2019

A Canonical Correlation Analysis of Self-Compassion, Life Balance, and Burnout in Counselors

Sarah Vanessa Silva
Walden University

Walden University

College of Counselor Education & Supervision

This is to certify that the doctoral dissertation by

Sarah Silva

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Christian Dean, Committee Chairperson, Counselor Education and Supervision Faculty
Dr. Cynthia Briggs, Committee Member, Counselor Education and Supervision Faculty
Dr. Jennifer Gess, University Reviewer, Counselor Education and Supervision Faculty

The Office of the Provost

Walden University
2019

Abstract

A Canonical Correlation Analysis of Self-Compassion, Life Balance, and Burnout in Counselors

by

Sarah Silva

MA, The Chicago School of Professional Psychology, 2012

BA, Rutgers University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2019

Abstract

The counseling profession seeks to support and enrich the quality of life of the general public by providing effective clinical services. Many counselors struggle with practicing self-care regularly, increasing the risk of burnout. When counselors provide services while experiencing burnout, they risk harming clients being served. The conservation of resources theory suggests that there is an increased risk of maladaptive coping and burnout when there is a decrease in resources used to protect someone from experiencing stress. A quantitative survey research study using a nonprobability convenience sampling was used to explore the relationship between counselor burnout, life balance, and self-compassion among fully licensed and provisionally licensed counselors throughout the United States with at least 2 years of experience (N = 331). Two canonical correlation analyses were conducted to determine (a) if there was any significant relationship between the subscales of the Juhnke-Balkin Life Balance Inventory, measuring life balance, and the Counselor Burnout Inventory (CBI), measuring burnout, and (b) if there was a significant relationship between the subscales of the CBI, measuring burnout, and the Self-Compassion Scale, measuring self-compassion. Both canonical correlation analyses indicated a statistically significant relationship. Particularly, professional counselors who experience burnout are experiencing poor work-life balance. Additionally, professional counselors who do not experience burnout had higher levels of self-compassion. The potential social change impact from this research study is that a better understanding of how to mitigate and/or prevent experiences of burnout in counselors may improve counselor's quality of life, mitigate turnover, counselor burnout, reduce client harm, and increase the quality of clinical services.

A Canonical Correlation Analysis of Self-Compassion, Life Balance, and Burnout in Counselors

by

Sarah Silva

MA, The Chicago School of Professional Psychology, 2012

BA, Rutgers University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

November 2019

Dedication

To all counselors-- your selfless heart for walking alongside people's mental health journeys towards a better quality of life is often underappreciated. I hope you know how valuable each of you are, and I hope this research study can assist you in learning to take care of you first. I know that I wouldn't be writing this right now if I didn't.

Acknowledgements

I would first and foremost like to acknowledge my dissertation committee, Dr. Christian Dean, Dr. Cyndi Briggs, and University Research Reviewer Dr. Jennifer Gess for your support and encouragement throughout the dissertation process. Dr. Christian Dean, words cannot begin to describe how thankful I am for the continuous support and humor you've provided throughout this transformative process. I appreciate your guidance in helping me navigate the Counselor Education and Supervision domains to assist me in developing into the counselor educator I want to be. You encouraged me to think big, to be a leader in creating significant impact in the counseling profession. I feel unstoppable and look forward to continuing to collaborate with you in the future. Dr. Cyndi Briggs, thank you for your kindness, encouraging emails, and reminders to be human. Dr. Jennifer Gess, thank you for taking the time to thoroughly examine my dissertation and provide me with detailed feedback to enhance my writing.

I wouldn't be here without also acknowledging a few other key members throughout my doctoral program. Dr. Melinda Haley, thank you for kickstarting me into this doctoral program by providing detailed feedback on APA formatting, encouragement, and kindness throughout coursework and residency. Dr. Walter Frazier, thank you for your continued support and advocacy throughout residency and via email. Dr. Mark Stauffer, thank you for reminding me that I'm a natural leader both at residency and at the Association for Humanistic Counseling conference. Your kindness and emphasis on mindfulness reminds me to be human. Dr. Lori Ann Stretch, thank you for your support, guidance, and expertise throughout internship. Your support has been a critical component to my development as a counselor educator. Dr. George Vera, thank

you for your support, guidance, and critical questions to help me think critically about my role in the counseling profession. Dr. Ryan Dump, thank you for your kindness, thoughtfulness, and for pushing me past my limits throughout my internship experience. Dr. Michelle Perepiczka, thank you so much for your willingness, passion, and drive to teach me the ways of being a quantitative researcher. I look forward to continuing to collaborate with you in the future. Dr. Rick Balkin, thank you for your interest in my dissertation topic, your expertise in data analysis, and for your continued support and humor throughout.

To my peers, thank you for believing in me and looking to me for inspiration throughout the dissertation process. While I am humbled by this, I hope you know that you are capable, passionate, driven, and will join me when you are ready. Keep pushing past the obstacles. Remember you are now the creator of knowledge.

To my family, thank you for believing in me and celebrating my progress the past 3 years. While I know you don’t understand everything I do, know that I did this for you and for our ancestors in Portugal. You told me to work hard for what I want in life, and that's what I did. I am proud to be a first generation American and college student, and I wouldn't change it if I could.

To my friends, old and new, thank you for cheering me on, celebrating with me, and reminding me that I'm an inspiration to others.

To my team at Accepting Therapy, thank you for your kindness, thoughtfulness, support, flexibility, and excitement these past couple of years as I built up the practice while completing my doctoral program in Counselor Education and Supervision. I continue to learn and grow personally and professionally so that I can

continue to support you and help you grow as a clinician. Thanks for being such an amazing team!

To David, thank you for inspiring me to challenge myself. You made sure I worked on my dissertation 20 plus hours a week during my literature review. You kept telling me that I made the dissertation process look easy. Thanks for reminding me how awesome I am.

Lastly, it's important for me to acknowledge myself. I never would have thought that I would be Dr. Sarah Silva one day. The past few years I have pushed past barriers to become a better version of myself while contributing to the counseling profession. I value my passion and perseverance to challenge myself to be a better human for me and those lives around me. I look forward to contributing to the world, one step at a time.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

Introduction

The counseling profession aims to enrich the quality of life of individuals through the practice of counseling (American Counseling Association [ACA], 2014). The hallmark of counseling affords the counselor the opportunity to provide quality treatment for clients (Sangganjanavanich & Balkin, 2013). A counselor's professional identity is grounded in the ACA Code of Ethics (2014), with values based in autonomy, nonmaleficence, beneficence, justice, fidelity, and veracity. Beneficence is defined by the ACA Code of Ethics (2014) as "working for the good of the individual and society by promoting mental health and well-being" (p. 3). Although self-care is an act of beneficence, many counselors struggle with practicing self-care regularly, increasing the risk for burnout (ACA, 2014; Coaston, 2017). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards (2016) also require counseling curriculum to cover self-care strategies appropriate for counselors, as neglecting self-care may lead to counselor impairment (ACA, 2014; Coaston, 2017). Counselor burnout is a byproduct of hearing stories of mental health distress that affects about 56% of mental health workers (Acker, 2012). If not addressed, burnout symptoms may persist for 10 to 15 years (Bakker & Costa, 2014). Despite the decades of research on burnout, there has yet to be a consensus on empirically validated interventions that prevent and/or mitigate the experience of burnout (Jaworska-Burzyńska, Kanaffa-Kilijańska, Przysiężna, & Szczepańska-Gieracha, 2016; Maslach, Leiter, & Jackson, 2012; Paris & Hoge, 2010).

Self-compassion and life balance are protective factors that help reduce the likelihood of experiencing burnout in nurses and counseling trainees (Dev, Fernando, Lim, & Consedine, 2018; Nelson, Hall, Anderson, Birtles, & Hemming, 2018; Richardson, Trusty, & George, 2018; Schreiber, 2018). High levels of self-compassion acts as a barrier against burnout (Coaston, 2017). Additionally, life balance can help someone identify satisfying levels of activity in various domains of life that contribute to health, meaning, and sustainability (Balkin et al., 2018). Further research on self-compassion and life balance in counselors can improve the quality of life of counselors and clients served. By identifying ways to mitigate and/or prevent counselor burnout, counselor education can improve training on empirically validated ways to combat burnout within counselor educators, counselors, clinical supervisors, and counselors in training.

Problem Statement

According to the American Community Survey (U.S. Census Bureau, 2016), there are 747,456 licensed professional counselors in the United States. However, 60% of the 43.8 million people who have a mental illness in the United States did not get treatment in the previous year (National Alliance on Mental Illness, 2018). Of course, not every person with a mental illness will attempt to get treatment due to lack of access, socioeconomic status, perceived stigma from others, self-stigma, or times a counselor is available (Choi, DiNitto, & Marti, 2014; Jennings et al., 2017; Ofonedu, Belcher, Budhathoki, & Gross, 2017). However, if the 26.3 million people did decide to see a counselor, this would lead to additional stress and emotional exhaustion for counselors.

This leads to a counselor responding through denial, disbelief, detachment in the workplace, and ultimately a decrease in the ability to empathize (Knight, 2013). Role stress and emotional exhaustion can also lead to employee turnover in counselors (Acker, 2012). Given the hallmark of a professional counselor is providing quality treatment for clients, the increased risk of burnout is a significant concern for the profession (Sangganjanavanich & Balkin, 2013).

Burnout is defined as the result of the inability to care or emotional exhaustion, reduced personal accomplishment, and depersonalization (Chang, 2014). Some additional symptoms found in those who experience burnout include feeling helpless, hopeless, and powerless (Lee et al., 2007). Burnout is increasing amongst health care professionals around the world (Chang, 2014). This is due to the added stress of budget cuts, reduced insurance reimbursements, delayed payments from insurance reimbursements, and increased client caseloads (Lee, Cho, Kissinger, & Ogle, 2010; Puig, Yoon, Callueng, An, & Lee, 2014). Duties such as being responsible for the treatment of individuals with mental illness, high job demands, differing work expectations, and low support in one's role as a clinician contributes to the origin of stress for mental health providers (Acker, 2012). Some researchers have suggested that burnout is an occupational hazard and contributes to high rates of turnover (Consiglio, Borgogni, Alessandri, & Schaufeli, 2013; Darr & Johns, 2008; Lampert & Glaser, 2018; Young, 2015).

The impact of being in the counseling profession has engendered an abundance of literature on the understanding and experience of burnout in counselors (Acker, 2012; Carrola, Olivarez, & Karcher, 2016; Lent & Schwartz, 2012; Young, 2015). Counselor

burnout has been studied for several decades and is known to be a contributor to health risks, decreased effectiveness in the workplace, and diminished psychological well-being, including depression (Lampert & Glaser, 2018; Sim, Zanardelli, Loughran, Mannarino, & Hill, 2016). Burnout is known to jeopardize the welfare of clients and have a detrimental effect on client reported outcomes (Dev et al., 2018; Young, 2015). Clients being treated by providers with high levels of burnout report lower client satisfaction and higher rates of hospitalization (Salyers, Flanagan, Firmin, & Rollins, 2015). In a study conducted by Salyers et al. (2015), 68% of clinicians reported that the experience of burnout affects consumer or client outcomes.

Burnout is a concern for the individual, organization, and clients served (Bridgeman, Bridgeman, & Barone, 2018). Burnout can lead to an increased risk for chronic fatigue, the flu, headache, sleep disorders, and increased risk for alcohol and other drug use (Arslan & Acar, 2013). Additionally, clients are at risk of receiving poor treatment and are subject to increased error due to counselor's burnout (Bridgeman et al., 2018). Most counselors are aware of the dangers of burnout as roughly 75.7% of counselors surveyed reported that a counselor who experiences burnout is a threat to the counseling profession (Puig et al., 2012). Regardless of the negative impact of burnout, counseling professionals often find it difficult to maintain a lifestyle of wellness in their lives (Puig et al., 2012). The ACA Code of Ethics (2014) section C.2.g recommends that counselors monitor themselves for any signs of impairment that may impact services provided to clients. Puig et al. (2012) further stated that counselors who are impaired should not offer therapeutic services to individuals, as it may negatively impact a client's

treatment. While the ACA Code of Ethics (2014) suggested that impairment may occur in the counseling profession, often those who work in the counseling profession do not recognize the degree to which caring for others may have on their health and well-being (Bridgeman et al., 2018).

Researchers have identified that the act of self-compassion is a protective factor against burnout (Dev et al., 2018). Schreiber (2018) claimed that self-compassion could increase work-life balance in nurses. However, these studies that address self-compassion, self-care, life balance, and burnout are centered around the experience found in nurses and counseling trainees (Dev et al., 2018; Nelson et al., 2018; Richardson et al., 2018; Schreiber, 2018). Experiences of burnout found in nurses and counseling trainees may differ from those of professional counselors due to their differing roles and responsibilities (Bridgeman et al., 2018; Bryant & Constantine, 2006). Research on the relationship between self-compassion, life balance and burnout could be beneficial for professional counselors. The counseling profession is not fully aware of the relationship between burnout and other areas of life such as life balance and self-compassion among postgraduate counselors. Awareness of this relationship, if any, may be helpful in the development and implementation of specific strategies and practices to reduce the onset of burnout in counseling professionals.

Purpose of the Study

The purpose of this quantitative survey research study was to investigate the relationship if any, between the subscales of life balance, self-compassion, and burnout in counselors. In this research study, I explored and quantified the relationship between the

subscales of self-compassion, as measured by the Self-Compassion Scale (SCS) and burnout, as measured by the Counselor Burnout Inventory (CBI). I also explored and quantified the relationship between the subscales of life balance, as measured by the Juhnke Balkin Life Balance Inventory (JBLI), and burnout, as measured by the CBI. In this quantitative survey research study, I focused on counselors in the United States who are licensed (i.e., Licensed Clinical Professional Counselor [LCPC]) or provisionally licensed (i.e.. Licensed Professional Counselor [LPC]) and have worked as counselors for the past 2 years. In addition to the inventory questions, participants were asked for demographic information including gender identity, race, ethnicity, religious affiliation, sexual orientation, age, marital status, clinical licensure, additional clinical or clinical supervision licenses or credentials, state of residence, area of workplace (urban, rural, suburb), mental health discipline (clinical mental health counseling, school counseling, counselor education, marriage and family therapy, rehabilitation counseling, substance abuse counseling), highest level of education, work setting (hospital, community mental health center, college/university counseling center, private practice, residential treatment, inpatient substance abuse treatment), years of practice, hours worked per week, self-care practices (exercise, reading, music, family, travel, hobby), and length of time for each self-care practice. The purpose of this study was to explore the relationship, if any, between the subscales of burnout and life balance in counselors, as well as the relationship, if any, between burnout and self-compassion in counselors.

Research Questions and Hypotheses

Research Question 1

What is the relationship, if any, between the subscales of life balance and burnout as measured by the JBLI and the CBI?

H_0: There is no statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

H_a: There is a statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

Research Question 2

What is the relationship, if any, between the subscales of self-compassion and burnout as measured by the SCS and the CBI?

H_0: There is no statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

H_a: There is a statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

Theoretical Framework

Conservation of Resources Theory

The conservation of resources (COR) theory argues that people want to acquire and protect resources they value (Alarcon, 2011; Dubois, Bentein, Mansour, Gilbert, & Bédard, 2013; Hyung, O'Rourke, & O'Brien, 2014). Some of these resources include objects, personal characteristics, social support, self-esteem, social standing, and energies or money that is valued by individuals (Alarcon, 2011; Hyung et al., 2014). The COR

theory suggests that when an individual's resources are threatened or depleted, strain occurs (Alarcon, 2011). Loss of resources are conceptualized as demands, and so the fewer resources one has, the higher the demands become (Alarcon, 2011). This then leads to individuals adapting maladaptive coping strategies (Alarcon, 2011). Maladaptive coping then leads to the experience of burnout (Alarcon, 2011; Dubois et al., 2013). The COR theory suggests that if a counseling professional has high demands and few resources, maladaptive coping will occur and lead to the experience of burnout.

The COR theory takes account resources people use to protect themselves from experiencing stress, depression, anger, anxiety, and burnout (Huang et al., 2016). The following is an example of how draining resources over time may lead to the experience of burnout in counselors:

> A professional counselor has been practicing in the field of counseling for the past twelve years. This counselor has worked in a variety of settings and has been in their current role as a counselor in a mental health center for the past three years. This counselor is fulfilled with their positive work environment that offers support from peers as well as from upper management. Outside of work, this counselor enjoys the support they get from friends, family, and children. This counselor often maintains a healthy self-care practice and sense of life balance through exercising four times a week, eating balanced meals, spending time with loved ones, and reading books. Some internal resources for this counselor include a positive view of self and feeling passionate about the work provided to clients.

A few months later, this counselor is informed at work that productivity requirements must be increased by 40% due to state-wide budget cuts in mental health. While this counselor is concerned about the possible decrease in positive work environment, they continue to work hard to meet the productivity requirements. This adjustment has increased the amount of time spent outside of work to finish documentation from clients seen in any given day. Due to this increased work responsibility, this counselor has decreased personal reading and time spent with children.

A couple weeks later this counselor learns that one of their parents had a stroke. This counselor now feels obligated to take their parent to the doctors every week due to being an only child. Due to this new responsibility, this counselor has decreased time spent with friends as well as time spent exercising from four days to two days a week. While this counselor has increased anxiety and guilt about their parent not doing well, they still feel like they're able to manage everything, as they are still able to exercise twice a week, have healthy meals, and feel passionate about the work provided to clients.

Due to the decreased time spent with children, this counselor begins to feel like a bad parent and cuts another resource out of their lives, healthy meals. This counselor now turns to maladaptive coping such as unhealthy meals and a bottle of wine every night to cope with the stressors related to work and personal obligations to their parent. Over a period of time of managing stressors in this

way, this counselor feels like there is no point in exercising at all, leading to a more negative view of self.

Alarcon (2011) generated a meta-analysis on the COR theory as it relates to job demands, resources, and attitudes of burnout. Within the meta-analysis, Alarcon reviewed and analyzed previous studies from 1981 to 2010 that included the Maslach Burnout Inventory as the measure of burnout. The three hypotheses tested included the following: demands are positively related to the three constructs of burnout, perceived control and autonomy at work are negatively related to the three constructs of burnout, and job satisfaction and organizational commitment are negatively related to the three constructs of burnout (Alarcon, 2011). All three hypotheses were confirmed after conducting the meta-analysis, suggesting that the COR theory is well suited for the understanding of burnout (Alarcon, 2011).

Life balance and self-compassion may help assist counselors to retain resources, as life balance focuses on balancing work and personal life (Davis, Balkin, & Junke, 2014). Additionally, the consistent act of self-compassion assists people with being compassionate towards one's self, including the recognition that suffering, inadequacy, and failure are all part of being human (Neff, 2003). Self-compassion is being open to one's suffering by being kind, nonjudgmental, and caring to the self (Neff, 2003). When people care for and are accepting of themselves, they are more likely to set boundaries and limitations with any component of life that may threaten the resources they need to care for themselves (Neff, 2003). Counselor resources would be less likely to be depleted if counselors were more accepting and self-compassionate.

Nature of the Study

The research design of this dissertation study was a quantitative nonexperimental design (see Creswell & Creswell, 2018). The method of this study was a quantitative survey research study (see Creswell & Creswell, 2018). The intent was to study the relationships between the subscales of burnout, self-compassion, and life balance. Participants signed an electronic informed consent, completed a demographic questionnaire, and completed the JBLI, the SCS, and the CBI. A nonexperimental research design affords the researcher with the opportunity to investigate relationships and differences between variables (Creswell & Creswell, 2018). The data analyses included two canonical correlations (one to measure the relationship between subscales of burnout and self-compassion and another to measure the relationship between subscales of burnout and life balance).

Definitions

Burnout: Maslach and Jackson (1984) believed that burnout encompasses three components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to "feelings of being emotionally overextended and drained by one's contact with other people" (Maslach & Jackson, 1984, p. 134). Emotional exhaustion is the stress aspect of burnout that includes feeling overstretched affectively and believing as though an individual does not have enough emotional resources to cope in the workplace (Jackson & Maslach, 1982; Lent & Schwartz, 2012; Maslach & Jackson, 1984). Emotional exhaustion is also defined as the subjective experience that includes feeling stressed and emotionally strained by work-

related duties (Acker, 2012; Jackson & Maslach, 1982; Maslach & Jackson, 1984). Depersonalization refers to "an unfeeling and callous response toward these people, who are usually the recipients of one's service or care" (Maslach & Jackson, 1984, p. 134). Depersonalization is also the social aspect of burnout that includes a disconnected response to others (Jackson & Maslach, 1982; Lent & Schwartz, 2012; Maslach & Jackson, 1984). Reduced personal accomplishment refers to "a decline in one's feelings of competence and successful achievement in one's work with people" (Maslach & Jackson, 1984, p. 134). Based on the CBI, burnout is explained by five variables that include exhaustion, negative work environment, devaluing client, incompetence, and deterioration in personal life (Lee et al., 2007).

Life balance: The life balance construct has been defined in various ways throughout peer-reviewed literature. The term life balance differs from work-life balance, as work-life balance is centered around balancing work and life versus an overall wellness lifestyle (Balkin et al., 2018). Work-life integration is a new term for work-life balance, coined in 2012 due to balance being an "unachievable ideal in today's fast-paced world" (Tajlili, 2014, p. 255). Life balance is centered on wholeness and wellness, rather than being static (Karaman, Balkin, & Juhnke, 2018). Life balance is understood by the regular practices people engage in their lives (Matuska & Christiansen, 2008). Simmons (2012) further contended that life balance is one's ability to balance work and home life to achieve "harmony in physical, emotional, and spiritual health" (p. 25).

Self-compassion: Self-compassion is defined by Neff (2003) as being open to one's suffering, being kind and understanding to the self as well as being nonjudgmental

about one's failures. Self-compassion allows people to be caring and kind to themselves when they have failed, not met expectations, or felt inadequate (Stuntzner, 2014, 2017). The practice of self-compassion requires a mindful awareness of emotions, understanding, connection to common humanity, and self-kindness (Coaston, 2017). Self-compassion encourages people to forgive themselves for imperfections and accept who they are (Stuntzner, 2014, 2017).

Assumptions

Various assumptions were presumed for this research study. One of the assumptions of this study included the notion that counselors experience burnout throughout their career and that counselors have difficulties managing life balance. The assumption that someone who experiences burnout is impaired is another assumption of this research study. While research has been conducted on life balance and burnout in nurses and counselor interns, I assumed that a counselor's ability to manage burnout and/or integrate life balance is different than when compared to counseling interns or nurses (see Dev et al., 2018; Nelson et al., 2018; Richardson et al., 2018; Schreiber, 2018). Another assumption of this study was that the participants met eligibility criteria, understood the objectives of this survey research study, and understood the constructs of interest. I also presumed that all participants who took this survey research study answered honestly without bias or engaging in social desirability behaviors. Lastly, I assumed that the survey questions used had comparable validity and reliability to the survey results in previously published research literature.

Scope and Delimitations

I limited this research study to professional counselors who have been practicing at least 2 years to align with existing research on burnout in counselors. By limiting my theoretical framework to COR theory, I highlighted the importance of resources on a counselor's well-being. The scope of this research study comprised participants from the United States who were drawn from online groups (LinkedIn, Facebook), listservs (i.e., Chicago Therapists), the state licensing board of Ohio, and counseling associations in the following states: Illinois, Indiana, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Jersey, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, and Washington. The findings of this study may contribute to the generalizability of counselors experiencing burnout to identify ways to mitigate and prevent burnout.

Limitations

There are limitations to consider with any research study. Some limitations of this exploratory quantitative survey research study included that the JBLI, SCS, and CBI are all self-reported measures. Brenner (2017) argued that some sources of survey methodology error result from measurement, nonresponse, coverage, processing, and adjustment errors. Participants of a survey research study may have difficulties comprehending the questions and reporting an answer (Brenner, 2017). Other times, participants apply meaning to certain questions on a survey that are not intended by the researcher, creating an error (Brenner, 2017). Social desirability is another error that occurs within survey research (Brenner, 2017). Social desirability is when a participant tends to embellish positive behaviors and restrain negative behaviors with hopes of

following normative social behavior or impressing the researcher (Brenner, 2017). Survey nonresponse occurs when either the participant does not answer a question (item nonresponse) or fails to respond or is not able to be contacted by the researcher (unit nonresponse; Brenner, 2017). Results of this study may not be accurate and may not be generalizable to the counseling profession. Another implication is that each participant may have a different understanding of burnout, self-compassion, or life balance, which could have altered the participants' responses when participating in this research study. Lastly, confounding variables such as environment, stress, burnout, mood, time constraints, education level, personal beliefs, or values could have impacted the results of the study.

Significance

The results of this quantitative survey research study could be used to assist the field of counselor education and supervision to provide better support to the success of counselors, clinical supervisors, counselor educators, counselors in supervision, counselors in training, and the well-being of clients. Learning more about the relationship of self-compassion and life balance to burnout in counselors provides a possible empirically validated method to prevent and/or mitigate the experience of burnout in counselors. Results from this research study may provide counseling professionals and stakeholders with data to promote funding for the development of prevention programs, training programs to provide better support to counselors, counselors in training, clinical supervisors, counselor educators, and most importantly to decrease the level of harm to clients being served. This is helpful to the field of counselor education and supervision

due to the notion that counseling professionals are afforded with the opportunity to provide quality care and treatment to clients and the general public. With the increased knowledge about burnout prevention, counselor educators can then train counselors in training on how to prevent the experience of burnout. The results of this study might lead to the development and implementation of ways to prevent and minimize counseling professionals from the experience of burnout, dissatisfaction with life, and most importantly from preventing harm to clients served. This study might also provide information that confirms the need for self-compassion and increased life balance to increase retention and reduce burnout for counselor educators, clinical supervisors, and counselors in the profession.

Additionally, it is necessary to review the social change implications of this quantitative survey research study. Social change requires there to be some change that is intended to break the normative structures within a society (De la Sablonnière, 2017). According to the Healthcare Cost and Utilization Project (HCUP; 2017), mental health and substance use inpatient stays in the United States have increased 20.1% between 2005 and 2014, accounting for about 6% of all inpatient stays in 2014. Hence, in promoting change through decreased burnout in mental health providers, hospitalizations may decrease, contributing to social change in the United States. Decreased burnout in professional counselors might improve quality of mental health services while also decreasing the funds allotted to inpatient hospitalizations.

The information gathered from this research study can then contribute to social change, as counselor educators are then able to potentially decrease client harm by

developing and implementing programs specific for counselors to learn how to prevent and/or mitigate the experience of burnout. The ACA Code of Ethics (2014) section A.4.a strives for professional counselors to avoid harming clients served in order to abide by the ethical principles of nonmaleficence and beneficence. In focusing on social change to mitigate client harm, the community and general public are being better protected.

Summary

Counselors fill a critical role in supporting the general public through distress, grief, trauma, mood disorders, psychosis, crisis, and life transitions (Mullen, Morris, & Lord, 2017). A counselor who maintains a healthy balance between work and caring for self can contribute to increased well-being, effectiveness as a counselor, and increased job satisfaction, while reducing turnover, burnout, and client harm (Arslan & Acar, 2013; Holowaychuk, 2018; Puig et al., 2012; Wester, Trepal, & Myers, 2009). If client treatment outcomes rely on clinical interventions and the therapeutic relationship (Swift & Parkin, 2017), then the vision for decreasing client harm and increasing treatment effectiveness rests on the strength of the counselor to maintain their well-being (ACA, 2014; Sangganjanavanich & Balkin, 2013).

As healthcare legislation in the United States continues to shift towards counselors being reliant on managed care companies, short-term outpatient treatment, and short-term inpatient treatment, counselors are faced with larger outpatient caseloads and decreased funds available for clients who require long-term treatment (Acker, 2012). The limited funding available to mental health organizations has led to role overload and decreased availability for counselor support (Acker, 2012). It is imperative that

employers of counselors focus on maintaining the well-being of counseling professionals (Bridgeman et al., 2018). If the ACA Code of Ethics (2014) postulates that counselors refrain from practicing while impaired, it is imperative that the counseling profession act towards ensuring that counseling professionals are equipped to deal with the cost of caring for clients (Figley, 2002; Mullen et al., 2017). By using the SCS (Neff, 2003), the JBLI (Davis et al., 2014), and the CBI (Lee et al., 2007) to determine the relationship between the subscales of self-compassion and burnout and life balance and burnout, counselors could then identify an empirically validated way to prevent and/or mitigate the experience of counselor's burnout. If self-compassion and life balance do improve conditions of counselor's perceived levels of burnout, as measured by the CBI (Lee et al., 2007), then self-compassion and life balance training could be developed to improve the effectiveness of counselors to mitigate and prevent counselor's burnout.

In the following chapter, I provide additional context to the battle for counselors to manage experiences of burnout. I expand the foundation for understanding factors influencing burnout, comparing burnout in counseling with other professions. I also explore how the field of counseling has attempted and struggled for decades to identify an intervention that assists counselors in mitigating and/or preventing burnout.

Chapter 2: Literature Review

Introduction

For decades, researchers have explored the negative psychological costs for counselors and other health professionals of caring for clients (Mullen et al., 2017). Being empathic and compassionate, the key elements that drive people to enter the counseling profession, are also the elements that can drive someone to experience burnout (Mullen et al., 2017; Thompson, Amatea, & Thompson, 2014). Succumbing to a client's emotional distress over time is emotionally taxing and can lead to counselor impairment (ACA, 2014; Mullen et al., 2017; Wester et al., 2009).

Previous research studies have documented the consequences of burnout for counselors who expose themselves to caring, being empathic, and treating individuals in distress (Baldwin-White, 2016; Carrola, Sass, & Lee, 2012; Leiter & Maslach, 2016; Moate, Gnilka, West, & Bruns, 2016; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012 ; Sim et al., 2016; Templeton & Satcher, 2007; Testa & Sangganjanavanich, 2016; Wardle & Mayorga, 2016; Wilkerson, 2009). Despite the detrimental effect burnout has on counselors, clients, and the profession of counseling, there is minimal peer-reviewed literature that addresses ways to mitigate or prevent the experience of burnout (Maslach, 2003; Rupert, Miller, & Dorociak, 2015; Sansbury, Graves, & Scott, 2015; Wilkinson, Infantolino, & Wacha-Montes, 2017; Zhao, Li, & Shields, 2018). The field of counseling has struggled to find interventions to alleviate and avoid burnout (Dreison et al., 2018; Jaworska-Burzyńska et al., 2016; Paris & Hodge, 2010). As noted by the extensive history represented above, it is clear that the counseling

profession continues to search for answers on how to effectively mitigate and/or prevent the experience of burnout.

In Chapter 1, a rationale for the study on exploring the relationship between the subscales of burnout, self-compassion, and life balance was presented. The importance of preventing and mitigating burnout in the counseling profession is necessary for the well-being of counselors, clients, and the future of the counseling profession. This chapter includes a review of the literature covering the COR theory, a discussion of the construct of burnout, other terms synonymous to burnout, factors that lead to burnout, symptoms of burnout, effects of burnout, how burnout impacts the workplace, protective factors related to burnout, and an exploration of recovering from burnout. Additionally, a discussion of the life balance construct, including the effects of life balance, research related to life balance and burnout, the construct of self-compassion, and research related to self-compassion and burnout are presented.

Literature Search Strategy

Burnout is a popular construct to research, as a search in databases PsycINFO, PsycARTICLES, and Academic Search Complete yielded 28,085 peer-reviewed articles from 1913 to 2019. A PsycINFO, PsycARTICLES, and Academic Search Complete database search of burnout yielded 20,523 peer-reviewed scholarly journal articles from 2008 to 2019, suggesting that the majority of research on burnout has taken place over the last decade. However, a PsycINFO, PsycARTICLES, and Academic Search Complete database search of burnout and counselor yielded 286 peer-reviewed scholarly journal articles from 2008 to 2019. Additionally, a PsycINFO, PsycARTICLES, and Academic

Search Complete database search of burnout, counselor, and self-compassion yielded five peer-reviewed scholarly journal articles from 2008 to 2019. Of these five journal articles, three addressed the use of self-compassion as a tool to moderate burnout in counselors in training. Moreover, a PsycINFO, PsycARTICLES, and Academic Search Complete database search of burnout, counselor, and life balance yielded four results. While there may be a tremendous amount of research on burnout, there is minimal research on the relationship between burnout, self-compassion, and life balance in counselors.

Theoretical Foundation

Conservation of Resources Theory

The COR theory argues that people want to acquire and protect resources they value (Alarcon, 2011; Dubois et al., 2013; Hyung et al., 2014). Some of these resources include objects, personal characteristics, social support, self-esteem, social standing, and energies or money that is valued by individuals (Alarcon, 2011; Hyung et al., 2014). Internal resources can include self-awareness and cognitive emotional regulation skills (Choi et al., 2014). External resources may consist of autonomy in the workplace, social support, and positive feedback on work performance (Choi et al., 2014). Some resources that help mitigate the loss of resources when stress occurs is self-efficacy and a high level of self-worth (Birkeland, Richardsen, & Dysvik, 2018).

The COR theory supports the notion that people are motivated to obtain, retain, foster, and protect resources they value (Hobfoll, 1989; Huang, Wang, Wu, & You, 2016). People invest in the resources they have so that they can manage stressors efficiently (Arnold, Connelly, Walsh, & Martin Ginis, 2015). People with many resources

are often able to gain resources more efficiently than those with fewer resources (Arnold et al., 2015; Arnold, Connelly, Gellatly, Walsh, & Withey, 2017; Hobfoll & Freedy, 1993). When there is a reduction in resources, people often become defensive in hopes of conserving the few resources they have (Arnold et al., 2015; Arnold et al., 2017). The COR theory suggests that when an individual's resources are threatened, depleted, or lost, strain occurs, causing people to experience a great deal of stress (Alarcon, 2011; Huang et al., 2016). Loss of resources are conceptualized as demands and so the fewer resources one has, the higher the demands become (Alarcon, 2011). The COR theory suggests that if a counseling professional has high demands and few resources, maladaptive coping will occur and lead to the experience of burnout (Alarcon, 2011; Arnold et al., 2015; Dubois et al., 2013). The COR theory contends that burnout occurs when one goes through extended periods of time with minimal or a long-standing depletion of resources (Arnold et al., 2015; Huang et al., 2016).

Alarcon (2011) engendered a meta-analysis of 231 research studies that confirmed the COR theory is well suited for the understanding of burnout. Stressors are a demand that play an integral role in the COR theory as well as burnout (Hobfoll & Freedy, 1993). The experience of low resources and high demands leads to a deterioration in resources like energy and self-efficacy, two components related to the emotional exhaustion and decreased personal accomplishment found in burnout (Alarcon, 2011; Hobfoll & Freedy, 1993). Additionally, according to the COR theory, emotional exhaustion occurs first, followed by cynicism (a maladaptive coping technique), and lastly a decrease in personal accomplishment (Alarcon, 2011; Hobfoll & Freedy, 1993). Lheureux, Truchot, and

Borteyrou (2016) also used the COR theory to explain how burnout occurs in general practitioners. Moreover, plenty of researchers have used the COR theory to explain burnout (Arnold et al., 2017; Arnold et al., 2015; Bakker & Oerlemans, 2016; Blanch & Aluja, 2012; Carlson, Ferguson, Hunter, & Whitten, 2012; Consiglio et al., 2013; De Cuyper, Mäkikangas, Kinnunen, Mauno, & Witte, 2012; De Cuyper, Raeder, Van der Heijden, & Wittekind, 2012; Dubois et al., 2013; Halbesleben, Neveu, Paustian-Underdahl, & Westman, 2014; Hildenbrand, Sacramento, & Binnewies, 2018; Hu, Schaufeli, & Taris, 2017).

Life balance and self-compassion might be helpful in assisting counselors to retain resources, as life balance focuses on balancing work and personal life (Davis et al., 2014). Additionally, the consistent act of self-compassion assists people with being compassionate towards one's self, including the recognition that suffering, inadequacy, and failure are all part of being human (Neff, 2003). Self-compassion is being open to one's suffering by being kind, nonjudgmental, and caring to the self (Neff, 2003). In a recent study, self-compassion led to higher levels of personal improvement through enhanced acceptance (Zhang & Chen, 2016). Yadavaia, Hayes, and Vilardaga (2014) further concluded that acceptance and commitment therapy is successful in increasing self-compassion. Counselor resources would be less likely to be depleted if counselors were more accepting of themselves and more self-compassionate. Adopting the COR theory to burnout, life balance, and self-compassion could contribute to understanding the role of life balance and self-compassion in mitigating and/or preventing the experience of burnout.

Literature Review

The study of burnout in mental health care is not a novel idea (Bridgeman et al., 2018). The existing literature emphasizes a counselor's responsibility to provide quality care for clients (Sangganjanavanich & Balkin, 2013; ACA, 2014). The ACA Code of Ethics (2014) section C.2.g posits that counselors are to be aware of signs of impairment in order to refrain from providing therapeutic services to clients when impaired. Furthermore, it is important to prevent "imminent harm to clients" (ACA, 2014, p. 9). Understanding the history of burnout in the counseling profession is vital, as it could affect all counseling professionals (Acker, 2012; Leiter & Maslach, 2001; Morse et al., 2012). In this literature review, I synthesize the history of burnout as it relates to the counseling profession, noting other terms synonymous to burnout, demands from state funding and health insurance managed care companies, factors that lead to burnout, symptoms of burnout, detrimental effects of burnout, burnout in the workplace, client treatment outcomes, protective factors for burnout, and recovering from burnout. I also explore the importance of maintaining life balance and self-compassion as a way to mitigate the experience of burnout. Finally, I describe the influence of the COR theory on burnout and connect the literature between burnout, life balance, and self-compassion with the direction and intent of this quantitative survey research study.

The Burnout Construct

The cost of being empathic and caring often leads to the crippling experience of counselor's burnout (Figley, 2002). Burnout has been defined in a variety of ways by numerous scholars since 1974 when it was first described by Freudenberger (1974) as the

effects that occur from adhering to professional responsibilities within the work environment. Burnout was initially defined as a work-related concern due to occupational stress (Freudenberger, 1974; Maslach, 1976; Sangganjanavanich & Balkin, 2013). Throughout the 1980s and 1990s, researchers sought out to define burnout through hundreds of empirical studies (Brook & Brook, 1995; Dupree & Day, 1995; Harris, 1984; Himle, Jayaratne, & Thyness, 1991; Jackson & Maslach, 1982; Lee & Ashforth, 1990; Leiter & Maslach, 1988; Macinick & Macinick, 1990; Maslach & Florian, 1988; Maslach & Goldberg, 1998; Maslach & Jackson, 1981; Maslach & Jackson, 1985; Niebrugge, 1994; Pines & Aronson, 1988; Robinson et al., 1991; Sangganjanavanich & Balkin, 2013; Shelledy, Mikles, May, & Youtsey, 1992). An abundance of literature points to the definition of burnout developed by Maslach et al. (1981, 1993, 1996, 2001) that includes a state of physical, mental, and emotional exhaustion, depersonalization, and a decreased sense of accomplishment (Maslach, 1976; Pines & Aronson, 1988; Silbiger & Pines, 2014).

Maslach and Jackson (1984) believed burnout encompassed three components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion refers to “feelings of being emotionally overextended and drained by one’s contact with other people,” (Maslach & Jackson, 1984, p. 134). Emotional exhaustion is the stress aspect of burnout that includes feeling overstretched affectively and believing as though an individual does not have enough emotional resources to cope in the workplace (Lent & Schwartz, 2012; Jackson & Maslach, 1982; Maslach & Jackson, 1984). Emotional exhaustion is also defined as the subjective experience that

includes feeling stressed and emotionally strained by work-related duties (Acker, 2012; Jackson & Maslach, 1982; Maslach & Jackson, 1984). Depersonalization refers to "an unfeeling and callous response toward these people, who are usually the recipients of one's service or care," (Maslach & Jackson, 1984, p. 134). Depersonalization is also the social aspect of burnout that includes a disconnected response to others (Lent & Schwartz, 2012; Jackson & Maslach, 1982; Maslach & Jackson, 1984). Reduced personal accomplishment refers to "a decline in one's feelings of competence and successful achievement in one's work with people," (Maslach & Jackson, 1984, p. 134). Reduced personal accomplishment is also related to reduced productivity within the workplace (Jackson & Maslach, 1982; Lent & Schwartz, 2012; Maslach & Jackson, 1984).

Burnout is very common in the helping professions (Au, Kehn, Ireys, Blyler, & Brown, 2018; Bakker & Costa, 2014; Bianchi, Truchot, Laurent, Brisson, & Schonfeld, 2014; Chang, 2014; Choi et al., 2014; Di Benedetto & Swadling, 2014; Mamidenna & Viswanatham, 2014; Mészáros, Ádám, Szabó, Szigeti, & Urbán, 2014; Salloum et al., 2015; Schaufeli, Leiter, & Maslach, 2009), with as many as 21-67% of mental health workers experiencing burnout (Morse et al., 2012). Due to the distressful narratives told by clients, practicing counselors are privy to high levels of emotional engagement, which is linked with higher levels of burnout (Choi, Puig, Kim, Lee, & Lee, 2014; Lee et al., 2007; Lee, Cho, Kissinger, & Ogle, 2010). Additionally, burnout has been considered a response to interpersonal stressors that occur in the workplace (Melquíades Menezes, Ribeiro César Alves, de Araújo Neto, Barbosa Davim, & de Oliveira Guaré, 2017). Therefore, counselors are dually susceptible to burnout due to both the impact of

providing counseling services as well as exposure to any other interpersonal stressors at work.

There appears to be a significant negative connotation to the experience of burnout. Scholars have described burnout as a loss of human caring (Maslach & Pines, 1979), the inability to care (Chang, 2014), problematic (Morse et al., 2012), or crippling (Figley, 2002). One researcher compared burnout in physicians to the zombies of *The Walking Dead* (Doolittle, 2016). Burnout is also listed as a condition of clinical attention in the World Health Organization International Classification of Diseases (ICD-10) (Z73.0) and is defined as a "state of vital exhaustion" (Jaworska et al., 2016, p. 43). Some researchers, like Hobfoll and Freedy (1993) view burnout as the culmination of one's exposure to chronic job stress, while other researchers view burnout as a psychological experience caused by chronic job stress (Cooper, Dewe, & O'Driscoll, 2001; Melquíades et al., 2017). Burnout could also be identified as the result of prolonged stress at work with minimal resources to manage or cope effectively with such stressors (Ahola et al., 2014; Hobfoll & Freedy, 1993; Huang et al., 2016; Melquíades et al., 2017). Another understanding of burnout includes emotional fatigue due to stressors in the workplace (Sangganjanavanich & Balkin, 2013).

Burnout is a social problem in a variety of workplace settings and professions around the world. For instance, in school counselor's burnout results from prolonged stress and minimal resources to cope with the stress (Kovač, Krečič, Čagran, & Mulej, 2017). In healthcare professions such as nursing or medical doctors, it is estimated that 10-70% of nurses and 30-50% of medical doctors are affected by burnout (Bridgeman, et

al., 2018). General practitioners are also more likely to turn to increased substance use and suicidal ideation, plan or attempts when experiencing burnout (Lheureux et al., 2016). In medical students, burnout is a risk factor for dropping out of medical school and suicidal ideation (Dyrbye et al., 2010). Additionally, burnout has also been identified as a social problem in countries outside the United States and includes but is not limited to Korea, Japan, Philippines, Hong Kong (Puig et al., 2014), Nigeria (Ojedokun & Idemudia, 2014), Japan (Saijo et al., 2014), United Arab Emirates (Abdulrahman, Farooq, Al Kharmiri, Al Marzooqi, & Carrick, 2018), Romania (Baciu & Vîrgă, 2018), Brazil (Melquíades et al., 2017), Taiwan (Lin, 2012), and Malaysia (Ismail et al., 2015).

Other Terms Synonymous to Burnout

The construct of burnout brought about a few key terms similar to but separate from burnout in hopes of capturing the various experiences that occur from caring for clients. One term found within the literature of burnout is compassion fatigue, defined by scholars as the "state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal associated with the patient" (Figley, 2002, p. 1435; Mathieu, 2014). Additionally, compassion fatigue is an empathetic tension and exhaustion that occurs over time when treating people in distress (Turgoose & Maddox, 2017). A recent narrative review of research studies (Turgoose & Maddox, 2017) also noted that compassion fatigue could make it difficult for helping professionals to be empathetic or compassionate in their professional roles. Figley (2002) claimed that 73.5% of counselors rated themselves on the Compassion Fatigue Self Test for Psychotherapists as being at moderate, high, or

extremely high risk for compassion fatigue. Merriman (2015) also stated that compassion fatigue education is necessary to discuss when counselor education faculty educate counselors in training, as new counselors have higher chances of experiencing compassion fatigue. While the terms burnout and compassion fatigue can overlap, the main distinctive difference is that burnout emphasizes the impact of environmental and organizational stressors within the workplace and compassion fatigue emphasizes individual psychological and emotional processes as a result of working with clients (Turgoose & Maddox, 2017).

Another term often found in peer-reviewed literature related to, but distinct from burnout and compassion fatigue is secondary traumatic stress (STS) (Figley, 2002). Secondary traumatic stress occurs when someone experiences the emotions, stress, and trauma symptoms associated with hearing or knowing about a traumatic event someone else has experienced (Figley, 2002). The symptoms experienced with STS are comparable to those appearing in posttraumatic stress disorder (PTSD), including hypervigilance, avoidance, isolation, hyperarousal, and intrusive thoughts or memories (Turgoose & Maddox, 2017). This experience of STS is solely related to knowing the details of another person's trauma and is not associated with one's own experience of PTSD (Turgoose & Maddox, 2017). Some risk factors for STS include working long hours, a significant number of clients who have experienced trauma and working with clients who are distressed adolescents and children (Whitt-Woosley & Sprang, 2018).

Lastly, another term found within the literature of burnout is vicarious traumatization (VT). Vicarious traumatization is defined by McCann and Pearlman

(1990) as the negative effects (negative beliefs of themselves and others) of engaging empathically with others who experience trauma. Foreman (2018) further concludes that VT results in a negative transformation for the counselor that often interrupts their views of being competent as a clinician. This may lead to black and white thinking, cynicism, social withdrawal, anxiety, and depression if not addressed by the counselor experiencing VT (Foreman, 2018). While all of these terms have different names and definitions, their concepts often overlap which makes it difficult for counselors to understand them (Newell, Gardell, & MacNeil, 2016; Turgoose & Maddox, 2017). For continuity, the rest of this literature review focused primarily on burnout.

Factors That Lead to Burnout

It is necessary for counselors to be able to recognize early warning signs of burnout (Estévez-Mujica, & Quintane, 2018; Kim et al., 2018). A considerable amount of research has focused on the various factors that lead to the experience of burnout in counselors (Maslach & Leiter, 2008). There were five themes found when searching through peer-reviewed literature on factors that lead to burnout including the following: social support, work environment, demographics, personal values and coping styles, and changes in political climate. The social support factors that lead to burnout include lack of social and/or family support (Melquíades et al., 2017) as well as insufficient opportunities for social interaction or team building at the workplace (Bridgeman et al., 2018). While supervisor support typically buffers burnout (Birkeland, Richardsen, & Dysvik, 2018), poor support offered by clinical supervisors when a counselor is

experiencing high demands leads to further distress (Tucker, Jimmieson, & Bordia, 2018).

The second and most salient theme of risk factors for counselor's burnout includes various factors related to the work environment. Sources of stress to consider as risk factors for burnout include high job demands, expectations to meet productivity standards, low support at work (Acker, 2012; Ahola et al., 2014), culture of the workplace, caseload size or high workloads, and type of work setting (Bridgeman et al., 2018; Viehl, Dispenza, McCullough, & Guvensel, 2017). Counselors who work in institutional settings (hospitals, residential treatment, inpatient substance abuse treatment) tend to be more vulnerable to the experience of burnout (Wallace, Lee, & Lee, 2010). Lack of participation at work is another risk factor for burnout (Ahola et al., 2014). To the contrary, obsessive passion for work, defined as the uneven importance given to work in one's life, is linked with burnout, role conflict, and work-family conflict (Birkeland et al., 2018). Hence, both underworking (Ahola et al., 2014) and overworking are precursors to counselor's burnout (Birkeland et al., 2018).

Inadequate financial income and decreased social recognition at the workplace can also contribute to the onset of burnout (Bridgeman et al., 2018). A recent research study contended that there is a positive correlation between job insecurity and burnout (Jiang & Probst, 2017). The sample size for this study was 23,778 people from 30 countries (Jiang & Probst, 2017), suggesting income and job insecurity are risk factors for burnout. A literature search in databases Academic Search Complete, PsycINFO, and PsycARTICLES yielded no results for counselor, income, and burnout.

There was conflicting evidence surrounding the correlation between hours spent counseling per week and compassion fatigue. For instance, Flannelly, Roberts and Weaver (2005) indicated the number of counseling hours is directly related to compassion fatigue. However, other researchers found no correlation between hours spent counseling and compassion fatigue (Baird & Jenkins, 2003; Thompson et al., 2014). Despite the conflicting research findings, as job demands increase, there is less time to manage stressful situations (Bridgeman et al., 2018; Rabenu & Aharoni-Goldenberg, 2017) making a counselor more susceptible to compassion fatigue and burnout.

Other risk factors associated with burnout include not having control in the workplace as well as job ambiguity, or ambiguous role expectations (Bridgeman et al., 2018). Having an unclear role within the workplace can cause strain on a counselor (Wallace et al., 2010). Not having transparency between one's role and upper management can also contribute to the onset of burnout (Bridgeman et al., 2018). In fact, an email study conducted by Estévez-Mujica and Quintane (2018) contended that the higher levels of exhaustion and burnout were associated with high levels of email transactions between employees and upper management.

The third theme of risk factors for counselor's burnout includes a variety of factors related to demographics. Age is a high indicator in predicting emotional exhaustion, depersonalization, and personal accomplishment, with younger counselors being more vulnerable (Lim, Kim, Kim, Yang, & Lee, 2010). Moreover, there are inconsistencies with gender and counselor's burnout. In one research study, male mental

health professionals reported higher levels of burnout than females (Dupree & Day, 1995), whereas in another research study female counselors reported higher levels of emotional exhaustion than males (Lent & Schwartz, 2012). Additionally, for counselors who identify as sexual minorities, some risk factors for burnout include workplace heterosexism, perceptions of workload and workplace support, and identity concealment (Viehl et al., 2017; Viehl et al., 2018).

The next theme of risk factors for burnout includes personal values and coping styles. Personal values influence one's motivation to make decisions and personal values also affect one's thoughts, emotions, and behavior, especially those related to work (Tartakovsky, 2016). The ACA Code of Ethics (2014) also contains professional values that counselors are recommended to abide by in their practice of counseling. These professional values include enhancing human development, embracing diversity, advocating for social justice, safeguarding the counselor-client relationship, and practicing in an ethical manner (ACA, 2014). Value congruence between one's personal values and professional values enhances a person's well-being and commitment to the workplace (Tartakovsky, 2016). When a counselor's values do not align with those at the workplace or a person's personality is misaligned with the job roles and expectations, burnout can occur (Bridgeman et al., 2018; Wallace et al., 2010). A recent research study explored the relationship between personal values and burnout in social workers (Tartakovsky, 2016). Results revealed that people who had a higher preference for values such as benevolence, universalism, and achievement were less associated with the experience of burnout (Tartakovsky, 2016). However, individuals who preferred values

like power (social status gained through control and dominance over other people) and face (sense of security and power through maintaining public image and avoiding humiliation) were associated with higher levels of burnout (Tartakovsky, 2016). Hence, people whose values did not align with their profession were more likely to experience burnout (Tartakovsky, 2016), making this a likelihood for the counseling profession as well.

Aside from the influence of personal values on burnout, personal coping styles also contribute to the onset of burnout. Coping includes a set of behavioral and psychological approaches that are used to manage, tolerate, or reduce stressors that occur in one's life (Lazarus & Folkman, 1984; Wilski, Chmielewski, & Tomczak, 2015). The three coping styles include active coping, or problem-focused coping, emotion-focused coping, and avoidance related coping (Wilski et al., 2015). Problem-focused or active coping includes an individual's ability to take action when a stressor occurs (Wilski et al., 2015). Problem-focused coping is linked with decreased levels of burnout in nurses, case managers, mental health workers, teachers, and physiotherapists (Carmona, Buunk, Peiró, Rodríguez, & Bravo, 2006; Elliott, Shewchuk, Hagglund, Rybarczyk, & Harkins, 1996; Garrosa, Rainho, Moreno-Jiménez, & Monteiro, 2010; Koeske, Kirk, & Koeske, 1993; Leiter, 1991; Wilski et al., 2015). Both avoidant and emotional coping strategies are linked with higher levels of burnout (Wallace et al., 2010; Wilski et al., 2015). In a recent research study on physiotherapists, individuals felt more burned out when they used more emotion-focused coping versus problem-focused coping strategies to manage stressors

(Wilski et al., 2015). When coping is dysfunctional, and there is a mismatch in coping resources with job expectations, burnout can result (Ahola et al., 2010).

Changes in the healthcare legislation is the final theme that emerged from reviewing peer-reviewed literature on risk factors for burnout. Changes in healthcare legislation within the United States has contributed to changes in mental health care. In recent years, mental health care in the U.S. has moved towards providing quality care at a lower cost to the insurance companies and to the consumer (Acker, 2012). However, this dramatic shift in working with managed care insurance companies to lower the cost of mental health treatment has resulted in counselors being overworked, altering the quality of care counselors provide to their clients (Acker, 2012). Counselors who work with clients with severe mental illness are faced with additional challenges of dealing with insurance companies that do not understand the need for people to have long-term support (Acker, 2012). Limited funding causes a financial strain on mental health care organizations, leading to decreased opportunities for professional development or administrative support (Acker, 2012). The shift in how mental health care is provided to clients may contribute to the onset of burnout.

Symptoms of Burnout

Burnout affects people in a variety of ways, including both physical and psychological ways (Sangganjanavanich & Balkin, 2013). A variety of symptoms have been documented by researchers who have studied burnout. The symptoms related to burnout include constant fatigue, insomnia, lack of appetite, decreased concentration, changes in memory, anxiety, being negligent at work, irritation, increase in peer conflicts,

isolation, and imposter syndrome (Melquíades et al., 2017). Burnout can also lead to overwhelming feelings of exhaustion, cynicism, feeling detached from one's employment, and feeling ineffective and unaccomplished (Maslach, 2003; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). Other symptoms include depression, exhaustion, insomnia, substance abuse, decreased self-esteem, difficulties in maintaining relationships, and helplessness (Sangganjanavanich & Balkin, 2013). During a session with a client, burnout may be exhibited through a loss of empathy for the client, loss of respect, loss of positive feelings towards a client experiencing trauma, and the increase in boundary violations within the therapeutic setting (Wallace et al., 2010). People who suffer from burnout report feeling "disillusioned, helpless, irritated, and completely worn-out," (Bakker & Oerlemans, 2016, p. 757).

Effects of Burnout

Many times, healthcare professionals are not aware of how their work of helping others affects their own mental and physical well-being (Bridgeman et al., 2018). The cost of caring is known to lead to negative consequences such as poor physical well-being, poor mental well-being, decreased work performance, and increased turnover rates for individuals who experience burnout (Birkeland, Richardsen, & Dysvik, 2018; Leiter & Maslach, 2009; Melquíades et al., 2017). Emotional exhaustion, a key component of burnout, has been correlated with job dissatisfaction, lack of professional efficacy, intent to quit, and turnover (Acker, 2012). Burnout also increases the risk for people to become sick with the flu, headache, chronic fatigue and hinders one's ability to recover quickly (Arslan & Acar, 2013). Research findings by Acker (2012) demonstrated that 56% of

mental health workers reported moderate to high levels of emotional exhaustion, 73% reported moderate to high levels of role stress, and 50% considered quitting their jobs. Previous longitudinal studies have indicated that if left untreated, burnout can persist throughout five, ten, or fifteen years (Bakker & Costa, 2014). Sangganjanavanich and Balkin (2013) further argued that burnout might lead to cynicism, pessimism, bitterness, difficulties with tolerance, decreased motivation, and the overuse of sarcasm.

Burnout is habitually associated with increased depression, anxiety, sleep disturbances, impaired memory, alcohol consumption, and neck and back pain (Morse et al., 2012). There have been some challenges with identifying the role anxiety plays in one's experience of burnout. Anxiety is a common human reaction to stressors that includes physiological, emotional, and cognitive responses (Lee, Veach, Macfarlane, & Leroy, 2015). Anxiety can be broken up into state anxiety and trait anxiety. State anxiety is the "subjective feelings of tension, apprehension, nervousness, and worry" that may occur in any situation one experiences (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983, p. 4). Trait anxiety is the individual differences in the intensity and frequency of one's experience of anxiety (Spielberger et al., 1983). A recent study concluded that higher levels of trait anxiety were associated with compassion fatigue in genetic counselors (Lee et al., 2015). However, anxiety has also been associated as a symptom of burnout (Melquíades et al., 2017). Yet in another research study on community healthcare workers in China, burnout was found to mediate the effects of occupational stress on anxiety symptoms (Ding, Qu, Yu, & Wang, 2014). Hence, being able to manage

burnout can significantly decrease the impact of stress levels on anxiety symptoms (Ding et al., 2014).

Emphasizing how damaging burnout can be for counselors, it has also been associated with increased suicide. The suicide rate as a result of burnout is approximately 3.7-4.5% for female primary care physicians, 250-400% higher than the suicide rate in women of other professions (Kuwada, 2016). For male physicians, the suicide rate is lower at 1.5-3% (Kuwada, 2016). When examining specific fields within medicine, Moffic (2018) found that psychiatrists had a higher rate of suicide due to burnout compared to other disciplines within medicine, with general physician suicide rates being double than that of the general public (Gold, Sen, & Schwenk, 2013; Kreimer, 2018). One supporting factor for increased suicide in psychiatrists is that self-disclosing suicidal ideation may harm a psychiatrist's image, license, and career, leading to the avoidance of seeking mental health treatment (Moffic, 2018). In another research study, increased knowledge of how to commit suicide and access to means (firearms, lethal substances, poisoning) are a contributing factor for suicide in nurses (Alderson, Parent-Rocheleau, & Mishara, 2015; Gold et al., 2013). Additionally, Alderson et al. (2015) reported that there continues to be a lack of research studies on suicide in the health professions. A literature search in databases Academic Search Complete, PsycINFO, and PsycARTICLES confirms Alderson et al. (2015), as a search yielded zero peer-reviewed articles on suicide or suicidal ideation in counselors, with most literature centered around client suicide and counselors.

Burnout is not only a concern for mental health professionals, but it is also a concern for clients served (Viehl et al., 2017). Burnout contributes to "insufficient attention to customers," (Arslan & Acar, 2013, p. 284) and leads to a decreased ability to complete job requirements, increasing negative outcomes and the likelihood of harming clients served (Figley, 2002; Lampert & Glaser, 2018; Landrum, Knight, & Flynn, 2012; Mullen et al., 2017; Viehl et al., 2017). In healthcare studies, burnout is correlated with poor patient safety outcomes as well as an increase in medical errors (Bridgeman et al., 2018). A study conducted on medical residents in Ireland found that 64% of residents who were experiencing burnout made a medical error in comparison to only 22% of residents who did not report experiencing burnout (O'Connor et al., 2017; Bridgeman et al., 2018). In a study on teachers experiencing burnout conducted by Van der Linden, Keijsers, Eling, and Van Schaijk (2005), findings were indicative of increased cognitive failures and increased mistakes being positively correlated with burnout. Counselors are wasting client resources and access to mental health services by continuing to work impaired and violating the ACA Code of Ethics (2014). The ACA Code of Ethics (2014) indicates that a counselor's primary responsibility is to maintain welfare of clients (section A.1.a), suggesting that counselors are not being respectful of a client's best interest if they are not providing adequate care.

Burnout and the Workplace

The cost of burnout is estimated at $120 billion USD per year in the United States (Goh, Pfeffer, & Zenios, 2015). Despite this, the American Institute of Stress estimates job stress costs United States employers over $300 billion each year due to absenteeism,

job turnover, decreased productivity, and medical, legal, and insurance costs (The American Institute of Stress, n.d.). Burnout is more frequent in occupations that include a high percentage of face to face interaction such as counseling, teachers, police officers, lawyers, nurses, and customer representatives (Arslan & Acar, 2013). Employers should have an interest in promoting wellness into people they employ and train (Bridgeman et al., 2018) due to the negative cost burnout has on performance and quality of care provided. Organizations are plagued by employees being stressed at work to meet work expectations (Ismail et al., 2015). People experiencing burnout do not manage job performance at the typically expected levels (Bakker & Costa, 2014). Since one of the symptoms of burnout is fatigue, it is not surprising that research findings have indicated a loss of energy leads to increased difficulties in performing job duties (Silbiger & Pines, 2014). Moreover, people who experience burnout are less willing to help other people and less likely to receive help from others, causing a decline in productivity (Bakker & Costa, 2014).

Research findings indicate that burnout jeopardizes the welfare of clients (Young, 2015), and is highly correlated with decreased motivation, employment turnover, and decreased work performance in mental health professionals (Ismail et al., 2015; Salloum et al., 2015; Silbiger & Pines, 2014). According to Figley (2002), the experience of burnout may lead to the need to alter one's job and/or career to manage the chronic symptoms of burnout. Job turnover rates in the mental health field have been reported at 30% to 60% annually for community mental health workers, child welfare, and social workers (Paris & Hoge, 2010). Additionally, 50% of mental health professionals working

in a rehabilitation facility reported they would leave their roles within the next two years (Paris & Hoge, 2010). Additionally, turnover becomes a higher likelihood when stress levels are high, and there is minimal coworker support (Aronsson et al., 2017; Young, 2015). The impact of turnover on clients receiving substance abuse services is correlated with unpredictability, discontinuity of care, and longer inpatient treatment (Young, 2015). High turnover rates also force employers to continue to spend limited funds on recruitment, hiring, and training new staff (Young, 2015).

In addition to increased sick days and increased job turnover, burnout can also lead to presenteeism (Bakker & Costa, 2014). Presenteeism is defined as going to work when one should be off sick, either for illness or when one is not effective (Bakker & Costa, 2014). Burnout also interferes with one's capacity to perform job duties, leading to the loss in job satisfaction, turnover, absenteeism, decrease in work commitment, and decline in quality of service provided (Maslach, Jackson, & Leiter, 1996; Sangganjanavanich & Balkin, 2013).

Job satisfaction is important in the workplace and is often described as the reaction one has towards their jobs (Arslan & Acar, 2013). Job satisfaction is associated with life satisfaction and is a common indicator of psychological health at work (Arslan & Acar, 2013). When people identify work as important to them, low levels of burnout are reported even in stressful situations (Silbiger & Pines, 2014). Additionally, when people's work is not important, and people feel they have failed themselves or others, they begin to feel helpless and hopeless, which leads to the experience of burnout

(Silbiger & Pines, 2014). Arslan and Acar (2013) outlined that decreased experiences of burnout were associated with higher satisfaction levels with employment and life.

Protective Factors

There were three themes associated with protective factors for burnout. The themes include aspects of social support, associated factors related to work environment, and intrapersonal associated factors. Within the first theme of social support, coworker and social support were indicative as protective factors for burnout (Viehl et al., 2017). Birkeland et al. (2018) further contended that perceived coworker support was identified as the most important buffer to experiencing emotional exhaustion.

The second theme of protective factors for burnout centers around the work environment. Some protective factors for professional counselors include less paperwork, smaller caseloads, and increased flexibility at work (Viehl et al., 2017). Professional counselors working in private practice are also at a lower risk for burnout because of the increased autonomy and flexibility that accompanies private practice settings (Thompson et al., 2014; Viehl et al., 2017). Moreover, people who perceive their supervisors and superiors to be fair are less likely to experience burnout (Bridgeman et al., 2018).

The third theme of protective factors for burnout in counselors includes intrapersonal factors such as increased self-reflection, as it has the capacity to be aware of early warning signs for burnout (Mullen et al., 2017). Researchers Thompson et al. (2014) used the transactional stress and coping theory to examine various predictors and protective factors for compassion fatigue and burnout in mental health counselors. Multiple regression analyses revealed that counselors reported less burnout when they

reported fewer maladaptive coping skills, higher mindfulness attitudes, and a positive perception of their work environment (Thompson et al., 2014). Active coping techniques, such as taking steps towards developing and implementing a plan of action to handle a problem, were associated with lower levels of burnout (Carver, Scheier, & Weintraub, 1989; Wallace et al., 2010). Another intrapersonal protective factor is self-awareness, which is an integral component to self-care and balance between self, life, and work (Lin, 2012). While there are various protective factors that assist in mitigating burnout, health care professionals are continuously subjected to stressors from assisting others, making it necessary for researchers to identify ways to help prevent the experience of burnout (Melquíades et al., 2017).

Recovering From Burnout

Due to the consequences caused by burnout, it is integral to the counseling profession that counselors have access to appropriate ways of coping with burnout. Morse et al. (2012) noted the irony that the thousands of peer-reviewed articles on burnout have yet to focus on ways to combat the experience of burnout. Despite the extensive research on defining burnout, including risk factors and the consequences of burnout, there has yet to be effective interventions developed and evaluated for the treatment of burnout (Awa, Plaumann, & Walter, 2010; Maslach, 2003). Self-care is generally the recommended remedy to manage and reduce experiences of burnout (Dorociak, Rupert, & Zahniser, 2017; Salloum, Kondrat, Johnco, & Olson, 2015; Zahniser, Rupert, & Dorociak, 2017). Self-care may be difficult to define, however, Lee and Miller (2013) define self-care as a range of activities that one engages in with the

sole intent of managing one's physical and emotional well-being. Clinical supervision is also known to contribute to preventing and mitigating counselors' experience of burnout (Azar, 2000; Wallace et al., 2010).

Previous studies have attempted to identify ways for counselors to recover from burnout. Jaworska-Burzyńska, Kanaffa-Kilijańska, Przysiężna, and Szczepańska-Gieracha (2016) reviewed current empirically validated ways to reduce burnout and noted the wide range of interventions used to reduce burnout. These interventions include the following: transcendental meditation, mindfulness based stress reduction (MBSR), stretching exercises, exercise, aromatherapy, electro-acupuncture, workshops organized by mental health specialists, support groups, autogenic training and laughter therapy, cognitive behavior therapy, psychosocial and communication skills development training, relaxation training, adaptive coping training, transpersonal psychology, and recreational music making (Barbosa et al., 2013; Bittman, Bruhn, Stevens, Westengard, & Umbach, 2003; Blonk, Brenninkmeijer, Lagerveld, & Houtman, 2006; Brake, Gorter, Hoogstraten, & Eijkman, 2001; Cohen-Katz et al., 2005; Cohen & Gagin, 2005; De Vibe et al., 2013; Dias, Pagnin, Pagnin, Ribeiro Reis, & Olej, 2012; Elder, Nidich, Moriarty, & Nidich, 2014; Ewers, Bradshaw, McGovern, & Ewers, 2002; Friedman, 2017; Gorter, Eijkman, & Hoogstraten, 2001; Jaworska-Burzyńska et al., 2016; Jonas, Leuschner, & Tossmann, 2017; Kanji, White, & Ernst, 2006; Le Blanc, Hox, Schaufeli, Taris, & Peeters, 2007; Martins et al., 2011; Montero-Marin, Asun, Estrada-Marcen, Romero, & Asun, 2013; Ossebaard, 2000; Sluiter et al., 2005; Tsai et al., 2013; Van Dierendonch, Garssen, & Visser, 2005; Van Rhenen, Blonk, van der Klink, van Dijk, & Schaufeli, 2005; Varney &

Buckle, 2013; Zolnierczyk-Zreda, 2005). Jaworska-Burzyńska et al., (2016) contended that while 64.64% of authors managed to reduce burnout, the significant differences in methodologies suggest that there is still minimal support for an empirically validated approach to prevent or mitigate the experience of burnout in counselors.

A recent mixed methods study conducted by Dobie, Tucker, Ferrari, and Rogers (2016) in Australia centered around the efficacy of mental health professionals practicing mindfulness-based stress reduction. Following the brief mindfulness-based stress reduction program, quantitative and qualitative participant feedback revealed a perceived reduction in psychological distress (Dobie et al., 2016). Lanham, Rye, Rimsky, and Weill (2012) conducted a quantitative study that explored how gratitude relates to burnout and job satisfaction in mental health professionals. The results concluded that increased workplace-specific gratitude had a negative relationship with emotional exhaustion and depersonalization, even after controlling for demographic/job contextual variables and hope (Lanham et al., 2012). Gratitude can enhance well-being, job satisfaction, and has the potential to mitigate burnout (Lanham et al., 2012). Gratitude exercises such as keeping a daily journal of five things one is grateful for requires minimal effort and may be a helpful tool for counselors (Lanham et al., 2012).

In another study conducted in the Netherlands, Bakker and Oerlemans (2016) highlighted how individuals who had higher levels of work engagement were able to satisfy their daily needs, cope with their own psychological needs, and stay happy. Conversely, individuals who were not engaged in work and not able to meet their daily needs had higher levels of burnout (Bakker, & Oerlemans, 2016). Although researchers

intend to generate empirically validated studies that have practical implications for counselors, not all studies that focus on recovery in burnout have been able to do so successfully. For instance, Salloum et al. (2015) focused on trauma-informed self-care (TISC) as another alternative to recovering from burnout. However, while trauma-informed self-care (TISC) resulted in higher levels of compassion satisfaction and lower levels of burnout, it was further noted the measure of TISC has been unvalidated in peer-reviewed literature (Salloum et al., 2015). Additionally, Paris and Hodge (2010) reviewed research studies that attempted to develop interventions for burnout and found that the studies had weak methodologies. Difficulties surrounding the development of an intervention for burnout has historically been due to designing an appropriate intervention that can be implemented in a longitudinal study (Maslach, 2003). It is essential to standardize research methods available to prevent and/or mitigate burnout (Jaworska-Burzyńska et al., 2016). Empirical support is lacking for burnout interventions (Maslach, Leiter, & Jackson, 2012; Paris & Hoge, 2010), suggesting that research in this area continues to be limited and warranted.

Maslach (2003) also speculated that interventions for burnout should not include the term burnout in the title of the intervention due to its negative connotation of being associated with the inability to care (Chang, 2014), seen as problematic (Morse et al., 2012), or viewed as crippling (Figley, 2002). Instead, Maslach (2003) encouraged researchers to use the word engagement in the title of the burnout intervention to increase effectiveness on reducing burnout. Engagement was defined as “a persistent, positive motivational state of fulfillment in employees that is characterized by vigor, dedication,

and absorption," (Maslach, 2003, pp. 190-191). Hence, the use of life balance and self-compassion as an intervention for overall wellness may be better perceived by counselors.

The Life balance Construct

Life balance is a vital construct in the counseling profession, often studied in relation to other terms including well-being, satisfaction, stress, or balance (Davis et al., 2014). The life balance construct has been difficult to define in peer-reviewed literature. Some define balance as the different life roles in people's lives (Karaman et al., 2018). Others view life balance as a pattern of daily activity that is meaningful, healthy, satisfying, and sustainable (Matuska & Christiansen, 2008). The term life balance differs from work-life balance, as work-life balance is centered around balancing work and life versus an overall wellness lifestyle (Balkin et al., 2018). Work-life integration is a new term for work-life balance, coined in 2012 due to balance being an "unachievable ideal in today's fast-paced world," (Tajlili, 2014, p. 255). Life balance is centered on wholeness and wellness, rather than being static (Karaman, Balkin, & Juhnke, 2018). Life balance is understood by the regular practices people engage in their lives (Matuska & Christiansen, 2008). Simmons (2012) further contended that life balance is one's ability to balance work and home life to achieve "harmony in physical, emotional, and spiritual health," (p. 25).

A significant amount of research on life balance has centered around how women balance roles differently than men, as women who are mothers are faced with the desire to succeed as a parent and professional (Bryant & Constantine, 2006). Since most

professional counselors are women, it is highly probable that most counselors can relate to the struggles of maintaining a sense of balance in their lives (Tajlili, 2014). Female counselor educators report not having time for self-care activities to support their own mental and physical wellness (Hermann, Ziomek-Daigle, & Dockery, 2014). The developers of the Juhnke Balkin Life Balance Inventory (JBLI) operationally defined life balance on domains such as optimism, relationships, stress/anxiety, career satisfaction, and overall health (Davis et al., 2014). The JBLI was developed to assess life balance and point out areas of imbalance, concern, and dissatisfaction in one's life (Davis et al., 2014). Healthy work-life balance can improve work performance, productivity, and reduce turnover and work-related errors (Dwi Putranti, 2018). Despite the benefits of life balance, the term life balance is rarely used in conversation (Dwi Putranti, 2018).

Effects of Life Balance

Counselor wellness is fostered throughout one's clinical training as an essential component of being an effective professional counselor (Puig et al., 2012; Wester et al., 2009). Healthy boundaries in relationships and work responsibilities contribute to personal well-being (Holowaychuk, 2018). In a qualitative study conducted by Lin (2012), counselors found that recovery from burnout required a balance between self, life, and work. As life satisfaction increases, emotional exhaustion decreases (Arslan & Acar, 2013), suggesting that increased life balance contributes to decreased experiences of burnout. Life situations can be dealt with positively and constructively through emotional wellness (Owen & Çelik, 2018). Moreover, many diseases can be prevented by a healthy lifestyle (Owen & Çelik, 2018).

Balance and self-care contribute to the prevention of compassion fatigue in nurses (Mattioli, 2018). Mattioli (2018) suggested that energy was identified as an integral component to avoiding compassion fatigue. Therefore, it is essential for nurses to assess and manage their levels of energy in order to moderate compassion fatigue (Mattioli, 2018). Some strategies suggested by Mattioli (2018) to increase levels of energy included engaging in hobbies, eating a balanced diet, sleeping well, exercising, nurturing friendships and familial relationships, engaging in relaxing and enjoyable activities, and pursuing spiritual fulfillment.

When people maintain life balance, their lives are reported to be more satisfying, meaningful, and less stressed (Matuska, 2012). Life balance also relates to lower experiences of stress and a higher sense of personal well-being (Matuska, 2012). According to Ismail et al. (2015), organizations should develop and implement work-life balance initiatives to assist employees in maintaining balance. Balance contributes to one's need for equilibrium across multiple roles in life (Tajlili & Baker, 2018). Some specific principles to achieving life balance include mindfulness, being deliberate about living, a secure identity, planning, humor, optimism, and gratitude (Henderson & Montplaisir, 2013; Lee et al., 2018). Additionally, balance is easier to achieve when you are self-aware of your goals, desires, and needs (Simmons, 2012).

Research Related to Life balance and Burnout

A literature search in databases Academic Search Complete, PsycINFO, and PsycARTICLES yielded 546 results for life balance and burnout, several of which discussed the role that life balance plays in buffering the onset of burnout in social work

(Fouché & Martindale, 2011), nurses (Pearson, 2015), psychiatrists (Umene-Nakano et al., 2013), medical residents (Rodrigues et al., 2018), physicians (Fralick & Flegel, 2014; Starmer, Frintner, & Freed, 2016), and educators (Kinman & Jones, 2008; Richards, Hemphill, & Templin, 2018). A literature search in databases Academic Search Complete, PsycINFO, and PsycARTICLES yielded seven results for counselor, life balance, and burnout. Of the seven articles, two focused on school counselors (Bryant & Constantine, 2006; Evans & Payne, 2008), two on university counselors (Lin, 2012; Loveland, 2018), two on wellness in counselor education (Wester et al., 2009; Yager & Tovar-Blank, 2007), and one on assistance seeking behaviors in male and female surgeons (Sanfey et al., 2015).

A mixed methods study on nurse educators discovered that support and personal time management assisted in achieving life balance while high demands and high workload decrease feelings of life balance (Owens, 2017). Additionally, there is a strong negative relationship between life balance and burnout in nurse educators (Owens, 2017). Wester et al. (2009) contended that for counselor educators to manage burnout, setting limits and recognizing the need for life balance may be key. Another research study confirms this by stating that burnout recovery requires balance of self, life, and work in University counselors (Lin, 2012), indicating that life balance can prevent and/or mitigate the experience of burnout.

The Self-Compassion Construct

All people are worthy of compassion (Neff, 2003). Self-compassion is defined by Neff (2003) as being open to one's suffering, being kind and understanding to the self as

well as being nonjudgmental about one's failures. Self-compassion allows people to be caring and kind to themselves when they have failed, not met expectations, or felt inadequate (Stuntzner, 2014; Stuntzner, 2017). The practice of self-compassion requires a mindful awareness of emotions, understanding, connection to common humanity, and self-kindness (Coaston, 2017). Self-compassion encourages people to forgive themselves for imperfections and accept who they are (Stuntzner, 2014; Stuntzner, 2017).

In a review of the literature, Barnard and Curry (2011) noted that high levels of self-compassion could buffer against burnout. Coaston (2017) further supported this statement by stating "self-compassion can serve as a protective factor against such potentially debilitating effects of work-related burnout" (p. 286). In a recent research study, higher levels of burnout predicted lower levels of self-compassion in nurses (Dev, Fernando, Lim, & Consedine, 2018).

Dev et al. (2018) used the Copenhagen Burnout Inventory (CBI) to assess burnout in nurses from New Zealand and Britain. The Self-Compassion Scale Short Form (SCS-SF) was administered to assess self-compassion (Dev et al., 2018). The Barriers to Physician Compassion Scale was also utilized to assess barriers to compassion (Dev et al., 2018). Results of this research study highlighted self-compassion as mitigating burnout and burnout related barriers to compassion in nurses (Dev et al., 2018).

Additionally, higher levels of self-compassion may protect one from experiencing burnout (Dev et al., 2018). Drawing on the work of Dev et al., (2018), burnout predicts increased barriers to compassion among nurses. Similarly, in another research study, counseling students who had higher levels of self-compassion and well-

being also had lower levels of compassion fatigue and burnout (Beaumont, Durkin, Hollins Martin, & Carson, 2016). In this research study, the Professional Quality of Life Scale (ProQOL) was administered to assess compassion satisfaction, compassion fatigue, and STS (Beaumont et al., 2016). The SCS was used to measure self-compassion and the short Warwick and Edinburgh Mental Well-being Scale (sWEMWBS) scale was used to assess well-being over the past two weeks (Beaumont et al., 2016). The Compassion for Others (CFO) scale was also used to assess compassion for others (Beaumont et al., 2016). Burnout was not assessed in this research study. Additionally, the association between burnout and self-compassion has yet to be made in professional counselors.

Research Related to Self-Compassion and Burnout

A literature search in databases Academic Search Complete, PsycINFO, and PsycARTICLES yielded 182 peer-reviewed articles for self-compassion and burnout between 1999 and 2019. The following highlights several research studies that have utilized self-compassion as an intervention for burnout. A Swedish study on psychologists revealed the effects of a six week online mindful self-compassion program to combat symptoms of stress and burnout (Eriksson, Germundsjö, Åström, & Rönnlund, 2018). The SCS was utilized to assess self-compassion (Eriksson et al., 2018). The Five Facets Mindfulness Questionnaire (FFMQ) was administered to assess mindfulness skills and the Perceived Stress Scale (PSS) was utilized to assess perceived levels of stress (Eriksson et al., 2018). Burnout was assessed through the administration of the Shirom-Melamed Burnout Questionnaire (SMBQ) (Eriksson et al., 2018). Results of this research study indicated the six week online mindful self-compassion program increased self-

compassion and mindfulness skills in psychologists (Eriksson et al., 2018). There was also a significant decline in perceived stress and burnout symptoms in participants (Eriksson et al., 2018), indicating that self-compassion does have the capacity to mitigate and/or prevent the experience of burnout in counselors.

A cross-sectional research study addressed the relationship between self-compassion and burnout while accounting for depression in mental health workers of the Minneapolis Veterans Affairs (Atkinson, Rodman, Thuras, Shiroma, & Lim, 2017). Instruments administered in this research study included the Copenhagen Burnout Inventory (CBI), the SCS, and the Patient-Health Questionnaire (PHQ-2) to assess depression (Atkinson et al., 2017). Results indicated a negative correlation between self-compassion and burnout as well as between self-compassion and depression (Atkinson et al., 2017). Atkinson et al. (2017) posited that self-compassion may be an integral component of resilience to the experience of burnout.

A recent study linked self-compassion as a possible protective factor for burnout in 440 Spanish health care professionals (Montero-Marin et al., 2016). This cross-sectional study administered the Burnout Clinical Subtype Questionnaire (BCSQ-36), the Maslach Burnout Inventory-General Survey (MBI-GS), the Self-Compassion Scale (SCS), the Utrecht Work Engagement Scale (UWES) and the Positive and Negative Affect Schedule (PANAS) (Montero-Marin et al., 2016). Results confirmed that burnout is associated with the negative elements of self-compassion; isolation, self-judgment, and over-identification (Montero-Marin et al., 2016). Hence, self-compassion can be used as a protective factor for burnout (Montero-Marin et al., 2016). Montero-Marin et al. (2016)

also argued that self-compassion has been associated with improved patient trust and increased quality of care.

In another research study, Fong and Loi (2016) examined the relationship between self-compassion, distress factors, and depression in students. In this cross-sectional study, assessments administered included the SCS, the Satisfaction With Life Scale (SWLS) to measure happiness, the Flourishing Scale (FS) to measure social-psychological well-being, Positive and Negative Affect Schedule (PANAS) to measure positive and negative affect, the Perceived Stress Scale (PSS-10) to measure perceived stress, the Maslach Burnout Inventory-Student Survey (MBI-SS) to measure burnout, the Center for Epidemiological Studies Depression Scale-Revised (CESD-R) to measure depression, and the Marlow-Crowne Social Desirability Scale-Form C (MC-C) to measure social desirable responding (Fong & Loi, 2016). Results of this study indicated that self-compassion may help mitigate student stress, distress, and burnout (Fong & Loi, 2016).

Summary and Conclusions

In summary, the historical understanding of burnout in professional counselors includes the symptoms, risk factors, protective factors, and effects of burnout (Bakker & Costa, 2014; Maslach, 2003; Morse et al., 2012; Salloum et al., 2015). Counselors are at risk of negative emotional outcomes, including burnout. Some researchers have indicated that if not addressed, burnout may lead to a decrease in client treatment outcomes as well as increased job turnover (Acker, 2012; Ahola et al., 2015; Birkeland et al., 2018; Maslach, 2003; Salloum et al., 2015). Interventions to protect against and reduce the

experience of burnout have increased over the past twenty years. Despite this increase in research on interventions, there has yet to be a consensus of what specific interventions are empirically validated to cope with and/or prevent the experience of burnout (Maslach, 2017). Self-compassion has been proven to be associated with personal well-being (Coaston, 2017; Neff, 2003). Additionally, maintaining life balance, as defined by the JBLI, is a topic that has been talked about but not researched to mitigate or prevent the experience of burnout (Davis et al., 2014; Davis & Tuttle, 2017). By better understanding the relationship between life balance, self-compassion, and burnout, the counseling profession might be able to develop an empirical model on how to mitigate or prevent burnout in counselors. This research study examined the relationship between the subscales of burnout in counselors and the subscales of self-compassion and life balance. In Chapter 3, I present how I intended to utilize the CBI, JBLI, and SCS to examine the relationship between the subscales of burnout in counselors and the subscales of self-compassion and life balance.

Chapter 3: Research Method

Introduction

In this chapter, I explore the research design and approach for examining the relationship between burnout subscales and life balance subscales in counselors and examining the relationship between burnout subscales and self-compassion subscales in counselors. The strength of the relationship between each of the subscales, if any, could provide direction for the future of counselor training on ways to mitigate and/or prevent burnout. The research questions, research design, justification for the design, relationship to the problem statement, and setting and sample characteristics are presented in this chapter. I also present data collection procedures as well as how the canonical correlation relates to this research study. The steps taken to ensure participant's information is protected, anonymous, and secure are explained.

Research Design and Rationale

This research study involved the use of two canonical correlation analyses (CCA) on multiple sets of variables. A CCA is a multivariate analysis of correlation in which simultaneous comparisons can be made among multiple independent and dependent variables (Sherry & Henson, 2005). A canonical correlation measures the strength of linear composites between independent and dependent variables, or canonical variates (Sherry & Henson, 2005). For this research study, the dependent variables were the subscales of the CBI. Hence, the dependent variables for the first canonical variate were exhaustion, negative work environment, devaluing client, incompetence, and deterioration in personal life. The independent variables for the first canonical variate

were the subscales of the JBLI. These independent variables included the following: positive orientation, stress/anxiety, substance use/abuse, spiritual support, friendship, sleep disturbance, career, sex/intimacy, global health, and quality of relationships. For the second canonical variate, the dependent variables remained the same and are listed as follows: exhaustion, negative work environment, devaluing client, incompetence, and deterioration in personal life. The independent variables for the second canonical variate were the subscales of the SCS*:* self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification. All independent and dependent variables in this study are interval. However, due to the way the CCA is conducted and interpreted, the CCA treats the variables of each measure as if they were ratio (Tabachnick & Fidell, 2013).

The first CCA was between the subscales of the CBI and the subscales of the JBLI (See Figure 1). The second CCA was between the subscales of the CBI and the SCS (See Figure 2). Additionally, the goal of a CCA is to define relations between paired sets of variables (Uurtio et al., 2017). In this research study, the first CCA addressed and quantified the relationship between the five subscales of burnout, as defined by the CBI (exhaustion, negative work environment, devaluing client, incompetence, and deterioration in personal life), and the 10 subscales of life balance, as defined by the JBLI (positive orientation, stress/anxiety, substance use/abuse, spiritual support, friendship, sleep disturbance, career, sex/intimacy, global health, & quality of relationships). The second CCA addressed and quantified the relationship between the five subscales of burnout, as defined by the CBI, and the six subscales of self-compassion, as defined by

the SCS (self-kindness, self-judgment, common humanity, isolation, mindfulness, & over-identification).

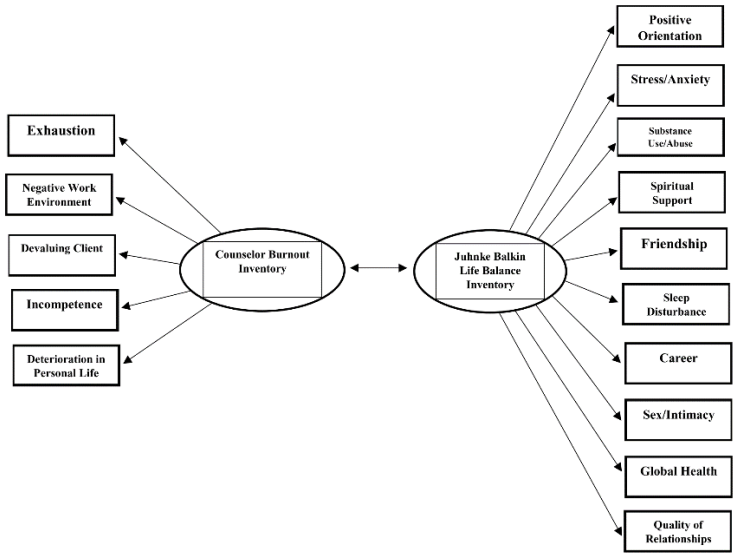

Figure 1. Illustration of the first canonical function used to answer Research Question 1. This CCA has five predictor variables and 10 criterion variables.

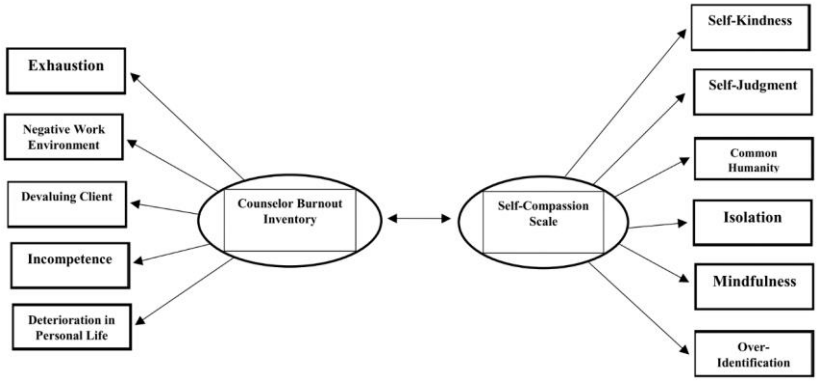

Figure 2. Illustration of the second canonical function used to answer Research Question 2. This CCA has five predictor variables and six criterion variables.

There are several advantages to using the CCA to analyze the data in this survey research study. A canonical correlation affords the researcher the opportunity to examine the relationship between two variable sets (Sherry & Henson, 2005). The CCA, being a multivariate technique, limits the probability of Type 1 error from occurring (Sherry & Henson, 2005). Type 1 errors occur when a result is mistakenly found to be statistically significant (Sherry & Henson, 2005). It is necessary for researchers to decrease the chances of a Type 1 error from occurring. When Type 1 errors occur, researchers risk being able to identify what is an error versus a statistically significant relationship between variables (Sherry & Henson, 2005). Another advantage to the CCA is that it "may best honor the reality of psychological research" (Sherry & Henson, 2005, p. 38). The CCA was a well-suited statistical analysis for this research study, as it quantifies and explores the strength of the relationship between two sets of variables (Markati, Psychountaki, Kingson, Karteroliotis, & Apostolidis, 2018).

Before beginning any analysis within SPSS statistics software, it is necessary to clean up the data collected to mitigate any errors (Flamez, Lenz, Balkin, & Smith, 2017). This might include managing any missing values as well as determining whether or not to keep outliers (Flamez et al., 2017). Survey measurements often lack 100% participation, which threatens the value of the survey method, making it critical for researchers to decide what to do with missing values and outliers (Groves, Cialdini, & Couper, 1992). Prior to analyzing the data collected, assumptions were tested to ensure that error was reduced (see Creswell & Creswell, 2018). One of the assumptions for a CCA was to ensure that the data distribution is normal (Markati et al., 2018). After testing for

assumptions consistent with canonical correlations, SPSS was used to run the analysis. Statistical and practical significance of the results are reported.

Methodology

Population

I drew my sample from the population of counselors who were licensed (i.e., LCPC) or provisionally licensed (i.e., LPC) throughout the United States. Participants were recruited through online groups (LinkedIn, Facebook), listservs (i.e., Chicago Therapists), the state licensing board of Ohio, and counseling associations in the following states: Illinois, Indiana, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Jersey, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, and Washington. According to the American Community Survey (U.S. Census Bureau, 2016), there are 747,456 counselors in the United States.

Setting and Sampling Criteria

Sampling Method

To collect data for my dissertation, I used a survey methodology approach through the administration of the JBLI, CBI, and SCS (Davis et al., 2014; Groves et al., 2009; Lee et al., 2007; Neff, 2003). The survey research study was conducted via an online web-based survey using Qualtrics. The sampling design used to obtain participants for this survey research study was a single-stage sampling procedure (see Creswell & Creswell, 2018). Participants were recruited using a nonprobability convenience sampling procedure in which I chose participants based on their availability and willingness to participate in my dissertation study (see Creswell & Creswell, 2018). This

is also known as purposive sampling (Creswell & Creswell, 2018). This sampling strategy provided a representative sample of the larger counselor population, despite knowing that probability of exact representation or inclusion were not known.

Sample Size

The recommendations for sample size for a canonical correlation is 10 participants per variable (Hair, Black, Babin, & Anderson, 2010). Within the three instruments for this study, there were 21 variables. The minimum sample size for this research study was 210 participants, resulting in a 10-to-1 ratio of participants to variables. This sample size coincided with previous research studies using a canonical correlation (Hair et al., 2010; Markati et al., 2018).

Procedures for Recruitment, Participation, and Data Collection

Participants eligible for participation included counselors who were licensed (i.e., LCPC) or provisionally licensed (i.e., LPC) and have worked as counselors for the past 2 years. Because I sampled counselors throughout the United States, I collected data from various avenues. I recruited my sample from online groups (LinkedIn, Facebook), listservs (i.e., Chicago Therapists), the state licensing board of Ohio, and counseling associations in the following states: Illinois, Indiana, Kansas, Louisiana, Maryland, Mississippi, Missouri, New Jersey, New York, North Dakota, Oregon, South Carolina, Tennessee, Vermont, and Washington.

Samples from online groups including LinkedIn and Facebook are public information in which I posted access to the online survey assessments in both LinkedIn and Facebook. LinkedIn customers were eligible if they resided within the United States

and identified as a counselor. Through LinkedIn, I messaged eligible prospective participants a link to this research study. Through Facebook, I posted this research study in therapist and counselor groups for perspective participants. Because the link to the survey was posted publicly to all individuals who were eligible, anonymity remained intact. State licensing boards and state counseling associations were contacted to obtain permission to contact counselors licensed in each respective state. Once permission was obtained, eligible prospective participants were emailed with a link to the survey research study.

Upon obtaining the prospective participants' contact information, a link to Qualtrics was included in an e-mail sent to prospective participants. The email included Institutional Review Board (IRB) approval and an informed consent to the survey research study, informing participants of the benefits and risks of the study as well as inclusion that all responses were anonymous and confidential. After the informed consent, participants completed the demographic questionnaire and were presented randomly with the JBLI, the CBI, and the SCS. Randomization of the JBLI, CBI, and SCS was a function created through Qualtrics with the purpose of mitigating limitations of test influence in responding to each of the assessments. Total completion time for this survey research study was estimated between 10 and 15 minutes from start to finish. Participation in the study was voluntary, with the option to withdraw from the research study at any time.

Qualtrics, an online website, included the IRB approval, informed consent, and a demographic questionnaire. Qualtrics maintains participant confidentiality while also

providing the researcher with data collected to download to SPSS for data analysis. Once there was an adequate number of participants who completed the survey, I retrieved the data from Qualtrics and analyzed the data using two canonical correlations in SPSS. I will submit findings from this study as a journal article for publication consideration in the *Journal of Counseling Development, The Professional Counselor, Journal of Mental Health*, and/or the *Journal of Humanistic Counseling*. I did not plan to provide any follow-up with participants as their identity is unavailable as part of the confidentiality and protection of participants.

Instrumentation and Operationalization of Constructs

Demographic Questionnaire

A demographic questionnaire was administered to all participants, obtaining information regarding age, gender/gender identity, state of residence, race, ethnicity, marital status, sexual orientation, religious affiliation, employment status, years in the counseling field, mental health discipline (clinical mental health counseling, school counseling, counselor education, marriage and family therapy, rehabilitation counseling, substance abuse counseling), highest level of education, clinical license(s) obtained, work place setting (community mental health center, outpatient hospital, school, private practice, inpatient psychiatric hospital, residential treatment, substance abuse treatment, community, college/university counseling center), hours worked per week, self-care practices (exercise, reading, music, family, travel, hobby), and length of time for each self-care practice. Respondents with less than two years of experience were excluded.

The length of time required to work as a counselor was based on the notion that one is fully immersed in the professional role after two years of working in a counseling setting.

Counselor Burnout Inventory

The CBI was administered to participants. Developed in 2007, the CBI is comprised of 20 statements using a Likert-type scale (Lee et al., 2007). The responses are on a five-point response scale and range from *never true* to *always true*. There are five subscales that assess burnout in counselors within the CBI. The subscales are as follows: exhaustion, negative work environment, devaluing client, incompetence, and deterioration in personal life (Lee et al., 2007). An example of a statement on the CBI is *Due to my job as a counselor, I feel tired most of the time* (Lee et al., 2007). Each of these subscales had a moderate to high reliability at .80 for exhaustion, .83 for negative work environment, .83 for devaluing client, .81 for incompetence and .84 for deterioration in personal life (Lee et al., 2007). Permission to use the CBI was received via personal communication on 11/21/18.

Juhnke Balkin Life Balance Inventory

For this survey research study, the JBLI was administered to participants. Developed in 2014, the JBLI is comprised of 72 statements using a Likert-type scale (Davis et al., 2014). The responses are on a five point response scale and range from *strongly agree* to *strongly disagree* and participants are asked to select the response that is most closely aligned with their feelings of each statement (Davis et al., 2014). There are ten subscales that assess life balance within the JBLI. The subscales are as follows: positive orientation, stress/anxiety, substance use/abuse, spiritual support, friendship,

sleep disturbance, career, sex/intimacy, global health, and quality of relationships (Davis et al., 2014). An example of a statement on the JBLI is *I often awaken at least once a night and have difficulty falling back to sleep* (Davis et. Al., 2014). Each of these subscales had a moderate to high reliability ranging from .77 for career to .92 for positive orientation (Davis et al., 2014). Permission to use the JBLI was received via personal communication on 1/7/19.

Self-Compassion Scale

The SCS was administered to participants of this research study. Developed in 2003, the SCS is comprised of 26 statements using a Likert-type scale (Neff, 2003). The responses are on a five point response scale, ranging from *almost never* to *almost always* and participants are asked to designate how often they act in the manner stated in each statement (Neff, 2003). There are six subscales that assess self-compassion within the SCS. The subscales are self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification (Neff, 2003). An example of a statement on the SCS is *when I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people* (Neff, 2003). Each of the subscales had a moderate to high reliability ranging from .78 for self-kindness, .77 for self-judgment, .80 for common humanity, .79 for isolation, .75 for mindfulness and .81 for over-identification (Neff, 2003). Internal consistency for the SCS was .92 (Neff, 2003). The intention of the SCS is to generate an overall self-compassion score versus looking at each subscale individually. Because the CCA looks at each subscale individually instead of the instrument as a whole, scoring will be adjusted to reflect accuracy of each subscale. The SCS instructions

for scoring advise one to reverse score the questions related to self-judgment, isolation, and over-identification. Reverse scoring allows there to be an overall self-compassion score. However, in this research study, it is necessary to determine a participant's score for each subscale. Hence, in this research study, scores for self-judgment, isolation, and over-identification will not be reverse scored. The SCS is in the public domain on PsycTESTS and permission to use is not required. Permission to use the SCS is public information located in PsycTESTS.

Data Analysis Plan

The subsequent section discusses the process of collecting data and performing necessary analysis used to analyze data collected for this quantitative survey research study. Once sufficient data was collected, data sets were downloaded from Qualtrics to SPSS 25 (IBM, 2017). Prior to analyzing the data, it was necessary to test for the following assumptions: missing data, multivariate normality, linearity, multicollinearity, and singularity (Sherry & Henson, 2005). After testing for assumptions, two canonical correlation analyses were conducted. The two canonical correlation analyses explored and quantified the relationship between the subscales of burnout and life balance and the subscales between burnout and self-compassion (Markati et al., 2018). After the CCA was completed, the Wilk's lambda (λ) was performed to test the significance of the canonical correlation (Sherry & Henson, 2005). Significance of the Wilk's lambda (λ) is set to $p < .05$ (Sherry & Henson, 2005). A value closer to zero is indicative of a high correlation, whereas a value near one indicates a low correlation (Sherry & Henson,

2005). Only canonical variants that are significant were interpreted (Sherry & Henson, 2005).

Research Questions and Hypotheses

Research Question 1

What is the relationship, if any, between the subscales of life balance and burnout as measured by the JBLI and the CBI?

H_0: There is no statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

H_a: There is a statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

Research Question 2

What is the relationship, if any, between the subscales of self-compassion and burnout as measured by the SCS and the CBI?

H_0: There is no statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

H_a: There is a statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

Threats to Validity

Due to the sampling method of purposive convenience sampling used to obtain participants throughout the United States, it was necessary to consider threats to the validity of this survey research study. The instruments utilized for this survey research study have been previously used in other research studies and are confirmed to be reliable

and valid (Davis et al., 2014; Lee et al., 2007; Neff, 2003). Some threats to internal validity include selection bias and mortality rates of participants (Creswell & Creswell, 2018). Selection bias occurs when participants are selected based on a specific set of characteristics (Creswell & Creswell, 2018). Mortality occurs when participants drop out prior to completing the survey research study (Creswell & Creswell, 2018). Furthermore, operational definitions of burnout, life balance, and self-compassion assist in maximizing external validity. One limitation to the CCA is that the researcher must be aware that the findings of a CCA should not be considered as causal inferences (Sherry & Henson, 2005).

Ethical Procedures

For this quantitative survey research study to be approved, Walden University guidelines for social science research were met and this research study was approved by the IRB prior to data collection. Once IRB and Walden University approved the study, potential participants were contacted for participation.

Participants were informed that this survey research aimed to explore and quantify the relationship between the subscales of burnout and life balance and between the subscales of burnout and self-compassion. Participant's information were kept confidential and separate from their CBI, SCS, and JBLI results by de-identifying the participant's name and other identifying information. Only the researcher had access to this information in order to protect the participant's privacy. The conclusion of the survey prompted an automated message on the Qualtrics website thanking the participant for their participation as well as providing them with resources to gain access to mental

health services, support groups, and other tools related to work life balance and self-care practices.

Chapter Summary

This quantitative survey research study aimed to explore and quantify the relationships between the subscales of burnout and life balance and between the subscales of burnout and self-compassion through two canonical correlations. The instruments used in this survey research study were the CBI, the JBLI and the SCS (Davis et al., 2014; Lee et al., 2007; Neff, 2003). This research study needed a minimum of 210 participants to run the CCA's. With 747,456 counselors in the United States, there was an adequate opportunity to gather at least 210 participants through purposive sampling. In Chapter 4, data collection and a summary of the research results and their impacts on the hypotheses are reviewed. Both research questions would also be addressed in the next chapter.

Chapter 4: Results

Introduction

Counselor burnout has been a problem for decades, with research on this topic beginning in the early 1970s (Freudenberger, 1974; Maslach, 1976). Despite the extensive literature on understanding burnout and its experience in counselors, the counseling profession is seeking to identify an empirically validated method to prevent and/or mitigate the experience of burnout in counselors (Jaworska-Burzyńska et al., 2016; Maslach et al., 2012; Paris & Hoge, 2010). Preventing and/or mitigating counselor impairment is critical to counselors per the ACA Code of Ethics (2014, code C.2.g.). Additionally, counselors are expected to take part in self-care practices to "maintain and promote their own emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities" (ACA, 2014, p. 8). Preventing and/or mitigating counselor impairment can ultimately assist in counselor retention and more importantly to decrease client harm (Arslan & Acar, 2013; Figley, 2002; Holowaychuk, 2018; Lampert & Glaser, 2018; Landrum et al., 2012; Mullen et al., 2017; Puig et al., 2012; Sangganjanavanich & Balkin, 2013; Wester et al., 2009; Viehl et al., 2017).

The purpose of this quantitative survey research study was to explore the relationship, if any, between the subscales of burnout and life balance in counselors, as well as the relationship, if any, between burnout and self-compassion in counselors. Two CCAs were used to explore the relationships between these subscales. Clarification on the possible connection between self-compassion and counselor burnout and between life balance and counselor burnout may provide the counseling profession with a possible

empirically validated method to prevent and/or mitigate the experience of counselor burnout. Empirically validated assessments used to explore these relationships includes the SCS to measure self-compassion (Neff, 2003), the JBLI to measure life balance (Davis et al., 2014), and the CBI to measure counselor burnout (Lee et al., 2007).

There were two research questions identified in this quantitative survey research study include the following:

Research Question 1

What is the relationship, if any, between the subscales of life balance and burnout as measured by the JBLI and the CBI?

H_0: There is no statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

H_a: There is a statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

Research Question 2

What is the relationship, if any, between the subscales of self-compassion and burnout as measured by the SCS and the CBI?

H_0: There is no statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

H_a: There is a statistically significant relationship between the subscales of self-compassion and burnout as measured by the SCS and the CBI.

In this chapter, I describe the data collection, study analysis techniques, variables for the analyses, as well as the descriptive statistics, CCAs, and resulting data interpretation.

Data Collection

I gained Walden's IRB approval on May 21, 2019 (IRB # 05-21-19-0693578). I began the research study with the distribution of the survey on May 22, 2019, through contacting licensed professional counselors in the state of Ohio (letter of cooperation received via email on April 30, 2019). The following counseling associations distributed this survey on my behalf as the researcher: Illinois Counseling Association, Indiana Counseling Association, Louisiana Counseling Association, Maryland Counseling Association, Oregon Counseling Association, South Carolina Counseling Association, Vermont Counseling Association, and Washington Counseling Association. The Missouri Counseling Association and New York Counseling Association used Facebook to disseminate the research study, with Missouri requesting to post about the request for participation on their Facebook page. The survey was also distributed to Facebook and LinkedIn counselor groups. This initial participation request was designed to last 1 week and included a description of the survey purpose, two screening questions to meet eligibility criteria, IRB approval number, and a link to the Qualtrics survey with informed consent. I used Qualtrics to create and organize the survey with the link from the survey included in the email to the state organizations listed above as well as Ohio professional counselors and also to distribute the survey online in Facebook and LinkedIn posts on

various counseling groups. Responses trickled in over several days, with minimal additional responses in the second week.

On June 7, 2019, I requested an addendum to the IRB application to add additional state counseling associations and listservs. The following states were added as partner organizations who agreed to display a study invitation on my behalf: New Jersey Counseling Association, Tennessee Counseling Association, Mississippi Counseling Association, Kansas Counseling Association, and North Dakota Counseling Association. Additionally, the following listservs were requested as potential sources to obtain participation: CESNET, which includes graduate students and counselor educators as well as the Chicago Therapists Listserv, a listserv that provides a space for licensed professional counselors to consult with one another. An addendum was generated to expand the pool of potential participants due to large sample size needed of 210 participants. At the time the addendum was requested, 140 additional participants were needed to meet sample size requirements.

On June 14, 2019, I sent out my first participation request on the CESNET-Listserv and the Chicago Area Therapists-Listserv. On June 21, 2019, I sent out my second participation request on the CESNET-Listserv and the Chicago Area Therapists-Listserv. While waiting to receive responses through the CESNET-Listserv and the Chicago Area Therapists-Listserv, I continued to post my survey request for participation on Facebook and LinkedIn. On June 22, 2019, I met my targeted sample size of 210 participants. Because I intended to collect data until July 8, 2019, I continued to disseminate my research study with the hopes of collecting a more robust sample size and

to also account for any responses that were ineligible. On July 1, 2019, I sent out my third and final participation request on the CESNET-Listserv and the Chicago Area Therapists-Listserv. On July 8, 2019, I closed the Qualtrics survey for participation, with a total of 393 recorded responses, 331 of which were eligible to use for data analysis.

The number of potential participants reached is unknown due to counselor associations distributing my survey research study as well as request for participation being distributed via social media websites Facebook and LinkedIn. While it is estimated that the request for participation reached several thousand professional counselors, with 4,603 from the CESNET-Listserv and 2,474 members in the Chicago Area Therapist-Listserv, I am not aware of what number of persons read my dissertation participation request. Based on the inability to accurately identify the number of prospective respondents received the request for participation, it is difficult to determine response rates for this survey research study. However, I was able to determine the completion rate of those individuals who started the survey on Qualtrics. In total, 134 participants began and did not complete the survey research study, and 331 out of 393 participants completed and were eligible to participate in the survey research study. With a total of 527 participants who began the survey, there was a completion rate of 62.9%. Though this is a high response rate, there were thousands of prospective participants who did not participate. Nonetheless, I exceeded my targeted sample size of 210 eligible participants needed for a CCA (see Chapter 3 for discussion of targeted sample size needed for CCA). In Chapter 3, I indicated another method of reaching participants was through state licensing boards. The only state to provide a letter of cooperation for this research study

was Ohio. All other emails sent out were either ignored, denied, or required payment for access to professional counselor's information.

Results

Demographics

In this survey research study, I used nonprobability convenience sampling to obtain participants who identified as provisionally or fully licensed professional counselors in the United States. Personal demographics collected included age, gender, race, ethnicity, sexual orientation, state of residence, last year's salary, hours spent working per week, and hours spent on direct client hours each week. Additional demographics requested of participants included current number of indirect hours spent each week on tasks such as documentation, report writing, and other miscellaneous tasks required for one's role as a counselor. Participants were also asked about specialization of Master's degree, highest level of education, whether participant's degree was accredited by CACREP, APA, COAMFTE, or CORE, clinical licensure type, additional clinical or clinical supervision licensure, their current mental health discipline, workplace setting, and area of workplace. Participants were also asked about types of self-care practices they engage in and how much time is spent on self-care each week. Eligibility questions used for this quantitative survey research study included number of years since completing a Master's degree in counseling as well as clinical license obtained. Participants with less than 2 years of experience or without a provisional or full clinical professional counselor license were not eligible to participate in this survey research study. Tables 1 through 4 provide a breakdown of participant demographics.

The majority of participants were female (*n* = 272, 82.18%), then male (*n* = 56, 16.92%), and two participants identified as nonbinary/third gender (0.6%), and one participant preferred not to disclose preferred gender. The ages of participants ranged from 25 to 82, with a mean age of 42 years. Participants were also asked about their salary for 2018, with a wide range from $0 to $175,000. There was a mean salary of $59,959. Some participants (*n* = 13, 3.93%) preferred not to disclose their salary. According to the U.S. Department of Labor Bureau of Labor Statistics (2019), the average salary for substance abuse, behavioral disorder, and mental health counselors is $44,630. (reference Table 3 for comparison between current sample and ACA [2014] Counselor Compensation Study).

Tables 1 and 2 display detailed specifics of state characteristics and other demographics for the sample in this research study. Although some states only had one participant, 46 states and the District of Columbia were represented. Figure 3 displays the statistics per state region. Table 3 displays the comparison between various demographics from current sample to the ACA (2014) Counselor Compensation Study.

Table 1

Participant State Characteristics as a Percentage of the Sample

State region	*n*	Percentage
South	117	35.35%
Texas	39	11.78%
Alabama	2	0.6%
Louisiana	7	2.11%
Tennessee	2	0.6%
Florida	20	6.04%
Georgia	7	2.11%
Oklahoma	1	0.3%

(table continues)

Virginia	5	1.51%
Mississippi	9	2.72%
South Carolina	14	4.23%
North Carolina	7	2.11%
District of Columbia	2	0.6%
Arkansas	1	0.3%
Maryland	2	0.6%
Kentucky	1	0.3%
Midwest	156	47.13%
Illinois	87	26.28%
Wisconsin	3	0.9%
Minnesota	7	2.11%
Indiana	4	1.2%
Michigan	4	1.2%
Ohio	37	11.18%
Missouri	7	2.11%
North Dakota	1	0.3%
South Dakota	1	0.3%
Kansas	2	0.6%
Nebraska	1	0.3%
West	26	7.85%
Alaska	1	0.3%
Hawaii	1	0.3%
Colorado	8	2.42%
Nevada	1	0.3%
California	3	0.9%
Arizona	1	0.3%
New Mexico	3	0.9%
Wyoming	1	0.3%
Idaho	1	0.3%
Montana	1	0.3%
Washington	2	0.6%
Oregon	2	0.6%
Utah	1	0.3%
Northeast	32	9.67%
Pennsylvania	6	1.81%
New Jersey	4	1.2%
New York	11	3.32%
Connecticut	2	0.6%
Massachusetts	5	1.51%
Vermont	2	0.6%
Maine	1	0.3%

(table continues)

State region	*n*	Percentage
New Hampshire	1	0.3%

Note. State regions were generated based off of the U.S. Census Bureau (2016).

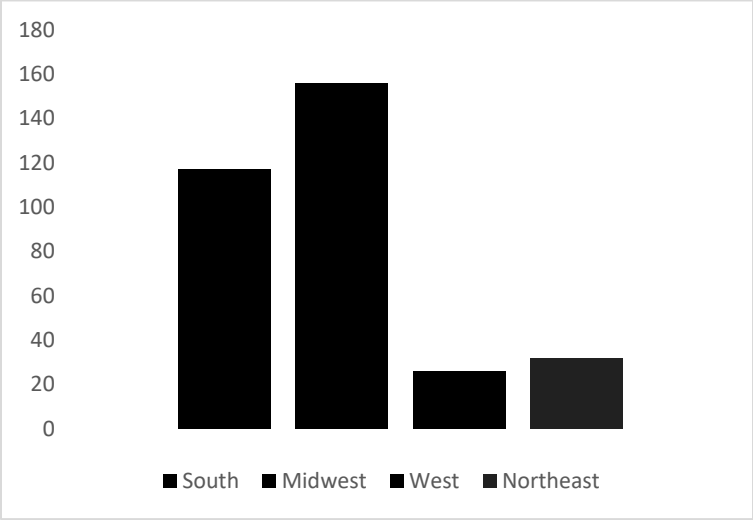

Figure 3. Statistics per state region South (117), Midwest (156), West (26), and Northeast (32).

Table 2

Participant Demographic Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Sexual orientation		
Heterosexual	297	89.73%
Lesbian/Gay	13	3.93%
Bisexual	12	3.63%
Queer	9	2.72%
Marital Status		
Married	225	67.98%
Single	45	13.6%
Divorced	26	7.85%
Partnered	20	6.04%
Never been married	8	2.42%

(table continues)

Characteristic	*n*	Percentage
Separated	4	1.21%
Widowed	3	0.9%
Ethnicity*		
Not Hispanic or Latino	298	90.58%
Hispanic or Latino	31	9.42%
Race		
White or Caucasian	263	79.46%
Hispanic or Latino	15	4.53%
Black or African American	33	9.97%
Asian	8	2.42%
Some other race	1	0.3%
Two races including some other race	5	1.51%
Two races excluding some other race, and three or more races	2	0.6%
Other	4	1.21%

Note. For the characteristic of ethnicity, two participants did not answer this question.

Table 3

Demographic Characteristics of Current Sample in Comparison to ACA 2014 Study

Characteristic	Current sample	2014 ACA study
Years of experience		
2 to 5 years	29.31%	22% (1-3 years)
6 to 9 years	26.28%	17% (4-7 years) 11% (8-10 years)
10-15 years	24.17%	13% (11-15 years)
16-20 years	8.16%	10% (15-20 years)
21-30 years	9.37%	19% (20+ years)
31-40 years	2.11%	N/A
More than 40 years	0.6%	N/A
Workplace setting		
Private practice	54.68%	20%

(table continues)

Characteristic	Current sample	2014 ACA study
Community mental health center	18.73%	14% (Counseling/Rehabilitation agency-private)
Outpatient hospital	5.74%	4% (Hospital)
Substance abuse treatment	4.83%	N/A
College/University counseling center	4.53%	15%
Residential treatment	3.32%	N/A
School	3.32%	19% (K-12 School)
Community/in-home	2.42%	N/A
Inpatient psychiatric hospital	1.51%	N/A
Online	0.91%	N/A
Hours worked per week		
Less than 10 hours	5.14%	5% (0-12 hours)
11-15 hours	2.11%	9% (13-24 hours)
16-20 hours	8.16%	N/A
21-30 hours	11.48%	16% (25-36 hours)
31-39 hours	16.01%	N/A
40 hours	22.05%	53% (36-48 hours)
41 -50 hours	25.98%	14% (49-60 hours)
51-60 hours	6.34%	N/A
61-70 hours	1.81%	14% (60+ hours)
71+ hours	0.91%	N/A
Income		
Clinical mental health	$62,629	$40,421
Rehabilitation counseling	$52,572	$53,561
Counselor education	$75,680	$66,405
Other	$54,268	$51,074

Note. Categories did not entirely match from current sample to the ACA (2014) study, making it difficult to infer comparisons. Other category in Income includes substance abuse counseling and marriage and family counseling for current sample. Other category for Income in ACA (2014) study was not disclosed.

In reviewing the demographics of the current sample in comparison to that of the counseling profession, as indicated by the ACA (2014) Counselor Compensation Study, it appears that the current sample is mostly representative of the counseling profession (reference Table 3). However, there are some differences in years of experience,

workplace setting, and income. The current sample included a wide range of years of experience, with the most variation occurring with counselors who have over 20 years of experience, 12.08% (current sample) and 19% (ACA Study) respectively. Other variations between the current study and the ACA (2014) study include 10 to 15 years of counselor experience, 24.17% (current sample) and 13% (ACA Study) respectively. There may be other differences in years of experiences, however this was difficult to determine due to the categories differing between the current study and the ACA (2014) study. As it relates to workplace setting, there was a vast difference in counselors working in private practice, with 54.68% in the current study and 20% in the ACA (2014) study. Another significant variation in workplace setting was in schools, with 3.32% for the current study and 19% for the ACA (2014) study. When comparing income levels from the current sample to the ACA (2014) study, the greatest variation was in the income levels for counselors working in Clinical Mental Health Counseling, $62,629 (current sample) and $40,421 (ACA study). This $22,208 difference may be due to the 34.68% difference in counselors working in private practice settings for this current sample. Another variation in income was for counselor educators, $75,680 (current sample) and $66,405 (ACA study). This variation in income for counselor educators may be due to variations in counselor educators who are associate or full professors versus being assistant professors. Additionally, the 5 year difference may also be due to increases in salary over a five year period even if the counselor educators did not get promoted. There may also be some differences in hours worked per week, however, this

was difficult to determine due to the categories being different between the current sample and the ACA (2014) study.

Tables 4 through 6 display various characteristics related to the counseling profession as percentages of the sample (*N*=331).

Table 4.

Participant Counseling Specific Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Years of experience		
2 to 5 years	97	29.31%
6 to 9 years	87	26.28%
10-15 years	80	24.17%
16-20 years	27	8.16%
21-30 years	31	9.37%
31-40 years	7	2.11%
More than 40 years	2	0.6%
Clinical licensure type		
Full clinical licensure	284	85.8%
Provisional clinical licensure	47	14.2%
Specialization in master's degree		
Clinical mental health counseling	101	30.61%
Mental health counseling	79	23.94%
Other	54	16.36%
Counseling psychology	34	10.30%
Clinical psychology	30	9.09%
Community counseling	23	6.97%
School counseling	5	1.52%
Human service	3	0.91%
Counseling		
Community psychology	1	0.3%
Education level completed		
Master's degree	272	82.18%
Doctorate	48	14.50%

(table continues)

Characteristic	*n*	Percentage
Education specialist certificate	11	3.32%

Note. Full clinical licensure includes the following clinical licenses: LCPC, LPCC, LACMH, LMHC, LIMHP, LCMHC, LPC-MH, LPC/MHSP, and LPC. Provisional clinical licensure includes the following clinical licenses: ALC, LPC, LAC, PCCI, LPCC, LACMH, LGPC, RMHC, LAPC, LPCA, PLPC, LLPC, LCCI, PLMHP, LPC/I, LPC-I, APC, LMHCA, PCT, and PPC. The Other category in specialization for Master's Degree includes Forensic Psychology, Art Therapy, Rehabilitation Counseling, etc.

Table 5.

Participant Counseling Accreditation, Additional License, and Current Mental Health Discipline Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Degree accreditation		
CACREP	208	63.22%
APA	10	3.04%
CORE	5	1.52%
COAMFTE	4	1.22%
Other	28	8.51%
None	74	22.49%
Additional licenses or certifications		
NCC	125	30.86%
LPC-S	44	10.86%
LPCC-S	30	7.41%
ACS	19	4.69%
CADC	19	4.69%
CCMHC	13	3.21%
MAC	8	1.98%
RPT	5	1.23%
RPT-S	2	0.49%
Other	140	34.57%
Current mental health discipline		
Clinical mental health counseling	272	82.18%
Substance abuse counseling	21	6.34%
Counselor education	19	5.74%

(table continues)

Characteristic	*n*	Percentage
Marriage and family therapy	9	2.72%
School counseling	6	1.81%
Rehabilitation counseling	4	1.21%

Note. The Other category in degree accreditation includes NBCC, BSRB, CAEP, CHEA, and MPCAC. The Other category in additional clinical or clinical supervision licenses/credentials includes RN, JD, CRC, CSAT, CCTP, ATR-BC, ACHT, EMDR, CCPG, None, etc.

Table 6.

Participant Counselor Workplace Setting and Work Hour Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Workplace setting		
Private practice	181	54.68%
Community mental health center	62	18.73%
Outpatient hospital	19	5.74%
Substance abuse treatment	16	4.83%
College/University Counseling center	15	4.53%
Residential treatment	11	3.32%
School	11	3.32%
Community/in-home	8	2.42%
Inpatient psychiatric hospital	5	1.51%
Online	3	0.91%
Area of workplace		
Urban	145	43.94%
Suburban	139	42.12%
Rural	46	13.94%
Direct counseling hours per week		
1- 5 hours	24	7.25%
6-10 hours	44	13.29%
11-15 hours	49	14.80%
16-20 hours	55	16.62%
21-25 hours	71	21.45%
26-30 hours	54	16.31%

(table continues)

Characteristic	*n*	Percentage
31-35 hours	21	6.34%
36-40 hours	8	2.42%
41+ hours	5	1.51%
Indirect counseling hours per week		
1-5 hours	89	26.89%
6-10 hours	94	28.40%
11-15 hours	56	16.92%
16-20 hours	43	12.99%
21-25 hours	25	7.55%
26-30 hours	10	3.02%
31-35 hours	8	2.42%
36-40 hours	5	1.51%
41+ hours	1	0.3%
Hours worked per week		
Less than 10 hours	17	5.14%
11-15 hours	7	2.11%
16-20 hours	27	8.16%
21-30 hours	38	11.48%
31-39 hours	53	16.01%
40 hours	73	22.05%
41 -50 hours	86	25.98%
51-60 hours	21	6.34%
61-70 hours	6	1.81%
71+ hours	3	0.91%

Note. Indirect counseling hours per week includes time spent on documentation, report writing, and other miscellaneous tasks required for the role as a counselor.

The last set of demographic questions asked about current self-care practices. Table 7 displays participant self-care practice characteristics as a percentage of the sample (*N*= 331).

Table 7.

Participant Self-Care Practice Characteristics as a Percentage of the Sample

Characteristic	*n*	Percentage
Current self-care Activities		
Time with family/friends	303	23.58%

(table continues)

Characteristic	*n*	Percentage
Reading	231	17.98%
Music	230	17.90%
Exercise	212	16.50%
Traveling	172	13.39%
Other	137	10.66%
Time spent each week on self-care		
< 1 hour	15	4.53%
1-5 hours	167	50.45%
6-10 hours	114	34.44%
11-15 hours	21	6.34%
16-20 hours	10	1.21%
21-30 hours	4	1.21%

Note. Other self-care activities include hobbies such as video games, cooking, fishing, kayaking, TV, adult coloring, massage, writing, pets, gardening, etc.

Descriptive Statistics

After consenting to participate and responding to the demographic questionnaire, respondents were asked to complete the SCS, JBLI, and CBI, in no particular order. A survey flow was generated in Qualtrics to randomize the order in which respondents took the SCS, JBLI, and CBI to minimize limitation of test fatigue. Respondents were asked to indicate their level of counselor burnout, as administered by the CBI, using Likert-type scale questions ranging from *never true* to *always true*. Respondents were asked to indicate their level of self-compassion, as administered by the SCS, using Likert-type scale questions ranging from *almost never* to *almost always*. Respondents were asked to indicate their level of life balance, as administered by the JBLI, using Likert-type scale questions ranging from *strongly agree* to *strongly disagree*.

Collected data from the 331 participants was analyzed using IBM SPSS Version 25. Descriptive statistics and bivariate correlations were conducted on all survey items,

listed in tables 11 and 12. It is important to note the differences in scoring for each of the assessments. For the JBLI, higher scores are oriented towards wellness or higher levels of life balance (Davis et al., 2014). For example, higher scores in sleep disturbance indicate better quality of sleep and higher scores in substance use indicate less likelihood one is to use substances. Therefore, lower scores for sleep disturbance indicate a higher likelihood that one had difficulties with sleep and lower scores for substance use indicate a higher likelihood that one uses or abuses substances. In this research study the following include means for each of the subscales of the JBLI: positive orientation (*M* = 4.09), global health (*M* = 3.26), quality of relationships *(M* = 4.17), substance use/abuse (*M* = 4.54), spiritual support (*M* = 4.05), sleep disturbance (*M* = 3.12), stress/anxiety (*M* = 3.32), sex/intimacy (*M* = 3.64), career (*M* = 4.35), and friendship (*M* = 4.15) (reference Table 11).

Table 8.

Means and (Standard Deviations) of the Ten Juhnke-Balkin Life Balance Inventory Subscales Across Samples

Factor	Davis et al. (2014)	Balkin et al. (2018)	Current sample
Positive orientation	3.99 (.68)	3.92 (1.11)	4.09 (.62)
Global health	3.35 (.77)	3.49 (.75)	3.26 (.81)
Quality of relationships	3.67 (.84)	3.67 (1.09)	4.17 (.91)
Substance use/abuse	3.56 (.95)	3.50 (.97)	4.54 (.57)
Spiritual support	3.88 (.82)	3.87 (1.33)	4.05 (.83)
Sleep disturbance	3.10 (.88)	3.54 (.96)	3.12 (.96)
Stress/anxiety	3.14 (.78)	3.65 (.89)	3.32 (.74)
Sex/intimacy	3.79 (.73)	3.79 (.99)	3.64 (.88)
Career	3.78 (.66)	3.68 (1.11)	4.35 (.59)
Friendship	3.98 (.67)	3.95 (1.24)	4.15 (.61)

Note. Participants in Davis et al. (2014) included 346 individuals with varying levels of education from high school to graduate school. Participants in Balkin et al. (2018) included 115 individuals identifying as African American. Current sample included 331 participants identifying as professional counselors.

Table 8 demonstrates the means and standard deviations of the ten JBLI subscales across samples. With no current peer-reviewed research including the JBLI with counselors, the current sample was compared to that of two other studies that used the JBLI with different populations. Compared to data from Davis et al. (2014) on the development of the JBLI, counselors in the current sample had higher levels of positive orientation, quality of relationships, substance use/abuse, spiritual support, sleep disturbance, stress/anxiety, career, and friendship. Please note that higher levels in the substance use/abuse category, sleep disturbance, and stress/anxiety indicate that participants in the current sample are better able to cope, as scores for the JBLI are inverted. For example, higher scores in sleep disturbance indicate better quality of sleep and higher scores in substance use indicate less likelihood one is to use substances. Additionally, the current sample had lower levels of sex/intimacy (M = 3.64, M = 3.79, respectively).

For the CBI, higher scores are oriented towards higher levels of perceived counselor burnout (Lee et al., 2007). For example, higher scores in exhaustion indicate a higher likelihood that one experiences exhaustion in their life and higher scores in devaluing client indicate a higher likelihood that one devalues their clients. In this research study the following include means for each of the subscales of the CBI: exhaustion (M = 2.83), incompetence (M = 2.10), negative work environment (M = 2.14), devaluing client (M = 1.43), and deterioration in personal life (M = 2.36) (reference Table 11).

Table 9.

Means and (Standard Deviations) of the Five Counselor Burnout Inventory Subscales Across Samples

Factor	United States counselors	Professional school counselors	Current sample
Exhaustion	2.78 (.76)	3.03 (.83)	2.83 (.90)
Incompetence	2.30 (.60)	2.23 (.65)	2.10 (.70)
Negative work environment	2.50 (.87)	2.64 (.90)	2.14 (1.02)
Devaluing client	1.59 (.49)	1.31 (.38)	1.43 (.51)
Deterioration in personal life	2.40 (.71)	2.31 (.82)	2.36 (.81)

Note. United States counselors sample includes research by Puig et al. (2014). Professional school counselors sample includes research by (Gnilka et al., 2015).

Table 9 demonstrates the means and standard deviations of the five CBI subscales across samples. The current sample is similar to that of the United States counselors, indicating that this current sample may be representative of the counselor population in the US. Some differences from the US counselor sample is a decrease in incompetence, negative work environment, devaluing client, and deterioration in personal life, which may be indicative that the counselors in the current sample may feel more competent, have a better work environment, value their clients more, and have a decrease of impact in their personal life. Counselors in the current sample did have more exhaustion, however, than the US sample (M = 2.83, M = 2.78, respectively), but less exhaustion than school counselors (M = 3.03).

For the SCS, higher scores are oriented towards higher levels of reported self-compassion (Neff, 2003). For example, higher scores in self-kindness indicate a higher

likelihood that one is kind to themselves and higher scores in isolation indicate a higher likelihood of one feeling alone in their failures (Neff, 2003). In this research study the following include means for each of the subscales of the SCS: self-kindness (*M* = 3.46), self-judgment (*M* = 2.80), common humanity (*M* = 3.66), isolation (*M* = 2.71), mindfulness (*M* = 3.82), and over-identification (*M* = 2.65) (reference Table 12).

Table 10.

Means and (Standard Deviations) of the Six Self-Compassion Scale Subscales Across Samples

Factor	Neff (2003)	Current sample
Self-kindness	3.05 (.75)	3.46 (.79)
Self-judgment	3.14 (.79)	2.80 (.92)
Common humanity	2.99 (.79)	3.66 (.73)
Isolation	3.01 (.92)	2.71 (.99)
Mindfulness	3.39 (.76)	3.82 (.67)
Over-identification	3.05 (.96)	2.65 (.90)

Table 10 demonstrates the means and standard deviations of the six SCS subscales across samples. With no available peer-reviewed literature that includes means and standard deviations of each SCS subscale in counselors, the current sample was compared to that of the original data sample by Neff (2003). Compared to the data from Neff (2003) which included 391 undergraduate students, the current sample had higher levels of self-kindness, common humanity, and mindfulness. Based on this comparison to a sample that did not include counselors, it is important that future research studies focus on assessing self-compassion levels in the counseling profession. Coaston (2017) indicates that high levels of self-compassion can act as a protective factor against counselor burnout.

Table 11 shows descriptive statistics and correlations for the JBLI and CBI. As a reminder, the scoring on the JBLI is reversed, meaning that higher scores are oriented towards wellness or higher levels of life balance (Davis et al., 2014). For example, higher scores in sleep disturbance indicate better quality of sleep and higher scores in substance use indicate less likelihood one is to use substances. Table 12 shows descriptive statistics and correlations for the SCS and CBI.

Table 11.

Descriptive Statistics and Correlations for the JBLI and CBI

Scale	N	M	SD	Global health	Quality of relation.	Substance use/ abuse	Spiritual support	Sleep disturb	Stress/ anxiety	Sex/Intimacy	Career	Friendship	Exhaustion	Incompetence	Neg work environment	Devaluing client	Det. in personal life
Positive orientation	331	4.09	0.62	.44**	.38**	.17**	.39**	.52**	.60**	.47**	.53**	.59**	-.50**	-.48**	-.28**	-.32**	-.49**
Global health	331	3.26	0.81		.14**	0.02	.22**	.45**	.43**	.28**	.18**	.24**	-.38**	-.29**	-.14**	-.13*	-.33**
Quality of relation.	331	4.17	0.91			.18**	.15**	.13*	.22**	.59**	.22**	.18**	-.15**	-.14*	-.21**	-.12*	-.30**
Substance use/ abuse	331	4.54	0.57				.28**	.17**	.14*	0.08	.13*	.12*	-.12*	-0.04	-.11*	-.16**	-.12*
Spiritual support	331	4.05	0.83					.24**	.33**	.17**	.24**	.20**	-.22**	-.22**	-0.09	-.20**	-.23**
Sleep disturb	331	3.12	0.96						.51**	.29**	.25**	.28**	-.46**	-.33**	-.24**	-.15**	-.43**
Stress/anxiety	331	3.32	0.74							.29**	.41**	.36**	-.56**	-.42**	-.34**	-.28**	-.50**
Sex/Intimacy	331	3.64	0.88								.27**	.26**	-.26**	-.26**	-.23**	-.24**	-.32**
Career	331	4.35	0.59									.31**	-.39**	-.47**	-.38**	-.40**	-.29**
Friendship	331	4.15	0.61										-.27**	-.34**	-.17**	-.30**	-.30**
Exhaustion	331	2.83	0.90											.53**	.42**	.38**	.63**
Incompetence	331	2.10	0.70												.29**	.41**	.43**
Negative work environ.	331	2.14	1.02													.33**	.43**

(table continues)

Scale	N	M	SD	Global health	Quality of relation.	Substance use/ abuse	Spiritual support	Sleep disturb	Stress/ anxiety	Sex/Intimacy	Career	Friendship	Exhaustion	Incompetence	Neg work environment	Devaluing client	Det. in personal life
Devaluing Client	331	1.43	0.51														.39**
Det. in Personal Life	331	2.36	0.81														

Note. Positive orientation, stress/anxiety, substance use/abuse, spiritual support, friendship, sleep disturbance, career, sex/intimacy, global health, and quality of Relationships represent the subscales on the JBLI. Exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life represent the subscales on the CBI. **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed).

Table 12.

Descriptive Statistics and Correlations for the SCS and CBI

Scale	N	M	SD	Incompetence	Negative work environment	Devaluing client	Deterioration in personal life	Self-kindness	Self-judgment	Common humanity	Isolation	Mindfulness	Over-identification
Exhaustion	331	2.83	0.9	.53**	.42**	.38**	.63**	-.37**	.41**	-.22**	.47**	-.29**	.37**
Incompetence	331	2.1	0.7		.29**	.41**	.43**	-.40**	.46**	-.24**	.47**	-.33**	.43**
Negative work environment	331	2.14	1.02			.33**	.43**	-.20**	.18**	-0.07	.25**	-.16**	.22**
Devaluing Client	331	1.43	0.51				.39**	-.21**	.28**	-0.09	.31**	-.21**	.28**
Deterioration in personal life	331	2.36	0.81					-.38**	.41**	-.17**	.39**	-.30**	.35**
Self-kindness	331	3.46	0.79						-.74**	.59**	-.68**	.73**	-.65**
Self-judgment	331	2.8	0.92							-.42**	.75**	-.57**	.77**
Common humanity	331	3.66	0.73								-.46**	.64**	-.44**
Isolation	331	2.71	0.99									-.60**	.70**
Mindfulness	331	3.82	0.67										-.61**
Over-identification	331	2.65	0.9										

Note. Exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life represent the subscales on the CBI. Self-Kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification represent the subscales on the SCS. **. Correlation is significant at the 0.01 level (2-tailed).

Defining and Interpreting the Canonical Correlation Analysis

As stated in Chapter 3, the following paragraphs include a reminder of how the CCA works and is interpreted. A canonical correlation is a multivariate analysis that allows the researcher to examine the relationship between two variable sets (Sherry & Henson, 2005). In this survey research study, the first CCA explores the relationship between the subscales of the CBI and the JBLI and the second CCA explores the relationship between the subscales of the CBI and the SCS. Before interpreting each canonical variate, the researcher must see if the entire CCA is significant by looking at the Wilks λ (Tabachnick & Fidell, 2013). A value closer to zero is indicative of a high correlation, whereas a value near one indicates a low correlation, with the first canonical variate typically having a higher correlation than the canonical variates following (Sherry & Henson, 2005). Then the researcher reviews how many of the canonical roots or variates are significant (Tabachnick & Fidell, 2013). In this research study there is a maximum of five canonical variates, as there are only five subscales of the CBI, with the SCS having six subscales and the JBLI having ten subscales (reference Figure 1 and Figure 2).

A CCA measures the strength of linear composites between canonical variates (Sherry & Henson, 2005). The correlations to the canonical variate (COR) are viewed first to determine significance (Tabachnick & Fidell, 2013). Afterwards, the canonical variate coefficient (COE) table is viewed to determine the strength of the significance (Tabachnick & Fidell, 2013). If the value is over .30, the COR can be interpreted as significant (Tabachnick & Fidell, 2013), (reference tables 8 through 17). With the

canonical variates that are significant, the researcher then compiles themes for each significant canonical variate, as the CCA explores latent variables (Tabachnick & Fidell, 2013).

Canonical Correlation Analysis- 1

The first CCA was performed to answer research question one: What is the relationship, if any, between the subscales of life balance and burnout as measured by the JBLI and the CBI?

A CCA was performed between the JBLI subscales and the CBI subscales. An alpha level of .05 was utilized. Correlation cutoffs of .30 or higher were used to interpret the canonical variates (Tabachnick & Fidell, 2001). If the correlation to the canonical variate (COR) is not higher than .30, then it is not considered significant per the current sample size, as values under .30 represent "…less than a 10% overlap in variance…" (Tabachnick & Fidell, 2013, p. 592). Assumptions for normality, linearity, and homoscedasticity were evaluated through distributions of scatterplots. All assumptions were met and no multivariate outliers were detected. When conducting the analysis between the JBLI and CBI, a sample size of 331 cases was used and accepted for data analysis in SPSS.

A statistically significant relationship was found between JBLI subscales and the CBI subscales, Wilks $\lambda = .000$. Four out of five canonical roots or variates were significant. The first canonical variate was significant, $\lambda = .36$, $F (50, 1444.55) = 7.28$, $p < .001$ accounting for 49.81% ($r_c = .71$) of the overlapping variance. The second canonical root was significant, $\lambda = .71$, $F (36, 1189.68) = 3.10$, $p < .001$, accounting for 17.96% ($r_c =$

.42) of the overlapping variance. The third canonical root was significant, λ = .87, F (24, 922.90) = 1.88, *p* = .007, accounting for 6.01% (r_c= .25) of the overlapping variance. The fourth canonical root was significant, λ = .93, F (14, 638) = 1.77, *p* = .040, accounting for 4.77% (r_c= .22) of the overlapping variance. The fifth canonical root was not significant, accounting for less than 2.69% (r_c= .16) of the overlapping variance. Therefore, only four of the five canonical variates were interpreted as significant. According to research question one, the null hypothesis was rejected, as there is a statistically significant relationship between the subscales of life balance and burnout as measured by the JBLI and the CBI.

Shown in Table 13 are the correlations and standardized canonical variate coefficients for the JBLI subscales and the CBI subscales as they relate to the first canonical variate.

Table 13.

Correlations and standardized canonical variate coefficients on the CBI and JBLI for the first canonical variate.

Scale	COR	COE
Counselor Burnout Inventory		
Exhaustion	**0.88**	**0.42**
Incompetence	**0.78**	**0.37**
Negative work environment	**0.58**	**0.15**
Devaluing client	**0.55**	**0.08**
Deterioration in personal life	**0.79**	**0.26**
Juhnke-Balkin Life Balance Inventory		
Positive orientation	**-0.83**	**-0.16**
Global health	**-0.55**	**-0.10**
Quality of relationships	**-0.33**	**0.00**
Substance use/abuse	-0.18	-0.00
Spiritual support	**-0.37**	**0.01**

(*table continues)*

Scale	COR	COE
Sleep disturbance	**-0.67**	**-0.20**
Stress/anxiety	**-0.85**	**-0.41**
Sex/Intimacy	**-0.48**	**-0.09**
Career	**-0.72**	**-0.35**
Friendship	**-0.53**	**-0.07**

Note. Correlations ≥ 0.30 are bolded. COR= correlations to the canonical variate. COE= Standardized canonical variate coefficient.

The first canonical variate ($\lambda = .36$, $F (50, 1444.55) = 7.28$, $p < .001$) included scores on both subscales of the CBI, exhaustion (0.88), incompetence (0.78), negative work environment (0.58), devaluing client (0.55), deterioration in personal life (0.79), and the subscales on the JBLI: positive orientation (-0.83), global health (-0.55), quality of relationships (-0.33), spiritual support (-0.37), sleep disturbance (-0.67), stress/anxiety (-0.85), sex/intimacy (-0.48), career (-0.72), and friendship (-0.53). As all five subscales for measuring counselor burnout in professional counselors increases, there is less life balance on nine out of ten subscales, with substance use/abuse not being significant. Therefore, the theme of the first canonical variate is *counselors who experience burnout have poor work-life balance*. This suggests that counselors who are emotionally exhausted, feel incompetent in their work, have a perceived negative work environment, deterioration in personal life, and who devalue their clients also have a negative outlook on life, may not pay attention to their overall health, may not be paying attention to the quality of their relationships, are not turning to spiritual support to cope, have increased sleep disturbances, have increased stress/anxiety, are not satisfied with their intimacy or sex life, have less career satisfaction, and are having trouble maintaining their friendships. Hence, counselors may not be intentional about working towards life balance.

Shown in Table 14 are the correlations and standardized canonical variate coefficients for the JBLI subscales and the CBI subscales as they relate to the second canonical variate.

Table 14.

Correlations and standardized canonical variate coefficients on the CBI and JBLI for the second canonical variate.

Scale	COR	COE
Counselor Burnout Inventory		
Devaluing Client	**-0.59**	**-0.74**
Deterioration in Personal Life	**0.37**	**0.73**
Juhnke-Balkin Life Balance Inventory		
Global health	**-0.33**	**-0.17**
Sleep disturbance	**-0.41**	**-0.39**
Career	**0.60**	**0.89**

Note. Correlations ≥ 0.30 are bolded. COR= correlations to the canonical variate. COE= standardized canonical variate coefficient.

The second canonical variate $\lambda = .71$, $F (36, 1189.68) = 3.10$, $p < .001$, included scores on both subscales of the CBI, devaluing client (-0.59) and deterioration of personal life (0.37) and the subscales on the JBLI: global health (-0.33), sleep disturbance (-0.41), and career (0.60). As devaluing of client decreases and deterioration of personal life in professional counselors increases, there is an increase in difficulties with maintaining overall health, increased difficulties with sleep, and increased career satisfaction. Therefore, the theme of the second canonical variate is *I love my job and I'm not paying attention to my personal life.* Even though professional counselors are taking a personal toll on themselves, it does not necessarily translate to how professional counselors treat their clients, suggesting that counselors do practice ethically according to this sample.

The second canonical variate indicates that professional counselors are focused on assisting others over assisting themselves.

Shown in Table 15 are the correlations and standardized canonical variate coefficients for the JBLI subscales and the CBI subscales as they relate to the third canonical variate.

Table 15.

Correlations and standardized canonical variate coefficients on the CBI and JBLI for the third canonical variate.

Scale	COR	COE
Counselor Burnout Inventory		
Exhaustion	**-0.33**	**-1.08**
Deterioration in personal life	**0.48**	**1.03**
Juhnke-Balkin Life Balance Inventory		
Quality of relationships	**-0.85**	**-0.89**
Sex/Intimacy	**-0.49**	**-0.14**

Note. Correlations ≥ 0.30 are bolded. COR= correlations to the canonical variate. COE= standardized canonical variate coefficient.

The third canonical variate $\lambda = .87$, $F (24, 922.90) = 1.88$, $p = .007$ included scores on both subscales of the CBI, exhaustion (-0.33) and deterioration of personal life (0.48) and the subscales on the JBLI: quality of relationships (-0.85) and sex/intimacy (-0.49). As exhaustion decreases and deterioration of personal life in professional counselors increases, there is less focus on the quality of relationships and sex/intimacy. Therefore, the theme of the third canonical variate being *I'm energized by my work but I'm not paying attention to the quality of my relationships or my sex life.* This suggests that counselors may be energized by their work as professional counselors, but they're not paying attention to the quality of their relationships or their sex/intimate life.

Shown in Table 16 are the correlations and standardized canonical variate coefficients for the JBLI subscales and the CBI subscales as they relate to the fourth canonical variate.

Table 16.

Correlations and standardized canonical variate coefficients on the CBI and JBLI for the fourth canonical variate.

Scale	COR	COE
Counselor Burnout Inventory		
Incompetence	**-0.32**	**-0.49**
Negative work environment	**0.72**	**0.99**
Juhnke-Balkin Life Balance Inventory		
Positive orientation	**0.39**	**0.72**
Spiritual support	**0.43**	**0.48**
Friendship	**0.52**	**0.45**

Note. Correlations ≥ 0.30 are bolded. COR= correlations to the canonical variate. COE= standardized canonical variate coefficient.

The fourth canonical variate $\lambda = .93$, $F(14, 638) = 1.77$, $p = .040$ included scores on both subscales of the CBI, incompetence (-0.32) and negative work environment (0.72) and the subscales on the JBLI: positive orientation (0.39), spiritual support (0.43), and friendship (0.52). As incompetence decreases and negative work environment in professional counselors increases, there is an increase in positive orientation to life, an increase in spiritual support, and an increase in friendships. Therefore, the theme of the fourth canonical variate is *I perceive myself as competent even though I don't like my work environment.* The fourth canonical variate demonstrates that professional counselors are thriving on relationships with friends and spiritual support outside of work despite enduring a negative work environment. Keep in mind this may not mean that counselors

do not like their work as a counselor, but rather may mean that counselors do not like the company they work for, colleagues, or practices and policies in their current work environment. In the fourth canonical variate, professional counselors are driven by other experiences outside of work. The fifth canonical variate was not significant, p =0.186, and will not be interpreted.

Canonical Correlation Analysis- 2

The second CCA was performed to answer research question two: What is the relationship, if any, between the subscales of self-compassion and burnout as measured by the SCS and the CBI? A second CCA was performed between the CBI subscales and the SCS subscales. An alpha level of .05 was utilized. Correlation cutoffs of .30 or higher were used to interpret the canonical variates, as values under .30 represent "…less than a 10% overlap in variance…" (Tabachnick & Fidell, 2013, p. 592). Assumptions for normality, linearity, and homoscedasticity were evaluated through distributions of scatterplots. All assumptions were met and no multivariate outliers were detected. When conducting the analysis between the CBI and SCS, a sample size of 331 cases was used and accepted for data analysis in SPSS.

A statistically significant relationship was found between SCS subscales and the CBI subscales, Wilks λ= .000. One out of five canonical roots were significant. The first canonical root was significant, λ = .62, F (30, 1282) = 5.39, p < .001 accounting for 33.33% (r_c= .58) of the overlapping variance. The other four canonical roots were not significant, with the second accounting for less than 3.55% (r_c= .19) of the overlapping variance, the third accounting for less than 1.75% (r_c= .13) of the overlapping variance,

the fourth accounting for less than 1.15% (r_c= .11) of the overlapping variance, and the fifth accounting for less than 0.43% (r_c= .07) of the overlapping variance. Therefore, only one of the five canonical variates were interpreted. According to research question two, the null hypothesis was rejected, as there is a statistically significant relationship between the subscales of self-compassion and burnout as measured by the Self-Compassion Scale and the Counselor Burnout Inventory.

Table 17.

Correlations and standardized canonical variate coefficients on the CBI and SCS for the first canonical variate.

Scale	COR	COE
Counselor Burnout Inventory		
Exhaustion	**-0.83**	**-0.34**
Incompetence	**-0.87**	**-0.53**
Negative work environment	**-0.43**	**0.03**
Devaluing client	**-0.56**	**-0.10**
Deterioration in personal life	**-0.75**	**-0.28**
Self-Compassion Scale		
Self-kindness	**0.80**	**0.15**
Self-judgment	**-0.91**	**-0.32**
Common humanity	**0.44**	**-0.10**
Isolation	**-0.95**	**-0.56**
Mindfulness	**0.65**	**0.01**
Over-identification	**-0.82**	**-0.11**

Note. Correlations to the canonical variate ≥ 0.30 are significant and bolded, therefore all variates were significant. COR= correlations to the canonical variate. COE= standardized canonical variate coefficient.

The first canonical variate $\lambda = .62$, $F(30, 1282) = 5.39$, $p < .001$ included scores on both subscales of the CBI, exhaustion (-0.83), incompetence (-0.87), negative work environment (-0.43), devaluing client (-0.56), deterioration in personal life (-0.75) and the subscales on the SCS: self-kindness (0.80), self-judgment (-0.91), common humanity (0.44), isolation (-0.95), mindfulness (0.65), and over-identification (-0.82). As all five

subscales on the counselor burnout inventory decrease, there is an increase in self-kindness, common humanity, and mindfulness. Therefore, the theme of the first canonical variate is *I engage in practices related to self-compassion and I don't experience burnout.* The first canonical variate demonstrates that professional counselors who do not experience burnout are engaging in self-compassion practices such as self-kindness, common humanity, and mindfulness. This demonstrates how self-compassion can be an antidote to counselor burnout. The other four canonical variates were not significant and will not be interpreted. Any variable not listed in table seventeen signifies that there was not a significant correlation to the canonical variate and was not able to be interpreted.

Summary

This chapter analyzed the results from the participants who were eligible to take part in the survey research study. Results of this study found statistical significance between four of five canonical variates between the CBI and the JBLI. Results of this study also found statistical significance between one of five canonical variates between the CBI and the SCS. In the following chapter, I will interpret these findings with some possible explanations and rationales for these results with a discussion of the limitations of the study, recommendations for future research studies, and social justice implications from this survey research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Counselor burnout is a significant concern for professional counselors, mental health organizations, and clients who seek mental health services (Bridgeman et al., 2018; Viehl et al., 2017). Striving to identify an empirically validated method to battle counselor burnout, researchers have attempted to identify various methods of managing burnout and have recognized the need for an empirically validated method to prevent and/or mitigate the experience of burnout in professional counselors (Jaworska et al., 2016). The purpose of this quantitative survey research study was to explore the relationship between the subscales of burnout with the subscales of life balance and the subscales of burnout with the subscales of self-compassion in professional counselors. The main findings of this study indicated: (a) professional counselors who have poor work-life balance tend to experience a greater degree of burnout; and (b) counselors who engage in self-compassion practices don't experience burnout.

Interpretation of the Findings

In reviewing the findings for this survey research study, there were five themes that emerged. The first theme suggests that professional counselors who experience burnout have poor work-life balance, with scores on both subscales of the CBI, exhaustion (0.88), incompetence (0.78), negative work environment (0.58), devaluing client (0.55), deterioration in personal life (0.79), and the subscales on the JBLI, positive orientation (-0.83), global health (-0.55), quality of relationships (-0.33), spiritual support (-0.37), sleep disturbance (-0.67), stress/anxiety (-0.85), sex/intimacy (-0.48), career (-

0.72), and friendship (-0.53). As all five subscales for measuring counselor burnout in professional counselors increases, there is less life balance. This finding is supported by previous literature on counselor educators and university counselors, which indicated that life balance is important to manage burnout (Lin, 2012; Wester et al., 2009). Professional counselors who had high levels of exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life also had difficulties with maintaining a positive outlook on life, overall health, quality of relationships, spiritual support, increased sleep disturbances, stress and anxiety, difficulties with sex/intimacy, decreased levels of career satisfaction, and difficulties maintaining friendships. Because all five variables from the CBI loaded on the first canonical variate, the sample of professional counselors in this survey research study experience burnout. In this research study, the following include means for each of the subscales of the CBI: exhaustion (*M* = 2.83), incompetence (*M* = 2.10), negative work environment (*M* = 2.14), devaluing client (*M* = 1.43), and deterioration in personal life (*M* = 2.36; reference Table 11). These scores match those in prior research studies, with exhaustion, incompetence, negative work environment, and deterioration in personal life being higher than scores of devaluing clients (Gnilka, Karpinski, & Smith, 2015). Professional counselors in the current sample did have higher levels of exhaustion than the U.S. sample (*M* = 2.83, *M* = 2.78, respectively), but less exhaustion than school counselors (*M* = 3.03; Reference Table 14).

When looking at the JBLI for the first canonical variate, professional counselors in this sample had very low levels of life balance across all 10 variables (positive

orientation, global health, quality of relationships, spiritual support, sleep disturbance, stress/anxiety, sex/intimacy, career, and friendship; reference Table 13).

The second theme of this study suggests that professional counselors enjoy their job as counselors but do not pay attention to their personal life, with scores on both subscales of the CBI, devaluing client (-0.59) and deterioration of personal life (0.37) and the subscales of the JBLI, global health (-0.33), sleep disturbance (-0.41), and career (0.60; reference Table 14). As devaluing of client decreases and deterioration of personal life in professional counselors increases, there are more sleep problems and increased career satisfaction. Professional counselors who valued their clients had higher levels of deterioration in their personal life, poor sleep, decreased focus on global health, yet they enjoyed their careers. This finding is supported in the literature, as burnout is often associated with increased sleep disturbances and increased anxiety symptoms (Morse et al., 2012). Despite professional counselors not focusing on their own well-being, they seemed to enjoy their work and had high levels of valuing their clients. While this does not indicate decreased harm provided to clients, it at least suggests that professional counselors in this study are practicing ethically.

The third theme of this study suggests that professional counselors enjoy their work but do not pay attention to the quality of their relationships, with scores on both subscales of the CBI, exhaustion (-0.33) and deterioration of personal life (0.48) and the subscales of the JBLI, quality of relationships (-0.85) and sex/intimacy (-0.49; reference Table 15). As exhaustion decreases and deterioration of personal life in professional counselors increases, there is less focus on the quality of relationships and sex/intimacy.

Professional counselors who had low levels of exhaustion had higher levels of deterioration in personal life, decreased levels in quality of relationships, and decreased levels of sex/intimacy. This may suggest that professional counselors are so consumed by their work as professional counselors that they do not work on cultivating their relationships or sex/intimate life. This result is further supported by the literature on the COR theory. The COR theory asserts that decreased resources will lead to strain, a deterioration of one's personal life, and burnout (Alarcon, 2011; Dubois et al., 2013; Hyung et al., 2014). Because social support is considered a resource that is valued by individuals, it is typically valued unless there are high demands and low resources (Alarcon, 2011; Hyung et al., 2014). With the results of the third canonical variate having low levels of exhaustion but high levels of deterioration in personal life, it is possible that with continued strain on the quality of relationships, the counselor may turn to maladaptive coping, which may ultimately lead to the experience of burnout (Alarcon, 2011; Arnold et al., 2015; Dubois et al., 2013). It would be important to see how coping styles alter when a counselor's resources are being depleted.

The fourth theme of this study suggests that professional counselors perceive themselves as being competent but do not like their work environment. Per the COR theory, over time, negative work environment can lead to the experience of burnout (Alarcon, 2011). Professional counselors who had low levels of incompetence had high levels of negative work environment and higher levels of positive orientation, spiritual support, and friendships. This may suggest that even when professional counselors do not like their work environment (i.e., supervisor, agency rules, coworkers), they perceive

themselves as competent in their counseling skills, have a positive outlook on life, and turn to spiritual supports and friendships.

The fifth theme of this study relates to counselor burnout and self-compassion. This theme suggests that professional counselors who engage in self-compassion practices do not experience burnout. Professional counselors who felt competent in their counseling skills had lower levels of exhaustion, valued their clients, enjoyed their work environment, paid attention to their personal life, and engaged in self-compassion practices such as self-kindness, common humanity, and mindfulness. Participants of this study who had low levels of burnout on all five subscales of the CBI also had low levels of self-judgment, isolation, and over-identification. It appears as though practices of self-compassion may be an antidote to counselor burnout. Future research is needed to determine if self-compassion does mitigate or prevent the experience of burnout in counselors (reference Table 17). The challenge of studying self-compassion in counselors lies in the limited use of the SCS among counselors. A larger sample size would be necessary to increase statistical power and contribute to more generalizability amongst counselors.

Limitations of the Study

It is necessary to review the limitations of the generalizability of the results of this study. One of the limitations of this survey research study is that potential respondents may have not seen, ignored, or deleted the request for participation, a common limitation of all online survey research (Dillman, Smyth, & Christian, 2014). The JBLI, SCS, and CBI are all self-reported measures, increasing the chances of poor responses rates and

ultimately making it difficult for researchers to generalize findings to the population being studied (Coughlan, Cronin, & Ryan, 2009). With an increase in demand for survey research in the United States, response rates continue to fall, making it more difficult to generalize findings for research studies (Coughlan et al., 2009). Because I was not able to identify the response rate, I am also unable to determine if these results are generalizable to the counseling population.

Other limitations include whether or not participants had difficulties comprehending the questions and reporting an answer (Brenner, 2017), did not complete the questionnaires, or sought help to do so (Coughlan et al., 2009). Other times, participants may apply meaning to certain questions on a survey that are not intended, creating an error (Brenner, 2017). Participants may have had a different understanding of burnout, self-compassion, or life balance than the instruments intended to measure, which may i the participants' responses when participating in this research study. While it is implied that professional counselors understand the meaning of burnout, self-compassion, and life balance, this is an important limitation to consider. Another limitation of this study includes social desirability, as participants may have embellished positive behaviors and restrained negative behaviors with hopes of following normative social behavior or impressing me (see Brenner, 2017). I purposefully included eligibility questions to obtain access to the three assessments in order to avoid survey nonresponse, which occurs when either the participant does not answer a question (item nonresponse) or fails to respond or is not able to be contacted by the researcher (unit nonresponse; see Brenner, 2017). Yet another limitation is potential confounding variables such as

environment, stress, burnout, mood, time constraints, education level, personal beliefs, or values that may have impacted a participant's responses and affected the results of this study.

The following limitations listed are limitations of the assessments used in this survey research study. For the JBLI, a limitation includes the notion that all respondents are in or are seeking an intimate relationship. For the CBI, a limitation includes the assumption that all counselors work for an agency setting and are not self-employed. Considering the fact that 181 (54.68%) respondents reported working in private practice, it is possible that the results of the CBI are not generalizable to the counseling profession. When reviewing the Counselor Compensation Study (ACA, 2014), only 20% of counselors reported working in private practice. Therefore, the sample in this study may be more representative of counselors working in private practice, not in other work environments. For the SCS, a limitation includes the notion that counselors do not minimize their experiences. Consequently, counselors who identify English as a second language may not understand what it means to be cold-hearted.

The following limitations listed are limitations according to the sample size for this survey research study. This sample doesn't have gender skewness and may not be generalizable to male professional counselors or transgender professional counselors due to a majority of the sample size identifying as female (n= 272, 82.18%). This sample may also not be generalizable to professional counselors who identify as lesbian, gay, bisexual, or queer, as a majority of professional counselors in this sample identified as heterosexual (n =297, 89.73%). The results of this study may also not be generalizable to

the entire counseling population due to the high percentage of professional counselors who identified as working in private practice settings (*n* =181, 54.68%). This percentage differs from the Counselor Compensation Study conducted by the American Counseling Association (ACA, 2014). Out of 7,282 counselors who participated (unlicensed and licensed), only 20% of counselors reported working in private practice. Additionally, because 54.68% of the sample reported working in private practice, the average income reported for 2018 was $59,959, which is $19,538 higher than the average reported for clinical mental health counselors in the Counselor Compensation Study (ACA, 2014). Differences in income also pose another limitation to generalizability of the results of this survey research study.

Recommendations

Recommendations for future research studies include having a wider range of sample size as it relates to gender, race, sexual orientation, and state of residence. It is recommended that research be conducted to study if there are gender, race, or sexuality differences between how self-compassion and life balance impact the experience of burnout in counselors. Participation for this study was collected in May 22- July 8, 2019. It is recommended that a similar study be conducted during different seasons of the year to see if the level of burnout, self-compassion, or life balance changes with the climate. A significant number of participants were Master's level licensed professional counselors (82.18%). A study should be developed to examine doctoral level licensed professional counselors that identify as counselor educators to understand how self-compassion and life balance contribute to the experience of burnout. An additional recommendation is to

study how coping styles differ when a counselor's resources are being depleted. It is also recommended to identify ways to reach professional counselors who did not participate, as those counseling professionals may currently be experiencing burnout and may not have participated in this research study due to being overwhelmed or emotionally exhausted. Another recommendation is to determine if there is a relationship between the subscales of the JBLI and the subscales of the SCS.

This study can also be replicated with the intent to follow professional counselors over a couple decades to explore the impact of life balance and self-compassion on burnout. It is recommended that research be conducted to study the adverse effects of decreased self-compassion, decreased levels of life balance, and increased levels of burnout on client outcomes as well as on the outcomes of supervisees and students. It is recommended that research be conducted to study the awareness and action taken by counselors once burnout is recognized. It is also recommended to conduct a control group experiment to determine how self-compassion interventions affect counselor burnout. This study can also be the catalyst to develop a training program for counselors to learn how to implement self-compassion and life balance into their lives to prevent and/or avoid the experience of burnout. A qualitative research study is also recommended to better understand the high levels of self-judgment and isolation, two subscales of the SCS, in professional counselors. This may be helpful in gaining a better understanding of how counselors engage in self-compassion practices versus feeling competent in their skills as a counselor. Additionally, another qualitative survey research study is

recommended to understand how work environment impacts the experience of burnout in counselors.

Implications

With the high need for the counseling profession to identify an empirically based method to prevent and/or mitigate the experience of burnout in professional counselors, it is certain that there are implications of this research study. The desired results of this survey research study were to contribute to the knowledge base in the field of counseling regarding the exploration of the relationship between burnout, life balance, and self-compassion in professional counselors in the United States of America. By exploring the relationship between burnout, life balance, and self-compassion in professional counselors, this study could provide clarity, advocacy, and positive social change to improve counselor's experiences and mitigate turnover, physical ailments related to stress, counselor burnout, and to reduce harm provided to clients being served (Acker, 2012; Arslan & Acar, 2013; Consiglio, Borgogni, Alessandri, & Schaufeli, 2013; Darr & Johns, 2008; Holowaychuk, 2018; Lampert & Glaser, 2018; Morse et al., 2012; Puig et al., 2012; Wester et al., 2009; Young, 2015).

While future studies are needed to determine how self-compassion and life balance contribute to decreased experiences of professional counselor burnout, the field of counseling needs to encourage and support professional counselors to learn how to implement self-compassion and life balance with the sole purpose to decrease harm to clients served and counselor burnout. If the field of counseling is to continue to promote that counselors "empower diverse individuals, families, and groups to accomplish mental

health, wellness, education, and career goals" (ACA, 2014, p. 3), then the counseling profession needs to advocate for training programs to assist counselors understand how to implement self-compassion and life balance into their lives.

Social Change Implications

Social change efforts impact individuals and communities on an individual, organizational, and global scale (Walden University, 2016). All research should include its capacity to impact society, as the results of research are limited and not practical without any efforts made towards social change (De la Sablonnière, 2017). The social change potential of this survey research study is to improve the overall life balance of professional counselors and to advocate for professional counselors in workplace settings that do not receive adequate support and resources. Additionally, this survey research study may contribute to social change by decreasing harm to clients receiving mental health treatment. Following are the individual, organizational, and global social change implications of this research study.

Individual social change implications. The ACA Code of Ethics (2014) section C.2.g acknowledged that counselors do not work impaired, as it risks the quality of services provided to clients. Additionally, the social change potential of this survey research study is to improve quality of care provided to clients being served, as section A.4.a of the ACA Code of Ethics (2014) recommends professional counselors avoid harming clients served in order to abide by the ethical principles of nonmaleficence and beneficence. The counseling profession's mission to decrease client harm and increase client outcomes in mental health treatment lies on the strength of the counselor to

maintain their well-being (Sangganjanavanich & Balkin, 2013; ACA, 2014). Therefore, it will be important for the counseling profession to focus on counselor well-being through life balance and self-compassion to create social change. If only some counselors focus on decreasing burnout, only a few members of society will be impacted (De la Sablonnière, 2017). Hence, reviewing how this survey research study impacts social change on an organizational level is necessary.

Organizational social change implications. For this research study to impact individuals, organizations, and the larger society, stakeholders and other persons of authority must share the same long-term goals put forth in this current study (De la Sablonnière, 2017; Fenton, 2016). As previously mentioned in Chapter one, mental health and substance use inpatient stays in the United States have increased 20.1% between 2005 and 2014, accounting for about 6% of all inpatient stays in 2014 (HCUP, 2017). Therefore, decreasing experiences of burnout in mental health providers may improve the quality of care provided to clients, decreasing inpatient hospitalizations and contributing to social change in the United States. At times, there is a desire to create positive social change, but lack of funding and other policy restrictions often make it difficult to implement and sustain (De la Sablonnière, 2017). Therefore, it may be helpful to advocate for the counseling profession at different mental health organizations, one state at a time, to develop, implement, and sustain procedures to impact the well-being of counselors and clients being served. With organizations on board, the potential for social change increases. In order to make a larger social change impact, global social change implications must be discussed.

Global social change implications. When reviewing literature on how social change can have a global impact, it is necessary to understand how local social change efforts can impact society on a global level (Green, 2016). In this research study, social change implications are geared towards improving the quality of life of counselors in order to provide better mental health treatment to clients seeking mental health treatment, making the community and general public better protected. As more members of society in different regions of the world recognize the social change potential of decreasing harm provided to clients by counselors who are experiencing burnout, there will be an increased likelihood that this research study may impact social change on a global level (De la Sablonnière, 2017). This research study provides possible directions of an intervention for social change that may improve the quality of life for individuals and society at large (Liu & Bernardo, 2014). The first step is to share this research with the counseling profession and stakeholders who have resources to make a larger impact.

Conclusion

The counseling profession seeks to identify an empirically validated method to prevent and/or mitigate the experience of burnout in professional counselors (Jaworska et al., 2016; Maslach, 2003; Rupert, Miller, & Dorociak, 2015; Sansbury, Graves, & Scott, 2015; Wilkinson, Infantolino, & Wacha-Montes, 2017; Zhao, Li, & Shields, 2018). Burnout is a significant problem in the counseling field, with an estimated cost of $300 billion in the United States each year due to absenteeism, job turnover, decreased productivity, and medical, legal, and insurance costs (The American Institute of Stress, n.d.). Researchers who have attempted to identify a way to manage counselor burnout

have not been able to identify an empirically validated method, adding pressure to professional counselors that research has failed to identify an empirically based model to prevent and/or mitigate the experience of burnout (Dreison et al., 2018; Jaworska-Burzyńska et al., 2016; Paris & Hodge, 2010). Professional counselors have assumed that the only way to manage burnout has been to engage in more self-care practices, many times counselors struggle with practicing self-care regularly, increasing the risk for burnout (ACA, 2014; Coaston, 2017).

As demonstrated by the findings of this quantitative survey research study, professional counselors who experience burnout are experiencing poor work-life balance, decreased attention in their personal life, decreased quality of their relationships and negative work environment. Additionally, counselors who practice self-compassion do not experience burnout. It's time that the future of the counseling profession focused on supporting counselors, with the first step being to develop training programs to prevent and intervene counselor burnout across the nation.

References

Abdulrahman, M., Farooq, M., Al Kharmiri, A., Al Marzooqi, F., & Carrick, F. (2018). Burnout and depression among medical residents in the United Arab Emirates: A multicenter study. *Journal of Family Medicine & Primary Care*, *7*(2), 435–441. doi:10.4103/jfmpc.jfmpc_199_17

Acker, G. M. (2012). Burnout among mental health care providers. *Journal of Social Work*, *12*(5), 475–490. doi:10.1177/1468017310392418

Ahola, K., Honkonen, T., Isometsä, E., Kalimo, R., Nykyri, E., Aromaa, A., & Lönnqvist, J. (2005). The relationship between job-related burnout and depressive disorders--results from the Finnish Health 2000 Study. *Journal of Affective Disorders*, *88*(1), 55–62.doi:10.1016/j.jad.2005.06.004

Ahola, K., Hakanen, J., Perhoniemi, R., & Mutanen, P. (2014). Relationship between burnout and depressive symptoms: A study using the person-centred approach. *Burnout Research*, *1*(1), 29–37. doi:10.1016/j.burn.2014.03.003

Alarcon, G. M. (2011). A meta-analysis of burnout with job demands, resources, and attitudes. *Journal of Vocational Behavior*, *79*(2), 549–562. doi:10.1016/j.jvb.2011.03.007

Alderson, M., Parent-Rocheleau, X., & Mishara, B. (2015). Critical review on suicide among nurses: What about work-related factors? *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *36*(2), 91–101. doi:10.1027/0227-5910/a000305

Alqashan, H. F., & Alzubi, A. (2009). Job satisfaction among counselors working at stress center—Social Development Office—in Kuwait. *Traumatology, 15*(1), 29–39. doi:10.1177/1534765608330052

American Counseling Association. (2014). 2014 ACA Code of Ethics. Retrieved from http://www.counseling.org/Resources/aca-code-of-ethics.pdf

American Institute of Stress (n.d.). Workplace stress. Retrieved from https://www.stress.org/workplace-stress/

Arnold, K. A., Connelly, C. E., Gellatly, I. R., Walsh, M. M., & Withey, M. J. (2017). Using a pattern-oriented approach to study leaders: Implications for burnout and perceived role demand. *Journal of Organizational Behavior, 38*(7), 1038–1056. doi:10.1002/job.2182

Arnold, K. A., Connelly, C. E., Walsh, M. M., & Martin Ginis, K. A. (2015). Leadership styles, emotion regulation, and burnout. *Journal of Occupational Health Psychology*, *20*(4), 481–490. doi:10.1037/a0039045

Aronsson, G., Theorell, T., Grape, T., Hammarström, A., Hogstedt, C., Marteinsdottir, I., …Hall, C. (2017). A systematic review including meta-analysis of work environment and burnout symptoms. *BMC Public Health*, *17*(1), 264–264. doi:10.1186/s12889-017-4153-7

Arslan, R., & Acar, B. N. (2013). A research on academics on life satisfaction, job satisfaction and professional burnout. *Yaşam Doyumu, İş Doyumu Ve Mesleki Tükenmişlik Kavramlarina Yönelik Akademisyenler Üzerinde Bir Araştirma.*, *18*(3), 282–298.

Atkinson, D. M., Rodman, J. L., Thuras, P. D., Shiroma, P. R., & Lim, K. O. (2017). Examining burnout, depression, and self-compassion in veterans affairs mental health staff. *Journal of Alternative and Complementary Medicine*, *23*(7), 551–557. doi:10.1089/acm.2017.0087

Au, M., Kehn, M., Ireys, H., Blyler, C., & Brown, J. (2018). Care coordinators in integrated care: Burnout risk, perceived supports, and job satisfaction. *American Journal of Preventive Medicine*, *54*(6), S250–S257. doi:10.1016/j.amepre.2018.01.044

Awa, W. L., Plaumann, M., & Walter, U. (2010). Burnout prevention: A review of intervention programs. *Patient Education and Counseling*, *78*(2), 184–190. doi:10.1016/j.pec.2009.04.008

Azar, S. T. (2000). Preventing burnout in professionals and paraprofessionals who work with child abuse and neglect cases: A cognitive behavioral approach to supervision. *Journal of Clinical Psychology*, *56*(5), 643–663. doi:10.1002/(SICI)1097-4679(200005)56:5<643::AID-JCLP6>3.0.CO;2-U

Baciu, L., & Vîrgă, D. (2018). Well-being and turnover intentions among Romanian social workers. *Social Work Review / Revista de Asistenta Sociala*, (1), 89–107.

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*(1), 71–86. doi:10.1891/vivi.2003.18.1.71

Bakker, A. B., & Costa, P. L. (2014). Chronic job burnout and daily functioning: A theoretical analysis. *Burnout Research, 1*(3), 112–119. doi:10.1016/j.burn.2014.04.003

Bakker, A. B., & Oerlemans, W. G. M. (2016). Momentary work happiness as a function of enduring burnout and work engagement. *Journal of Psychology, 150*(6), 755–778. doi:10.1080/00223980.2016.1182888

Baldwin-White, A. (2016). Psychological distress and substance abuse counselors: An exploratory pilot study of multiple dimensions of burnout. *Journal of Substance Use*, *21*(1), 29–34. doi:10.3109/14659891.2014.949316

Balkin, R. S., Reiner, S. M., Hendricks, L., Washington, A., McNeary, S., Juhnke, G. A., & Hunter, Q. (2018). Life balance and work addiction among African Americans. *Career Development Quarterly*, *66*(1), 77–84. doi:10.1002/cdq.12123

Barbosa, P., Raymond, G., Zlotnick, C., Wilk, J., Toomey, R. I., & Mitchell, J. I. (2013). Mindfulness-based stress reduction training is associated with greater empathy and reduced anxiety for graduate healthcare students. *Education for Health: Change in Learning & Practice*, *26*(1), 9–14. doi:10.4103/1357-6283.112794

Barnard, L. K., & Curry, J. F. (2011). Self-compassion: Conceptualizations, correlates, & interventions. *Review of General Psychology, 15*(4), 289–303. doi:10.1037/a0025754

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016a). Compassion for others, self-compassion, quality of life and mental well-being measures and their

association with compassion fatigue and burnout in student midwives: A quantitative survey. *Midwifery, 34*, 239–244. doi:10.1016/j.midw.2015.11.002

Beaumont, E., Durkin, M., Hollins Martin, C. J., & Carson, J. (2016b). Measuring relationships between self-compassion, compassion fatigue, burnout and well-being in student counsellors and student cognitive behavioural psychotherapists: A quantitative survey. *Counselling & Psychotherapy Research*, *16*(1), 15–23. doi:10.1002/capr.12054

Bianchi, R., Truchot, D., Laurent, E., Brisson, R., & Schonfeld, I. S. (2014). Is burnout solely job-related? A critical comment. *Scandinavian Journal of Psychology*, *55*(4), 357-361. doi:10.1111/sjop.12119

Birkeland, I. K., Richardsen, A. M., & Dysvik, A. (2018). The role of passion and support perceptions in changing burnout: A Johnson-Neyman approach. *International Journal of Stress Management*, *25*(2), 163–180. doi:10.1037/str0000057

Bittman, B., Bruhn, K. T., Stevens, C., Westengard, J., & Umbach, P. O. (2003). Recreational music-making: A cost-effective group interdisciplinary strategy for reducing burnout and improving mood states in long-term care workers. *Advances in Mind-Body Medicine*, *19*(3–4), 4–15. doi:10.2202/1548-923x.1044

Blanch, A., & Aluja, A. (2012). Social support (family and supervisor), work–family conflict, and burnout: Sex differences. *Human Relations*, *65*(7), 811–833. doi:10.1177/0018726712440471

Blonk R., Brenninkmeijer V., Lagerveld S., & Houtman I. (2006). Return to work: A comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among the self-employed. *Work & Stress*, *20*(2), 129–144. doi:10.1080/02678370600856615

Brake, H. T., Gorter, R., Hoogstraten, J., & Eijkman, M. (2001). Burnout intervention among Dutch dentists: Long-term effects. *European Journal of Oral Sciences*, *109*(6), 380–387. doi:10.1034/j.1600-0722.2001.00086.x

Brenner, P. S. (2017). Toward a social psychology of survey methodology: An application of the approach and directions for the future. *Sociology Compass*, *11*(7), n/a-N.PAG. doi:10.1111/soc4.12491

Bridgeman, P. J., Bridgeman, M. B., & Barone, J. (2018). Burnout syndrome among healthcare professionals. *American Journal of Health-System Pharmacy*, *75*(3), 147–152. doi:10.2146/ajhp170460

Brook, R. J., & Brook, J. A. (1995). Sequential tree method of examining the relationship between job stress and mental health. *Perceptual and Motor Skills*, *80*(1), 287–290. doi:10.2466/pms.1995.80.1.287

Bryant, R. M., & Constantine, M. G. (2006). Multiple role balance, job satisfaction, and life satisfaction in women school counselors. *Professional School Counseling*, *9*(4), 265–271. doi:10.1177/2156759x0500900403

Bureau of Labor Statistics, U.S. Department of Labor. (2019, August). *Occupational Outlook Handbook*, Substance Abuse, Behavioral Disorder, and Mental Health

Counselors. Retrieved from https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm

Carlson, D., Ferguson, M., Hunter, E., & Whitten, D. (2012). Abusive supervision and work– family conflict: The path through emotional labor and burnout. *The Leadership Quarterly*, *23*(5), 849–859. doi:10.1016/j.leaqua.2012.05.003

Carmona, C., Buunk, A. P., Peiró, J. M., Rodríguez, I., & Bravo, M. J. (2006). Do social comparison and coping styles play a role in the development of burnout? Cross-sectional and longitudinal findings. *Journal of Occupational and Organizational Psychology*, *79*(1), 85–99. doi:10.1348/096317905X40808

Carrola, P. A., Olivarez, A., & Karcher, M. J. (2016). Correctional counselor burnout: Examining burnout rates using the Counselor Burnout Inventory. *Journal of Offender Rehabilitation*, *55*(3), 195–212. doi:10.1080/10509674.2016.1149134

Carrola, P. A., Yu, K., Sass, D. A., & Lee, S. M. (2012). Measurement invariance of the Counselor Burnout Inventory across cultures: A comparison of U. S. and Korean counselors. *Measurement and Evaluation in Counseling and Development*, *45*(4), 227–244. doi:10.1177/0748175612447630

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). COPE Inventory [Test Development]. doi:10.1037/t10027-000

Chang, K. (2014). An opportunity for positive change and growth: Music therapists' experiences of burnout. *Canadian Journal of Music Therapy*, *20*(2), 64–85. Retrieved from http://www.musictherapy.ca/en/publications/journal.html

Choi, N. G., DiNitto, D. M., & Marti, C. N. (2014). Treatment use, perceived need, and barriers to seeking treatment for substance abuse and mental health problems among older adults compared to younger adults. *Drug and Alcohol Dependence*, *145*, 113–120. doi:10.1016/j.drugalcdep.2014.10.004

Choi, H., Puig, A., Kim, K., Lee, S., & Lee, S. M. (2014). Examining differential effects of internal and external resources on counselor burnout symptoms in South Korea. *Journal of Employment Counseling*, *51*(1), 2–15. doi:10.1002/j.2161-1920.2014.00037.x

Coaston, S. C. (2017). Self-care through self-compassion: A balm for burnout. *Professional Counselor*, *7*(3), 285–297. doi:10.15241/scc.7.3.285

Cohen, M., & Gagin, R. (2005). Can skill-development training alleviate burnout in hospital social workers? *Social Work in Health Care*, *40*(4), 83–97. doi:10.1300/j010v40n04_05

Cohen-Katz J, Wiley S, Capuano T, Baker DM, Deitrick L, & Shapiro S. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout: A qualitative and quantitative study, part III. *Holistic Nursing Practice*, *19*(2), 78–86. doi:10.1097/00004650-200503000-00009

Consiglio, C., Borgogni, L., Alessandri, G., & Schaufeli, W. B. (2013). Does self-efficacy matter for burnout and sickness absenteeism? The mediating role of demands and resources at the individual and team levels. *Work & Stress*, *27*(1), 22–42. doi:10.1080/02678373.2013.769325

Cooper, C.L., Dewe, P.J., & O'Driscoll, M. P. (2001). *Foundations for organizational science. Organizational stress: A review and critique of theory, research, and applications.* Thousand Oaks, CA, US: Sage Publications, Inc.

Coughlan, M., Cronin, P., & Ryan, F. (2009). Survey research: Process and limitations. *International Journal of Therapy & Rehabilitation*, *16*(1), 9–15. doi:10.12968/ijtr.2009.16.1.37935

Council for Accreditation of Counseling and Related Educational Programs (CACREP). (2016). CACREP Standards. Retrieved from http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Thousand Oaks, CA: Sage

Darr, W., & Johns, G. (2008). Work strain, health, and absenteeism: A meta-analysis. *Journal of Occupational Health Psychology, 13*(4), 293-318. doi:10.1037/a0012639

Davis, R. J., Balkin, R. S., & Juhnke, G. A. (2014). Validation of the Juhnke--Balkin Life Balance Inventory. *Measurement & Evaluation in Counseling & Development*, *47*(3), 181–198. doi:10.1177/0748175614531796

Davis, S. N., & Tuttle, J. D. (2017). Context, opportunity, and demands: Satisfaction with work-life balance in 26 countries. *Journal of Comparative Family Studies*, *48*(4), 329–348. doi:10.3138/jcfs.48.4.329

De Cuyper, N., Mäkikangas, A., Kinnunen, U., Mauno, S., & Witte, H. D. (2012). Cross-lagged associations between perceived external employability, job insecurity, and

exhaustion: Testing gain and loss spirals according to the Conservation of Resources Theory. *Journal of Organizational Behavior*, *33*(6), 770–788. doi:10.1002/job.1800

De Cuyper, N., Raeder, S., Van der Heijden, B. I. J. M., & Wittekind, A. (2012). The association between workers' employability and burnout in a reorganization context: Longitudinal evidence building upon the conservation of resources theory. *Journal of Occupational Health Psychology*, *17*(2), 162–174. doi:10.1037/a0027348

De la Sablonnière, R. (2017). Toward a psychology of social change: A typology of social change. *Frontiers in Psychology*, *8*. doi:10.3389/fpsyg.2017.00397

Dev, V., Fernando, A. T., Lim, A. G., & Consedine, N. S. (2018). Does self-compassion mitigate the relationship between burnout and barriers to compassion? A cross-sectional quantitative study of 799 nurses. *International Journal of Nursing Studies*, *81*, 81–88. doi:10.1016/j.ijnurstu.2018.02.003

De Vibe, M., Solhaug, I., Tyssen, R., Friborg, O., Rosenvinge, J. H., Sørlie, T., & Bjørndal, A. (2013). Mindfulness training for stress management: A randomised controlled study of medical and psychology students. *BMC Medical Education*, *13*, 107–107. doi:10.1186/1472-6920-13-107

Dias, M., Pagnin, D., Pagnin, V. de Q., Ribeiro Reis, R. L., & Olej, B. (2012). Effects of electroacupuncture on stress-related symptoms in medical students: A randomised controlled pilot study. *Acupuncture In Medicine*, *30*(2), 89–95. doi:10.1136/acupmed-2011-010082

Di Benedetto, M., & Swadling, M. (2014). Burnout in Australian psychologists: Correlations with work-setting, mindfulness and self-care behaviours. *Psychology, Health & Medicine*, *19*(6), 705–715. doi:10.1080/13548506.2013.861602

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). Internet, phone, mail, and mixed mode surveys: The tailored design method (4th ed.). Hoboken, NJ, US: John Wiley & Sons Inc.

Ding, Y., Qu, J., Yu, X., & Wang, S. (2014). The mediating effects of burnout on the relationship between anxiety symptoms and occupational stress among community healthcare workers in China: A cross-sectional study. *PLoS ONE*, *9*(9). doi:10.1371/journal.pone.0107130

Dobie, A., Tucker, A., Ferrari, M., & Rogers, J. M. (2016). Preliminary evaluation of a brief mindfulness-based stress reduction intervention for mental health professionals. *Australasian Psychiatry*, *24*(1), 42–45. doi:10.1177/1039856215618524

Doolittle, B. R. (2016). Are we the walking dead? Burnout as zombie apocalypse. *Annals of Family Medicine*, *14*(6), 578–580. doi:10.1370/afm.1975

Dorociak, K. E., Rupert, P. A., & Zahniser, E. (2017). Work life, well-being, and self-care across the professional lifespan of psychologists. *Professional Psychology: Research and Practice*, *48*(6), 429–437. doi:10.1037/pro0000160

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of

intervention research. *Journal of Occupational Health Psychology*, *23*(1), 18–30. doi:10.1037/ocp0000047

Dubois, C.-A., Bentein, K., Mansour, J. B., Gilbert, F., & Bédard, J.-L. (2013). Why some employees adopt or resist reorganization of work practices in health care: Associations between perceived loss of resources, burnout, and attitudes to change. *International Journal Of Environmental Research And Public Health*, *11*(1), 187–201. doi:10.3390/ijerph110100187

Dupree, P. I., & Day, H. D. (1995). Psychotherapists' job satisfaction and job burnout as a function of work setting and percentage of managed care clients. *Psychotherapy in Private Practice*, *14*(2), 77-93. doi:10.1996-02674-009.

Dwi Putranti, H. R. (2018). Organizational commitment of hospital nurses: An empirical study on work-life balance and burnout management. *European Researcher*, *9*(3), 235–248. doi:10.13187/er.2018.3.235

Dyrbye, L. N., Power, D. V., Massie, F. S., Eacker, A., Harper, W., Thomas, M. R., … Shanafelt, T. D. (2010). Factors associated with resilience to and recovery from burnout: A prospective, multi-institutional study of US medical students. *Medical Education*, *44*(10), 1016–1026. doi:10.1111/j.1365-2923.2010.03754.x

Elder, C., Nidich, S., Moriarty, F., & Nidich, R. (2014). Effect of transcendental meditation on employee stress, depression, and burnout: A randomized controlled study. *The Permanente Journal*, *18*(1), 19–23. doi:10.7812/TPP/13-102

Elliott, T. R., Shewchuk, R., Hagglund, K., Rybarczyk, B., & Harkins, S. (1996). Occupational burnout, tolerance for stress, and coping among nurses in

rehabilitation units. *Rehabilitation Psychology*, *41*(4), 267–284. doi:10.1037/0090-5550.41.4.267

Eriksson, T., Germundsjö, L., Åström, E., & Rönnlund, M. (2018). Mindful self-compassion training reduces stress and burnout symptoms among practicing psychologists: A randomized controlled trial of a brief web-based intervention. *Frontiers in Psychology, 9*. doi:10.3389/fpsyg.2018.02340

Estévez-Mujica, C. P., & Quintane, E. (2018). E-mail communication patterns and job burnout. *PLoS ONE*, *13*(3), 1–25. doi:10.1371/journal.pone.0193966

Evans, Y. A., & Payne, M. A. (2008). Support and self-care: Professional reflections of six New Zealand high school counsellors. *British Journal of Guidance & Counselling*, *36*(3), 317–330. doi:10.1080/03069880701729466

Ewers P, Bradshaw T, McGovern J, & Ewers B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of Advanced Nursing*, *37*(5), 470–476. doi:10.1046/j.1365-2648.2002.02115.x

Fenton, N. (2016). Left out? Digital media, radical politics and social change. *Information, Communication & Society*, *19*(3), 346–361. doi:10.1080/1369118X.2015.1109698

Figley, C. R. (2002). Compassion fatigue: Psychotherapist's chronic lack of self care. *Journal of Clinical Psychology*, *58*(11), 1433–1441. doi:10.1002/jclp.10090

Flamez, B., Lenz, A. S., Balkin, R. S., & Smith, R. L. (2017). *A counselor's guide to the dissertation process: Where to start and how to finish*. John Wiley & Sons.

Flannelly, K. J., Roberts, S. B., & Weaver, A. J. (2005). Correlates of compassion fatigue and burnout in chaplains and other clergy who responded to the September 11th attacks in New York City. *Journal of Pastoral Care & Counseling: JPCC*, *59*(3), 213–224. doi:10.1177/154230500505900304

Fong, M., & Loi, N. M. (2016). The mediating role of self-compassion in student psychological health. *Australian Psychologist*, *51*(6), 431–441. doi:10.1111/ap.12185

Foreman, T. (2018). Wellness, exposure to trauma, and vicarious traumatization: A pilot study. *Journal of Mental Health Counseling*, *40*(2), 142–155. doi:10.17744/mehc.40.2.04

Fouché, C., & Martindale, K. (2011). Work–life balance: Practitioner well-being in the social work education curriculum. *Social Work Education*, *30*(6), 675–685. doi:10.1080/02615479.2011.586566

Fralick, M., & Flegel, K. (2014). Physician burnout: Who will protect us from ourselves? *Canadian Medical Association Journal*, *186*(10), 731–731. doi:10.1503/cmaj.140588

Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues*, *30*, 159-207. doi:10.1111/j.1540-4560.1974.tb00706.x

Friedman, K. (2017). Counselor self-care and mindfulness. *Contemporary Buddhism*, *18*(2), 321–330. doi:10.1080/14639947.2017.1373437

Garrosa, E., Rainho, C., Moreno-Jiménez, B., & Monteiro, M. J. (2010). The relationship between job stressors, hardy personality, coping resources and burnout in a

sample of nurses: A correlational study at two time points. *International Journal of Nursing Studies*, *47*(2), 205–215. doi:10.1016/j.ijnurstu.2009.05.014

Gnilka, P. B., Karpinski, A. C., & Smith, H. J. (2015). Factor structure of the Counselor Burnout Inventory in a sample of professional school counselors. *Measurement and Evaluation in Counseling and Development*, *48*(3), 177–191. doi:10.1177/0748175615578758

Goh, J., Pfeffer, J., & Zenios, S. A. (2015). The relationship between workplace stressors and mortality and health costs in the United States. *Management Science*, *62*(2), 608–628. doi:10.1287/mnsc.2014.2115

Gold, K. J., Sen, A., & Schwenk, T. L. (2013). Details on suicide among US physicians: Data from the National Violent Death Reporting System. *General Hospital Psychiatry*, *35*(1), 45–49. doi:10.1016/j.genhosppsych.2012.08.005

Gorter, R. C., Eijkman, M. A., & Hoogstraten, J. (2001). A career counseling program for dentists: effects on burnout. *Patient Education and Counseling*, *43*, 23–30. doi:10.1016/S0738-3991(00)00141-5

Green, J. J. (2016). Community development and social development: Informing concepts of place and intentional social change in a globalizing world. *Research on Social Work Practice*, *26*(6), 605–608. doi:10.1177/1049731515627194

Groves, R. M., Fowler, F. J. Jr., Couper, M. P., Lepkowski, J. M., Singer, E., & Tourangeau, R. (2009). *Survey methodology* (2nd. ed.). Hoboken, NJ: John Wiley & Sons.

Groves, R. M., Cialdini, R. B., & Couper, M. P. (1992). Understanding the decision to participate in a survey. *Public Opinion Quarterly*, 56 (4), 475-495. doi:10.1086/269338

Hair, J. F., Black, W. C., Babin, B. J., & Anderson R. E. (2010). *Multivariate data analysis.* (7th Ed.). Upper Saddle River, NJ: Prentice Hall.

Halbesleben, J. R. B., Neveu, J.-P., Paustian-Underdahl, S. C., & Westman, M. (2014). Getting to the "COR": Understanding the role of resources in conservation of resources theory. *Journal of Management*, *40*(5), 1334–1364. doi:10.1177/0149206314527130

Harris, P. L. (1984). Assessing burnout: The organizational and individual perspective. *Family & Community Health, 6,* 32-43. doi: 10.1984-24710-001

Healthcare Cost and Utilization Project (HCUP) (2017). Trends in hospital inpatient stays in the United States, 2005-2014. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.jsp

Henderson, D. A., & Montplaisir, B. F. (2013). From good to great: Examining exemplary counselor development. *Journal of Counseling & Development*, *91*(3), 336–342. doi:10.1002/j.1556-6676.2013.00102.x

Hermann, M. A., Ziomek-Daigle, J., & Dockery, D. J. (2014). Motherhood and counselor education: Experiences with work-life balance. *Adultspan Journal*, *13*(2), 109–119. doi:10.1002/j.2161-0029.2014.00030.x

Hildenbrand, K., Sacramento, C. A., & Binnewies, C. (2018). Transformational leadership and burnout: The role of thriving and followers' openness to

experience. *Journal of Occupational Health Psychology*, *23*(1), 31–43. doi:10.1037/ocp0000051

Himle, D. P., Jayaratne, S., & Thyness, P. (1991). Buffering effects of four social support types on burnout among social workers. *Social Work Research & Abstracts*, *27*(1), 22–27. doi:10.1093/swra/27.1.22

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44,* 513-524. doi: 10.1037/0003-066X.44.3.513

Hobfoll, S.E., & Freedy, J. (1993). Conservation of resources: A general stress theory applied to burnout. In W. B. Schaufeli, B. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 115-133). Washington, DC: Taylor & Francis.

Holowaychuk, M. K. (2018). Setting boundaries to protect personal time. *Veterinary Team Brief*, *6*(6), 13–17.

Hu, Q., Schaufeli, W. B., & Taris, T. W. (2017). How are changes in exposure to job demands and job resources related to burnout and engagement? A longitudinal study among Chinese nurses and police officers. *Stress & Health: Journal of the International Society for the Investigation of Stress*, *33*(5), 631–644. doi:10.1002/smi.2750

Huang, J., Wang, Y., Wu, G., & You, X. (2016). Crossover of burnout from leaders to followers: A longitudinal study. *European Journal of Work and Organizational Psychology*, *25*(6), 849–861. doi:10.1080/1359432X.2016.1167682

Hyung In Park, O'Rourke, E., & O'Brien, K. E. (2014). Extending conservation of resources theory: The interaction between emotional labor and interpersonal influence. *International Journal of Stress Management, 21*(4), 384–405. doi:10.1037/a0038109

IBM Corp. Released 2017. IBM SPSS Statistics for Windows, (Version 25.0) [Computer 91 software]. Armonk, NY: IBM Corp.

Ismail, A., Saudin, N., Ismail, Y., Samah, A. J. A., Bakar, R. A., & Aminudin, N. N. (2015). Effect of workplace stress on job performance. *Economic Review: Journal of Economics & Business / Ekonomska Revija: Casopis Za Ekonomiju i Biznis, 13*(1), 45–57.

Jackson, S. E., & Maslach, C. (1982). After-effects of job-related stress: families as victims. *Journal of Occupational Behavior, 3*(1), 63–77. doi:10.1002/job.4030030106

Jaworska-Burzyńska, L., Kanaffa-Kilijańska, U., Przysiężna, E., & Szczepańska-Gieracha, J. (2016). The role of therapy in reducing the risk of job burnout—A systematic review of literature. *Archives of Psychiatry and Psychotherapy, 18*(4), 43–52. doi:10.12740/APP/65815

Jennings, K. S., Goguen, K. N., Britt, T. W., Jeffirs, S. M., Wilkes, J. R. I., Brady, A. R., … DiMuzio, D. J. (2017). The role of personality traits and barriers to mental health treatment seeking among college students. *Psychological Services, 14*(4), 513–523. doi:10.1037/ser0000157

Jiang, L., & Probst, T. M. (2017). The rich get richer and the poor get poorer: Country- and state-level income inequality moderates the job insecurity-burnout relationship. *Journal of Applied Psychology, 102*(4), 672–681. doi:10.1037/apl0000179

Johns, G., & Miraglia, M. (2015). The reliability, validity, and accuracy of self-reported absenteeism from work: A meta-analysis. *Journal of Occupational Health Psychology*, *20*(1), 1–14. doi:10.1037/a0037754

Jonas, B., Leuschner, F., & Tossmann, P. (2017). Efficacy of an internet-based intervention for burnout: A randomized controlled trial in the German working population. *Anxiety, Stress & Coping: An International Journal*, *30*(2), 133–144. doi:10.1080/10615806.2016.1233324

Kanji, N., White, A., & Ernst, E. (2006). Autogenic training to reduce anxiety in nursing students: randomized controlled trial. *Journal Of Advanced Nursing*, *53*(6), 729–735. doi:10.1111/j.1365-2648.2006.03779.x

Karaman, M. A., Balkin, R. S., & Juhnke, G. A. (2018). Turkish adaptation of the Juhnke–Balkin Life Balance Inventory. *Measurement and Evaluation in Counseling and Development*, *51*(3), 141–150. doi:10.1080/07481756.2017.1308226

Kim, J. J., Brookman-Frazee, L., Gellatly, R., Stadnick, N., Barnett, M. L., & Lau, A. S. (2018). Predictors of burnout among community therapists in the sustainment phase of a system-driven implementation of multiple evidence-based practices in

children's mental health. *Professional Psychology: Research & Practice*, *49*(2), 132–141. doi:10.1037/pro0000182

Kinman, G., & Jones, F. (2008). A life beyond work? Job demands, work-life balance, and wellbeing in UK academics. *Journal of Human Behavior in the Social Environment*, *17*(1–2), 41–60. doi:10.1080/10911350802165478

Knight, C. (2013). Indirect trauma: Implications for self-care, supervision, the organization, and the academic institution. *The Clinical Supervisor*, *32*(2), 224–243. doi:10.1080/07325223.2013.850139

Koeske, G. F., Kirk, S. A., & Koeske, R. D. (1993). Coping with job stress: Which strategies work best? *Journal of Occupational and Organizational Psychology*, *66*(4), 319–335. doi:10.1111/j.2044-8325.1993.tb00542.x

Kovač, J., Krečič, M., Čagran, B., & Mulej, M. (2017). Effect of supervision on stress and burnout in school counsellors: A case of action research. *Systemic Practice & Action Research*, *30*(4), 395–406. doi:10.1007/s11213-016-9400-9

Kreimer, S. (2018). Preventing physician suicide: Recognizing symptoms, improving support. American Association for Physician Leadership. Retrieved from https://www.physicianleaders.org/news/-preventing-physician-suicide-recognizing-symptoms-improving-support.

Kuwada, G. T. (2016). Strategy for preventing practice burnout: Suicide among physicians and surgeons. *Foot & Ankle Online Journal*, *9*(1), 47–50. doi:10.3827/faoj.2016.0901.0010

Lampert, B., & Glaser, J. (2018). Detached concern in client interaction and burnout. *International Journal of Stress Management*, *25*(2), 129–143. doi:10.1037/str0000053

Landrum, B., Knight, D. K., & Flynn, P. M. (2012). The impact of organizational stress and burnout on client engagement. *Journal of Substance Abuse Treatment*, *42*(2), 222–230. doi:10.1016/j.jsat.2011.10.011

Lanham, M. E., Rye, M. S., Rimsky, L. S., & Weill, S. R. (2012). How gratitude relates to burnout and job satisfaction in mental health professionals. *Journal of Mental Health Counseling*, *34*(4), 341–354. doi:10.17744/mehc.34.4.w35q80w11kgpqn26

Lazarus, R. S., Folkman, S. (1984). *Stress, appraisal, and coping.* New York: Springer.

Le Blanc, P. M., Hox, J. J., Schaufeli, W. B., Taris, T. W., & Peeters, M. C. W. (2007). Take care! The evaluation of a team-based burnout intervention program for oncology care providers. *Journal of Applied Psychology*, (1), 213. doi:10.1037/0021-9010.92.1.213

Lee, R. T., & Ashforth, B. E. (1990). On the meaning of Maslach's three dimensions of burnout. *Journal of Applied Psychology*, *75*(6), 743–747. doi:10.1037/0021-9010.75.6.743

Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., … Yu, K. (2007). Counselor Burnout Inventory. *PsycTESTS*. doi:10.1037/t10697-000

Lee, S. M., Baker, C. R., Cho, S. H., Heckathorn, D. E., Holland, M. W., Newgent, R. A., … Yu, K. (2007). Development and initial psychometrics of the Counselor Burnout Inventory. *Measurement and Evaluation in Counseling and Development*, *40*(3), 142–154. doi:10.1080/07481756.2007.11909811

Lee, S. M., Cho, S. H., Kissinger, D., & Ogle, N. T. (2010). A typology of burnout in professional counselors. *Journal of Counseling & Development*, *88*(2), 131–138. doi:10.1002/j.1556-6678.2010.tb00001.x

Lee, J.-Y., Kim, S.-Y., Bae, K.-Y., Kim, J.-M., Shin, I.-S., Yoon, J.-S., & Kim, S.-W. (2018). The association of gratitude with perceived stress and burnout among male firefighters in Korea. *Personality and Individual Differences*, *123*, 205–208. doi:10.1016/j.paid.2017.11.010

Lee, J. J., & Miller, S. E. (2013). A self-care framework for social workers: Building a strong foundation for practice. *Families in Society-The Journal Of Contemporary Social Services*, *94*(2), 96–103. doi:10.1606/1044-3894.4289

Lee, W., Veach, P. M., Macfarlane, I. M., & Leroy, B. S. (2015). Who is at risk for compassion fatigue? An investigation of genetic counselor demographics, anxiety, compassion satisfaction, and burnout. *Journal of Genetic Counseling; New York*, *24*(2), 358–370. doi:10.1007/s10897-014-9716-5

Leiter, M. P. (1991). Coping patterns as predictors of burnout: The function of control and escapist coping patterns. *Journal of Organizational Behavior*, *12*(2), 123–144. doi:10.1002/job.4030120205

Leiter, M. P., & Maslach, C. (1988). The impact of interpersonal environment on burnout and organizational commitment. *Journal of Organizational Behavior*, *9*(4), 297–308. doi:10.1002/job.4030090402

Leiter, M. P., & Maslach, C. (2001). Burnout and quality in a speed-up world. *Journal for Quality & Participation*, *24*(2), 48.

Leiter, M. P., & Maslach, C. (2009). Nurse turnover: The mediating role of burnout. *Journal of Nursing Management*, *17*(3), 331–339. doi:10.1111/j.1365-2834.2009.01004.x

Leiter, M. P., & Maslach, C. (2016). Latent burnout profiles: A new approach to understanding the burnout experience. *Burnout Research*, *3*(4), 89–100. doi:10.1016/j.burn.2016.09.001

Lent, J., & Schwartz, R. C. (2012). The impact of work setting, demographic characteristics, and personality factors related to burnout among professional counselors. *Journal of Mental Health Counseling*, *34*(4), 355–372. doi:10.17744/mehc.34.4.e3k8u2k552515166

Lheureux, F., Truchot, D., & Borteyrou, X. (2016). Suicidal tendency, physical health problems and addictive behaviours among general practitioners: Their relationship with burnout. *Work & Stress*, *30*(2), 173–192. doi:10.1080/02678373.2016.1171806

Lim, N., Kim, E. K., Kim, H., Yang, E., & Lee, S. M. (2010). Individual and work-related factors influencing burnout of mental health professionals: A meta-

analysis. *Journal of Employment Counseling*, *47*, 86-96. doi:10.1002/j.2161-1920.2010.tb00093.x

Lin, Y.-N. (2012). Experiences of burnout, self-care, and recovery of female university counsellors in Taiwan. *Canadian Journal of Counselling and Psychotherapy*, *46*(3), 221–238.

Linden, D. van der, Keijsers, G., Eling, P., & Schaijk, R. van. (2005). Work stress and attentional difficulties: An initial study on burnout and cognitive failures. *Work & Stress*, *19*(1), 23–36. doi:10.1080/02678370500065275

Liu, J. H., & Bernardo, A. B. I. (2014). Social psychology for social change: Foundations for and introduction to a program of action-oriented research. *Journal of Pacific Rim Psychology*, *8*(2), 29–34. doi:10.1017/prp.2014.4

Loveland, E. (2018). Feeling the Burn. *Journal of College Admission*, (238), 48–53.

Macinick CG, & Macinick JW. (1990). Strategies for burnout prevention in the mental health setting. *International Nursing Review*, *37*(2), 247–246.

Mamidenna, S., & Viswanatham, K. N. (2014). Burnout and retaliatory behaviour intents in the workplace -- An exploratory study. *ASCI Journal of Management*, *44*(1), 54–65.

Markati, A., Psychountaki, M., Kingston, K., Karteroliotis, K., & Apostolidis, N. (2018). Psychological and situational determinants of burnout in adolescent athletes. *International Journal of Sport and Exercise Psychology*, 1–16. doi:10.1080/1612197X.2017.1421680

Martins, A. E., Davenport, M. C., Del Valle, M. de la P., Di Lalla, S., Dominguez, P., Ormando, L., … Ferrero, F. (2011). Impact of a brief intervention on the burnout levels of pediatric residents. *Jornal De Pediatria*, *87*(6), 493–498. doi:10.2223/JPED.2127

Maslach, C. (1976). Burned-out. *Human Behavior*,*5,* 16-22.

Maslach, C. (2001). What have we learned about burnout and health? *Psychology & Health*, *16*(5), 607. doi:10.1080/08870440108405530

Maslach, C. (2003). Job burnout, job burnout: New directions in research and, new directions in research and intervention. *Current Directions in Psychological Science*, *12*(5), 189–192. doi:10.1111/1467-8721.01258

Maslach, C. (2017). Finding solutions to the problem of burnout. *Consulting Psychology Journal: Practice and Research*, *69*(2), 143–152. doi:10.1037/cpb0000090

Maslach, C., & Florian, V. (1988). Burnout, job setting, and self-evaluation among rehabilitation counselors. *Rehabilitation Psychology*, *33*(2), 85–93. doi:10.1037/h0091691

Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied & Preventive Psychology*, *7*(1), 63–74. doi:10.1016/S0962-1849(98)80022-X

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, *2*(2), 99–113. doi:10.1002/job.4030020205

Maslach, C., & Jackson, S. (1984). Burnout in organization settings. *Applied Social Psychology Annual.* 5. 133-153.

Maslach, C., & Jackson, S. E. (1985). The role of sex and family variables in burnout. *Sex Roles*, *12*(7–8), 837–851. doi:10.1007/BF00287876

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *MBI manual* (3rd ed.). Mountain View, CA: Consulting Psychologists Press.

Maslach, C., Jackson, S., & Leiter, M. (1997). The Maslach Burnout Inventory manual. In *Evaluating Stress: A Book of Resources*, 3, 191–218.

Maslach, C., Jackson, S. E., Leiter, M. P., Schaufeli, W. B., & Schwab, R. L. (1981). Maslach Burnout Inventory [Third Edition Manual]. *MBI-HSS*.

Maslach, C., & Leiter, M. P. (2008). Early predictors of job burnout and engagement. *Journal of Applied Psychology*, *93*(3), 498–512. doi:10.1037/0021-9010.93.3.498

Maslach, C., Leiter, M. P., & Jackson, S. E. (2012). Making a significant difference with burnout interventions: Researcher and practitioner collaboration. *Journal of Organizational Behavior*, *33*(2), 296–300. doi:10.1002/job.784

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job Burnout. *Annual Review of Psychology*, *52*(1), 397.

Mathieu, F. (2014). Occupational hazards: Compassion fatigue, vicarious trauma and burnout. *Canadian Nurse*, *110*(5), 12–13.

Mattioli, D. (2018). Focusing on the caregiver: Compassion fatigue awareness and understanding. *MEDSURG Nursing*, *27*(5), 323–327.

Matuska, K. (2012). Validity evidence of a model and measure of life balance. *OTJR: Occupation, Participation and Health; Thousand Oaks*, *32*(1), 229–237. doi:10.3928/15394492-20110610-02

Matuska, K. & Christiansen, C. (2008). A proposed model of lifestyle balance. *Journal of Occupational Science.* 15. 9-19. doi:10.1080/14427591.2008.9686602.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3,* 131-149. doi:10.1007/BF00975140

Melquíades Menezes, P. C., Ribeiro César Alves, É. S., de Araújo Neto, S. A., Barbosa Davim, R. M., & de Oliveira Guaré, R. (2017). Burnout syndrome: A reflective analysis. *Journal of Nursing UFPE / Revista de Enfermagem UFPE*, *11*(12), 5092–5101. doi:10.5205/1981-8963-v11i12a25086p5092-5101-2017

Menold, N., Bluemke, M., & Hubley, A. M. (2018). Validity: Challenges in conception, methods, and interpretation in survey research. *Methodology: European Journal of Research Methods for the Behavioral and Social Sciences*, *14*(4), 143–145. doi:10.1027/1614-2241/a000159

Merriman, J. (2015). Enhancing counselor supervision through compassion fatigue education. *Journal of Counseling & Development*, *93*(3), 370–378. doi:10.1002/jcad.12035

Mészáros, V., Ádám, S., Szabó, M., Szigeti, R., & Urbán, R. (2014). The Bifactor Model of the Maslach Burnout Inventory-Human Services Survey (MBI-HSS)-an alternative measurement model of burnout. *Stress & Health: Journal of the International Society for the Investigation of Stress*, *30*(1), 82–88. doi:10.1002/smi.2481

Moate, R. M., Gnilka, P. B., West, E. M., & Bruns, K. L. (2016). Stress and burnout among counselor educators: Differences between adaptive perfectionists, maladaptive perfectionists, and nonperfectionists. *Journal of Counseling & Development*, *94*(2), 161–171. doi:10.1002/jcad.12073

Moffic, H. S. (2018). Suicides and psychiatrists. *Psychiatric Times*, *35*(7), 18A-18B.

Montero-Marin, J., Asun, S., Estrada-Marcen, N., Romero, R., & Asun, R. (2013). Effectiveness of a stretching program on anxiety levels of workers in a logistic platform: A randomized controlled study. *Atencion Primaria*, *45*(7), 376–383. doi:10.1016/j.aprim.2013.03.002

Montero-Marin, J., Zubiaga, F., Cereceda, M., Demarzo, M. M. P., Trenc, P., & Garcia-Campayo, J. (2016). Burnout subtypes and absence of self-compassion in primary healthcare professionals: A cross-sectional study. *PLoS ONE*, *11*(6). doi:10.1371/journal.pone.0157499

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health*, *39*(5), 341–352. doi:10.1007/s10488-011-0352-1

Mullen, P. R., Morris, C., & Lord, M. (2017). The experience of ethical dilemmas, burnout, and stress among practicing counselors. *Counseling and Values*, *62*(1), 37–56. doi:10.1002/cvj.12048

NAMI (2018). National Alliance on Mental Illness general mental health facts. Retrieved from https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self & Identity*, *2*(3), 223. doi:10.1080/15298860309027

Nelson, J. R., Hall, B. S., Anderson, J. L., Birtles, C., & Hemming, L. (2018). Self–compassion as self-care: A simple and effective tool for counselor educators and counseling students. *Journal of Creativity in Mental Health*, *13*(1), 121–133. doi:10.1080/15401383.2017.1328292

Niebrugge, K. M. (1994). Burnout and job dissatisfaction among practicing school psychologists in Illinois.

O'Connor, P., Lydon, S., O'Dea, A., Hehir, L., Offiah, G., Vellinga, A., & Byrne, D. (2017). A longitudinal and multicentre study of burnout and error in Irish junior doctors. *Postgraduate Medical Journal*, *93*(1105), 660–664. doi:10.1136/postgradmedj-2016-134626

Ofonedu, M. E., Belcher, H. M. E., Budhathoki, C., & Gross, D. A. (2017). Understanding barriers to initial treatment engagement among underserved families seeking mental health services. *Journal of Child and Family Studies*, *26*(3), 863–876. doi:10.1007/s10826-016-0603-6

Ojedokun, O., & Idemudia, E. (2014). Burnout among paramilitary personnel in Nigeria: A perspective from Conservation of Resources Theory. *South African Journal of Psychology*, *44*(1), 106–117. doi:10.1177/0081246313516256

Ossebaard, H. C. (2000). Stress reduction by technology? An experimental study into the effects of brainmachines on burnout and state anxiety. *Applied Psychophysiology & Biofeedback*, *25*(2), 93–101. doi:10.1023/A:1009514824951

Owens, J. (2017). Life balance in nurse educators: A mixed-methods study. *Nursing Education Perspectives (Wolters Kluwer Health)*, *38*(4), 182–188. doi:10.1097/01.NEP.0000000000000177

Owen, F. K., & Çelik, N. D. (2018). Lifelong healthy lifestyle and wellness. *Yaşam Boyu Sağlıklı Yaşam ve İyilik Hali.*, *10*(4), 430–443. doi:10.18863/pgy.364108

Paris, M., & Hoge, M. (2010). Burnout in the mental health workforce: A review. *Journal of Behavioral Health Services & Research*, *37*(4), 519–528. doi:10.1007/s11414-009-9202-2

Pearson, G. S. (2015). Maintaining work/life balance in our professional practice. *Perspectives in Psychiatric Care*, *51*(3), 155–156. doi:10.1111/ppc.12129

Pines, A. M., & Aronson, E. (1988). *Career burnout: Causes and cures*, New York: Free Press.

Puig, A., Baggs, A., Mixon, K., Park, Y. M., Kim, B. Y., & Lee, S. M. (2012). Relationship between job burnout and personal wellness in mental health professionals. *Journal of Employment Counseling*, *49*(3), 98–109. doi:10.1002/j.2161-1920.2012.00010.x

Puig, A., Yoon, E., Callueng, C., An, S., & Lee, S. M. (2014). Burnout syndrome in psychotherapists: A comparative analysis of five nations. *Psychological Services*, *11*(1), 87–96. doi:10.1037/a0035285

Rabenu, E., & Aharoni-Goldenberg, S. (2017). Understanding the relationship between overtime and burnout. *International Studies of Management & Organization*, *47*(4), 324–335. doi:10.1080/00208825.2017.1382269

Richards, K. A. R., Hemphill, M. A., & Templin, T. J. (2018). Personal and contextual factors related to teachers' experience with stress and burnout. *Teachers & Teaching*, *24*(7), 768–787. doi:10.1080/13540602.2018.1476337

Richardson, C. M. E., Trusty, W. T., & George, K. A. (2018). Trainee wellness: Self-critical perfectionism, self-compassion, depression, and burnout among doctoral trainees in psychology. *Counselling Psychology Quarterly*, 1–12. doi:10.1080/09515070.2018.1509839

Robinson SE, Roth SL, Keim J, Levenson M, Flentje JR, & Bashor K. (1991). Nurse burnout: Work related and demographic factors as culprits. *Research in Nursing & Health*, *14*(3), 223–228. doi:10.1002/nur.4770140309

Rodrigues, H., Cobucci, R., Oliveira, A., Cabral, J. V., Medeiros, L., Gurgel, K., … Gonçalves, A. K. (2018). Burnout syndrome among medical residents: A systematic review and meta-analysis. *PLoS ONE*, *13*(11), 1–17. doi:10.1371/journal.pone.0206840

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice*, *46*(3), 168–174. doi:10.1037/a0039297

Saijo, Y., Chiba, S., Yoshioka, E., Kawanishi, Y., Nakagi, Y., Itoh, T., … Yoshida, T. (2014). Effects of work burden, job strain and support on depressive symptoms

and burnout among Japanese physicians. *International Journal Of Occupational Medicine And Environmental Health, 27*(6), 980–992. doi:10.2478/s13382-014-0324-2

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, 54–61. doi:10.1016/j.childyouth.2014.12.023

Salyers, M. P., Flanagan, M. E., Firmin, R., & Rollins, A. L. (2015). Clinicians' perceptions of how burnout affects their work. *Psychiatric Services, 66*(2), 204–207. doi:10.1176/appi.ps.201400138

Sanfey, H., Fromson, J., Mellinger, J., Rakinic, J., Williams, M., & Williams, B. (2015). Surgeons in difficulty: An exploration of differences in assistance-seeking behaviors between male and female surgeons. *Journal of the American College of Surgeons*, *221*(2), 621–627. doi:10.1016/j.jamcollsurg.2015.02.015

Sangganjanavanich, V. F., & Balkin, R. S. (2013). Burnout and job satisfaction among counselor educators. *Journal of Humanistic Counseling, 52*(1), 67–79. doi:10.1002/j.2161-1939.2013.00033.x

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clinicians: Individual and organizational tools for self-care. *Trauma, 17*(2), 114–122. doi:10.1177/1460408614551978

Schalewski, L., Utt, J., & Valencia, B. (2018). Increasing survey data quality using screening validity questions. *Oracle: The Research Journal of the Association of*

Fraternity/Sorority Advisors, *13*(2), 18–28. Retrieved from https://cdn.ymaws.com/www.afa1976.org/resource/collection/0E038C73-3450-45DA- A3B4-C5C64D5ED39B/Oracle_2_2018.pdf

Schaufeli, W., Leiter, M., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International*, *14*(2–3), 204–220. doi:10.1109/emr.2010.5645750

Schreiber, M. L. (2018). Care and compassion for self: Nurses should look inward more often. *MEDSURG Nursing*, *27*(2), 75–75.

Shelledy DC, Mikles SP, May DF, & Youtsey JW. (1992). Analysis of job satisfaction, burnout, and intent of respiratory care practitioners to leave the field or the job. *Respiratory Care*, *37*(1), 46–60.

Sherry, A., & Henson, R. K. (2005). Conducting and interpreting canonical correlation analysis in personality research: A user-friendly primer. *Journal of Personality Assessment*, *84*(1), 37–48. doi:10.1207/s15327752jpa8401_09

Silbiger, A., & Pines, A. M. (2014). Expatriate stress and burnout. *The International Journal of Human Resource Management*, *25*(8), 1170–1183. doi:10.1080/09585192.2013.824911

Sim, W., Zanardelli, G., Loughran, M. J., Mannarino, M. B., & Hill, C. E. (2016). Thriving, burnout, and coping strategies of early and later career counseling center psychologists in the United States. *Counselling Psychology Quarterly*, *29*(4), 382–404. doi:10.1080/09515070.2015.1121135

Simmons, S. (2012). Striving for work-life balance. *AJN The American Journal of Nursing*, *112*(1), 25. doi:10.1097/01.NAJ.0000410173.98529.f6

Sluiter, J. K., Bos, A. P., Tol, D., Calff, M., Krijnen, M., & Frings-Dresen, M. H. W. (2005). Is staff well-being and communication enhanced by multidisciplinary work shift evaluations? *Intensive Care Medicine*, (10), 1409. doi:10.1007/s00134-005-2769-z

Spielberger, C. D., Gorsuch, M. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the state-trait anxiety inventory*: *Sampler set.* Redwood City: Mind Garden Consulting Psychologist Press, Inc.

Starmer, A. J., Frintner, M. P., & Freed, G. L. (2016). Work–life balance, burnout, and satisfaction of early career pediatricians. *Pediatrics*, *137*(4), 1–10. doi:10.1542/peds.2015-3183

Stuntzner, S. (2014). Compassion & self-compassion: Exploration of utility as potential components of the rehabilitation counseling profession. *Journal of Applied Rehabilitation Counseling; Manassas*, *45*(1), 37–44.

Stuntzner, S. (2017). Compassion and self-compassion: Conceptualization of and application to adjustment to disability. *Journal of Applied Rehabilitation Counseling; Manassas*, *48*(2), 15–25.

Swift, J. K., & Parkin, S. R. (2017). The client as the expert in psychotherapy: What clinicians and researchers can learn about treatment processes and outcomes from psychotherapy clients. *Journal of Clinical Psychology*, *73*(11), 1486–1488. doi:10.1002/jclp.22528

Tabachnick, B. G., & Fidell, L. S. (2001). *Using multivariate statistics*. Boston: Pearson/Allyn & Bacon.

Tabachnick, B. G., & Fidell, L. S. (2013). *Using multivariate statistics*. Boston: Pearson Education.

Tajlili, M. H. (2014). A framework for promoting women's career intentionality and work-life integration. *Career Development Quarterly*, *62*(3), 254–267. doi:10.1002/j.2161-0045.2014.00083.x

Tajlili, M. H., & Baker, S. B. (2018). The future work-life balance attitudes scale: Assessing attitudes on work-life balance in millennial college women. *Journal of Asia Pacific Counseling, 8*(2), 57–74. doi:10.18401/2018.8.2.2

Tartakovsky, E. (2016). Personal value preferences and burnout of social workers. *Journal of Social Work*, *16*(6), 657–673. doi:10.1177/1468017315589872

Templeton, M. C., & Satcher, J. (2007). Job burnout among public rehabilitation counselors. *Journal of Applied Rehabilitation Counseling; Manassas, 38*(1), 39–45.

Testa, D., & Sangganjanavanich, V. F. (2016). Contribution of mindfulness and emotional intelligence to burnout among counseling interns. *Counselor Education and Supervision*, *55*(2), 95–108. doi:10.1002/ceas.12035

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, *36*(1), 58–77. doi:10.17744/mehc.36.1.p61m73373m4617r3

Tsai, H. H., Yeh, C. Y., Su, C. T., Chen, C. J., Peng, S. M., & Chen, R. Y. (2013). The effects of exercise program on burnout and metabolic syndrome components in banking and insurance workers. *Industrial Health*, *51*(3), 336–346. doi:10.2486/indhealth.2012-0188

Tucker, M. K., Jimmieson, N. L., & Bordia, P. (2018). Supervisor support as a double-edged sword: Supervisor emotion management accounts for the buffering and reverse-buffering effects of supervisor support. *International Journal of Stress Management*, *25*(1), 14–34. doi:10.1037/str0000046

Turgoose, D., & Maddox, L. (2017). Predictors of compassion fatigue in mental health professionals: A narrative review. *Traumatology*. doi:10.1037/trm0000116

Umene-Nakano, W., Kato, T. A., Kikuchi, S., Tateno, M., Fujisawa, D., Hoshuyama, T., & Nakamura, J. (2013). Nationwide survey of work environment, work-life balance and burnout among psychiatrists in Japan. *PLoS ONE*, *8*(2). doi:10.1371/journal.pone.0055189

U.S. Census Bureau. (2016). American Community Survey. One-Year Public Use Microdata Sample (PUMS) analyzed by IHS Markit. (2018).

Uurtio, V., Monteiro, J. M., Kandola, J., Shawe-Taylor, J., Fernandez-Reyes, D., & Rousu, J. (2017). A tutorial on canonical correlation methods. *ACM Computing Surveys*, *50*(6), 1–33. doi:10.1145/3136624

Van Dierendonck, D., Garssen, B., & Visser, A. (2005). Burnout prevention through personal growth. *International Journal of Stress Management*, *12*(1), 62–77. doi:10.1037/1072-5245.12.1.62

Van Rhenen, W., Blonk, R. W. B., van der Klink, J. J. L., van Dijk, F. J. H., & Schaufeli, W. B. (2005). The effect of a cognitive and a physical stress-reducing programme on psychological complaints. *International Archives of Occupational and Environmental Health*, *78*(2), 139–148. doi:10.1007/s00420-004-0566-6

Varney, E., & Buckle, J. (2013). Effect of inhaled essential oils on mental exhaustion and moderate burnout: a small pilot study. *Journal of Alternative and Complementary Medicine*, *19*(1), 69–71. doi:10.1089/acm.2012.0089

Viehl, C., Dispenza, F., McCullough, R., & Guvensel, K. (2017). Burnout among sexual minority mental health practitioners: Investigating correlates and predictors. *Psychology of Sexual Orientation and Gender Diversity*, *4*(3), 354–361. doi:10.1037/sgd0000236

Viehl, C., Dispenza, F., Smith, J., Varney, M., Guvensel, K., Suttles, M., … Kaufmann, J. (2018). How do sexual minority men experience burnout in the mental health field: A grounded theory study. *Journal of Gay & Lesbian Mental Health*, *22*(1), 52–70. doi:10.1080/19359705.2017.1357663

Walden University. (2016). *Social change.* Retrieved from: https://www.waldenu.edu/about/social-change

Wallace, S. L., Lee, J., & Lee, S. M. (2010). Job stress, coping strategies, and burnout among abuse-specific counselors. *Journal of Employment Counseling*, *47*(3), 111–122. doi:10.1002/j.2161-1920.2010.tb00096.x

Wardle, E. A., & Mayorga, M. G. . (2016). Burnout among the counseling profession: A survey of future professional counselors. *Journal on Educational Psychology*, *10*(1), 9–15. doi:10.26634/jpsy.10.1.7068

Wester, K. L., Trepal, H. C., & Myers, J. E. (2009). Wellness of counselor educators: An initial look. *Journal of Humanistic Counseling, Education & Development*, *48*(1), 91–109. doi:10.1002/j.2161-1939.2009.tb00070.x

Whitt-Woosley, A., & Sprang, G. (2018). Secondary traumatic stress in social science researchers of trauma-exposed populations. *Journal of Aggression, Maltreatment & Trauma*, *27*(5), 475–486. doi:10.1080/10926771.2017.1342109

Wilkerson, K. (2009). An examination of burnout among school counselors guided by stress-strain-coping theory. *Journal of Counseling & Development*, *87*(4), 428–437. doi:10.1002/j.1556-6678.2009.tb00127.x

Wilkinson, C. B., Infantolino, Z. P., & Wacha-Montes, A. (2017). Evidence-based practice as a potential solution to burnout in university counseling center clinicians. *Psychological Services*, *14*(4), 543–548. doi:10.1037/ser0000156

Wilski, M., Chmielewski, B., & Tomczak, M. (2015). Work locus of control and burnout in polish physiotherapists: The mediating effect of coping styles. *International Journal of Occupational Medicine & Environmental Health*, *28*(5), 875–889. doi:10.13075/ijomeh.1896.00287

Yadavaia, J. E., Hayes, S. C., & Vilardaga, R. (2014). Using acceptance and commitment therapy to increase self-compassion: A randomized controlled trial. *Journal of Contextual Behavioral Science*, *3*(4), 248–257. doi:10.1016/j.jcbs.2014.09.002

Yager, G. G., & Tovar-Blank, Z. G. (2007). Wellness and counselor education. *Journal of Humanistic Counseling, Education & Development*, *46*(2), 142–153. doi:10.1002/j.2161-1939.2007.tb00032.x

Young, S. (2015). Understanding substance abuse counselor turnover due to burnout: A theoretical perspective. *Journal of Human Behavior in the Social Environment*, *25*(6), 675–686. doi:10.1080/10911359.2015.1013658

Zahniser, E., Rupert, P. A., & Dorociak, K. E. (2017). Self-care in clinical psychology graduate training. *Training and Education in Professional Psychology*, *11*(4), 283–289. doi:10.1037/tep0000172

Zhang, J. W., & Chen, S. (2016). Self-compassion promotes personal improvement from regret experiences via acceptance. *Personality and Social Psychology Bulletin*, *42*(2), 244–258. doi:10.1177/0146167215623271

Zhao, J.-L., Li, X.-H., & Shields, J. (2018). Managing job burnout: The effects of emotion-regulation ability, emotional labor, and positive and negative affect at work. *International Journal of Stress Management*. doi:10.1037/str0000101

Zołnierczyk-Zreda, D. (2005). An intervention to reduce work-related burnout in teachers. *International Journal of Occupational Safety and Ergonomics: JOSE*, *11*(4), 423–430. doi:10.1080/10803548.2005.11076661

Appendix A: Demographic Questionnaire

Please respond to the following questions in the space provided.

*If your primary professional identity is as a psychologist, marriage and family therapist, or social worker, unfortunately you are not eligible to participate in this study. Thank you for your time and interest.

1. Gender: ☐female ☐male ☐non-binary/third gender (feel free to specify_____)

☐prefer not to say

2. Age: _____ years old

3. State of residence: _____

4. Ethnicity:

☐Not Hispanic or Latino

☐Hispanic or Latino

5. Race:

☐White or Caucasian

☐Hispanic or Latino

☐Black or African American

☐American Indian or Alaska Native

☐Asian

☐Native Hawaiian or Pacific Islander

☐Some other race

☐Two races including Some other race

☐Two races excluding Some other race, and three or more races

☐Other _____

6. Marital Status:

☐Single

☐Married

☐Divorced

☐Widowed

☐Separated

☐Never Been Married

☐Partnered

7. Sexual Orientation:

☐Heterosexual

☐Lesbian/Gay

☐Bisexual

☐Transgender

8. What was your salary last year? _____

9. What is the current number of direct hours spent on counseling clients each week?

☐1-5 hours

☐5-10 hours

☐10-15 hours

☐15-20 hours

☐20-25 hours

☐25-30 hours

☐30-35 hours

☐35-40 hours

☐40+ hours

10. What is the current number of indirect hours spent each week on tasks such as documentation, report writing, and other miscellaneous tasks required for your role as a counselor?

☐1-5 hours
☐5-10 hours
☐10-15 hours
☐15-20 hours
☐20-25 hours
☐25-30 hours
☐30-35 hours
☐35-40 hours
☐40+ hours

11. What is the current number of hours you work per week?

☐ less than 10 hours
☐ 11 – 15 hours
☐ 16 – 20 hours
☐ 21 – 30 hours
☐ 31 – 39 hours
☐ 40 hours
☐ 41 – 50 hours
☐ 51 – 60 hours
☐ 61 – 70 hours
☐ 71+ hours

12. Years since completing your Master's degree:

☐Two to five years
☐Six to nine years
☐10-15 years
☐16-20 years
☐21-30 years
☐31-40 years
☐More than 40 years

13. Specialization in Master's degree:

☐Mental Health Counseling

☐Clinical Mental Health Counseling

☐School Counseling

☐Clinical psychology

☐Community psychology

☐Community Counseling

☐Human Service Counseling

☐Counseling psychology

☐Other: _____ (Please Specify)

14. Highest level of education:

☐Master's degree

☐ Education Specialist Certificate (Ed.S.)

☐Doctor of Philosophy

15. Was your degree accredited by any of the following accrediting bodies?

☐CACREP

☐APA

☐COAMFTE

☐CORE

☐Other: _____ (Please Specify)

☐None

16. Clinical license obtained:

☐***provisional clinical licensure*** (i.e. ALC, LPC, LAC, PCCI, LPCC, LACMH, LGPC, RMHC, LAPC, LPCA, PLPC, LLPC, LCCI, PLMHP, LPC/I, LPC-I, APC, LMHCA, PCT, or PPC)

☐ ***full clinical licensure*** (i.e. LCPC, LPCC, LACMH, LMHC, LIMHP, LCMHC, LPC-MH, LPC/MHSP, LPC)

☐None of the above

17. Additional clinical or clinical supervision licenses or credentials (choose as many as appropriate):

☐ACS

☐CADC

☐LPC-S

☐LPCC-S

☐NCC

☐MAC

☐CCMHC

☐RPT

☐RPT-S

☐Other: _____

18. Current mental health discipline (choose only one):

☐Clinical Mental Health Counseling

☐School Counseling

☐Counselor Education

☐Marriage and Family Therapy

☐Rehabilitation Counseling

☐Substance Abuse Counseling

19. Work place setting (choose only one):

☐Community Mental Health Center

☐Outpatient Hospital

☐School

☐Private Practice

☐Inpatient Psychiatric Hospital

☐Residential Treatment

☐Substance Abuse Treatment

☐Community/In-home

☐College/University Counseling Center

☐Online

20. Area of workplace:

☐Urban

☐Rural

☐Suburban

21. Which of the following are self-care practices you engage in?

☐Exercise

☐Reading

☐Music

☐Time with family/friends

☐Traveling

☐Other Hobby _____

22. How much time is spent on self-care each week?

☐ less than 1 hour

☐ 1 – 5 hours

☐ 6 – 10 hours

☐ 11 – 15 hours

☐ 16 – 20 hours

☐ 21 – 30 hours

☐31+ hours

Appendix B: Counselor Burnout Inventory

Counselor Burnout Inventory

Counseling Program

Korea University

Instructions: This questionnaire is designed to measure the counselor's burnout level. There are no right or wrong answers. Try to be as honest as you can. Beside each statement, circle the number that best describes how you feel.

	1 Never True	**2 Rarely True**	**3 Sometimes True**	**4 Often True**	**5 Always True**
1. Due to my job as a counselor, I feel tired most of the time.	1	2	3	4	5
2. I feel I am an incompetent counselor.	1	2	3	4	5
3. I am treated unfairly in my workplace.	1	2	3	4	5
4. I am not interested in my clients and their problems.	1	2	3	4	5
5. My relationships with family members have been negatively impacted by my work as a counselor.	1	2	3	4	5
6. I feel exhausted due to my work as a counselor.	1	2	3	4	5
7. I feel frustrated by my effectiveness as a counselor.	1	2	3	4	5

8. I feel negative energy from my supervisor.	1	2	3	4	5
9. I have become callous toward clients.	1	2	3	4	5
10. I feel like I do not have enough time to engage in personal interests.	1	2	3	4	5
11. Due to my job as a counselor, I feel overstressed.	1	2	3	4	5
12. I am not confident in my counseling skills.	1	2	3	4	5
13. I feel bogged down by the system in my workplace.	1	2	3	4	5
14. I have little empathy for my clients.	1	2	3	4	5
15. I feel I do not have enough time to spend with my friends.	1	2	3	4	5
16. Due to my job as a counselor, I feel tightness in my back and shoulders.	1	2	3	4	5
17. I do not feel like I am making a change in my clients.	1	2	3	4	5
18. I feel frustrated with the system in my workplace.	1	2	3	4	5
19. I am no longer concerned about the welfare of my clients.	1	2	3	4	5
20. I feel I have poor boundaries between work and my personal life.	1	2	3	4	5

Preliminary Scoring Information for the Counselor Burnout Inventory

This inventory is designed to assess the five dimensions of counselor burnout.

Dimension 1 = Exhaustion

Item 1, Item 6, Item 11, Item 16

Dimension 2 = Incompetence

Item 2, Item 7, Item 12, Item 17

Dimension 3 = Negative Work Environment

Item 3, Item 8, Item 13, Item 18,

Dimension 4 = Devaluing Client

Item 4, Item 9, Item 14, Item 19

Dimension 5 = Deterioration in Personal Life

Item 5, Item 10, Item 15, Item 20

From: 이상민[교수 / 교육학과]
Sent: Wednesday, November 21, 2018 03:38 AM
To: Sarah Silva
Subject: Re: Access to CBI for Dissertation Study

You have my permission to use CBI for your dissertation research.

Best regards,

Sang Min Lee.

2018 년 11 월 21 일 (수) 오전 12:10, Sarah Silva <sarah.silva@waldenu.edu>님이 작성:

> Hello Dr. Lee,
>
> I am reaching out to inquire about receiving access to the CBI for my dissertation study. I will be using it to do a canonical correlation on counselors between burnout, self-compassion, and life-balance.
>
> Let me know if you have any questions.
>
> Thanks so much.
>
> Sarah
>
> **Sarah Silva, MA, LCPC**
> PhD Student
>
> Counselor Education & Supervision
>
> Walden University
>
> Sent from Mail for Windows 10

Appendix C: Juhnke-Balkin Life Balance Inventory

Juhnke-Balkin Life Balance Inventory

Below, please circle the boxed answer that best matches how you feel for each of the 72 questions.

(Circle the boxed answer below which best matches how you feel)

1. My future looks exciting to me.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
2. I am able to make satisfying choices regarding my life.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
3. Within the last six months I have not misused prescription drugs.	Strongly Agree	Agree	Neither Agree or	Disagree	Strongly Disagree

			Disagree		
4. I am comfortable with my spiritual – religious beliefs.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
5. Family and/or friends who know me well would say I am an unhappy person.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
6. I often awaken at least once a night and have difficulty falling back to sleep.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
7. I am good at what I do in the workplace.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
8. I do at least one fun activity each day (e.g., go for a walk, read the paper, etc.).	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
9. I experience happiness each day.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
10. I enjoy life.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
11. Most people who know me well believe that I have healthy habits.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
12. My marital partner or significant other and I have a good relationship.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
13. My spiritual - religious beliefs bring me feelings of purpose.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
14. I am unhappy with my appearance.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
15. The frequency of my sexual experiences is good.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
16. Very close friends and/or family tell me I need to relax more.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
17. My spiritual – religious beliefs provide little comfort.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
18. I usually do not get enough sleep.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
19. I derive satisfaction from my work.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
20. Most weeks I spend less than $10 on alcohol or nondoctor prescribed drugs.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
21. I exercise on a regular basis.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
22. Family and/or friends who know me well say	Strongly	Agree	Neither	Disagree	Strongly

that I am a happy person.	Agree		Agree or Disagree		Disagree
23. I have a difficult time forming friendships or relationships.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
24. I have healthy ways to relieve my stress.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
25. I am in relatively good shape.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
26. One time per week or more, I wish I were not alive.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
27. Within the last six months I have attempted to "cut down" on my alcohol or drug use.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
28. I have chosen a vocation that matches who I am.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
29. Within the last year I have not angered anyone due to my drinking or drugging.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
30. Family members and/or friends who rarely drink alcohol or use nonprescribed drugs have recently expressed concerns about my drinking or drugging behaviors.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
31. My sexual experiences frequently are disappointing or nonexistent.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
32. 33. I enjoy sex.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
33. I worry that stressful events in my life will result in unhealthy decisions or negatively effect my health.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
34. I generally feel good about my eating habits.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
35. My marital partner or significant other loves me.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
36. My life feels hopeless.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
37. My current job is personally fulfilling.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
38. I have a satisfying amount of intimacy within my life.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
39. I usually feel refreshed when I awaken from sleep.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
40. I would say that I am one of the physically	Strongly Agree	Agree	Neither Agree or	Disagree	Strongly Disagree

healthiest persons in my age group.			Disagree		
41. I have a marital partner or significant other I trust and enjoy.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
42. I draw strength from my religious – spiritual beliefs.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
43. I look forward to spending time with my partner or significant other.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
44. I have good friends who I enjoy.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
45. I feel sad or "empty" most days.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
46. Most of my friends would say that I am a "good friend."	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
47. During the last year my drinking or drug use has hurt others.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
48. I am happy most of the day.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
49. My intimate experiences are rewarding.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
50. Within the last six months I have not felt significant feelings of depression.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
51. I would describe myself as a generally calm person.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
52. My friendships and interpersonal relationships with others are mostly rewarding.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
53. I generally find little sexual joy or satisfaction.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
54. I tend to overreact to stressful events.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
55. I rarely experience happiness in my day.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
56. I have few if any major aches or pains.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
57. I generally eat a healthy or balanced diet.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
58. Within the last six months I have not had significant feelings of anxiety.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
59. I manage my stress well.	Strongly	Agree	Neither	Disagree	Strongly

	Agree		Agree or Disagree		Disagree
60. My marital partner or significant other and I are not very compatible.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
61. Even when I am tired I have difficulty falling asleep.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
62. Family and/or friends who know me well would say that I am in good physical condition.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
63. I really do not have any spiritual or religious beliefs.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
64. I would say I am a "healthy sleeper" who gets enough sleep.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
65. Friends and/or family who know me well would say that I like my job or career.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
66. I feel tired often.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
67. I am optimistic about the future.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
68. I often become anxious or depressed when I think about my work.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
69. I often find my spiritual – religious beliefs cause me concern or dissatisfaction.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
70. I feel conflicted about my religious – spiritual beliefs.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
71. Overall, I would describe my friends as mentally healthy people.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree
72. I weigh at least 10 pounds more than I should.	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Thank you so very much for your help.

From: Sarah Silva
Sent: Sunday, April 7, 2019 06:47 PM
To: rsbalkin
Cc: Gerald Juhnke
Subject: Re: Email Confirmation to Use JBLI

Hello Dr. Balkin and Dr. Juhnke,

Thank you for allowing me to utilize the JBLI for my dissertation survey research study. I agree to the two stated conditions in your email.

I look forward to sharing my results with you.

Sarah Silva

Get Outlook for Android

From: rsbalkin <rsbalkin@olemiss.edu>
Sent: Sunday, April 7, 2019 3:19:58 PM
To: Sarah Silva
Cc: Gerald Juhnke
Subject: Email Confirmation to Use JBLI

Hi Sarah,

On behalf of Dr. Gerald Juhnke and myself, we grant you permission to use the JBLI for your dissertation research contingent upon your agreement with the following:

1. Use of the JBLI will fit the intended purposes of the instrument (e.g., Davis, Balkin, & Juhnke, 2014).
2. You will share de-identified data with Drs. Richard S. Balkin and Gerald A Juhnke for the purposes of furthering the development and utilization of the JBLI.

Truly,

Rick

--
Richard S. Balkin, Ph.D., LPC, NCC
Editor, Journal of Counseling & Development
Fellow, American Counseling Association
Professor and Doctoral Program Coordinator

Appendix D: Self-Compassion Scale

(Self-Compassion Scale)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				Almost always
1	2	3	4	5

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items (reverse scored): 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items (reverse scored): 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items (reverse scored): 2, 6, 20, 24

To compute a total self-compassion score, take the mean of each subscale, then compute a total mean.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the scores of the total mean is used.)

To Whom it May Concern:

Please feel free to use the Self-Compassion Scale in your research. You can e-mail me with any questions you may have. I would also ask that you please e-mail me about any results you obtain with the scale, and would appreciate it if you send me a copy of any article published using the scale. The appropriate reference is listed below.

Best,

Kristin Neff, Ph. D.
Assistant Professor
Educational Psychology Dept.
University of Texas at Austin
1 University Station, D5800
Austin, TX 78712

e-mail: kristin.neff@mail.utexas.edu
Ph: (512) 471-0382
Fax: (512) 471-1288

Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity, 2, 223-250.*