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Factors Contributing to Burnout Levels Among Public Sector Rehabilitation Counselors

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MS, Southern University and A&M College, Baton Rouge, 2007

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Dissertation Submitted in Partial Fulfillment of the

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Abstract

Burnout has led to turnover and poor counselor performance within public sector rehabilitation. Scholarly literature on burnout among mental health counselors and school counselors are abundant. However, few researchers have compiled studies to evaluate burnout among rehabilitation counselors. No research could be found that examined the relationships among job demand, control, support, and burnout among public sector rehabilitation counselors. The Job Demand Control- Support (JDC-S) model indicates that stress from work is developed based on work demands, perceptions of control, and the perceived support that is received. The purpose of this research study was to determine the extent of the prediction, if any, between burnout and job demand, job control, and job support for public sector rehabilitation counselors. This study examined the following research question through a multiple linear regression: Job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) predicts burnout (as measured by the Maslach Burnout Inventory) among public sector rehabilitation counselors. Instruments used in the study included the Job Content Questionnaire and the Maslach Burnout Inventory. An electronic questionnaire was sent to 1,000 certified rehabilitation counselors throughout the United States;197 were returned. The results of this study suggest that there is a likelihood of a lower risk of stress because of high autonomy on the job. Moreover, there was a significant prediction between burnout (as described by emotional exhaustion, depersonalization, and personal accomplishment) to job demand, job control, and job support. Results of the study may contribute to social change through increasing the wellness of counselors within the public rehabilitation counseling sector, which, in turn, could lead to improvement in the quality of services for clients.

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Dedication

There is an African Proverb that states, “It takes village to raise a child.” I dedicate this dissertation to my village: Frances Jackson (my mother), Anthony Lloyd, Sr. (my dad), Edward and Minnie Jackson (my grandparents), Kimberly and Melvin Jackson (my aunt and uncle), Anthony Lloyd, Jr. (my brother), and Mia and Madison Jackson (my two favorite little cousins).

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When I walked across the stage at my high school graduation, the words I chose to be read as I crossed the stage were “Trust in the Lord, with all thine heart, lean not to thy own understanding, in all thy ways acknowledge Him and He will direct your path!” Thank you, God, for directing my path and teaching me how to trust you during this doctoral journey.

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Chapter 1: Introduction to the Study

Introduction

In the 1970s, burnout became a vital concept in the psychological literature (Freudenberger, 1974). The topic of burnout has inspired research on job stress in various areas of work within the helping field. Now, burnout is usually defined as a syndrome that is caused by depersonalization, lack of personal accomplishments, and emotional exhaustion (Blau, Tatum, & Goldberg, 2013; Lanham, Rye, Rimsky, & Weill, 2012; Lee, Cho, Kissinger, & Ogle, 2010; O'Sullivan & Bates, 2014). It is often experienced in jobs that are demanding and is prevalent within the helping professions (Romani & Ashkar, 2014; Schaufeli, Leiter, & Maslach, 2009). Research has identified burnout in various professional fields including teachers, human service workers, medical and health care providers, and professional counselors (Chang, 2009; Cheung & Chow, 2011; Edwards & Dirette, 2010; Gingras, de Jonge, & Purdy, 2010; Lee, 2010; Thomas, Kohli, & Choi, 2014; Wilczek-Ruzyczka, 2011).

A *hidden handicap* of rehabilitation counselors is burnout due to the particular demands of providing services to persons with disabilities (O'Sullivan & Bates, 2014). Determining if there is a predictive quality that burnout has with job demands, job control, or job support within public sector rehabilitation counselors may help develop a course of action to help prevent it. In the United States, rehabilitation services are divided into the public and private sectors (Roessler & Rubin, 2006). Public sector rehabilitation services, also known as vocational rehabilitation services, provide various services to clients who are deemed eligible based on a program's eligibility requirements. Public sector rehabilitation counselors work with clients with disabilities through both state- and federal-level programs. Private sector rehabilitation counselors provide services that include case management, forensic rehabilitation, life care planning, and disability

management.

The findings of this research study could positively impact social change in the field of rehabilitation counseling. First, understanding the relationships among these factors could contribute directly or indirectly to decreasing burnout. This study can could suggest? Generate? further research that would outline the factors to focus on regarding burnout and vocational rehabilitation services. Second, findings could contribute to increasing the wellness of counselors within the public rehabilitation counseling sector and could lead to improvement in the quality of services provided to clients.

The following sections in this chapter give an overview of this study: Background, Problem Statement, Purpose of the Study, Research Questions, Theoretical Framework, Nature of the Study, Definitions, Assumptions, Delimitations, Limitations, and Significance.

Background

Scholarly articles related to burnout among mental health counselors and school counselors are abundant (Bardhosi, Schweinle, & Duncan, 2014; Lee et al., 2010; Lent & Schwartz, 2012; Mullen & Gutierrez, 2016; Thompson, Amatea, & Thompson, 2014; Wallace, Lee, & Lee, 2010). However, few researchers have studied burnout among rehabilitation counselors. According to Garske (2007), research in rehabilitation traditionally focuses on the client, the nature of services, and service interventions. After a thorough review, there is a gap in the literature on burnout and counselor wellness within rehabilitation counseling. Research on burnout in rehabilitation counseling is outdated with studies that were completed over 2 decades ago (O'Sullivan & Bates, 2014).

Research has shown that high demand and low control causes both psychological and physical strain (Blom, Bodin, Bergstrom, Hallsten, & Svedberg, 2013). Devereux, Hastings, and

Noone (2009) indicated that jobs that have high demand, low control, and low social support cause stress. The study was needed because burnout has been described as rehabilitation counselors' *hidden handicap* (O'Sullivan & Bates, 2014). O'Sullivan and Bates (2014) indicated that there is a significant gap in research on burnout and vocational rehabilitation counselors.

Problem Statement

Burnout has led to poor counselor performance and turnover within public sector rehabilitation (O'Sullivan & Bares, 2014). Determining if there is a predictive quality that burnout has with job demands, job control, or job support within public sector rehabilitation counselors may help develop a course of action to help prevent burnout. No research could be found in the literature that examined the relationships among job demand, control, support, and burnout among public sector rehabilitation counselors. Therefore, this research project aimed to fill a gap in the literature.

Purpose of the Study

The purpose of this research study was to determine the extent of the prediction, if any, between burnout and job demand, job control, and job support for public sector rehabilitation counselors. Instruments used in the study included the Job Content Questionnaire to measure the predictor variables (job demand, job control, and job support; Karasek & Theorell, 1990) and the Maslach Burnout Inventory (MBI) to measure the criterion variable of burnout (Maslach & Jackson, 1981).

Research Question

This study examined the following research question through a multiple linear regression: Do job demand, job control, and job support (as measured by subscales of the Karasek and

Theorell Job Content Questionnaire) predict burnout (as measured by the MBI) among public sector rehabilitation counselors?

H_0: There is no predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

H_1: There is a predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

Theoretical Framework

The theoretical framework for this study was the Karasek and Theorell (1990) Demand-Control-Support model. Karasek and Theorell developed this model, which indicates that stress from work is developed based on work demands, perceptions of control, and perceived support. The Job Demand-Control-Support (JDC-S) model has been successful in globalized industries at describing the potential causes of health problems for employers (Chen et al., 2011). Furthermore, it is one of the main theoretical models that is used to explain the relationship between job strain and the health of workers (Hoang, Corbiere, Negrini, Pham, & Reinharz, 2013). In 1979, Karasek introduced the Job Demand Control model to describe how job characteristics have an effect on the well-being of others (Karasek, 1979). Research indicated jobs that are high in demand, yet low in control and social support, have the highest risk of stress for workers (Devereux et al., 2009). Moreover, the Demand-Control-Support model is used to increase the productivity and engagement of workers.

Nature of the Study

The nature of this study was quantitative. Quantitative research methods were used to determine whether there were relationships among the variables. A multiple linear regression was used to answer the research question because this type of regression determines whether a predictive quality existed among two or more predictor variables and one criterion variable. The multiple linear regression analysis was used to examine the predictive quality of job demands, job control, and job support (predictor variables) for burnout (criterion variable). The inventories utilized in this study were a demographic survey, the Maslach Burnout Inventory-Human Service Survey (MBI-HSS), and the Job Content Questionnaire (JCQ).

The MBI is the most widely used burnout inventory and studies have provided strong evidence of reliability and validity (Lee, Lim, Yang, & Lee, 2011). The inventory measures emotional exhaustion, depersonalization, and personal accomplishment. Maslach and Jackson (1981) indicated that high scores of emotional exhaustion and depersonalization suggest the presence of burnout. In the MBI, the reliability coefficient of emotional exhaustion is reported as $r = .90$, depersonalization, $r = .79$, and personal accomplishment at $r = .71$.

As described by Chungkam, Ingre, Karasek, Westerlund, and Theorell (2013), the Karasek and Theorell Job Content Questionnaire is a 39-item assessment that has been validated through various subgroups of workers. The questionnaire measures job control, job demand, and job support. The model indicates that stress at work occurs due to an interaction between perceived work demands, perceived control, and perceived level of support (Karasek & Theorell, 1990). According to Nehzat, Huda, and Syed Tajuddin (2014), the Job Content Questionnaire has proven to be a reliable and valid instrument that assesses job stress in various occupations

and countries. In the Job Content Questionnaire, the reliability of job control is .70, psychological job demand is .72, and job support is .86 (Nehzat et al., 2014).

Definitions

Burnout: Maslach and Jackson (1981) described burnout as a state of exhaustion and depersonalization that causes a lack of professional efficacy and reduces the likelihood of personal accomplishments.

Emotional exhaustion: Emotional exhaustion is defined as feelings of fatigue (Maslach & Jackson, 1981; Morgan, deBruin, & deBruin, 2014). It is a chronic state of both emotional and physical depletion due to fatigue.

Depersonalization: Depersonalization occurs when an individual possesses a negative attitude towards work and has feelings of isolation from others on the job (Maslach & Jackson, 1981; Morgan et al., 2014).

Job demand: Job demand is the amount of activity that is required for workers to perform while at work (Devereux et al.,2009).

Job Control: Job control is related to the degree of autonomy of workers and their ability to have control over their work activity throughout the workday (Devereux et al., 2009).

Job Support: Job support is described as the socioemotional support that individuals receive from their peers and supervisors on the job (Devereux et al., 2009).

Public Rehabilitation Counseling. Public rehabilitation is a federal/ state program in every state that is designed to assist persons with disabilities meet their employment goals (Roessler & Rubin, 2006).

Private Rehabilitation Counseling. Private sector rehabilitation counseling provides services through Rehabilitation and Disability Case Management, Forensic Rehabilitation, Life Care Planning, and Social Security Vocational Expert (IARP, 2017).

Vocational Rehabilitation. The Federal/State vocational rehabilitation program authorized under the Rehabilitation Act empowers people with disabilities to maximize employment, economic self-sufficiency, independence, inclusion, and integration into society (RSA, 2014).

Vocational Rehabilitation Services. Vocational Rehabilitation Services are known as highly individualized processes that assist persons with disabilities gain and maintain employment (Gruman, Schimmel, Shugrue, Porter, Koppelman, & Robison, 2014).

Assumptions

This study involved five assumptions:

1. Participants in the study answered the questionnaire honestly.
2. Certified rehabilitation counselors in the public sector were willing to respond to the study questionnaire.
3. The study instruments were reliable and valid measures.
4. All participants in the study were capable of completing the survey.
5. Participants in the study worked in the public sector of rehabilitation counseling.

Delimitations

This study had several delimitations. The first was regarding geographical locations of participants. State vocational rehabilitation service is a shared federal-state program that exists within the 50 states and the possessions, commonwealths, or territories of the United States.

These services are delivered through agencies located in cities and regions within each state or political entity (RSA, 2014; Stapleton, Honeycutt, & Schechter, 2010).

Participants from this study were selected from a directory of rehabilitation counselors who were certified in rehabilitation; therefore, not all rehabilitation counselors were eligible to participate in the study because they may not have been certified, or they may not have been listed in the directory.

This study included current counselors of public sector rehabilitation services. Public sector rehabilitation counselors are known to have larger caseload sizes, which can lead to stress and burnout, ineffective counseling, and increased counselor turnover (Klerplec, Phillips, & Kosclulek, 2010). Therefore, this study examined burnout among a specific population of rehabilitation counselors and did not include individuals who had not worked in public sector rehabilitation counseling.

In addition, this study relied upon participants on a strictly volunteer basis. The sample was collected through criterion- based sampling. No one who participated in the study was compensated. Only those who were clearly motivated participated in the study by completing and submitting a survey form.

Limitations

There were several limitations within this study. One limitation was that the collected data were self-reported by participants. Self-reported surveys allow participants to describe their feelings (Mertens, 2009), but participants sometimes reveal only the information they want the researcher to know (Mertens, 2009). Furthermore, self-reported surveys may include individuals who exaggerate or underreport their feelings (Mertens, 2009).

Another limitation of this study was that all participants were certified rehabilitation counselors. Thus, the results of this study cannot be generalized to all public-sector rehabilitation counselors, but only to those who are certified.

Finally, this study cannot be generalized to rehabilitation counselors employed in other settings because the participants included only those who work in public sector rehabilitation.

Significance of the Study

This study was significant because the findings could positively impact social change in the field of rehabilitation counseling. First, understanding relationships among factors related to counselor burnout could lead to information that could contribute directly or indirectly to decreasing burnout. The results of this study could stimulate further research that could identify factors to focus on to prevent burnout among vocational rehabilitation counselors. In addition, the findings from this study could contribute to increasing the wellness of counselors within the public rehabilitation counseling sector, which, in turn, could lead to positive change in the quality of services for clients.

Summary

The chapter has given an overview of this study's background, problem statement, purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, delimitations, limitations, significance, and summary. Determining if there is a predictive quality that burnout has with job demands, job control, or job support within public sector rehabilitation counselors may help develop a course of action to help prevent burnout. No research could be found in the literature that examined the relationships among job demand, control, support, and burnout among public sector rehabilitation counselors. Therefore, this

research project aimed to fill a gap in the literature. In Chapter 2, I present a review of the literature.

Chapter 2: Literature Review

Introduction

A *hidden handicap* of rehabilitation counselors is burnout due to the particular demands of providing services to persons with disabilities (O'Sullivan & Bates, 2014). Burnout has led to turnover and poor counselor performance within public sector rehabilitation (O'Sullivan & Bares, 2014). Determining if there is a predictive quality of burnout with respect to job demands, job control, and job support within public sector rehabilitation counselors may help develop a course of action that could help prevent burnout. No research could be found that examined the relationships among job demand, control, support, and burnout in public sector rehabilitation counselors. Therefore, this research project filled a gap in the literature.

The purpose of this research study was to determine levels of burnout of rehabilitation counselors employed in the public sector in relation to job demand, control, and support. Instruments used in the study included the Job Content Questionnaire (Karasek & Theorell, 1990) and the MBI (Maslach & Jackson, 1981). The findings could positively impact social change in the field of rehabilitation counseling. First, understanding relationships among these factors could lead to information that could contribute directly or indirectly to decreasing burnout. Second, findings could contribute to increasing the wellness of counselors within the public rehabilitation counseling sector and could lead to improvement in the quality of services for clients.

Synopsis of Current Literature

In the following sections of this chapter, I provide the literature search strategy, the theoretical framework, the literature review, and a conclusion.

Literature Search Strategy

I developed the literature review using the following multidisciplinary databases: Google Books, Google Scholar, and EBSCOhost. The results included journal articles, books, and dissertations. I used the following keywords, in various combinations, in the searches: *burnout, counselor, rehabilitation counselor, vocational rehabilitation services, disability, disability rights, models of disability, Maslach Burnout Inventory, and Job Content Questionnaire.* The searches covered the following years: 2009-2019.

Theoretical Framework

Work Stress Models

According to Devereux, Hastings, and Noone (2009), there are various working stress models which include person-environment fit, cognitive behavioral, equity theory, and Demand-Control-Support. Within the person-environment fit theory, stress is derived from the degree of fit between workers and their environments. When individual characteristics, either biological or psychological, match with the environmental characteristics, workers are more satisfied on the job. The cognitive behavioral approach indicates a stressor is based on the worker's perception and there is no single thing that causes stress. As it relates to the equity theory, distress is caused when there is an inequitable relationship between the worker and the organization. Moreover, when workers feel the job demand is not equitably shared among workers, they view the work environment as unfair, which causes them to lack motivation.

Job Demand-Control-Support Model

The work stress model that will be used as the theoretical framework for this research is the JDC-S model. This model indicates stress from work is developed based on work demands, perceptions of control, and perceived support received. The JDC-S model has been successful in

globalized industries describing the potential causes of health problems for employers (Chen et al., 2011). Furthermore, the JDC-S is the main theoretical model utilized to explain the relationship between job strain and the health of workers (Hoang et al., 2013). The JDC-S was utilized in this study because the study examines whether job demand, job control, and job support predict burnout.

In 1979, Robert Karasek introduced the job demand-control model to describe how job characteristics influence the well-being of others (Karasek, 1979). He believed that both job demand and job control were vital influences of the health and well-being of workers. Later support was added to the model as an important characteristic needed in the work environment and it became the JDC-S model. The JDC-S model explains the mental strain that occurs in the workplace (Hausser, Mojzisch, Niesel, & Schulz-Hardt, 2010). Job environment models play a vital role in the process of burnout (Maslach et al., 2001; Wallace et al., 2010). In addition, job stress frameworks provide understanding regarding why burnout occurs (Wallace et al., 2010).

The JDC-S model is a multi-dimensional model that supports the idea that stress at work occurs due to an interaction between perceived work demands, perceived control, and the perceived level of support by workers (Chen, et al., 2011; Karasek & Theorell, 1990). The JDC-S model captures only the chronic stress of workload. It does not assess other chronic work stress, such as home-work conflict, job security, or other daily stresses (Armon, 2009).

Job demand. Job demand is based upon the amount of activity required for the worker to perform while at work. It describes the psychological demand related to the competitive nature of working with coworkers, work pace, the intensity, and the skills required on the job (Chen, et al., 2011). Role conflict is also analyzed within job demand (Hausser, Mojzisch, Niesel, & Shulz-Hardt, 2010).

Job control. Job control is based on the autonomy of workers and their ability to have control over their work activity throughout the workday. Furthermore, job control describes workers' ability to use their creativity (Chen, et al., 2011). It is the freedom to determine how to meet the job demand while at work (Armon, Shmuel, & Shirom, 2012).

Job support. Support is described as the socioemotional support individuals receive from their peers and supervisors on the job. Karasek and Theorell (1990) suggested socioemotional support on the job can promote good health, be an active coping mechanism, and help with the person's sense of identity. Furthermore, workers who felt that they could not consult with their supervisor about personal and work-related issues had higher levels of burnout compared to those who felt they could consult with their supervisors (Devereux et al., 2009).

Literature Review

The literature review will provide information regarding the disability right movement, models of disability, rehabilitation field, public sector vocational rehabilitation services, burnout, Maslach Burnout Inventory, and the Job Content Questionnaire.

Disability Rights Movement

In America, individuals who cope with a disability have had a long struggle for equality (Shapiro, 1993). In the 1800s, persons with disabilities were not considered capable of living. The Association for the Study of Higher Education (ASHE) Higher Education Report (2013) indicated society viewed persons with disabilities as incapable of thinking, learning, or achieving goals. Persons with disabilities were considered a disgrace and spent their entire lives in institutions or asylums for *purification*, in special schools, or hidden in family basements or attics (Fleischer & Zames, 2011; Pelka, 2012). Persons with disabilities were viewed as being abnormal and were forced to undergo sterilization. According to Pelka (2012), having a

disability was considered divine judgment against the person's family and community. Furthermore, persons who coped with disabilities were hidden from society, unless being used for entertainment, such in as circus acts. In the 1860s change began to emerge as Abraham Lincoln established funding for Gallaudet University in Washington, DC, for students who were deaf and hard of hearing (ASHE Higher Education Report, 2013). Gallaudet University is now a federally chartered private school for advanced education for individuals who cope with a hearing impairment.

Early 1900s. Americans soon become aware of the ability of many persons with disabilities (Fleischer & Zames, 2011). The advancement of medication helped many soldiers survive the war; however, numerous soldiers were injured (Fleischer & Zames, 2011; Pelka, 2012). After World War I, due to the vast number of veterans who returned home disabled, persons with disabilities began to be viewed differently. With the return of so many injured veterans who fought for the country, the thought that a person's disability was a burden decreased. Many soldiers could not return to their previous jobs they had performed before the war.

The Smith-Sears Veteran's Vocational Rehabilitation Act of 1918, also known as the Soldier's Rehabilitation Act of 1918, created a vocational rehabilitation program for disabled veterans due to the need for support that spanned beyond financial assistance (Pelka, 1997). Under the act, disabled veterans received training to learn new skills in jobs that matched their current barriers and ability. In 1920, the Smith-Fess Act helped in the evolution of the field of rehabilitation into assisting all persons with disabilities, not just disabled veterans (Petrick, 2015). The purpose of the act was to assist persons with disabilities to obtain and maintain employment through vocational education programs.

By the 1930s there was a great deal of advancement in technology, which assisted persons with disabilities, such as the production of wheelchairs (Fleischer & Zames, 2011). Barriers were decreased due to advancements in technology and medicine. These new advancements allowed persons with disabilities to become self-sufficient. In 1936, the Randolph-Sheppard Act was established allowing individuals who were blind to have vending precedence on federal property (Bybee & Cavenaugh, 2014). The purpose of the program was to assist persons who were blind with employment and self-support through the operation of vending facilities. These vending facilities were found in cafeterias, snack bars, and automatic vending machines.

Moreover, in 1938, the Wagner O' Day Act mandated the federal government to purchase products from facilities for persons who were blind. In 1943, the Barden-LaFollete Act (PL-113) allowed rehabilitation services to be expanded to assist those who coped with mental retardation and mental illness (Lee, Chronister, Tsang, Ingraham, & Oulvey, 2005). The act was the first federal-state rehabilitation support for persons who are blind. The act created a separate state plan for rehabilitation services for person who were blind.

Mid-1900s. Around the 1950s, persons with disabilities were still unable to experience basic American rights; which included access to buildings, bathrooms, telephones, and stores (Fleischer & Zames, 2011). Persons with physical limitations were unintentionally denied access to buildings and public transportation, which created impediments to finding employment, obtaining education, and taking care of personal business. However, by the 1960s persons with disabilities joined forces with minority groups and demanded their civil rights (Fleischer & Zames, 2011). During the fight for civil rights, the Javits-Wagner-O-Day Act of 1971 was passed that required all federal agencies to purchase specific supplies and services from non-profit

agencies that employed persons with significant disabilities.

In 1973, the Rehabilitation Act passed that gave civil rights to persons with disabilities and redirected vocational rehabilitation programs to expand their services to persons with severe disabilities (ASHE Higher Education Report, 2013). With the Rehabilitation Act of 1973 in effect, persons with disabilities could gain access to public buildings and transportation, allowing them to increase their self-sufficiency and independence. Additionally, it prohibited discrimination among qualified individuals due to their disability.

Nevertheless, despite steps in the right direction, persons with disabilities still faced discrimination. Many refused to be silent and fought for the civil rights of persons with disabilities (Shapiro, 1993). Persons with disabilities soon began to stand up for their rights and advocate for change. The Education for All Handicapped Children Act of 1975 passed and enabled all public schools to provide equal access to education and one free meal a day for students with disabilities (Jones, 2015). The act required that children with disabilities be evaluated, have an educational plan with parental direction of the child's education, and have an educational experience closely related to individuals without disabilities.

Late 1900s. By the 1980s disability activist began to lobby for one broad civil rights statute because persons with disabilities wanted the same provisions included in the Civil Rights Act of 1964, which prohibited discrimination against race, religion, nationality, origin, or gender (Fleischer & Zames, 2011). Disability was not included, therefore, activist fought and lobbied for equal rights for 10 years. In 1984, the Voting Accessibility for the Elderly and Handicapped Act was passed requiring polling places to be physically accessible for federal elections and when accessibility was unavailable other methods of voting must be available (Congressional Digest, 1990). In addition, the Fair Housing Act of 1988 was also amended to add disability (Mandelker,

2011). Individuals with disabilities cannot be discriminated in the sale and rental of housing. The Fair Housing Act of 1988 was amended due to the deinstitutionalization of disability groups. There was a drastic decrease in custodial facilities, which led to a need for adequate private housing for persons with disabilities.

In 1990, their persistence paid off and the American's with Disability Act (ADA) was passed, which assured persons with disabilities would gain equal treatment and access to employment opportunities, independent living, public accommodations, and economic self-sufficiency (ASHE Higher Education Report, 2013). The ADA is the legislation that finally brought down the barriers of exclusion of persons with disabilities. Title I of the ADA addresses the equal employment opportunity for persons with disabilities. Within the title, employers must provide reasonable accommodations for employers to assist in reducing the barriers of employment. Persons with disabilities must be given the same consideration for employment as persons without disabilities if they qualify for an employment opportunity.

Title II describes the rights for persons with disabilities to have access to public services. Therefore, individuals with disabilities have the rights to access state parks, public transportation, schools and universities, and all services provided by state and local government. Moreover, Title II protects individuals with disabilities from being denied access to higher education. Title III of the ADA provides persons with disabilities public accommodations by private entities, which included places such as restaurants, hotels, retail stores, and movies. Title IV of the ADA addresses telecommunication for individuals who cope with a speech or hearing impairment. This title requires phone companies to provide intrastate and interstate telephone relay services in every state for persons with communication disabilities. Title V of the ADA addresses many miscellaneous provisions that include protection from entity retaliation against

persons with disabilities for suing for legal rights and accommodations. The ADA has addressed many areas of discrimination and exclusion. The ADA has become one of the most vital pieces of legislation for persons with disabilities (ASHE Higher Education Report, 2013).

In addition, in the 1990s, the Education for all Handicapped Children Act of 1975 was renamed the Individuals with Disability Education Act (IDEA). The IDEA required that all children with disabilities receive free and appropriate education and education planned through an Individualized Education Program (IEP). The purpose of the IEP was to set goals for a child during the school year with professional, parent, and student involvement to ensure educational success. According to Spiel, Evans, and Langberg (2014), federal regulations indicated all services of a child's IEP must be need based and individualized to the needs of the child based upon the child's disability.

In 1998, individuals with disabilities were empowered to maximize employment, economic self-sufficiency, independence, and inclusion within an integrated society by congress through the Rehabilitation Act Amendments of 1998 (Bates-Harris, 2012). Though empowered by legislation, persons with disabilities still have the highest rates of unemployment in the United States (Gruman, et al., 2014). According to the Bureau of Labor and Statistics (2015), in 2014, 17.1 % of persons with disabilities were employed. The unemployment rates are often due to persons with disabilities being afraid of losing their social security benefits and or healthcare.

Therefore, the Workforce Investment Act of 1998 placed an emphasis on training and workforce development for adults who were economically disadvantaged (Mitchell & Zampitella- Freese, 2003). The program emphasized long term vocational training that assisted persons with disabilities in earning a skill towards employment. The Ticket to Work Program was established in 1999 (Kiernan & Hoff, 2010). The purpose of the Ticket to Work statute was

to encourage persons with disabilities to participate in job placement activities in Vocational Rehabilitation Service and other agencies, with eliminating the possibility of them losing their health care coverage. Furthermore, the program's aim was to move persons with disabilities from welfare to the labor market (Harris, Owen, Jones, & Caldwell, 2013). In 2001, the New Freedom Initiative ensured persons with disabilities could learn and develop skills to engage in productive work within an integrated setting (Bates-Harris, 2012). Additionally, it promotes the full participation of people with disabilities in society. Legislation continues to be created to help individuals who cope with disabilities.

The Workforce Innovation Opportunity Act of 2014 was established to take over the Workforce Investment Act (McClanahan & Sligar, 2015). This act looks at the future of individuals with disabilities to help them with economic growth and development. Moreover, the act places a special emphasis on transition aged students with disabilities and the need to prepare them for the world of work through pre-employment services.

Today, persons with disabilities, based on the ADA, have greater access to equal rights as persons without disabilities. They can attend school, find employment, and live independently. According to the United States Census Bureau (2010), 19.5 million working age persons (16–64 years old) coped with a disability. Moreover, among working age adults, 34.7% of persons with disabilities are employed (U.S. Census Bureau, 2010). Despite their limitations, Americans with disabilities are able to complete daily life activities with the assistance of technology and or medical advancement.

Models of Disability

The disability movement enhanced the debate around the models of disability due to the need for strategies to determine how best to meet the needs of persons with disabilities.

According to Tappenden and Chilcott (2014), the purpose of models is to represent reality and support decision making processes. Rehabilitation professionals often use models of disability to guide their way of practice (Smart, 2009). Models of disability reflect the views of those who developed them and do not include everything. Also, there is not one model that encompasses every aspect of disability due to its complex nature. Models include assumptions which are capable of being modified (Smart, 2009; Tappenden & Chilcott, 2014).

There are several models of disability that are utilized to define disability and treatment, which include the medical model, social model, biomedical model, biopsychosocial model, and rehabilitation model. The models of disability are useful in helping society understand issues related to disability. In addition, models of disability helped to define disability, structure research in rehabilitation, influence professional practice, and guide legislation (Smart, 2009). The model that will be discussed below is the rehabilitation model of disability.

The purpose of the rehabilitation model is to help persons with disabilities reach their optimal level of independence. Furthermore, the rehabilitation model places an emphasis on the involvement of persons with disabilities with their treatment and with their treatment professionals. The rehabilitation model of disability indicates that it is the responsibility of disabled persons to overcome their problems with the assistance of rehabilitation services. Also, it is like the medical model because it posits that disease can be cured and that care and treatment should be determined by professionals. However, the distinction is that the rehabilitation model not only considers the need for medical treatment, but it also recognizes the need for assistance from a team of professionals. Cameron (2010) indicated that the rehabilitation model is a goal oriented and time limited process. Within the rehabilitation model, it is important for individuals

with disabilities to be provided with accommodations and or equipment that allow them to adjust or readjust to living independently.

Rehabilitation Field

Rehabilitation services are designed according to the rehabilitation model (Cameron, 2010). The mission of rehabilitation counseling is to enhance the quality of life for persons with disabilities and assist persons with disabilities to live as independently as possible (Roessler & Rubin, 2006). Rehabilitation counselors provide case management, vocational assessments, vocational counseling, disability counseling, and job placement services to persons with disabilities. Rehabilitation counselors assist persons with various disabilities, which include physical, mental, developmental, cognitive, and emotional (O'Sullivan & Bates, 2014). In addition, rehabilitation counselors help persons with disabilities manage the effects of disability on employment and help them learn how to live as independently as possible.

Rehabilitation counselors work as consultants to help employers and businesses understand the laws, abilities, resources, and needs of persons with disabilities. They help develop treatment plans with clients based on their goals, abilities, strengths, and limitations. In addition, rehabilitation counselors consult with medical, psychological, and other professionals who collaborate to assist persons with disabilities address their issues and live independently. Rehabilitation counselors are known as advocates for persons with disabilities and help them locate resources, monitor their progress, and arrange services for them to obtain within the community. Throughout the process, rehabilitation counselors counsel and guide individuals with disabilities to live as independently as possible.

Rehabilitation counselors receive specialized education to work with individuals with disabilities (CRCC, 2015). Rehabilitation counselors are the only professional counselors whose

core curriculum focuses on working with individuals with disabilities to achieve their personal, career, and independent living goals (CRCC, 2015). Roessler and Rubin (2006) indicated that 43% of rehabilitation counselors graduate from a Council of Rehabilitation accredited master's degree program in rehabilitation counseling.

Rehabilitation counselors are certified through the Commission on Rehabilitation Counselor Certification (CRCC). Being a certified rehabilitation counselor (CRC) indicates that a counselor has a high level of specialized education and training within the field (CRCC, 2015). Certified rehabilitation counselors have a thorough understanding of key competency standards, adhere to the Code of Professional Ethics for Rehabilitation Counselors, and have a commitment to continuing education. In some jurisdictions, to work as a rehabilitation counselor, an individual does not have to be a CRC or hold professional licensure. According to McCarthy (2014), many public vocational rehabilitation counselors do not have a CRC or a counseling license.

Likewise, rehabilitation counselors are not included in the professional counselor licensure that other counselors must obtain. Due to a lack of clinical supervision, rehabilitation counselors lack the opportunity to enhance or practice their counseling skills. Furthermore, with many rehabilitation counselors not having a professional licensure or certification in rehabilitation counseling, there is no mandate for participation in continuing education.

In the United States, rehabilitation services are divided into two primary sectors: the public sector and private sector (Roessler & Rubin, 2006). The rehabilitation field assists persons with disabilities in a wide variety of services provided by individuals that include vocational rehabilitation counselors, vocational experts, vocational evaluators, and supported employment specialists. Every state has a public-sector rehabilitation agency designed to assist persons with

disabilities gain independence through employment. Lane, Shaw, Young, and Bourgeois (2012) reported that historically rehabilitation counselors worked within public-sector agencies, with the majority working for the state or federal vocational rehabilitation agencies.

In the 1970s, there was a change with the expansion of rehabilitation counseling, which led to private sector rehabilitation. Now, public sector rehabilitation counselors are finding themselves being outsourced to one-stop career centers as rehabilitation consultants and disability navigators (Lane et al., 2012). The purpose for private sector rehabilitation is to provide speedy and cost-effective services to help reduce workers compensation payments and long-term disability payouts. Private sector rehabilitation counselors provide services through disability litigation actions, programs for disabled veterans, federal and state workers compensation, medical insurance, and federal and state disability programs. Private sector rehabilitation counselors work for proprietary agencies and assist in similar capacities to private rehabilitation counselors. There is an increase in rehabilitation counselors within the private sector working in medical settings, transition programs, and disability management organizations (Zanskas & Strohmer, 2011).

Private sector. In the 1970s, private sector rehabilitation services were developed to close the service gap between persons with less severe disabilities and severe disabilities (Grubbs, Cassell & Mulkey, 2006). The rehabilitation counselor's purpose was to help save employers' money and time while resolving a Workers Compensation claim. There was a need to provide disability management to injured workers for them to return to work quicker. Employers and insurance companies needed a way to cut the cost of compensation during the rehabilitation process. Furthermore, when clients were provided services in public sector rehabilitation, they were being provided long term training programs, which caused insurance

companies to have to compensate clients until they completed training programs. Therefore, the purpose of many private sector rehabilitation counselors was to help the injured person receive services and return to work.

Private sector rehabilitation counselors provide services that include case management, forensic evaluations and testimony, life care planning, and disability management. Private sector rehabilitation counselors work in case management in various settings such as major business corporations, health insurance companies, and attorneys' offices. Rehabilitation counselors who work within forensics help provide expert testimony in litigation regarding workers' compensation or personal injury cases. Providing expert testimony requires private sector rehabilitation counselors to have knowledge of the law. Those who provide disability management services work with injured workers to help them throughout their recovery. They facilitate treatment to help with the return to work process and to reduce the length of time an individual is off work.

Rehabilitation counselors provide life care planning services. They assist clients to develop an organized plan that describes the needs of the individual currently and in the future, which includes the financial cost and needs of the injured worker. According to Robinson (2014), life care planning is one of the newest specialties available to rehabilitation counselors. Individuals who experience catastrophic injuries or have long term chronic health problems require lifetime medical and rehabilitation needs that are outlined within a life care plan. Life care planning allows worker's compensation attorneys, hearing officers, and judges to understand the long-term financial cost of assisting injured workers.

According to Zanskas and Strohmer (2011), there has been an increase in rehabilitation counselors working as forensic or vocational experts. These rehabilitation counselors provide

services in medical settings, transition programs, disability management, and organizations. In the 1990s, private practice rehabilitation counselors began developing more training programs not related to disability. Counselors within private practice had to have a general understanding of business and employer practices, organizational development, insurance rehabilitation, program evaluation, and benefits systems. Private rehabilitation counselors sometimes contract with federal government agencies to provide their knowledge of disability to determine whether individuals are capable of going to work.

Public sector. Public sector rehabilitation services, also known as vocational rehabilitation services, provide various services to clients who are determined eligible based on a program's eligibility requirements. Public sector rehabilitation counselors work with clients with disabilities through both state and federal levels. Federal Vocational Rehabilitation programs within the Veterans Administration work only with disabled veterans. Federal-state rehabilitation counselors work with all persons with disabilities, including veterans. Zanskas and Strohmer (2011) reported that 26–30% of all master's degree rehabilitation counselors obtain employment in federal-state vocational rehabilitation programs. Public sector rehabilitation counselors assist clients to minimize their barriers to employment and maximize their opportunities. Barriers to employment are decreased through services that address psychological, vocational, social and behavioral issues (O'Sullivan & Bates, 2014). Additionally, services include, but are not limited to, psychological and vocational assessments, individual and group counseling, training, job placement, and assistive technology. Public sector rehabilitation counselors are known to work with more severe disabilities and clients.

With the assistance of rehabilitation services, persons with disabilities have entered and remained in the labor market. According to Stapleton, Honeycutt, and Schechter (2010), state

vocational rehabilitation programs are the largest provider of vocational services assisting persons with disabilities gain and maintain employment. Vocational rehabilitation services have a vital role in assisting persons with disabilities obtain and maintain competitive employment. Competitive employment means the individual can compete with persons who are non-disabled with or without accommodations. Through public sector rehabilitation services, persons who cope with cerebral palsy, traumatic brain injury, cancer, multiple sclerosis, and psychiatric disabilities have experienced positive employment outcomes (Austin & Lee, 2014). Likewise, employment helps persons with disabilities have greater economic well-being, improved emotional and physical well-being, and greater self-sufficiency (Gruman et al., 2014).

Public Sector Vocational Rehabilitation Services

Vocational rehabilitation service is a joint federal state funded program governed by the Rehabilitation Services Administration (RSA; Stapleton et al., 2010). Vocational rehabilitation agencies are funded through RSA and through state-matched funds. The Federal-State Vocational Rehabilitation program authorized under the Rehabilitation Act empowers people with disabilities to maximize employment, economic self-sufficiency, independence, inclusion and integration into society (Parker & Szymanski, 1998). RSA was established for improving program management and effectiveness of vocational rehabilitation services. RSA evaluates all programs authorized by the Rehabilitation Act of 1973 and its subsequent amendments (RSA, 2014).

RSA conducts evaluation studies regarding the impact of services based upon section 14 of the Rehabilitation Act. RSA's 911 database is information designed and used by state vocational rehabilitation agencies that are responsible for collecting data. The information is collected by state agencies across the country and archived annually (Chiu et al., 2013). The

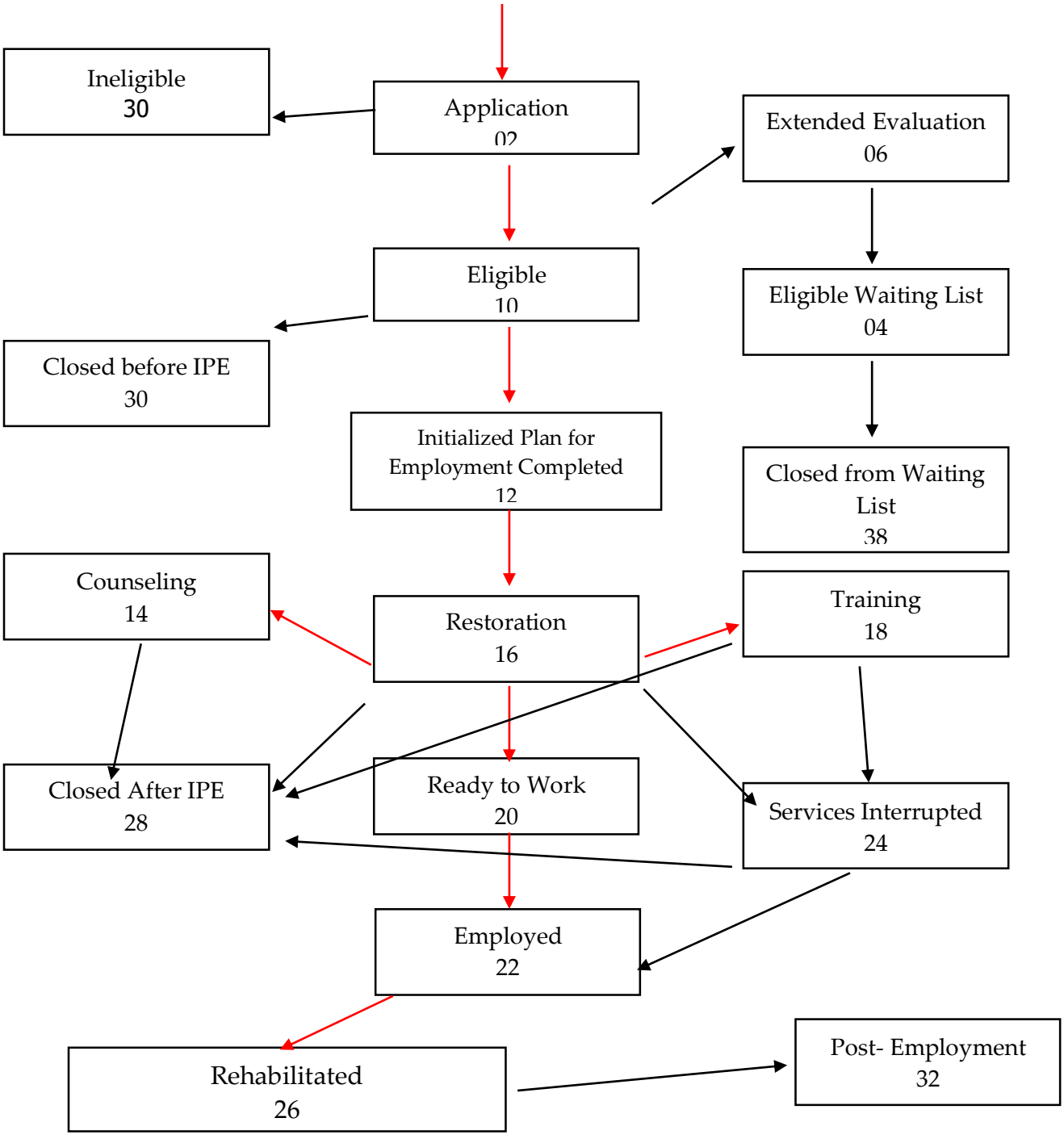
RSA 911 data contain records of demographics, disabilities served, vocational related services, and employment outcome information on all individuals that exited vocational rehabilitation programs (closed cases) in each fiscal year (Stapleton et al., 2010). In addition, RSA conducts longitudinal studies that track vocational rehabilitation participation and post vocational rehabilitation experiences for up to three years (RSA, 2014). This information is vital because it allows the public to view the work of vocational rehabilitation counselors and the multitude of client and client services that are provided on an individual basis.

According to Chiu et al. (2013), vocational rehabilitation services consistently prove effectiveness in assisting persons with disabilities gain and maintain employment. The overall employment rate for individuals with a disability who complete vocational rehabilitation services programs is approximately 60%. The latest data posted by RSA 911 (2014) indicated that 508,359 persons with disabilities were eligible for vocational rehabilitation (VR) services in the 2004-2005 fiscal years. The data contained 616,879 cases of persons with various disabilities who applied for vocational rehabilitation services. According to Honeycutt and Stapleton (2013), there were approximately 600,000 persons with disabilities who applied in each year for vocational rehabilitation services and 981,000 served total. Groomes, Vandergoot, Shoemaker, and Collins (2015) indicated that public vocational rehabilitation programs serve about 1.2 million persons with disabilities each year. Disabilities ranged from sensory/communicative impairments, physical impairments, and mental impairments. Of the clients served, 78.7% coped with a significant disability and most clients were male (54.5%). By completion of the services provided, 33.5% of the cases closed achieved an employment outcome (RSA, 2014).

Vocational rehabilitation process. The purpose of vocational rehabilitation services is to assist persons with disabilities gain their independence through employment. Vocational

rehabilitation service is an organized process from application to closure. Figure 1 shows the vocational rehabilitation process consists of various phases, which are organized as status codes that are used in both federal and state vocational rehabilitation programs (North Carolina DHHS, 2008; Parker & Szymanski, 1998).

Figure 1. Vocational rehabilitation process.



Application status. Clients are referred (Status 00) to vocational rehabilitation services by their physician, counselor, social worker, case manager, organizations, or employers. Vocational rehabilitation counselors are also required to outreach within the community to educate persons about the services which vocational rehabilitation provides. Once a referral has been made, clients are required to complete an application (Status 02) for service. During the application appointment, counselors gather pertinent information regarding the client's demographic information, onset of disability, symptoms, and how the disability prevents the client from gaining and maintaining employment. The information is then used to determine the client's eligibility. In most cases, counselors refer the client for physical, mental, and or vocational evaluations. These evaluations assist counselors in not only determining eligibility, but evaluations also assist in further planning of services for the client.

Eligibility status. Eligibility determination must be established within 60 days of application according the Rehabilitation Amendments of 1992 (Parker & Szymanski, 1998). Once the counselor gathers the necessary documentation, eligibility of the client is determined. When documentation of the disability depicts a severity that may prevent the client from working the client is moved to extended evaluation (status 06). During extended evaluations, clients may participate in work-related activity to determine whether they are capable of working. Eligible clients (status 10) meet the following four criteria for the federal/state program in vocational rehabilitation: the individual must have a disability, the disability must impact the individual's ability to work, the individual must possess the capabilities and abilities to work, and the individual can benefit from the services. Vocational rehabilitation's eligibility requirements were established and defined in the Rehabilitation Act of 1973 (Stapleton et al., 2010). Being accepted into the program is the first step in gaining access to the vocational rehabilitation system

(Wilson, 2000). Clients who do not meet all four eligibility requirements cases are closed ineligible (status 08) and referred to other programs more beneficial to their needs.

After determining eligibility, the counselor and client jointly complete an assessment and planning of services. For clients who have been determined eligible for service but due to personal and or disability related issue need their case closed, their cases are closed after eligibility (status 30). Furthermore, being determined eligible does not mean an individual will receive services because some individuals choose not to participate in services after their eligibility has been established (Stapleton et al., 2010).

Active services status. Clients who choose to move forward with the process work jointly with their vocational rehabilitation counselor to complete an Individualized Plan for Employment (IPE). The IPE ensures personal choice in the development and planning of services (RSA, 2014). Moreover, it is mandated by current rehabilitation legislation and outlined in the Rehabilitation Act of 1973 guiding the practices of federal-state vocational rehabilitation agencies (Parker & Szymanski, 1998; Roessler & Rubin, 2006). The IPE is the central document of the rehabilitation process and is developed and signed by the counselor and client (Honeycutt & Stapleton, 2013). It outlines the client's employment goals and services needed to reach the goals (Honeycutt & Stapleton, 2013). According to O'Sullivan and Bates (2014), goals for clients vary and include disability restoration services and vocational placement. Nevertheless, the client is involved in the process and is an active participant. Once the client has signed the IPE (status 12), services for the client begin. Beveridge and Fabian (2007) found a positive relationship between weekly wages and obtaining an employment outcome consistent with the IPE. Less than 50% of clients find employment outside of their IPE goal. Therefore, planning and goal setting is a vital component in the vocational rehabilitation program.

Vocational rehabilitation services typically promote employment (Stapleton et al., 2010). Clients who participate in the vocational rehabilitation process receive multiple services that include disability restoration (status 16), counseling (status 14), and or training (status 18). According to Gruman et al. (2014), vocational rehabilitation counselors are required to provide persons with disabilities assessments, counseling and guidance, job development, placement opportunities, and case management.

Job ready status. When clients are job ready (status 20), they begin participating in various methods of job placement services. This service includes direct job placement and supported employment. Direct job placement is a traditional way of assisting clients to find employment with their current transferable work skills. Supported employment is utilized for clients who cope with severe disabilities. Supported employment is a method where clients get one-on-one assistance with finding and training on the job. Once the client becomes employed (status 22) and maintains employment for 90 days and services are complete, the case is closed successfully (status 26). However, individuals who participate in supported employment require an extended period to determine stability on the job. Clients who gain and maintain employment within their goals and complete services reach successful closure (O'Sullivan & Bates, 2014). Clients who do not follow through with services or are no longer interested in employment, or are unable to participate (due to death, incarceration, change in disability) are closed unsuccessful (status 28). vocational rehabilitation services have several other statuses depicted in Figure 1 (North Carolina DHHS, 2008; Parker & Szymanski, 1998); however, the services described above are considered the most common.

Order of selection. Vocational rehabilitation services utilize an order of selection process to assist individuals when funding is limited during a fiscal year (Stapleton, 2010). During the

order of selection process, individuals whose disability is determined severe in nature are provided services first. Severity of disability is determined when the client is determined eligible for services. Clients who have a severe impediment to employment within the functional limitations of mobility, communication, self-direction, work tolerance, interpersonal skills, and or work skills and require at least six months of multiple services are determined to have a severe disability. During an order of selection individuals who do not require at least six months of services are served next if funding is available during the fiscal year.

Successful closure. Vocational rehabilitation counselors are tasked with meeting yearly benchmarks. The number of benchmark closures varies among counselors and can range from 20-35 successful closures a year. Benchmarks are a measure of successful closure, which indicates how many clients a counselor has provided substantial service and helped them gain and or maintain employment for at least 90 days. A successful closure within vocational rehabilitation services indicates that the individual has received substantial services to reduce their impediments to employment and has been employed at least 90 days before closure status. Successful closure means the client does not need any further services from Vocational Rehabilitation to gain or maintain employment at this time. Post closure services can be provided to a client within a year of successful closure. Post closure services are services a client may need to maintain employment such as hearing aid replacements, vehicle modification, counseling, and many others. Public sector rehabilitation counselors are responsible for ensuring their clients' impediments to employment are reduced and that the clients can gain and maintain employment. Lastly, understanding and knowing the vocational rehabilitation process and providing services are vital to the work task of rehabilitation counselors.

Vocational rehabilitation services. Vocational rehabilitation counselors are responsible for providing and or arranging various services for individuals with disabilities. The services provided are to help reduce impediments to employment and to assist clients with gaining or maintaining employment. Vocational Rehabilitation is known as a highly individualized process that assists persons with disabilities in gaining and maintaining employment (Gruman et al., 2014). Therefore, each client receives services based upon individual needs and severity of the disability. According to Austin and Lee (2014), various vocational rehabilitation services are significantly related to successful employment outcome based on the client's disability.

On the job training is a service provided to determine whether a job is an appropriate fit for a client prior to being hired permanently. In this process, the employer gives an individual with a disability the opportunity to work for the business and learn on the job skills. During this time, vocational rehabilitation services may reimburse the employer for a portion of the client's salary; provide the client with needed training and accommodations to maintain the employment; or provide other supportive services. If the client is a good fit for the company and can work with necessary accommodations in place, the company can hire the client permanently. On the job training is a significant service for vocational rehabilitation clients who cope with cerebral palsy, traumatic brain injury, and cancer (Catalano, Pereira, Wu, Ho, & Chan, 2006; Huang et al, 2013; Strauser et al., 2010).

On the job supports are provided when a client obtains employment within an integrated setting and needs job coaching services or supported employment services to help maintain employment. Job coaching services include teaching or coaching the client to perform essential job tasks. Supported employment service is provided to clients who need direct assistance with job placement. Clients who need supported employment services often need applications

completed on their behalf, direct assistance with the interviewing process, and after being hired, they may need assistance directly on the job for the first few weeks to ensure they can maintain the employment. On the job supports can be determined when the client's IPE is completed or when the consumer is working and in danger of losing a job due to issues related to the disability. On the job supports is a significant service for individuals who cope with multiple sclerosis, intellectual disabilities, co-occurring psychiatric disabilities, diabetes, and cerebral palsy (Austin & Lee, 2014; Chiu et al., 2013; Huang et al., 2013; Sabo & Thornburg, 2015).

Job search and placement service is a significant service for individuals who cope with cerebral palsy, multiple sclerosis, intellectual disabilities, cancer, diabetes, or co-occurring psychiatric disabilities (Austin & Lee, 2014; Chiu et al., 2013; Huang et al., 2013). Rosenthal, Dalton, and Gervey (2007) found that vocational rehabilitation clients who cope with psychiatric disabilities were more likely than those who do not to have successful vocational outcomes when participating in vocational rehabilitation's job placement services. Job search and placement services are basic assistance with job leads, application completion, interviewing skills, and resume development. During this time, clients work directly with their counselor or a job placement specialist to find employment based on their skills and abilities.

Rehabilitation technology services are utilized to assist clients who need technology to eliminate barriers to employment. The technology includes all items that maintain, improve, or enhance the functional capabilities of clients with disabilities. These services can include mobility aide devices, vehicle modifications, prosthetics, hearing aids, and equipment for the visually impaired. These services are based on the needs of the client and vary. According to research, rehabilitation technology is a significant service for individuals who cope with multiple sclerosis, cerebral palsy, and cancer (Chiu et al., 2013; Huang et al., 2013; Strauser et al, 2010).

These individuals and other clients utilize the technology to provide the necessary accommodations needed on the job or to accommodate their limitations caused by the disability.

Vocational rehabilitation services also assist persons with disabilities in vocational and or academic training. The purpose of academic training is to assist individuals gain the necessary skills to become employable. RSA (2006) defined *training* as full or part time training above high school level leading to a degree, certificate, an or other recognized educational credential. According to Boutin and Accordino (2011), obtaining a higher education is a vital experience in the lives of individuals with disabilities. According to Xu and Matrz (2010), preemployment service such as vocational training is a strong predictor of competitive employment for persons with disabilities. Vocational and academic training is a significant service leading to employment for individuals who cope with psychiatric disorders and diabetes (Boutin & Accordino, 2011; Sabo & Thornburg, 2015).

Counseling and guidance is the direct service provided by the vocational rehabilitation counselor. Counseling and guidance is a significant service for individuals who cope with multiple sclerosis and cancer (Chiu et al., 2013; Strauser et al., 2010). During the vocational rehabilitation process, counselors counsel and guide individuals regarding the process and the roles and responsibilities within the counselor-client relationship. Counselors also provide counseling and guidance to their clients regarding comparable benefits and services available to them within the community. Within this service, counselors help their clients understand disability- related information, functional limitations, impediments to employment, and services available to assist them to help eliminate barriers to employment. The counseling techniques used with the client often are based upon the client and the disability. Counseling and guidance is

the fundamental service to enhance the counselor and client working relationship and allow the counselor to stay updated on information regarding the client and the services received.

Vocational rehabilitation counselors work with a variety of clients with various disabilities. Counselors are responsible for assisting these clients one-on-one and provide individualized services throughout the vocational rehabilitation process. Unlike counselors in many other settings, Vocational rehabilitation counselors do not work with clients for a set number of sessions acknowledged at the beginning of the process. Vocational rehabilitation counselors work with their clients who have a significant disability a minimum of six months (per federal regulations; Parker & Szymanski, 1998). However, many counselors find themselves on caseloads for up to a year or more until the impediment to employment is decreased or eliminated and employment success has been established. Counselors are not only challenged with having knowledge of all disabilities, but also have very large caseload sizes. O'Sullivan and Bates (2014) reported the average vocational rehabilitation counselor has a caseload of 143 clients. Large caseloads for vocational rehabilitation counselors lead to stress and burnout among counselors in the profession (O'Sullivan & Bates, 2014).

Burnout

In the 1970s, burnout became a vital concept in the psychological literature (Freudenberger, 1974). Herbert Freudenberger was the first to recognize burnout when he observed symptoms among his patients such as extreme work-related stress (Templeton & Satcher, 2007). Burnout initially was described as emotional overload, cynical reactions, and mental exhaustion (Barfard & Whelton, 2010). The topic of burnout has inspired research on job stress in various areas of work within the helping field. Now, burnout usually is defined as a syndrome caused by depersonalization, lack of personal accomplishments, and emotional

exhaustion (Blau et al., 2013; Lanham et al., 2012; Lee et al., 2010; O'Sullivan & Bates, 2014). According to Barford and Whelton (2010), Christina Maslach developed the three-dimensional model of burnout which includes emotional exhaustion, depersonalization, and personal accomplishment.

Emotional exhaustion involves the feelings of being stressed, drained, and or overextended (Acker, 2011). It is defined as feelings of fatigue and being emotionally drained (Lee et al., 2011; Maslach & Jackson, 1981; Morgan et al., 2014). Individuals who cope with emotional exhaustion experience both physical and psychological symptoms. Moreover, the pressures of the work environment often affect a person's capacity to interact with and address the needs of clients (Thomas, Kholi, & Choi, 2014). Being emotionally exhausted has a direct effect on the client, the counselor, coworkers, and the assigned job duties.

Depersonalization is when individuals become detached and or have cynical attitudes towards their jobs (Barford & Whelton, 2010). Furthermore, depersonalization occurs when individuals possess a negative attitude toward work and or isolate themselves from others on the job (Maslach & Jackson, 1981; Morgan et al., 2014). Persons who cope with depersonalization have lost a sense of identity and their thoughts and feelings appear irrational or unrealistic. According to Thomas, Kholi, and Choi (2014), depersonalization is an individual's conscious effort to disengage and create separation between self and others including clients.

Feeling of reduced personal accomplishment is a result related to the experience of emotional exhaustion and depersonalization (Barford & Whelton, 2010). The personal accomplishment factor is the self-evaluation process of burnout (Maslach, Schaufeli, & Leiter, 2001). The lack of personal accomplishment occurs when the individual feels useless to the organization and the clients being served (Thomas et al., 2014). Therefore, individuals who feel

reduced personal accomplishment often begin to decrease their performance on the job. The decrease in productivity is often due to the feelings that their contribution to work does not matter.

Characteristics of burnout. Burnout can be characterized as a failed attempt to cope with stressful conditions in an emotional demanding environment such as one with role conflict, role ambiguity, work overload, and a low quality of employee interactions (Barford & Whelton, 2010; Speakes-Lewis, 2011). These organization characters often affect individuals on the job and foster burnout among workers. Role conflict is when an individual's responsibilities overlap multiple conflicting roles on the job. Individuals who experience role conflict find themselves being stretched in various directions. Role conflict increases depersonalization in workers (Ghorpade, Lackrtiz, & Singh, 2011). In addition, role ambiguity occurs when individuals do not have the proper information to understand their role at work.

Ghorpade, Lackritz, and Singh (2011) found that individuals' feelings of personal accomplishment decreased when they experienced role ambiguity. Moreover, being unclear about one's job duties can cause an individual to decrease in productivity. Wallace, Lee, and Lee (2010) found that work overload often occurred when individuals had too many job duties and job pressures that often left them little to no time to complete tasks. Work overload causes individuals to feel overwhelmed and their work eventually begins to lack in quality and or begins to pile up. Another organization characteristic occurs when an office lacks employee interaction. According to Gunduz (2012), counselors who have social support have a more positive attitude toward their jobs. Moreover, a lack of perceived social support affects burnout levels (Brouwers, Tomic, & Boluijt, 2011).

Barford and Whelton (2010) suggested that the development of burnout is due to organizational characteristics and more. Individual characteristics and social support off the job are also predictors of burnout. Age of the employee, gender, and marital status are demographic factors shown to predict burnout (Barford & Whelton, 2010; Thomas et al., 2014). Age is consistent with years of experience in the field and younger employees have higher levels of burnout (Brewer & Shapard, 2004; Thomas et al., 2014). As age increases for workers, so does their level of experience and ability to understand their role expectations (Thomas et al., 2014). Therefore, employees in the later stages of their career are more immune to experiencing burnout (Barford & Whelton, 2010). Moreover, older workers have lower levels of absenteeism and higher rates of job satisfaction.

As it relates to gender, women have higher levels of burnout than men due to compassion fatigue and work frustrations. Compassion fatigue is the emotional stress that reduces compassion overtime for individuals who work directly with trauma victims. Employees who are married consistently have a lower score of burnout than those who are single. This possibly is because social supports off the job are effective factors that buffer the effects of burnout.

Personality traits are also predictors of burnout. According to Lee, Cho, Kissinger, and Ogle (2010), burnout occurs when workers perceive their work is not valued due to a lack of positive reinforcement or reward. Some individuals spend their time seeking perfection and acknowledgement on the job. The desire to accomplish goals and wanting to be the *best* can cause burnout (Wilczek-Ruzyczka, 2011). In addition, high levels of neuroticism have been found to be correlated with burnout (Barford & Whelton, 2010). Neuroticism is when individuals cope with long-term negative feelings that can include sadness, depression, guilt, envy, and anger. Individuals with neuroticism often feel every day small issues are major life problems for

them. Thus, a consistently strong relationship in emotional exhaustion, depersonalization, and reduced personal accomplishment has been reported in individuals who demonstrate neuroticism (Barford & Whelton, 2010).

Symptoms of burnout. Templeton and Satcher (2007) indicated that individuals who experience burnout have multiple symptoms. Burnout has similarities to stress and depression and can cause an individual's quality of life to diminish (Stanetic & Tesanovic, 2013). However, burnout is characterized by more than just stress (Guntupalli et al., 2014). Individuals can experience high stress in their work environments and not be at risk of burnout (Guntupalli et al., 2014). Burnout is associated with professional stress, personal characteristics, and environmental influences (Wilczek-Ruzyczka, 2011). Glise, Hadzibajramovic, Jonsdottir, and Ahlborg (2010) indicated that there is evidence that psychosocial work characteristics are also associated with burnout. Burnout has been described as emotional, mental, and physical symptoms caused by excessive and prolonged stress (Lanham et al, 2012).

Physical symptoms. Burnout has physical effects that cause individuals to experience fatigue, increased sickness, and physical pain for long periods of time (Stanetic & Tesanovic, 2013). According to Putnik, Jong, and Verdonk (2011), burnout is a major factor affecting sick leave at work. The physical pains experienced can be headaches, muscle aches, and back pain (Stanetic & Tesanovic, 2013). Burnout can cause individuals to experience a change in appetite. Burnout also can cause gastrointestinal disturbance, poor sleep patterns, and insomnia (Lee et al., 2011). In a longitudinal study of industrial workers, researchers reported burnout increased risk of cardiovascular disease (Lanham et al., 2012). Cardiovascular disease can be caused by prolonged stress, smoking, high blood pressure, and drug use. Persons with a high score of burnout have decreased work capacity, risk for long term sickness, and early retirement.

Emotional symptoms. Emotional symptoms of burnout are characterized by a sense of failure and self-doubt. Burnout can cause poor self-esteem, anxiety, and depression. (Sangganjanavanich, & Balkin, 2010). A depressed sense of personal achievement can cause an individual to experience burnout (Wilczek-Ruzyczka, 2011). Persons who cope with burnout have feelings of helplessness, pessimism, and loss of personal perspective (Stanetic & Tesanovic, 2013). Speakes-Lewis (2011) reported that persons who cope with burnout have continuous and deep thoughts regarding quitting their jobs and even leaving their profession. They feel trapped with decreased satisfaction, detachment, and loss of motivation. Moreover, a person coping with burnout may have an increased cynical and negative viewpoint due to feelings of defeat (Sangganjanavanich & Balkin, 2010).

Behavioral symptoms. According to Maslach (2003), when individuals begin to experience burnout, it can cause poor job performance, withdrawal from responsibilities, and decreased interaction with coworkers. Furthermore, workers who experience burnout lack the ability to be a team player, have difficulty organizing and completing daily tasks, and have a recurrent absenteeism at work, frequent tardiness, and often leave work early (Sangganjanavanich & Balkin, 2010). Moreover, individuals may begin to isolate themselves from others and utilize food, drugs, or alcohol to cope with their feelings. Prolonged symptoms of burnout can cause individuals to become substance dependent (Stanetic & Tesanovic, 2013).

Burnout affects an individual's social and interpersonal relationship with coworkers (Gunduz, 2012). Individuals may begin to take out their frustrations on others. Moreover, burnout causes a lack of tolerance and pessimism on the job (Sangganjanavanich & Balkin, 2010). Personal characteristics associated with burnout include defensiveness, dependence, and passivity (Wilczek-Ruzyczka, 2011). Maylett and Nielsen (2012) suggested that burnout can

cause *engagement exodus*, which is a mental disengagement from the workplace long before individuals leave their jobs. During engagement exodus, the people are no longer committed to the organization, though they continue to work.

Burnout and professionals. Burnout has been researched in professionals such as teachers, human service workers, medical and health care providers, and professional counselors (Chang, 2009; Cheung & Chow, 2011; Edwards & Dirette, 2010; Gingras et al., 2010; Lee et al., 2010; Thomas et al., 2014, Wilczek-Ruzyczka, 2011). Cordoba et al. (2011) suggested that high levels of stress affect much of the working population. Professional burnout has been associated with work ability, mental health, perfectionism, and emotional regulations (Aloe, Amo, & Shanahan, 2014). In addition, professionals who are more involved with their job duties are more likely to experience burnout than those who are detached from their work (Speakes-Lewis, 2011). Burnout is often experienced in demanding jobs and is prevalent within the helping professions (Romani & Ashkar, 2014; Schaufeli, Leiter, & Maslach, 2008). According to Tabaj, Pastirk, Bitenc, and Masten (2015), persons who work in the helping professionals often focus more on the needs of the individuals they serve and rarely are aware of how to satisfy their own needs. Helping professionals work in a constant imbalance of giving to their clients and often never receiving.

Teachers. According to Aloe, Amo, and Shanahan (2014), teacher burnout has dramatically risen due to the increasing diversity of students and decreasing levels of responsibility and involvement of parents. Teachers in K-12 must deal with daily issues of their students, separation from other adults, and feelings of being intellectually drained (Chang, 2009). Burnout among teachers has become a global concern with teacher burnout being reported in many countries (Aloe et al., 2014).

The demands of the job are positively related to burnout among teachers (Sulea, Filipescu, Horga, Ortan, & Fischmann, 2012). Teacher burnout has been detected as early as student-teaching and is associated with teacher turnover (Aloe et al., 2014). Brunsting, Sreckovic, and Lane (2014) indicated that at some point all teachers experience various levels of burnout. Moreover, contemporary teachers feel they have added responsibilities, a more difficult workload, less home support for students from parents, and a lack of school support due to changing performance standards (Aloe et al., 2014). In addition, dealing with the behaviors of students can cause teachers to become emotionally drained (Chang, 2009). Teachers cope with health complications due to burnout (Sulea et al., 2012). Moreover, teachers who decide to stay within the field and not deal with their issues related to burnout become ineffective and inadvertently harm the classroom and the school (Chang, 2009).

Human service workers. According to Thomas, Kohli, and Choi (2014), burnout has been researched among human service workers in child protective services and social services volunteers. When individuals work in a setting where they are caring for others, there is a greater risk of burnout (Speakes-Lewis, 2011). Within the human service industry, working with child and youth is one of the most emotionally exhausting careers (Barford & Whelton, 2010). They are faced with assessing and managing increasingly complex and an expanding caseload of at risk children (Lee, Weaver, & Hrostowski, 2011). Child care workers work with many children with psychological, behavioral, and emotional problems (Barford & Whelton, 2010). Child care workers experience emotional exhaustion which causes turnover, which is a critical concern for public child welfare services (Lee et al., 2011).

According to research, there is an increased risk of burnout in human service professionals who assist persons with HIV (Speakes-Lewis, 2011). HIV has shifted from a fatal

to a chronic disease, which has placed a higher demand on services that include medical, psychological, social, and educational service (Speakes-Lewis, 2011). These services are deemed vital in assisting persons with HIV, which has created a strain on helping professionals within the profession. Speakes-Lewis (2011) found that the majority of HIV healthcare workers experience one component of burnout. Due to the nature of the disease, human service workers are overwhelmed due to public attitudes about HIV and close patient/client contact.

Burnout levels of human service workers who serve individuals with intellectual disabilities (ID) are slightly lower than other human service workers (Mutkins, Brown, & Thorsteinsson, 2011). Nevertheless, burnout is still an issue in this work group. Work stressors include working with challenging behaviors, interpersonal issues with other staff, and organizational concerns. Individuals who cope with intellectual disabilities are often dependent and require emotional support from the persons who work with them. This often exposes the human service worker to highly stressful environments, which results in a higher risk of burnout.

Medical and healthcare professionals. Burnout affects the medical and healthcare field which includes physicians, nurses, and other personnel. According to Edwards and Dirette (2010), healthcare professionals are known as the profession with the highest risk for stress and burnout. Intensive care unit (ICU) physicians cope with high levels of emotional exhaustion, depersonalization, and decreased personal achievement (Guntupalli, Wachetel, Mallampalli, & Surani, 2014). Romani and Ashkar (2014) found that there is a high prevalence of burnout among physicians in that one-third of physicians have experienced burnout. Burnout is often caused by the inability of physicians to balance their personal and professional lives (Romani & Ashkar, 2014). In addition, 45.8% of physician's report having at least one symptom of burnout (Romani & Ashkar, 2014). Among ICU physicians, the common causes of burnout include

overwhelming and difficult work, being powerless to change, and making the impossible happen (Guntupalli et al., 2014). Furthermore, burnout has been found to increase medical errors and decrease job satisfaction (Romani & Ashkar, 2014).

Registered nurses are affected by burnout due to the conflict they experience with patients and coworkers, not receiving requested days off, making end of life decisions regarding patient care needs, complex patient load, long shifts, demanding physicians, and the fast pace environment (Guntupalli et al., 2014; Hunsaker, Chen, Maughan, & Heaston, 2014). ICU nurses have a higher rate of burnout at a younger age (Guntupalli et al., 2014). Moreover, nurses experiencing burnout are unable to provide acceptable levels of care for their patients due to exhaustion (Hunsaker et al., 2014). Thus, burnout affects nurses' retention, patient safety, and patient satisfaction (Hunsaker et al., 2014).

Dieticians also cope with burnout. Dieticians work in the helping profession with patients assisting them to change their diets due to complex medical illness (Gingras et al, 2010). Dieticians work with patients to provide them individualized nutrition plans. However, many of the patients they work with deal with social issues that dieticians are not prepared to address in their line of work, such as poverty eating behaviors and food insecurity. Dieticians who are not prepared to assist these patients may experience a reduced sense of workplace accomplishments. These issues dieticians experience cause burnout and questioning about whether to change fields. Though dieticians have lower levels of burnout than other healthcare professionals, it is still a workplace issue (Gingras et al., 2010).

Occupational therapists are healthcare professionals who have also been examined for the prevalence of burnout. Edward and Dirette (2010) described how occupational therapists experience burnout due to their direct work environment with clients. Factors such as role

conflict, lack of supervision, lack of professional identity, staff recruitment and retention, and increasing demands are all risk factors causing stress among occupational therapists. The lack of personal accomplishment, emotional exhaustion, and depersonalization have been found to have been experienced by occupational therapists (Edward & Dirette, 2010). Moreover, these factors were related to the lack of professional identity among those within the field. The lack of professional identity is due to the profession having a broad practice framework that tends to overlap with other professions within the field (Edward & Dirette, 2010).

Burnout and counselors. Blau, Tatum, and Goldberg (2013) indicated that burnout has been studied in various mental health workers including case managers, psychologists, psychotherapists, social workers, rehabilitation counselors, and intensive care workers. Due to the nature of the field and high involvement with clients and other professionals, mental health workers are likely to experience burnout (Sangganjanavanich & Balkin, 2010). Multiple job duties can cause high stress within the work environment when daily tasks are not managed properly among mental health professionals. In a survey completed by the American Counseling Association (ACA), 75.7% of mental health professionals indicated that a colleague coping with burnout is a significant threat to the profession of counseling (ACA, 2010; Puig et al., 2011). Of those professionals, 63.5% suggested that they were aware of colleagues who currently were coping with burnout.

Salyers, Rollins, Kelly, Lysaker, and Williams (2013) examined the job satisfaction and burnout among Veteran Administration and community mental health workers. The results of the study indicated a significant difference in burnout and job satisfaction among Veteran Administration and community mental health workers within the same city. Mental health workers in the Veteran Administration setting had less symptoms of burnout such as emotional

exhaustion than did those who worked in community mental health. Moreover, the Veteran Administration workers had more sense of personal accomplishment, more satisfaction with their jobs, and were less likely to have the intention to leave their current employment. The community mental health workers reported more concerns with schedule and pay. However, both the Veterans Administration workers and community mental health workers found satisfaction from working with their clients.

Craig and Sprang (2010) indicated that mental health professionals who provide therapy services are faced with daily life adversities that other professionals do not encounter. Burnout has been studied in marriage and family therapists, professional counselors, and school counselors (Lee et al., 2010; Thomas et al., 2014; Wilkerson, 2009). In addition, significant interaction with burnout and turnover has been reported among counselors who work with substance abuse treatment (Landrum, Knight, & Flynn, 2012). Stress is often induced by the mental health professional's encounter within therapy sessions (Craig & Sprang, 2010). Likewise, counselors working with trauma victims experience damaged emotional well-being which affects the functioning of the therapists (Ben-Porat & Itzhaky, 2011).

According to Lee et al. (2010), professional counselors experienced many issues caused by burnout due to high expectations of maintaining a balance between personal lives and providing therapeutic services. An inability to manage both can cause burnout and affect the counselor's well-being and have a negative effect on the clients they serve (Lee et al., 2010). Puig et al. (2011) suggested that mental health professionals experience job stressors which include heavy caseloads, demands for short-term therapy, financial constraints, and managed care issues. In addition, organizational variables such as role conflict, role diffusion, and job intensity have been found to have significant relationships with burnout (Carrola, Yu, Sass, &

Lee, 2012). Acker (2011) indicated that high job demand, conflicted expectations in the job role, limited opportunities for professional advancement, and low support cause stress among mental health providers. Job satisfaction is also important when working in the mental health field, because professionals with high levels of burnout and low levels of job satisfaction are likely to resign from their positions (Scanlan & Still, 2013).

Wilkerson (2009) indicated that school counselors face challenging role responsibilities that lead to burnout, such as helping the students prepare for the world of work and helping them cope with issues that may be affecting their ability to perform in school. School counselors are working with severe depression, suicide attempts, drug abuse, teen pregnancy, and various other abuse issues (Gunduz, 2012). Abuse specific counselors work with clients who cope with sexual addiction or substance dependence. They experience high levels of burnout due to the nature of the clients served (Wallace et al., 2010). Mental health professionals who work within a human service entity (such as schools) are known to be at the highest risk of burnout susceptibility (Puig et al., 2011). Sangganjanavanich and Balkin (2010) indicated that mental health professionals have the responsibility to care for those they serve with the sacrifice of putting their own health at risk. Additionally, young counselors appear to be more susceptible to burnout due to their lack of experience compared to older more mature counselors (Sangganjanavanich & Balkin, 2010). Thus, burnout often causes counselors to experience an excess of pressure so severe that it causes them to find work in more rewarding fields.

Burnout causes an inability to care properly for clients (Skovhalt, 2005). According to Wester, Trepal, and Myers (2009, p. 91), “Well counselors are more likely to produce well clients.” Thus, the mental, physical, and emotional health of the counselors has the ability to affect their clients. The ACA Code of Ethics (2014) states that “Counselors act to avoid harming

their clients." Moreover, counselors have an ethical obligation to evaluate, address, and improve their wellness when necessary (Wolf, Thompson, Thompson, & Smith-Adcock, 2014).

According to research, higher organizational stress was associated with lower client participation in treatment programs (Landrum et al., 2012). In addition, the working alliance between the counselor and the client is diminished due to high stress and burnout among counselors (O'Sullivan, 2012). A counselor who experiences burnout may lack empathy, respect, and positive feelings, and may experience therapeutic gridlock, or engage in boundary violations (Wallace et al., 2010). Therefore, it is vital for counselors to remediate impairments such as burnout when they occur. Counselors should be aware of the signs and symptoms related to their own mental or emotional problems (ACA, 2005). Likewise, counselors should build resiliency against burnout. Resiliency is built by a continuation of healthy decision making (Wester, Trepal, & Myers, 2009). Counselors should seek help or assistance when they observe warning signs of personal impairment, not just for themselves, but for the well-being of their clients (ACA, 2005).

According to Shillingford, Trice-Black, and Butler (2013), well-being or wellness is correlated with the quality of the professional life of individuals. Wellness is a vital concept within the counseling profession. Lawson and Myers (2011) indicated that counselors are more susceptible to mental and emotional disorders than others within the population. Therefore, it is imperative for counselors to understand wellness and build strategies for resilience.

Furthermore, wellness is the healthy balance of a person's mind, body, and spirit. For counselors to be effective within the profession, it is important for them to understand the need for wellness (Wolf et al., 2014). An inability to manage both personal and work life can cause burnout and affect the well-being of counselors and the clients they serve (Lee et al., 2010). Well counselors are more likely to promote wellness, while impaired counselors are likely to harm

their clients (Lawson & Myers, 2011). Counselor educators and students are learning the importance of self-care to help maintain mental, physical, and spiritual health. Self-care is the strategy that individuals use for relief, which includes relaxing and fun extracurricular activities. Self-care includes healthy activities such as sewing, gardening, exercising, and many other activities.

Burnout and vocational rehabilitation counselors. O'Sullivan and Bates (2014) indicated that there is a significant gap in research among burnout and vocational rehabilitation counselors. Research related to burnout in rehabilitation counseling is outdated with most studies having been completed over two decades ago (O'Sullivan & Bates, 2014). Likewise, there are few studies that focus on burnout among rehabilitation counselors (Templeton & Satcher, 2007). Payne (1989) suggested that rehabilitation counselors are vulnerable to burnout due to the job duties related to caseload management and size. Burnout has been described as the rehabilitation counselor's *hidden handicap* (O'Sullivan & Bates, 2014). In the field of vocational rehabilitation, burnout has led to turnover and poor counselor performance (O'Sullivan & Bates, 2014). When turnover occurs in rehabilitation, counselors must increase their workload until a new counselor is hired, which causes an increase in stress (Templeton & Satcher, 2007). Furthermore, counselors who worked in community agency settings are known to experience burnout at higher rates than those in private practice.

It is vital for rehabilitation counselors to understand this *hidden handicap*. Rehabilitation counselors repeatedly work with clients who have problems that are chronic in nature, which often changes the sense of optimism in professionals and perceptions of value in their work (Tabaj et al., 2015). The Code of Professional Ethics for Rehabilitation Counselors (CRCC, 2017) states that "rehabilitation counselors are alert to the signs of impairment from their own

physical, mental, or emotional problems and refrain from providing professional services." In addition, it is the responsibility of rehabilitation counselors to seek assistance when their impairments can likely harm a client. During a time of impairment, counselors should limit, if not suspend, their professional responsibilities until they are capable of returning to work with clients.

Gomez and Michaelis (1995) explored burnout in three agencies (a Department of Social Services, Vocational Rehabilitation, and Goodwill Industries) using the MBI. Individuals with direct contact in assisting clients to find employment were included in the study. The results indicated that low to moderate levels of burnout were found in all service providers within the three agencies (Gomez & Michaelis, 1995). Within all the agencies the size of caseloads did not have a significant effect on the level of burnout among the participants. Benchmarks were not a factor examined within this study because vocational rehabilitation counselors are the only professionals who must meet yearly benchmarks. However, providers who spent more time with consumers than they did completing paperwork had a greater sense of personal accomplishment (Gomez & Michaelis, 1995).

Mann Layne, Hohenshil, and Sigh (2004) examined whether stress has a direct effect on turnover intention and indirect effects through strain and coping resources. The study examined various demographics and their relationship with stress, strain, coping resources, and turnover interventions. The results of the study indicated that turnover is caused by the occupational stress that is inherent in the job function of rehabilitation counselors. Thus, stress can account for the turnover intentions of rehabilitation counselors in the field and not their individual coping skills.

Professional counselors experienced burnout due to a multitude of problems stemming from caseload management (Lee et al., 2010). Case management activities are a substantial part

of rehabilitation counselors' identified job duties (Wheaton & Berven, 1994). Furthermore, counselors are expected to manage these problems related to caseload management, provide quality services to their clients, and service clients with physical, mental, emotional, and comorbid disabilities. Rehabilitation counselors work with clients with various types of severe disability (Templeton & Satcher, 2007). In addition, rehabilitation counselors have to interface with medical personnel, medical systems, attorneys, legal systems, employers, and other agencies in which their clients are involved (Lane, Shaw, Young, & Bourgeois, 2012).

According to Klerplec et al. (2010), larger caseloads for rehabilitation counselors lead to stress and burnout, ineffective counseling, and increased counselor turnover. The need for increased caseload sizes is often surrounded by the pressures to increase successful closures (O'Sullivan & Bates, 2014). O'Sullivan and Bates (2014) indicated that on average vocational rehabilitation counselors carry a caseload of 143 clients. Rehabilitation counselors with larger caseloads are more likely to have negative attitudes towards their jobs, to exhibit an inability to cope, and to leave their positions (Layne, Hohensil, & Sigh, 2004). With large caseloads, there is a concern about care for clients due to counselors spending less time working with each client. In addition, helping professionals coping with burnout have more negative attitudes towards their clients, have reduced interactions, and provide less adequate services (Chao, McCallion, & Nickle, 2011). Furthermore, burnout affected the working alliance between counselors and clients (Klerplec et al., 2010). Clients who trust their counselors and have a mutual respect are more likely to engage in and follow through with services (O'Sullivan & Bates, 2014).

Templeton and Satcher (2007) examined whether years of working in current positions, caseload size, required number of annual closures, perceived administrative support, clearly defined work procedures, and being involved in agency decisions predicted burnout. In addition,

the study examined whether rehabilitation counselors differ in job burnout when compared to certain demographics. Rehabilitation counselors in two states were surveyed using the MBI-HSS. Counselors were low to moderate in their overall level of emotional exhaustion. Caseload size and annual closures were not predicters of burnout. However, the counselor's perceived administrative support was a significantly significant predictor of depersonalization and emotional exhaustion. As the perception of administrative support decrease, emotional exhaustion increased.

Maslach Burnout Inventory

The MBI (MBI) was created by a social psychologist Christina Maslach, who is known as the pioneer of research regarding job burnout (Maslach, 1976). The MBI is a widely used inventory to study the presence of burnout and its burnout indicator in over 90% of scientific studies regarding burnout (Kleiweg, Verbraak, & Van Dijk, 2013). The MBI has three subscales: depersonalization, emotional exhaustion, and personal accomplishment (Lee et al., 2011). Maslach describes burnout as a state of exhaustion and depersonalization that causes a lack of professional efficacy and or reduces the likelihood of personal accomplishments (Maslach & Jackson, 1981). Maslach and Jackson (1981) indicated that high scores of emotional exhaustion and depersonalization suggest a presence of burnout. Emotional exhaustion is defined as feelings of fatigue, loss of enthusiasm for work, feeling trapped, defeated, and helpless (Ramoni & Ashkar, 2014). Depersonalization is when the individual possesses a negative attitude towards works and or feelings of isolation from others on the job. Personal accomplishment is the individual's self-evaluation of their current situation. The inventory utilizes the Likert-type scales method to measure the opinions of others based upon a rating scale. The scale is one of the most widely used scales in survey research. It has three versions, which include the MBI-HSS

(HSS), MBI-Educators' Survey (ES), and MBI-General Survey (GS) (Aguayo, Bargas, de la Fuente, & Lozano, 2011). The MBI- HSS was used in this study.

MBI-HSS. The MBI-HSS is the original 22-item self-report scale designed to survey professionals in the Human Service Field. The MBI-HSS is an accepted measure to evaluate burnout among individuals that work with persons that cope with intellectual disability and dementia (Chao et al., 2011). According to Chao et al., (2011), the MBI-HSS is the burnout measure superior in distinguishing between burnout and other mental health syndromes such as depression or anxiety. Lent and Schwartz (2012) examined the external and internal factors that can affect burnout. Approximately 340 professionals completed an online survey of the MBI-HSS and the International Personality Item Pool. Results of the study indicated that working in community mental health settings may result in increased burnout.

Burnout has been studied throughout various fields utilizing all three of the MBI inventories. Though work provides a meaningful structure to life, it can cause stress for many due to multiple factors present on the job. Loera, Converso, and Viotti (2014) indicated that work related stress is a factor that affects burnout. Likewise, when stress it not managed properly among workers long term, burnout can occur (Devereux et al., 2009). There are various work stress models describing how workers are affected by stress on the job.

Job Content Questionnaire

The Job Content Questionnaire (JCQ) is an instrument that measures the job demand, decision latitude, and social supports on the job. Hoang, Corbiere, Negrini, Pham, and Reinharz (2013) indicated the JCQ is the golden standard for assessing job stress and strain. It has now been translated and utilized in more than 22 different languages and countries (Hoag et al.,

2013). It is a 39-item assessment validated through various subgroups of workers (Chungkam et al., 2013).

The JCQ was the first questionnaire utilized in research regarding occupational health in the 1970s (Persson et al., 2012). The JCQ presumes behavior is caused by the social environment. It is utilized to assess the relationship among work related psychosocial issues. In addition, the JCQ utilizes referring questions purposely aimed to minimize self-reflective responses (Persson et al., 2012).

Brouwers, Tomic, and Boluijt (2011) indicated stringent job demands, perceived lack of control, and perceived lack of social support increases level of burnout among professionals. Therefore, individuals may cope with burnout when they have a demanding workload with no autonomy or support on the job. Likewise, both control and support are predicted to prevent the increase of stress, which is caused by demand (Armon et al., 2012). Thus, when autonomy and social supports are present on the job, job demand does not increase levels of burnout among workers. When all three (job demand, job control, and job support) are at the highest level the worker perceives the demands to only be challenging.

Hill (2009) indicated counselor educators' unrealistic perceptions of their jobs cause the inability to properly prepare for job-related stress. Counselor educators are vulnerable to stress due to their job-related tasks, role overload, and job demand. Counselor educators felt the lack of collegial support increased the amount of work-related stress. Lanham et al. (2012) suggested social and supervisory support is one of the major predictors of burnout. Furthermore, high social support buffers the negative impact of high demands and high control within a work environment (Hausser et al., 2010).

In a study among school counselors, both supervisor and colleague support were related to less emotional exhaustion and an increase in personal accomplishment (Yildirim, 2008). Likewise, job satisfaction decreases when there are higher levels of emotional exhaustion (Sagganhanavanich & Balkin, 2010). Low levels of job satisfaction cause professionals to leave their jobs or provide low quality services (Scanlan & Still, 2013). Therefore, it is vital for organizations to create strategies to decrease burnout, increase job satisfaction, and minimize turnover to improve the workforce.

Summary

This chapter provided a literature search strategy, theoretical framework, and literature review for this quantitative research study. The chapter took a broad look at the disability movement and how it has created change in the lives of individuals with disability. It is because of the disability movement that public-sector rehabilitation services were established to assist individuals with disability gain their independence through work. Public-sector rehabilitation services continue to be vital to the independence of individual with disability. Therefore, it is vital for rehabilitation counselors to understand this *hidden handicap*, burnout. In chapter 3, I provide a discussion of the research methodology and design for this study.

Chapter 3: Research Method

Introduction

This chapter provides a broad overview of the methodological procedures I used in this study. The chapter is divided into the following sections: research design and rationale, methodology, threat to validity, ethical considerations, and summary.

Rehabilitation counselors' *hidden handicap* is burnout; this causes turnover and poor counselor performance within public sector rehabilitation services (O'Sullivan & Bates, 2014). This study is distinctive because it addresses burnout among state vocational rehabilitation counselors. Researchers traditionally focus on the client, the nature of services, and service interventions in the field of rehabilitation services (Garske, 2007). Determining if there is a predictive quality between burnout and to job demands, job control, or job support with public sector rehabilitation counselors may help develop a course of action to prevent burnout, if needed.

Research Questions

The study will examine the following research question through a multiple linear regression: Do job demand, job control, and job support (as measured by subscales of Karasek and Theorell Job Content Questionnaire) predict burnout (as measured by the MBI) among public sector rehabilitation counselors?

H_0: There is no predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

H_1: There is a predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

Purpose of the Study

The purpose of this research study was to determine whether burnout can be predicted by job demand, job control, or job support for public sector rehabilitation counselors. Instruments used in the study included the Job Content Questionnaire to measure the predictor variables (job demand, job control, and job support; Karasek & Theorell, 1990) and the MBI to measure the criterion variables (burnout; Maslach & Jackson, 1981). No research could be found on the relationships among job demand, control, support, and burnout among public sector rehabilitation counselors. Therefore, this research filled a gap in the literature.

Significance of the Study

This study was significant because the findings could positively impact social change in the field of rehabilitation counseling. First, understanding relationships among factors related to counselor burnout could lead to information that could contribute directly or indirectly to decreasing burnout. The results of this study could stimulate further research that could identify factors to focus on to prevent burnout among vocational rehabilitation counselors. In addition, the findings from this study could contribute to increasing the wellness of counselors within the public rehabilitation counseling sector, which, in turn, could lead to positive change in the quality of services for clients.

Research Design and Rationale

Quantitative research method answers the question in this research project because it will help determine the predictive quality of the variables in this study. A multiple linear regression

answered the research question because it explained the predictive quality between two or more predictor variables with one criterion variable. The multiple linear regression analysis was used to examine the predictive quality of job demands, job control, and job support (predictor variables) and burnout (criterion variable) within the study. The participants in the study were surveyed utilizing two instruments. Survey research is a nonexperimental design which is consistent with the quantitative method of examining predictive quality among variables. A survey design allows for data to be collected electronically, which allows for easier collection, and a more rapid response time at a low cost (Reynolds, 2006).

Criterion Variable

Burnout was the criterion variable within the study. Burnout is most widely defined as a syndrome caused by depersonalization, lack of personal accomplishments, and emotional exhaustion (Blau et al., 2013; Lanham et al., 2012; Lee et al., 2010; O'Sullivan & Bates, 2014). Emotional exhaustion involves feelings of being stressed, drained, and or overextended (Acker, 2011). Burnout involves having feelings of fatigue and being emotionally drained (Lee et al., 2011; Maslach & Jackson, 1981; Morgan et al., 2014). Depersonalization occurs when individuals become detached and or have cynical attitudes towards their jobs (Barford & Whelton, 2010). Furthermore, burnout occurs when individuals possess a negative attitude towards work or isolate themselves from others on the job (Maslach & Jackson, 1981; Morgan et al., 2014). Feeling of reduced personal accomplishment is related to the experience of emotional exhaustion and depersonalization (Barford & Whelton, 2010; Maslach et al., 2001). Reduced personal accomplishment occurs when individuals believe they are useless to the organization and the clients they serve (Thomas et al., 2014). Burnout will be measured by the scores of participants on the MBI-HSS (MBI-HSS).

Predictor Variables

The predictor variables in the study were job demands, job control, and job support. Job demand is based on the amount of activity required for workers to perform while at work (Devereux et al., 2009). Job control is based on the autonomy of workers and their ability to have control over work activity throughout the workday (Devereux et al, 2009). Job support is described as the socio-emotional support individuals on the job receive from peers and supervisors (Devereux et al., 2009). The Job Content Questionnaire Version 2.0 was used to measure these variables.

Methodology

Population

The target population assessed in this study was CRCs who specialize in public sector rehabilitation services who were currently working in the field. Public sector rehabilitation counselors are defined as vocational rehabilitation counselors who work for state or federal rehabilitation programs. The requirements to become a CRC are a master's degree or doctorate in rehabilitation counseling, counseling, or a qualifying counseling-related field, the completion of an internship or period of employment under a supervisor; and a passing score on the CRC Exam (CRCC, 2015).

The population in this study included both male and female certified rehabilitation counselors from various states. The counselors had a bachelor's degree or higher in a rehabilitation counseling program or other related counseling fields. The sample have included CRCs who did not hold a master's degree, due to a grandfather clause. According to the CRC certification guide, individuals were grandfathered into the CRC credentials between 1974 and 1975 (CRCC, 2015). Participants were from any of the 50 states within the United States.

Sampling Methods

An a priori power analysis was conducted with G* Power Version 3.1.7 for a linear multiple regression with three predictor variables and one criterion variable to detect a medium effect size of .15 with a power of at least .95 at alpha level .05 (Faul, Erdfelder, Buchner, & Lang, 2013). The outcome of the analysis determined the target sample size for adequate power in this study would be 119 participants. A total of 1,000 CRCs in the directory were contacted via e-mail to participate in the survey.

I invited approximately 1,000 individuals who were CRCs to participate in this study. Subjects were selected from a directory of CRCs utilizing convenient, criterion-based sampling. The directory with individuals' information was purchased from the Commission on Rehabilitation Counselor Certification (CRCC) website. When purchasing, I requested contact information for CRCs who specialized in Vocational Rehabilitation Services. The sampling strategy included obtaining a sample of CRCs who were employed by public sector rehabilitation services in the United States.

Participants were selected from this directory for the following reasons: (a) the directory provides accessibility to rehabilitation counselors; (b) individuals in the directory were known to have experience in the field of rehabilitation due to their credentialing; and (c) the directory provided a diversity of CRCs. I invited CRCs to participate in the study because they had passed the certification examination which assesses their knowledge of disabilities, rehabilitation services, counseling skills, and ethical considerations. CRCs also are required to maintain continuing education requirements which supports their knowledge and ability to practice in the field (CRCC, 2015).

Procedures

Once the Walden University IRB approved this study, I submitted my proposal, IRB approval, and a copy of the instruments to CRCC for approval to utilize the directory. Once I received approval, I contacted the participants selected from the CRCC directory via e-mail.

I sent the participants a solicitation e-mail to recruit them for the study via e-mail. To avoid my e-mail message being directed to spam, I sent messages to no more than 20 CRCs at a time. The e-mail included a link to the study via Surveymonkey.com that included the informed consent form and instruments. Surveymonkey.com is an online platform for surveys commonly used in social science research (SurveyMonkey Inc., 2017). The informed consent provided the participants with the background of the study, the procedures for participants, information regarding confidentiality, the voluntary nature of the study, and information regarding ethical concerns. If the counselors I contacted agreed to voluntarily participate in the study, they completed the informed consent form. Those who did not want to volunteer for the study were able to exit the survey website.

The initial e-mail to the participants was sent day one of week1. Appendix A references the initial e-mail sent to participants. On Day 1 of Week 3, a follow up e-mail was sent. Appendix B references the follow up e-mail sent to the participants. The survey was closed on Day 7 of Week 4.

Those who choose to participate completed a demographic questionnaire. The demographic questionnaire is found in Appendix C. After completing the demographic survey, the participants then completed a 22-item questionnaire which is the MBI- HSS. Permission to use the MBI-HSS is in Appendix D. The participants also were asked to complete a 39-item Job Content Questionnaire. Permission to use this instrument is in Appendix E.

I developed procedures to support those who might have been negatively impacted by participating in the study. Participants were made aware of how they could address their issues related to burnout. If participants felt they needed follow-up assistance to help them cope with their burnout, I was prepared to give them information about seeking counseling assistance. Counselors were able to contact their agency's Employment Assistance Program (EAP) or the Substance Abuse and Mental Health (SAMHSA) National Helpline 1-800-662- Help for follow-up related to any discomfort they might have felt as a result of participating in this study. Both EAP and SAMHSA provide confidential referrals for individuals who are facing mental health and employment related problems.

Instrumentation

Researchers use survey methods to numerically describe populations within a research study (Babbie, 1990). The inventories utilized in this study were a demographic survey, the MBI-HSS (MBI-HSS), and the Job Content Questionnaire (JCQ).

Demographics. A demographic questionnaire was utilized to gather information from the participants. The participants were asked to indicate their gender, age, highest level of education, race, location of employment, marital status, rehabilitation sector, whether they were currently employed in the field of public sector rehabilitation, years of experience in the field of rehabilitation counseling, credentials, and information regarding caseload management.

Maslach Burnout Inventory. The MBI is the most widely used burnout inventory. Studies have provided strong evidence that the MBI is reliability and validity (Lee et al., 2010; Lee et al., 2011). The MBI measures emotional exhaustion, depersonalization, and personal accomplishment (Lee et al., 2010; Lee et al., 2011). The MBI was an appropriate instrument for this study because it specifically examines the level of burnout among working individuals in a

human service field. The primary use for the MBI overall scale is to measure burnout among working age adults (Morgan, de Bruin, & de Bruin, 2014).

The MBI has various types of assessment based upon job category. The MBI used for this study was the HSS due to the participants working in the human services field. This inventory consists of a 22-item, self-report, Likert-type scale. The MBI-HSS is the original measure of burnout designed to survey professionals in human service fields. According to Chao et al. (2011), the MBI-HSS is the burnout measure that is superior in distinguishing between burnout and other mental health syndromes such as depression or anxiety. The MBI website provides permission to utilize the instrument with the purchase of the inventory. The average completion time to complete the MBI-HSS is 10–15 minutes.

The norm group for the MBI is working adults. The MBI-HSS is most appropriate for professionals and paraprofessional in settings that have direct contact with clients and or patients (Maslach, Jackson, & Leither, 2016). The settings include medical offices, hospitals, group homes and halfway houses, intellectual and mental health centers, correctional facilities, family, child, and youth services, and organizations that offer services working with alcoholism, drug abuse, family violence, and aging (Maslach et al., 2016). The survey is appropriate for occupational groups that include counselors, therapists, psychiatrists, doctors, nurses, lawyers, polices, clergy, and others (Maslach et al., 2016). Additional demographic information was not supplied by the instrument developer for the norm group.

There are a wide range of samples that generally show adequate internal consistency for each of three MBI-HSS scales (Maslach et al., 2016). According to Maslach and Jackson (1981), the reliability of each burnout subscale was established with a Cronbach's alpha rating of r = .90 emotional exhaustion, r = .79 depersonalization, and r = .71 personal accomplishments. The

reliability was established with a test/retest of graduate students in social welfare and administration in a health agency. Longitudinal studies of the MBI-HSS have found a high degree of stability. MBI- HSS scale scores do not vary markedly from a period of one month to a year (Maslach et al., 2016).

According to Maslach et al. (2016), the convergent validity was established in three different sets of correlations. First, the MBI scores of the participants and someone who knew the participant (spouse or co-worker) were correlated. The MBI-HSS scores for this study were $r = .68$, $p < .00$. Next, job characteristics that are known to contribute to burnout were correlated with the MBI scores. Lastly, the MBI scores and measures of various outcomes related to burnout were correlated. These correlations provide evidence for the validity of the MBI. The discriminant validity of the MBI-HSS has been measured to determine whether burnout can be distinguished from job dissatisfaction, job stress, anxiety, or depression. Job satisfaction had a moderately negative correlation with emotional exhaustion ($r = -.23$, $p<.05$) and depersonalization ($r = -.22$, $p<.02$). There was slightly positive correlation with personal accomplishment ($r = .17$, $p< .06$). The MBI-HSS correlated with depression showed the following correlations emotional exhaustion ($r = .33$), depersonalization ($r = .30$), and personal accomplishment ($r = .14$). This shows that there are solid psychometrics for the MBI.

According to Maslach et al. (2016), the scores from the MBI should be statistically averaged. The three MBI-HSS scale scores are calculated and interpreted separately. The MBI scores are statistically averaged based upon emotional exhaustion, depersonalization, and personal accomplishment. The responses of the MBI-HSS should not be combined to form a single burnout score. The MBI-HSS mean scores range from 0 (never) to 6 (daily). The means scores are calculated to obtain the sum and then divided by the number of items in the scale. If

the sum of the scores for emotional exhaustion and depersonalization are high, the score indicates a higher degree of burnout. While the higher the sum of the score for personal accomplishment, the lesser indication a higher degree of burnout (Maslach et al, 2016). The highest score for emotional exhaustion, depersonalization, and personal accomplishment is 6, which means daily. The lowest score is 0, which means never for emotional exhaustion, depersonalization, and personal accomplishment.

Karasek–Theorell Job Content Questionnaire (JCQ). The JCQ version 2.0 was be utilized to collect information regarding job demands, job control, and job support. It is an instrument which measures the job demand, decision latitude, and social support on the job. According to Chungkam et al. (2013), the Job Content Questionnaire is a 39-item assessment validated through various subgroups of workers. It was first utilized in research regarding occupational health in the 1970s (Persson et al., 2012). Hoang et al. (2013) indicated the JCQ is the current gold standard for assessing job stress and strain. The JCQ presumes behavior is caused by the social environment. The questionnaire does not focus on self-referring questions to purposely minimize self-reflective responses. The questionnaire takes approximately 15 minutes to complete.

The JCQ utilizes the Census Industrial Classification System. The norm group for the JCQ is working adults within the agriculture, forestry and fisheries industry, mining industry, manufacturing industry, transportation, communication, and other public industries, wholesale and retail trade industry, business and repair services industry, personal services industry, entertainment and recreation services industry, professional and related services, and public administration. The sample size in the study was within the public administration industry, which includes federal and state government.

According to Nehzat, Huda, and Syed Tajuddin (2014), the JCQ is a reliable and valid instrument that assesses job stress in various occupations and countries. The JCQ scale was reported to be reliable in the United States (Karasek, Brisson, Kawakami, Houtoman, Bongers, & Amick, 1998). Within the JCQ, the reliability of job control is Cronbach alpha rating job control r = .63 (men) r = .66 (women), job demand is r = .86 (men) r = .84 (women), and job support is r = .85 (men) r = .86 (women). The reliability was determined in a preliminary study with research laboratory staff in a university. The Job Demand, Control, and Support Model indicates stress at work occurs due to an interaction between perceived work demands, perceived control, and the perceived level of support by workers (Karasek & Theorell, 1990). Job demand is based on the amount of activity required for the worker to perform while at work (Devereux et al., 2009). Job control is based upon the autonomy of workers and their ability to have control over their work activity throughout the workday (Devereux et al., 2009). Job support is described as the socioemotional support individuals receive from their peers and supervisors on the job (Devereux et al., 2009). When job control is high and job demand is low, there is low strain on the job. If job demand is high and job control is high, there is high demand on the job. Passive strain on the job is measured by low job demand and low job control and active strain is when job demand and job control are high.

Scores the JCQ were averaged based upon the participant's job demand, job control, and job support. Scales 1 (Decision Latitude), 1a (Skills Discretion), 1b (Decision Authority), 2 (Psychological Demand), and 3 (Social Support) were statistically averaged to determine the sum of each scale.

Analysis

The research questions were analyzed using the Statistical Package for Social Sciences version 23 (SPSS). A linear multiple regression analysis was performed to determine the predictive quality between the independent and criterion variables. The p critical was set at p= 0.05. Normality, homoscedasticity of variance and linearity assumptions were verified prior to performing the multiple regression (Gall, Gall, & Borg, 2007; Thompson, 2006). Normality was analyzed by the skewness and kurtosis of the distribution for the criterion variable and standardized residuals, interpreting the Shaprio-Wilk analysis, and reviewing the box plots. Homoscedasticity and linearity assumptions were verified by analyzing the scatterplots. R^2 was calculated to investigate the variance accounted for in the model, which was practical significance (Courville & Thompson, 2001; Thompson, 2006).

Threats to Validity

According to Chen, Donaldson, and Mark (2011), all types of validity are related to the truth of inferences. Within this study, external validity is the degree to which the results of this study can be generalized to other public-sector rehabilitation counselors. External validity is the truth of generalization in casual relationships. According to Shadish, Cook, and Campbell (2001), external validity threats occur when researchers conclude incorrect inferences from the sample data and generalize to other or all populations.

Participants in the study included public sector rehabilitation counselors who were certified. Therefore, the findings of the study cannot be generalized to all rehabilitation counselors, specifically those who are not certified or those who do not work in the public sector.

Counselors may have indicated they do not experience burnout due to fear of reporting information to their supervisors. To address this external validity issue, I ensured participants

understood that the study is confidential and provided reminders of participant privacy throughout the survey process. Understanding that the survey was confidential may have assisted the participants in being open when answering the questions.

In addition, years of experience within the field of rehabilitation may also have been a potential threat to validity. Counselors who have worked in the rehabilitation counseling field longer may have a higher level of resilience to burnout that those who are considered new to the field. This concern was addressed by asking the participants the number of years they have worked in public sector rehabilitation.

Internal validity is an unanticipated event which may occur during the research process (Fink, 2013). Internal validity threats are the experiences which threaten the researcher's ability to draw correct inferences (Shadish, Cook, & Campbell, 2001). Internal threats to validity in this study required monitoring procedures used in the study to ensure that they did not make a difference in the results. I provided participants the option to stop the survey if they felt uncomfortable for any reason.

Ethical Considerations

As it relates to the nature of the study and the effects on the participants, I gave careful consideration to ethical issues. The study was submitted to the Walden University IRB for approval. I provided the participants with the informed consent form and my contact information regarding questions related to the study. The informed consent form clearly indicated that all the records and information provided by the participants would remain confidential and only I would have access to those records. I e-mailed the link for the instrument to the participants; however, the survey did not provide information which linked the e-mail address to a particular participant's survey. I advised the participants that they could withdraw from the study at any

time during the process. In addition, I advised participants that their decision to participate in this study would not affect their employment within the field of rehabilitation and that the information would not be provided to their employers. The names of participants were not be collected. Once the study was completed, I downloaded the responses using a password protected USB drive into SPSS. The records of this study will be kept private. Within the reporting of the data, there was no identifying information that could be used to identify a participant. Only I, as the researcher, have access to the records. After 5 years, the records will be destroyed by fire.

There were low to no physical risks or benefits for participating in the study. Individuals who participated did not undergo any physical or mental harm. Participation in the study was strictly voluntary, and individuals were not compensated for participating. There was a potential for participants to reflect and realize they cope with counselor burnout. Those who participated in the study may know and understand the signs of symptoms of burnout, but those in the helping field may be so focused on the needs of their clients that they are not aware of their needs or issues (Tabaj et al., 2015). I anticipated that participation in the study may have caused some participants to become aware of those signs and symptoms of burnout that they may have experienced. I provided participants with a national counseling helpline number if they felt a need to address any emotional issues because of completing the survey instrument. Participants had no obligation to complete any part of the study if they began to feel uncomfortable. I notified the participants that their participation was strictly voluntary, and they could stop the survey at any time.

Summary

This chapter described the methodology of this quantitative research study. The purpose of this research study was to determine the extent of the relationship, if any, between burnout and job demand, job control, and job support for public sector rehabilitation counselors. The participants in this study were assessed using the MBI and the Job Content Questionnaire. A multiple regression was performed to determine the predictive quality between the independent and criterion variables.

In Chapter 4, I will present the results of the study.

Chapter 4: Results

Introduction

The purpose of this research study was to determine the extent of the prediction, if any, between burnout and job demand, job control, and job support for public sector rehabilitation counselors. Instruments used in the study included the Job Content Questionnaire to measure the predictor variables (job demand, job control, and job support; Karasek & Theorell, 1990) and the MBI to measure the criterion variable of burnout (Maslach & Jackson, 1981).

Research Question

The study will examine the following research question through a multiple linear regression: Do job demand, job control, and job support (as measured by subscales of Karasek and Theorell Job Content Questionnaire) predict burnout (as measured by the MBI) among public sector rehabilitation counselors?

Research Null Hypothesis

H_0: There is no predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

Research Alternative Hypothesis

H_1: There is a predictive quality between burnout (as measured by the MBI) and job demand, job control, and job support (as measured by subscales of the Karasek and Theorell Job Content Questionnaire) of public sector rehabilitation counselors.

Data Collection

Following the approval of the Walden University IRB (Approval No. 09-28-18-0082736), I submitted my proposal, IRB approval, and a copy of the instruments to the

Commission on Rehabilitation Counselor Certification (CRCC) for permission to use the directory. Once I received approval, I received 1,000 participants from the CRCC directory, contacted them via e-mail, and invited them to participate by completing the survey. After 3 weeks of receiving the e-mail, I sent a reminder e-mail to each participant. The survey was closed on February 10, 2019.

A total of 197 certified rehabilitation counselors participated in the online survey, which yielded a 19.7% response rate. Of these participants, 33 were incomplete, and 45 did not currently work in public sector rehabilitation. Therefore, I removed them from the study, leaving 119 participants. I anticipated that the research project results would generalize to certified rehabilitation counselors in public sector vocational rehabilitation services in the United States. According to CRCC (2019), there were 16,000 CRCs in the United States. There is no documentation of how many of these CRCs work for public sector rehabilitation.

Results

Demographics

Of the total 119 participants who completed the survey, 79.8% were female and 74.8% were identified as White, alone. “Vocational rehabilitation counselor” was the job title with the highest number of participants (68.9%); the second highest number of participants classified their job title as “specialist” (10.9%). The majority of the participants indicated that they worked for public sector only (96.6%), while 3.4% indicated that they worked for public sector and academia. The participants’ average years of experience in public sector rehabilitation was 13.5. The maximum number of years was 34 and the minimum was 1 year. The average caseload size of the participants was 102 clients.

Table 1

Rehabilitation Sector

	Frequency	Percent	Valid Percent	Cumulative Percent
Public Sector	115	96.6	96.6	96.6
Public Sector and Academia	4	3.4	3.4	100.0
Total	119	100.0	100.0	

All analyses were completed using IBM SPSS, Version 25, to predict the relationship between the dependent variable and the three independent variables. The MBI–HSS, does not provide a single burnout score. However, the survey provides a score for depersonalization, emotional exhaustion, and personal accomplishment, which are three components of burnout. The scores cannot be combined to conclude a single burnout score. Therefore, each area that defines burnout was assessed against job demand, job control, and job support (independent variable).

The MBI-HSS subscale score for emotional exhaustion was calculated by summing the survey responses on emotional exhaustion questions #1, 2, 3, 6, 8, 13,14, 16, and 20. The total was divided by the sum of 9. The total resulting participants' score for emotional exhaustion subscale ranged from a minimum score of 4 to a maximum score of 52 (M= 26.44, SD = 12.189).

The MBI-HSS subscale score for depersonalization was calculated by summing the survey responses on depersonalization questions #5, 10, 11, 15, and 22. The total resulting participants' score for depersonalization subscale ranged from a minimum score of 0 to a maximum score of 20 (M= 6.55, SD =5.105).

Table 2

Participants' Job Title

	Frequency	Percent	Valid percent	Cumulative percent
Administrator	2	1.7	1.7	1.7
Director	3	2.5	2.5	4.2
Manager	3	2.5	2.5	6.7
Pre-Employment Counselor	1	.8	.8	7.6
Specialist	13	10.9	10.9	18.5
State Analyst	1	.8	.8	19.3
Supervisor	6	5.0	5.0	24.4
Therapist	1	.8	.8	25.2
Transition vocational rehabilitation counselor	5	4.2	4.2	29.4
Vocational rehabilitation blind counselor	1	.8	.8	30.3
Vocational rehabilitation consultant	1	.8	.8	31.1
Vocational rehabilitation counselor	82	68.9	68.9	100.0

The MB-HSS subscale score for personal accomplishment was calculated by summing the survey responses on personal accomplishment questions #4, 7, 9, 12, 17, 18, 19, and 21. The total resulting participants' score for personal accomplishment subscale ranged from a minimum score of 11 to a maximum score of 47 (M= 37.03, SD = 6.954).

Table 3

Descriptive Statistics for Burnout

	N	Minimum	Maximum	Mean	Std. Deviation	Variance
Emotional exhaustion	119	4	52	26.44	12.189	148.570
Depersonalization	119	0	20	6.55	5.105	26.063
Personal accomplishment	119	11	47	37.03	6.954	48.355
Valid N (listwise)	119					

The JCQ subscale score for job demand was calculated by [Q19 +Q20) x3 + (15- (Q22 + Q23+ Q26)) x2]. The total resulting participants' score for job demand subscale ranged from a minimum score of 7 to a maximum score of 33 (M= 23.65, SD = 6.127).

The JCQ subscale score for job control was calculated by summing Skills Discretion and Decision Authority. Skills Discretion was calculated by [Q3+ Q5+ Q7+ Q9+ Q11+ (5-Q4)]x 2. Decision Authority was calculated by [Q6+ Q10+ (5- Q8)]x 4. The total resulting participants' score for job control subscale ranged from a minimum score of 0 to a maximum score of 24 (M= 15.62, SD =4.850).

The JCQ subscale score for job support was calculated by summing Coworker Support and Supervisor Support. Coworker support was calculated by [Q53+ Q54+ Q56+ Q 58]. Supervisor support was calculated by [Q48+ Q49+ Q51+ Q52]. The total resulting participants' score for job support subscale ranged from a minimum score of 34 to a maximum score of 74 (M= 54.13, SD =6.435).

Table 4

Descriptive Statics for JDC-S

	N	Minimum	Maximum	Mean	Std. Deviation	Variance
Job Demand calculations	119	7	33	23.65	6.127	37.535
Job Support calculations	119	0	24	15.62	4.850	23.525
Job control calculations	119	34	74	54.13	6.435	41.405
Valid N (listwise)	119					

Linear Multiple Regression Results

The statistical analysis chosen was linear multiple regression to answer the following question: Do job demand, job control, and job support (as measured by subscales of Karasek and Theorell Job Content Questionnaire) predict burnout (as measured by the MBI) among public sector rehabilitation counselors?

The linear multiple regression was conducted to predict burnout between job demand, job control, and job support. A significant regression equation was found with F(3,115)= 24.25, p<.001 as it relates to emotional exhaustion (see Table 6). A significant regression equation was found with F(3, 115)= 4.24, p=.007 as it relates to depersonalization (see Table 7). A significant regression equation was found with F(3, 115)= 5.57, p=.001 as it relates to personal accomplishment.

Emotional Exhaustion

The results of the linear regression model were significant, $F(3,115) = 24.25$, $p < .001$, $R^2 = 0.39$, indicating that approximately 39% of the variance in emotional exhaustion is explainable by job demand, job control, and job support. Job demand significantly predicted emotional exhaustion, $B = 1.09$, $t(115) = 7.25$, $p < .001$. This indicates that on average, a one-

unit increase of job demand will increase the value of emotional exhaustion by 1.09 units. Job support significantly predicted emotional exhaustion, $B = -0.74$, $t(115) = -3.98$, $p < .001$. This indicates that on average, a one-unit increase of job support will decrease the value of emotional exhaustion by 0.74 units. job control did not significantly predict emotional exhaustion, $B = -0.22$, $t(115) = -1.49$, $p = .139$. Based on this sample, a one-unit increase in job control does not have a significant effect on emotional exhaustion. Table 5 summarizes the results of the regression model.

Table 5

Results for Linear Regression with Job Demand, Job Support, and Job Control Predicting Emotional Exhaustion

Variable	*B*	*SE*	CI	β	*t*	*p*
(Intercept)	23.89	7.95	[8.15, 39.64]	0.00	3.01	.003
JobDemand	1.09	0.15	[0.79, 1.39]	0.55	7.25	< .001
JobSupport	-0.74	0.19	[-1.11, -0.37]	-0.29	-3.98	< .001
JobControl	-0.22	0.14	[-0.50, 0.07]	-0.11	-1.49	.139

Note. CI is at the 95% confidence level. Results: $F(3,115) = 24.25$, $p < .001$, $R^2 = 0.39$

Unstandardized Regression Equation: emotional exhaustion = 23.89 + 1.09*job demand - 0.74*job support - 0.22*job control

More job demand predicted more emotional exhaustion and more job support predicted less emotional exhaustion. Job control did not predict emotional exhaustion.

Depersonalization

The results of the linear regression model were significant, $F(3,115) = 4.24$, $p = .007$, $R^2 = 0.10$, indicating that approximately 10% of the variance in depersonalization is

explainable by job demand, job control, and job support. Job demand significantly predicted depersonalization, $B = 0.21$, $t(115) = 2.73$, $p = .007$. This indicates that on average, a one-unit increase of job demand will increase the value of depersonalization by 0.21 units. Job Support significantly predicted depersonalization, $B = -0.20$, $t(115) = -2.09$, $p = .039$. This indicates that on average, a one-unit increase of job support will decrease the value of depersonalization by 0.20 units. Job control did not significantly predict depersonalization, $B = -0.01$, $t(115) = -0.14$, $p = .887$. Based on this sample, a one-unit increase in job control does not have a significant effect on depersonalization. Table 6 summarizes the results of the regression model.

Table 6

Results for Linear Regression with JobDemand, JobSupport, and JobControl Predicting Depersonalization

Variable	*B*	*SE*	CI	β	*t*	*p*
(Intercept)	5.28	4.04	[-2.72, 13.27]	0.00	1.31	.194
JobDemand	0.21	0.08	[0.06, 0.36]	0.25	2.73	.007
JobSupport	-0.20	0.09	[-0.38, -0.01]	-0.19	-2.09	.039
JobControl	-0.01	0.07	[-0.16, 0.13]	-0.01	-0.14	.887

Note. CI is at the 95% confidence level. Results: $F(3,115) = 4.24$, $p = .007$, $R^2 = 0.10$
Unstandardized Regression Equation: depersonalization = 5.28 + 0.21*job demand - 0.20*job support - 0.01*job control

More job demand predicted more depersonalization and more job support predicted less depersonalization. Job control did not predict depersonalization.

Personal Accomplishment

The results of the linear regression model were significant, $F(3,115) = 5.57$, $p = .001$, $R^2 = 0.13$, indicating that approximately 13% of the variance in personal accomplishment is explainable by job demand, job control, and job support. Job demand did not significantly

predict personal accomplishment, B = -0.10, t(115) = -1.01, p = .315. Based on this sample, a one-unit increase in job demand does not have a significant effect on personal accomplishment. Job support significantly predicted personal accomplishment, B = 0.48, t(115) = 3.81, p < .001. This indicates that on average, a one-unit increase of job support will increase the value of personal accomplishment by 0.48 units. job control did not significantly predict personal accomplishment, B = 0.04, t(115) = 0.45, p = .652. Based on this sample, a one-unit increase in job control does not have a significant effect on personal accomplishment. Table 7 summarizes the results of the regression model.

Table 7
Results for Linear Regression with Job Demand, Job Support, and Job Control Predicting Personal Accomplishment

Variable	*B*	*SE*	CI	β	*t*	*p*
(Intercept)	29.55	5.41	[18.82, 40.27]	0.00	5.46	< .001
JobDemand	-0.10	0.10	[-0.31, 0.10]	-0.09	-1.01	.315
JobSupport	0.48	0.13	[0.23, 0.73]	0.34	3.81	< .001
JobControl	0.04	0.10	[-0.15, 0.24]	0.04	0.45	.652

Note. CI is at the 95% confidence level. Results: $F(3,115) = 5.57$, $p = .001$, $R^2 = 0.13$
Unstandardized Regression Equation: personal accomplishment= 29.55 - 0.10*job demand + 0.48*job support + 0.04*job control

More Job Support predicted more personal accomplishment. Job demand and job control did not predict emotional exhaustion.

Summary

In this chapter, I summarized the results of this quantitative survey research designed with a linear multiple regression analysis. Quantitative research methods were used to determine whether there were relationships among the variables. A multiple linear regression was used to answer the research question because this type of regression determines whether a predictive

quality existed among two or more predictor variables and one criterion variable. The multiple linear regression analysis was used to examine the predictive quality of job demands, job control, and job support (predictor variables) for burnout (criterion variable). The inventories utilized in this study were a demographic survey, the Maslach Burnout Inventory-Human Service Survey (MBI-HSS), and the Job Content Questionnaire (JCQ). In Chapter 5, I describe limitations of the data, recommendation for future research, and implications for social change for public sector rehabilitation counselors.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

A *hidden handicap* of rehabilitation counselors is burnout due to the particular demands of providing services to persons with disabilities (O'Sullivan & Bates, 2014). Burnout has led to turnover and poor counselor performance within public sector rehabilitation (O'Sullivan & Bares, 2014). Determining whether burnout can be predicted by job demand, job control, or job support within public sector rehabilitation counselors may help develop a course of action to help prevent burnout. No research has been conducted that examines the relationships among job demand, job control, job support, and burnout among public sector rehabilitation counselors. Therefore, this research project aimed to fill that gap.

The purpose of this research study was to determine whether burnout could be predicted by job demand, job control, or job support for public sector rehabilitation counselors. Instruments used in the study included the Job Content Questionnaire to measure the predictor variables (job demand, job control, and job support; Karasek & Theorell, 1990) and the MBI to measure the criterion variable of burnout (Maslach & Jackson, 1981).

In this research project, I evaluated one research question regarding burnout and job demand, job control, and job support using a multiple linear regression analysis. The statistical analysis and results were reviewed in Chapter 4. In this chapter, I provide an interpretation of the results, a review the limitations of this study, recommendations for future research, and implications for social change.

Interpretation of Findings

In this section, I interpret the findings from this research project in relation to the theoretical framework of this study. I then interpret the findings based on the research question.

Theoretical Framework

The theoretical framework for this study was the Karasek and Theorell (1990) Demand-Control-Support model, which indicates that stress from work is developed based on work demands, perceptions of control, and perceived support that is received. The JDC-S model has been used successfully in globalized industries to describe the potential causes of health problems for employers (Chen et al., 2011). Furthermore, it is one of the main theoretical models that is used to explain the relationship between job strain and the health of workers (Hoang, Corbiere, Negrini, Pham, & Reinharz, 2013). In 1979, Karasek introduced the Job Demand Control model to describe how job characteristics have an effect on the well-being of others (Karasek, 1979). Research indicated that jobs that are high in demand, yet low in control and social support, have the highest risk of stress for workers (Devereux et al., 2009). Moreover, the Demand, Support, and Control Model can be used to increase productivity and engagement among workers.

The results of this study provided empirical data on burnout and job demand, job control, and job support. In this study, I found that public sector rehabilitation counselors view their positions as high in demand, low in support, but high in control. The results of this study suggest there is a likelihood of a lower risk of stress because of high autonomy on the job. Moreover, there was a significant prediction between Burnout (as described by emotional exhaustion, depersonalization, and personal accomplishment) to job demand, job control, and job support.

Job Demand

Job demand is based upon the amount of activity required for the worker to perform while at work. It describes the psychological demand related to the competitive nature of working with coworkers, work pace, the intensity, and the skills required on the job (Chen et al.,

2011). Role conflict is also analyzed within job demand (Hausser, Mojzisch, Niesel, & Shulz-Hardt, 2010). The results of this study demonstrated that participants believed they have moderate to high job demand as public sector rehabilitation counselors.

Job Control

Job control is based on the autonomy of workers and their ability to have control over their work activity throughout the workday. Furthermore, jJob control describes workers' ability to use their creativity (Chen et al., 2011). Job control is the freedom to determine how to meet the job demand while at work (Armon, Shmuel, & Shirom, 2012). Participants in this study believed that they have high autonomy as public sector rehabilitation counselors.

Job Support

Job support is described as the socioemotional support individuals receive from their peers and supervisors on the job. Karasek and Theorell (1990) suggested socioemotional support on the job can promote good health, can be an active coping mechanism, and can help with the person's sense of identity. Furthermore, workers who felt that they could not consult with their supervisor about personal and work-related issues had higher levels of burnout compared to those who felt they could consult with their supervisors (Devereux et al., 2009). Participants in this study believed they had low support as public sector rehabilitation counselors.

Burnout

Maslach and Jackson (1981) indicated the high scores of emotional exhaustion and depersonalization and feelings of reduced personal accomplishment suggest a presence of burnout. The participants in this study reported high scores of emotional exhaustion, low scores of depersonalization, and high scores of personal accomplishment. Therefore, the results of this study suggested there is not a presence of burnout among public sector rehabilitation counselors.

Emotional Exhaustion and JDC-S

Emotional Exhaustion is defined as feelings of fatigue (Maslach & Jackson, 1981; Morgan, deBruin, & deBruin, 2014). Emotional exhaustion is a chronic state of both emotional and physical depletion due to fatigue. In this study, I found there was a significant relation between job demand, job control, and job support and emotional exhaustion. There was a high level of emotional exhaustion for the participants within this study. When emotional exhaustion is high, there is greater chance of burnout. In addition, based on the results of the study, on average when emotional exhaustion is increased there is an increase of job demand and job support. There was no indication that job control predicts emotional exhaustion.

Depersonalization and JDC-S

Depersonalization occurs when an individual possesses a negative attitude toward work and has feelings of isolation from others on the job (Maslach & Jackson, 1981; Morgan et al., 2014). In this study, I found a significant relationship among job demand, job control, and job support and depersonalization. However, there was a low level of depersonalization for the participants in this study. This could indicate that no matter how public sector rehabilitation counselors feel about the job demand, they continue to work well with their coworkers and clients. When there is a low level of depersonalization, the likelihood of burnout is decreased. On average, as job demand increased depersonalization increase. However, as job support increases there is a decrease in depersonalization. There was no indication that job control predicts depersonalization.

Personal Accomplishment and JDC-S

The lack of personal accomplishment occurs when the individual feels useless to the organization and the clients being served (Thomas et al., 2014). Therefore, individuals who feel

reduced personal accomplishment often begin to decrease their performance on the job. The decrease in productivity is often due to the feelings that their contribution to work does not matter. In this study, I found there was a significant relationship among job demand, job control, and job support. The participants appear have a high level of personal accomplishment. Furthermore, high levels of personal accomplishment decrease the probability of burnout. Based on this sample, as job demand increase it does not have an effect on personal accomplishment. However, on average as job support increases, personal accomplishments increase. There was no indication that job control predicts personal accomplishment.

Limitations of the Study

There are several limitations within this study. One limitation is that that data collected was self-reported by participants. Self-reported surveys are methods that allow participants in a study to describe their feelings (Mertens, 2009). When using self-reported surveys, participants sometimes reveal only the information they want the researcher to know (Mertens, 2009). Furthermore, in self-reported surveys individuals may exaggerate their feelings or under report their feelings (Mertens, 2009). O'Sullivan and Bates (2014) described burnout as a *hidden handicap* of rehabilitation counselors. Respondents from the survey may have been uncomfortable with self-reporting their true feelings related to burnout. Self- reported data collection may reduce the validity and generalizability of the results of this study.

Another limitation of this study is that all participants were certified rehabilitation counselors. The study cannot be generalized to all public-sector rehabilitation counselors, only to those who are certified. There is no documentation of how many rehabilitation counselors within the public sector have earned their certification.

An additional limitation of this study was that it cannot be generalized to rehabilitation counselors employed in settings other than the public sector. The participants included only those who work in public sector rehabilitation. This study did not include CRCs who work in private sector rehabilitation or CRCs who do not work in vocational rehabilitation services.

Social Change Implications

This study is significant because the findings could positively impact social change in the field of rehabilitation counseling. First, understanding relationships among factors related to counselor burnout could lead to information which can contribute directly or indirectly to decreasing burnout. The results of this study could stimulate further research that could identify factors to focus on preventing burnout among vocational rehabilitation counselors. In addition, the findings from this study could contribute to increasing the wellness of counselors within the public rehabilitation counseling sector, which, in turn, could lead to positive change in the quality of services for clients.

Consideration for Future Research

Additional research is needed related to burnout and public-sector rehabilitation services. A *hidden handicap* of rehabilitation counselors is burnout due to the particular demands of providing services to persons with disabilities (O'Sullivan & Bates, 2014). Future research should focus on both Certified Rehabilitation Counselors and Non-Certified Rehabilitation Counselors who work in public sector rehabilitation. Because it was difficult to access public rehabilitation counselors who are not certified, I did not survey non-certified public-sector counselors. Future research projects should also focus on certified rehabilitation counselors who work in private sector settings.

Conclusion

I conducted this research to understand whether burnout could be predicted in public sector rehabilitation counselors by job demand, job control, and job support. I found that more job demand predicts more emotional exhaustion and more depersonalization. Job demand does not predict personal accomplishment. In addition, more job support predicts less emotional and depersonalization and more personal accomplishment. More or less job control does not predict emotional exhaustion, depersonalization, or personal accomplishment. Additional support for public sector rehabilitation counselors is needed. Public sector rehabilitation should create strategies to decrease high levels of emotional exhaustion and job demand among counselors. In addition, the results of this research project suggest that there are low levels of job support for public sector rehabilitation counselors. Therefore, public sector rehabilitation should also create strategies to increase job support for public sector rehabilitation counselors.

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Appendix A: Email to Participants

I am writing to you to request your participation in a survey. Your responses to this survey will help evaluate burnout levels of certified rehabilitation counselors in the field of public sector rehabilitation counseling. The survey will take approximately 30 minutes to complete. Please click the link below to go to the survey website (or copy and paste the link into your internet browser).

Survey Link: http://www.surveymonkey.com/r/BurnoutandCRC

Your participation in the survey is completely voluntary and all responses will be kept confidential. No personally identifiable information will be associated with your responses to any reports of these data. If there are any questions, please contact the primary investigator, Monica E. Jackson, at monica.jackson2@waldenu.edu or the dissertation committee chair, Dr. Theodore Remley, at Theodore.Remley@waldenu.edu Please note Walden University granted IRB approval. My IRB approval # is 09-28-18-0082736.

Thank you very much for your time and cooperation.

Respectfully submitted,

Monica E. Jackson, MS, LPC, CRC

CES Doctoral Student

Walden University

Appendix B: Follow up Email to Participants

I am writing to you to request your participation in a survey. This is the second notification, thank you if you have already participated. If you have not, please consider being a part of the process. Your responses to this survey will help evaluate burnout levels of certified rehabilitation counselors in the field of public sector rehabilitation counseling. The survey will take approximately 30 minutes to complete. Please click the link below to go to the survey website (or copy and paste the link into your internet browser).

Survey Link: http://www.surveymonkey.com/r/BurnoutandCRC

Your participation in the survey is completely voluntary and all responses will be kept confidential. No personally identifiable information will be associated with your responses to any reports of these data. If there are any questions, please contact the primary investigator, Monica E. Jackson, at monica.jackson2@waldenu.edu or the dissertation committee chair, Dr. Theodore Remley, at Theodore.Remley@waldenu.edu Please note Walden University granted IRB approval. My IRB approval # is 09-28-18-0082736. Thank you very much for your time and cooperation.

Respectfully submitted,

Monica E. Jackson, MS, LPC, CRC

CES Doctoral Student

Walden University

Appendix C: Demographic Survey Questions

1. Are you a Certified Rehabilitation Counselor?
    a. Yes
    b. No
2. Are you currently employed in public sector rehabilitation services?
    a. Yes
    b. No
3. What is your gender?
    a. Male
    b. Female
    c. Other _____
    d. Would Rather Not Specify
4. What is your age? _____
5. What is the highest level of education?
    a. Bachelor's Degree
    b. Master's Degree
    c. Ph.D. or other doctoral degrees
6. What is your race?
    a. White, alone
    b. Black or African Alone
    c. American Indian and Alaska Natives
    d. Asian, only
    e. Native Hawaiian and other
    f. Pacific Islander
    g. Two or more races
    h. Hispanic or Latino
    i. Other _____
    j. Would Rather Not Specify
7. What State do you work in? _____
8. What is your marital status
    a. Never been married
    b. Married
    c. Separated
    d. Divorced
    e. Widowed
    f. Other _____
    g. Would Rather Not Specify

9. Which area of Rehabilitation Services do you work?
    a. Public Sector
    b. Private Sector
    c. Academia
    d. Public Sector and Academia
    e. Private Sector and Academia
    f. Other_____
10. How many years of experience do you have in public sector rehabilitation services? _____
11. Do you have any of the other following credentials (select all that apply)?
    a. Licensed Professional Counselor (LPC)
    b. Certified Vocational Evaluator (CVE)
    c. Licensed Master Social Worker (LMSW)
    d. Licensed Clinical Social Worker (LCSW)
    e. Certified Life Care Planner (CLCP)
    f. Other _____
12. What is your average caseload size? _____
13. Do you think your caseload size is difficult to manage?
    a. Yes
    b. No
14. What is your yearly benchmark size? _____
15. Did you meet your yearly benchmark in the last fiscal year?
    a. Yes
    b. No
    c. I do not have yearly benchmarks
    d. Other _____
16. Are you on track to meet your yearly benchmarks for this fiscal year?
    a. Yes
    b. No
    c. I do not have yearly benchmarks
    d. Other _____
17. Do the expectations to meet yearly benchmark cause stress for you?
    a. Yes
    b. No
    c. I do not have yearly benchmarks
    d. Other _____

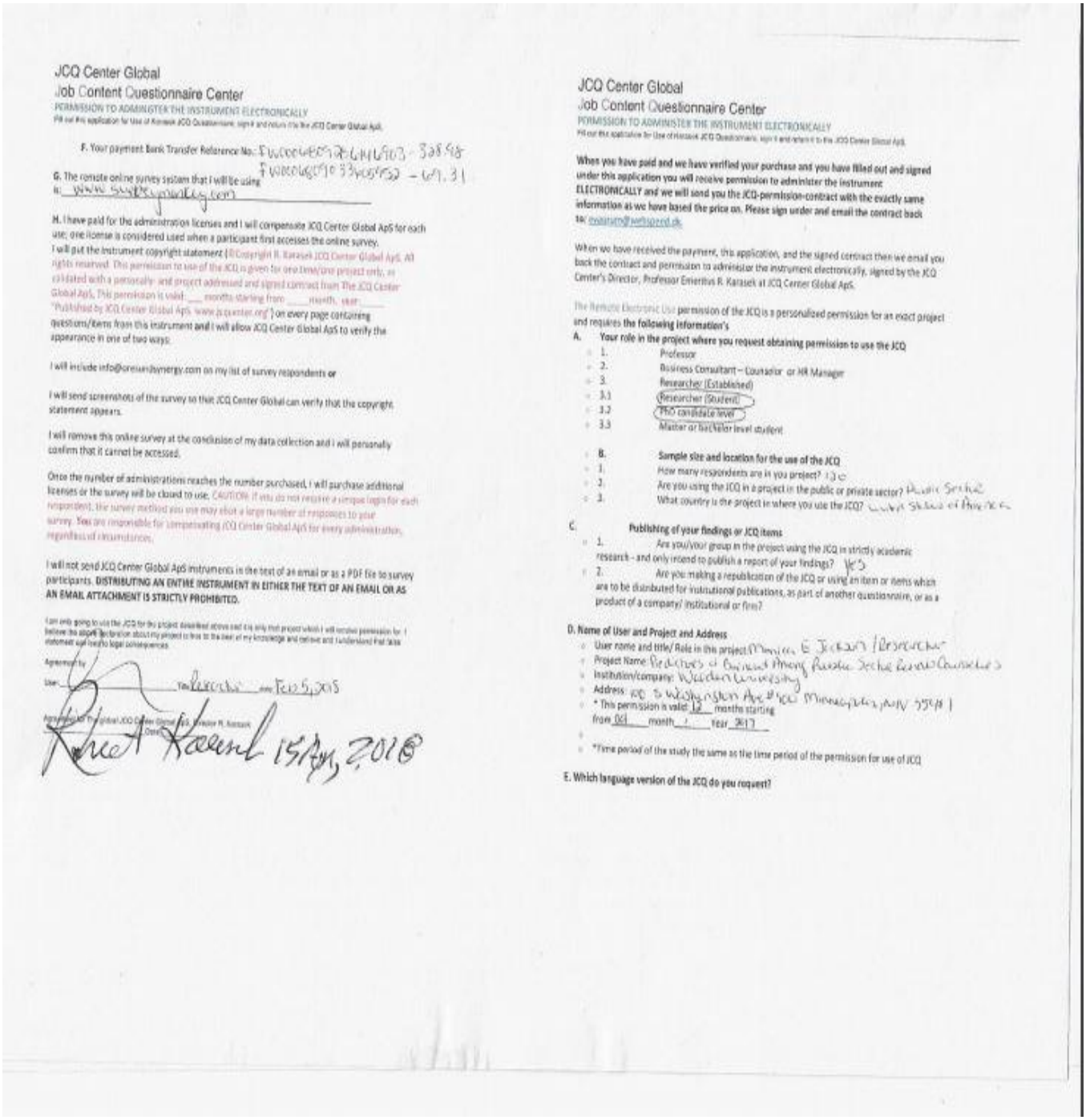
Appendix D: MBI Approval Information

Effective date is May 3, 2018 for: Monica Jackson

Your name: Monica E. Jackson E-mail address: monica.jackson2@waldenu.edu Repeat e-mail address: monica.jackson2@waldenu.edu Phone number: 3137291560 Company/institution: Walden University Your project title: Predictors of Burnout Among Public Sector Rehabilitation Counselors Mind Garden Sales Order or Invoice number for your purchase of reproduction licenses: QUTXTQRRP The name of the Mind Garden instrument you will be using: MBI- HSS Monica Jackson 3 You have agreed to the following guidelines: Question Answer I have paid for my administration licenses and I will compensate Mind Garden, Inc. for each use; one license is considered used when a participant first accesses the online survey. I agree to this condition. I will put the instrument copyright statement (from the footer of my license document; includes the copyright date, copyright holder, and "All rights reserved in all media. Published by Mind Garden, Inc. www.mindgarden.com") on every page containing questions/items from this instrument and I will send screenshots of the survey so that Mind Garden can verify that the copyright statement appears. I agree to this condition. I will remove this online survey at the conclusion of my data collection and I will personally confirm that it cannot be accessed. I agree to this condition. Once the number of administrations reaches the number purchased, I will purchase additional licenses or the survey will be closed to use. I agree to this condition. I will not send Mind Garden instruments in the text of an e-mail or as a PDF file to survey participants. I agree to this condition. Question Answer Please specify the name of and web address for the remote online survey website you will be using and describe how you will be putting this

instrument online: www.surveymonkey.com Monica Jackson 4 Question Answer Your name (as electronic signature): Monica E. Jackson Date: 02/02/2018

Appendix E: Job Content Questionnaire Approval



JCQ Center Global

Job Content Questionnaire Center

PERMISSION TO ADMINISTER THE INSTRUMENT ELECTRONICALLY

Fill out this application for Use of Karasek JCQ Questionnaire, sign it and return it to the JCQ Center Global ApS.

F. Your payment Bank Transfer Reference No.: FW0004605726446903 - 338.98
FW0004605710 33405952 - 69.31

G. The remote online survey system that I will be using is: www.surveymonkey.com

H. I have paid for the administration licenses and I will compensate JCQ Center Global ApS for each use; one license is considered used when a participant first accesses the online survey.
I will put the instrument copyright statement (© Copyright R. Karasek JCQ Center Global ApS. All rights reserved. This permission to use of the JCQ is given for one time/one project only, as validated with a personally- and project addressed and signed contract from The JCQ Center Global ApS. This permission is valid: ___ months starting from ____month, year_____
"Published by JCQ Center Global ApS. www.jcquestor.org") on every page containing questions/items from this instrument and I will allow JCQ Center Global ApS to verify the appearance in one of two ways:

I will include info@oresundsynergy.com on my list of survey respondents or

I will send screenshots of the survey to this JCQ Center Global can verify that the copyright statement appears.

I will remove this online survey at the conclusion of my data collection and I will personally confirm that it cannot be accessed.

Once the number of administrations reaches the number purchased, I will purchase additional licenses or the survey will be closed to use. CAUTION: If you do not require a unique login for each respondent, the survey method you use may allow a large number of responses to your survey. You are responsible for compensating JCQ Center Global ApS for every administration, regardless of circumstances.

I will not send JCQ Center Global ApS instruments in the text of an email or as a PDF file to survey participants. **DISTRIBUTING AN ENTIRE INSTRUMENT IN EITHER THE TEXT OF AN EMAIL OR AS AN EMAIL ATTACHMENT IS STRICTLY PROHIBITED.**

I am only going to use the JCQ for the project described above and it is only that project which I will receive permission for. I believe the above declaration about my project is true to the best of my knowledge and I believe and I understand that false statement will lead to legal consequences.

Agreement by

User: _____ Title: Researcher date: Feb 5, 2018

Agreement by Original JCQ Center Global ApS, Professor R. Karasek
Owner

Robert Karasek 15th, 2018

JCQ Center Global

Job Content Questionnaire Center

PERMISSION TO ADMINISTER THE INSTRUMENT ELECTRONICALLY

Fill out this application for Use of Karasek JCQ Questionnaire, sign it and return it to the JCQ Center Global ApS.

When you have paid and we have verified your purchase and you have filled out and signed under this application you will receive permission to administer the instrument ELECTRONICALLY and we will send you the JCQ-permission-contract with the exactly same information as we have based the price on. Please sign under and email the contract back to: evasums@webspeed.dk

When we have received the payment, this application, and the signed contract then we email you back the contract and permission to administer the instrument electronically, signed by the JCQ Center's Director, Professor Emeritus R. Karasek at JCQ Center Global ApS.

The Remote Electronic Use permission of the JCQ is a personalized permission for an exact project and requires **the following information's**

A. **Your role in the project where you request obtaining permission to use the JCQ**
- 1. Professor
- 2. Business Consultant – Counselor or HR Manager
- 3. Researcher (Established)
- 3.1 (Researcher (Student))
- 3.2 (PhD candidate level)
- 3.3 Master or bachelor level student

B. **Sample size and location for the use of the JCQ**
- 1. How many respondents are in you project? 130
- 2. Are you using the JCQ in a project in the public or private sector? Public Sector
- 3. What country is the project in where you use the JCQ? United States of America

C. **Publishing of your findings or JCQ items**
- 1. Are you/your group in the project using the JCQ in strictly academic research – and only intend to publish a report of your findings? YES
- 2. Are you making a republication of the JCQ or using an item or items which are to be distributed for institutional publications, as part of another questionnaire, or as a product of a company/ institutional or firm?

D. **Name of User and Project and Address**
- User name and title/ Role in this project: Monica E Jackson / Researcher
- Project Name: Predictors of Burnout Among Public Sector Human Service Workers
- Institution/company: Walden University
- Address: 100 S Washington Ave #900 Minneapolis, MN 55401
- * This permission is valid: 12 months starting from: 06 month: 1 year: 2017
- *Time period of the study the same as the time period of the permission for use of JCQ

E. **Which language version of the JCQ do you request?**