BURNING BRIGHTLY: A GROUNDED THEORY STUDY ON PROFESSIONAL COUNSELORS AND OVERCOMING BURNOUT

by

ANDREA D. G. WHITTEN

JUNFEI LU, COMMITTEE CHAIR
JOY J. BURNHAM, COMMITTEE CO-CHAIR
MILLIE DAWSON-HARDY
HEATHER FYE
ROBERT MCKINNEY

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ABSTRACT

Burnout is a prevalent issue in the counseling profession that inhibits counselor well-being, work satisfaction, job turnover, and clinical efficacy. Despite this phenomenon's pervasiveness and negative impact, relatively little is known about how counselors recover from burnout while remaining in the counseling profession. This study aimed to employ a grounded theory approach to explain the process of burnout recovery in practicing counselors. The study explored the lived experiences of six participants who had experienced burnout and recovered during their counseling careers. Data collection consisted of semi-structured interviews that were primarily concerned with participants' experiences of burnout and recovery. The data were analyzed using a three-step coding process. The following themes were constructed from the data: exhaustion, psychological symptoms, systemic factors, clinical disengagement, reduced clinical efficacy, recognition, advocacy, preparation for change, active recovery, and maintenance. Based on these findings, the theory, *Boiling Over: A Grounded Theory on Counselors and Overcoming Burnout*, was constructed. This theory explains the process of burnout recovery in practicing counselors. The two processes are illustrated in Figures 1 and 2. Figure 1 illustrates how the impact of systemic factors on counselors leads to the development of psychological symptoms, exhaustion, clinical disengagement, and reduced clinical efficacy experienced by participants during burnout. Figure 2 illustrates the process of burnout recovery in counselors, outlined in the grounded theory as a set of stages. Counselors enter burnout recovery in stage one, Recognition, but counselors may not move sequentially through the stages. Depending on the circumstances, counselors may repeat stages or engage in aspects of

multiple stages at once. Following Recognition, counselors move through the remaining stages of burnout recovery: Advocacy, Preparation for change, Active recovery, and Maintenance. After discussing these results, recommendations, and implications for counselor educators and supervisors, practicing counselors, the mental health system, and researchers are presented.

Keywords: counselor, counseling, burnout, burn out, burnout recovery, burn out recovery

DEDICATION

This dissertation is dedicated to my father, Gerald Gregg, whose unwavering pride in me inspired me to pursue my greatest dreams.

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CHAPTER I:

INTRODUCTION

It is estimated that 67 of every 100 professional counselors experience severe burnout at some point in their careers (Morse et al., 2012; Yang & Hayes, 2020). Individuals suffering from burnout experience exhaustion, withdrawal from work, depersonalization, and diminished sense of personal accomplishment (Baker & Gabriel, 2021; Maslach et al., 2001; Maslach & Leiter, 2016, Reyes Ortega et al., 2019). Maslach and Leiter (2016) have defined burnout as a work-related phenomenon resulting from prolonged exposure to interpersonal stress in one's work. Burnout occurs across professions but is most common in occupations where individuals work closely with people, commonly known as the helping professions. Those individuals who frequently exercise the most empathy as part of their work are most likely to develop burnout (Figley, 2015). Burnout has a negative impact on clinicians' physical and psychological well-being, effectiveness with their clients, and job satisfaction (Yang & Hayes, 2020). Burnout has received increasing attention in the mental health field due to its impact on public health, and ongoing research has developed an understanding of its symptoms and factors contributing to its development (Acker, 2010; Hammond et al., 2018; Kaeding et al., 2017; Papathanasiou et al., 2017; Schonfeld et al., 2019; Tzeletopoulou et al., 2018; Yang & Hayes, 2020).

Burnout can be understood as the natural counterpoint to *engagement*, "an energetic state of work involvement with personally fulfilling activities that enhance one's sense of professional efficacy" (Maslach & Leiter, 2008, p. 498). If engagement is at the far-right end of the spectrum, burnout exists on the far left. First identified in healthcare workers in the 1970s (Freudenberger,

1974), burnout is characterized by three primary symptom clusters: emotional exhaustion, depersonalization, and a decreased feeling of personal accomplishment (Maslach & Jackson, 1981). The World Health Organization (2019) recently included burnout in its 11th revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. This further validates the recognition of burnout as a phenomenon that interferes with one's workplace functioning and overall quality of life.

Professional counselors may be uniquely vulnerable to the development of burnout. In a study on burnout in counselors-in-training, Wardle and Mayorga (2016) found that more than 85% of participants showed some level of burnout. This statistic is distressing, considering the participants had not even officially entered the field yet and were already experiencing symptoms of burnout. Professional counselors provide support, encouragement, and strategies to help clients work through stress and other negative emotions. Unfortunately, evidence suggests that counselors often do not provide themselves with the same level of care they provide to their clients (Barton, 2020). In a study of professional counselors in the United Kingdom, participants reported feeling isolated, having poor boundaries, lacking self-care and self-compassion, experiencing tension between caring for themselves and others, and harboring a belief that self-care is selfish (Barton, 2019).

The negative impact of burnout on professional counselors and their clients is far-reaching. In a literature review from 2009 to 2020, Yang and Hayes (2020) found that burnout negatively affected counselors' physical and psychological well-being, job satisfaction, job retention rate, and overall effectiveness with their clients. Additionally, Yang and Hayes (2020) found that counselor burnout hindered client engagement and therapeutic outcomes. Burned-out counselors may find themselves in a seemingly never-ending cycle of poor physical health and

burnout, with one issue continually exacerbating the other (Hammond et al., 2018). A burned-out counselor is also more likely to sacrifice time for relaxation and self-care to attend to perceived client needs which can worsen physical health issues (Kaeding et al., 2017).

In addition to physical health issues, burnout also increases counselors' risk of developing mental health issues such as depression, anxiety, and secondary traumatic stress (Fong et al., 2016; Hammond et al., 2018; Papathanasiou et al., 2017; Shoji et al., 2015; Tzeletopoulou et al., 2018). This information is distressing considering the impact it could have on one's personal and professional life. Moreover, burnout is not only detrimental to the afflicted counselor. Symptoms of burnout such as depersonalization, reduced sense of personal accomplishment, and decreased motivation and productivity have been shown to hinder counselors' ability to work effectively with their clients, decreasing positive outcomes for clients of burned-out counselors (Delgadillo et al., 2018; Hammond et al., 2018; Wampold, 2015).

Problem Statement

Previous research has indicated the prevalence and pervasiveness of burnout within the mental health profession (Figley, 2015; O'Connor et al., 2018; Wardle & Mayorga, 2016). Burned-out counselors experience problems at work and in their personal lives (Hammond et al., 2018). Additionally, counselors experiencing burnout pose a significant risk of harm or negligence to their clients (Delgadillo et al., 2018). To add to this concern, currently, there is no theory that explains the process by which counselors overcome burnout. We understand what burnout is in general terms, but our understanding of the process by which one may overcome burnout is inadequate (Ahola et al., 2017).

Purpose of the Study

This research aimed to explain how counselors experience and recover from burnout. The phenomenon of burnout is nuanced and multi-faceted, resulting in a unique experience for each counselor suffering from it (Barton, 2020; Morse et al., 2012; Yang & Hayes, 2020). While numerous qualitative and quantitative studies have described the experience of burnout, research has fallen short of providing a detailed account of how one may recover (Ahola et al., 2017; Yang & Hayes, 2020). This research aimed to further the current understanding of burnout and one's recovery from it.

Research Questions

This research posed two research questions at the outset of the study. The first research question centered around participants' lived experiences of burnout to further explore the burnout experience in counselors. Question 1 was "How do counselors experience burnout?" The second question centered around the participants' experiences of burnout recovery. Question 2 was "How do counselors recover from burnout?"

Significance of the Study

Conducting research to examine how professional counselors recover from burnout is essential for several reasons. First, this study has implications for counseling and burnout research. The existing literature has primarily focused on describing the characteristics of burnout and factors that may contribute to an individual's development of burnout symptoms (Yang & Hayes, 2020). This study aimed to address a gap in the literature by focusing specifically on professional counselors' recovery from burnout. A deeper understanding of burnout recovery is needed to develop frameworks for future research and interventions (Ahola et al., 2017).

Second, this research offered potential benefits to counselor educators who work with counselors-in-training. Gaining a better understanding of how professional counselors may recover from burnout may help counselor educators integrate this information into their coursework, policies, and programs (Maslach & Leiter, 2016). Third, this study offered potential benefits to practicing professional counselors by providing information on burnout recovery (Maslach & Leiter, 2016; Yang & Hayes, 2020). This may help counselors to alter, adapt, and improve their professional practices in such a way that may help them to prevent or recover from burnout themselves. Finally, this inquiry indirectly benefits clients served by the counseling community.

Based on the research previously discussed, it is reasonable to assume that counselors who are not experiencing burnout are less likely to cause harm to their clients (Delgadillo et al., 2018; Hammond et al., 2018; Wampold, 2015). By providing the counseling field with more information about burnout recovery, this study may improve the overall quality of care the counseling community can provide for their clients.

Assumptions

A constructivist approach guided this study. The constructivist approach maintains the following assumptions as it relates to qualitative inquiry (Creswell & Poth, 2018):

1. Assumptions of *ontology*: This research aimed to understand and access the realities and experiences of professional counselors who experience recovery from burnout related to their professional work.
2. Assumptions of *epistemology*: The researcher collected authentic accounts of professional counselors' burnout recovery experiences presented by the research participants.

3. Assumptions of *axiology*: The researcher maintained transparency in her values and biases regarding the topic under study and report them to the reader in a positionality and reflexivity statement.
4. Research reflexivity: The researcher shared her interest and background with the phenomenon under study to maintain transparency about her position as a licensed professional counselor (LPC) who identifies as having experienced burnout during her professional career.
5. Research subjectivity: The researcher recognized the value and essential role of examining subjectivity in effectively collecting, analyzing, and interpreting data.

Limitations and Delimitations

Creswell and Poth (2018) discussed three possible limitations that apply to all qualitative research designs: the integrity of research data, the quality of the research instrument, and the generalizability of research findings. Regarding the first limitation, it was essential to note that there was no way to guarantee participants' honesty or truthfulness with the researcher. About the second limitation, it was necessary to state that the researcher was the primary data collection instrument. Therefore, the findings of this study were as strong or weak as the researcher's skills. Finally, the generalizability of the research findings was a potential limitation given the small sample size (i.e., ten participants) in this study. This study was delimited to ten practicing professional counselors who have experienced and recovered from burnout in the last five years. This research was confined to interviewing 10 practicing counselors in the U.S. at the time of the study.

Operational Definitions

Abductive reasoning: Making an educated prediction based on incomplete observations (Charmaz, 2021).

Burnout: a work-related phenomenon resulting from prolonged exposure to interpersonal stress in one's work (Maslach & Leiter, 2016).

Depersonalization: cynicism, negative or inappropriate attitudes towards clients, irritability, loss of idealism, and withdrawal (Maslach & Leiter, 2016).

Decreased Personal Accomplishment: inefficacy, reduced productivity, low morale, and inability to cope (Maslach & Leiter, 2016).

Engagement: "an energetic state of work involvement with personally fulfilling activities that enhance one's sense of professional efficacy" (Maslach & Leiter, 2008, p. 498).

Exhaustion: wearing out, loss of energy, depletion, debilitation, and fatigue (Maslach & Leiter, 2016a).

Inductive reasoning: making a generalized conclusion based on a specific observation (Charmaz, 2021).

Counselor: individual who holds a license in their state of practice to provide services aimed at improving an individual's mental and emotional health. Counselors may hold various forms of licensure including but not limited to Licensed Professional Counselor (LPC), Licensed Clinical Professional Counselor (LCPC), Licensed Mental Health Counselors (LMHC), Licensed Independent Clinical Social Worker (LICSW), or Licensed Marriage and Family Therapist (LMFT). For this study, the terms "counselor" and "professional counselor" were used to describe all licensed, practicing counselors.

Summary

It has been established that burnout is prevalent among professional counselors (Figley, 2015; Wardle & Mayorga, 2016). Burnout results in adverse physical and mental health effects for professional counselors (Fong et al., 2016; Hammond et al., 2018; Kaeding et al., 2017; Papathanasiou et al., 2018; Shoji et al., 2015; Tzeletopoulou et al., 2018). Additionally, burnout inhibits counselors' abilities to work effectively with their clients, resulting in possible neglect or harm (Delgadillo et al., 2018; Hammond et al., 2018; Wampold, 2015). Previous research has established common characteristics and contributing factors of this condition (Yang & Hayes, 2020); however, research has failed to provide a detailed picture of the experience of burnout recovery in professional counselors. Therefore, further study was needed to examine the process through which professional counselors recover from burnout.

CHAPTER II:

LITERATURE REVIEW

Historical Overview

The syndrome of burnout first entered the research literature in the 1970s. Two seminal articles were published in the early 1970s, one by Freudenberger (1974) and the other by Ginsburg (1974). Freudenberger has been widely credited with introducing the term 'burnout' in his 1974 article, *Burnout: The High Cost of High Achievement*. In his original article, Freudenberger described burnout as "becoming exhausted by making excessive demands on energy, strength, or resources" in the workplace (Freudenberger, 1974, p. 159). Freudenberger (1974) described the syndrome of burnout as being characterized by several physical and behavioral symptoms, including exhaustion, headaches, gastrointestinal problems, trouble sleeping, shortness of breath, irritation, suspicion of others, overconfidence, cynicism, and depression. Additionally, Freudenberger (1974) believed that personality characteristics played a role in the development of burnout, stating that "the dedicated and the committed" (p. 74) were those most likely to experience burnout.

Freudenberger (1974) based his initial findings on his observations and personal experiences while working in a free clinic in New York City. Freudenberger described positions at the free clinic as physically and emotionally exhausting, with inadequate pay and long hours. He believed that work environments that required intensive emotion, empathy, personal commitment, and motivation likely led to an increased risk of burnout (Freudenberger, 1974; Heinmann & Heinmann, 2017). Freudenberger (1974) believed that workers in these settings

tended to set themselves up for the “burnout trap” (p. 74) by taking on too many responsibilities and working too intensely for an extended period due to a desire to be helpful. Therefore, Freudenberger posited that the intersection of work environment, client characteristics, and clinician personality created the perfect storm for the development of burnout.

Freudenberger (1974, 1977a, 1977b) examined the symptoms of burnout, factors that contributed to burnout, and strategies for burnout prevention. These themes dominated burnout research for roughly 50 years since Freudenberger’s initial work. Freudenberger pioneered burnout research, effectively predicting research conducted in the 40 years following his original article. Even so, burnout research has evolved substantially over the past 50 years. Freudenberger ushered in the first phase of burnout research, which was largely qualitative (Maslach & Leiter, 2016). It generated detailed descriptions of the burnout experience grounded in fieldwork, observation, and case studies (Edelwich & Brodsky, 1980; Freudenberger & Richelson, 1980; Guditus, 1981; Maslach, 1976; Pines et al., 1981).

In the late 1970s and early 1980s, Maslach and her colleagues continued research into burnout, agreeing with Freudenberger’s (1974, 1977a, 1977b) initial findings. Burnout can have severe consequences for those suffering from the syndrome, their clients, and their organizations (Jackson & Maslach, 1982; Maslach, 1976; Maslach & Jackson, 1979; Maslach & Pines, 1977; Pines & Maslach, 1978, 1980). Burnout can result in decreased quality of life and increased personal exhaustion, distress, interpersonal problems, job turnover, physical ailments, and abuse of substances. This early research helped expand the understanding of burnout as a syndrome of consistent symptoms and experiences (i.e., emotional exhaustion, decreased sense of personal accomplishment, and depersonalization).

Defining Burnout

Early exploratory research provided detailed descriptions of burnout syndrome based on observations, case studies, personal experience, and interviews (Maslach & Leiter, 2017). Over time, researchers were able to conceptualize burnout as a psychological phenomenon made up of emotions, attitudes, expectations, and motives that produced a negative experience for the individual resulting in distress, decreased functioning, and negative consequences (Maslach & Leiter, 2017). Additionally, researchers identified three dimensions of the burnout phenomenon: exhaustion, feelings of cynicism or depersonalization, and a decreased sense of personal accomplishment (Maslach & Jackson, 1981; Maslach, 1993). While several definitions of burnout were proposed in the early years of burnout research, these three dimensions appeared in many of them (Maslach & Leiter, 2017). Researchers continue to widely utilize this conceptualization in the burnout literature (Koutsimani et al., 2019).

Burnout vs. Compassion Fatigue

To properly define the phenomenon of burnout, it is important to differentiate it from compassion fatigue because the two terms are often utilized interchangeably in the mental health community (Robino, 2019). Conceptual confusion between the two phenomena often occurs because both are the result of individuals' experiences of prolonged stress related to their work; however, the symptoms of each differ significantly (Rivera-Kloeppel & Mendenhall, 2021). Figley (2002) defined compassion fatigue as "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal (e.g., anxiety) associated with the patient" (p. 1435). Compassion fatigue is conceptualized as a psychological response to hearing and holding empathetic space for the pain and suffering of another person (Figley,1995; Robino 2019). Compassion fatigue differs

from burnout in that it results in additional symptoms of feelings of helplessness and confusion, re-experiencing of the traumatic story, avoidance of reminders of the event, and chronic anxiety (Figley, 1995; Figley, 2002, Martin-Cuellar et al., 2019; Robino, 2019). These additional symptoms cause compassion fatigue to resemble secondary traumatic stress rather than burnout more closely. Although burnout may precede or co-occur with compassion fatigue, the differences in symptomology between the two phenomena call for clear differentiation (Figley & Figley, 2017).

Assessment of Burnout

Defining the characteristics of burnout prompted researchers to develop measures to assess them (Maslach & Leiter, 2017). In 1981, Maslach and Jackson published *The Measurement of Experienced Burnout*. This article introduced the field to the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981), an instrument that researchers can use to assess one's experience of burnout by measuring the three dimensions of burnout. The MBI was the first burnout measure based on a comprehensive program of psychometric research (Maslach & Jackson, 1981; Maslach et al., 1996). While the MBI (Maslach & Jackson, 1981) was specifically developed to assess the three dimensions of burnout, other researchers developed measures focused solely on the exhaustion dimension (e.g., Freudenberger & Richelson, 1980; Pines et al., 1981). There continues to be a distinction between measures that assess several dimensions of burnout and those that only assess one reflecting different conceptualizations of the burnout phenomenon (Leiter & Maslach, 2016; Maslach & Leiter, 2016; Maslach & Leiter, 2017).

There are many variations in conceptualizations of burnout and corresponding measures. Some researchers follow a multi-dimensional conceptualization like that of Maslach and Jackson

(1981). One such example is the Bergen Burnout Inventory (BBI) (Feldt et al., 2014) which measures three dimensions of burnout: work-related exhaustion, cynicism towards the meaning of one's work, and feelings of inadequacy at work. Alternatively, the Oldenburg Burnout Inventory (OLBI) (Halbesleben & Demerouti, 2005) measures two dimensions of burnout: exhaustion and disengagement. In comparison, others only assess the exhaustion dimension of burnout. For example, the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005) assesses physical and psychological exhaustion across three dimensions: personal, work-related, and client-related. Similarly, the Shirom-Melamed Burnout Questionnaire (SMBQ) (Shirom & Melamed, 2006) focuses on lessening physical, emotional, and cognitive resources.

These researchers developed inventories to measure the experience of burnout in human service professionals (Kristensen et al., 2005; Mashlach & Jackson, 1981; Shirom & Melamed, 2006); however, none of their conceptualizations were specific to professional counselors. Maslach and Leiter (2016) posited that burnout conceptualizations varied widely due to differences in the burnout experience from one profession to another. Lee et al. (2007) conceptualized counselor burnout as consisting of five dimensions: exhaustion, incompetence, negative work experience, devaluing client, and deterioration in personal life. Lee et al. (2007) developed the Counselor Burnout Inventory (CBI), the first inventory to examine the burnout experience specifically in professional counselors. Since its development, the CBI has become the most used instrument by researchers examining burnout in professional counselors (Bardhoshi et al., 2019; Fye et al., 2020).

Research Assessment vs. Clinical Diagnosis

All the previously discussed measures were developed to help researchers study the burnout phenomenon's nature, causes, and consequences. However, mental health professionals

have begun to call for a measure that will provide a clinical diagnosis for burnout, indicating that a person requires treatment (Maslach & Leiter, 2017). Unfortunately, there is currently no measure to establish a clinical diagnosis of burnout (Maslach & Leiter, 2017; van Dam, 2021). Burnout is not included as an official diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association, 2022), the most used diagnostic resource for mental health professionals in the United States. In the absence of a clinical assessment, three approaches have emerged to develop individual diagnosis: determining arbitrary cutoffs for "high" scores on previously established research measures, determining a set of scores that are correlated with an independent clinical diagnosis of burnout, or simplifying the conceptualization of the burnout phenomenon (Maslach & Leiter, 2017).

For the first approach, scores on research measures are divided into three categories: high, average, and low. Individuals who score in the high category are experiencing a severe case of burnout: that is, therefore, considered clinical burnout (Maslach & Leiter, 2017). In the second approach, patterns of scores are correlated with work-related neurasthenia, a diagnosis found in the *International Classification of Diseases* (ICD 11) (World Health Organization, 2019), serving as the equivalent of clinical burnout (Schaufeli et al., 2001, van Dam, 2021). Clinically validated cutoff scores were developed for each of the three MBI scales (Schaufeli et al., 2001). When utilizing this strategy, one is experiencing clinical burnout when one has a high score on the exhaustion MBI scale and a high score on at least one of the other two MBI scales (Roelofs et al., 2005). The third strategy has been to simplify the conceptualization of burnout by reducing it to the single dimension of exhaustion (Maslach & Leiter, 2017). For example, the primary symptoms of work-related neurasthenia are persistent fatigue and weakness (World Health Organization, 2019). Using this as the equivalent of clinical burnout reduces the

conceptualization of burnout to one's experience of exhaustion (Maslach & Leiter, 2017). Maslach et al. (2009) argued that this strategy undermined previously developed conceptualizations of burnout by ignoring the role of cynicism and the impact burnout had on professional efficacy.

Calls for burnout to be established as a medical diagnosis raise the question of whether burnout should be considered a mental illness (Maslach & Leiter, 2017). Numerous researchers have posed this question since the beginning of burnout research, given the link between burnout, anxiety, and depression (Maslach & Leiter, 2017). Despite much debate among practitioners and researchers, there continues to be no diagnostic standard for burnout (Arvidsson et al., 2016; Rotenstein et al., 2018; Shoman et al., 2021). Some have speculated that burnout is simply another form of depression; however, research has established a clear difference between burnout and depression (Bakker et al., 2000; Glass & McKnight, 1996; Leiter & Durup; 1994). These studies showed that burnout is specifically related to work context. This differs from depression which pervades every aspect of one's life. While the correlation between burnout and word-related neurasthenia may suggest that it is reasonable to view burnout as a mental illness, another point of view is that burnout causes mental dysfunction (Maslach & Leiter, 2017). Some researchers believe that burnout serves as a mediating state, precipitating anxiety, depression, low self-esteem, etc. (Korczak et al., 2010; Maslach & Leiter, 2017; van Dam, 2021).

Conceptual Models of Burnout

Identifying and defining the burnout phenomenon was the first phase of burnout research. Next, researchers sought to explain the phenomenon utilizing existing concepts and theories (Maslach & Leiter, 2017). Conceptualizations have varied, with researchers debating key theoretical points such as the definition of the phenomenon itself, how the phenomenon develops

over time, and which factors are key in the phenomenon's development (Maslach & Leiter, 2016; Maslach & Leiter, 2017)

Sequential Stage Models

Burnout was initially conceptualized as a series of stages that develop over time (Guditus, 1981; Maslach, 1982). Several models were developed based on this assumption, though they differed on each stage and how one might progress through the stages over time (Maslach & Leiter, 2017). The foundational assumption of the initial sequential stages model is that each stage precipitates the development of the next (Maslach & Leiter, 2017). The idea that burnout develops across a sequence of stages arose from early, exploratory qualitative interviews with human services workers in the 1970s and was conceptualized as the process model (Maslach, 1982).

According to the process model, burnout develops across three stages corresponding to each of the dimensions of the burnout experience: exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 1982). Emotional exhaustion occurs because workplace demands exceed the individual's emotional resources. As one attempts to cope with emotional exhaustion, they may withdraw, become cynical, and feel disconnected from their work, leading the individual to experience a lack of accomplishment, low efficacy, and failure (Maslach, 1982).

Another sequential stage conceptualization is the phase model of burnout. It differs from the process model (Maslach, 1982) in that it conceptualizes burnout as occurring in eight phases (Golembiewski & Munzenrider, 1988). The phase model utilizes the three burnout dimensions (Maslach & Jackson, 1982) and splits them into high and low categories, creating eight different patterns. Golembiewski and Munzenrider (1988) hypothesized that burnout began with depersonalization and cynicism, decreased personal accomplishment, and exhaustion.

As depicted in Table 1, the eight phases increase in severity of symptomology as they progress. The researchers specify that these eight phases do not necessarily occur in a straight path; rather, they may vary based on individual experience. The eight phases represent acute and chronic burnout experiences, with the latter occurring in phases I, II, IV, and VIII. Acute burnout experiences, on the other hand, may progress in myriad ways through the phases depending on individual and workplace factors (Golembiewski & Munzenrider, 1988).

An alternative sequential stage conceptualization is the transactional model of burnout (Guditus, 1981). According to the transactional model, the experience of burnout increases in severity in each stage, becoming more detrimental to the individual as the stages progress. The first stage is brought on by a discrepancy between work demands and personal resources. The second stage consists of exhaustion and anxiety in response to work-related stressors. Finally, the third stage includes a change in one's attitude and behavior as the individual begins to feel cynical and disconnected from their work. The transactional model of burnout serves as a conceptual bridge between models of burnout that focus on sequential stages and those that focus on the role of imbalances between work demands and resources in the development of burnout (Leiter & Maslach, 2016).

Imbalance Models

Two developmental models arose that focused on the role of imbalances between work demands and resources in one's development of burnout: the Conservation of Resources (COR) model (Hobfoll & Freedy, 1993) and the Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007). The COR model posits that burnout develops because of persistent threats to one's available resources. One will adjust to protect those resources when one's resources are threatened. The researchers found that even the threat of losing resources might initiate the

development of burnout (Hobfoll & Freedy, 1993). Similarly, the JD-R model suggests that burnout develops when there is an imbalance between one's work demands and the available resources to meet those demands. Inadequate resources leave one unable to address or reduce work demands leading the individual to develop burnout (Bakker & Demerouti, 2007).

A third model varies from the previously discussed imbalance models of burnout. The Areas of Worklife (AW) model focuses on imbalances between the individual and their job (Leiter & Maslach, 2004). Leiter and Maslach (2004) identified six areas where these imbalances occur: reward, values, control, workload, fairness, and community. Imbalances in these areas impact one's experiences of burnout. Therefore, the greater the imbalance between the individual and the job, the greater the likelihood of burnout. Conversely, the greater the fit between the individual and the job, the less likely it is for one to develop burnout (Leiter & Maslach, 2004). To operationalize this conceptual framework of burnout, the researchers developed the Areas of Worklife Scale (AWS) to assess the mismatch between an individual and their job across the six domains (Leiter & Maslach, 2004).

Multidimensional vs. One-Dimensional Models

Every conceptual model of burnout includes exhaustion as a key defining feature of the phenomenon (Maslach & Leiter, 2017). The exhaustion dimension captures the physical and emotional experience of feeling overwhelmed and depleted (Maslach & Leiter, 2016). So, it is unsurprising that exhaustion is the most reported and thoroughly analyzed dimension of burnout (Maslach & Leiter, 2017). As previously discussed, some measures of burnout only assess the exhaustion dimension because it is considered the sole defining criterion (Maslach & Leiter, 2017). Additionally, numerous studies focus on this single dimension as the defining characteristic of burnout (Bergman, 2001; Makikangas et al., 2012; Makikangas & Kinnunen,

2016). However, Maslach and Leiter (2017) have argued that while exhaustion was necessary to understand burnout, it was insufficient to conceptualize the phenomenon fully.

The depersonalization and inefficacy dimensions differentiate the experience of burnout from chronic exhaustion. Exhaustion captures the physical and emotional strain of burnout but does not reflect how burnout impacts one's relationship to their work (Maslach & Leiter, 2017). While those experiencing burnout are certainly exhausted, they have also lost a connection with their work resulting in cynicism and decreased feelings of personal accomplishment (Maslach & Leiter, 2017). Therefore, multi-dimensional burnout models fully describe the experience by capturing feelings of exhaustion, depersonalization, and inefficacy.

Researchers have explored the multiple dimensions of burnout in various patterns or combinations, resulting in the development of five specific burnout profiles that correspond to various MBI scale scores: burnout, disengaged, overextended, ineffective, and engaged (Maslach & Leiter, 2008; Maslach et al., 2018; Leiter et al., 2013; Leiter & Maslach, 2016). For instance, a full burnout profile is identified by the combination of high scores on the exhaustion and depersonalization scales and low scores on the personal accomplishment scales. Alternatively, a disengaged profile is identified by high scores on the depersonalization scale, with low scores on the other two dimensions (Maslach et al., 2018). A full summary of the various profiles can be found in Table 1. Longitudinal research has shown that individuals categorized into the disengaged and overextended profiles were more likely to experience changes in their level of burnout over a year (Maslach & Leiter, 2008). A follow-up study showed that the direction of those changes (i.e., whether the individual experienced burnout) over a year also had implications for the individual's long-term health (Leiter et al., 2013). These studies demonstrate

the importance of considering all three dimensions of burnout when conceptualizing the phenomenon.

Themes in Counselor Burnout Literature

The counseling profession has received substantial attention in burnout research over the years (Boy & Pine, 1980; Elman & Dowd, 1997; Kraus, 2005; Lee et al., 2010; Lent & Schwartz, 2012; O'Connor et al., 2018; Papathanasiou et al., 2017; Puig et al., 2012; Steel et al., 2015; Thompson et al., 2014; Wardle & Mayorga, 2016). Freudenberger (1974) discussed the inherent stress associated with caring for others. So, it is no surprise that professional counselors would be at an increased risk of developing burnout (Morse et al., 2012). Research specifically on counselor burnout has shown that its negative impact is far-reaching, affecting both the counselor and their clients (Maslach & Leiter, 2017; Yang & Hayes, 2020). Therefore, it is crucial to understand the causes, effects, preventive measures, and recovery methods for counselors experiencing this syndrome (Barton, 2020; Maslach & Leiter, 2017; Rollins et al., 2021).

Exploring the literature on burnout in professional counselors revealed several themes, including predictors of burnout, the impact of burnout, and burnout prevention (Yang & Hayes, 2020). Predictors of burnout include systemic factors and individual factors (Barton, 2020; Cardosa da Costa & Pinto, 2017; Gutierrez & Mullen, 2016; Landrum et al., 2012). The impact of burnout includes effects on counselors and effects on clients (Delgadillo et al., 2018; Papathanasiou et al., 2017; Tzeletopaulou et al., 2018).

Burnout prevention includes individual prevention strategies as well as supervision-based prevention strategies (Barton, 2020; Callendar & Lenz, 2018; Coaston, 2017; Dickinson & Kottman, 2021; Kovac et al.,2017; Lenz & Smith, 2010; Maslach & Leiter, 2016; McCarty et al.,

2022; Miller & Sprang, 2017; Newton et al., 2020; Ohrt et al.,2015; Rivera-Kloeppel, 2021). Individual prevention strategies discussed in prior research focused on the use of self-awareness and self-care (Baker & Gabriel, 2021; Barton, 2020; Coaston, 2017). These studies emphasize the importance of early intervention to increase the likelihood of these strategies being successful. Individual strategies alone may be insufficient (Baker & Gabriel, 2021). Therefore, research also explored the effectiveness of supervision-based strategies (Callendar & Lenz, 2018; Lenz & Smith, 2010; McCarty et al., 2022; Miller & Sprang, 2017).

Predictors of Counselor Burnout

In general, the cause of burnout is believed to be a mixture of personal and systemic issues (Cardosa da Costa & Pinto, 2017). Many issues may increase or decrease a counselor's likelihood of developing burnout. These predictive factors can be broken into the following categories: work factors and counselor factors (Yang & Hayes, 2020). Work factors include work environment, job demand, and level of support at work. Counselor factors include mental health history, coping resources, and personality (Barton, 2020; Gutierrez & Mullen, 2016; Landrum et al., 2012; Yang & Hayes, 2020).

Systemic Factors

One of the more prominent possible predictors of burnout from previous research studies is factors related to one's work (Yang & Hayes, 2020). Within the context of work factors, there are three issues that previous researchers were most interested in including work environment, job demand, and level of support at work (Hammond et al., 2018; Holman et al., 2018; Kim et al., 2018; Lent & Schwartz, 2012; Steel et al., 2015; Thompson et al., 2014; Warren et al., 2013). In the work environment category are the nature of the work setting and the characteristics of the work environment (Kim et al., 2018; Thompson et al., 2014). Under the category of job demands

are workload and caseload (Hammond et al., 2018; Holman et al., 2018; Kim et al., 2018; Steel et al., 2015). Under the category of support are co-worker support, administrative support, and clinical supervisor support (Fahy, 2007; Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011).

Work environment. The work environment has been examined as a potential predictor of burnout among professional counselors (Yang & Hayes, 2020). The first component of the work environment is the work setting. There are several settings in which a professional counselor may work, including private practice, inpatient care, academic settings, and community mental health centers. Numerous studies have found that counselors in private practice experience less burnout than in other settings (Craig & Sprang, 2010; Lent & Schwartz, 2012; Warren et al., 2013). However, the research is mixed regarding the differences between inpatient and outpatient settings. Some studies found that those working in inpatient settings experienced higher rates of burnout (Craig & Sprang, 2010). Other studies have concluded that counselors in outpatient settings experienced higher rates of burnout (Lent & Schwartz, 2012). Given these discrepancies, work environment characteristics may be more important than the work setting alone.

Work environment characteristics can vary widely from workplace to workplace and may play a role in the likelihood of a counselor developing burnout symptoms. For example, fast-paced, high-demand work environments are associated with an increased likelihood of organizational inefficiency and lack of supervisory support, which may increase a counselor's chance of developing burnout symptoms (Lent & Schwartz, 2012). Similarly, professional counselors who describe their work environment as providing high levels of autonomy and control report lower rates of emotional exhaustion and increased feelings of personal

achievement (Lasalvia et al., 2009; Rupert et al., 2009; Steel et al., 2015; Vilardaga et al., 2011). These studies indicate a strong relationship between counselors' perceptions of their work environment and the likelihood of developing burnout; however, there have been mixed findings regarding the importance of one's perception of their work environment. For example, Thompson et al. (2014) found that positive perceptions of one's work environment were associated with a decreased likelihood of experiencing burnout. Alternatively, Kim et al. (2018) did not find a significant relationship between one's perceptions of their work environment and emotional exhaustion, one of the subscales of the CBI (Lee et al., 2007). Work environment characteristics seem to predict a counselor's likelihood of developing burnout. However, the predictive accuracy of work environment alone has yet to be determined (Yang & Hayes, 2020).

Job demand. In considering the level of demand associated with one's work, researchers have examined both the physical and psychological demands associated with the work of counseling (Hammond et al., 2018; Holman et al., 2018; 2018; Kim et al., 2018; Steel et al., 2015; Vilardaga, 2011). In general, job demand can be broken down into workload and caseload categories (Hammond et al., 2018; Holman et al., 2018; Kim et al., 2018). One's perception of workload is related to the physical demands of the job and is often determined by the number of hours the counselor works per week. On the other hand, one's caseload is related to the psychological demands of counseling work and is determined by the total number of clients on a counselor's caseload (Yang & Hayes, 2020).

The literature supports a connection between perceptions of heavy work demands and emotional exhaustion regardless of the level of supervisory support provided to the clinician (Bonsaksen et al., 2021; Gibson et al., 2009; Steel et al., 2015). However, research has yielded mixed results regarding the relationship between job demand and feelings of personal

accomplishment and depersonalization. Both Gibson et al. (2009) and Steel et al. (2015) found no significant relationship between perceived job demands and feelings of personal accomplishment. Additionally, while Steel et al. (2015) found a significant positive relationship between perceived psychological job demand and depersonalization, Gibson et al. (2009) found no relationship between these two factors.

As previously discussed, a counselor's workload is the number of hours the clinician works each week (Yang & Hayes, 2020). Research into the relationship between workload and symptoms of burnout has shown a positive correlation between workload and emotional exhaustion (Hammond et al., 2018). Additionally, counselors' workloads have been shown to correlate negatively with feelings of personal accomplishment (Hammond et al., 2018; Kim et al., 2018). In 2013, Warren and colleagues found that counselors who worked less than 35 hours a week experienced lower emotional exhaustion and cynicism rates than counselors who worked more than 35 hours a week. Similarly, Hammond et al. (2018) conducted a qualitative study with six clinical psychologists who worked an average of 44 hours per week in private practice. Hammond et al. (2018) concluded that the psychologist's high workload contributed to the experience of burnout.

Another factor contributing to a counselor's job demand experiences is clinical caseload. Besides the counseling workload, the clinical caseload plays an important role in influencing the counselor's perception of work demands (Yang & Hayes, 2020). Acker (2010) examined the relationship between caseload and burnout in 591 clinical social workers. Acker found a significant positive relationship between the clinician's caseload size and personal exhaustion and depersonalization. Similarly, Kim et al. (2018) conducted a study with 733 professional counselors in community mental health agencies. This study showed a significant positive

relationship between caseload size and emotional exhaustion. Additionally, Kim et al. (2018) noted that counselors' reported sense of autonomy and perception of supervisory support did not offset their experience of personal exhaustion.

Support. Several studies have examined the relationship between perceived support in the workplace and counselors' development of burnout symptoms (Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011). Support can come from several places in a counselor's work environment, including co-workers, clinical supervisors, and administrative supervisors (Yang & Hayes, 2020). Research indicates that strong support systems in the workplace may offset the impact of some other variables leading to counselor burnout. For example, counselors who reported higher levels of perceived support from co-workers experienced lower rates of emotional exhaustion and increased feelings of personal accomplishment (Vilardaga et al., 2011).

Similarly, counselors who reported high levels of support from clinical and administrative supervisors also exhibited increased feelings of personal accomplishment and lower rates of emotional exhaustion (Gibson et al., 2009; Jovanovic et al., 2016). However, it is worth noting that increased support alone may not decrease all symptoms of burnout, especially when other factors, such as client characteristics, may exacerbate burnout symptoms. Vilardaga et al. (2011) found an inverse relationship between supervisory support and emotional exhaustion in a sample of substance abuse counselors. Still, no relationship was found with depersonalization or feelings of personal accomplishment. It is thought that the challenges associated explicitly with substance abuse treatment (i.e., high job turnover, demanding clients, and low salary) may be the cause of these findings (Fahy, 2007; Vilardaga et al., 2011).

Individual Factors

Numerous studies have examined the relationship between the characteristics of counselors and the likelihood of developing burnout symptoms (Figley & Figley, 2017; Hammond et al., 2018; Hensel et al., 2015; Sharpless & Barber, 2015; Warren et al., 2013). While the findings of these studies provided mixed results, the role of counselors' characteristics appears to be a significant variable in counselors' development of burnout. The themes found most often in the literature are the mental health history of counselors and their use of coping strategies (Barton, 2020; Baker & Gabriel, 2021; Figley & Figley, 2017; Hammond et al., 2018; Hensel et al., 2015; Sharpless & Barber, 2015; Thompson et al., 2014; Warren et al., 2013). Counselors' mental health history may lead to countertransference in the counseling relationship, increasing the counselor's risk of developing burnout (Hammond et al., 2018; Hensel et al., 2015; Sharpless & Barber, 2015; Warren et al., 2013). Counselors' use of coping skills may serve as a protective factor against burnout (Yang & Hayes, 2020); however, many counselors who have experienced burnout report difficulty utilizing these skills (Baker & Gabriel, 2021; Barton, 2020)

Mental health history. Research on the relationship between the mental health history of counselors and their chance of developing burnout is limited; however, the existing literature is thought-provoking. Counselors bring their life experiences into their work with clients (Figley, 1995). Many counselors even pursue counseling careers because of their past traumatic experiences or their own experiences with mental health issues (Esaki & Larkin, 2013). These experiences can lead clinicians to work with a specific population based on their personal experiences (Hensel et al., 2015). Unfortunately, these choices may lead the counselor into a situation where countertransference and burnout are likely (Hensel et al., 2015). Past trauma and

mental health issues may be triggered while working with clients who have similar experiences, making it difficult for the counselor to differentiate their emotional reactions from their clients (Sharpless & Barber, 2015).

Studies have shown that countertransference can increase burnout risk (Hammond et al., 2018; Warren et al., 2013). Hammond and colleagues (2018) found that four of the six participants in their qualitative study reported feelings of countertransference leading up to their development of burnout. Similarly, Warren et al. (2013) surveyed 298 counselors working with clients who had eating disorders. Warren and colleagues (2013) found that counselors who reported frequent, strong emotional reactions to their clients were at an increased likelihood of experiencing emotional exhaustion. Conversely, Choi et al. (2014) found that managing countertransference could be a protective factor against the development of burnout. Choi and colleagues (2014) postulated that countertransference could decrease a counselor's ability to cope with stress, making them more susceptible to emotional exhaustion and decreased feelings of personal accomplishment.

Past mental health history is not always an indicator of future burnout in professional counselors. In the previously discussed study, Warren et al. (2013) also found that counselors who had struggled with an eating disorder reported greater feelings of personal accomplishment than their colleagues when working with clients with eating disorders. Similarly, numerous studies have shown that counselors in recovery from substance abuse often experience an increased perception of personal accomplishment when working with clients with substance abuse diagnoses (Elman & Dowd, 1997; Laudet & White, 2008; Margolis et al., 2000). The research indicates that the experience of similar mental health issues between counselor and

client could be either helpful or harmful depending on how this factor intersects with other protective or risk factors (Figley & Figley, 2017; Yang & Hayes, 2020).

Use of coping strategies. The use of coping or self-care strategies to mitigate the effect of work-related stressors in counselors has been a key area of interest in the burnout literature (Yang & Hayes, 2020). The topics of coping and self-care will be revisited in the burnout prevention section; however, a lack of healthy coping resources is also implicated in predicting burnout. People typically engage in coping strategies when they experience stress. Unfortunately, not all coping strategies are helpful or healthy (Barton, 2020). Moreover, counselors-in-training are not always provided with the necessary training to practice self-care once independently working in the field (Barton, 2020).

Whether one's work causes it, chronic stress has been associated with burnout in professional counselors (Hammond et al., 2018). While no one can control all the external stressors in their job or life, one's behaviors, emotions, and thoughts in response to stress often dictate the amount of subjective distress experienced (Yang & Hayes, 2020). Therefore, coping resources of counselors are vital in determining their risk of developing burnout (Yang & Hayes, 2020). It could be assumed that because counselors spend so much time helping their clients develop healthy coping skills, they would naturally apply these same principles in their own lives (Barton, 2020). Unfortunately, many counselors do not give themselves the same understanding and compassion they provide for their clients (Adams, 2014).

Barton (2020) conducted a qualitative study with five professional counselors with at least eight years of practice experience. All participants reported feeling inadequately prepared to cope with the demands of counseling work. Additionally, the participants all reported viewing self-care as "selfish" and inherently at odds with their roles as helpers (Barton, 2020, p. 519).

Finally, these participants also recognized that these views were harmful to their overall well-being and ability to work with their clients effectively; however, they reported experiencing a disconnect between their knowledge and feelings in this area. Similarly, Baker and Gabriel (2021) conducted a qualitative study to examine counselors' use of self-care during distress. The researchers found that the participants lacked information and awareness of the importance of self-care practices. Additionally, the participants reported that they did not take time off work or engage in any self-care practices during personal distress (Baker & Gabriel, 2021). Maladaptive beliefs and coping strategies such as these have been associated with higher rates of burnout (Thompson et al., 2014).

Impact of Counselor Burnout

The impact of burnout is broad, producing deleterious effects for both counselors and their clients. In reviewing the literature, burnout's negative impacts on counselors can be broken into the following categories: physical, psychological, and work-related (Delgadillo et al., 2018; Hammond, 2018; Kaeding et al., 2017; Norcross & VandenBos, 2018; Papathanasiou et al., 2017; Tzeletopoulou et al., 2018). Additionally, the negative impact of burnout on clients can be summarized in the following categories: engagement in the therapeutic process and outcomes in therapy.

Effects on Counselors

Physical. Burnout can negatively impact the physical health of counselors and well-being in numerous ways. Several studies have noted burnout's physical symptoms, including flu-like symptoms, gastrointestinal distress, sleep problems, back pain, and neck pain (Acker, 2010; Hammond et al., 2018; Kaeding et al., 2017). The relationship between burnout and poor physical health may be self-perpetuating, with one factor exacerbating the other repeatedly.

Hammond et al. (2018) noted that counselors reported sleep difficulties when feeling burned out. These sleep disturbances contributed to difficulties with concentration and emotion regulation, worsening the counselors' experience of burnout.

Unfortunately, these self-perpetuating patterns appear common in the burnout experience. Kaeding et al. (2017) noted the relationship between the sedentary nature of counseling work and the experience of back and neck pain. These physical ailments are aggravated by emotional distress and exhaustion, two hallmark symptoms of burnout. Additionally, many counselors sacrifice time for relaxation to stay on top of professional responsibilities, putting them at greater risk of developing other physical symptoms (Kaeding et al., 2017). While regular exercise, a healthy diet, and a regular sleep schedule are recommended to combat the physical symptoms of burnout, these activities are often challenging for the burned-out counselor to do consistently (Norcross & Vandenbos, 2018).

The physical experience of burnout can be quite debilitating. Several qualitative studies have noted the physical symptoms of burnout and the physical experience of burnout in the body (Engebretsen & Bjorbaekmo, 2019; Kavalieratos et al., 2017). Engebretson and Bjorbaekmo (2019) examined the lived experiences of counselors suffering from burnout. Participants in Engebrestsen and Bjorbaekmo's study described the physical experience of burnout as feeling trapped in a body that could not do what they would like it to do. This experience was described as a "balancing act" of managing the counselor's desire to behave a certain way while coping with what their body could do (Engebretsen & Bjorbaekmo, 2019, p. 1472).

Psychological. Poor psychological health can be just as detrimental to the overall functioning of a professional counselor as poor physical health (Papathanasiou et al., 2017). Ongoing exposure to work-related stressors and burnout can deplete one's resources to cope with

daily personal and professional responsibilities making them more vulnerable to mental health problems (Hammond et al., 2018). Counselors experiencing burnout are at an increased risk of developing psychological health issues such as depression, anxiety, secondary traumatic stress, and general psychological distress (Fong et al., 2016; Hammond et al., 2018; Papathanasiou et al., 2017; Tzeletopoulou et al., 2018).

In a two-year longitudinal study on the relationship between burnout and depression, Fong et al. (2016) found that novice counselors struggling with burnout were more likely to develop depression. The researchers found a marked increase in rates of both burnout and depression in the first year of practice. The study demonstrated a similar trajectory of participants' experiences of burnout and depression over two years. The researchers noted that the experience of burnout and depression were related but separate, with each impacting a different aspect of participants' lives (i.e., burnout impacting work experiences and depression impacting personal experiences). The researchers hypothesized that the participants' experiences of depression were likely a consequence of burnout but noted that further study was needed to develop a better understanding of this relationship.

Given the correlation between burnout and other mental health issues, it can often be difficult to discern which issue developed first. Shoji et al. (2015) explored the directional relationship between burnout and secondary traumatic stress (STS) in a longitudinal study among human service workers. The study was conducted in two parts to obtain data about the participants' experiences of burnout or STS six months apart. The researchers found that participants' experiences of burnout symptoms predicted their development of STS symptoms six months later. Conversely, symptoms of STS were not found to predict the development of burnout symptoms six months later. These findings support the assumption that ongoing

exposure to work-related stress and burnout depletes one's internal resources, increasing the likelihood of developing additional mental health issues (Shoji et al., 2015).

Some studies have examined the impact of burnout on counselors' internal resources and ability to recover from work-related stress. Barton (2020) conducted a qualitative study that examined counselors' experiences of caring for their mental, emotional, and spiritual well-being while experiencing burnout symptoms. Participants reported difficulty setting boundaries, feelings of isolation, guilt around self-care practices, and trouble practicing self-compassion. Barton (2020) noted the importance of overcoming these obstacles through increased self-awareness, education on burnout, and normalization of counselor needs. Similarly, Hammond and colleagues (2018) found that participants reported psychological distress related to work and guilt around taking needed breaks from work. These two studies demonstrate the self-perpetuating pattern of burnout that must be broken if counselors are to be able to recover.

Work-related. Numerous studies have examined the relationship between burnout and job satisfaction, job turnover, and counselor effectiveness (Delgadillo et al., 2018; Lee et al., 2011; Salyers, Flanagan et al., 2015). Burnout is negatively correlated with job satisfaction (Delgadillo et al., 2018), unsurprisingly given that burnout is also associated with increased professional demands, decreased work autonomy, increased anxiety in session, increased over-time hours, and reduced supervision (Steel et al., 2015; Westwood et al., 2017). Earlier in this review, work conditions were discussed as a factor that could contribute to the development of burnout. This next section will explore how burnout can negatively impact counselors' job satisfaction and turnover.

In a study on the relationships between burnout, job satisfaction, and job turnover in 34 occupational therapists, Scanlan and Still (2013) found an association between job satisfaction

and burnout. The researchers found that counselors experiencing depersonalization and exhaustion were more likely to report low rates of job satisfaction. Participants who scored higher on the Oldenburg Burnout Inventory (OLBI) (Halbesleben & Demerouti, 2005) showed decreased scores on the Job Satisfaction Scale (JDSS) (MacDonald & MacIntyre, 1997). In a similar study, Delgadillo et al. (2018) examined the effects of burnout on counselors' job satisfaction in a sample of 49 professional counselors. The researchers found that counselors who reported higher ratings of depersonalization and emotional exhaustion and lower ratings of feelings of personal accomplishment experienced lower rates of job satisfaction. These studies support the relationship between burnout and overall job satisfaction. Given the low rates of job satisfaction in burned-out counselors, it is not a far leap to expect high turnover rates, and the research supports this.

Scanlan and Still (2013) also found high turnover rates in their sample of occupational therapists experiencing burnout symptoms. The researchers found that the most common reasons participants reported for leaving their jobs were supervision problems and chronic stress and fatigue related to work. The results indicated a positive relationship between turnover intention and symptoms of burnout. Additionally, the researchers found a negative relationship between turnover intention and job satisfaction. Greenham et al. (2019) found similar results in 98 school counselors. The researchers examined the relationship between perceived work stress and job turnover intention. Perceived work stress can be conceptualized as the effort one puts into job performance and the perceived pressure to over-commit to one's work (Greenham et al., 2019). The more effort and over-commitment a person experiences, the greater their work stress. While this is not a formal assessment of burnout, work stress positively correlates with burnout symptoms (Bardoshi et al., 2014). Additionally, Greenham et al. (2019) found that participants

who reported higher rates of work stress reported higher rates of job turnover intention as well. The findings of these studies support the relationship between symptoms of burnout, job satisfaction, and job turnover in mental health professionals.

Effects on Clients

Until now, we have primarily focused on the experience of burnout and its impact on professional counselors and other mental healthcare providers. Unfortunately, burnout affects the clinician and the client (Delgadillo et al., 2018; Salyers, Fukui, et al., 2015; Wampold, 2015). Burned-out counselors report feeling less effective in their work with clients (Delgadillo et al., 2018; Hammond et al., 2018), and this sense of decreased effectiveness is likely correct. Counselor burnout often results in reduced client engagement (Salyers, Fukui et al., 2015; Wampold, 2015) and poor treatment outcomes (Delgadillo et al., 2018; Salyers, Fukui et al., 2015).

Client engagement. Counselor burnout can harm client engagement in therapy, often resulting in the discontinuation of therapeutic services (Yang & Hayes, 2020). Salyers, Flanagan, and colleagues (2015) explored the effects of counselor burnout on clinical work in 120 professional counselors. The researchers found that burned-out counselors reported reduced empathy, communication, therapeutic alliance, and client engagement in the therapeutic process. Additionally, participants who reported higher levels of depersonalization were more likely to experience decreased client engagement. The researchers speculated that the clinician's experience of depersonalization reduced the therapeutic alliance and hindered client engagement in the therapeutic process. This speculation may have merit. Wampold (2015) extensively reviewed the literature on common therapeutic factors and their relationship to therapeutic outcomes. The therapeutic alliance was important in mediating other factors' effects. Clinicians

who developed a strong therapeutic alliance were repeatedly found to produce better client outcomes (Wampold, 2015).

Client outcomes. Client outcomes are arguably the most important variable to examine when determining the impact of counselor burnout on clients. If a client experiences a poor outcome from a therapeutic experience, they have not received the care they need and do not reach their therapeutic goals (Yand & Hayes, 2020). It is reasonable to assume that counselor burnout is associated with poor treatment outcomes for clients. This assumption has been substantiated in the literature (Delgadillo et al., 2018; Salyers, Flanagan et al., 2015; Yang & Hayes, 2020).

Delgadillo et al. (2018) examined the effect of counselor burnout on therapeutic outcomes in a sample of 49 counselors and 2,223 clients. The researchers found that counselors experiencing symptoms of burnout were more likely to produce poor treatment outcomes with their clients. Specifically, the researchers noted that counselors reporting high levels of depersonalization were more likely to have poor treatment outcomes. Delgadillo et al. hypothesized that high levels of depersonalization likely interfered with developing a strong therapeutic alliance, hindering the entire therapeutic process and obstructing therapeutic outcomes. Interestingly, counselor burnout was the only factor shown to have a relationship with therapeutic outcomes in this study. The researchers examined possible associations between therapeutic outcomes and caseload size, clinician experience, ethnicity, and age, but none correlated with treatment outcomes. Salyers, Flanagan, and colleagues (2015) found similar results in their study examining the relationship between burnout and clinical work. The researchers found that participants who reported fewer burnout symptoms experienced better treatment outcomes with their clients. Additionally, 68% of these participants believed

professional burnout hindered client outcomes (Salyers et al., 2015). The findings support the assumption that counselor burnout negatively impacts clients by decreasing the quality of care and interfering with clients reaching their counseling goals.

Treatment and Prevention

The previously discussed literature demonstrates the nature of the burnout experience and the cost of burnout to both counselors and clients. Given the scope and impact of counselor burnout, researchers have made a great effort to understand how burnout might be prevented or treated. Unfortunately, this research has yielded mixed findings, and further work is needed to establish consistent strategies to prevent or treat burnout in professional counselors (Newton et al., 2020; Maslach & Leiter, 2016; Rivera-Kloeppel, 2021). The following sections will explore the most relevant themes in counselor burnout prevention and treatment research, including the effectiveness of individual and supervision methods to prevent or alleviate counselor burnout.

Individual

Self-care is commonly discussed as the best defense against burnout and includes numerous coping resources and wellness strategies (Coaston, 2017). Practicing counselors and counselors in training are encouraged by the American Counseling Association (2014) and the Association for Counselor Education and Supervision (2011) to be self-aware of possible signs or symptoms of burnout in their professional work.

Early intervention is considered the best method to prevent burnout symptoms from taking a toll on the counselor or clients (Newton et al., 2020). In a study of 136 counselors in training, Newton et al. (2020) examined the relationship between three self-care strategies (i.e., mindfulness, emotional regulation, and social support) and symptoms of burnout (i.e., emotional exhaustion, depersonalization, and decreased feelings of personal accomplishment). The

researchers found significant relationships between all self-care strategies and symptoms of burnout, indicating that regular use of mindfulness, emotional regulation, and social support can be protective factors against burnout.

Barton (2020) also explored the importance of self-care practices in preventing and treating burnout in professional counselors. Barton's (2020) qualitative study examined the lived experiences of five professional counselors who had been practicing in the field for eight or more years. Participants reported the importance of learning to engage in self-care to mediate the stressors associated with the work of counseling. Interestingly, participants reported feeling inadequately prepared to care for themselves early in their careers (Barton, 2020). Participants discussed the personal and professional growth required to learn how to provide themselves with compassion and engage in regular self-care practices throughout their careers. Ultimately, participants reported the helpfulness of self-care practice in reducing their sense of work-related stress (Barton, 2020). This qualitative account provides a small glimpse into the real-world experience of burnout and the use of self-care practices to alleviate burnout symptoms.

While self-care practices may be beneficial in preventing or treating burnout, self-care is just one aspect of a holistic approach to burnout treatment and prevention (Baker & Gabriel, 2021; Barton, 2020). Some counselors experience guilt and shame concerning their experience of burnout symptoms and blame their burnout symptoms on their inability to perform adequate self-care practices (Miller & Sprang, 2017). Self-blame around burnout symptoms decreases help-seeking behaviors and likely prolongs the burnout experience (Coaston, 2017). Additionally, a counselor's perception of self-care practices as another responsibility to manage may increase stress levels for an emotionally exhausted clinician (Miller & Sprang, 2017). The focus on self-care as the only burnout prevention and treatment method ignores the systemic factors

contributing to burnout (Coaston, 2017). Therefore, we need to examine the supervisory and educational strategies for burnout prevention and treatment explored in the literature.

Education and Supervision

Clinical supervision supports practicing counselors and counselors in training in their personal and professional development (Bernard & Goodyear, 2018). Symptoms of burnout can be addressed through supervision, providing supervisees with much-needed support, encouragement, and guidance (Bernard & Goodyear, 2018). Given this, it makes sense that researchers have examined the use of supervision to prevent or treat burnout. So far, this research has yielded mixed results, and additional research is needed to establish the utility of supervision in burnout prevention and treatment.

Ohrt et al. (2015) explored the effects of a wellness intervention within group supervision over one semester with 88 counselors in training. The wellness intervention consisted of an hour-and-a-half psychoeducational presentation on burnout and wellness, goal development, and weekly supervision meetings. The goals of the intervention were to improve symptoms of burnout (i.e., depersonalization, exhaustion, and decreased personal accomplishment) and increase wellness in counselors in training. Unfortunately, the researchers found no difference between the control and treatment groups following the intervention. The intervention did not effectively improve symptoms of burnout or overall wellness. Additionally, the researchers found that the counselors in training reported increased emotional exhaustion in both groups by the end of the semester. While these results are disappointing, other studies have yielded more promising results.

The usefulness of supervision to prevent or treat burnout has also been examined by school counselors. Kovac et al. (2017) conducted a study to explore the mediating effects of

supervision on school counselors' experiences of occupational stress and burnout. Participants were separated into two groups: experimental and control. The experimental group participated in individual supervision for one hour a week for four weeks. The control group did not participate in supervision and conducted their work lives normally. The researchers found that the participants in the experimental group reported decreased perceptions of work-related stress. The experimental group's rate of burnout was not significantly reduced; however, the researchers noted non-significant decreases in burnout symptoms. These results indicated that the participants might have shown greater improvements in this area if the supervision intervention had been provided for a prolonged period (Kovac et al., 2017).

Over the last several years, additional research has been published regarding new models of supervision developed to address work-related stress and burnout (Callendar & Lenz, 2018; Lenz & Smith, 2010; McCarty et al., 2022; Miller & Sprang, 2017). These models are relatively new. The effectiveness of new models needs further research to provide insight into emerging research trends in burnout prevention and treatment. There are several models worth noting. Miller and Sprang (2017) developed a supervision model for counselors working with clients who have experienced trauma, assuming that these counselors would be at an increased risk of developing burnout symptoms. The Components-Based Practice and Supervision Model (CE-CERT) (Miller & Sprang, 2017) provides a practice, training, and supervision model that specifically targets the long-term impact of working with traumatic experiences. The CE-CERT model consists of five skills: experiential engagement, regulating rumination, intentional narrative, reducing emotional labor, and parasympathetic recovery (Miller & Sprang, 2017). The researchers hypothesized that practical skill development and use are needed for counselors to

recover from the inherent stress of trauma work. This model of supervision and practice requires follow-up studies to explore its efficacy and effectiveness.

The Wellness Model of Supervision (WELMS) was developed by Lenz and Smith (2010). WELMS addresses the development of wellness practices through the supervisory relationship. The WELMS emphasizes the supervisee's well-being, overall health, introspection, goals, and values (Lenz & Smith, 2010). WELMS is grounded in the Wellness Model (Myers, Sweeney, & Witmer, 2000). Callendar and Lenz (2018) evaluated the effectiveness of the WELMS on counselors' perceptions of their quality of life. The researchers conducted three case studies with counselors in training. Each participant engaged in supervision based on the WELMS for one hour a week for ten weeks. Results provided preliminary support for the WELMS in mediating the stress associated with counseling work. Participants did not experience an improvement in burnout symptoms related to ten weeks of supervision; however, weeks five and eight depicted weekly improvement in symptoms. Callendar and Lenz (2018) speculated that these differences could be attributed to when the supervision was administered in relation to the participants' training. Additional research is needed to establish the WELMS as an effective means of reducing burnout in training counselors (Callendar & Lenz, 2018).

McCarty et al. (2022) proposed Adlerian-Informed Supervision (AIS) to protect supervisees from burnout while working in the juvenile justice system. Adlerian-Informed Supervision (McCarty et al., 2022) integrates the discrimination model of supervision with the Respectfully Curious Inquiry/ Therapeutic Encouragement model (RCI/TE). This is an Adlerian supervision approach previously developed by Millerian and colleagues (2006). AIS (McCarty et al., 2022) aims to increase supervisees' experiences of the *Crucial C's*: connected, count, capable, and courageous (Dickinson & Kottman, 2021), which the researchers believe will

decrease supervisees' experiences of burnout symptoms and improve overall supervision outcomes. Within the RCI/TE framework, the supervisor engages the supervisee in collaborative communication to explore the supervisee's experiences of the *Crucial C's*. This framework encourages the supervisors to provide the supervisee with empathy, active listening, validation, and empowerment (McCarty et al., 2022). The researchers believe improving these factors will provide a strong protective resource against burnout in counselors in training.

Conclusion

This literature review explored the most prevalent themes and advances in burnout research up to this writing. The available literature has explored the nature of burnout, common factors contributing to the risk of burnout symptoms, the impact burnout has on counselors and clients, and methods of preventing and treating burnout individually and through education and supervision. While the literature on burnout in mental health professionals is expansive, we still lack a thorough understanding of how counselors recover from burnout once symptoms develop (Maslach & Leiter, 2017; Yang & Hayes, 2020).

CHAPTER III: METHOD

Introduction

This study aimed to explore the process through which counselors recover from burnout. For an overview, this chapter provides the following: (a) a restatement of the research questions, (b) a discussion of the method employed for the study, (c) an explanation of the study's methodology, (d) a rationale for the chosen method, (e) a discussion of the researcher's positionality concerning the present study, (f) a description of the research participants, (g) a discussion of the measures used during the pre-screening process (h) a description of data collection and analysis procedures, and (i) an exploration of ethical considerations and concerns of validity.

Research Questions

The research questions for this study were 1) how do counselors experience burnout; and 2) how do counselors recover from burnout?

Method Selection

Qualitative research allows the researcher to engage in a reflexive process privileging participants' stories and lived experiences to gain an in-depth and nuanced understanding of a given phenomenon (Charmaz, 2006; Creswell & Poth, 2018). In qualitative research, the researcher actively participates in the research process by gathering and interpreting data (Corbin & Strauss, 2014). Qualitative research uses an open, flexible design standing in contrast to the rigor of quantitative designs (Corbin & Strauss, 2014). Qualitative inquiry is primarily concerned

with understanding how different parts of a phenomenon come together to form the whole and how participants perceive a phenomenon (Merriam, 1998). Qualitative research utilizes a deductive reasoning strategy and focuses on building theory rather than testing theory (Merriam, 1998).

Qualitative methods allow researchers to explore participants' lived experiences (Corbin & Strauss, 2014). The emergent research design of qualitative methods allows researchers to collect and analyze data simultaneously (Hatch, 2002). This process enables researchers to maintain flexibility, allowing the data to unfold in potentially novel or unexpected ways. As data is collected and analyzed, the research is adjusted based on emerging data. Qualitative research is exploratory by nature (Algozzine & Hancock, 2017). This design enables the researcher to explore the phenomenon of burnout and burnout recovery without assumptions dictating the direction the data is allowed to go.

There are three reasons why a qualitative approach was adopted for the study. The primary motivation is that currently, no theories explain the process of burnout recovery in professional counselors, and qualitative inquiry enables the researcher to build a theory with the data collected. The second reason for using a qualitative approach is that the phenomenon of burnout recovery is explained and described more thoroughly through the narrative description. Finally, a third reason for using a qualitative approach is that the flexibility and openness of qualitative inquiry provide rich, robust data necessary for theory building.

As previously discussed, burnout research begins with qualitative inquiry, which provides future researchers with conceptual models to base later quantitative work (Maslach & Leiter, 2016). Early qualitative research has laid the foundation of burnout research because it provided detailed descriptions of real-world experiences with this phenomenon (Maslach & Leiter, 2016).

This study contributes to a similar foundational underpinning for future research on burnout recovery by exploring lived experiences of burnout and recovery in professional counselors.

Research Design

Theory explains phenomena, understands events, and explains behavior (Glaser & Strauss, 1967). Grounded theory is utilized to explain a phenomenon when no current theories exist to serve as a theoretical framework (Corbin & Strauss, 2008). A grounded theory study aims to develop a theory to explain the phenomenon under study (Charmaz, 2014). More than any other factor, theory construction differentiates grounded theory from other methods of qualitative research (Charmaz, 2021). Grounded theory was chosen as the most appropriate method for this study because there is currently no theory explaining the process through which counselors recover from burnout. A grounded theory design allows researchers to construct a theory grounded in the data provided by participants.

Grounded theory is "a generalized methodology, a way of thinking about and conceptualizing data" (Corbin & Strauss, 2014, p. 275). The grounded theory method develops theory systematically as data is collected and analyzed (Charmaz, 2014; Glaser & Strauss, 1967; Corbin & Strauss, 2014). The ongoing interaction between data and analysis allows the developing theory to evolve with the data (Corbin & Strauss, 2014). Qualitative research always provides detailed descriptions of participants' experiences; however, grounded theory takes this a step further by taking this information and utilizing it to create "explanatory theoretical frameworks" (Charmaz, 2006, p.6). Charmaz (2021) developed ten strategies to distinguish grounded theory from other forms of qualitative inquiry:

1. Simultaneous data collection and analysis;
2. Analytic focus on actions and processes rather than themes and structure;

3. Use of constant comparative methods;
4. Utilizing data to construct new conceptual categories;
5. Using systemic data analysis to develop inductive abstract analytical categories;
6. Identifying patterns within the collected data;
7. Focus on theory construction over a narrative description of existing theories;
8. Theoretical sampling;
9. Researchers search for variation in categories; and
10. Pursuit of developing categories rather than ensuring an empirical topic is covered.

These strategies inform the process of constructing grounded theory and differentiate grounded theory from other forms of qualitative research. It is important to remember that this primary purpose is theory development, not purely narrative description (Charmaz, 2014, 2021).

Glaser and Strauss (1967) contended that the grounded theory method produced a complete theory that fitted the data and was useful, conceptually dense, durable over time, flexible, and explanatory. Since grounded theory was first introduced in 1967, three branches of grounded theory have developed: classical grounded theory, Straussian grounded theory, and constructivist grounded theory (Charmaz, 2021). The next section will present a brief overview of constructivist grounded theory and a rationale for why constructivist grounded theory was the best fit for this study.

Constructivist Grounded Theory

Charmaz (2014, 2021) was a student of both Glaser and Strauss and developed her own adaptation of grounded theory, which she identified as constructivist grounded theory. Constructivist grounded theory utilizes the open-ended, comparative, inductive, and emergent

approach of Glaser and Strauss's (1967) original grounded theory while rejecting the notions of an objective external reality, neutral researcher, and detached pragmatism typically associated with original grounded theory (Charmaz, 2021). According to Charmaz (2014), "neither data nor theories are discovered" (p. 10). Instead, Charmaz (2014) asserted that theory was constructed based on collected data and the researcher's experiences, perspectives, and research practices.

Constructivist grounded theory assumes that social reality is multiple, processual, and constructed (Charmaz & Belgrave, 2019). Therefore, Charmaz (2014, 2021) asserted that the researcher's positionality (i.e., privileges, perspectives, and interactions) must be considered an intrinsic factor of the research process. Research is conducted within a particular situation and naturally includes what a researcher and participants bring to the research and do within the research process (Charmaz, 2014; Clarke, 2005). The research itself is constructed. This perspective encourages the researchers' reflexivity about their actions and decisions. Researchers must examine their privileges and preconceived ideas, which may influence data analysis (Charmaz et al., 2018).

The epistemological underpinnings of Charmaz's constructivist grounded theory differentiate it from Glaser and Strauss' (1967) original grounded theory (Charmaz, 2021). Constructivist grounded theory is built on the following pragmatic assumptions: (a) it takes a problem-solving approach, (b) it views reality as fluid, (c) it assumes a positioned and embodied knowledge producer, (d) it assumes multiple perspectives, (e) it aims to study people's actions to solve emergent problems, (f) it sees both facts and values as fundamental, and (g) it views truth as conditional (Charmaz, 2021). Additionally, constructivist grounded theory emphasizes the researcher's role in co-constructing data with participants, the researcher's subjectivity and role in the analytic process, and the researcher's use of reflexivity (Charmaz et al., 2018; Charmaz,

2021). Constructivist grounded theory utilizes inductive and abductive reasoning, drawing conclusions from small and sometimes incomplete observations (Charmaz, 2021). Finally, Charmaz's grounded theory situates theory and the research process within their creation's social, historical, cultural, and situational conditions (Charmaz, 2016).

Charmaz (2021) is critical of the prescriptive and rule-bound nature of Glaser and Strauss's grounded theory. Charmaz (2021) strongly believes in the need for flexibility during the research process asserting that this creates the potential for developing interpretations of the data. She encourages researchers to make peace with the ambiguity in data collection, coding, and analysis (Charmaz, 2014). Constructivist grounded theory allows researchers to create methodological strategies to answer emergent questions (Charmaz & Belgrave, 2019). Charmaz (2014) recommends flexible guidelines for constructing grounded theory rather than methodological rules and requirements that must be strictly adhered to.

The primary aim of constructivist grounded theory is to study participants' meanings, actions, and processes (Charmaz et al., 2018; Charmaz, 2021). This aligns well with the study's goal, which is to examine the process through which professional counselors recover from burnout. Constructivist grounded theory informs participant selection, interview protocols, and the process of data collection, coding, and reflexive memo writing. These methods provide the researcher with rich data from which theory can be constructed. The following sections will provide an in-depth discussion of these procedures.

Positionality

The topic of burnout became of interest to me early in my career as I developed symptoms of burnout within a year of graduating from my master's counseling program. Since then, I have experienced symptoms of burnout periodically, though never as severe as that first

year in practice. My firsthand experiences with burnout led me to pursue my Ph.D. in counselor education to help counselors-in-training develop the necessary skills to provide quality care to their clients while practicing in such a way as to reduce the likelihood of burnout. I have learned that burnout recovery is a multi-dimensional topic that few strongly understand.

Participants in this study were fully licensed counselors like me. While I did not have a previous personal relationship with any participants, we shared a career field and similar experiences working in this field. I may have lived experiences as a licensed counselor like the participants. Additionally, given my firsthand experiences with burnout and my role as a professional counselor and counselor educator, I was aware that I was entering into this study with preconceived ideas about the experience of burnout and the importance of this topic for the field of counseling and counselor education.

Participants

The study employed purposeful sampling during participant recruitment and selection, identifying individuals knowledgeable of the topic under investigation (Savin-Baden & Major, 2013). The researcher targeted individuals who met the following criteria: 1) holding a current license that enables them to provide counseling; 2) having worked directly with clients for at least five years; 3) selecting at least five of the six criteria listed on the evidence of past burnout experience survey (see Appendix B); 4) current Maslach Burnout Inventory (Maslach & Jackson, 1981) assessment results indicated the engaged profile (Leiter & Maslach, 2016) (see Table 1).

Participants were recruited from the following sources: the Counselor Education and Supervision Network Listserv (CESNET-L), the Alabama Counseling Association Listserv, Abundance Practice Builders Facebook group, the Group Practice Exchange Facebook group, LMHC Licensed Mental Health Counselors and LPC Central Facebook group, Therapists

Supporting Therapists Facebook group, and Private Practice Builders: The group for Therapists, Counselors, and Coaches Facebook group. CESNET-L was emailed to counselors, counselor educators, and supervisors throughout the United States. The Alabama Counseling Association's Listserv was emailed to current members of the Alabama Counseling Association. Each Facebook group consisted of licensed professional counselors throughout the United States. Participants were recruited through email, flyers, and social media posts. The following information was provided to all prospective participants: informed consent, anticipated time commitment, the purpose of the study, and inclusion/exclusion criteria for participation. Four participants were initially recruited for this study. Two additional participants were recruited toward the end of the data analysis to confirm that theoretical saturation had been reached. Therefore, a total of six participants were recruited. Each participant was offered a $25 Visa gift card as an incentive for participation in this study.

Instrumentation

Demographic Measure

Demographic information was collected from each participant upon recruitment for the present study. The demographic data that was utilized for this study included age, race/ethnicity (i.e., Caucasian, African American, Hispanic or Latino, Asian, Native American, Pacific Islander, and more than one race), gender (i.e., male, female, non-binary, transgender female, and transgender male), geographic location, work setting (i.e., private practice, inpatient mental health hospital or facility, outpatient agency, school/university, and other), and number of years working in the counseling profession.

Maslach Burnout Inventory Health Services Survey

The Maslach Burnout Inventory Health Services Survey (MBI-HSS) (Maslach et al., 1981) was developed to examine feelings of burnout among individuals working in human service professions (i.e., occupations where the primary job function is intense interaction with one's clients) (Maslach et al., 2018). While other versions of the MBI-HSS have since been developed, the MBI-HSS is the original and most widely utilized version. The reliability of the three scales of all versions of the MBI-HSS exceeds the minimum reliability recommendations for research instruments. In a review of 84 peer-reviewed studies, the average reliability estimates for the MBI-HSS were found to be in the high .80s for the emotional exhaustion scale and the high .70s for both the depersonalization and personal accomplishment scales (Wheeler et al., 2011).

The validity of the MBI-HSS has been established through numerous studies and reviews that showed the relationship between work attributes and experienced burnout (Maslach et al., 2018). Alcaron (2011) conducted a meta-analysis to examine the relationship between MBI-measured burnout and job demands and resources. Emotional exhaustion scores were found to be strongly correlated with increases in job demand. Additionally, resources were found to have a strong relationship with personal accomplishment scores. Emotional exhaustion and depersonalization were found to have a strong negative correlation with job satisfaction and organizational commitment and a moderate positive correlation with turnover intentions (Alcaron, 2011).

The MBI-HSS consists of 22 questions about how frequently one experiences burnout symptoms rated on a seven-point Likert scale ranging from *never* to *every day*. The MBI-HSS assesses three core aspects of the burnout experience: emotional exhaustion, depersonalization,

and lack of personal accomplishment (Maslach et al., 2018). The emotional exhaustion scale consists of nine items and measures one's feelings of being emotionally overextended and exhausted by one's work. High scores on this scale indicate higher levels of burnout. The depersonalization scale contains five items and measures one's experience of an unfeeling and impersonal response toward client care and treatment. Higher scores on this scale indicate higher levels of burnout. Finally, the personal accomplishment scale consists of eight items and measures one's feelings of competence and success in one's work with clients. Lower scores on this scale indicate higher levels of burnout (Maslach et al., 2018).

When examining the specific psychometric properties of the MBI-HSS, numerous studies have found the instrument to have a stable factor structure and be consistently valid and reliable across various settings and occupations (Maslach et al., 2018). Following its initial development, the three-factor structure of the MBI-HSS was verified with samples from different occupational groups (Golembiewski et al., 1983; King & Beehr, 1983). The three-factor model was also tested by a confirmatory factor analysis based on three composite score indicators for each of the MBI-HSS subscales (Lee & Ashforth, 1993). The researchers found that the emotional exhaustion and depersonalization scales were distinct but correlated with each other. Additionally, the emotional exhaustion and depersonalization scales were found to be more highly correlated with mental and physical strain measures than the personal accomplishment scale. The personal accomplishment scale correlated more highly with control-oriented coping.

During the initial development of the MBI-HSS, internal reliability was estimated using Cronbach's coefficient alpha (Cronbach, 1976) for the three subscales: .90 for the emotional exhaustion scale, .79 for the depersonalization scale, and .71 for the personal accomplishment scale (Maslach & Jackson, 1981). The standard error of measurement for each scale was 3.80 for

the emotional exhaustion scale, 3.16 for the depersonalization scale, and 3.73 for the personal accomplishment scale. Follow-up studies showed that reliability coefficients for each of the three domains remained internally consistent across a range of samples (Kalliath & O'Driscoll, 2000; Maslach et al., 2018; Meier, 1984). Test-retest reliability has also been examined in several studies (Maslach et al., 2018). Lee and Ashforth (1993) conducted a study with two test sessions separated by eight months. The researchers found that the test-retest reliability coefficients were .74 for the emotional exhaustion scale, .72 for the depersonalization scale, and .65 for the personal accomplishment scale. Other studies were conducted with three and six-month intervals, finding reliability coefficients of .59, .50, and .63, respectively, at six-month intervals (Leiter, 1990) and .75, .64, and .62 at three-month intervals (Leiter & Durup, 1996). More recently, Grau-Alberoloa and colleagues (2010) examined test reliability utilizing a *t*-test to determine whether mean scale scores differed significantly on assessments taken one year apart. The researchers found that only the means on the emotional exhaustion scale differed significantly ($p < .001$) between the two tests. Neither the depersonalization nor the personal accomplishment scales showed significantly different means between the first and second tests.

Convergent validity of the MBI-HSS has been established by correlating scale scores with others' observations, job conditions previously linked to burnout, and long-term burnout outcomes (Maslach et al., 2018). To examine the relationship between MBI scale scores and others' observations, researchers ask a knowledgeable observer to complete an assessment of their observations of the individual's behaviors which have been predicted to be linked to MBI scale scores. For example, police officers with high scores on the emotional exhaustion scale were reported to frequently come home upset, tense, exhausted, and complaining about work by their spouses (Jackson & Maslach, 1982; Maslach & Jackson, 1979). In two studies with a

sample of police officers and their spouses, spouses' ratings were strongly correlated with MBI scale scores.

The validity of the MBI-HSS is also established through data confirming the hypothesis that job conditions are related to the three burnout domains (Maslach et al., 2018). Research prior to the development of the MBI-HSS had predicted that increased client load would result in an increased experience of burnout (Maslach & Pines, 1977). Maslach and Jackson (1984) confirmed this pattern in a follow-up study. They found that large caseloads (i.e., 40 or more clients a day) were associated with high emotional exhaustion and depersonalization scores and low scores on the personal accomplishment scale. Lee and Ashforth (1996) conducted a meta-analysis of studies that utilized the MBI-HSS and reported that job demands were strongly related to MBI-HSS scale scores. A more recent meta-analysis conducted by Alcaron (2011) reviewing 30 years of burnout research found that job conditions such as role conflict, role ambiguity, and workload were consistently related to burnout, as indicated by MBI-HSS scores.

Long-term burnout outcomes have also supported the validity of the MBI-HSS (Maslach et al., 2018). High burnout scores have been associated with turnover intention, impairment in one's relationships, difficulty with family and friends, insomnia, increased substance use, and physiological health complaints. High burnout scores on the MBI-HSS were predictive of one's desire to leave one's job (Alcaron, 2011; Jackson & Maslach, 1982; Maslach & Jackson, 1979; Maslach & Jackson, 1984). The emotional exhaustion and depersonalization scales were most associated with turnover intentions (Alcaron, 2011; Jourdain & Chenevert, 2010). Leiter and Maslach (1988) found that individuals who had experienced negative interactions with their supervisors were more likely to have high scores on the emotional exhaustion scale. Conversely, Asai and colleagues (2007) found that physicians who felt they had plenty of time to

communicate with their patients demonstrated lower scores on the emotional exhaustion and depersonalization scales and higher scores on the personal accomplishment scale.

The relationship between burnout scores and having trouble in relationships with family and friends has also been supported by research. In a sample of police officers, higher burnout scores were associated with an increased likelihood of the police officer experiencing conflict with their spouse and children (Jackson & Maslach, 1982; Maslach & Jackson, 1979). In the same studies, police officers who reported high burnout scores were more likely to experience insomnia and report the use of alcohol and tranquilizers to cope with stress. Finally, high burnout scores have been associated with physiological health complaints. Kim and colleagues (2011) found that social workers with high burnout scores reported more physiological health complaints than their colleagues with low burnout scores. Additionally, Jourdain and Chenevert (2010) found that nurses with high burnout scores were more likely to report sleep, appetite, and health problems.

Burnout profiles. Leiter and Maslach (2016) published research identifying distinct burnout patterns along the burnout-engagement continuum. The researchers found that individuals with different MBI-HSS scale scores had different work-related experiences. This research developed five unique burnout profiles: engaged, ineffective, overextended, disengaged, and burnout. The engaged profile represents individuals with low scores on the emotional exhaustion and depersonalization scales and a high score on the personal accomplishment scale. The ineffective profile represents individuals with low to moderate scores on the emotional exhaustion and depersonalization scales and a low score on the personal accomplishment scale. The overextended profile represents individuals with a high score on the emotional exhaustion scale and low to moderate scores on the depersonalization and personal accomplishment scales.

The disengaged profile represents individuals with low to moderate scores on the emotional exhaustion and personal accomplishment scales and a high score on the depersonalization scale. Finally, the burnout profile represents individuals with high scores on the emotional exhaustion and depersonalization scales and a low score on the personal accomplishment scale (Maslach et al., 2018). Table 2 summarizes the five burnout profiles and their associated scale scores.

Table 1

Five Burnout Profiles and their Associated Scores

Profile Types	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Engaged	Low	Low	High
Ineffective	Low to Moderate	Low to Moderate	Low
Overextended	High	Low to Moderate	Low to Moderate
Disengaged	Low to Moderate	High	Low to Moderate
Burnout	High	High	Low

The MBI-HSS was administered online through the Mind Garden (mindgarden.com) administration and scoring service. Mind Garden developed a personal report for each participant's scale scores, including a summary of the participant's burnout profile. Only participants whose scores met the engaged profile were included in the study.

Pre-Screening

Each participant completed the demographic measure (see Appendix D), evidence of past burnout experience survey (see Appendix B), and the MBI-HSS (see Appendix E) electronically during the recruitment phase of participant selection to determine the selection of participants who met the necessary criteria for this study. The demographic measure and evidence of past

burnout experience survey was distributed via Qualtrics. The MBI-HSS was distributed and scored by Mind Garden (mindgarden.com). Individuals who met the following criteria were invited by email to set up a pre-screen phone call with the researcher: (a) holding a current license that enables them to provide counseling, (b) having worked directly with clients for at least five years, (c) selecting at least five of the six criteria listed on the evidence of past burnout experience survey, (d) and whose MBI-HSS score report indicated an engaged profile. During the pre-screening phone call, the researcher verified the information provided on the demographic measure and evidence of past burnout experience survey. Additionally, the researcher discussed the nature of the study and the necessary time commitment being made by participants to confirm participants' willingness to participate. Once this information was confirmed, the researcher set the day and time for the participant's initial interview.

Data Collection

The primary type of data collected was interview data. Data was analyzed as it was collected, with additional data collection being shaped by ongoing analysis. Interviews were conducted via Zoom, and all interviews were recorded and transcribed utilizing the Zoom transcription feature. Interview transcripts were compared to interview audio for accuracy and corrected by the researcher when needed. Interview recordings and transcripts were stored in UA Box.

The researcher utilized semi-structured interviews, which included focused questions about the participants' experience of burnout recovery while allowing the researcher to ask additional questions not included in the interview protocol. Such follow-up questions encouraged participants to clarify or provide more detail on their initial responses (i.e., 'Tell me more about

what you mean when you say'). The following questions were included in the initial interview protocol:

1. Tell me a little about what initially attracted you to the counseling profession.
2. Describe your work as a professional counselor.
3. Please recall a time in your career when you experienced burnout (exhausted, cynical, and/or ineffective).
    a. What physical symptoms do you recall experiencing?
    b. What emotional symptoms do you recall experiencing?
    c. How did your symptoms affect your relationship with clients?
    d. How did your experience of burnout affect your sense of effectiveness in your work?
4. Please describe your experience of recovering from burnout.
    a. What factors contributed to your recovery from burnout?
        i. What factors helped with your physical/emotional symptoms?
        ii. What factors helped with your relationship with your clients?
        iii. What factors helped with your feelings of effectiveness in your work?
5. What work-related factors, if any, contributed to your recovery?
    a. Work environment?
    b. Job demands?
    c. Support?
6. What personal factors, if any, contributed to your recovery?
    a. Coping strategies?
    b. Personal health?

7. What professional factors, if any, contributed to your recovery?
    a. Supervision?
    b. Training?
8. How does your experience of recovering from burnout influence your current practice to prevent exhaustion?
9. How does your experience of recovering from burnout influence your current work with clients?
10. How does your experience of recovering from burnout influence your current sense of effectiveness in your work?
11. What else do you think is important for me to know or understand about your recovery experience?
12. Do you have any questions for me?

As initial interviews were conducted, the researcher engaged in a parallel iterative process to inform future data collection based on developing codes, categories, and themes identified in initial participant interviews. Participants engaged in a second interview to provide insight into emerging categories. New paths of inquiry were introduced in the second round of interviews to deepen the researcher's understanding of emergent categories and inform future analysis. The following questions were included in the second interview protocol:

1. Has anything come to mind since our last interview about your burnout recovery experience that you would like to share?
2. Talk about your experience of realizing you were experiencing burnout. What helped you come to this realization?

3. What was your experience of asking for change within the systems that contributed to your development of burnout?
4. In what ways, if any, did these systems reinforce negative beliefs you held at the time?
5. What was your experience of feeling heard or valued while you were asking for change within these systems?
6. What was your experience of transitioning from looking for solutions/change within the system to looking for solutions outside the system?
7. What was your experience with guilt/shame during your recovery from burnout?
8. What helped you develop an understanding of what you wanted and needed during your recovery from burnout?
9. Talk about the process of developing a new self-care routine during your recovery from burnout.
10. What does your current practice of burnout prevention look like?
    a. Describe how you maintain your recovery from burnout.
11. What else do you think is important for me to know or understand about your recovery experience?
12. Do you have any questions for me?

Theoretical Sampling

Theoretical sampling occurs when the researcher adjusts data collection procedures to focus on saturating emerging categories (Charmaz, 2014). Theoretical sampling may involve interviewing initial participants more than once or recruiting additional participants. This study utilized theoretical sampling following initial interviews by constructing interview protocols based on previously collected data and conducting follow-up interviews with the initial

participants. Follow-up interviews focused on gaining a more in-depth understanding of participants' meanings. Interview protocols for follow-up interviews were developed to focus data collection on emergent categories. Additionally, the researcher took field notes during or immediately following each interview attending to the participants' use of body language and other non-verbal communication during the interview. These field notes were utilized during data analysis and aided in the construction of interview protocols for follow-up interviews.

Theoretical Concerns

The primary goal of grounded theory data collection strategies is to construct a theory, and interviewing is the main tool for developing focused data for generating conceptual categories (Charmaz, 2014, 2021). However, when focusing on theory construction, four theoretical concerns affect which data the researcher seeks out and how this data is collected: theoretical plausibility, direction, centrality, and adequacy (Charmaz, 2021). Charmaz (2014, 2021) recommends incorporating theoretical thinking throughout data collection. Theoretical concerns were woven into the data collection and analysis procedures of the study. The researcher began data collection by constructing open-ended questions designed to explore participants' experiences and concerns related to their experience of burnout recovery. As data were collected, the researcher began initial coding while attending to emergent areas for possible theoretical interest. The researcher focused on these emergent ideas in the interview protocol for follow-up interviews.

As follow-up interviews were conducted, the researcher treated recurring statements from participants as theoretically plausible. As data were collected, the researcher was attentive to patterns and participant statements that clustered together. These patterns and recurring statements were organized into tentative categories that guided the developing theory. As the

researcher developed the theoretical direction of the collected data, theoretical centrality also developed. The researcher entered the foreground of the data collection process and made choices about which lines of inquiry appeared to be most central. During the next round of follow-up interviews, the researcher focused interview questions on gaining more detail about the emerging central themes of the data. Constant comparison of collected data with emerging themes and categories facilitated the researcher's assessment of theoretical adequacy.

Data Security

Mind Garden

Mind Garden was utilized to allow participants to electronically complete the MBI-HSS. Mind Garden also scored each participant's MBI-HSS and produced a report to summarize each participant's burnout pattern. Participant information was processed and encrypted by offsite, secure servers that utilize industry-standard Secure Sockets Layer encryption, a procedure developed by Netscape for sharing private information online (Mind Garden, 2023). Additionally, Mind Garden (2023) employs a range of security practices to secure web access to data, limit database access to essential staff members, and address any security vulnerabilities. Mind Garden's policies prohibit employees from viewing personal information without business justification. Utilizing an online service to gather and store participant data does involve inherent risks. No method of data transmission over the Internet, or method of electronic storage, is 100% secure and this was communicated to participants in informed consent documents completed prior to data collection.

UA Box

UA Box is a cloud storage service available to students, faculty, and staff at The University of Alabama. UA Box was utilized to store participant data during the process of data

collection and analysis. UA Box is compliant with the standards set by the Health Insurance Portability and Accountability Act for the storage of Protected Health Information. The University of Alabama (2023) has a Health Insurance Portability and Accountability Act Business Associate Agreement (HIPAA BAA) with UA Box.

Data Analysis

In accordance with grounded theory methodology, data collection and analysis procedures co-occur, enabling the researcher to shape data collection based on themes constructed from the data (Corbin & Straus, 2015). This study utilized the constant comparative method, a process by which the researcher continuously compares developed codes with previously collected data and new data as it is generated. The process by which the researcher constantly collects and analyzes data and engages in constant comparison is an iterative procedure (Charmaz & Belgrave, 2019). Numerous analytic techniques co-occur throughout the research process, including data collection, initial coding, constant comparison, focused coding and categorizing, and theory construction (Tweed & Charmaz, 2011). These procedures continue until theoretical saturation is reached and the researcher can construct a complete theory. Theoretical saturation is the point at which collecting and analyzing additional data do not teach the researcher anything new about the phenomenon under study (Charmaz, 2021).

In grounded theory, coding develops the "bones of your analysis" (Charmaz, 2014, p. 113); therefore, coding procedures should be conducted with thoughtfulness and intention. The initial data analysis phase involved open coding to organize the data (Charmaz, 2014). Data was analyzed line-by-line to identify initial codes. These codes informed ongoing data collection and analysis. During this coding stage, the researcher strived to maintain openness to every possible theoretical direction indicated by their interpretation of the data (Charmaz, 2014). Effective

initial coding categorizes clients' lived experiences and encourages the researcher to think about the data in new and possibly unexpected ways (Charmaz, 2014).

Initial codes provided potential paths for analysis, directing the next phase of the coding process. In the second coding stage, focused codes were developed by examining the initial codes, comparing them with each other, and comparing them with the data. Focused coding enabled the researcher to determine the adequacy of the initial codes by ensuring that these codes reveal patterns and themes in the collected data (Charmaz, 2014). The researcher developed themes and categories from the initial codes in focused coding. Focused codes represented the framework of the burgeoning analysis; however, moving from initial to focused coding was not an entirely linear process. Since both initial and focused coding were emergent processes, the researcher maintained awareness that unexpected insights could have arisen at any point, altering the direction of the analysis (Charmaz, 2014).

The final phase of the coding process was selective coding. The researcher developed the focused codes into categories during this phase and explored relationships between each category (Charmaz, 2014). The researcher also identified a central theme under which the developed categories were classified. The central theme explained the experience of burnout and recovery from the perspectives of the researcher and participants. Additionally, the central theme described the relationships between developed categories and accounted for any variation found within the categories (Charmaz, 2014). Once the central theme was identified, the researcher continued to engage in constant comparison to determine the theoretical adequacy of the theory under construction.

In addition to open coding, the researcher engaged in memo writing throughout the analytic process. Memo-writing enabled the researcher to analyze data and codes early in the

research process (Charmaz, 2014). Memo-writing allowed the researcher to reflect on the data, develop new ideas, write analytic notes, and fill out categories (Charmaz, 2014). Memos served as a space for the researcher to engage in reflexivity, grappling with their role and influence in the research process. The researcher kept a journal for memo writing throughout the research process. Memos were utilized to inform ongoing data collection, analysis, and researcher reflexivity.

The analytic process was conducted until theoretical saturation was reached. Charmaz (2014) encourages novice researchers not to confuse saturation with repetition. Saturation is not necessarily reached when the data starts to repeat itself; rather, it occurs when no new theoretical insights are developed from continued data collection (Charmaz, 2014). Theoretical saturation is not achieved by a certain number of participants but by the quality of data collected (Burmeister & Aitken, 2012). Quality data demonstrates depth and complexity, describing the phenomenon under study (Burmeister & Aitken, 2012). While sampling continued until saturation was reached, the presence of saturation superseded sample size considerations (Charmaz, 2014; Glaser, 1992). Therefore, the researcher focused on sampling adequacy over sample size to obtain thick and rich data. The researcher ensured that theoretical saturation was reached by attending to theoretical concerns throughout data collection and analysis, obtaining additional data when needed to saturate emergent categories fully, and engaging in constant comparison to assess the adequacy of the developed theory to explain the data.

Ethical Considerations

At the outset of this research, a few ethical issues were anticipated. First, the researcher was aware of ethical considerations typically associated with qualitative research: privacy and anonymity. Participant privacy was safeguarded by keeping all recordings and transcripts in a

locked filing cabinet in the researcher's office or an encrypted, password-protected folder on the researcher's computer. De-identifying any personal information that participants provided preserved participant anonymity. Additionally, the researcher was aware that the topics of burnout and burnout recovery might elicit negative emotional experiences from participants. Therefore, participant well-being was safeguarded by providing each participant with informed consent about the risk of eliciting negative emotions during research participation and referrals for mental health professionals in the participants' local communities.

Validity Considerations

Quantitative research has developed a technical term known as validity. Statistical validity is measured by tests that can be conducted with mathematical calculations (Fitzpatrick, 2019). Qualitative researchers have hesitated to use the term validity because of its technical nature in quantitative research (Cresswell & Poth, 2018). Other labels for describing the effectiveness of qualitative research are reliability, applicability, accuracy, and credibility (Glaser & Strauss, 1967). The term credibility is the label that this study used. Credibility indicates that the findings are trustworthy (Nassaji, 2020). Several techniques are used to enhance the credibility of qualitative research. This study employed four techniques: member checking, peer review, expert analysis, and researcher positionality.

Member checking involves returning interview transcripts to participants for their review (Daniel, 2019). Participants inspect the contents of their interviews to ensure that the transcripts accurately reflect their perspective on the phenomenon they experienced. Ensuring that the data accurately represents the participants' perspectives enhances the findings' overall credibility (Cresswell & Poth, 2018). Participants' concerns were discussed with the researcher prior to the presentation of the dissertation.

Peer review involves the input of a peer in the counselor education field (Holley & Harris, 2019). The researcher had two peers review the study. These peers read the findings and made comments concerning the nature of the findings. These peer reviewers acted as objective reviewers to assist the investigator in detecting and eliminating researcher bias (Holley & Harris, 2019).

Expert analysis is like peer review but has a slightly different perspective. The expert analysis involves the participation of an individual with expertise in qualitative research methodology (Creswell & Poth, 2018; Holley & Harris, 2019). This expert qualitative methodologist examined the research process to determine that the protocols and procedures of qualitative methodology are being followed (Creswell & Poth, 2018). Dr. Alan Webb has demonstrated expertise in qualitative research and agreed to conduct the expert analysis of the study.

Researcher positionality was recorded in the third chapter of this study. The researcher's positionality statement was built around three questions. What attracted the researcher to this topic? How is the researcher positioned in this study? What preconceived notions does the researcher bring to this study? The narrative crafted around these three questions gives the reader insight into the perspective of the person who is conducting the research (Charmaz, 2014). This insight places the reader in a position to establish a personal assessment of the findings outlined in the study. This liberty of assessment enhances the overall credibility of the study.

Conclusion

The research employed a qualitative methodology to construct a theory that offered understanding and elucidated the process of counselor burnout and recovery. This theory was developed based on the experiences of counselors who had experienced both burnout and

recovery. To achieve this outcome, the study utilized the constructivist grounded theory approach as outlined by Charmaz (2006, 2014). Overall, this research employed a range of techniques to establish credibility and reduce potential biases from participants, researchers, and theoretical perspectives. The research design called for a three-step coding that involved constant comparison and simultaneous data collection. The analytical process involved initial coding, focused coding, and selective coding.

CHAPTER IV: FINDINGS

This chapter presents the results of this study and outlines the development of a novel grounded theory. The primary aim of the research was to elucidate the lived experiences of burnout and subsequent recovery among counselors. This objective was achieved through two guiding research questions that investigated the interconnected experiences of participants who had experienced burnout during their careers and demonstrably recovered, as validated by their scores on the Maslach Burnout Inventory Health Services Survey (MBI-HSS; Maslach et al., 1981). The research questions were developed to guide the data collection and to provide substance and direction to the theory. The resultant theory offers a framework for understanding the complex transition from burnout to renewed well-being among counselors.

This chapter summarizes the collected interview data of six participants who reported having experienced burnout and recovered. The interviews were primarily concerned with participants' lived experiences of burnout and subsequent recovery. From this data, a conceptualization of burnout and the process of burnout recovery was constructed. The reader will be provided with demographic information, interview passages, findings, and a constructed theoretical framework to facilitate a full understanding of the data.

The research design highlighted participants' lived experiences through an iterative data collection and analysis process. Data analysis involved a thorough and continuous review of the interview data to ensure that themes constructed from the data accurately reflected the experiences reported in the participants' interviews. The analysis was conceptualized as a three-step coding process consisting of initial, focused, and selective coding (Charmaz, 2006). The

researcher consulted with participants throughout the analytical method to ensure that participants' experiences were authentically reflected. Core categories were constructed from the data and provided additional understanding and explanation regarding the experience of burnout and burnout recovery among counselors. Interview data, constructed categories, and findings will be discussed throughout this chapter. The chapter will conclude with a summary of findings leading to further discussion and implications provided in the next chapter.

Participant Descriptions

Summaries of participants' demographic information were provided to give additional insight into their background, clinical experience, and experience of burnout. Participants were assigned pseudonyms to protect their identity and maintain confidentiality. Interview data will be described in an upcoming section. Data presented in these descriptions were obtained through a brief demographic questionnaire and during the interviews.

Participant 1: Carly

Carly is a cis-gender woman in her thirties with more than five years of experience in counseling. Carly is a licensed professional counselor and licensed mental health counselor in Iowa and Pennsylvania, respectively. Carly has worked in private practice for the last two years, where she works with anxiety, depression, and trauma in adults. Before entering private practice, Carly worked for an agency providing school-based therapy to elementary school students and their families. When discussing her experience of burnout, Carly highlighted the following systemic issues: feeling pressure from workplace leadership, lack of support, managing heavy workloads outside of sessions, normalization of burnout among colleagues and leadership, low wages, and receiving inadequate training and consultation. Carly reported experiencing physical and emotional exhaustion, disengagement from her clinical work, and a decreased sense of

effectiveness with her clients when she was in burnout. When discussing her experience of burnout recovery, Carly highlighted the importance of the following: feeling effective with clients, setting boundaries, receiving support from other clinicians, seeking out training and consultation, having a sense of autonomy in her work, and finding balance in her personal life.

Participant 2: Sophia

Sophia is a cisgender woman in her forties with more than five years of experience in counseling. Sophia is a licensed professional counselor in Alabama and currently works in a private practice where she sees adolescents and adults. Before entering private practice, Sophia worked in the partial hospitalization program at a local community mental health center in Alabama. Additionally, Sophia spent time working as a mental health counselor within a local school system. When discussing her experience of burnout, Sophia highlighted the following systemic issues: feeling pressure from workplace leadership, being encouraged by workplace leadership to maintain unhealthy boundaries, and managing a high caseload. Sophia reported experiencing physical and emotional exhaustion, a decreased sense of effectiveness with her clients, feelings of guilt and shame, physical illness, and self-doubt during her burnout experience. Sophia discussed the importance of the following during her burnout recovery experience: setting boundaries, a sense of autonomy in her work, feeling effective with clients, developing self-care, and receiving support from other counselors.

Participant 3: Jackie

Jackie is a cisgender woman in her fifties with more than ten years of experience in counseling. Jackie is a licensed clinical social worker in Oregon, where she has worked in private practice for the last four years, specializing in treating trauma in adults. Before entering private practice, Jackie worked in a community mental health center providing counseling to

individuals experiencing homelessness. When discussing her experience of burnout, Jackie highlighted the following systemic issues: lack of support, managing a stressful caseload, feeling pressure from workplace leadership, and anger towards the system. Jackie reported experiencing physical and emotional exhaustion, guilt and shame, a decreased sense of effectiveness, and disengagement from her clinical work during her burnout experience. Jackie also noted that she used what she considered to be unhealthy coping strategies while she was in burnout. Jackie discussed the importance of the following during her experience of burnout recovery: going into private practice, setting boundaries, having a sense of autonomy in her work, finding a sense of balance in her personal life, and developing self-care.

Participant 4: Caroline

Caroline is a cisgender woman in her thirties with more than five years of experience in mental health counseling. Caroline is a licensed independent clinical social worker in Alabama. Caroline currently works in private practice, providing counseling to individuals and couples experiencing post-partum mood disorders. Before entering private practice, Caroline worked in a multi-specialty outpatient medical facility providing counseling to individuals. When discussing her experience of burnout, Caroline highlighted the following systemic issues: feeling undervalued by her workplace, lack of support, pressure from workplace leadership, and anger toward the system. During her experience of burnout experience, Caroline reported experiencing emotional and physical exhaustion, cynicism, and detachment from work, as well as a decreased sense of effectiveness and accomplishment at works. Caroline emphasized the importance of the following during her experience of burnout recovery: advocating for change in the system, developing an understanding of her needs, engaging in personal mental health care, self-

awareness, setting boundaries, developing self-care, receiving support from friends and family, and developing healthy coping strategies.

Participant 5: Amanda

Amanda is a cisgender woman in her thirties with more than ten years of experience in counseling. Amanda is a licensed professional counselor and alcohol and drug counselor in Alabama. Amanda currently works in private practice, providing counseling to adolescents and adults with depression, anxiety, attention-deficit hyperactivity disorder, and substance use disorders. Before going into private practice, Amanda worked in a community mental health agency providing counseling to children and adolescents in an intensive outpatient unit. Amanda also spent time working with individuals with opioid use disorder at a methadone clinic. When discussing her experience of burnout, Amanda highlighted the following systemic issues: feeling pressure from workplace leadership, workplace encouragement of unhealthy boundaries, inadequate supervision, and managing a stressful caseload. Amanda reported experiencing physical and emotional exhaustion, feelings of cynicism towards her work, a decreased sense of effectiveness and accomplishment in her work, anxiety, guilt, shame, and feeling overly responsible for her clients during her burnout experience. Caroline discussed the importance of the following during her experience of burnout recovery: seeking out training and education, engaging in personal mental health care, receiving adequate supervision and consultation, receiving support from other counselors, finding a sense of balance in her personal life, and recovering from guilt and shame.

Participant 6: Hope

Hope is a cisgender woman in her thirties with more than ten years of experience in counseling. Hope currently works in private practice, providing counseling to adults via

telehealth. Before going into private practice, Hope worked as a crisis counselor for an agency that provided a crisis hotline to the local area. When discussing her experience of burnout, Hope highlighted the following systemic issues: managing a stressful caseload, feeling afraid of workplace leadership, receiving inadequate supervision, feeling a lot of responsibility with little power, and working under dysfunctional leadership. Hope reported experiencing physical and emotional exhaustion, cynicism towards her work, a decreased sense of effectiveness and accomplishment in her work, physical illness, and a sense of feeling trapped in her job during her experience of burnout. Hope discussed the importance of the following during her experience of burnout recovery: feeling empowered by her workplace, receiving support from other counselors, advocating for change in the system, receiving support from friends and family, and recovering physically.

Participant Summary

All participants in this study identified as counselors; however, they held different licenses based on their education, training, and state of licensure. Four participants were licensed professional counselors. One participant was a licensed clinical social worker. One participant was a licensed independent clinical social worker. Two participants held dual licenses. One of these participants was a licensed mental health counselor in addition to being a licensed professional counselor, and the other was an alcohol and drug counselor in addition to being a licensed professional counselor. All the participants had at least five years of experience providing mental health counseling. Three participants had more than ten years of experience but less than twenty years of experience.

The participants lived in various states across the United States, including Alabama, Iowa, and Oregon, with four currently residing in Alabama. The participants were also licensed

in multiple states, including Alabama, Iowa, Oregon, North Dakota, and Pennsylvania. Two participants were licensed in various states. All the participants identified as white, with one participant identifying as white and Jewish. All the participants identified as cisgender women.

All the participants currently work in private practice. Five participants described their burnout experiences as having occurred while they worked in community mental health agencies. One participant described her burnout experience while working for a crisis response hotline. All participants reported experiencing physical and emotional exhaustion, cynicism and detachment from their work, and a decreased sense of effectiveness and/or accomplishment during their burnout experiences. All participants noted the significance of systemic factors in their development of burnout.

Results

The following findings were constructed from the data by utilizing and implementing the abovementioned steps. Results are presented in thematic form, organized by their corresponding research question.

Research Question One (RQ1)

RQ1 was "*How do counselors experience burnout?"* The primary form of data collection was semi-structured interviews. Each participant engaged in two interviews, which focused, in part, on understanding how the participants experienced burnout during their careers as counselors. Although burnout experiences varied across participants, five themes emerged throughout the analytical process: *systemic factors, psychological symptoms, reduced clinical efficacy, exhaustion,* and *clinical disengagement.*

Systemic Factors

The first theme of RQ1 was systemic factors. This term was linked to how participants attributed workplace, or systemic factors as causes of their burnout. These factors varied across participants and included workplace pressure, lack of support, inadequate supervision, stressful caseloads, high workloads, receiving low wages, poor leadership, unrealistic expectations from the workplace, fear of workplace leadership, and feeling unable to use their best clinical judgment. For the purposes of this study, systemic factors can be understood as the systemic or workplace variables that contribute to the individual's development of burnout. An analysis of the data revealed the following themes in participants' descriptions of their experience of systemic factors: dysfunctional leadership, workload, compensation, and resentment.

Dysfunctional leadership. The experience of dysfunctional leadership was a prominent theme throughout the interview data, with six participants reporting experiences with dysfunctional leadership. Participants discussed two primary topics that held meaning and significance to them as they shared their experiences of dysfunctional leadership. These topics included lack of support and pressure from workplace leadership.

Lack of support from workplace leadership was a common experience reported by all six participants. Sophia recalled the lack of support from the administration she experienced working in a community mental health agency and her need to rely on co-workers instead stating, "We couldn't count on administration. All we could count on was each other, and that was besides my family, and in the work environment, it was them. That was it." Many of the participants shared the belief that their workplace prioritized profit over the clinicians' well-being. For example, Caroline stated that she "didn't feel supported" by the administration and felt as though she was not "valuable in this system." Jackie shared a similar experience of feeling

under-valued while attempting to advocate for change in the community mental health agency where she experienced burnout:

> [They] could give me the power to make the changes that [they] claim to want, and all of the staff wants, but you know, like, we communicated until we're blue in the face, and it is pretty clear what the issues are, and [administrators] don't care because [they're] more interested in the bottom line.

Participants noted how the administration did not prioritize the clinicians' needs or well-being. Amanda recalled that "there was a lack of support and recognition of the importance of self-care" from the administration in the intensive outpatient program she worked at during her burnout experience. This lack of support from workplace leadership inhibited participants' use of self-care and boundaries. Amanda reflected on how her experiences modeled poor boundaries and self-care habits stating, "I almost feel like these organizations set me up to have my own bad habits, like because they didn't value creating the boundaries and the structure, I didn't value it until I realized I had to value it."

While lack of support from administration was noted by all six participants, five participants also noted a lack of clinical support and poor clinical supervision. Carly reflected on how isolating the lack of clinical support was for her:

> It was a somewhat isolating time. There wasn't anyone I could run things by on a, like, daily basis…It felt like a lot of the responsibility was on me and like I was kind of working in a bubble when it came to actually doing therapy.

Several of the participants shared that they did not receive any clinical supervision through their workplace, resulting in feelings of isolation, confusion, and self-doubt for the clinicians who were new to the profession at the time. For those who did receive clinical supervision through their workplace, participants discussed the conflict this created. For example, Sophia shared her experience of feeling unable to ask for support from her supervisor due to fear of how this might have impacted her employment:

> If I could have come to them and said Hey, I can't do all this and it's affecting my health, it's affecting my home life… If I had went to somebody said, hey, I can't do this. Something is gonna have to give. I knew if I had done that, they would have just found a way to get rid of me. I was fresh out of grad school. So, I didn't want that.

Sophia later shared that although weekly supervision meetings were technically required by her employer, her supervisor rarely attended these meetings. Instead, Sophia recalled that supervision meetings would only occur if she was not "doing everything to the level they wanted [her] to do." Jackie shared a similar experience:

> So, when you're at an agency, supervision basically looks like your supervisor telling you all the shit that you have undone. Since I usually had my shit done and they were usually stressed out, I usually got to be my supervisor's best friend, and this happened again and again. One time it was like zombie supervision. Like we just talked about the zombie apocalypse and what we were going to do when it happened, like, you know and crack each other up. Like, I'm going to wield a machete. I like a double barrel shotgun. So, like, supervision was pretty crappy.

Supervisors being inattentive or absent was prevalent among participants' experiences. For example, Amanda recalled participating in a virtual supervision meeting in which her supervisor had turned off his camera, and Amanda realized part-way through the meeting that the supervisor was teaching a class during the supervision meeting. Amanda shared that it was not unusual for her supervisor to miss scheduled supervision meetings later telling Amanda to log the hours as if the meeting had occurred.

Two participants also shared their experiences of supervisors using demeaning and disrespectful language during supervision meetings. Hope recounted a time when she reached out to her supervisor for support and her supervisor responded by mocking her. Amanda recalled her supervisor encouraging her to leave the field during one supervision meeting, which led Amanda to feel like a "broken counselor" for the remainder of burnout experience. Hope reflected on her experience of being sexually harassed by a client on the phone and her supervisor responding by telling her to "grow up and be a professional." These experiences took

an emotional toll on the participants with each participant considering their supervision experience to be "harmful" in nature.

All six participants also discussed the role of pressure from supervisors and workplace leadership in their development of burnout. Pressure was associated with clinical outcomes, professional boundaries, and management of high caseloads. Participants had a common experience of workplace leadership maintaining rigid expectations of clinical outcomes while maintaining that clinicians should be capable of managing extremely high caseloads, long work hours, and low compensation. Sophia reflected on this aspect of her experience of burnout stating, "It's kind of hard to be all you can be when you're burnt out by having to do everything for everybody."

In hindsight, participants felt that the expectations of workplace leadership were unrealistic, but at the time these expectations were normalized to the point that the participants accepted them. Caroline shared, "Working long hours, staying late, and, you know, seeing as many clients as possible, oh yeah, like, that was normal. That was normalized and almost expected." Carly shared how workplace leadership not only normalized unrealistic expectations, but espoused the belief that industry norms were more extreme than the expectations of the agency. Carly stated, "I remember them making it just seem like it would never really get better than what we had at the agency."

Workload. Workload was also a prevalent topic among participants throughout the interview process with six participants noting its significance. For this study, the term *workload* is utilized to categorize participants' experiences of the amount of work involved in client care, documentation, and hours spent at their jobs. Participants highlighted these three factors when reflecting on how workload related to their development of burnout.

Aspects of client care that participants found to be most draining were the size of their caseload and the severity of the clients' symptoms. Carly shared that she found it stressful to see 30 or more clients a week while also attending Individual Education Program (IEP) meetings, meetings with the client's guardian ad litem or caseworker, and meetings with the client's teachers. Similarly, Jackie shared that she had more than 70 people on her caseload and saw up to 14 clients a day. Providing care to such many clients led the participants to feel physically and emotionally exhausted. Amanda reflected on her experience and the impact it had on her:

> When I was at the methadone clinic we had dosing hours, medicating hours, from 5:00 am to 10:00 am. So, we had to see all of our clients during that five-hour timeframe. And so, it was often like back-to-back clients. And so, I could have a session with a client, and it would be emotionally really heavy and there was no time to sit with how that impacted me. I just had to power through.

In addition to large caseloads, all six participants described their caseloads as consisting of high-severity cases. Participants described a case as high in severity if the client's presenting concerns included trauma, abuse, neglect, active substance use, and/or mental health diagnoses that impact the client's ability to function effectively in day-to-day life. Sophia described how difficult it was for her to hear students' stories of abuse and neglect in their home lives. Despite contacting Child Protective Services for assistance, Sophia stated, "it would take them a month to get the kid out." Sophia discussed the impact this experience had on her sharing, "The trauma I heard from kids haunted me." Similarly, Jackie shared how continually hearing stories of trauma and loss while working with clients who were chronically experiencing homelessness impacted her. Jackie stated, "I just get too sad. Like, I could not pull myself out of the sadness."

Amanda shared that hearing clients' accounts of traumatic experiences was a regular occurrence during her time working at a methadone clinic; however, hearing these stories was not the most difficult part of working with these clients for her. Amanda reflected on her

experience of losing several clients to overdose and health issues during this time, and the impact that it had on her:

> I could have told you a year and a half ago exactly how many clients that I lost while I was working there, and the fact that I can't recall that immediately right now is a sign that I'm in a better place because I held on to that number so tightly before, but I had multiple clients either overdose or die because of health concerns, but I had within the first six months of working there, you know, a young person overdosed and, and then it was the pandemic while I was working there, and opioid use and overdose, just soared during that time. And so, I had multiple experiences of death of clients. There were somewhere around five and for various reasons, they weren't all overdoses, but it was painful, nonetheless. And I constantly kind of felt on edge at that job wondering like, when is the next person going to die? And I felt constantly just anxious and worried and keyed up and like an adrenaline high and couldn't sleep. I mean, I just, it was hard. I was exhausted.

Jackie also discussed the emotional toll losing clients had on her while working in a community mental health agency sharing that she lost four clients in the span of one year. Jackie described one loss that hit her especially hard:

> She'd been clean and sober for two years when she was diagnosed with breast cancer, and it was too far along because, you know, when you have severe mental illness and you're using drugs, like, you don't care about your physical health. And she knew that something was going on all that time and was just afraid and in denial. And so then to go through the process of dying with this person who is sober for the first time in her life and starting to figure herself out was heartbreaking.

Following this loss, Jackie noticed that she began pulling away from her clinical work stating, "I was showing up late. I was leaving early. I could not function, and I was just really depressed." These losses left participants feeling depressed, exhausted, anxious, and overwhelmed. Amanda shared that the high-severity nature of her caseload meant that she was also frequently on-call, meaning she could receive a call from a client in crisis at any time. Amanda shared that this aspect of her job caused her to feel "a high degree of anxiety and stress."

Outside of direct client care, all six participants noted that excessive paperwork and clinical documentation contributed to their experience of burnout. Given the amount of time that participants spent engaging directly with clients each day, there was little time left over for

clinical documentation. In addition, participants shared the belief that the amount of paperwork required by their employers was extreme and unnecessary. Carly shared, “I would work into the evening, maybe take a break for a few hours, and then start doing notes again before bed.” This routine often left Carly feeling exhausted, often sacrificing sleep to complete paperwork by the agency’s deadline of 7:00 a.m. Similarly, Sophie shared how difficult it was for her to provide adequate support to her clients while simultaneously keeping up with documentation requirements:

> I was trying to do all kinds of things for [the clients], and [the agency] just kept piling everything on us. You know, I want you to do all this stuff and all these groups and take [the clients] and do all this stuff, but then I want you to do 5000 documentations along with it.

Documentation was described as a constant source of stress for the participants. Carly stated, “there was always tons and tons of paperwork that had to be done at any given time.” Additionally, Carly shared that time spent on paperwork was “unpaid time,” leading her to resent the requirement and the amount of time she spent on it.

Compensation. Poor compensation was discussed as a contributing factor to burnout for five of the participants. Compensation was impacted by factors such as insurance reimbursement and agency funding. Carly shared that she was only paid if the students to whom she provided counseling had Medicaid benefits. Unfortunately, this was not always known at the time services were provided. Carly shared an example of this:

> I remember I had three boys that I was seeing at one point who were brothers and I think over the course of a month, between all of them I had done like 13 or 14 sessions. And then it was like, we'd find out oh, actually, their Medicaid wasn't active this month. So, you're not going to get paid for any of those sessions.

To offset the lost income when these occurrences happened, Carly shared that she would increase the number of sessions she conducted, assuming 10% of them would not be reimbursed

by Medicaid. Sophia recalled feeling “stretched thin” due to working long hours for relatively little pay while working as a school-based counselor. Sophia attributed her low salary to the lack of funding schools often receive for mental health services for students.

Similarly, Jackie recalled that she made less than $40,000 a year, despite maintaining a caseload of more than 70 clients. Jackie, like Sophia, attributed her low salary to the lack of funding provided to community mental health agencies like the one she was working at. Caroline shared that the low salary she received at the outpatient medical facility she worked caused her to feel “under-valued” by the administration. Additionally, Caroline shared her perspective on the disparity between the administration’s words and actions stating, “You say you need the services, but that is all I’m getting from you. You’re not backing that up with policies and procedures.” Amanda also shared how poor compensation impacted her perspective of the agency she worked for stating, “It really affected my attitude towards the organization and the work. It kind of piles on top of the already emotionally exhausting nature of the job.”

Resentment. Five participants discussed the anger and resentment they developed toward the systems or organizations they worked for during their burnout experiences. Participants discussed two primary sources of resentment towards their places of employment: poor client care and unrealistic expectations of clinicians.

Four participants discussed poor client care as a primary reason they developed anger and resentment towards the systems that employed them. Participants shared the belief that systemic issues contributed to poor client care, and the agencies they worked for often prioritized revenue over the needs of clients. Amanda shared that the organization did not recognize “the significance of the heaviness of the work” and was “very motivated by revenue.” Amanda went on to state that “sometimes it felt like they were seeing the revenue and not the clients.” Jackie

shared a similar experience as she recalled the administration's response to her efforts to advocate for changes within the agency: "It didn't matter if I presented what, you know, the folks needed for retention in the sky in giant letters. They didn't care if it conflicted with the bottom line." The belief that agencies were prioritizing profit over client care led participants to develop anger and resentment. Caroline shared, "I couldn't talk about it without becoming so angry." Caroline recalled how her frustration leaked into her work with clients stating, "I can just think of multiple times where I had been talking with a patient and I remember saying, I know you're frustrated. I am frustrated too, but I don't know what else to do."

Participants also attributed their resentment to the unrealistic expectations placed on them by their workplaces. Sophia recalled that she knew that burnout is often associated with disconnection from client care but noted that this was not her experience. Sophia reflected on the amount of pressure she put on herself to maintain high quality client care despite the lack of support and resources she received from the agency she worked for and the anger that eventually developed:

> I would feel guilt for trying to put some boundaries and I knew that it was stressing me. And I knew I've read where people would get like, you know, be burned out and not like want to serve or they would you know, take it out on the clients. I never did that. Never. I put it on myself. I was like, well, I just got to do this better. I got to learn how to manage this better because it's not their fault, you know? And so, I would just be like, okay, I feel guilty that I couldn't handle it all. I feel guilt that I wasn't able to juggle home and work effectively. Then I would have anger because I would feel like these people shouldn't be putting all this on me.

Jackie shared that it was common for the agency she worked for to require her to work with clients at an "inappropriate level of care" due to the acuity of the client's symptoms. Jackie recalled feeling unheard by the administration stating, "they're not listening to me every time, and then of course it turns out not to be manageable, because the person cycles through therapist after therapist."

Systemic issues played a significant role in the participants' experiences of burnout. Participants noted dysfunctional leadership, workload, compensation, and resentment towards their places of employment as contributing factors to their development of burnout. In summary, Jackie shared her perspective on the impact systemic factors have on counselors' development of burnout:

> It's never the clients who burn you out. It's always the system. You know, it's always the fact that your caseload is too high. Your pay is too low to take decent care of yourself. You know, we get blamed for burnout when it is literally the system's fault.

Psychological Symptoms

Psychological symptoms were the second theme constructed from RQ1. This term was linked to the cognitive and emotional symptoms that participants associated with their experience of burnout. These symptoms varied across participants, and included depression, sadness, anxiety, panic, hypervigilance, self-doubt, negative self-talk, guilt, and shame. For this study, psychological symptoms can be understood as emotions and thought processes that participants noted as significant factors in their burnout experiences. An analysis of the data revealed the following themes in participants' descriptions of their experience of psychological symptoms: depression, anxiety, and cognition.

Depression. All six participants noted depressive symptoms during their experience of burnout. For this research, depressive symptoms include depressed mood (i.e., feelings of sadness, emptiness, or hopelessness), loss of interest or pleasure in activities, weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue, excessive or inappropriate guilt, decreased concentration, and thoughts of death or suicide (American Psychiatric Association, 2013).

Participants noted that these symptoms extended into their personal lives impacting their home lives and relationships. Carly recalled that she pulled back from her personal relationships during her burnout experience. She shared that she often showed up late or left early from social gatherings, because she had difficulty feeling present in social interactions. Similarly, Amanda recalled that she had difficulty feeling present with her children in the evening because of sadness, hopelessness, and emotional exhaustion experienced during her burnout experience.

In addition to the negative impact these symptoms had on participants' personal relationships, participants also shared the impact these symptoms had on their own mental health and well-being. Jackie, who was familiar with clinical depression from previous experiences, shared the depressive symptoms she experienced while in burn out:

> So, not sleeping. You know, either eating too much or not eating. Like just not pursuing health goals. You know, like when you just let everything slide, you know, you just go home, like I'd go home, and I just like face down on the bed you know? I'm going to bed at eight o'clock at night because I'm just exhausted and not sleeping.

Participants recalled chronic feelings of sadness, bouts of tearfulness, and feelings of hopelessness. Amanda shared that she experienced "a lot of sadness and tearfulness" during her experience of burnout. Caroline shared that she felt unable to "compartmentalize" her feelings of sadness and hopelessness which resulted in a loss of the motivation, energy, and passion she previously had for her work. For one participant, the depressive symptoms became so severe that she began to have suicidal thoughts. Hope shared her recollection of that time:

> I have a profound memory of my brand-new husband just holding me as I am sobbing with despair, and I'm just having all of these flashes of suicide plans going through my head because I mean, I'm here and I know the effective ones. So, I just remember having all of these flashes of suicide plans running through my head in that instance. But yeah, just deep depression, deep hopelessness.

Five participants noted that their experience of depressive symptoms included intense feelings of guilt and shame. Feelings of guilt and shame were typically linked to participants' decreased sense of effectiveness in their clinical work.

Decreased sense of effectiveness will be discussed in greater detail in a later section. For now, we will focus on the emotional experience of guilt and shame shared by the participants. Carly shared that she often felt guilty because she believed that emotional fatigue interfered with her ability to facilitate positive change in her clients. Sophia shared that she typically gave "100%" to her clients and felt a great deal of guilt when she noticed she was no longer able to do that. Sophia shared, "they were kind of getting like 60% towards the end." Sophia shared that she also felt guilt due to not being able to "handle it all." Sophia shared that she felt torn between her work life and her home life. She was unable to set boundaries with her work because her clients were "dependent" on her, despite complaints from her partner and children. Similarly, Jackie shared that she often experienced guilt and shame due to not "living up to [her] own standards."

Anxiety. Four participants noted experiencing significant anxiety during their burnout experiences. Participants shared that their anxiety inhibited their ability to sleep, create health boundaries with work, or be fully present in their personal lives. Caroline shared that she often lost sleep because she was preoccupied with worry throughout the night. Amanda shared that she often felt like she was holding her breath waiting for the next crisis or client loss. Sophia shared that her anxiety was "off the charts" during her burnout experience due to the constant anticipation of a client in crisis. Amanda shared that her anxiety became so severe that she mistook it for a physical health issue stating:

> I really felt like I was about to pass out. I was in my 20s and I was having these symptoms. I actually went to a cardiologist and like had a full work up because I really thought there was something majorly physically wrong with me. And it turns out I was having anxiety."

Participants shared that they experienced panic, feeling on edge, shakiness, and chronic worry during their burnout experiences. Amanda recalled these feelings stating, “I felt a high degree of anxiety and stress knowing my phone could ring at any time with an adolescent on my caseload that could be actively suicidal or self-harming.” Similarly, Sophia recalled how her anxiety often led her to bring work home with her stating, “I'm bringing my computer home. I’m working on treatment plans from home. Doing notes from home. I’m taking phone calls. I'm running back up and down there.” For one participant, chronic anxiety led to panic attacks. Amanda shared, “I had panic attacks. My heart rate would speed up. I would feel like I was getting dizzy. That was the first time I was ever treated for any mental health condition.” Amanda attributed the intense anxiety she experienced to the “overwhelming” sense of responsibility she felt for her clients.

Cognition. Four participants noted that cognitive symptoms played a significant role in their experience of burnout. For this study, cognitive symptoms can be understood to be the thought processes participants associated with their experience of burnout. An analysis of the data revealed that the primary theme among cognitive symptoms was self-doubt.

Three participants noted that they doubted their clinical abilities and fitness for the profession during their experience of burnout. Carly shared that she often experienced “doubt-based self-talk” and questioned whether what she was doing was effective. Sophia shared that her experience working in a partial hospitalization program “planted seeds of self-doubt” despite having a strong confidence in her clinical skills prior to beginning the job. Sophia recalled thinking, “What if I’m not good at this? What if I can’t do this?” Amanda shared similar experiences stating that she would often “second-guess [herself] as a professional.” Carly, Sophia, and Amanda shared that these thoughts led them to doubt whether they should stay in the

counseling profession based on feedback they received from their employers. Carly shared her perspective on some of the feedback she and her colleagues received:

> It was very normalized in that like, there was a lot of reinforcement for having a lot of clients. Like, you got a lot of praise and recognition when you had a lot of billable hours and there was a lot of concern expressed if somebody wasn't getting enough hours.

The normalization of high caseloads and long hours led Carly to doubt whether she was right for the mental health profession. Sophia shared a similar experience of doubting whether she had the ability to keep up with the demands of this profession:

> It was well if you can't handle it, then obviously, you are not good at this. You know, obviously, you need to choose something else. Obviously, if you can't handle a caseload of 300 people and you can't be everything to everybody and be here anytime we ask and work from home and answer on call 24 hours a day then you're not meant to be in this field.

Sophia recalled how demoralizing this was for her stating, "It just was so diminishing to me." The participants shared how self-doubt impacted their attitudes towards work and exacerbated other symptoms of burnout they were experiencing such as depression, anxiety, and an overall decreased sense of effectiveness.

Exhaustion

Exhaustion was the third theme constructed from RQ1. This term was linked to participants' reports of mental, emotional, and physical exhaustion during their experiences of burnout. Six participants noted that exhaustion of burnout played a significant role in their experiences. Participants noted that physical and emotional exhaustion interfered with their ability to be present in their personal relationships and life outside of work. Participants also recalled that they felt more irritable and less able to be present in their clinical work. Carly recalled feeling conflicted between her need for rest and maintaining her personal relationships:

> A friend would want to get together in the evening, and I'd feel conflicted because I'd want to go but I'd also know that after, you know, after working long hours and you

> know, being emotionally exhausted, I probably wouldn't really have the energy to show up the way I would want to.

Carly remembered feeling like she “didn’t have the energy for things outside of work,” and this took a toll on her social life and personal relationships. Similarly, Jackie recalled feeling so tired that she had difficulty fully being present for her sessions with clients stating, “There was definitely an awareness of like, I'm tired. I'm like, you know, I'm trying not to yawn in sessions.” Participants noted that their overall sleep was affected during their burnout experiences. Caroline shared that she “wasn’t sleeping” and was “drinking loads of coffee” to get through her days. Amanda recalled that she often felt like she was “running on adrenaline” and would often have difficulty sleeping at night due to concern for her clients’ well-being. Similarly, Jackie shared that she often felt “tired and run-down” but was unable to sleep at night despite chronically feeling exhausted.

Clinical Disengagement

The fourth theme constructed from RQ1 was clinical disengagement. This term was linked to participants’ reports of withdrawing from their work with clients during their burnout experiences. For this study, clinical disengagement can be understood as decreased empathy for clients, irritability, loss of idealism, and withdrawal. Six participants discussed their experiences of clinical disengagement during their interviews.

Carly reflected on her experience of withdrawing from her work with clients during her experience of burnout. Carly noted that her attitude towards clients shifted from empathetic and engaged to frustrated and withdrawn. Working as a school-based counselor, Carly often had short, 45-minute sessions with students. Carly stated, “the kid only had 45 minutes with me, and I feel like I was frustrated with them.” Carly recalled that she felt a great deal of guilt associated with her clinical disengagement but continued to feel the need to withdraw from her clinical

work. Disengaging often provided Carly with a "mental break." This was needed during her experience of burnout. Carly recounted her experience of creating these spaces during sessions where she could disengage for a few moments:

> I would sometimes structure activities so that there'd be a section or a portion of the session that the client, in theory, could do a little bit more independently. Like an art activity where I'm like, okay, for like five minutes, you're just going to draw according to this prompt or whatever and, you know, then I wasn't really as engaged during that that time.

Jackie recalled similar experiences during her time working with chronically unhoused individuals. Jacked reported that she had less patience, compassion, and overall capacity to hold space for her clients during her experience of burnout. Hope also recalled difficulty holding space for her clients stating, "I could sense myself struggling to give empathy to my higher need clients." Jackie recounted the impact her disengagement had on her clients stating, "there was at least one person who fell through the cracks," because she had lost the motivation to follow-up with clients who had ceased compliance with the program. Like Carly, Jackie and Hope reported feelings of guilt as they reflected on their experiences of clinical disengagement.

Clinical disengagement included withdrawing from work and reductions in overall productivity. Sophia reflected on the shift in attitude that she experienced during burnout. Sophia reported that when she first entered the profession she was "lit to save the world" and "invested" in her work with clients. This changed during her experience of burnout. Sophia recalled, "I hated going to work even though I loved the people." Caroline recalled that she stopped taking on new clients, and cancelled sessions with clients more frequently. Caroline stated, "I just didn't care." Jackie shared her experience of how clinical disengagement impacted her overall performance at work:

> I started being late to work, and I'm that person who's compulsively early. I started leaving early, and I'm that person who gets everything done before I go. And so, I was

> basically doing things that were out of character, and I didn't care. And I've never received any kind of reprimand at work ever. And I got a verbal warning.

Similarly, Caroline shared that although she once had a passion and excitement for her work, she lost these feelings during her experience of burnout. Caroline stated that she had a “shortened fuse” and felt unable to help clients with their lives when she did not “know what to do in [her] life.” Participants shared experiences of avoiding or putting off work by delaying session start times, showing up to work late, leaving work early, and procrastinating clinical documentation. Carly shared an example of this:

> Back when I was working at the school, I would just be back-to-back with sessions all day long. So, I just remember sort of like delaying sometimes, because I would usually go to the classroom to pick up the child. So, I'd be like, okay, I can wait like three more minutes. So, I kind of found myself postponing.

Participants noted the shift that these behaviors were from the work ethic and clinical engagement they displayed prior to developing burnout. Clinical disengagement often led participants to experience a decrease in their sense of effectiveness and confidence in their clinical skills when working with clients.

Reduced Clinical Efficacy

Reduced clinical efficacy was the fifth theme constructed from RQ1. This term was linked to a participant’s sense of effectiveness in their clinical work with their clients. An analysis of the data revealed the following themes: reduction in clinical effectiveness, reduction in confidence in clinical skills, and recognition of need for change.

Reduction in clinical effectiveness. All six participants noted a decrease in the effectiveness of their clinical skills during their burnout experiences. Participants noted that this was a marked change from their previous sense of effectiveness with clients, and the decrease in efficacy caused significant stress for the participants. Sophia recalled feeling like she was “just

throwing band-aids on people" and was unable to provide the level of clinical support that she was accustomed to. Sophia shared, "it's kind of hard to be all you can be when you're burnt out from having to do everything for everybody." Caroline recalled feeling like she was doing a "disservice" to her clients, because she was not providing the level of care, she had previously been able to provide. Carly reflected on how her experience of burnout impacted "the amount of effort [she] put in" to her work with clients leading her to feel guilt and shame. Similarly, Amanda shared, "At the end, I was questioning my effectiveness. I worried that my emotional state was getting too much in the way of being able to think clearly about treatment planning and interventions."

Reduction in confidence. Three participants shared that their experience of diminished clinical efficacy led them to lose confidence in their clinical skills. Decreased effectiveness with clients was not seen as a temporary result of burnout, rather these participants saw it as a personal failing on their part. Carly shared what it was like for her when she began questioning her clinical skills:

> I didn't feel like I was being very effective with the kids I was working with. I don't think the teachers and parents were necessarily noticing a lot of positive change in their behavior and symptoms. So, I think there was just kind of that sense of like, no matter what I do, it's not really good enough. Like, maybe I just don't know what I'm doing. And so I think sometimes I would be like, Okay, let's, you know, we'll do an activity, but then if they didn't want to engage in it, like I would just kind of feel more frustrated and kind of like okay, well just play a game or something, which probably always was needed, but at the time, I just remember feeling very, like ineffective.

Caroline shared similar feelings, stating, "I lost trust and confidence in myself and how much of a change we're really making." The lost confidence in their clinical skills left the participants feeling frustrated, exhausted, and in doubt of themselves and their fitness for the profession. Jackie recalled her thoughts during this time, "I said to myself, like you're not doing okay. And it's going to start to affect your clients and that's not okay."

Recognition of the need for change. All six participants who noted a decrease in their clinical efficacy recalled that this recognition was a driving force behind their recovery. This recognition will be discussed in greater detail in a later section. It is worth noting that the participants identified loss of clinical efficacy as a moment of realization that change was needed. Sophia shared that viewing herself as a "guiding light" in her clients' therapeutic journeys was an important aspect of her counselor identity. However, she lost this perspective for a time during her burnout experience:

> Yeah, because I couldn't be everything to everybody. I mean, I was giving what I could give because, you know, you have one cup to pour out of. So, I wasn't effective. There's no way that I could have been a guiding light back then because I was just trying to manage the shit show. So, even though I'm not saying I wasn't a good therapist back then. I just was doing the best I could do with the amount of people that I had and the amount of stuff I had to do.

For Sophia, losing her sense of effectiveness with her clients was the catalyst to leaving her position as a school-based counselor. Sophia, having already experienced burnout earlier in her career, stated:

> At that point I could see on the horizon me starting to burn out over it, because for me, I have to feel effective. If I feel like I'm stretched too thin, and I feel like I'm just putting Band-Aids on people I don't feel effective and if I don't feel effective that that really bothers me. So, I started feeling like I wasn't effective, and I didn't want to go back to that burnout stage. So, that's why I left.

Similarly, Caroline shared that her inability to provide the quality of services she was accustomed to led her to lose the "joy" she previously found in her work with clients, and this was a "red flag" to her. Caroline shared her perspective on how decreased clinical efficacy contributed to her experience of other burnout symptoms:

> We're not really, I can't speak for everybody, but we're not in it for the money. So, it's like, if you aren't getting a return on helping people then that's where like, there's a kind of domino effect that starts.

For Caroline, this domino effect led to anxiety, loss of self-care habits, and an inability to fully be present with her family at the end of the workday. Amanda and Jackie recalled the recognition that burnout was impacting their effectiveness with clients came a bit more slowly, because they had such strong rapport with their clients. Amanda shared her recollection of how she came to recognize the negative impact burnout was having on her clinical work:

> I had really good relationships with my clients, but I will say that sometimes I wondered if they were feeding off of my worry for them. I never had anyone say that to me and I never got direct feedback that was particularly negative, but the way that I can look back and see that it affected my clients was that I think they could tell I was overly invested. Maybe they could feel my anxiety and worry about them, you know, and I remember, there was a time or two that I felt a client trying to comfort me and I was like, whoa, this is not good.

Amanda shared that this realization helped her see the need for change in her work circumstances. Jackie shared a similar perspective when she recalled how she did not initially realize the negative impact burnout was having on her clinical effectiveness, because she was focused on advocating for her clients within the system she worked for. Jackie stated:

> You're just thinking you can fight the system and change the system and then even maybe realizing you can't change the system, but you want to be there to help the folks that are still in the system. Then realizing, oh, God, it's harming them and sorry, but you're not effective anymore.

Both Jackie and Amanda shared that they felt willing to work, despite burnout, for the sake of their client's well-being; however, recognizing that their clinical efficacy had diminished helped them see that continuing to work while burned out was not in their clients' best interests.

Research Question Two (RQ2)

Research Question Two (RQ2) was *how do counselors recover from burnout?* The primary form of data collection was semi-structured interviews. Each participant engaged in two interviews, which focused, in part, on understanding how the participants recovered from burnout during their careers as counselors. Although burnout recovery experiences varied across

participants, five themes emerged throughout the analytical process: *recognition, advocacy, preparation for change, active recovery,* and *maintenance.* Each theme will be further elaborated upon and detailed in the following sections.

Recognition

Recognition was the first theme constructed from RQ2. This term was linked to how participants came to recognize their experiences as burnout. All six participants noted moments of realization that the experiences they were having could be attributed to burnout. Catalysts for this recognition varied widely between participants and will be discussed in detail in this section.

Carly shared that she recognized a need for change when she realized that she could not "do [her] best work" when she was continuously "bending over backwards to help." Similarly, Sophia shared that she came to realize that she was "stretched too thin" by the demands of her workplace and the clinical caseload she was responsible for completing. Ultimately, Sophia shared that she noticed a reduction in her clinical effectiveness, which felt unacceptable to her. Jackie also noted that her concern for her clients played a role in helping her recognize her burned-out state. Jackie shared, "I said to myself, you're not doing okay and it's going to start to affect your clients and that's not okay."

In addition to recognizing a reduction in clinical efficacy, which was discussed in a previous section, participants also noticed changes in their emotional states. Caroline shared that she first began to acknowledge that there was a problem when she "couldn't have a conversation without bringing emotion into it." Caroline explained that she became concerned about the impact her emotional state and attitude may have been having on the students she was supervising. Caroline recalled feeling worried that she was being "hypocritical" because she was no longer modeling appropriate behavior for her supervisees. Caroline also recalled that she

found her inability to be fully present at home with her family to be a “red flag.” Jackie also shared how her emotional state caused her to recognize that she was experiencing burnout. Jackie, who had previously experienced depression, realized a need for change when she noticed depressive symptoms in herself:

> I don't really think I was clinically depressed, but I knew that I was headed there. That's the thing is like, I knew the slide into depression. And I was just like, No, I'm not. I'm not doing this again, because I know what this is. I need to change.

Hope shared a similar experience of how her emotional state alerted her to burnout. During her first year working for a crisis hotline, Hope had been distracted by planning her wedding; however, following her return to work after her honeymoon, Hope noticed a concerning change in her emotional state:

> I do have a memory of when I thought, wait a second, I'm feeling kind of depressed. I mean, I've kind of dealt with depression on and off throughout my life. Why am I suddenly feeling depressed? And at first, I was thinking is this just like, post wedding blues that I'm in? It finally occurred to me how it had been a year working in a really crazy job. And I just remember thinking, oh, this is way bigger than what I thought.

Amanda had similar concerns about her emotional well-being that led her to seek out counseling for herself. Amanda shared that she came to recognize her state of burnout during her first therapy session, which prompted her to make the decision to leave her job:

> In that therapy session, you know, she validated me. I didn't feel so crazy. She normalized. She was like you've done a lot of really good work in the time that you've been there. You've put in your time, like why do you feel like you have to keep giving from a dry well? Like, I think I just felt permission to leave.

Amanda went on to share that this conversation with her counselor provided her an alternative perspective. Amanda stated, “I was seeing an opportunity to create a more balanced life for myself.” Similarly, Jackie recalled that a conversation with a friend prompted her to recognize the significance of her symptoms. Jackie stated, “I have this memory of a friend asking me if I might be burned out and then realizing, oh, fuck yes, you are.” While Amanda and Jackie came

to recognize their burned-out state from conversations with others, Caroline recalled gaining this recognition through creating a curriculum on self-care and burnout for her supervisees:

> I was presenting on burnout and self-care and things and I'm very much a practice what you preach type person. My goal was to share that, like, you have to figure out what works for you. So, in talking through that with students and modeling those type things. I was like, oh my gosh, you set your boundaries like, you have this personal life outside of students. Like you have your job, your role as a social worker. And then you have this role as a teacher. So, as I set my boundaries in my personal and professional roles, I realized that's not going to be enough or like, at the extent that I'm at, you've got to do more. That's how I realized like, oh, okay. Yeah, this is serious. This is not just like your average, like, oh, I need to take off a day or two. This is not something that I can just take FMLA and leave for three weeks and come back rejuvenated.

Regardless of the catalyst, participants shared the belief that these moments of recognition marked the beginning of a search for solutions, change, and ultimately recovery from burnout.

Advocacy

Advocacy was the second theme constructed from RQ2. This term was linked to participants' efforts to initiate change within their systems of employment during their recovery from burnout. Five participants shared their attempts to advocate for change within the organizations they worked.

Caroline recalled how she began advocating for change shortly after coming to recognize her state of burnout:

> I was on the mission to fix it. I was like, okay, I got to get more pay, you know, I started advocating for me and my team. We didn't really have much of a team honestly, but the team we did have, I started advocating for, like, we need more people, and I verbalized like, I'm getting to my whit’s end like of like, I can't give any more.

Like Caroline, Jackie felt a level of responsibility to advocate for the clinicians who worked under her. Jackie served as a supervisor and director at a community mental health center, and recalled her experience of mediating conversations between the administration and clinicians:

> I spent like three years trying to, you know, figure out what the admins wanted and trying to figure out what my staff wanted and trying to get them all on the same page and doing, you know, group exercises to get people closer together and, like, still write the admins

> for them. It was the bottom line. It was an us and them mentality. It didn't matter if I presented what, you know, the folks needed for retention, you know, in the sky in giant letters. They didn't care, right, if it conflicted with the bottom line.

Both Caroline and Jackie shared that their advocacy efforts left them feeling unheard and undervalued by the organizations they worked for. Caroline shared her perspective, "I'm not valued, but yet you say you need these services. But that's all I'm getting from you. You're not backing that up with policies and procedures." Sophia's advocacy efforts differed slightly from Caroline and Jackie's. Sophia recalled reaching out to the administration for support when she began to feel "stretched thin" as a school-based counselor stating, "So I tell them this, I need some help. I need resources. I can't do this." Sophia shared that she did feel heard and understood by the administration. Unfortunately, like Caroline and Jackie, Sophia's requests for additional support were not accommodated.

Amanda shared that her advocacy efforts began in response to a continuing education class she took at the beginning of her burnout recovery. Amanda shared that she gained a better understanding of her sense of ineffectiveness in her clinical work from this class. This insight led her to advocate for changes in the substance use program she was working for during this time:

> That class just kind of framed why I was struggling in that environment, because from I when I started that job, I knew that I knew nothing about what I was doing. And so, I dug deep into a whole bunch of research about harm reduction. We didn't even have Narcan spray in the building when I started in this job, and per the federal opioid guidelines we were supposed to be giving a Narcan prescription or a physical Narcan spray to every single client that had an intake and that was not happening. So, I advocated to get Narcan sprays, and I was a counselor. That wasn't my job, but I would constantly see these failures in the program, and I felt this desire to fix them.

Amanda believed that her advocacy efforts hindered her recovery, because she was not successful in initiating the changes that she believed were necessary for the program to be helpful to her clients. Hope was the only participant, out of the five, that reported attempts at advocacy. She shared positive changes from advocacy attempts. Hope recalled that she "took one

for the team" by making a report to administration about the problematic practices of her supervisor. Hope stated, "I reported on her everything that everyone else had been too reluctant to admit." This report resulted in the supervisor being demoted and transferred to a different agency. Hope shared that she quit shortly after making this report with concerns about retaliation.

All five participants who reported advocacy efforts shared that they ultimately came to terms with the ineffectiveness of their attempts to produce widespread change in their workplaces. Amanda recalled how it was for her to come to this realization:

> I just realized I can't fix it all, and it's, you know, creating more anxiety for me to feel like I can and that's just not healthy to have that that viewpoint or that perspective, that somehow you can rescue or fix things or make things better.

Jackie shared a similar realization that she could not initiate change in her organization regardless of her close relationship with administration. Jackie stated, "I knew these folks. I liked them. I just could not change their minds." Hope reflected on her decision to leave her job following the report she made about her supervisor. Although she advocated for a change in leadership, she did not expect to ultimately change the system. Hope shared, "I was not expecting to change the system. That thought never entered my mind. I was in a very powerless position to change anything." This feeling of powerlessness ultimately led Hope to leave the job rather than continue her advocacy efforts. Caroline shared a similar experience. Despite being initially optimistic about her attempts to initiate systemic change, Caroline's perspective shifted following nine months of advocacy with little progress. Caroline stated, "I got out of the headspace of 'How am I going to fix this in the system?' to 'How am I going to be happy and live?' Like, 'How am I going to survive and support my family?'" Ultimately, each of the

participants who attempted to initiate changes in their workplaces decided to abandon advocacy efforts to focus on their own well-being.

Preparation for Change

Preparation for change was the third theme constructed from RQ2. This phrase was linked to participants' experiences of preparing to make changes in support of their burnout recovery process. All six participants shared their experiences of preparing prior to initiating change during their recovery from burnout.

Caroline shared that she began preparing for change months in advance of her resignation by working with a growth coach. Caroline shared that working with the growth coach helped her to explore important questions that aided in her decisions. Caroline stated, "I was trying to tap into like, okay, what do I enjoy? I hadn't thought about it, like, what makes me happy. What do I want to do? What do I need?" Caroline also shared that she began working with the human resources department at her workplace to make financial preparations for her eventual resignation. Caroline ultimately decided to take several months off from work to focus entirely on her recovery from burnout. Similarly, Hope decided to take some time off from work while she prepared for change. During this time, Hope explored volunteer work that would create less pressure for her. Hope shared, "I just wanted to experience doing my work with having total control over how I do my work." Both Caroline and Hope shared that time away from a paid position provided them with the opportunity to self-reflect and determine what steps would be best for them to take next.

While some participants took time away from work to help them explore their options, others felt certain of their next steps. Four participants decided to enter private practice; however, preparation was needed before following through on these decisions. Prior to leaving her position

as a school-based counselor to go into private practice, Sophia gathered information to ensure this would be the right decision for her. Sophia shared what this process looked like for her:

> I started my research and my husband had tried to get me to go into private practice before anyway. So, I said, well, I will just I will test the waters. So, I talked to [a colleague] and she sent out some feelers for me. And then I just started going on lunches with people who had private practices to see if I wanted to do this or not and the risk involved and things.

Sophia highlighted her initial fears about becoming her own boss and uncertainty about the risks involved in private practice. Similarly, Jackie shared how she had to work through her feelings of fear, uncertainty, and self-doubt prior to making the decision to go into private practice:

> I've got these like neuro-divergent things going on that I was a little afraid would not help me in private practice. You know, like, am I going to procrastinate and not bill and not make any money? Am I not going to do my paperwork because there's nobody breathing down my neck and, you know, get in trouble? And so like, you know, I was just nervous. I just, I've always worked for someone since I was like, 16 you know, like, I've never, never not. And so just the idea that I was going to be working for myself was terrifying.

Amanda also had initial hesitations about entering private practice due to her desire to work with underserved communities. Her preparation involved reframing her perspective of her role in the mental health field. Amanda described this experience:

> I think I had a hard time initially seeing myself in private practice because I felt like I should be working for these underserved communities, whether it be community mental health or addiction work. And then I was like, you know what? No, like, I had to kind of reframe how I saw my role in this field. I had to realize that for myself and my own mental health and kind of how deeply empathetic I am and in terms of like, sometimes it's hard for me to separate myself and I'm not saying that like to toot my own horn, it's a struggle. But I recognized that I needed to, you know, work with a different population and that that's okay, and that I don't have to work with, you know, a certain set of individuals to be effective or helpful or to do meaningful work.

Reframing her perspective of her role and the kind of work that could feel meaningful for her enabled Amanda to make the move to private practice that she felt was best for her recovery process. For several participants, preparing for change provided a proverbial 'light at the end of the tunnel.' Caroline shared how this experience facilitated her next steps:

> To know that I was getting out of it was like a relief. To know that I would not wake up and just hate everything and driving to get to work and all that. So, it was really that perspective shift that was that bridge to figuring out what to do.

Following these preparations, participants described their experiences of initiating the changes they believed were necessary to recover from burnout.

Active Recovery

Active recovery was the fourth theme constructed from RQ2. This term was associated with participants' descriptions of their behaviors, changes, and experiences while actively recovering from burnout. An analysis of the data revealed the following themes: increased clinical efficacy, self-care, and support. These subcategories are described in detail below.

Increased clinical efficacy. All six participants noted a marked improvement in their experiences of clinical effectiveness during their recovery from burnout. Participants discussed several factors that contributed to increased efficacy in their clinical work, including supervision, consultation, continuing education, and work autonomy.

Four participants noted the role that supervision played in improving their clinical effectiveness. Participants discussed the necessity of changing supervisors in their recovery process due to feeling unsupported by prior supervision experiences. Hope recalled that her previous supervision had left her feeling "unprepared" for clinical work. For Amanda, changing supervisors was pivotal in her recovery from burnout. Amanda described the experience of meeting with her new supervisor for the first time and how impactful this supervisory relationship was for her:

> And I remember the first time I met with that new supervisor, I felt like I was like constantly on the edge of tears, and I was trying so hard to keep it in when I would meet with her because I was so ashamed of my sadness and tearfulness with the other supervisor. If I showed emotion with that other supervisor, it was very put down, you know, and it was demeaned and it was, 'you need to get it together.' And I felt so vulnerable even shifting supervisors because of kind of the mindset that I was in at that

> time. But yeah, it was a completely different experience. It was very healing to work with her. She challenged me in some good healthy ways and kind of helped me see some different perspectives and ways of working and she was very encouraging, but she also was honest, you know, but just in a much gentler way.

Amanda shared that the support she received from her new supervisor enabled her to regain confidence in her clinical work. Similarly, Jackie shared that her new supervisor helped hold her accountable while learning to set healthy boundaries with work. Jackie shared that her supervisor helped her with "fine-tuning" her practice to develop a work-life balance. Carly shared that working with a different supervisor enabled her to "get caught up" and feel confident in her clinical work. Hope found that working with a new supervisor offered her a new perspective on her clinical skills. The supervisor empowered her to use interventions that prior supervisors had not supported. Sophia noted the importance of working with a supervisor not affiliated with her workplace. Sophia shared that she decided to pay an outside supervisor because she was receiving inadequate supervision from her employer. Sophia reported that the supervisor change was "beneficial" and supported her as she learned to work with children in the school system. Ultimately, all four participants who noted the significance of supervision in their recovery experiences decided to pursue private supervision.

Three participants also noted the importance of pursuing consultation and continuing education during their recovery experiences to improve their clinical efficacy. Carly shared how consultation supports her professional well-being:

> I benefit from connection and collaboration with therapists. So, I think just that desire for community and support, and I just always noticed that when I do have, you know, consultation and collaboration, it just always like re-energizes me and makes me feel more confident.

Jackie also shared the importance of consultation in improving her sense of clinical effectiveness. Jackie shared that she started a consultation group to help her grow her clinical

skills for working with trauma. Jackie shared, “That was really great because you can just talk to other people about what it's like doing the work and like the different things that you struggle with.” Amanda shared that pursuing continuing education provided her with validation and a new perspective on her experiences. Amanda recalled the role that continuing education played in her recovery from burnout:

> I had lots of clients that were dealing with grief that had lost friends or family members to overdose or just had natural grief in their lives, or I had clients that died while I was there. And so that grief counseling class was very healing for me. There lots of opportunities for personal reflection when I took that class. I met with a hospice representative, that that was just very healing in that journey. She kind of framed some things in a light that was just like an ‘aha moment.’ So, a lot of the continuing education was just very informative and educational, but it was also very validating to my experience, and it gave me some perspectives that things could be different.

Similarly, Carly recalled that engaging in continuing education during her recovery process improved her overall confidence in her clinical work. Carly stated, “I always can come back to that if I’m feeling stuck.”

Five participants discussed the significance of having a sense of autonomy in their work during their recovery from burnout. Participants noted that the sense of autonomy they gained upon entering private practice enabled them to make the clinical decisions they felt were best, improving their overall confidence and experience of effectiveness in their clinical work. Carly reported that “having [her] own space and [her] own decisions” supported her recovery from burnout. Sophia shared similar feelings. She stated, "Just having control over what is put on me and knowing that I can do this. I can be effective with this.” Sophia reported that this was “very liberating” during her recovery from burnout. Jackie also reflected on the importance of autonomy in her work, stating, “I’m in control of everything that I do. I can live up to my own standards now because I am my own boss.” Participants also reported that work autonomy empowered them to make decisions that supported their overall wellness, which they believed

improved their ability to be present and attuned with their clients. Caroline shared that "you hold a lot more power" working in private practice enabling her to set a routine and boundaries to prevent re-entering burnout in the future. Hope shared, "It's so much healthier. I have the freedom to refer and things like that. I have noticed within myself just more freedom to empathize with not even just my clients but just people." Amanda shared a similar experience:

> I entered into a one-person LLC private practice, where I just feel like I have more control over creating balance for myself, you know, physical, emotional, mental. I can set my schedule. I can do check-ins with myself and ask, 'what can you take and what can't you take right now' and really pace myself versus other people telling me what I have to do in terms of productivity and things like that.

Increased clinical efficacy played a significant role in the participants' recovery from burnout. While reflecting on her motivation for recovery, Carly recalled, "I started seeing real progress in my clients, and I think that's what fueled me." Sophia shared that she was able to "fully invest" in her clinical work during her recovery from burnout. Sophia stated, "I definitely think I'm a much better therapist now than I was." Similarly, Jackie recalled, "I really needed to see folks getting better." Jackie believed that seeing improvements in her clients' outcomes was vital to her recovery from burnout. Amanda recalled how she "reframed how [she] saw [her] role in this field" during her recovery process. This resulted in increased clinical efficacy because Amanda no longer felt like she needed to "rescue" her clients from their problems. Amanda stated, "I'm able to let go and allow them on their journey, which is actually much more empowering for them."

Self-care. All six participants discussed the importance of self-care during their recovery from burnout. Participants described the process of developing a new self-care routine, setting boundaries, and finding a balance between their work and personal lives.

Five participants shared experiences of developing new self-care practices during their recovery from burnout. Caroline shared, “It took me two years to develop a self-care routine.” For Sophia, self-care was not something she intentionally engaged in prior to her recovery from burnout. Sophia shared that self-care “wasn’t really talked about a lot” during her graduate program or early career as a counselor. Given that she was developing a self-care plan for the first time, Sophia shared that it took “trial and error” to figure out what self-care practices were best for her. Alternatively, Jackie shared that she knew what self-care practices she needed but had difficulty implementing them. Jackie shared what the process of developing self-care practices looked like for her during her recovery from burnout:

> I would say it's complicated because I might know explicitly what it needs to look like, but then I had to work to kind of pare down my caseload. So, I would say at the beginning of this year, for instance, I went down to three days, but then I still had a group on Fridays. And I realized, nope, I don't want to have the group on Fridays. And then I had my perfect number of clients and people wandered off for the summer. And then suddenly, I had like five clients too many. You know what I mean? So, it's a process of like, you know what you need, but you're testing those boundaries, and then you realize, you need to stop doing that and then you lean into your ‘no.’ So even that is kind of a process. It's not like suddenly you’re in recovery.

Similarly, Caroline shared that the process of developing self-care involved “getting back to baseline and intentionally bringing good things into [her] life.” For Caroline, this meant engaging in activities that she knew she previously enjoyed, such as yoga, gardening, journaling, drawing, and spending time with her family. Amanda began developing her self-care by recognizing her limits. Amanda shared:

> I would love to make a whole lot of money in private practice. Absolutely. But I am like, I need to pace myself. So, I'm pacing myself. I am recognizing what I can and can't handle. I'm not trying to be like I can take all these clients and help them because somehow, I can be responsible and help them all. I'm just recognizing my limits, giving myself space for my emotions, not overworking myself, and making sure I have time for my kids.

Amanda's self-care routine involved getting "adequate rest," exercising, spending time in nature, spending time with her family, and giving herself "space to decompress" between clients. Hope developed her self-care routine by asking herself, "What life would be like if [she] did more of what [she] wanted to do?" Having experienced significant physical illness at the beginning of her recovery process, Hope shared that she focused her self-care on physically recuperating from both illness and burnout.

Five participants discussed the importance of setting boundaries to create space to care for themselves effectively. Participants' boundaries were primarily focused on their clinical workload and their expectations. Participants discussed the difficulty involved in establishing new boundaries. Caroline shared, "I started setting hard boundaries, and it was hard because boundaries are hard." Amanda shared the perspective shift she needed to be able to set boundaries in her clinical practice:

> I was just kind of recognizing that I'm one person and I cannot fix all these broken systems. I'm not responsible for it. I didn't create it. I can do what I can in the moment, but then at the end of the day, I am not in control of all these pieces of the puzzle.

This change in perspective enabled Amanda to establish boundaries in her clinical caseload, work hours, and day structure. Amanda stated, "I've been really intentional in private practice about scheduling my clients in a way that gives me some space for taking some deep breaths and not feeling rushed." Carly shared that establishing boundaries has enabled her to prioritize time for herself, although becoming comfortable setting boundaries was difficult for her when she first entered private practice. Carly stated:

> I struggled with it at first because I had the mentality of like, 'oh, it's going to be really hard to get clients and you just need to take anybody who is willing to see you at whatever time and whatever they're able to pay'. So, I started off with a lot of really reduced the clients and I was seeing people like early in the morning and in the evening. I eventually recognized that was leading to feelings of resentment at times. I realized in order to do my best work, I needed to just say 'okay, these are my hours and if these

> hours don't work for you, I wouldn't be a good fit.' And that was that's been helpful. Just having boundaries.

Sophia shared a similar experience: "I felt like I could start setting these work boundaries, even though I did struggle with it in the beginning." Over time, Sophia implemented changes in her boundaries with work by no longer bringing her computer home, not taking work calls after work hours, and utilizing her commute home from work to engage in self-care through listening to music.

Although participants discussed the difficulties of initially setting boundaries, they also shared the necessity of boundaries during their recovery from burnout. Caroline shared that boundary-setting was the first step of her active recovery from burnout. Caroline stated, "Setting boundaries, that was the first step of like, 'Okay, how does this feel? Is this supporting you?'" Exploring the boundaries that she needed to support her recovery facilitated Caroline's development of a self-care routine. Jackie shared that establishing boundaries involved 'trusting [her] gut." Jackie stated, "I decreased the number of days I was working per week. I established what I thought was a reasonable caseload, and I have tried to stick to that." Jackie also shared, "I have a way of that I set up my schedule so that I can take breaks if I need to take a nap or a walk." These changes created space in Jackie's week for her to engage in self-care and focus on her life outside of work. Amanda shared her experience of setting a similar boundary: "I have some clients that I feel heaviness more so than with others after a session is over. So, I try to schedule those in a way that I have some space between that client and another client."

Participants discussed how these boundaries enabled them to establish a balance between their work and personal lives. Amanda shared, "I really began valuing myself and having balance in my own emotional and mental health." Before initiating her recovery from burnout, Amanda recalled that she often had to decline invitations to social engagements due to her work

obligations. One work-life balance indicator for Amanda was having time for her social life and personal relationships again. Amanda stated, “I was able to be home and personally feel like I was able to invest time in my family and my kids and friendships, you know, and doing fun things with friends.” Caroline shared that she began to cultivate balance during her recovery by “doing stuff around the house, and things had been neglected.” Caroline further stated, “I started doing things that made me happy, like spending time with my kid and just being present.” Jackie shared that she developed balance incrementally throughout her recovery from burnout. Jackie shared, “I would say every time there’s a change, I know I need to do all the things. It’s just that I can’t really do all the things at once. So, sometimes, it’s just learning to be comfortable with a little bit at a time.” Jackie created balance by using boundaries to change the structure of her workday. Jackie stated, “It was a huge adjustment, but now it’s like, I do a couple of sessions, then I get a nap or a snack. It’s just perfect because it’s nice and flexible. I can just tailor it to what I need.” Developing a balance between their work and personal lives enabled participants to engage more fully in both.

Support. All six participants discussed the importance of receiving support during their active recovery from burnout. Participants discussed three primary sources of support: support from other counselors, personal therapy, and friends and family.

Five participants discussed how receiving support from other counselors facilitated their recovery from burnout. Carly discussed her experience of entering private practice and beginning her recovery from burnout alongside several colleagues in the field. Carly stated:

> A lot of people that I work with, and a lot of my friends went into private practice or group practices with different expectations around the same time within the last few years. So, for several of us, there was sort of a collective, ‘Oh, this is a lot better.’ We have a lot more time. We have a lot more energy. We’re more present.

Carly shared that going through burnout recovery with other counselors normalized the process for her and helped her feel supported. Carly shared that "talking through things with other therapists and having them normalize it is really helpful." Similarly, Sophia shared that a group of counselors in the partial hospitalization program she worked in played a large role in supporting her when she decided to leave that job because several of them decided to leave around the same time. Sophia shared, "We just kind of became each other's support system. It has kind of helped us all deal with the guilt of leaving." For Jackie, support from colleagues helped her recognize her burned-out state. Jackie shared that it took "feedback from a trusted colleague, and [she] was like, 'whoa, what's happening here?" Jackie believed connecting with others in the field is essential to her recovery process. Jackie stated, "You can't be siloed in this work, or you're going to go down a bad path without even realizing it." Similarly, Hope found that connecting with other counselors at the crisis support line she worked for helped her to recognize her burnout. Hope shared that receiving support from other counselors "really validated [her] experience." Hope reflected on the impact this had on her:

> I knew I was not an idiot or crazy for thinking these things and feeling this way. Everyone was in exactly the same spot that I was in, both people who had been there for a little bit longer and people who had not been there as long. Everyone had the same experience I was having.

Amanda also shared how connecting with other counselors who had similar experiences to hers provided her with support during her recovery. Amanda shared that "being able to be part of a community of counselors that understood the challenges and the emotional difficulty was helpful."

Four participants discussed how receiving support from engaging in personal therapy facilitated their recovery from burnout. Carly shared that she believes going to therapy has "made [her] a more compassionate and present therapist." Carly sought out personal counseling

for the first time during her recovery from burnout. Carly stated, “I think actually experiencing what therapy looks like with a therapist and what it’s like to be the recipient of therapy is a big part of what gave me confidence.” Jackie shared how engaging in counseling helps her hold her boundaries and let go of negative thoughts. Jackie reflected on a time when she felt upset with herself for not upholding a boundary and how her counselor provided her with compassion and normalized her experience. Jackie stated:

> When I realized what had happened, I immediately was like, I'm so mad at myself right now because I said no twice and then the third time, I couldn't hold it. She just normalized that, like, ‘you're just one of those people who really doesn't want to pathologize people. You're willing to extend yourself possibly more than someone else might be. And yes, that's getting you into trouble, but like, you can be aware of that and not let it happen again.’ She was just so helpful because we’re often our worst critics.

Talking with her counselor about her difficulties and maintaining her boundaries enabled Jackie to provide herself with compassion and understanding. Caroline shared that engaging in personal counseling helped her work through guilt related to leaving her previous job and exploring her needs as she entered recovery from burnout. In reflecting on how counseling helped her let go of guilt and negative self-talk, Caroline stated, “I can’t tell you how important therapy was for me to get out of that headspace.” Caroline shared that therapy also provided her with a space to “talk about options without any repercussions” as she was planning to leave her job. Amanda also began counseling shortly after beginning her recovery from burnout. Amanda shared that counseling “helped [her] to reflect in a safe space on what was good for [her] and what wasn’t.” Amanda shared that her counselor validated and normalized her experience of burnout. Amanda shared that this support enabled her to “get unstuck” and move forward with her recovery.

Five participants discussed how support from friends and family facilitated their recovery from burnout. Hope recalled how her husband supported her decision to leave her job. Hope shared, “My husband could see what was going on, and he was alarmed. So, he was like, ‘I don’t

care if I have to drive a trash truck. You've got to get out of there. Just stop working." Amanda shared a similar experience of receiving support from her husband:

> My husband, of course, was supportive, and he was like, 'I think you need to leave the methadone clinic,' and I was like, 'No.' You know, I felt such a sense of responsibility to my clients because I felt like such an outlier from the abstinence-only approach. So, I felt like I was abandoning them. He was like, 'There's always going to be clients in need of support. This world is not short of people in need of your support. And if you're not supporting them here, there will be supportive people elsewhere.'

This support helped Amanda feel able to leave her job and begin recovering from burnout. Caroline also noted the importance of receiving support from her husband, which enabled her to take a break from work and focus on her recovery. Caroline stated, "It took my support system with my husband for me to actually say, 'I'm going to take a break. I need it.'" Similarly, Jackie shared that her partner facilitated her burnout recovery by encouraging her to go into private practice. Jackie stated, "Part of it was my partner who just kept saying like, 'I don't know why you keep working for people. You could be your own boss.' like just over and over until I actually heard him." Hope shared that support from her mother also played a vital role in her recovery from burnout. Hope, who was simultaneously recovering from a serious physical illness alongside burnout, shared how her mother came to stay with her for a time to support her recovery. Hope shared that her mother "acted as [her] caretaker for about a month," enabling her to focus entirely on her own health and well-being.

Maintenance

Maintenance was the fifth theme constructed from RQ2. This term was associated with participants' descriptions of maintaining their recovery to avoid re-entering burnout. Participants described the self-care practices, boundaries, and self-awareness required to maintain their recovery. All six participants discussed their experiences of maintaining their recovery from burnout.

Participants described their self-care as ongoing practices requiring consistency and flexibility. Caroline shared her experience of maintaining her self-care routine:

> I do a daily guided meditation to start my day off. As I go through my day if I'm just overwhelmed and like, I'm just high energy. Yeah, those are red flags or those are warning signs. So, I will do another guided meditation. I'll do yoga. If I'm at home, I'll go for a walk. So, I gauge my body. I'm like, 'What self-care do you need? Do you need physical self-care? Mental self-care? Do you need social self-care? Like what do you need? So, I really identify that and then I go from there based on the flexibility in my support system and the money it costs, you know. I'm very intentional about bringing those in daily or weekly.

Similarly, Carly shared that she had noticed the impact on her overall well-being when she fell out of practice with her self-care habits. Carly stated, "I've noticed how it affects me on the weeks that I don't do that. Like, I do know what works for me and it's just having confidence that that is the right thing to do." Sophia shared that she had found it important to take regular breaks from work to maintain her self-care practices. Sophia stated, "Still, to this day, there are times that I'm just tired of hearing people talk. I really need to go home or go on vacation for a couple of days, and then I'll be alright." For Jackie, maintaining her self-care required her to attend to her daily structure and habits to ensure she felt her best. Jackie shared what maintaining her self-care practices looked like for her:

> I try to do yoga every morning. I try to take a shower at night. The thing is, I work from home. And so, I think part of that is realizing even if you work from home, you still need to have a schedule, or you're going to roll out of bed and into your sessions with pajamas and bedhead, which that's not me.

Participants also described how they have maintained their boundaries to prevent burnout from developing again. Carly reflected on how it could be difficult to maintain boundaries; however, she had come to recognize the importance of upholding them. Carly shared, "I do notice the weeks where I push the boundaries, I start to feel that burnout feeling just kind of creeping in a little bit." Recognizing the relationship between maintaining her boundaries and the

development of burnout has motivated Carly to continue upholding her boundaries. Caroline shared that she had found it simpler to maintain her boundaries than it was to set them initially. Caroline stated, “Boundaries have been important for sure, but I'm not rigid with them anymore. Like, they’re already made, you know.” Caroline shared that it took some time for her to become comfortable maintaining the boundaries that she had set; however, now that several years have passed, she feels fully comfortable with them. For Sophia, maintaining her boundaries helped her feel in control of whether she would develop burnout in the future. Sophia shared her perspective:

> If I get burned out now, it's my fault. I mean, I would have put myself in that position. There's nobody telling me, you know, take on more clients, over schedule yourself, work from home, take the calls. If I do those things, that's because I chose to do it, but I'm not going to choose to do that.

Boundaries gave Sophia a sense of personal responsibility, which had made her feel confident in her ability to maintain them.

Ultimately, participants emphasized the significance of staying self-aware to proactively address burnout before it recurs. Caroline discussed the importance of utilizing her self-awareness to guide which self-care practices, boundaries, or changes she needed to make based on her feelings. Caroline shared:

> It just really comes back to self-awareness and having those tools in my tool belt from these years of figuring it out. So, I'm not in that window of trying to figure it out again. I figured out what works for me. Now, I'm just pivoting and adapting to where and when they're needed.

Jackie discussed the importance of recognizing that burnout recovery was not a linear process. Jackie believed she had gone back and forth between burnout, active recovery, and maintenance throughout her career. Jackie shared that it had sometimes felt like “two steps forward, six steps back, three steps forward, one step back, four steps forward, five steps back” over the course of

her experiences with burnout. Carly shared a similar view of what it had been like for her to maintain recovery from burnout. Carly shared, "There is definitely a learning curve and, you know, regressions." Caroline viewed maintenance as "an ongoing process and evolution of preventing burnout." Each of these perspectives highlighted the ongoing and flexible nature of maintaining recovery from burnout. All six participants shared the belief that maintenance was not a destination, but an ever-changing practice that they would continue to engage in for the remainder of their careers.

Conclusion

Chapter IV provided insight into the experiences of burnout and recovery among six practicing counselors. The analytical process sought to explore participant experiences to explain the phenomenon of burnout recovery. An examination of the data in four stages revealed predominant themes that are detailed in this chapter as findings. In this chapter, demographic and descriptive information regarding participants was also detailed and condensed.

RQ1, which sought to explore the ways that counselors experience burnout, was restated. The first theme was *systemic factors*. This theme was associated with how participants identified workplace or systemic factors as causal factors for their burnout. Four primary sub-categories of systemic factors were constructed: *dysfunctional leadership*, *workload*, *compensation*, and *resentment*. The second theme was *psychological symptoms,* which were linked to the cognitive and emotional symptoms that participants associated with their experience of burnout. Three primary sub-categories of psychological symptoms were constructed, which were *depression*, *anxiety*, and *cognition*. The third theme was *exhaustion*, which was linked to participants' reports of mental, emotional, and physical exhaustion during their experiences of burnout. The fourth theme was *clinical disengagement*, which was linked to participants' reports of withdrawing

from their work with clients during their burnout experiences. The fifth and final theme related to RQ1 was *reduced clinical efficacy*, which was linked to participants' sense of effectiveness in their clinical work with their clients. Three primary sub-categories of reduced clinical efficacy were identified: *reduction in clinical effectiveness*, *reduction in confidence in clinical skills*, and *recognition of need for change*.

RQ2 sought to understand the ways in which counselors recover from burnout. Five primary themes were constructed related to the second research question. The first theme was *recognition*, which was linked to how participants came to recognize their experiences as burnout. The second theme was *advocacy*, which was linked to participants' efforts to initiate change within their systems of employment during their recovery from burnout. The third theme was *preparation for change*, which was linked to participants' experiences of preparing to make changes in support of their burnout recovery process. The fourth theme was *active recovery*, which was associated with participants' descriptions of their behaviors, changes, and experiences while actively recovering from burnout. Three sub-categories of active recovery were identified: *increased clinical efficacy*, *self-care*, and *support*. The fifth and final theme related to RQ2 was *maintenance*, which was associated with participants' descriptions of maintaining their recovery to avoid re-entering burnout.

In Chapter V, a predominant theoretical framework will be presented, which was developed through participant interviews and a comprehensive analysis of the data, aimed at elucidating the process of burnout recovery among counselors. A theoretical framework offers a visual representation of the connections between identified themes and processes. The primary theoretical framework constructed from this grounded theory study was utilized to explore how the existing literature aligned with the present results and to elucidate how this original research

contributed to the current understanding in the field. Chapter V will also provide a discussion of the implications, limitations, and recommendations resulting from this study.

CHAPTER V:

DISCUSSION

This chapter presents the grounded theory constructed to explain the phenomenon of burnout recovery in counselors. Additionally, this chapter offers further discussion concerning the findings, implications, and recommendations for practitioners, educators, and researchers. The primary purpose of this research has been to explain the phenomenon of burnout recovery in practicing counselors. This grounded theory study involved six practicing counselors who had experienced burnout and recovered during their counseling careers. Participants engaged in semi-structured interviews exploring their lived experiences of burnout and recovery.

Through a four-step analytical process, the researcher constructed themes that conceptualized participants' experiences of burnout and recovery. From this analysis, a predominant theory of burnout recovery in counselors was constructed and visually presented in Figures 1 and 2. The sections below will explain the components of this theoretical framework. This chapter concludes with the discussion, limitations, implications, and recommendations sections.

Boiling Over: A Grounded Theory on Counselors and Overcoming Burnout

As the interview data was analyzed and the research questions were explored, a depiction of burnout recovery in counselors was constructed. This conceptualization of burnout recovery in counselors was developed from the data. This chapter presents these findings as a theory about how counselors recover from burnout.

A graphical depiction of the theory assists in illustrating the thematic progression as narrated by the participants during the interviews. The key themes linked to the theory are depicted in Figures 1 and 2. Some themes outlined in the preceding chapter were not shown as distinct categories in the visual representation of the theory but were instead elaborated upon as subcategories of the ones that were incorporated. The theory has been shown in two figures to differentiate between the two phenomena: burnout and burnout recovery.

Figure 1

Graphic Representation of the Burnout Component of the Grounded Theory

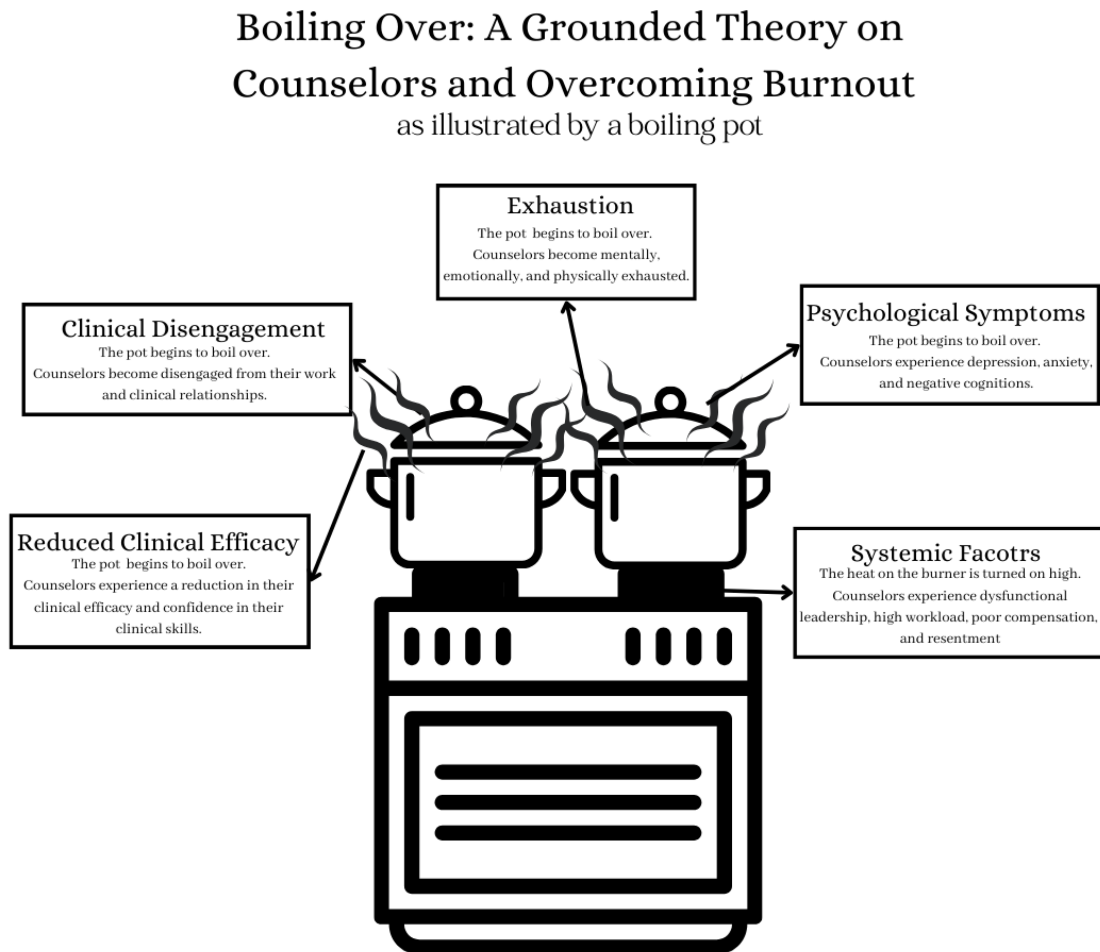
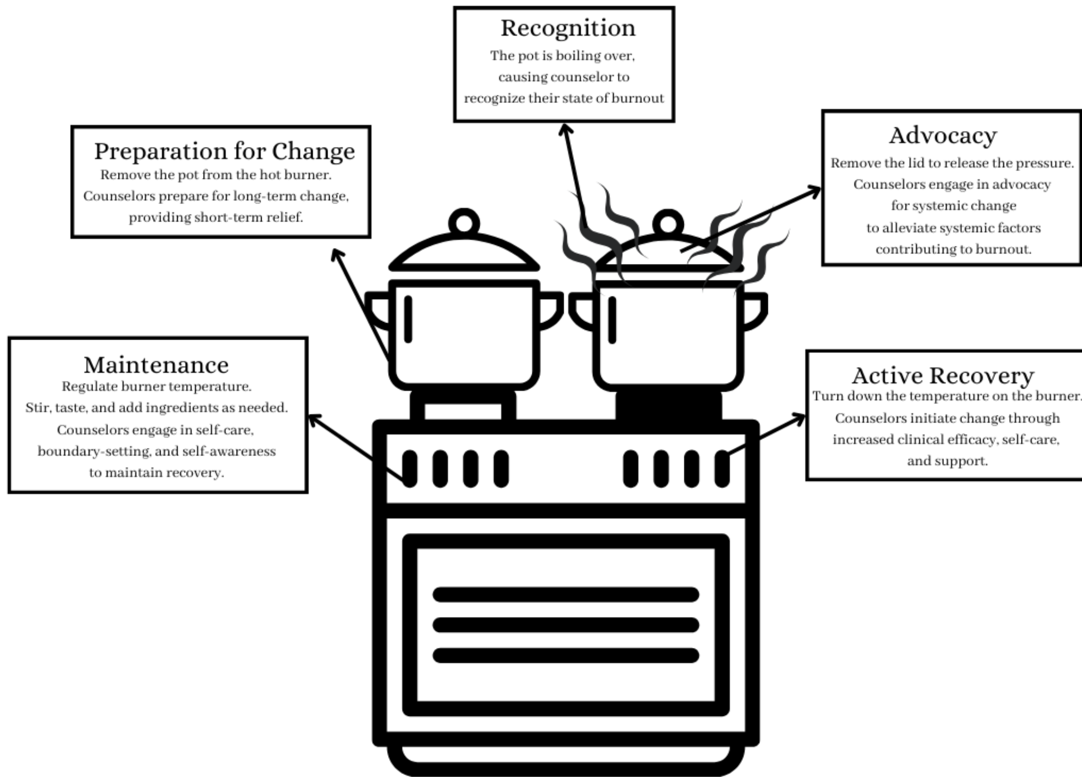


Figure 2

Graphic Representation of the Recovery Component of the Grounded Theory



The Boiling Pot

The boiling pot was chosen as the graphic representation of choice for this grounded theory because of its ability to illustrate the experience of burnout recovery in counselors via an appropriate metaphor. This metaphor illustrates the iterative nature of the stages and components of the grounded theory. In addition, given that the phenomenon of burnout is often colloquially associated with heat, the imagery of the boiling pot is a more captivating choice as opposed to other illustrations. Symbolic representations of the theoretical framework using the imagery of a boiling pot will be elaborated upon in subsequent sections of the grounded theory.

Burnout

The process of developing burnout is illustrated in Figure 1. This process is separated from the process of burnout recovery depicted in Figure 2 to differentiate the two phenomena clearly. Figure 1 illustrates how the impact of systemic factors on counselors leads to the development of psychological symptoms, exhaustion, clinical disengagement, and reduced clinical efficacy. These findings align with previous research that conceptualized burnout as a process that developed through a linear progression of stages, increasing in severity over time (Golembiewski & Munzenrider, 1988; Guditus, 1981; Leiter & Maslach, 2016; Maslach, 1982). The theory presented here also presents stages of burnout; however, it differs from prior sequential stage models in that it does not conceptualize the development of burnout as a linear progression. Additionally, the present theory places a great deal of emphasis on the role of systemic variables in the development of burnout. This aligns closely with the Areas of Worklife (AW) model (Leiter & Maslach, 2004), which focuses on imbalances between the individual and their job. Like the AW model, the current theory focuses on the role of one's work environment as a primary catalyst for the subsequent development of burnout.

Systemic factors. The first stage of the theory pertains to the systemic factors contributing to a counselor's development of burnout. Employment systems involve many factors that are outside of the employee's control. These factors may positively or negatively impact the employee, depending on whether they support or inhibit the employee's work, well-being, and attitude toward work. In the development of burnout, counselors experience several factors that negatively impact their well-being. The primary factors elucidated in this study are dysfunctional leadership, high workload, poor compensation, and resentment. When counselors experience a lack of support and pressure from workplace leadership, large caseloads of clients with severe symptoms, excessive paperwork, and poor compensation, counselors become angry and resentful towards their systems of employment.

Figure 1 illustrates how systemic factors associated with a counselor's employment turn up the heat on the burner, increasing the temperature and pressure within the pot. The longer that the burner is turned to high heat (i.e., counselors experience negative systemic factors), the more likely it is for the pot to begin to boil and eventually boil over in reaction to the prolonged exposure to the heat source. All participants in this study discussed the significance of systemic factors on their development of burnout throughout their responses and further described how these factors influenced their ultimate choices to enter private practice.

These findings align with prior research that explored the role of systemic variables in counselors' development of burnout. Systemic variables such as work setting (Craig & Sprang, 2010; Lent & Schwartz, 2012; Warren et al., 2013), level of work demand (Hammond et al., 2018; Holman et al., 2018; 2018; Kim et al., 2018; Steel et al., 2015; Vilardaga, 2011), caseload size and severity (Acker, 2010; Kim et al., 2018), and workplace support (Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011) have been shown by prior research to be predictors

of one's likelihood of developing burnout. The present study supports prior findings, given that all the participants in this study attributed the development of their symptoms of burnout to the systemic variables they were experiencing at the time. The primary systemic variables discussed by participants in the present study are dysfunctional leadership, workload, compensation, and resentment. Prior research has found that counselors who reported high levels of clinical and administrative support experienced greater feelings of personal accomplishment and lower rates of emotional exhaustion (Gibson et al., 2009; Jovanovic et al., 2016). Prior research has shown that counselors who reported high workloads experienced increased rates of emotional exhaustion (Hammond et al., 2018; Kim et al., 2018). The present findings support the existing literature but also provide new insights into the significance of compensation and counselors' attitudes toward their workplaces.

Symptoms of burnout. Developing symptoms associated with burnout is the second stage of the theoretical framework. These symptoms indicate that there is an alteration in the counselor's functioning, and change may be necessary. In Figure 1, the steam rising from the boiling pot illustrates these symptoms. Steam, like the symptoms, is a visible consequence of the boiling water within the pot. Symptoms do not occur in a sequential order and were experienced in a variety of ways by the participants in this study.

The first symptom category counselors experience during burnout is psychological symptoms including depression, anxiety, and negative thoughts. Symptoms of depression result in counselors withdrawing from activities they previously enjoyed. Counselors may experience sadness, tearfulness, and feelings of hopelessness. In severe circumstances, counselors may develop thoughts of suicide. Counselors also experience anxiety, especially in relation to their work with clients. Counselors may feel restless, on edge, and have difficulty creating boundaries

between their work and personal lives. Finally, counselors experience changes in their thought processes, resulting in negative self-talk and self-doubt. These cognitive changes may hinder counselors' experience of clinical efficacy and ability to attune with their clients. These findings align with prior research that has found that counselors who are experiencing burnout are at an increased risk of also developing depression, anxiety, secondary traumatic stress, and general psychological distress (Fong et al., 2016; Hammond et al., 2018; Papathanasiou et al., 2017; Tzeletopoulou et al., 2018). The findings of the present study support previous research that has illustrated the ways in which burnout negatively impacted counselors' mental and emotional well-being (Barton, 2020; Hammond et al., 2018).

The second symptom category that counselors experience during burnout is exhaustion. This includes mental, emotional, and physical exhaustion. Mental and emotional exhaustion occurs as the result of systemic factors such as high caseloads, regularly working with clients who have severe symptomology, and excessive documentation requirements. The previously discussed psychological symptoms may cause sleep disturbances. These sleep disruptions cause the counselor to not achieve adequate rest each night, resulting in physical exhaustion during the workday. Physical exhaustion may also be attributed to systemic factors such as excessive documentation requirements, long work hours, or pressure from workplace leadership. These findings align with prior research that has established exhaustion as a primary symptom associated with burnout (Maslach & Leiter, 2016). Difficulties with sleep have been commonly reported in the burnout literature, contributing to counselors' experience of physical and psychological exhaustion during burnout (Hammond et al., 2018; Engebretson & Bjorbaekmo, 2019; Yang & Hayes, 2020).

The third symptom category counselors experience during burnout is clinical disengagement. Clinical disengagement, or withdrawing mentally, emotionally, and physically from one's clinical work, negatively impacts both counselor and client. Clinical disengagement occurs as the result of counselors' experiencing prolonged exhaustion, psychological symptoms, and exposure to negative systemic factors. These findings align with prior research, which has established clinical disengagement or depersonalization as a primary symptom associated with burnout (Maslach & Leiter, 2016). Like the present findings, prior research has indicated that clinical disengagement inhibited job satisfaction and contributed to decreased feelings of personal accomplishment (Delgadillo et al., 2018; Scanlan & Still, 2013). Clinical disengagement also interferes with the counselor's ability to build rapport and attune with their clients, which eventually leads to a reduction in the counselor's clinical effectiveness (Delgadillo et al., 2018; Hammond et al., 2018).

The fourth symptom category that counselors experience during burnout is reduced clinical efficacy. As previously stated, clinical disengagement leads to a reduction in counselors' experience of effectiveness in their clinical work with clients (Delgadillo et al., 2018; Hammond et al., 2018). Additionally, counselors may lose confidence in their clinical skills and overall ability to be helpful to their clients (Delgadillo et al., 2018; Salyers et al., 2015). These findings align with prior research that has established reduced feelings of personal accomplishment as a primary symptom associated with burnout (Maslach & Leiter, 2016). Participants in this study emphasized the importance of feeling effective in their clinical work. Decreased clinical efficacy led the counselors in this study to experience reductions in their sense of personal accomplishment. Additionally, participants in this study noted that this symptom category served

as a catalyst to recognizing their state of burnout and exploring needed changes to begin recovery.

Burnout Recovery

Figure 2 illustrates the process of burnout recovery in counselors. This section will describe the stages involved in burnout recovery in a linear fashion; however, it should be noted that burnout recovery is an iterative process. Based on the findings of this study, counselors enter burnout recovery in stage one, *recognition*, but counselors may not move sequentially through the stages. Depending on the circumstances, counselors may repeat stages or engage in aspects of multiple stages at once. The phenomenon of burnout recovery in counselors has not been fully explored in prior research (Yang & Hayes, 2020), and this component of the grounded theory contributes to filling this gap in the literature.

Recognition. Recognition is the third stage of the theory and marks a counselor's entry into their recovery from burnout. This stage is evident by the counselor's realization that the symptoms they have been experiencing can be attributed to burnout. This stage is illustrated in Figure 2 by the steam rising from the boiling pot, indicating that the pot is boiling over. The steam is also utilized in Figure 1 to depict the symptoms counselors experience because of burnout. The steam serves the purpose of illustrating both stages because these stages are inextricably linked to one another. The symptoms of burnout are the warning signs that a problem is developing. If the steam is not addressed, the pot will inevitably boil over. Therefore, once the steam is recognized as an indicator of probable burnout, the counselor can initiate needed changes. Prior research has indicated the importance of self-awareness and recognizing burnout to increase the likelihood of early intervention strategies being successful (Newton et al., 2020). Recognition is needed for counselors to be able to employ interventions that help recover

from burnout (Baker & Gabriel, 2021; Barton, 2020). Prior research has also found that guilt and shame might interfere with counselors' ability to recognize their state of burnout (Coaston, 2017; Miller & Sprang, 2017). The present findings largely align with the findings of prior research; however, the present study provides additional insight into the role of clinical efficacy in counselors' recognition of burnout. Participants in the present study discussed the ways in which decreased clinical effectiveness serves as a catalyst to their recognition of burnout.

Advocacy. The fourth stage in the theory is advocacy. During this stage, counselors may advocate for changes in their systems of employment in the hopes of alleviating negative systemic factors contributing to their burnout. This stage is illustrated in Figure 2 with the removal of the lid on the boiling pot. Removing the lid releases pressure on the pot's contents, which interrupts the overflow of water. In this stage, counselors work alongside the administration to negotiate changes in their work environments to improve the quality of leadership, reduce workplace pressures, and alleviate clinical disengagement. It is worth noting that not all counselors will go through this stage of the theory. In this study, five out of six participants discussed their advocacy efforts. The participant who did not advocate for systemic changes noted that she did not believe that she would be successful in initiating the needed changes; therefore, she moved straight from *recognition* to *preparation for change*. Of the five participants who did attempt to advocate for changes, none were successful. However, it is assumed that the remaining stages of the theory would progress as described in the following sections regardless of the outcome of advocacy efforts. As illustrated in Figure 2, removing the lid from the pot is a temporary stopgap to halt the overflow of water. Additional action is necessary to prevent the water from boiling over again.

The role of systemic factors in the development of burnout has been thoroughly explored in the literature (Hammond et al., 2018; Holman et al., 2018; Kim et al., 2018; Lent & Schwartz, 2012; Steel et al., 2015; Thompson et al., 2014; Warren et al., 2013). However, there is a lack of information in the literature about counselors' efforts to advocate for changes within their systems of employment. The findings of the present study help fill this gap in the literature. Given that all the participants in the present study were unsuccessful in their advocacy efforts and chose to ultimately leave their places of employment, the findings align with prior research that has linked burnout with job turnover among counselors (Greenham et al., 2019; Scanlan & Still, 2013).

Preparation for change. The fifth stage of the theory is preparation for change. This stage is illustrated in Figure 2 by the removal of the pot from the hot burner. This allows the water to cool and the steam to begin to dissipate. Preparing for change involves a process of exploration in which the counselor determines the changes that are both within their power and likely to aid in the alleviation of burnout symptoms. Preparing for change provides temporary relief to counselors, because they can generate hopefulness for the changes they are planning to initiate. Preparation inevitably varies widely from counselor to counselor and is based on the counselor's symptomology, financial situation, access to support, and available options. Often, this stage occurs while the counselors are still being exposed to harmful systemic factors; therefore, the relief experienced in this stage is temporary unless further action is taken.

Given the limited information available in the literature on burnout recovery in counselors, this stage in the theory provides insight into the preparation that may be needed prior to counselors' engagement in active recovery. A prior study conducted by Barton (2020) found that counselors felt inadequately prepared to care for themselves upon entrance into the field of

counseling. Additionally, Miller and Sprang (2017) found that counselors experienced guilt and shame associated with burnout symptoms, inhibiting their ability to utilize recovery interventions. The findings of the present study, which indicated that counselors needed time to prepare for active recovery with their own therapy, self-exploration, and engagement with support systems, support prior research that seems to indicate that counselors are often missing needed resources to begin active recovery (Barton 2020; Miller & Sprang, 2017).

Active recovery. The sixth stage of the grounded theory is active recovery. During this stage, counselors initiate changes to alleviate their burnout symptoms and experience the relief associated with this symptom reduction. This stage is illustrated in Figure 2 in the use of the temperature controls to turn down the heat of the burner enabling the cook to return the pot to the hot burner at a temperature that will not cause an overflow of water. While there are inherent stressors associated with the work of counselors, these may be tolerated with appropriate safeguards. In this stage, counselors may make changes to their employment, establish boundaries, utilize support systems, develop regular self-care practices, experience increased clinical efficacy, and experience a new sense of balance between their work and personal lives. As in the previous stage, specific actions taken during active recovery will vary greatly depending on the counselor's needs, symptomology, and available options.

The findings of the present study align with prior research, which has shown the importance of self-care practices and coping skills to prevent counselors' development of burnout (Barton, 2020; Baker & Gabriel, 2021; Coaston, 2017; Miller & Sprang, 2017; Newton et al., 2020). Additionally, prior research has shown the importance of personal, clinical, and administrative support in the prevention of burnout (Fahy, 2007; Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011). The findings of the present study add additional insight into

the importance of developing a renewed sense of clinical efficacy during counselors' active recovery from burnout. Prior research has illustrated the detrimental effects of decreased clinical effectiveness (Delgadillo et al., 2018; Hammond et al., 2018) on counselors experiencing burnout; however, the present research illustrates the ways in which a renewed sense of clinical effectiveness can aid in the recovery process.

Maintenance. The seventh and final stage of the grounded theory is maintenance. During this stage, counselors intentionally maintain the self-care practices, boundaries, and self-awareness they developed during active recovery. This stage is depicted in Figure 2 by the utilization of the burner's temperature control to regulate the temperature. Additionally, the cook may add ingredients, stir, and taste the pot's contents, as needed. This illustrates the iterative nature of burnout recovery. Counselors utilize their self-awareness to stay attuned to their experiences, needs, and possible symptom development. Should counselors notice warning signs of the development of burnout, they can utilize resources and strategies developing during active recovery to alleviate the pressure and regulate the temperature on their burner.

At times, counselors may need to re-enter the previously completed phases to work through burnout if it develops in the future. Participants in this study noted that they often became aware of burnout warning signs within themselves and were able to temporarily re-initiate prior stages to alleviate symptoms before they became as severe as their previous experiences. Participants also noted that they became more adept at recognizing warning signs of burnout the longer they were in the maintenance phase, resulting in it becoming easier to maintain their recovery over time. The findings of this study align with prior research, which has shown that continually utilizing burnout prevention strategies such as self-care, coping skills, support, and supervision/consultation is needed to prevent the development of burnout (Barton,

2020; Baker & Gabriel, 2021; Coaston, 2017; Newton et al., 2020). The present study provides new insight into the iterative, ongoing process of burnout recovery. Both burnout prevention and recovery require ongoing attention to counselors' use of coping skills, supports, and self-awareness.

Limitations

Since this study is qualitative in nature, the findings cannot be broadly applied or generalized. Several limitations should be taken into account when considering the findings of the study. The first limitation relates to the age of the participants. Participant ages ranged from 30-60. It is possible that counselors in their 20s who were earlier in their careers may responded differently to the questions or had different experiences of burnout and recovery. The second limitation relates to the geographic residence of the participants. Four out of the six participants were currently residing in and holding their clinical licenses in Alabama. Given the differences in culture, attitude, training, and systemic variables between states and geographic regions, counselors in other geographic regions of the United States may respond differently to the questions or have different experiences of burnout and recovery. A third limitation relates to the gender of the participants. All six participants identified as cisgender women; therefore, this study did not provide the perspectives of cisgender men, transgender individuals, or non-binary individuals. A fourth limitation relates to researcher bias. As a licensed professional counselor who had experienced both burnout and recovery as a practicing counselor, the researcher had prior personal experience with the phenomena in question. In an attempt to mitigate this limitation, the researcher's positionality was presented in the study and to the participants. Additionally, two peer reviewers and an expert reviewer were engaged to add to the credibility of this research. A fifth limitation relates to the preliminary and exploratory nature of the study.

Although a theoretical framework of the process of burnout recovery was constructed in the study, it is a theory that should be considered in need of additional inquiry and research.

Implications and Recommendations

The theory constructed in this study is an original contribution to the literature and adds to the profession's existing understanding of burnout and recovery among counselors. Additional inquiry into the process and experience of burnout recovery among counselors and counselors-in-training can further assist counselors, counselor educators, counselor supervisors, and researchers. Recommendations and implications for counselor education, clinical practice, mental health systems, and research are provided below.

Counselor Education and Supervision

Counselor educators and supervisors have a crucial role in assisting counselors-in-training and licensed counselors in acquiring the necessary skills to anticipate the possibility of experiencing burnout throughout their careers (Calledar & Lenz, 2018; Kovac et al., 2017; McCarty et al., 2022; Miller & Sprang, 2017; Ohrt et al., 2015). Counselor educators and supervisors should be aware of the prevalence and symptomology of burnout, the role of systemic factors in the development of burnout, and the process of burnout recovery. The findings of this study show that counselor educators and supervisors can provide necessary support to clinicians suffering from burnout (Baker & Gabriel, 2021; Barton, 2020; Coaston, 2017). As illustrated in the previously discussed findings, support is a key aspect of burnout recovery (Fahy, 2007; Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011).

Additionally, the findings of this research reflect the harmful effects of inadequate supervision and training. The findings of this study suggest that counselors who receive inadequate supervision and training may be at an increased risk of developing burnout, which

aligns with previous findings on the role of supervisory support in the development of burnout (Fahy, 2007; Gibson et al., 2009; Jovanovic et al., 2016; Vilardaga et al., 2011). Without the support, education, and feedback provided by satisfactory supervision, counselors lack an important understanding of how to best support their clients (Yang & Hayes, 2020). Counselors lose confidence in their clinical skills and feel incapable of providing effective care to their clients. Inadequate training at the master's level leaves novice counselors feeling under-prepared for working with clients in the 'real world.' These clinicians are left with the responsibility of pursuing continuing education to bridge the gap left by their master's programs (Vilardaga et al., 2011). Producing counselors who are knowledgeable, skilled, and fully prepared for clinical work is the primary responsibility of counselor educators and supervisors (Bernard & Goodyear, 2018). Additionally, upholding this responsibility may safeguard and prepare novice counselors for the likelihood of developing burnout during their career.

Clinical Practice

This research also carries implications for practicing counselors. Counselors should be aware of the prevalence and symptomology of burnout (Newton et al., 2020) Awareness of the symptoms of burnout may improve a counselor's ability to recognize the development of burnout within themselves should it occur (Newton et al., 2020). Understanding the prevalence of burnout could normalize the experience for counselors who experience this phenomenon, increasing their likelihood of seeking necessary support and change (Newton et al., 2020). Participants in this study discussed the vital role of recognizing their state of burnout, which enabled them to initiate efforts to recover. The findings of this research also illustrate the importance of recognizing the negative impact that burnout can have on clinical practice. The participants in this study highlighted the significance of recognizing the ways in which their

burnout was negatively impacting their clients, prompting them to begin exploring changes needed for recovery. Therefore, prioritizing the needs and well-being of clients may encourage counselors suffering from burnout to initiate their recovery.

This research also provides insight into the process of burnout recovery, which could be helpful for counselors who are currently experiencing burnout. Counselors may utilize the theoretical framework provided in this study as a guide for their own burnout recovery experiences. While individual experiences may vary from the framework provided in this research, counselors may benefit from the practical understanding of how other counselors have recovered. With this knowledge, counselors are encouraged to reflect on their current professional well-being, develop necessary boundaries and self-care practices, and seek out support as needed (Baker & Gabriel, 2021; Barton, 2020; Coaston, 2017). Ultimately, counselors should develop the self-awareness necessary to monitor their own functioning to safeguard both themselves and their clients from the detrimental impact of burnout (Newton et al., 2020).

Mental Health Systems

This research presented the role of systemic issues in the development of burnout in counselors, which carries implications for mental health systems in the United States. Poor funding, dysfunctional leadership, and lack of support impact counselor well-being, clinical efficacy, and retention (Hammond et al., 2018; Holman et al., 2018; Kim et al., 2018; Yang & Hayes, 2020). The counselors in this study chose to enter private practice rather than continue working in community mental health and crisis centers, despite their initial investment in the mission of these organizations. Ultimately, these issues inhibit the capability of community mental health systems to provide adequate care to the clients they serve.

This research suggests that broad advocacy for systemic change at the local, state, and national levels is needed to aid in the prevention of burnout in counselors. There are multiple areas in which advocacy should be focused; however, each of these requires an injection of funding into community mental health agencies across the nation. This funding would enable these organizations to provide sufficient compensation, access to adequate supervision and continuing education, and the appropriate number of staff to ensure reasonable caseloads for clinicians. The findings of this research suggest that changes such as these may decrease the likelihood of counselor burnout and turnover (Delgadillo et al., 2018; Lee et al., 2011; Salyers, Flanagan et al., 2015). Moreover, these factors may also aid in the recovery of counselors currently experiencing burnout. In conclusion, systemic change could result in fewer counselors experiencing burnout, which improves the overall health of the profession and the likelihood of positive outcomes for clients.

Research

The theory presented in this study requires additional inquiry and research. The theory is representative of the participants' experiences as counselors with more than five years of experience who have experienced burnout and recovery; however, this theory should be compared to the experiences of counselors with a diversity of demographics. Additional research exploring the experiences of burnout and recovery among counselors of various demographics could provide insight into the applicability of this theory among counselors with a broad range of backgrounds. The topic of burnout recovery among counselors-in-training and novice counselors also requires additional research. Although these populations will have had less time in which to recover from burnout, the phenomenon is still worthy of exploration to ascertain any differences that may exist between this population and more seasoned counselors.

An additional recommendation for future research is to further explore the systemic variables that contribute to the development of burnout in counselors. This inquiry could provide insight into the systems-level solutions that may be required to increase the sustainability of community mental health agencies across the United States. Research of this nature could support local, state, and national advocacy for the reform of the community mental health care system in the United States.

Conclusion

This chapter provided a discussion of the grounded theory constructed to explain the phenomenon of burnout recovery in counselors. A visual depiction of the theory is presented in Figures 1 and 2, which are followed by a thorough explanation of the theory and its components. The theory constructed in this study describes the process of the development of burnout and recovery from burnout in practicing counselors. Systemic factors contribute to the development of burnout symptoms including psychological symptoms, exhaustion, clinical disengagement, and reduced clinical efficacy. Counselors begin the process of burnout recovery by first recognizing these symptoms as indicators of burnout. Often this recognition is prompted by the counselor's acknowledgement of decreased effectiveness in their clinical work. Once counselors recognize their state of burnout, they may choose to engage in advocacy to address the systemic factors at play. Regardless of the outcome of advocacy efforts, counselors begin preparing for changes needed to recover from burnout. Advocacy and preparation for change provide temporary relief to the counselor by increasing their hopefulness. Next, counselors move into active recovery where they initiate the changes they prepared to make during the previous stage. As a result of these changes, counselors move into maintenance where they utilize the skills

developed in the previous stages to maintain their recovery. This theory is iterative in nature, and counselors don't necessarily progress through the stages in a linear fashion.

Limitations of the study included a small sample size with relatively little diversity among participants, findings that cannot be generalized to the overall population of counselors, and the potential effect of researcher bias. Implications for counselor educators and supervisors included the necessity of increased awareness of burnout and the process of recovery as well as the importance of providing adequate supervision, training, and support. Implications for practicing counselors included the necessity for increased awareness around burnout and the process of burnout recovery as well as the negative impact that burnout has on the clients of burned-out counselors. Implications for research included the continued study of the applicability of the grounded theory to a broader range of counselors from various backgrounds. An additional implication for research is the necessity to further study the systemic variables associated with the development of burnout in counselors.

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APPENDIX A:

INTERVIEW 1 PROTOCOL

1. Tell me a little about what initially attracted you to the counseling profession.
2. Describe your work as a professional counselor.
3. Please recall a time in your career when you experienced burnout (exhausted, cynical, and/or ineffective).
    a. What physical symptoms do you recall experiencing?
    b. What emotional symptoms do you recall experiencing?
    c. How did your symptoms affect your relationship with clients?
    d. How did your experience of burnout affect your sense of effectiveness in your work?
4. Please describe your experience of recovering from burnout.
    a. What factors contributed to your recovery from burnout?
        i. What factors helped with your physical/emotional symptoms?
        ii. What factors helped with your relationship with your clients?
        iii. What factors helped with your feelings of effectiveness in your work?
5. What work-related factors, if any, contributed to your recovery?
    a. Work environment?
    b. Job demands?
    c. Support?
6. What personal factors, if any, contributed to your recovery?

    a. Coping strategies?
    b. Personal health?
7. What professional factors, if any, contributed to your recovery?
    a. Supervision?
        i. Can you provide an example of a time when that happened?
        ii. What were you thinking/feeling during this time?
    b. Training?
        i. Can you provide an example of a time when that happened?
8. How does your experience of recovering from burnout influence your current practice to prevent exhaustion?
9. How does your experience of recovering from burnout influence your current work with clients?
10. How does your experience of recovering from burnout influence your current sense of effectiveness in your work?
11. What else do you think is important for me to know or understand about your recovery experience?
12. Do you have any questions for me?

APPENDIX B:

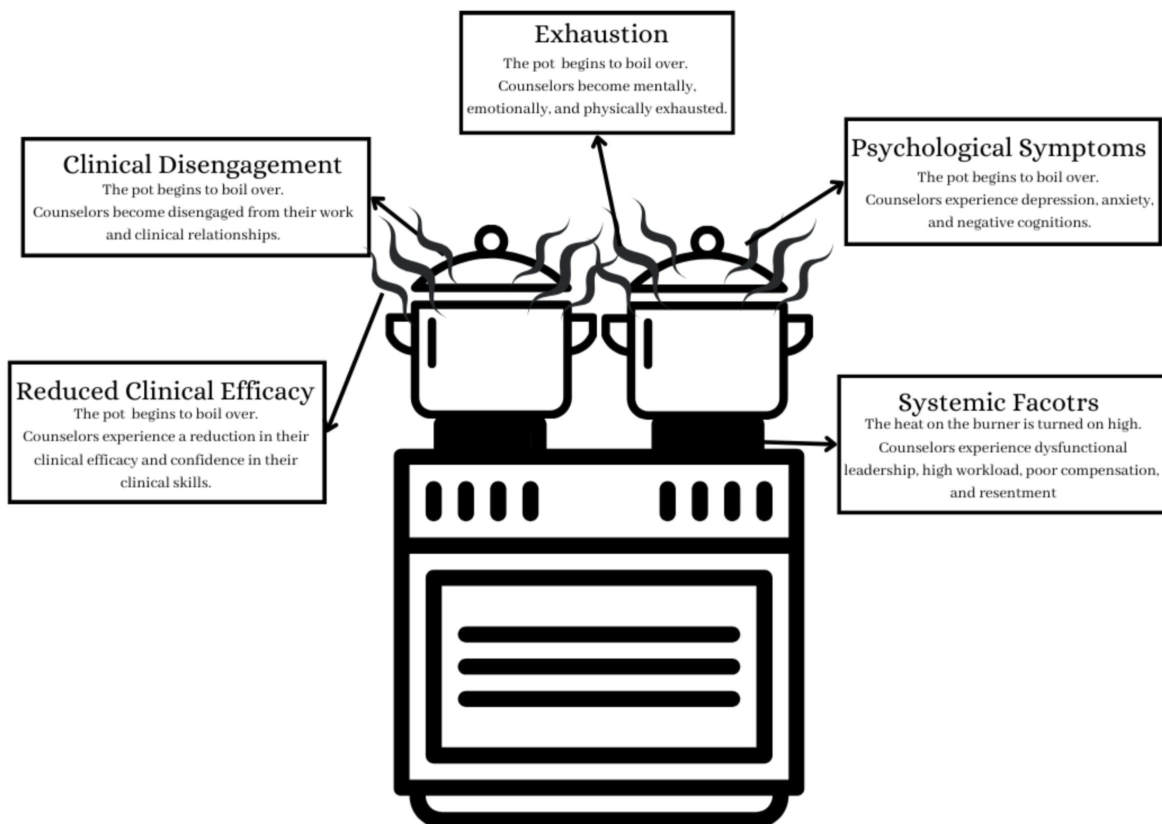
INTERVIEW 2 PROTOCOL

1. Has anything come to mind since our last interview about your burnout recovery experience that you would like to share?
2. Talk about your experience of realizing you were experiencing burnout. What helped you come to this realization?
3. What was your experience of asking for change within the systems that contributed to your development of burnout?
4. In what ways, if any, did these systems reinforce negative beliefs you held at the time?
5. What was your experience of feeling heard or valued while you were asking for change within these systems?
6. What was your experience of transitioning from looking for solutions/change within the system to looking for solutions outside the system?
7. What was your experience with guilt/shame during your recovery from burnout?
8. What helped you develop an understanding of what you wanted and needed during your recovery from burnout?
9. Talk about the process of developing a new self-care routine during your recovery from burnout.
10. What does your current practice of burnout prevention look like?
    a. Describe how you maintain your recovery from burnout.

11. What else do you think is important for me to know or understand about your recovery experience?
12. Do you have any questions for me?

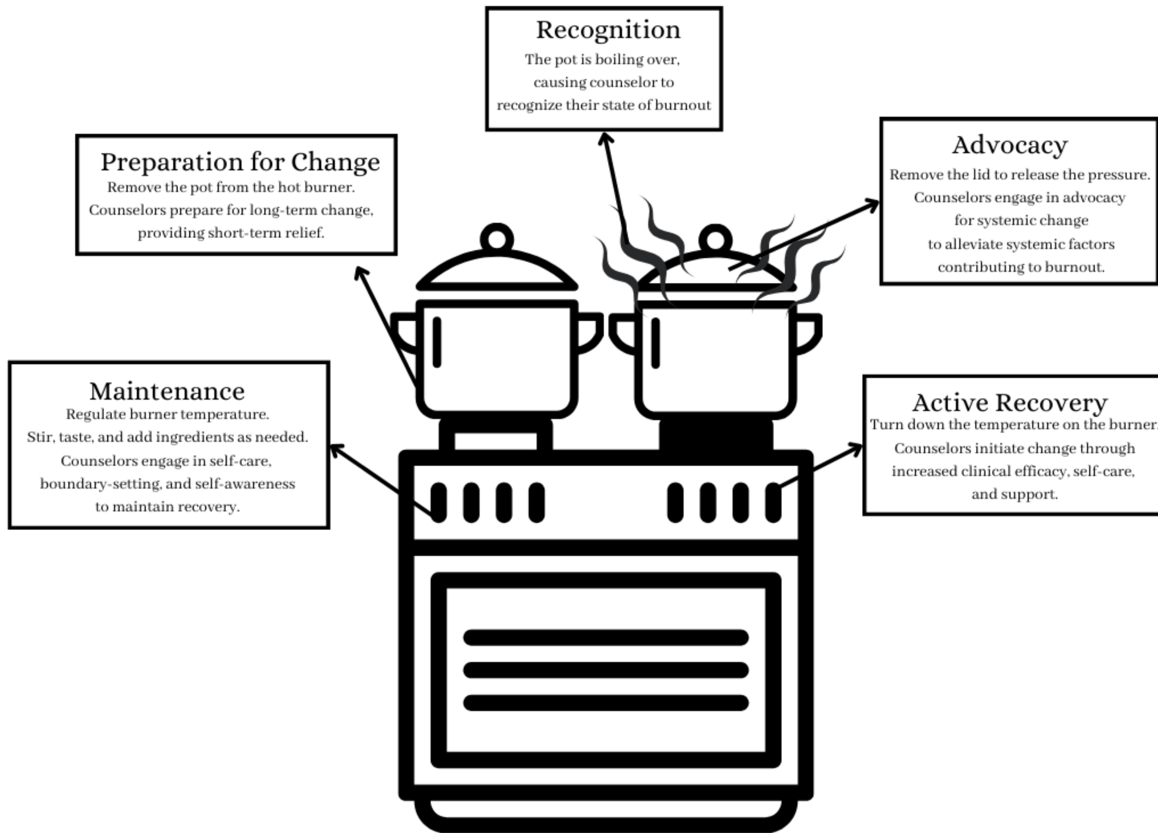
APPENDIX C:

GROUNDED THEORY GRAPHIC REPRESENTATION



Boiling Over: A Grounded Theory on Counselors and Overcoming Burnout

as illustrated by a boiling pot



APPENDIX D:

DEMOGRAPHICS SURVEY

1. Age:

2. Race/Ethnicity:

3. Gender:

4. What state do you currently live in?

5. What is your current work setting (i.e. private practice, inpatient mental health hospital or facility, outpatient agency, school/university)?

6. How many years have you worked in the counseling profession?

APPENDIX E:

MBI-HSS REVIEW COPY

For use by Andrea Gregg only. Received from Mind Garden, Inc. on August 29, 2022

Appendix 1. Review Copy: MBI Human Services Survey

MBI Human Services Survey

Christina Maslach & Susan E. Jackson

The purpose of this survey is to discover how various people working in human services or the helping professions view their job and the people with whom they work closely.

Because people in a wide variety of occupations will answer this survey, it uses the term ***recipients*** to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following pages are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about *your* job. If you have *never* had this feeling, write the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

For Review Only

Example:

How often:	**0**	**1**	**2**	**3**	**4**	**5**	**6**
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	**Statement:**
1. _________	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "How often." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week but not daily), you would write the number "5."

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Review Copy: MBI Human Services Survey

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

How often 0-6	Statements:
1. ________	I feel emotionally drained from my work.
2. ________	I feel used up at the end of the workday.
3. ________	I feel fatigued when I get up in the morning and have to face another day on the job.
4. ________	I can easily understand how my recipients feel about things.
5. ________	I feel I treat some recipients as if they were impersonal objects.
6. ________	Working with people all day is really a strain for me.
7. ________	I deal very effectively with the problems of my recipients.
8. ________	I feel burned out from my work.
9. ________	I feel I'm positively influencing other people's lives through my work.
10. ________	I've become more callous toward people since I took this job.
11. ________	I worry that this job is hardening me emotionally.
12. ________	I feel very energetic.
13. ________	I feel frustrated by my job.
14. ________	I feel I'm working too hard on my job.
15. ________	I don't really care what happens to some recipients.
16. ________	Working with people directly puts too much stress on me.
17. ________	I can easily create a relaxed atmosphere with my recipients.
18. ________	I feel exhilarated after working closely with my recipients.
19. ________	I have accomplished many worthwhile things in this job.
20. ________	I feel like I'm at the end of my rope.
21. ________	In my work, I deal with emotional problems very calmly.
22. ________	I feel recipients blame me for some of their problems.

For Review Only

(Administrative use only)

EE Total score: _______ DP Total score: _______ PA Total score: _______

EE Average score:_____ DP Average score:_____ PA Average score:_______

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APPENDIX F:

EVIDENCE OF PAST BURNOUT EXPERIENCE SURVEY

Please select any of the following that you experienced in relation to your work during the same two-week period, that was a change from previous functioning, during the last five years (Maslach & Jackson, 1981; Maslach & Leiter, 2016).

- Emotional exhaustion
- Physical fatigue
- Feelings of cynicism towards your clients or work
- Feelings of detachment from your job
- A sense of ineffectiveness in your work
- Lacking a feeling of accomplishment in your work

APPENDIX G:

RECRUITMENT STATEMENT

Colleagues,

My name is Andrea Whitten, and I am a doctoral candidate completing my PhD in Counselor Education and Supervision at the University of Alabama. As part of my dissertation, I am seeking participants for my research study titled: "Burning Brightly: A Grounded Theory Study on Burnout and Professional Counselors". This study is being conducted under the direction of Dr. Junfei Lu, Associate Professor in the University of Alabama Department of Educational Studies in Psychology, Research Methodology, and Counseling.

I am requesting your assistance in distributing information regarding my dissertation research study along with the attached research flyer to participants who may meet eligibility criteria and be interested in participating in the study.

The purpose of this research study is to examine the experience of burnout recovery in professional counselors. This study is intended to provide further support to professional counselors, counselor educators, and counseling students to effectively recover from burnout. Additionally, this study is intended to aid in the delivery of quality, effective counseling to clients receiving mental health services by improving the overall well-being of professional counselors.

Individuals who meet the following criteria will be invited by email to set up a pre-screen phone call with the researcher: (a) hold a current license in counseling, (b) has worked directly with clients for at least five years, (c) indicate a past experience of burnout, and (d) and whose Maslach Burnout Inventory Health Services Survey (MBI-HSS) score report indicates an Engaged profile. Prospective participants will be asked to complete several questionnaires to determine eligibility which will take approximately 20-30 minutes to complete. If selected, participants will be asked to take part in two semi-structured 60–120-minute individual interviews. Each interview will be audio and video recorded.

Each participant will be given a $25 gift card for contribution to the study. Participation is completely voluntary, and participants may withdraw at any time with no penalty. All information collected will be handled confidentially, and all data collected will be stored securely in a password-protected Box folder.

If you are interested in participating in this study, please contact Andrea Whitten at adgregg@crimson.ua.edu. Please feel free to share this email and flyer with anyone who might be interested in participating.

APPENDIX H:

IRB APPROVAL LETTER

THE UNIVERSITY OF ALABAMA | Research & Economic Development
Office for Research Compliance

July 12, 2023

To: Andrea Gregg
Department of ESPRMC
College of Education
The University of Alabama
Box 870231

From: Carpantato T. Myles, MSM, CIM, CIP
Director & Research Compliance Office

Re: **Notice of Approval**

IRB Application #:	eprotocol # 23-02-6365
Project Title:	"Burning Brightly: A Grounded Theory Study on Burnout and Professional Counselors"
Submission Type:	New
Approval Date:	July 12, 2023
Expiration Date:	July 11, 2024
Funding Source:	None
Review Category:	EXPEDITED
Approved Documents:	Informed Consent, Recruitment Flyer

Dear Ms. Gregg:

The University of Alabama Institutional Review Board has approved your proposed research. Therefore, your application has been approved according to 45 CFR part 46 as outlined below:

(7) *Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.*

The approval for your application will lapse, as noted above. If your research will continue beyond this date, please submit the Continuing Review to the IRB as University policy requires before the lapse. Please note any modifications made in research design, methodology, or procedures must be submitted to and approved by the IRB before implementation. Please submit a final report form when the study is complete.

Please use reproductions of the stamped IRB-approved informed consent to obtain consent from your participants.

All the best with your research.

166 Rose Administration | Box 870127 | Tuscaloosa, AL 35401 | 205-348-8461 | rscompliance@ua.edu