

1-8-2026

A Comparative Analysis of Rural and Urban Mental Health Counselors' Burnout Levels During the COVID-19 Pandemic

Pietro Martucci
Walden University

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Walden University

College of Social and Behavioral Health

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Pietro Martucci

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
2025

Abstract

A Comparative Analysis of Rural and Urban Mental Health Counselors' Burnout Levels

During the COVID-19 Pandemic

by

Pietro Martucci

MS, Walden University, 2017

BS, Bemidji State University, 2014

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

February 2026

Abstract

The COVID-19 pandemic substantially increased occupational demands on mental health counselors, intensifying burnout and threatening clinician well-being, workforce sustainability, and quality of care. Guided by Resiliency Theory, this quantitative cross-sectional study examined burnout among rural and urban mental health counselors during the COVID-19 pandemic, with geographic location serving as the independent variable. Participants included 108 licensed master's- and doctoral-level counselors in the United States who provided direct clinical services in rural or urban settings between March 1, 2020, and March 1, 2021. Data were collected using an online survey that included a demographic questionnaire and the Maslach Burnout Inventory–Human Services Survey (MBI-HSS), which measures Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). Descriptive statistics and multiple linear regression analyses were conducted. Results indicated that geographic location significantly predicted PA, $F(1, 106) = 4.741, p = .032, R^2 = .007$; however, geographic location did not significantly predict EE ($p = .085$) or DP ($p = .937$). These findings suggest that while emotional exhaustion and depersonalization may be experienced similarly across practice settings, professional fulfillment is more context-dependent and influenced by structural supports and professional opportunities. From a social change perspective, addressing contextual disparities in counselor support systems may reduce burnout, strengthen resilience, and promote equitable access to quality mental health care during and following a global pandemic.

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Dedication

This dissertation is dedicated to my parents. To my mother, I am eternally grateful for the perseverance, strength and love you have given me. I am thankful for your prayers and knowledge that you have used to gently guide me through this challenging time. Thank you for being my mother and my friend. Thank you to my father for teaching me the importance of hard work. Thank you for being my example of what a man can be and what a father should be.

To my brother Jason, thank you so much for being my friend and always knowing when I need a good laugh. My brother Vince, thank you for words of encouragement and enthusiasm. My sister Terysa, thank you for being the sister I need.

To my partner Dominic, thank you so much for allowing me the space to complete this. Thank you for being my support when I struggled and doubted this decision. Thank you for your unconditional love and making me smile again.

Lastly, I would like to thank my heavenly father. I have felt your guidance throughout this journey and understand the importance of you in my life. Thank you for your protection and guidance.

Acknowledgments

I would like to thank the members of my committee. Thank you to my chair, Dr. Suzie Dukic, for her guidance, support, honesty, enthusiasm and patience. I am truly honored that you chose to guide me through this process and help me see past the “fluff”. My second committee member, Dr. James Smith, for his guidance, encouragement and kind words that made his quick reviews easy to resolve. Thank you both for your professionalism and knowledge. I am extremely grateful. I would also like to acknowledge and thank Dr. Elizabeth Suarez for her insights and guidance.

I could not have made it to this point in my doctoral journey without the support from my classmates, Dr. Danielle Lee, Dr. Kimberly Davis and soon to be doctor Sitonja Valenzuela. I cannot express how grateful I am for meeting you and having the honor to call you, my friends.

Lastly, I would like to acknowledge all of the mental health counselors and professionals that worked so diligently during the pandemic. Thank you for the work that you did then and continue to do.

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Chapter 1: Introduction to the Study

The work of a mental health counselor can be both rewarding and challenging. It may pose particular difficulties in managing the stress of clients as well as the counselors. According to Young and Cashwell (2016), mental health counselors are prone to experiencing stress-related disorders, including burnout and compassion fatigue, owing to the emotional demands of their work. Cieslak (2016) stated burnout can impede a counselor's professional development and negatively affect their ability to serve their clients. Furthermore, counselors who exhibit symptoms of burnout, such as internal strains, tend to have higher rates of absenteeism and turnover (Young & Cashwell, 2016). An example of the emotional challenges counseling may have on a counselor may be with the experience of providing counseling during a global pandemic.

The COVID-19 pandemic was a global experience for many professionals that challenged their emotional and physical well-being (Aráñez-Litam et al., 2021). Mental health counselors were not immune to these challenges and experienced higher rates of stress, secondary traumatic stress, and compassion fatigue than prior to the pandemic (Aráñez-Litam et al., 2021). Additionally, as stated by Aráñez-Litam et al. (2021), counseling can be a more individualized profession, which may have amplified the feelings of isolation during the pandemic. Geographically, some counselors practicing in different regions may have been able to navigate the challenges of the pandemic differently.

Due to the recency of the COVID-19 pandemic, there are limited studies (Aráñez-Litam et al., 2021; Denning et al., 2021; Gleeson 2020) that explore the effects the

pandemic had on counselors, more specifically, the differences, if any, geographical location may have had on counselor burnout. Therefore, I conducted an analysis to determine if there is a relationship between geographical location (rural/urban) of practice and burnout levels of mental health counselors during the COVID-19 pandemic.

Chapter 1 offers a comprehensive overview of various aspects of the proposed study. Firstly, I provide an overview of the background for this study, identify the problem statement, describe the purpose of the study, outline the research question, and present the hypotheses. Next, I examine the conceptual framework and the nature of the study and provide operational definitions. The final section of this chapter covers the assumptions, limitations, scope, delimitations, and significance of the study.

Background

Abbas et al. (2021) conducted a study to examine the impact of the COVID-19 pandemic, specifically during the lockdown period in England, on mental health services. The study found that the pandemic not only directly affected the acute mental health services provided by mental health professionals, but it also affected how patients and clients experienced their symptoms. The study revealed a significant increase in severe depression, psychotic symptoms, and suicidal tendencies. These findings have important implications for mental health professionals and policymakers, as they highlight the urgent need for additional resources and support to address the mental health challenges resulting from the pandemic.

Aráñez-Litam et al. (2021) conducted a nationwide study with a sample of professional counselors who provided services during the COVID-19 pandemic. The aim

of the study was to investigate the relationship between perceived stress, coping response, resilience, posttraumatic stress, and burnout, secondary traumatic stress, and compassion satisfaction. The findings of the study contribute to the research on the effects of resilience and coping among mental health and crisis counselors. The study's results provide valuable insights for professionals working in the field of mental health and crisis counseling and could inform future interventions and support programs aimed at reducing burnout and secondary traumatic stress among counselors.

Beaumont et al. (2016) conducted a study to investigate the relationship between self-compassion, compassion fatigue, well-being, and burnout among final-year student cognitive behavioral psychotherapists (CBPs) and person-centered counselors. The authors utilized three tools to collect data - The Professional Quality of Life Scale (ProQOL), The Self-Compassion Scale, and the Maslach Burnout Inventory (MBI). The study revealed a negative correlation between self-compassion and burnout. Those who demonstrated a higher level of compassion for others reported experiencing less burnout and greater well-being. Despite their genuine desire to help others, counselors often experience significant stress and trauma due to their professional responsibilities, which can lead to burnout. As a result, the research team recommended that further studies should be conducted to explore this phenomenon among both students and professionals.

Bolton et al. (2017) delved into the concept of *resilience* and provided a solution-focused perspective to define it. The authors offered valuable insights into how professionals can navigate adverse environments and adapt to potential disadvantages by practicing through a solution-focused lens. This article presented a theoretical framework

of resilience theory and its impact on mental health professionals who work with limited resources. Complementing this theoretical perspective, Britt et al. (2021) provided early empirical evidence that perceived resilience can predict adaptive outcomes even before traumatic exposure, with social connection emerging as a critical mechanism linking resilience to positive post-adversity adjustment.

Denning et al. (2021) aimed to investigate the impact of the COVID-19 pandemic on the overall well-being of healthcare workers. The authors used a quantitative survey to screen burnout levels among professionals working on the front lines of the pandemic. The authors were able to identify significant factors and predictors of burnout among healthcare workers, including job roles, personal safety, gender, COVID-19 testing, and psychological states, such as anxiety and depression. Although the study primarily focused on healthcare workers in a hospital setting, such as doctors and nurses, the data gathered can provide valuable insights into the mental health challenges that professionals faced during the COVID-19 pandemic. The study's findings may be useful for a better understanding of the impact of the pandemic on healthcare workers and design interventions to mitigate burnout.

Dev et al. (2018) presented valuable insights on the impact of burnout symptoms on helping professionals and their ability to provide quality care and compassion for their clients. The authors emphasized that helping professionals with higher levels of self-compassion encountered fewer obstacles in the provision of care to their clients or patients. These findings underscore the importance of self-compassion in the caregiving

profession and suggest that measures to enhance self-compassion among professionals may help to improve the quality of care provided to clients.

Goodwin et al. (2023) conducted a study on the experiences of psychologists who practiced in rural areas of Canada during the COVID-19 pandemic. According to the study, psychologists practicing in rural locations have long encountered unique challenges such as limited accessibility to care and support for both clients and professionals, professional isolation, and technology concerns. The authors of the study suggested that these challenges may have been further compounded by the pandemic, leading to both new and existing challenges being exacerbated for rural psychologists.

Lasalvia et al. (2021) conducted a study in which they analyzed the levels of burnout among healthcare workers in a location significantly impacted by the COVID-19 pandemic. The study used the Maslach Burnout Inventory-General Survey (MBI-GS) to assess the levels of burnout among professionals working in intensive care units. The study findings indicated a higher risk of burnout and highlighted the need for greater attention to the psychological well-being of healthcare providers during the pandemic.

Søvold et al. (2021) provided critical insights into the experiences of public health professionals during the COVID-19 pandemic. The research shed light on the challenges encountered by healthcare providers while navigating care for their patients as well as their own well-being. The study highlighted the importance of mental health and well-being of healthcare providers during a global pandemic. It emphasized that the demand for care during such times is increasingly high and could have a negative impact on the care provided to patients and the overall health and well-being of the healthcare

providers. These findings are important for healthcare organizations to consider in order to ensure the well-being of their healthcare providers and the quality of care provided to patients, especially during pandemics and other high-stress situations.

Numerous studies have examined the phenomenon of burnout among mental health counselors, yet minimal research has explored the impact of COVID-19 on this matter. Additionally, while some studies have explored the experience of burnout among rural counselors, or among urban counselors specifically, there is a lack of research that compares the experience of burnout between rural and urban mental health counselors during the pandemic.

Problem Statement

Many mental health counselors may find difficulties in managing the stress of their clients as well as the stress they may feel in their personal world (Young & Cashwell, 2016). According to Cieslak (2016), mental health counselors may be more vulnerable to experiencing stress-related disorders, such as compassion fatigue and burnout, due to the emotional demands of their work with their clients. Furthermore, burnout can impede a counselor's professional development or even impede the work with their clientele (Cieslak, 2016). Moreover, mental health counselors who have experienced symptoms of burnout, such as internal strains, reported higher instances of absences and turnover (Young & Cashwell, 2016).

The COVID-19 pandemic has caused mental and physical stress for people all around the world, leading to an increase in demand for mental health services (Denning et al., 2021). This has put additional pressure on counselors, who must support their

clients while taking care of their own emotional well-being (Aráñez-Litam et al., 2021). The pandemic has also introduced challenges for counselors to provide services within strict guidelines, especially when in-person counseling is restricted or prohibited. To address this, many counselors have turned to telehealth services such as Zoom or videoconferencing. Nonetheless, not all clients have access to these services, particularly those living in rural areas. Some rural counselors may face unique challenges that their urban counterparts do not, such as limited resources and accessibility issues (Pullen & Oser, 2014).

Mental health counselors who practice in rural areas may face unique challenges that their counterparts in urban or densely populated regions may not encounter. As noted by Hastings and Cohn (2013), these challenges primarily center around inadequate resources and limited professional support. The COVID-19 pandemic has only exacerbated the difficulties faced by these counselors by stretching their already limited resources and support even further. Therefore, it is imperative to investigate the differences that rural and urban counselors may have experienced during the pandemic's peak (Aráñez-Litam et al., 2021). The aim of this research study was to provide a comprehensive understanding of these differences and offer support to all mental health counselors, both during times of global crisis and in their everyday practice.

Purpose of the Study

The study aimed to identify the extent of burnout experienced by counselors, with geographical location (e.g., rural or urban location) serving as the independent variables. The results of this study are expected to provide valuable insights into the impact of

location on counselor burnout levels, which can be useful in developing targeted interventions and support mechanisms to alleviate burnout among mental health professionals.

Research Questions and Hypotheses

Research question (RQ)1: Does geographical location of mental health practice, that is, urban or rural, predict burnout levels of mental health counselors, during the COVID-19 pandemic?

H_0 1: Geographical location of mental health practice does not predict burnout levels of mental health counselors during the COVID-19 pandemic.

H_a 1: Geographical location of mental health practice does predict burnout levels of mental health counselors during the COVID-19 pandemic.

Conceptual Framework for the Study

The theoretical framework was based on resiliency theory. Prior research on burnout, such as Grant and Kinman (2012) and Silveira and Boyer (2015), has employed this theory to explore the factors that enable individuals to overcome adversity. According to Bolton et al. (2017), resiliency theory comprises three constructs that define how individuals navigate challenging situations: risk factors, protective factors, and vulnerability factors.

Utilizing resiliency theory, this study aimed to understand how mental health counselors, practicing in rural and urban locations, experienced burnout during the COVID-19 pandemic. Bolton et al. (2017) previously utilized resiliency theory to understand the role of risk, environmental, and vulnerability factors in an individual's

experience of stressors and overcoming them. This framework was applied to explore burnout among rural and urban mental health professionals during the COVID-19 pandemic. The findings of this study could have significant implications for mental health professionals and their resilience during future crises.

Nature of the Study

This study utilized a nonexperimental survey design to explore the relationship between rural and urban geographical locations (independent variable) and the level of burnout (dependent variable). The research methodology that was employed was quantitative, utilizing statistical analysis to examine the potential relationship among variables. A linear regression analysis was used to assess the potential effect of the independent variable on the dependent variable. This approach aimed to provide a better understanding of whether geographical location during the COVID-19 pandemic predicts burnout. The validated instruments, MBI and BRS, were used to assess burnout levels during the pandemic, alongside a demographic questionnaire that collected specific information such as age, gender, race, years of experience, years of licensure, and type of practice.

The survey was administered online via Survey Monkey, an online HIPAA-compliant platform. I used a nonprobability convenience sampling method to recruit participants, leveraging various counseling organizations such as the American Mental Health Counselors Association (AMHCA), American Counseling Association (ACA), Minnesota Counseling Association (MCA), and counseling discussion boards and groups

on social media platforms. Finally, all data collected was analyzed using IBM Statistical Package for Social Sciences (SPSS) version 30.

Definitions

Burnout: Burnout is described as a psychological syndrome that may result from exposure to chronic and emotional stressors (Dev et al., 2018). To further explain, burnout is feeling emotionally exhausted and experiencing decreased accomplishment within a professional setting (Maslach et al., 1981). While burnout can be identified in various professions, the focus of this study was to look at burnout as it pertains to mental health counselors

COVID-19 pandemic: The COVID-19 pandemic was a global outbreak of coronavirus, caused by the severe acute respiratory syndrome coronavirus 2. On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a global pandemic. As a result, measures were taken in many regions around the world to contain the outbreak, including government-mandated lockdowns. These lockdowns required individuals to stay at home and practice social distancing, in order to curb the spread of the virus (Hechler et al., 2023; Saglietto et al., 2020).

Resilience: While originally defined as the ability to recover from physical illness, resilience has evolved to encompass the capacity to rebound from stressors and persevere despite ongoing challenges (Grant & Kinman, 2012). While bouncing back implies a return to an original state, resilience can also be defined as the ability to survive despite stress (Smith et al., 2008).

Rural location: A rural location is generally defined as an area outside of an urban environment. However, similar to urban areas, rural settings offer unique elements such as diverse economic, social, and emotional experiences, as noted by Goodwin et al. (2023). For the purpose of this research study, I referred to prior studies that have examined the differences between urban and rural areas and define a rural location as towns, villages, and municipalities that are located at least 60 miles away from urban areas and have a population of 10,000 or less (Church et al., 2010; Dyck & Hardy, 2013; Goodwin et al., 2023).

Urban location: While many studies have explored urban locations (Adhikari et al., 2020; Boardman et al., 2001; Rudenstine et al., 2023a) authors may have differing opinions as to what or how to exactly define an urban location. For the purpose of this study, using prior research as a template, an urban location was defined as a geographical area that consists of a central city or two with a population of at least 50,000 residents (Rudenstine et al., 2021, 2023a, 2023b).

Assumptions

The following are the assumptions that were made by the author of this research study. Firstly, based on a study conducted by Yin et al. (2023), it was assumed that professionals who practice in urban environments face significant challenges in their practice, similar to or exceeding the challenges experienced by professionals in rural environments. Secondly, it was assumed that not all professionals who were actively working during the COVID-19 pandemic experienced burnout symptoms, as stated by another study conducted by Denning et al. (2021). Additionally, it was assumed that the

participants who completed the survey met the eligibility criteria and did not participate if they did not meet the criteria. Lastly, it was assumed that the participants who completed the study understood the survey questions, answered truthfully, and did not intentionally provide socially desirable responses.

Scope and Delimitations

The purpose of this study was to examine the experiences of licensed counselors who were practicing during the COVID-19 pandemic in the United States. The study focused on licensed counselors at the master's or doctoral level, who were independently practicing within the country during the time period of May 1, 2020 through April 1, 2021 (see Minihan et al., 2024). Participants provided information regarding their geographical location, specifically whether they are practicing in an urban or rural area. This study provided valuable insights into how licensed counselors managed their practices during a public health crisis.

The research study was intended to include participants who have been recruited through the listservs and websites of national, regional, and state counseling associations. The focus of this study was to examine the impact of global crises on the resilience, stress, and burnout levels of professional counselors during the COVID-19 pandemic. It is important to note that the study sample did not include school counselors, licensed alcohol and drug counselors, or counselors who are not independently licensed; therefore, the results may not be generalizable to these groups. The findings of this study may contribute to the broader understanding of the aforementioned factors among professional counselors during periods of global crises.

Limitations

It is important to acknowledge some limitations of this study. Firstly, I designated a specific time frame, (May 2020-April 2021,) based on prior research studies of the COVID-19 pandemic. Since this experience occurred a few years ago, it was anticipated that this time lapse could have created a challenge for some participants to provide accurate information on their emotional experiences during that period. Consequently, there was a possibility of respondents not being able to answer definitively about their experience. Secondly, the surveys were self-administered and self-reported, which could have raised concerns about the accuracy of the responses. For example, respondents to surveys sometimes present socially desirable responses, which can impact the validity of the results. Lastly, there was a possibility of unequal representation of respondents within the sample size, since the study inquired about the experience of both rural and urban practicing counselors during the pandemic.

Significance

The study aimed to provide valuable insights into burnout among licensed mental health counselors practicing in rural areas. The objective was to determine if this study's findings could aid mental health counselors in addressing disparities between rural and urban counseling services, resources, and supports that may exacerbate burnout symptoms, especially during global crises. It was also anticipated that this study could provide foundational elements to new counselors regarding the importance of addressing burnout and identifying coping strategies.

As societal and personal demands continue to become increasingly complex, the demand for mental health services is high (Beaumont et al., 2016). However, counselors experiencing burnout may struggle to establish and maintain a strong therapeutic alliance; research shows that lower quality in the therapeutic relationship and reduced relational depth among psychotherapists are linked with higher burnout levels (Zarzycka & Jankowski, 2022). Thus, this study was designed to potentially help identify coping strategies for counselor burnout and present an opportunity to support mental health professionals. Providing competent and non-impaired mental health services can benefit individuals and the community, ultimately promoting overall mental health wellness.

Summary

Chapter 1 presented the foundational elements of the research. It provided a purposeful context and background literature that constituted a blueprint for the research problem. The chapter also highlighted a gap in the literature regarding burnout among various mental health professionals and their geographical location of practice during the COVID-19 pandemic. Additionally, the chapter contained the problem statement, purpose, RQ, and hypotheses. Moreover, it detailed the conceptual framework, operational definitions, assumptions, and scope of the study. Finally, the chapter clarified the delimitations, limitations, and significance of this quantitative study. Chapter 2 of this study offers a comprehensive analysis of the theoretical framework and presented a detailed review of the current literature that is relevant to the research problem. This chapter is intended to provide an in-depth understanding of the subject matter and contribute significantly to the research study.

Chapter 2: Literature Review

Introduction

In this study, I focused on burnout as it pertains to mental health counselors in both rural and urban locations of their practice during the COVID-19 pandemic. A clear understanding of burnout is crucial for mental health counseling. Defining burnout and showcasing its impact on mental health counselors is imperative. Furthermore, it is important to acknowledge that rural and urban counselors could have encountered different challenges during the COVID-19 pandemic, which may have exacerbated their burnout experience.

The experience of providing mental health care to individuals during a global pandemic is not unique. The pandemic presented numerous obstacles that impeded counselors' capacity to administer sufficient care to their clients (Aráñez-Litam et al., 2021). Additionally, periods of isolation and “lockdown” brought challenges and innovations that expanded and reduced a client’s access to counseling. Because of the limitations of face-to-face interactions, counselors were challenged with finding alternative delivery methods to the counseling experience.

Literature Search Strategy

I conducted a literature search strategy that included an in-depth review of peer-reviewed journals, articles, and books on burnout, mental health counselors, and rural and urban mental health counselors. The keywords searched were *counselor*, *counselor burnout*, *burnout*, *rural mental health counselors*, *rural counselors*, *rural therapists*, *urban mental health counselors*, *urban counselors*, *urban therapists*, *COVID-19*,

COVID-19 pandemic, pandemic, Maslach's Burnout Inventory (MBI) and quality of life in the databases Psych INFO, SAGE Journals, SocINDEX with Full Text, Taylor and Francis Online and Health and Psychosocial Instruments (HaPI). Due to the recent experience of the COVID-19 pandemic, I focused my primary search to journal articles and articles within the last 5 years. For keywords and variables that had more substantiated history and foundational history, I searched for articles that included time frames of a more extended period, including 1980 to 2025.

Theoretical Framework

In examining the experience of burnout, it is important to examine an individual's coping strategies and resiliency when navigating high-intensity and emotionally exhaustive experiences. Maunder et al. (2023) conceptualize resilience as a dynamic process involving three interrelated components: the ability to withstand stress, respond effectively to disruption, and recover rapidly. This framing highlights resilience not as a fixed trait, but as an adaptable capacity that supports functioning in the face of adversity. Regarding mental health counselors, resiliency is essential in how counselors protect themselves from the emotional elements of their work. Some professionals can experience a highly intensive experience with little response. In contrast, others may have an internalized reaction and more difficulty pushing back from the emotional impact. This is best defined through resiliency theory.

According to Goldstein and Brooks (2012), resilience theory sheds light on why certain individuals are able to overcome difficult experiences while others cannot. It provides the framework for how a person combats and counteracts the adverse effects of

overwhelming situations. How a person experiences and responds to stress, utilizes support, and possesses their level of self-efficacy are all elements of their resilience (Bolton et al., 2017). Furthermore, within resiliency theory, three factors are examined when analyzing how a person protects themselves from complex situations and the consistency in recovering from them. These three factors are protective factors, risk factors, and vulnerability factors. Protective factors include the environment or characteristics of the experience; risk factors pertain to the events of the perceived danger, and vulnerability factors include the individual's negative personality traits (Bolton et al., 2017).

My research on mental health counselors' experiences during the global pandemic was based on resiliency theory. Perceived stress and stressors were explored through the use of resources and support, and the self-efficacy required to continue providing professional care to clients. Utilizing resiliency theory allowed for a deeper insight into these critical aspects of counseling.

Burnout

Although there are multiple lenses to view the phenomenon, burnout does not have a universal definition. For this study, burnout is described as a psychological syndrome that may result from exposure to chronic and emotional stressors (Dev et al., 2018). To further explain, burnout is the feeling of being emotionally exhausted and experiencing a decrease in accomplishment within a professional setting (Maslach et al., 1981). Conversely, the term burnout has been used broadly to describe any feeling of

being overwhelmed. However, this may reduce the validity of the term and the severity of the experience of the individuals that experience it.

Compared to other professions, those in helping professions or human services, there are higher reports of burnout (Sangganjanavanich & Balkin, 2013). This may result from the emotional demands that individuals in a helping profession experience. Additionally, a counselor who experiences burnout is responsible for responding to the emotional output of their clients and patients and navigating their emotional wellness. According to Cieslak (2016), mental health counselors may be more vulnerable to experiencing stress-related disorders, such as burnout, due to the emotional component of their work.

Burnout in Mental Health Counselors

According to Yang and Hayes (2020), mental health counselors face a unique challenge, as their primary focus is to assist their clients through emotional stressors while managing the toll of hearing complex and stressful scenarios. Moreover, Yang and Hayes identified stress and strain, emotional exhaustion (EE), and depersonalization (DP) as the most noted reasons for turnover in the counseling field. In addition, the incidence of counselor burnout has risen over time and is anticipated to become a significant issue in the field (Wardle & Mayorga, 2016).

Distinguishing between the individual and the professional can prove to be a challenging task. Wardle and Mayorga (2016) stated that many counselors do not immediately recognize their work's impact on them and will often excuse symptoms as part of being a counselor. Additionally, some counselors do not utilize self-care or coping

strategies as effectively as they may need to. In a study that examined counselor burnout, over 85% of the participants indicated symptoms of burnout, however, they were not paying attention to or managing their symptoms (Wardle & Mayorga, 2016). Because of the lack of focus on personal well-being, mental health counselors experiencing burnout can begin a decline in psychological, emotional, and physical health (Wardle & Mayorga, 2016).

Factors Contributing to Mental Health Counselor Burnout

Yang and Hayes (2020) asserted that counselor burnout directly results from neglecting the counselor's well-being and failing to utilize coping strategies and resources to meet professional responsibilities. Additional factors include EE, high caseloads, and an understanding of how much control within their job a counselor feels they have as influences to higher instances of burnout (Yang & Hayes, 2020). These stress factors can have a direct adverse effect on the quality of work a counselor provides.

When a counselor is experiencing burnout, it can be difficult to recognize symptoms before feeling emotionally exhausted, which magnifies the initial feelings and makes the counselor feel even more overwhelmed (Merriman, 2015). This could provide an unhealthy relationship between the counselor and the client. Counselors experiencing burnout may experience a loss of empathy with their clients, respect for themselves and their clients, and difficulties with maladaptive coping (Wallace et al., 2010). Moreover, if a counselor is experiencing burnout, it can be considered an act of impairment, which could lead to an opportunity for the counselor to harm their client and an ethical violation (ACA, 2014, A4a.). These factors could be indicators to a counselor that is experiencing

burnout. However, a counselor might not have a clear understanding of the severity of their symptoms until they have been assessed. The MBI is one measure that could provide a clearer understanding of counselor burnout.

Measuring Burnout Through Maslach's Burnout Inventory

The MBI has long been used to identify symptoms of burnout and determine varying levels (Maslach, 2003). While there are varying iterations of this survey, the symptoms of EE, DP, and reduced personal accomplishment (PA) are all themes of each survey (Maslach et al., 2010). The survey is self-administered and allows participants to best describe their experience with burnout, which may provide a better overall understanding of the phenomenon. Additionally, as the survey has grown to include differing professions and subcategories of those professions, researchers can identify additional elements of burnout, which include beneficial coping strategies, a participant's overall well-being, and even self-compassion (Beaumont et al., 2016).

The Role of Resilience

The concept of resilience is a crucial consideration when facing adversity or stress. Specifically, it can serve as a protective factor against burnout by enabling individuals to effectively manage their work responsibilities without succumbing to pressure (Smith et al., 2008). While originally defined as the ability to recover from physical illness, resilience has evolved to encompass the capacity to rebound from stressors and persevere despite ongoing challenges (Grant & Kinman, 2012). While bouncing back implies a return to an original state, resilience can also be defined as the ability to survive despite stress (Smith et al., 2008). It may be beneficial for professionals

in the counseling field to expand this definition to include emotional stress as well. Ultimately, prioritizing self-care and mental health could help foster resilience and mitigate the risk of burnout.

Resiliency and Job Satisfaction

Mental health counselors are a vital asset to the healthcare industry, but their profession comes with unique stressors that can make their work challenging. One of the most significant stressors, according to Wallace et al. (2010), is the emotional strain that counselors experience when dealing with complex emotional issues that their clients bring up during therapy sessions. This strain can be emotionally taxing, as counselors are tasked with helping clients manage their emotional stress. Counselors may also encounter unique challenges in their professional role, such as ethical dilemmas, negative counseling experiences, countertransference, and self-doubt (Litam et al., 2021). It is essential for counselors to acknowledge and manage these complex professional stressors effectively to avoid emotional stress responses that could harm their clients, lead to burnout, and reduce job satisfaction.

Litam et al. (2021) stated the cultivation of resilience is an essential aspect of professional counselors' abilities to manage stress effectively. Additionally, counselors often work with clients who face a diverse range of stressors, requiring them to be adaptable in their approach. This can pose a challenge, particularly for those who lack resilience. However, counselors who are able to proactively manage their stress levels, using appropriate resources and coping strategies, can derive greater satisfaction from their work. Lambert and Lawson (2013) suggested that counselors working in highly

stressful environments who prioritize self-care strategies have reported increased levels of posttraumatic growth and overall job satisfaction. Managing stress and emotional difficulties can vary greatly depending on the individual. It can be a complex task to accurately measure and quantify these experiences. As a result, it is imperative to establish a clear differentiation in assessing resilience in order to comprehend the diverse experiences one may encounter.

Measuring Resiliency

The evaluation of resilience is a multifaceted undertaking that encompasses the measurement of individual traits and coping mechanisms, in addition to other factors that promote resilience (Smith et al., 2008). The Brief Resilience Scale (BRS) is a useful tool that can aid in comprehending an individual's capacity to recuperate from stress and predict future health outcomes. The BRS is an instrument that measures 6 constructs included in the definition of resilience. The first of the constructs, resilience-related, provided data surrounding the “personal characteristics that embody resilience” (Smith et al., 2008). This construct allowed insight into how a person experiences a stressor and how they respond when that stressor is no longer present. The next construct focused on additional personal characteristics, which includes a person’s optimistic and pessimistic viewpoints; their purpose in life; their ability to be expressive with words and feelings and a person’s tendency to gravitate to a negative perspective. The third construct is the coping styles of the individual. This includes 14 different coping strategies. The fourth construct explores social relationships, which include interpersonal relationships, support systems, and negative social interactions. Lastly, the fifth construct, health-related

outcomes, provides data regarding the amount of physical exercise, experience with anxiety and depression, assessing anxiety and depression, physical symptoms, how a person perceives stress, and an assessment of positive and negative affect (Smith et al., 2008).

The BRS assessment is a tool for analyzing an individual's capacity to manage and cope with stress. According to Smith et al., (2008), it is particularly relevant for mental health counselors who seek to understand the contributing factors to resiliency and why some professionals are better equipped to manage extreme stress and emotional overwhelm than others. According to results from the BRS, optimism and social support are two resources that can prove helpful in dealing with such challenges (Smith et al., 2008). However, in some instances, those resources may be limited or inaccessible, such as during the COVID-19 pandemic.

COVID-19 Pandemic

The global COVID-19 pandemic brought unprecedented challenges to communities, families, and individuals worldwide (Katz & Jung, 2022). Additionally, these challenges have transformed daily routines and activities, making it challenging for individuals to navigate their lives safely (Katz & Jung, 2022). One field that has experienced increased difficulties is mental health care. Abbas et al. (2021) stated that despite the steady demand for mental health services in the years prior to the pandemic, the implementation of strict regulations for services, coupled with growing fears of possible infections, have resulted in a shortage of available resources. Furthermore, the

authors highlighted the crucial need to address this issue, as mental health care remains a fundamental aspect of overall health and well-being.

Global Lockdown

As a result of the COVID-19 pandemic, numerous countries worldwide implemented lockdown measures as a precautionary measure to hinder the spread of the virus. The United States was subject to lockdown measures from March to July of 2020, as reported by the National Institutes of Health in 2023. According to Maina et al. (2020), Italy, during their lockdown experienced a surge in depression, anxiety, and sleep disturbances. Additionally, the isolation and fear associated with the outbreak exacerbated psychiatric symptoms in some individuals.

Benatti et al., 2020 concluded that during the period of lockdown, the demand for mental health services did not significantly increase; however, this could have been due to a fear of infection that deterred individuals from seeking assistance. Furthermore, it is important to note that mental health services were still necessary, and many marginalized communities experienced an increase in demand for mental health services during the lockdown, which went unaddressed. As highlighted by Manning et al. (2023), people with disabilities (PWD) faced significant challenges in accessing mental health services, owing to both environmental and attitudinal barriers.

Additionally, Abbas et al. (2021) noted that individuals with existing severe and persistent mental illness diagnoses experienced increased levels of anxiety but were hesitant to seek help due to perceived biases by the medical system. Brausch et al. (2022) further noted that adolescents and teens in rural areas with limited resources had

increased levels of depression, anxiety, emotion dysregulation, and suicidal ideation during the pandemic. These requirements and challenges underscore the experiences of individuals striving to manage their mental health, however, mental health counselors also faced individual professional and personal perspectives when treating their clients during both the lockdown and throughout the pandemic.

Challenges to Mental Health Counselors During the COVID-19 Pandemic

In the midst of the ongoing COVID-19 pandemic, mental health counselors were faced with the formidable task of providing support to their clients as they navigated a mental health crisis and attempted to cope with the effects of lockdowns, quarantines, infections, and societal restrictions (Szlamka et al., 2021). Moreover, counselors needed to manage their own emotional distress and concerns, which were brought on by a decrease in clientele, unemployment, professional limitations on service delivery, and the taxing nature of listening to clients' experiences (Litam et al., 2021). Additionally, the pandemic presented a significant challenge to mental health counselors by restricting the ways in which they delivered their services to their clients.

Telehealth

To mitigate the risk of infection, professional counseling services were advised to refrain from in-person interactions and to limit face-to-face counseling sessions (Isaacs et al., 2023). As a result of the suggested limited face-to-face contact, telehealth has emerged as a viable solution, allowing counselors to continue their work with clients. According to the Health Resources and Service Administration (HRSA, 2023), telehealth involves the use of various technologies, such as computers, the internet, phones, and

tablets, to facilitate health-related services. This permits providers to engage with clients and patients without the need for face-to-face interaction.

The use of telehealth as a counseling modality produced some unique challenges that some counselors found difficult (Hill et al., 2023). One particular challenge is assessing if a client is a good candidate for telemental health services. Isaacs et al. (2023) stated that mental health interventions were not as effective on adolescents and teens when delivered through telemental health. Additionally, individuals that are experiencing more severe mental health crises may not respond to the use of telehealth to deliver a personalized experience.

One concern related to using technology in counseling sessions could be its reliability. While it is a convenient option, it also has its limitations. According to a study conducted by Hill et al. (2023), during the COVID-19 pandemic, many clients and counselors had to resort to a modality they were not accustomed to using in their day-to-day practice. Isaacs et al. (2023) suggested that many clients were not familiar with videoconferencing and were uncertain about creating a private space for their session or ensuring reliable internet access. Additionally, some individuals who lacked access to internet-based technologies had to rely on a phone, which could further reduce the personal touch in the client-counselor interaction. Furthermore, counselors may miss nonverbal cues when using a phone (Isaacs et al., 2023). These limitations could undermine the effectiveness of the counseling session.

Empathic Occupational Hazards

The COVID-19 pandemic had a personal impact on many mental health counselors, who were expected to manage its effects both in their professional and personal lives (Szlamka et al., 2021). Similarly, to their clients, many mental health counselors experienced mental health issues, stress, isolation, and fear (Szlamka et al., 2021). Juggling these two worlds could have proven overwhelming for some mental health professionals. According to a study by Thomas and Morris (2017), mental health counselors could have faced challenges in managing their own emotional well-being while providing support for clients in processing emotional pain. During the pandemic, the emotional stressors experienced by counselors could be heightened, potentially leading to occupational exhaustion (Szlamka et al., 2021). It is important for counselors to prioritize their emotional well-being and seek appropriate support to ensure their ability to serve their clients effectively.

Mental health counselors are vulnerable to experiencing empathy-related stress responses such as compassion fatigue, burnout, and vicarious trauma during the course of their careers (Lawson, 2007). If left unaddressed, these symptoms could harm the counselor's physical and emotional well-being and compromise the quality and ethical nature of the counseling relationship. In addition to the emotional labor inherent in their work, counselors may also struggle with personal stressors that have been exacerbated by the pandemic, further complicating their ability to maintain overall wellness. Moreover, Gleeson (2020) stated, consistent exposure to chronic stress and stressors may impede a counselor's capacity to implement self-care strategies that are essential for preserving

their own mental well-being., Consistent exposure to chronic stress and stressors may impede a counselor's capacity to implement self-care strategies that are essential for preserving their own mental well-being (Gleeson, 2020).

The pandemic presented a range of unique challenges for professional counselors (Hill et al., 2023). These challenges had the potential to complicate further the already complex task of producing effective work with clients, both during the pandemic and in its aftermath. It is important to consider the additional barriers that counselors faced during this time and work to mitigate them in order to provide the highest quality care to those in need. A potential hindrance to the effectiveness of counseling during the pandemic could have stemmed from the geographic location of the counselor's practice.

Rural and Urban Mental Health Counselors

Mental health care providers in different geographical locations may encounter unique challenges in delivering care to their clients. According to Mongelli et al. (2020), some of the obstacles that individuals face when seeking mental health care include limited insurance coverage, societal stigma surrounding mental health, inadequate access to care providers, and lengthy wait times for appointments. Navigating the challenges of providing mental health care in both rural and urban areas can be difficult for counselors. However, providers in certain regions may find it particularly challenging, which can lead to ineffective care for clients and increased professional burnout (Yin et al., 2023). For example, the experiences of rural counselors underscore the ongoing need to adapt traditional counseling practices and delivery models to better reflect the systemic and contextual factors influencing mental health, challenges that are especially acute in

impoverished rural communities and have been further magnified by the COVID-19 pandemic (Crumb et al., 2019). This is especially true for rural mental health counselors, who need more targeted training and resources to address the unique cultural and service challenges of working in rural communities (Crumb et al., 2020). In addition, the COVID-19 pandemic highlighted the urgent need for expanded disaster mental health training for rural counselors, who often face multiple roles and limited resources when responding to crises in their communities (Crumb et al., 2021).

Access to Care

According to recent research by Mongelli et al. (2020), a significant percentage of Americans, approximately 65%, are in need of treatment for moderate to severe mental health concerns. Additionally, access to quality mental health care may be limited for certain populations, particularly those residing in rural areas. Weinzimmer et al. (2021) found that rural residents have less access to mental health counseling services, which can result in a decreased number of providers available to manage the mental health needs of the community. This situation could place a greater burden on the available mental health providers.

Mental health counselors practicing in urban areas may have more resources available, but the volume of work could contribute to increased levels of depression, anxiety, and burnout (Yin et al., 2023). Rural providers also experience high levels of stress, the lack of resources and providers could magnify the mental strain they experience when trying to balance the needs of their clients (Mongelli et al., 2020; Wolde, 2022; Yin et al., 2023). These challenges underscore the need for continued

efforts to improve access to quality mental health care for all individuals, regardless of their geographic location.

An additional challenge for rural counselors is navigating insurance limitations that restrict the quality and quantity of care. Mongelli et al. (2020) stated that 28 million Americans do not have access to adequate medical coverage. Moreover, many individuals who live in rural areas may have a lower socioeconomic status and rely on Medicaid or Medicare, which could limit their access to mental health counselors who are authorized to provide services. This could create a higher demand for specific providers with specialized skills. As a result, counselors in rural locations could face increased pressure as they struggle to meet the needs of their communities (Johansson et al., 2019). Additionally, rural counselors may encounter unique educational challenges that their urban counterparts may not typically experience.

Counselors working in rural and isolated areas may encounter difficulties when it comes to pursuing continued education and receiving cultural competency training that is tailored to the distinctive cultural factors, diversity, and personal values prevalent in rural communities (Carnes-Holt & Weatherford, 2013). According to Carnes-Holt and Weatherford (2013) the treatment of rural and isolated clients may not receive adequate coverage in research literature or public policy training. Despite the availability of numerous training opportunities and continuing education programs online, they may not address the wide-ranging cultural factors and unique challenges that rural communities face.

Furthermore, it is worth noting that access to quality supervision, which is crucial in interpreting information, may be limited. McNichols et al. (2016) stated that rural counselors practiced from a more isolating perspective and infrequently interacted with other professionals, professional organizations or continuing educational opportunities that could build their professional competency. Additionally, Mongelli et al. (2020) posited that rural counselors received little to no education on cultural competency, unlike urban-based counselors. This can limit the effectiveness of working with diverse or underserved cultures, which can create additional stress and pressure for serving the communities that rural counselors practice in (Harris et al., 2022; Mongelli et al., 2020). A viable solution to this issue could be integrating technology to facilitate accessible care for all involved parties.

Technological Interventions

The discourse on leveraging technology such as telehealth and telemental health to facilitate access to various healthcare providers, including counselors, has been a continuing topic for several years (Weinzimmer et al., 2021). This can be an effective way to reduce the disparities that rural clients may experience in receiving care. However, for it to be an effective modality, it must be accessible. Weinzimmer et al. (2021) stated that rural residents face challenges in accessing these services due to limited internet connectivity and technology availability. Moreover, rural mental health counselors were more willing to participate in telehealth services than urban providers, but were limited by state-level regulatory frameworks, and insufficient third-party funding for telehealth services (Weinzimmer et al., 2021). The experiences during the

COVID-19 pandemic have underscored the significance of telehealth services for both urban and rural counselors and their clients.

During the COVID-19 pandemic, mental health counselors in both rural and urban areas had to adapt to new circumstances and utilize telehealth to connect with their clients while minimizing the risk of infection (Chauhan et al., 2020). Mental health services worldwide shifted to video- and phone-based modalities—a transition that enhanced access, particularly in rural regions, and supported continuity of care during lockdowns and periods of heightened infection risk (Appleton et al., 2021). Rural providers, however, were often compelled to adopt telehealth rapidly despite limited training and infrastructure, highlighting both the necessity and the challenges of this abrupt shift in service delivery (Shroeder et al., 2021). This became increasingly essential as social isolation and fear of infection or death led to heightened levels of distress among individuals (Wolde, 2022). Consequently, there had been a notable rise in the “help-seeking behaviors” and treatment of mental health symptoms of rural adolescents during the start of and throughout the pandemic (Brausch et al., 2022).

Additionally, the accessibility of mental health services during the COVID-19 pandemic was closely related to increased demand, as the pandemic’s impact on individuals' mental health created a greater need for counseling and therapy (Brausch et al., 2022). With the shift to remote work and the limitations of face-to-face interactions, mental health professionals were challenged to find alternative delivery methods to provide effective care to their clients. However, the availability of mental health services

meant that individuals had better access to the support they needed during a difficult time.

Summary

It is widely acknowledged that resiliency serves as a protective factor against stress and other adverse experiences. Resilience is understood as a dynamic process of maintaining or restoring mental health in response to adversity and can be strengthened through targeted interventions and protective factors that mitigate the effects of stress (Abate et al., 2024). Research has demonstrated that resilience not only helps individuals maintain mental health in the face of stress but also significantly reduces the development of clinical conditions like PTSD following trauma (Casiraghi & Trujillo, 2025).

Despite some studies suggesting a potential association between resiliency, stress, and burnout, research could not be found that has examined the extent to which resiliency and stress may predict burnout in individuals employed in the counseling profession. Previous literature has explored the experiences of burnout in mental health counselors (Mongelli et al., 2020; Wolde, 2022; Yin et al., 2023). However, as the COVID-19 pandemic is a more recent experience, there is limited research as to how the pandemic increased or decreased the phenomenon. It is concerning that burnout rates are escalating in the counseling profession, despite it being a common issue across professions (Aráñez-Litam et al., 2021).

I was interested in conducting a comprehensive analysis of burnout, especially during the pandemic, to gain a better understanding of this phenomenon. This examination included an assessment of how mental health counselors in both rural and

urban areas have managed this challenging period. Despite previous studies exploring burnout levels among these professionals, (Avent Harris et al., 2022; Deen et al., 2012; Litam et al., 2021; Wolde, 2022) research could not be found comparing the coping mechanisms, strategies, resources, and resiliency employed by rural and urban counselors in the wake of the COVID-19 pandemic.

Chapter 3 provides a comprehensive understanding of the research process, highlighting the rigorous approach and attention paid to maintaining the highest ethical standards. This chapter offers an in-depth overview of the methodology employed. This includes selecting a quantitative research design, data collection instruments, study sample, and selection process, data analysis procedures, and the ethical standards and practices implemented to ensure participant protection.

Chapter 3: Research Method

Introduction

The aim of this study was to investigate whether there is a predictive correlation between geographical location and burnout in the counseling profession during the COVID-19 pandemic. In Chapter 2, an in-depth review of the relevant research and the theoretical framework was presented. In this chapter, a comprehensive overview of the methodology of this study is provided, including the research design, the selection of the population to be studied, and a description of the instruments used for data collection. Additionally, the procedures for analyzing the data, potential threats to the validity of this study, and any ethical concerns that may arise are addressed.

Research Design and Rationale

For this study, a nonexperimental, cross-sectional survey design was utilized to investigate the correlational relationship between geographical location (e.g., rural or urban) as the independent variable and level of burnout as the dependent variable. This study employs statistical analysis to examine the relationship among variables (Rudestam & Newton, 2015). This design was appropriate as it aims to determine the extent to which rural or urban location may predict levels of burnout in mental health counselors. A nonexperimental design is also suitable to explore past events and analyze them for new information or new conclusions. In the case of this study, the period of time is during the COVID-19 pandemic and the aim is to determine if burnout was more prominent during this period of time, due to unique challenges as they pertain to geographical locations of

practice. Moreover, a linear regression analysis was used to evaluate the potential effect of the independent variable on the dependent variable.

Methodology

The study involved voluntary participants who were requested to complete a survey providing their demographic information. The survey was utilized to measure the independent variable, rural or urban location, and the dependent variable, which is level of burnout. The data collected was analyzed using regression data analysis to draw inferences about the potential relationship between the variables in the study and to test the null hypothesis.

Surveys have been proven to be an efficient and cost-effective method of collecting data, enabling researchers to gather a wide range of information in a short amount of time (Groves et al., 2009; Labott et al., 2013; Rudestam & Newton, 2015). A survey was conducted to assess burnout among the participants. I utilized the MBI and BRS surveys, which have been utilized in previous studies to measure similar variables (Eaves & Payne, 2019; Ogrresta et al., 2008; Porter et al., 2018; Smith et al., 2008). Additionally, the survey included questions to gather demographic information that will include age, gender, years of experience and licensure, and geographical location of practice. In order to gather data, I used an online platform called Survey Monkey. This platform provides participants with an easy and convenient way to submit their responses.

Population

For this study, the target population was master's level, licensed mental health counselors or/and doctoral-level, licensed mental health counselors who practiced during the COVID-19 Pandemic, March 1, 2020 through March 1, 2021, in either a rural or urban location within the United States. Participants needed to have been employed with an organization, hospital, or in private practice.

Sampling Procedure

This study utilized nonprobability sampling methods, which are used for nonrandom selection criteria, according to Etikan et al. (2016). Participants from both rural and urban areas were involved in answering the RQ. Due to the unknown size of the population, nonproportional quota sampling was used.

Sample Size

I utilized version 3.1 of G*Power (Faul et al., 2009) to calculate the required sample size for the study. The chosen α level was .05 (5%), and two predictors were selected. The power level ($1-\beta$) was set at .80 (80%), and .15 was chosen for the effect size. Based on these inputs, the recommended sample size was 67. However, a previous study of burnout excluded some participants due to their failure to meet the criteria, such as not being independently licensed or not responding to the survey multiple times (Ogresta et al., 2008). Therefore, I decided to set the a priori sample size at 74 to account for such participants and ensure sufficient data for the study.

Procedures for Recruitment, Participation, and Data Collection Recruitment

I sought to enlist licensed master's and doctoral-level mental health counselors in the United States who were employed by an organization, agency, an institution providing direct services or in private practice during the COVID-19 Pandemic and who worked in either an urban or rural location. To recruit participants, professional counseling listservs and websites for national, regional, and state counseling associations were utilized. The research participation request was also posted on the American Counseling Association (ACA) website.

Participation

The survey was conducted via a web-based program called SurveyMonkey. SurveyMonkey employs a HIPAA-compliant server to securely store all data collected from participants, and implements appropriate administrative, physical, and technical safeguards to protect personal health information (PHI) (SurveyMonkey, 2022). Participants could conveniently access the survey at any time but did need to complete it within the time frame assigned. Informed consent was sought at the beginning of the survey, and demographic questions were asked to garner information regarding age, gender, marital status, ethnicity, race, and geographical location of practice.

Additionally, the demographic questions helped to understand the various resources and self-care strategies employed by participants. While these were not part of the official RQs, the data provided additional information to build on existing or future research. The filter question ascertained whether participants practiced during the COVID-19 Pandemic with a simple “yes” or “no” response. If participants answer “no,”

the survey concluded, and they were thanked for their time. If participants answer “yes,” they were directed to complete the remainder of the survey. The questions throughout the survey provided participants with an opportunity to express their personal and professional experiences during the COVID-19 Pandemic. Upon completion of the survey, participants received a debriefing document that provided them with additional contact information.

Data Collection

The data collection process began upon the receipt of approval from the Institutional Review Board (IRB) at Walden University. Demographic questionnaire and surveys were manually entered into Survey Monkey. The data transmission process followed SurveyMonkey's confidential and secure measures, which include the use of encryption (Survey Monkey, 2022). I ensured that the survey results are securely stored on a password-protected drive, with access limited only to authorized personnel. To comply with Walden University's regulations, the data will be retained for a period of 5 years. After the required time frame, all collected data will be permanently deleted.

The expected time to complete the survey was approximately 20 minutes, based on the duration required to complete each instrument. Participants received instructions via email and were required to review the informed consent before providing their consent to participate in the study by selecting "yes" or "no". If the participants selected "yes", they automatically began the survey. However, if they selected "no", they were exited from the survey. Participants had the option to exit the survey at any time, and their consent was immediately revoked from the study. After completing the survey,

participants received a message of appreciation and the contact information of this author. The survey was accessible for a duration of one and a half months. At the designated time of closure of the survey, the data was cleaned before being exported to SPSS for further analysis.

Instrumentation and Operational Constructs

To gather data for this study, I utilized a demographic questionnaire and two pre-existing measurement scales. The scale used in this study was the updated MBI-HSS (see Maslach et al., 1996). This scale was chosen based on its relevance to the study and the reliability and validity established in previous studies (see Ogresta et al., 2008; Smith et al., 2008.) A study by Porter et al. (2018) assessed burnout and resiliency among family medicine residency directors using single-item measures adapted from the MBI, demonstrating continued applicability and empirical support for using the MBI-derived constructs in healthcare professionals.

Demographic Questionnaire

As part of the study, a comprehensive demographic questionnaire was developed to gather pertinent information from the participants. The questionnaire provided a description of the sample, identified the participants, and ensured that they met the criteria for the study. The questionnaire covered several parameters such as age, gender, education level, highest degree earned, years of experience, years of licensure, and years of practice.

Maslach Burnout Inventory- Human Services Survey (MBI-HSS)

The MBI-HSS was developed in 1981 by Maslach and Jackson to assess burnout among professionals working in the human services and education fields. The current version is the third edition, updated by Maslach et al. (1996). The survey comprises 22 questions, and each question is categorized into one of three subscales: EE, DP, and PA. The participants were required to report their responses on a Likert scale that ranges from 0 (*never*) to 6 (*every day*), and the survey took approximately 10 minutes to complete.

The inventory initially comprised 47 items and was administered to 605 individuals. Maslach and Jackson conducted factor analysis using principal factoring with the first sample, and the analysis accounted for ten factors. After applying selection criteria to the items, the researchers reduced the items from 47 to 25. The 25-item survey was administered to 420 individuals, and the factor analysis was similar to the first one. A score of 0-16 indicates low EE, a score of 0-6 indicates low DP and a score of 0-31 reflects low PA. Maslach et al. (1996) evaluated the reliability of their survey by employing Cronbach's coefficient alpha, which yielded a high internal consistency score of .83.

The individual subscales also demonstrated strong reliability coefficients of .89 for EE, .74 for DP, and .77 for PA. Since its initial inception, the MBI-HSS has been used in several studies (Doherty et al., 2021; Gould et al., 2013; Hallberg & Sverke, 2004) to explore burnout amongst helping professionals. It should be noted that administering the survey does not require any specific qualifications.

The MBI-HSS is a tool for assessing burnout among professionals in human services and education fields. It is a practical and useful instrument for identifying burnout symptoms, which can have significant implications for the well-being of employees and the organizations they work for. This author gained permission to administer this survey.

Operationalization of Constructs

Data Analysis Plan

The statistical analysis of the research was carried out using the IBM Statistical Package for the Social Sciences, Version 30 (SPSS). SPSS is widely recognized for its basic statistical functions, including variance, frequency, bivariate statistics, and other data processing (Bala, 2017; Masuadi et al., 2021; Nagaiah & Ayyanar, 2016). To ensure data accuracy, only licensed professional mental health counselors who are employed with an organization, agency, or an institution providing direct services or in private practice were included as participants in the study. Moreover, participants who did not practice during the COVID-19 pandemic were excluded from the study. Only those surveys that were completed were included in the analysis, and outliers that may significantly differ from other observed data sets were filtered out.

RQ and Hypotheses

RQ1: Does geographical location of mental health practice, that is, urban or rural, predict burnout levels of mental health counselors, during the COVID-19 pandemic?

H_0 1: Geographical location of mental health practice does predict burnout levels of mental health counselor during the COVID-19 pandemic.

H_{a1}: Geographical location of mental health practice does not predict burnout levels of mental health counselor during the COVID-19 pandemic.

Statistical Tests

This study sought to analyze the relationship between multiple factors using multiple regression analysis. To accomplish this, I utilized a single dependent variable and independent variables in the regression (see Mishra & Min, 2010). To maintain the integrity of the analysis, I did not include any covariates or confounding variables. It is worth noting that the inclusion of covariates may have introduced bias into the results (Lenz & Sahn, 2017), while confounding variables could have led to inaccurate conclusions that do not reflect the true relationship between the variables (Pourhoseingholi et al., 2012).

Threats to Validity

External Validity

External validity is a crucial aspect of research that determines the extent to which study results can be applied to other settings or populations. It is important to be aware of the potential threats to external validity, which can arise when researchers make invalid assumptions. As noted by Onwuegbuzie and McLean (2003), these threats can compromise the integrity of the study results and limit the generalizability of the findings. One possible concern related to external validity is the risk of sampling bias. The research conducted by this author focused exclusively on licensed mental health counselors who practiced during the COVID-19 Pandemic and only those practicing in

urban or rural settings. As a result, the outcomes were not representative of the larger counseling community, and generalizability was limited.

Internal Validity

Internal validity is a crucial aspect of research that pertains to the significance of the outcome and the adequacy of data to support the claim (Onwuegbuzie & McLean, 2003). It also considers the extent to which the independent variable manipulation is responsible for the change in the dependent variable. However, there are a few threats to internal validity that could impact the research study, such as maturation. In cases where the passage of time, the impact felt by participants to a specific event could change, and therefore threats to internal validity can arise. This study's internal validity was a matter of concern, given the possibility that the emotional impact of the COVID-19 pandemic may have evolved since the height of the pandemic three years ago. This consideration warranted attention to ensure that the study's conclusions remained relevant and applicable in the present context.

Ethical Procedures

The commencement of data collection for the study was contingent upon the receipt of approval from Walden University's IRB, which ensures that the study is conducted in accordance with ethical standards. Upon approval, the IRB assigns an IRB number to the study. During the recruitment phase, invitation flyers and emails are sent to mental health agencies, universities, professional organizations, and social media platforms that clearly state the target population and the purpose of the study. Upon

clicking the survey link, potential participants were directed to a consent page that provides a detailed account of the study's purpose and procedures.

The consent form made it clear that participation in the study is voluntary and that participants have the right to withdraw at any time. Additionally, the informed consent disclosed that the study posed minimal risks and that participants would need to recall potentially traumatic memories of the COVID-19 Pandemic. The informed consent also included information regarding measures that have been taken to ensure the protection of a participant's privacy and the procedures related to the storage of data. Should participants require any clarification or have any questions, they were provided with my contact information as well as that of the university.

Upon completion of the survey, participants were directed to a debriefing page that extends gratitude for their participation and provides contact information for the study. If a participant decided to withdraw from the study, any data that had been initiated was not utilized in the final analysis. Participants were assured of their privacy and confidentiality prior to the beginning and the completion of this study. All data were securely collected and stored on a password-protected desktop computer and kept in a secure location. The desktop computer will have the data deleted no later than 5 years after the study's conclusion while being stored securely in accordance with Walden University's IRB requirements.

Summary

Chapter 3 aimed to describe a quantitative study that examined the potential relationship between burnout and the rural and urban geographical locations of

counseling practice during the COVID-19 pandemic. This chapter covered the methodology, population, criteria for recruitment, data collection methods, threats to validity, and ethical standards. In Chapter 4, a detailed account of the data collection process will be provided, which includes testing the hypothesis, data screening, organization of data, and findings. This study is intended to address important and timely questions about some of the challenges mental health counselors endure, and the information presented in Chapter 3 serves as a foundation for the subsequent analyses and interpretation of the data that will be presented in Chapter 4.

Chapter 4: Results

Introduction

This nonexperimental, cross-sectional survey study aimed to explore whether geographical location (e.g., urban or rural) is a significant predictor of burnout levels for mental health counselors during the COVID-19 pandemic, as measured by the MBI-HSS. The theoretical framework for burnout was resilience, a construct that reflects an individual's capacity to withstand stress, respond effectively to disruption, and recover quickly, key processes that support coping in adverse environments (see Maunder et al., 2023). This dynamic also offers insight into why some individuals navigate emotionally demanding and high-stress environments more effectively than others, a phenomenon Masten (1990, p. 227) described as "ordinary magic," reflecting resilience as arising from everyday adaptive systems. Moreover, recent research has demonstrated that resilience facilitates more effective stress adaptation, enabling individuals to manage pressure and anxiety more successfully, which in turn promotes better overall well-being (Sayed et al., 2024). This chapter presents the full results of the data collection from the online survey, the demographic characteristics of the sample, and the results of the statistical tests that were conducted using IBM SPSS Statistics (version 30) to answer the RQ.

Data Collection

Data were collected through an online survey hosted on Survey Monkey from October 25, 2024 to April 8, 2025. The target population was mental health counselors at the master's or doctoral-level, who were licensed, employed, and provided direct counseling services via an institution of private practice during the COVID-19 Pandemic

(i.e., from March 1, 2020 through March 1, 2021). To qualify for the study, they must have been practicing in a rural or urban location in the United States during that time period. A nonprobability sampling method was used to invite potential survey respondents who were accessible to me. After approval was gained from Walden University's IRB, invitations to the survey were sent using professional counseling listservs and websites for regional, state, and national counseling associations, such as the American Counseling Association. This resulted in nonrandom, nonproportional quota sampling selection criteria since the population size was unknown (see Etikan et al., 2016).

The survey began with informed consent, followed by questions about qualifying for the study and individual demographic characteristics, including age, gender, race/ethnicity, marital status, current employment status, highest level of education completed, total number of years of counseling experience, type of licensure, and length of time they had possessed the license. This was followed by the survey items: 22 questions from the MBI-HSS (Maslach et al., 1996). This specific version of the MBI is used to assess burnout for professionals who work directly with people, such as healthcare workers, teachers, and social workers. Thus, it was appropriate for mental health counselors.

According to the G*Power analysis (Faul et al., 2009), the minimum required sample size, based on α level .05 (5%), power level (1- β) at .80 (80%), effect size of .15, and two predictors was $N = 67$. The survey was left open until $N = 131$ responses were obtained, to ensure there was a sufficient number of fully completed and qualified

responses. The results were downloaded from Survey Monkey as a Microsoft Excel file and the data were inspected. There were 110 fully completed responses. Two were excluded due to marking of geographic location as “other” (i.e., not rural or urban). This left a final sample of $N = 108$ for the analysis.

Results

The following is a summary of the RQ, the null and alternative hypotheses, and the results of the linear regressions that were conducted to answer the RQ. Also included are frequencies for geographical location and each demographic characteristic to help describe the obtained sample. See Table 1 for a reporting of each frequency.

Table 1

Demographic Characteristics

Characteristic	<i>N</i>	%
Geographic location		
Rural	39	36.11
Urban	69	63.89
Gender identity		
Woman	83	76.85
Man	20	18.52
Genderqueer/non-binary	5	4.63
Age		
18-24	3	2.78
25-34	37	34.26
35-44	27	25.00
45-54	18	16.67
55-64	15	13.89
65+	8	7.41
Race/ethnicity		
Asian	4	3.70
Black/African American	13	12.04
Hispanic/Latino	16	14.81
Mixed	14	12.96
Native American/Alaska Native	2	1.85
Native Hawaiian	0	0.00

Characteristic	<i>N</i>	%
Other	1	0.93
White	58	53.70
Marital status		
Single	32	29.63
Married	34	31.48
Widowed	3	2.78
Separated	3	2.78
Divorced	15	13.89
Partnered	21	19.44
Employment status		
Employed, full time	81	75.00
Employed, part time	17	15.74
Unemployed, looking for work	7	6.48
Unemployed, not looking for work	3	2.78
Retired	0	0.00
Highest education level		
Master's	85	78.70
Doctorate	23	21.30
Years of counseling experience		
0-1 years	0	0.00
1-3 years	0	0.00
3-5 years	22	20.37
5-7 years	29	26.85
7-9 years	15	13.89
10-20 years	21	19.44
20+ years	21	19.44
License type		
LPC	78	72.22
LPCC	30	27.78
Years of licensure		
0-1 years	1	0.93
1-3 years	1	0.93
3-5 years	33	30.56
5-7 years	24	22.22
7-9 years	16	14.81
10-20 years	14	12.96
20+ years	19	17.59

Descriptive Statistics

The 22-item MBI-HSS (Maslach et al., 1996) includes three individual subscales: EE, DP, and PA. Each item utilizes a Likert scale that ranges from 0 (*never*) to 6 (*every day*). Subscale scores were obtained by summing all items within each subscale, in alignment with guidelines set by Maslach et al. (1996).

Maslach et al. (1996) cautioned against combining scores from each subscale into a single total because research conducted while developing the MBI-HSS demonstrated that burnout exists along multiple dimensions. Accordingly, the most accurate interpretation of burnout is to assess it in relation to scores across the three subscales (Maslach et al., 1996). For this reason, three linear regressions were conducted in SPSS to answer the RQ, one for each subscale. The arithmetic mean (*M*) and standard deviation (*SD*) for each MBI-HSS subscale are reported in Table 2.

Table 2

Descriptive Statistics

	<i>M</i>	<i>SD</i>	Min
EE Subscale	27.56	13.20	4
DP Subscale	4.74	5.29	0

RQ and Hypotheses

The RQ was as follows: Does geographical location of mental health practice (e.g., urban or rural) predict burnout levels of mental health counselors, during the COVID-19 pandemic?

*H*₀₁: Geographical location of mental health practice does predict burnout levels of mental health counselors during the COVID-19 pandemic.

H_{a1} : Geographical location of mental health practice does not predict burnout levels of mental health counselors during the COVID-19 pandemic.

Assumptions Tests

To test the null hypothesis, three separate linear regressions were conducted in SPSS, one for each MBI-HSS subscale. Again, per guidelines by Maslach et al. (1996), the three subscale scores were calculated individually, as the total of all items for each subscale (e.g., EE, DP, and PA). The total scores from the EE, DP, and PA subscales were then entered one at a time into SPSS as a dependent variable (DV), with geographical location (e.g., rural or urban) as the independent variable (IV).

Simple linear regression typically assumes the IV is continuous, but it is acceptable to use a categorical IV as a predictor by using dummy coding (Ro & Bergom, 2020). Prior to each regression, geographical location was re-coded as 0 (*rural*) and 1 (*urban*). The assumption that the DV is continuous was met, as numeric totals for the EE, DA, and PA were used for each regression. Another key assumption is that a linear relationship exists between the IV and DV. However, in this case the IV is a dummy-coded categorical variable (e.g., 0, 1). Thus, this assumption is not applicable given that the regression model for this analysis is more comparable to a *t*-test that compared the means of each MBI-HSS subscale across the two categories of rural versus urban (Campbell, 2024). Homogeneity of variance was confirmed using Levene's test, with all subscales meeting this criterion ($p > .05$), as seen in Table 3. The results of each remaining assumption apply to the DV (e.g., independence of observations, outliers,

homoscedasticity, and normality of the residuals), and, therefore, are presented separately for each MBI-HSS subscale.

Table 3

Tests of Homogeneity of Variances

Based on Mean	Levene Statistic	df1	df2	Sig.
EE	2.24	2	105	.111
DA	1.29	2	105	.279
PA	1.51	2	105	.225

Linear Regression Results

The following section presents the results of each linear regression for the EE, DA, and PA subscales. The statistical significance of each analysis of variance is presented along with the amount of variance that is explained by the predictor variable. Finally, the levels of significance for the coefficients are provided with the results of each assumption test.

EE

Geographic location, as urban or rural, was not a statistically significant predictor for EE, $F(1, 106) = 3.033, p = .085, R^2 = .028$. See Table 4 for full results from the analysis of variance for the linear regression.

Table 4

Analysis of Variance for EE

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	518.53	1	518.53	3.033	.085 ^b
	Residual	18124.13	106	170.98		
	Total	18642.67	107			

- a. Dependent variable: EE subscale
 b. Predictors: (Constant), Geographical location

The amount of variance that was explained in the EE subscale by geographical location was negligible (approximately 2.8%). This is congruent with EE as a nonsignificant variable in this linear regression. See Table 5 for the model summary results.

Table 5

Model Summary for EE

Model	R	R Square	Adj. R^2	Std. Error of the Estimate	Durbin-Watson
1	.167 ^a	.028	.019	13.076	1.84

a. Dependent Variable: EE subscale

This is further confirmed in the non-significant result for this coefficient ($p = .085$). Thus, changes in rural versus urban has no effect on EE levels. The regression coefficients and standard errors are presented in Table 6.

Table 6

Coefficients for EE

Model ^a	Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% CI for B	
	B	Std. Error	Beta			Lower	Upper
1 (Constant)	24.64	2.09		11.77	<.001	20.49	28.79

What is/was the geographical location of the practice you worked at during the Covid-19 pandemic?	4.56	2.62	.167	1.74	.085	-.63	9.76
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a. Dependent variable: EE Subscale

The assumption of independence of residuals was met, based on a Durbin-Watson value of 1.84, which falls within the acceptable range of 1.5 to 2.5. The absence of a Casewise Diagnostics table in the SPSS output indicates that no cases had residuals large enough to be flagged as outliers. This supports the validity of the model and suggests that no individual cases unduly influenced the regression line (Campbell, 2024; Ro & Bergom, 2020). Levene's test of homogeneity of variance ($p = .549$) confirmed there was homoscedasticity (i.e., constant variance of the residuals). Although the conventional method to test this assumption is to inspect a scatterplot of residual values plotted against predicted values, Levene's test was deemed preferable for this analysis because it is a more valid and precise method with a dummy coded IV (Campbell, 2024; Ro & Bergom, 2020).

DP

The regression analysis was repeated for the DP subscale. Again, geographic location was the IV. The result was not statistically significant, $F(1, 106) = .006$, $p = .937$, $R^2 = .000$ (see Table 7).

Table 7*Analysis of Variance for DA*

Model		Sum of Squares	<i>Df</i>	Mean Square	<i>F</i>	Sig.
1	Regression	0.18	1	0.18	.006	.937 ^b
	Residual	2990.56	106	28.21		
	Total	2990.74	107			

a. Dependent variable: DP subscale

b. Predictors: (Constant), Geographical location

None of the variance in the DP subscale was explained by geographical location (approximately 0.0%). This is congruent with DP as a nonsignificant variable in this linear regression. See Table 8 for the full model summary results.

Table 8*Model Summary for DA*

Model	R	R Square	Adj. <i>R</i> ²	Std. Error of the Estimate	Durbin-Watson
1	.008 ^a	.000	-0.01	5.31	1.86

a. Dependent Variable: DP subscale

Again, no predictive effect was found for geographical location as a co-efficient in the regression analysis ($p = .008$). Changes in rural versus urban has no influence on levels of DA. See Table 9 for the regression coefficients results.

Table 9*Coefficients for DA*

Model ^a	Unstandardized Coefficients		Standardized Coefficients	<i>t</i>	Sig.	95.0% CI for <i>B</i>	
	<i>B</i>	Std. Error	Beta			Lower	Upper
1	(Constant)	4.80	.85	5.64	<.001	3.11	6.48

What is/was the geographical location of the practice you worked at during the Covid-19 pandemic?	-0.09	1.06	-0.01	-0.08	.937	-2.19	2.03
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a. Dependent variable: DP Subscale

The assumption of independence of residuals was met, with a Durbin-Watson value of 1.86, which falls within the acceptable range of 1.5 to 2.5. The Casewise Diagnostics table identified two outliers. Because these cases deviate from their predicted values, they may influence the model, but the impact is likely minimal due to the sample size for the regression analysis of $N = 108$ (Campbell, 2024; Ro & Bergom, 2020). The result of Levene's test of homogeneity of variance was passed based on $p = .234$, which confirms there is homoscedasticity (Campbell, 2024; Ro & Bergom, 2020).

PA

Statistical significance was observed for the PA subscale. Geographic location was a significant predictor for PA, $F(1, 106) = 4.741, p = .032, R^2 = .007$. See Table 10 for results of the ANOVA.

Table 10

Analysis of Variance for PA

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	149.34	1	149.34	4.74	.032 ^b

1	Residual	3338.66	106	31.50
	Total	3488.00	107	

a. Dependent variable: PA subscale

b. Predictors: (Constant), Geographical location

The amount of variance explained by the model is presented in Table 11.

Geographic location explained approximately 4.3% of the total variance in the PA subscale. This was sufficient to achieve statistical significance.

Table 11

Model Summary for PA

Model	R	R Square	Adj. R^2	Std. Error of the Estimate	Durbin-Watson
1	.207 ^a	.043	.034	5.62	1.83

a. Dependent variable: PA subscale

The regression analysis using dummy-coded variables for geographical location (0 = rural, 1 = urban) indicates that working in an urban location is associated with higher PA. The coefficient is statistically significant $t(106) = 2.18, p = 0.032$. The 95% CI [0.22, 4.68] does not include 0, confirming that the difference is reliable (see Table 12).

Table 12

Coefficients for PA

Model ^a		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	95.0% CI for B	
		B	Std. Error	Beta			Lower	Upper
1	(Constant)	7.77	.90		8.65	<.001	5.99	9.55

What is/was the geographical location of the practice you worked at during the Covid-19 pandemic ?	2.45	1.12	.21	2.18	.032	.22	4.68
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a. Dependent variable: PA Subscale

The assumption of independence of residuals was met with a Durbin-Watson value of 1.83. No Casewise Diagnostics table was produced, indicating no outliers. Levene's test of homogeneity of variance passed ($p = .608$), confirming homogeneity of variance (Campbell, 2024; Eisenhauer, 2006; Ro & Bergom, 2020).

Summary

In summary, the results of this study reveal that geographical location (urban vs. rural) is not a significant predictor for EE or DP, as it pertains to the MBI-HSS. However, it does demonstrate modest predictive value for PA, with urban counselors reporting slightly higher burnout scores. These findings suggest that while geography may influence some aspects of professional fulfillment, it may not be a primary factor in all dimensions of burnout. Chapter 5 presents an interpretation of these findings, a discussion of the study's limitations, and recommendations and implications for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This nonexperimental, cross-sectional study examined whether geographic location (urban or rural) predicted burnout levels for licensed mental health counselors who provided direct services during the COVID-19 pandemic. The purpose was to identify differences based on geographical location (e.g., rural or urban work setting) to help ensure practitioners across these settings have equitable access to resources that are needed to prevent and/or alleviate burnout during crises. It was anticipated that gaining insight into the impact of location on counselor burnout levels will be useful for developing targeted interventions and support mechanisms for this population. This underscores the study's value in informing evidence-based counselor support strategies that address both individual resilience and systemic resource disparities in rural and urban contexts.

Grounded in resilience theory, the study used the MBI-HSS to assess burnout. Data were collected from $N = 108$ mental health counselors via an online survey. All participants were actively practicing in either a rural ($n = 39$) or urban setting ($n = 69$) at the master's or doctoral level between March 2020 and March 2021. The RQ of this study was as follows: Does geographical location of mental health practice, that is, urban or rural, predict burnout levels of mental health counselors during the COVID-19 pandemic? The null hypothesis was that geographical location of mental health practice does not predict burnout levels of mental health counselors during the COVID-19 pandemic, while the research hypothesis was that geographical location is predictive of

burnout. This chapter includes an interpretation of the findings and a discussion of the limitations of this study, recommendations, and this study's implications.

Interpretation of the Findings

A rigorous examination of counselor burnout requires the use of a measurement framework that acknowledges its multidimensional nature rather than reducing it to a singular construct. Factor analysis conducted by Maslach and Jackson (1996) established that burnout is best understood as a multidimensional construct. For this reason, the MBI-HSS includes three distinct but related subscales for assessing burnout: EE, DP, and PA. Combining them into a single score compromises the validity of the measure. Therefore, to ensure that this study relied on the most valid comparison of burnout levels between rural and urban counselors, the results are presented according to the three multiple regression analyses conducted for each MBI-HSS subscale.

The following underlying assumptions for linear regression were also considered for this study. The criterion of conducting each regression analysis using a single continuous numeric dependent variable (i.e., each MBI-HSS subscale score) was met. When using a categorical predictor variable (i.e., geographical location), dummy coding is required (Ro & Bergom, 2020). Therefore, each regression model was analogous to a t-test, as it compared the means of each MBI-HSS subscale for rural versus urban counselors (Campbell, 2020). Homoscedasticity was confirmed using Levene's test, with all subscales $p > .05$ and no highly influential outliers were detected.

Although the group sizes in the regression analyses were unequal ($n = 39$ vs. $n = 69$), this imbalance is not problematic, particularly when group variances are similar

(Cohen et al., 2003). Unequal group sizes do not threaten the validity of the regression model so long as the assumption of homogeneity of variance is met (Cohen et al., 2003). Thus, the findings may be considered valid. This remainder of this chapter includes an interpretation of the results and a discussion of limitations, recommendations, and the implications of this study.

EE

The EE subscale of the MBI-HSS measures feelings of being emotionally overextended and depleted by one's work, often reflecting the first stage of burnout (Maslach & Jackson, 1981; Maslach et al., 1996). For this subscale, the regression analysis indicated a marginally nonsignificant relationship between geographical location and burnout ($p = .085$), suggesting a weak but potentially meaningful effect that requires further study. Obtaining a p -value close to .05 implies that even though there is no statistical significance there may be practical significance and real-world relevance of the findings. To better understand the explanatory power of this regression model, it is also helpful to examine the effect size of $\eta^2 = 0.028$. Using Cohen's (1988) criteria, this finding is considered small to medium, which is not trivial. This indicates that future research is warranted since the predictor of rural versus urban has a modest but meaningful impact on EE.

Scores on the EE subscale range from 0 to 54, with higher scores indicating greater burnout in this dimension (Maslach et al., 1996). According to the MBI Manual, EE scores are typically categorized as low (0–16), average (17–26), and high (27 or above) (Maslach et al., 1996; Maslach et al., 2016). In this sample, the mean EE score

was 27.56 ($SD = 13.20$), placing the group average in the high burnout category. This suggests that, on average, participants experienced substantial emotional fatigue during the study period. High EE scores have been associated with reduced job satisfaction, poorer mental health outcomes, and greater likelihood of attrition among helping professionals (Maslach & Leiter, 2016). Given the high mean and wide variability observed, it is likely that a considerable proportion of counselors in both rural and urban settings experienced severe EE, which may have impaired their ability to provide sustained, high-quality care. The elevated EE scores align with research documenting increased emotional strain among mental health professionals during the COVID-19 pandemic, reflecting the combined effects of increased caseloads, adaptation to telehealth, and heightened client distress (Mogwitz et al., 2025).

Reasons for not rejecting the null hypothesis include the small sample size, nonprobability sampling, and limited recruitment via listservs and emails. This aligns with Serdar et al. (2020), who explain how low statistical power due to small samples can reduce the likelihood of detecting significant effects. Although EE is a key facet of burnout, its associations with organizational or individual outcomes may be modest, sometimes becoming attenuated by contextual moderating factors such as workplace safety climate or compensation structures (Opoku et al., 2021). Measurements of this construct may also vary substantially across different predictor variables (Shoman et al., 2022).

Additionally, another possible explanation for the lack of statistically significant findings on the EE and DP subscales is that individual characteristics, such as counselor

resilience or the use of effective coping strategies, may have exerted a greater influence on burnout levels than location alone. In a multiple regression analysis conducted during the COVID-19 pandemic, higher resilience among professional counselors was significantly linked with lower levels of compassion fatigue and burnout, underscoring the protective role resilience plays in mitigating emotional strain (Litam, 2021).

The conceptual framework of this study is rooted in resiliency theory. Resiliency theory examines differences in responses to adversity based on variance in factors associated with risk, protection, and vulnerability (Bolton et al., 2017). As a theoretical framework, resilience emphasizes the personal and interpersonal resources individuals draw upon in response to adversity and reflects their capacity to cope effectively with stress and recover from adversity. Mental health counselors who had higher levels of resilience or who employed more effective coping mechanisms to navigate the emotional demands and DP risks associated with their work during the pandemic may have experienced less EE and DP regardless of practice setting.

In addition to individual coping resources, workplace factors like access to supportive relationships, organizational backing, and adequate job resources also appear to influence the risk of burnout. Maslach and Leiter (2016) underscored that burnout develops partly from resource depletion. This means that low levels of support and insufficient resources can exacerbate EE and cynicism. More recent studies have reinforced this view, noting that tangible resources like manageable caseloads, adequate training, and flexible scheduling can buffer against burnout in high-demand environments (Bakker & de Vries, 2021). This is also true for intangible support, like encouragement

by supervisors or collaborating with co-workers during the pandemic (Panagioti et al., 2021). This suggests that resource availability and perceived support are two protective factors that can mitigate negative effects from prolonged work-related stress. However, they are distinct types of factors.

The COVID-19 pandemic introduced specific stressors that likely heightened EE among counselors, irrespective of practice setting. For many, the rapid transition to telehealth required learning new technologies while maintaining therapeutic effectiveness, often in the absence of adequate training or infrastructure (Békés & Aafjes-van Doorn, 2020). Increased caseloads, heightened client distress, and the need to provide crisis intervention in a prolonged state of uncertainty may have further depleted emotional reserves. Urban counselors may have contended with larger client volumes and organizational restructuring, whereas rural counselors may have faced isolation from peers and reduced access to supervision or referral networks. These pandemic-related conditions may have contributed to elevated EE scores across the board, potentially reducing the magnitude of differences attributable to geographic location.

DP

The DP subscale assesses an unfeeling and impersonal response toward clients or recipients of care (Maslach & Jackson, 1981; Maslach et al., 1996). This reflects a counselor's emotional distancing from clients and the development of cynical attitudes, as a defensive response to overwhelming emotional demands (Maslach & Jackson, 1981; Maslach et al., 1996). A detached or cynical attitude can develop as a coping mechanism in high-stress settings (Maslach & Jackson, 1981; Maslach et al., 1996). It was

hypothesized for this study that the work environment during the COVID-19 pandemic was this type of high-stress environment.

In contrast to the findings for EE, the DP regression analysis ($p = .937$) was neither statistically nor practically significant. In fact, the p-value is very close to 1, indicating that no evidence was found in this study that geographical location predicts DP. A possible explanation for this non-finding is that internal predisposition had a stronger influence than environment. For example, in a 2024 systematic review and meta-analysis, higher levels of cognitive empathy were associated with significantly lower DP for medical students (Cairns et al., 2024). Therefore, DP could be more closely associated with individual capacities, like one's ability to understand other people's perspective, as opposed to simply an external, contextual variable like practice setting of rural or urban.

Scores on the DP subscale range from 0 to 30, with higher scores indicating more frequent experiences of emotional detachment or cynicism toward clients (Maslach et al., 1996; Maslach et al., 2016). According to the MBI-HSS interpretive guidelines, DP scores are categorized as low (0–5), average (6–9), and high (10 or above). The overall mean DP score in this study was 4.74 (SD = 5.29), placing the sample in the low DP range. This indicates that, on average, participants were not experiencing frequent emotional distancing or cynicism toward clients at the time of data collection. The low could mean that, despite other burnout risks observed in this sample, mental health counselors may have maintained a degree of personal connection and empathy with clients during the COVID-19 pandemic.

Pandemic-specific factors may also have minimized geographical differences in DP by creating similar client-interaction challenges for both rural and urban counselors. For instance, widespread adoption of telehealth, reduced in-person contact, and heightened crisis intervention demands may have equally influenced emotional distancing across settings. In addition, resilience or other personal attributes, such as cognitive empathy, emotion regulation skills, and professional coping strategies, could have buffered counselors from developing higher DP during this period. This suggests that interventions to reduce DP may be more effective if they focus on enhancing individual competencies, such as empathy training and reflective practice, alongside structural supports, rather than relying solely on geographic resource allocation.

PA

The PA subscale evaluates feelings of competence and successful achievement in one's work with people, where higher scores are associated with greater professional efficacy and lower burnout (Maslach & Jackson, 1981; Maslach et al., 1996). Urban counselors reported higher PA scores than rural counselors, suggesting that perceived professional efficacy may be influenced by practice setting (see Table 13).

Table 13

Personal Accomplishment Based on Geographical Location

Geographical location	<i>N</i>	Mean	<i>SD</i>
Rural	39	8.539	5.423
Urban	69	9.449	5.310

This was the only regression result in this study that reached significance ($p = .032$). For this regression model, the effect size was small to moderate, meaning that

while the difference was not large, it was meaningful (Cohen, 1988). Although this effect size was only slightly larger than what was found for EE, it was observed in conjunction with statistical significance. Therefore, the predictor of geographical location makes a small but real difference in burnout levels, explaining about 4.3% of the differences in PA.

Scores on the PA range from 0 to 48, with higher scores reflecting greater perceived professional efficacy and lower burnout in this dimension (Maslach et al., 1996). According to the MBI Manual, PA scores are typically categorized as low (0–31), average (32–38), and high (39 or above) (Maslach et al., 1996; Maslach et al., 2016). These cutoffs allow researchers to interpret the practical meaning of group mean scores and to identify whether respondents are experiencing diminished or enhanced PA relative to normative data.

Although urban counselors reported slightly higher PA scores than rural counselors, both groups fell well below the established low PA cutoff of 31 on the MBI-HSS (Maslach et al., 1996; Maslach et al., 2016). This indicates that, on average, both groups experienced markedly diminished perceptions of professional accomplishment during the study period. Low PA scores of this magnitude suggest reduced professional efficacy, which has been linked to higher overall burnout risk, lower job satisfaction, and increased likelihood of attrition among helping professionals. Therefore, while the statistically significant difference between groups points to a small but real effect of geographical location, the overall low PA levels observed across both urban and rural counselors underscore the broader concern that systemic and occupational factors during

the COVID-19 pandemic may have suppressed professional accomplishment regardless of practice setting.

Higher PA has been linked to greater job satisfaction, stronger professional identity, and reduced risk of attrition (Bakker et al., 2014; Kim et al., 2011). It is reasonable to infer that differences in PA could shape career longevity and, by extension, client outcomes. Previous studies have found that access to institutional resources, professional development opportunities, and supervisory support are positively associated with higher PA scores among helping professionals (Kim et al., 2011; McAuliffe et al., 2013). These factors are often more available in urban settings, where organizational infrastructure tends to be better resourced, potentially reinforcing counselors' perceptions of competence and accomplishment.

The findings of this study align with the original hypothesis that urban practitioners may benefit from greater access to resources and support systems. The availability of resources like sufficient staffing, continuing education, and peer support may bolster PA and act as a protective factor against other burnout dimensions (Bakker et al., 2014; Leiter & Maslach, 2016). In the context of the COVID-19 pandemic, PA may have functioned as a psychological buffer. During the pandemic, factors such as the rapid shift to telehealth service delivery, increased crisis intervention demands, and the need to adapt to evolving public health protocols may have influenced counselors' sense of PA in distinct ways across rural and urban settings. This could have helped mitigate the impact of occupational stressors associated with EE or DA. This would be consistent with prior

research which found that workers with high PA often report lower levels of exhaustion and DP, even in demanding environments (Leiter & Maslach, 2017; Kim et al., 2011).

Urban counselors reported greater perceived professional efficacy, potentially rooted in access to resources typically lacking in rural settings. According to Phillips (2020), rural communities historically experience reduced accessibility, limited availability of specialty services, and workforce shortages. These structural conditions may impede counselors' sense of effectiveness and accomplishment. These inequities in institutional support and resource infrastructure could have led to the observed difference in PA between rural and urban mental health counselors in this study. Although geographical location explained only 4.3% of the variance in PA, this still represents a meaningful distinction in the professional experiences of rural and urban mental health counselors.

Due to the small effect size, caution is warranted when interpreting the practical significance of this finding. Although statistically significant, the observed difference accounts for only a modest proportion of the variance in PA and may not translate to substantial real-world impact without considering other contributing factors (Cohen, 1992). Thus, the interplay between PA, resource access, and perceived efficacy underscores the need for targeted interventions to enhance PA among rural practitioners. This could include remote supervision programs, tele-mentoring, or support for expanding professional networks. These types of efforts could improve counselor well-being and retention, and therefore indirectly also support better client outcomes by leading to counselors who are more engaged.

Overall Analysis

Taken together, the analyses of the three MBI-HSS subscales, EE, DP, and PA, offered a nuanced view of burnout among rural and urban mental health counselors during the COVID-19 pandemic. Although there were statistically significant differences found only for PA; the results for EE and DP remain important for understanding the broader burnout profile across settings. EE and DP showed no statistically significant relationship to geographical location, with DP results especially distant from significance and EE showing a marginal, nonsignificant trend with a small-to-medium effect size. By contrast, PA differed significantly between rural and urban counselors, with urban counselors reporting higher perceptions of professional accomplishment. These findings contribute to the broader field of mental health counseling by clarifying how geographic context interacts with burnout dimensions, offering actionable insights for workforce retention, equitable resource allocation, and improved client outcomes.

The lack of significant geographical effects for EE and DP suggests that these dimensions may be shaped less by location and more by individual-level or organizational variables. This is consistent with research indicating that personal resilience, coping strategies, and interpersonal resources may act as protective factors that buffer emotional strain and cynicism, even in high-stress environments (Bolton et al., 2017; Litam, 2021). In particular, the resilience framework emphasizes the interplay of risk, protective, and vulnerability factors. This allows for the possibility that two counselors in different environments might experience similar burnout outcomes due to comparable levels of coping capacity, support, or other moderating influences. Moreover,

both EE and DP may be influenced by internal characteristics, such as empathy capacity, emotional regulation skills, or prior trauma exposure, that transcend the influence of setting (Cairns et al., 2024).

For EE, the small-to-medium effect size, combined with a *p*-value approaching significance, indicates that while location may exert some influence, it likely interacts with other variables not captured in this study. Prior research has shown that burnout in this dimension is often linked to resource depletion, insufficient support, and high workload demands (Bakker & de Vries, 2021; Maslach & Leiter, 2016). These factors can vary within both rural and urban environments, depending on the availability of supervision, manageable caseloads, and flexible scheduling (Panagioti et al., 2021). Given the pandemic's disruptions, ranging from telehealth transitions to shifting client needs, it is plausible that EE was affected more by the specific nature of counselors' pandemic workloads than by their geographic location alone.

Additionally, the DP findings suggest influences that extend beyond a simple rural–urban classification. DP reflects emotional detachment and cynicism, which in helping professions like counseling is often a coping mechanism for sustained emotional demands (Maslach & Jackson, 1981; Maslach et al., 1996). The absence of significant location-based differences suggests that detachment may be tied more to personal predispositions or shared pandemic stressors than to structural differences between settings. High-intensity client needs, social isolation, and pervasive uncertainty during COVID-19 may have created similar pressures on counselors regardless of location, equalizing the risk for DP across groups.

In contrast, the significant finding for PA highlights an area where location may play a more consistent role. Urban counselors reported higher PA scores, suggesting that greater access to institutional resources, training, and professional networks may bolster a sense of competence and achievement (Kim et al., 2011; McAuliffe et al., 2013). This finding aligns with the hypothesis that resource access can reinforce perceptions of professional efficacy, potentially buffering against other burnout dimensions (Bakker et al., 2014; Leiter & Maslach, 2016). However, the observed mean PA scores for both rural and urban counselors were well below the MBI-HSS cutoff for low accomplishment, indicating widespread reductions in perceived efficacy during the pandemic (Maslach et al., 1996; Maslach et al., 2016). This underscores that while location may confer some advantages, pandemic conditions exerted a broadly negative effect on counselors' professional self-assessments.

The interplay between the three subscales suggests a complex burnout profile. PA may have served as a psychological buffer, particularly for urban counselors, mitigating the effects of stressors that might otherwise have increased EE or DP. Conversely, lower PA in rural counselors could signal heightened vulnerability to other burnout dimensions over time, even if not detected in this cross-sectional analysis. The resilience framework supports this interpretation, emphasizing how resource levels, both tangible and intangible, influence the capacity to adapt to adversity (Bolton et al., 2017). Within the pandemic context, urban counselors' higher PA may reflect both access to external supports, such as continuing education, peer consultation, and institutional infrastructure, and internal resources that were bolstered by these supports.

These results highlight the importance of examining burnout not as a uniform construct, but as a multidimensional phenomenon in which different components may respond differently to environmental and personal factors. While EE and DP appear to be more sensitive to individual resilience and coping mechanisms, PA may be more directly tied to structural supports and professional opportunities that vary by setting. This highlights the value of targeted interventions: strengthening resource access and support systems in rural contexts to enhance PA, while also addressing individual-level resilience strategies across all settings to mitigate EE and DP. These conclusions set the stage for the subsequent discussion on implications, limitations, and recommendations for future research.

Limitations of the Study

This study has several limitations that should be considered. The use of convenience sampling may limit external validity, potentially reducing the representativeness of results for the broader population of mental health counselors (Jackson, 2015). Non-random sampling could have introduced unknown characteristics that differentiate respondents who completed the online survey from those who declined or did not receive the invitation (Tabachnick & Fidell, 2013). Recruitment was also restricted to IRB-approved invitations distributed through professional counseling listservs and websites of national, regional, and state counseling associations, such as the American Counseling Association (ACA). This approach excluded school counselors, licensed alcohol and drug counselors, and those not independently licensed, limiting generalizability to these groups.

Additionally, the sample was intentionally limited to licensed counselors at the master's or doctoral level practicing independently in either rural or urban areas within the United States from May 1, 2020, to April 1, 2021, during the COVID-19 pandemic. This narrow focus may constrain the applicability of findings to other contexts or time periods. The temporal distance between the pandemic and data collection poses a further limitation, as the lapse of several years may have affected participants' ability to accurately recall emotional experiences related to burnout. Research indicates that longer recall periods can reduce data quality due to memory decay, altering how experiences are reported (Conner & Barrett, 2012).

However, errors from delayed reporting are more prevalent for frequent, fragmented activities, such as internet use, than for sustained, emotionally significant experiences like counseling during a global crisis (Wonneberger et al., 2017). The emotionally charged nature of the pandemic may have enhanced the coherence of participant responses, potentially mitigating recall bias. Emerging research suggests that temporal distance has complex implications for self-reported data validity. Delayed reporting may introduce memory decay but can also allow participants time to process experiences, potentially enhancing the depth of retrospective reports (Dudzik & Broekens, 2023).

For affective experiences like burnout, an optimal reporting window may exist, balancing incomplete emotional responses (too soon) with forgotten details (too late). By specifying a clear time frame (May 2020–April 2021), this study prompted episodic memory, which research suggests reduces recall bias and improves result consistency

(Walentynowicz et al., 2018). Thus, while the time lapse may limit accuracy, the defined recall period and reflective space likely strengthened the validity of self-reports.

The small sample size ($N = 108$) also limits statistical power, despite exceeding G*Power recommendations (Cohen, 1992). Small samples in linear regression analyses can reduce the ability to detect effects, potentially explaining the lack of significant differences in EE and DP subscales of the MBI-HSS (Bakker & Demerouti, 2017; Field, 2018). The correlational, quasi-experimental design further prevents causal inferences, and potential confounding variables, such as differences in workload, resource access, or community support between rural and urban counselors, may have biased results (Shadish et al., 2002). These confounds, if unaddressed, could obscure geographic effects on burnout. Including covariates in regression analyses can partially mitigate such threats to internal validity (Shadish et al., 2002).

Self-report bias represents another limitation, as the MBI-HSS relies on subjective responses, which are susceptible to cognitive influences like social desirability (Bound et al., 2001). Burnout, being a sensitive topic, may lead to random or systematic misreporting, potentially distorting descriptive findings and reducing validity (Bauhoff, 2014). I assumed that participants met the eligibility criteria, understood the survey items, and responded truthfully without social desirability bias. Any discrepancies between reported and true burnout levels could further compromise results.

From a social justice perspective, these limitations highlight potential inequities in studying rural versus urban counselors. Convenience sampling and recruitment through professional networks may have underrepresented counselors in underserved rural areas

with limited access to such platforms, potentially skewing results. Similarly, unmeasured confounds like resource disparities could disproportionately affect rural counselors, masking burnout differences and underscoring the need for equitable research designs. Future research could explore these limitations by employing larger, randomized samples, controlling for resilience or resource access, and examining the impact of temporal distance on burnout recall accuracy (Gomes et al., 2022; Walentynowicz et al., 2018). This study is among the few to examine counselor burnout by subscale during the COVID-19 pandemic with a rural–urban comparison, making it a unique contribution to the literature on geographically contextualized counselor well-being.

Recommendations

The pattern of findings across the EE, DP, and PA subscales suggests that individual-level factors, such as resilience, empathy, and coping strategies, may exert a stronger influence on burnout outcomes than geographic location alone. Recent evidence supports this interpretation. For example, Lyon and Galbraith (2023) found that mental health practitioners with higher self-compassion, a closely related capacity, consistently reported lower levels of burnout across all dimensions, reinforcing the role of internal protective mechanisms. Additionally, Duncan (2024) identified several lifestyle and self-care practices (e.g., leisure time, exercise, perspective shifts) that predict lower burnout among counselors, indicating that personal behaviors and internal supports significantly buffer burnout, irrespective of external context.

Future Research

To expand on the results of this study's finding that only PA differed significantly between rural and urban mental health counselors, future research should more precisely define rural areas to examine the effects of fewer supports (Bolton et al., 2017) and clarify whether location directly influences burnout or whether individual resilience buffers some effects. Addressing social justice issues by focusing on systemic inequities, such as limited rural resources, could help explain geographic disparities and inform targeted interventions for underserved communities.

Future work could also replicate this study using additional measures beyond the MBI-HSS to capture a broader range of counselor experiences. This might reveal whether differences in EE or DP were undetected due to measurement limitations. Researchers should examine specific risk factors such as access to supervision, institutional funding, and training opportunities, as these may be particularly influential in marginalized rural settings. Mixed methods approaches combining surveys with qualitative interviews could further illuminate the lived experiences of counselors in these contexts (Shadish et al., 2002).

Future studies could also examine resilience as a covariate or moderator in the relationship between geographic location and burnout. Controlling for resilience could help isolate the effects of location and ensure that individual differences do not obscure systemic disparities, which may disproportionately affect marginalized communities. Such an approach would allow researchers to investigate whether resilience mediates or

buffers the impact of workplace stressors, ultimately supporting more equitable and tailored interventions for counselor well-being in diverse practice settings.

From a methodological standpoint, expanding the sample size to more than 200 participants could increase statistical power and improve the detection of small but meaningful effects (Field, 2018). Alternative designs, such as longitudinal or experimental studies, could help clarify causal relationships and track burnout recovery trajectories in the post-pandemic period. Recruitment strategies could aim for greater diversity and representation by going beyond professional listservs to include social media outreach and partnerships with counseling organizations. Additional predictors or moderators could be considered to explain unexplained variance in regression models, particularly pandemic-specific factors like technology access, telehealth-related challenges, and family care responsibilities.

An additional methodological gap concerns the reliability of burnout data reported by participants, particularly when there is a delay between the experiences and reporting. Because burnout is inherently subjective and typically measured via self-report, temporal distance may influence data accuracy. Future research could investigate how delays between events and self-reporting affect validity and reliability, and design studies that carefully consider the timing of data collection to minimize this risk.

Lastly, geographic classification could move beyond a simple rural–urban binary. Using typologies such as suburban, exurban, frontier, or micropolitan regions, defined by the U.S. Census Bureau or USDA Rural-Urban Continuum Codes, would allow researchers to account for factors like population density, proximity to metropolitan

areas, and access to healthcare and mental health services. Demographic questions could also address broader socioeconomic indicators (e.g., broadband access, commute times, and local mental health infrastructure). This multidimensional approach could uncover environmental influences on burnout that are obscured by overly broad categories.

Exploring how access to training, institutional resources, and community support influences burnout could help develop more equitable solutions for counselors working in underserved areas (Bolton et al., 2017; Grant & Kinman, 2012; Silveira & Boyer, 2015).

Practical Applications

The results of this study point to practical steps to support mental health counselors, particularly in rural areas where PA was lower. Organizations may address this gap by developing targeted professional development programs designed to bolster counselors' sense of efficacy. Some examples may include structured peer support networks, online mentoring relationships, and regular skill-building workshops, which can help rural counselors feel more valued and professionally connected despite resource limitations. These interventions should be prioritized in underserved regions to address social justice concerns, ensuring that rural practitioners have equitable access to the same opportunities and supports available to their urban counterparts.

Mental health agencies could also incorporate routine monitoring of counselor well-being using validated instruments such as the MBI-HSS alongside broader wellness measures. Regular assessments make it possible to identify early signs of burnout, track trends over time, and implement timely interventions before issues escalate. This approach builds on the study's COVID-19 context by creating infrastructure that prepares

agencies to respond quickly during future crises, which may place disproportionate strain on rural providers.

Beyond organizational actions, systemic policy change is critical. Policymakers could advocate for sustained and increased funding for rural mental health centers, with a focus on expanding access to high-quality supervision, continuing education, and cross-agency collaboration. Investments in broadband infrastructure, telehealth platforms, and crisis-response training could further reduce professional isolation and expand service capacity in rural areas. Funding should also support initiatives that foster interdisciplinary teamwork, enabling counselors to collaborate with other healthcare providers to meet complex community needs.

To directly integrate social justice principles, agencies and policymakers could implement equity audits to identify and address disparities in counselor support between rural and urban areas. These audits could inform the allocation of resources and training to the areas of greatest need. Additionally, cultural competency and anti-bias training could be embedded into professional development for counselors, ensuring that support structures not only address burnout but also equip practitioners to serve increasingly diverse rural populations with sensitivity and effectiveness.

Ultimately, professional associations can play a pivotal role by developing national guidelines for counselor support programs, promoting best practices for reducing burnout, and facilitating knowledge sharing across rural and urban settings. This multi-level strategy, combining organizational interventions, systematic monitoring, policy advocacy, professional collaboration, and equity-focused initiatives, has the potential to

not only reduce burnout risk but also improve counselor retention, elevate service quality, and ultimately enhance mental health care outcomes in underserved communities.

Implications

The findings of this study suggest several practical and policy-level actions to support mental health counselors. This is particularly needed in rural areas where PA scores were lower. These results indicate that targeted strategies are necessary to address both individual-level and systemic contributors to burnout while also advancing social justice in underserved communities.

First, organizations could implement targeted training programs designed to strengthen counselors' sense of professional accomplishment. Structured peer support groups, online mentoring opportunities, and access to specialized professional development can help rural counselors feel valued despite resource limitations. Such programs could be prioritized in underserved areas, ensuring equitable access to the same quality of support and development opportunities available to urban counselors.

Second, mental health agencies could adopt regular monitoring of burnout and well-being using tools such as the MBI-HSS in combination with validated wellness measures. This would allow early identification of burnout risk and provide timely interventions before symptoms escalate. Integrating well-being monitoring into routine organizational practice reflects a proactive stance toward counselor health, especially important in the context of crisis response scenarios like the COVID-19 pandemic. By establishing such systems, agencies can prepare for future emergencies that may disproportionately affect rural counselors.

Third, policymakers should advocate for increased funding allocations to rural mental health centers to enhance access to supervision, continuing education, and collaborative networks. Investments in technological infrastructure, such as broadband expansion, could support tele-supervision and virtual collaboration, and mitigate geographic isolation and improving the distribution of expertise.

From a social justice perspective, the aforementioned suggestions directly address structural inequities by improving the professional conditions of rural counselors and, in turn, enhancing client care in underserved areas. Social justice-oriented interventions could include state or federal funding earmarked for culturally competent training, expansion of mental health services in marginalized rural communities, and the development of policies that ensure equitable distribution of resources regardless of geography. Such efforts align with the ethical responsibility of the counseling profession to promote fairness, dismantle systemic barriers, and foster equitable mental health outcomes for all populations.

Conclusion

This study examined burnout among rural and urban mental health counselors during the COVID-19 pandemic, with a focus on the three subscales of the MBI-HSS: EE, DP, and PA. The only statistically significant difference found between rural and urban counselors was in PA, with urban counselors reporting higher scores. Although the effect size was small, the finding suggests that geographic location plays a measurable role in shaping counselors' perceptions of professional efficacy.

While EE and DP did not differ significantly between groups, the low PA scores across both rural and urban counselors highlight a broader concern: diminished perceptions of professional accomplishment may be widespread in the counseling field, particularly in high-stress contexts such as the COVID-19 pandemic. This underscores the importance of both individual and organizational protective factors, such as resilience, access to supportive supervision, and professional development, in buffering against burnout.

The findings of this study support the view that burnout is shaped by a combination of personal and systemic influences. Urban counselors may benefit from more abundant institutional resources, while rural counselors often face structural challenges such as reduced accessibility, fewer specialty services, and workforce shortages. These inequities not only influence counselor well-being but can also affect client outcomes, making them critical targets for intervention.

Future-oriented strategies should therefore balance individual resilience-building with systemic change. This includes expanding funding for rural mental health services, improving access to training and supervision, and implementing organization-wide wellness monitoring. From a social justice standpoint, these interventions are not simply operational improvements—they are ethical imperatives that ensure mental health professionals in all communities have the support they need to thrive, which in turn promotes equitable care for clients. By integrating these findings into policy, practice, and training, the profession can move toward a more sustainable and equitable mental health workforce. Such changes may help preserve counselor well-being, enhance

retention, and ultimately improve mental health outcomes in both rural and urban settings. While the higher PA scores among urban counselors aligned with the original hypothesis regarding resource advantages, the lack of significant differences in EE and DP was unexpected, suggesting that pandemic-related factors and individual resilience may have equalized burnout risk across settings.

The results of this study not only add to the growing body of research on counselor burnout but also emphasizes the urgent need for interventions that integrate both personal and systemic solutions. By acknowledging the complex interplay between individual resilience, resource access, and geographic context, these findings offer a clear roadmap for addressing professional well-being in a way that advances social justice and equity in mental health care. Implementing targeted supports, equitable funding, and ongoing monitoring will be essential to building a workforce that is both resilient and capable of delivering high-quality services to all communities, regardless of location.

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Appendix A: Demographic Questionnaire

Please respond to the following questions.

1. Age:

2. Gender:

A. Male

B. Female

C. Non-binary/Third Gender

3. Race:

A. White

B. Hispanic or Latino or Spanish Origin of any race

C. Black or African American

D. Native Hawaiian or Other Pacific Islander

E. Asian

F. American Indian or Alaskan Native

G. Mixed

H. Other

4. Marital Status

A. Single

B. Married

C. Widowed

D. Separated

E. Divorced

F. Partnered

5. Employment Status

A. Employed, working full-time

B. Employed, working part-time

C. Unemployed, looking for work

D. Unemployed, not looking for work

E. Retired

6. Highest Level of Education

A. Master's Degree (such as M.A., M.S.)

B. Doctorate (such as Ph.D., Ed.D., MD)

7. Years of Experience

A. 0-1 year

B. 1-3 years

C. 3-5 years

D. 5-7 years

E. 7-9 years

F. 10-20 years

G. More than 20 years

8. Type of License

A. LPC

B. LPCC

C. Other _____

9. Years of Licensure

- A. 0-1 year
- B. 1-3 years
- C. 3-5 years
- D. 5-7 years
- E. 7-9 years
- F. 10-20 years

10. Geographical Location of Practice

- A. Rural (for the purpose of this study a rural location is defined as towns, villages, and municipalities that are located at least 60 miles away from urban areas and have a population of 10,000 or less.)
- B. Urban (for the purpose of this study and urban location will be defined as a geographical area that consists of a central city or two with a population of at least 50,000 residents)

Appendix B: Request for Participants

Hello Colleagues,

My name is Pietro (Pete) Martucci and I am a doctoral candidate at Walden University. To fulfill the requirements for the doctoral dissertation, I am conducting a study called “*A Comparative Analysis of Rural and Urban Mental Health Counselors’ Burnout Levels During the COVID-19 Pandemic*” that will help me better understand the relationship between geographical location, resources, resiliency, and burnout among mental health counselors during the COVID-19 Pandemic. For this study, you are invited to participate in an anonymous questionnaire on resiliency and burnout.

About the study:

- One demographic questionnaire and two voluntary surveys, the entire process should take no longer than 5-7 minutes to complete.
- To protect your privacy, the questionnaire will be anonymous
- You can withdraw at any time
- This study has been approved by the Walden University IRB # 09-13-24-0450339

Participants must meet the following requirements:

- Doctoral or Master level independently licensed mental health counselor
- Practice in either a rural or urban location
- Practiced during the COVID-19 Pandemic, time period of May 1, 2020 through April 1, 2021

To confidentially participate, please click the following link here:

[Invitation to COVID-19 Burnout Study](#)

Thank you in advance,
Pietro Martucci, M.S., LPCC
Doctoral Candidate

Dissertation Chair: Dr. Suzie Dukic

Appendix C: MBI-HSS Online Survey License

For use by Pietro Martucci only. Received from Mind Garden, Inc. on July 28, 2024

Permission Letter

www.mindgarden.com

To Whom It May Concern,

The above-named person has made a license purchase from Mind Garden, Inc. and has permission to administer the following copyrighted instrument up to that quantity purchased:

Maslach Burnout Inventory forms: Human Services Survey, Human Services Survey for Medical Personnel, Educators Survey, General Survey, or General Survey for Students.

The license holder has permission to administer the complete instrument in their research, however, only three sample items from this instrument as specified below may be included in the research write-up, thesis, or dissertation. Any other use must receive prior written permission from Mind Garden. The entire instrument form may not be included or reproduced at any time in any other published material.

Citation of the instrument must include the applicable copyright statement listed below. Sample Items:

MBI - Human Services Survey - MBI-HSS:

I feel emotionally drained from my work.

I have accomplished many worthwhile things in this job. I don't really care what happens to some recipients.

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MBI - Human Services Survey for Medical Personnel - MBI-HSS (MP): I feel emotionally drained from my work.

I have accomplished many worthwhile things in this job.
I don't really care what happens to some patients.

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MBI - Educators Survey - MBI-ES:

I feel emotionally drained from my work.

I have accomplished many worthwhile things in this job. I don't really care what happens to some students.

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Please understand that disclosing more than we have authorized will compromise the integrity and value of the test.

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MBI - General Survey - MBI-GS:

I feel emotionally drained from my work. In my opinion, I am good at my job.

I doubt the significance of my work.

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MBI - General Survey for Students - MBI-GS (S): I feel emotionally drained by my studies.

In my opinion, I am a good student.

I doubt the significance of my studies.

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Sincerely,

Robert Most
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