOR REMOTE ONLINE USE OF MBI

Guidelines

You have agreed to the following guidelines:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have paid for my reproductions licenses and I will compensate Mind Garden, Inc. for every time the form is accessed or the participant logs in to access the survey. I understand that an administration or license is considered “used” when a respondent views one or more items/questions.</td>
<td>I agree to this condition.</td>
</tr>
<tr>
<td>I will put the instrument copyright statement (copyright date and copyright holder, including “Published by Mind Garden, Inc. <a href="http://www.mindgarden.com%E2%80%9D">www.mindgarden.com”</a>) on every page containing questions/items from this instrument and I will allow Mind Garden to verify the appearance in one of two ways: I will include <a href="mailto:info@mindgarden.com">info@mindgarden.com</a> on my list of survey respondents or I will send screenshots of the survey so that Mind Garden can verify that the copyright statement appears.</td>
<td>I agree to this condition.</td>
</tr>
<tr>
<td>I will remove this online survey at the conclusion of my data collection and I will personally confirm that it cannot be accessed.</td>
<td>I agree to this condition.</td>
</tr>
<tr>
<td>Once the number of administrations reaches the number purchased, I will purchase additional licenses or the survey will be closed to use.</td>
<td>I agree to this condition.</td>
</tr>
<tr>
<td>I will not send Mind Garden instruments in the text of an email or as a PDF file to survey participants.</td>
<td>I agree to this condition.</td>
</tr>
</tbody>
</table>
APPENDIX J: LICENSE AGREEMENT FOR USE OF DRS

DRS END USER LICENSE AGREEMENT - ACADEMIC
The DRS instrument(s) may be used by academic students and faculty for research projects and activities related to their academic programs, subject to the following terms.
This is an Agreement between you and the author (Paul T. Bartone, Ph.D.) which governs your access to and non-commercial use of the Dispositional Resilience Scale (DRS) and supporting copyrighted materials.

Definitions
The Materials means all documents provided to you as part of the DRS Tools package, including the DRS15 (all versions), the DRS15 scoring key (all versions), all norms documents, and any other versions of the DRS including translated versions as well as any new translations.

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Obligation to provide results
At the conclusion of the one-year license agreement, you agree to provide the author with summary data including number of cases surveyed, sample means, standard deviations, age and gender, and copies of any reports generated using DRS data.
Translations
You may translate the DRS instrument into a new target language for use with specific populations or
groups, providing that (1) the translation is as true and close as possible to the original source DRS
instrument, including item wording, instructions, response format and response option wording; (2)
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prior to use.

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WARRANTIES. ACCORDINGLY, SOME OF THE ABOVE LIMITATIONS MAY NOT APPLY TO
YOU.

Choice of Law and Forum You and the Author each agree that this Agreement and the relationship
between the parties shall be governed by the laws of the State of Maryland without regard to its conflict
of law provisions and that any and all claims, causes of action or disputes (regardless of theory) arising
out of or relating to this Agreement, or the relationship between you and the Author, shall be brought
exclusively in the courts located in the county of Anne Arundel, Maryland or the U.S. District Court for
the District of Maryland. You and the Author agree to submit to the personal jurisdiction of the courts
located within the county of Anne Arundel, Maryland or the District of Maryland, and agree to waive any
and all objections to the exercise of jurisdiction over the parties by such courts and to venue in such
courts.

Waiver and Severability of Terms The failure of the Author to exercise or enforce any right or
provision of this Agreement shall not constitute a waiver of such right or provision. If any provision of
this Agreement is found by a court of competent jurisdiction to be invalid, the parties nevertheless agree
that the court should endeavor to give effect to the parties’ intentions as reflected in the provision, and the
other provisions of this Agreement remain in full force and effect.
Traci Richards, LPC  
(757) 589-2973 | tperr021@odu.edu  
4000 Edinburgh Ct | Suffolk, VA 23434

EDUCATION

Doctorate in Counseling  
Old Dominion University (CACREP)  
May 2017

M.S. Ed, Clinical Mental Health Counseling  
Old Dominion University (CACREP)  
GPA 3.9; Committee Membership Chair Chi Sigma Iota  
Dec 2011

B.A., Psychology  
Indiana University  
GPA: 3.9, Psi Chi National Honor Society Member  
Dec 2008

LICENCES/CERTIFICATIONS

Licensed Professional Counselor  
Virginia  
License # 0701005703  
Jan 2014 - Current

SOCIETIES/MEMBERSHIPS

American Counseling Association  
2014

PROFESSIONAL EXPERIENCE

ODU Research Foundation- PACER and TEACH Grants  
Integrated Behavioral Health Specialist  
Provides integrated mental health services in a medical outpatient setting.  
11-15 to current

Old Dominion University  
Graduate Teaching and Research Assistant  
Norfolk, VA  
Responsible for teaching undergraduate and graduate courses and assisting with research.  
09-14 to 11-15

Genesis Counseling Center  
Outpatient Clinician  
Chesapeake, VA  
Provides outpatient therapeutic interventions for families, couples, and individuals.  
03-15 to current
PROFESSIONAL EXPERIENCE (CON’T)

Magellan Behavioral Health 01-14 to current
Military Family Life Counselor
Southeastern VA
Provides on-demand non-medical counseling to United States military troops and veterans.

Harbor Point Behavioral Health Center 09-14 to 07-15
Adolescent Inpatient Therapist- PRN
Portsmouth, VA
Provided inpatient therapeutic services on an as-needed basis.

Harbor Point Behavioral Health Center 06-12 to 09-14
Adolescent Inpatient Therapist
Portsmouth, VA
Provided inpatient assessment and therapeutic interventions for family, group, and individual therapies.

Institute for Family Centered Services 12-11 to 06-12
In-Home Counselor
Suffolk, VA
Conducted assessments and provided in-home clinical services to families and youth.

Western Tidewater Community Services Board 05-11 to 12-11
Outpatient Clinician - Internship
Suffolk, VA
Responsible for providing assessment and therapeutic interventions to over 35 clients with a diverse range of diagnoses including substance abuse in individual and group settings.

Norfolk Community Services Board 01-11 to 05-11
Outpatient Clinician – Practicum/Internship
Norfolk, VA
Provided assessment and therapeutic interventions to clients in both an individual and group setting. Coordinated with private and community resources.

Southern Hills Counseling Center, Inc. 03-09 to 05-09
Children’s Case Manager
Tell City, IN
Responsible for assessing needs, providing outreach, supportive services and linkages for children with serious mental illnesses.

Just Solutions 01-08 to 01-09
Mediator and Case Manager
Louisville, KY
Facilitated as neutral third party to assist in resolving interpersonal conflict.

United States Navy 06-00 to 09-06
Information System Technician
Maintained and managed the equipment and operators of government servers.

OTHER PROFESSIONAL EXPERIENCE

Supervision of Masters Students Fall 2015 – Present
Supervise Masters students in practicum in Mental Health Counseling
Provide Psycho-educational training for Masters students

Advanced Group Therapy Practicum (Old Dominion University) Fall 2015 – Spring 2016
Led process groups with undergraduate students

TEACHING EXPERIENCE

Old Dominion University:
Introduction to Human Services (HMSV 341) Fall 2014
Human Service Methods (HMSV 343 Writing Intensive) Spring 2015
Internship in Human Services (HMSV 468) Summer 2015
Career Development and Appraisal (Online) (HMSV 344)—co-taught Summer 2015
Non-Profit Fund Raising in Human Services (Online) (HMSV 441) – co-taught Summer 2015
Family Guidance (HMSV 491) Fall 2015
Advanced skills (COUN 634)—co-taught Fall 2016

PROFESSIONAL SERVICE

Guest Editorial Board Member. Journal of Human Services, Current Issues Winter Monograph. January 2015

PROFESSIONAL PRESENTATIONS

Military Family Life Presentations:
Strong Bonds Retreat 08 Mar 14
Fort Pickett Armory 06 Jun 14

ACES Conference: 8 – 11 Oct 2015
Using Fink’s Taxonomy of Significant Learning in Counseling Education – 1st Presenter
Using Dewey’s Theory of Education to Incorporate Experiential Learning Activities in the Social and Cultural Issues Course – co-presenter
Rubric Development for the Master’s Level Counseling Skills Course--- co-presenter