2007

Burnout is to Counselors What Weeds Are to Your Flower Garden

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Acknowledgements

I would like to take this opportunity to thank several individuals who have been an invaluable part of my personal and professional development. These individuals have become much more to me than mere colleagues, professors, and family; they have become dear friends who have traveled this journey with me.

I would like to begin by thanking Dr. Muhyi Shakoor for his mentoring, teaching, support, and kindness. The greatest lesson that I have learned from Muhyi has been that being a counselor is not this elusive "thing" you try to be with your clients, but something you just are; a way of being. I will consider myself successful, if one day my clients value my way of being as much as I value Muhyi's.

I would like to thank Dr. Tom Hernandez as well for his guidance, patience, support, and openness with me. He has been helpful in ways that I am sure he is not even aware of. He has helped me navigate my way through the new mental health track with ease and assurance. I have always known that he is there to back me up in any difficulty that I may face and for that I am eternally thankful.

Another individual that I want to thank is Dr. Leslie McCulloch. Leslie has challenged me in my learning and my expectations of myself. She has encouraged excellence from me and expected it. I do very much appreciate her accessibility and I want to thank her for seeing the potential within me.

Two more professors that have greatly impacted me are Dr. Patricia Goodspeed-Grant and Jeffery Cochran. Pat has been very helpful in translating to me what mental health counselors can in fact do in an environment that appears dominated by social workers. More importantly, she has taught me that being an advocate for the profession

will be one of the greatest skills that I can acquire. I want to thank Jeff Cochran as well. Jeff is one of the finest people I have ever met. He embodies in everyway unconditional positive regard. He showed me that a therapeutic relationship is enough in many instances to produce change. Since knowing Jeff, I now know what "prizing" an individual really means.

I would also like to thank my classmates. With their help I have learned more about who I really am. They have challenged me, encouraged me, supported me, and shared with me. I am a different person than who I was before I began this journey because of them.

Another group of individuals that I would like to acknowledge are the therapists at Orleans County Mental Health. I would like to thank them for their guidance, teaching, support, and friendship as I have begun to put into practice all I have learned. They welcomed me with open arms and were helpful in bridging the gap between social workers and counselors. They are a fine group of individuals.

I also must thank my family. I would like to thank my husband, Paul, who has graciously taken on more responsibility at home since I began this journey. Thank you for supporting me and encouraging me during this phase of my life. I want to thank my two children, Caleb and Tess, who do not remember life without mommy going to school. Thank you for sharing me and sacrificing our time together so that I could do this. To the rest of my family who have encouraged me through this process I thank you. Your confidence in me has been overwhelming. I love you all.

Lastly, I would like to thank my clients who continue to allow me to share their lives and own journeys with them. Thank you for your trust.

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Abstract

The causes, implications, and interventions for counselor burnout are examined for mental health counselors. *Burnout/Self-care Among Mental Health Counselors* was an eight week group run for the mental health counselors at Orleans County Mental Health. The Maslach Burnout Inventory-Human Service Survey Third Edition (MBI-HSS) was given to measure three specific areas of burnout: emotional exhaustion, depersonalization, and personal accomplishment. The results indicate that there was improvement for the group as a whole after participating in *Burnout/Self-care Among Mental Health Counselors*, in the areas of emotional exhaustion, and depersonalization. However the results indicate that after participating in *Burnout/Self-care Among Mental Health Counselors*, the group experienced fewer feelings of personal accomplishment than they previously did. Procedural methods used during the group will be identified along the results and a discussion as to the possible reasons for the results.

Burnout is to Counselors What Weeds Are to Your Flower Garden

Imagine investing time and energy into planting a flower garden; you painstakingly research which exact flowers would grow and flourish based upon your type of soil and the amount of sun, shade, or water that will be available. After completing your research you purchase the perfect flowers for your garden and you take care in planting each and every flower, putting them in just the right place. You then stand back and enjoy the beauty that all of your hard work has produced. Time goes by, and you stop spending as much time caring for your garden. You don't notice the weeds that have begun to grow; after all they are pretty small. Yet, those small weeds begin to grow. At this point you do notice that there are some weeds in your garden, but think to yourself that you'll get to them later. Before you know it, your beautiful garden is overrun with very large weeds. The weeds have become so big that they overpower most of the flowers that were put there with such care and steal the nutrients from the soil that those flowers need. You look at your garden and struggle to find the beauty that was once there. The thought of weeding your garden becomes overwhelming to you; a seemingly impossible job.

The same can be said for the counselor that spends an enormous amount of time and money in graduate school to become a counselor. The counselor works at developing his/her skills and is eager to put into practice everything that has been learned. Once in the workplace the counselor is satisfied, fulfilled, and pleased with the work that he/she begins to do. Then imagine the counselor in the business of his/her work, forgets to care for himself/herself; the counselor stops checking in with himself/herself to see how he/she is actually doing. Then slowly as time goes by he/she

starts to become frustrated by the "politics" and organizational structure at work; the counselor also begins to become emotionally exhausted by his/her work. The counselor may begin to think, "What difference am I really making," and his/her sense of personal accomplishment dwindles. At this time the counselor may notice that he/she is in a very different place than when he/she began practicing, but passes it off as an inevitable part of the job. As a result of not addressing these issues the counselor begins to then depersonalize his/her clients. The counselor has become ineffective in his/her work and in fact may be doing harm to his/her client, which is the polar opposite of what counseling is. The counselor suffers from burnout, which has robbed the counselor and his/her client of a healthy counseling process.

Mental health counselors often interact with clients who are experiencing psychosocial, social, or physical problems. The interactions between counselor and client can be charged with intense emotions experienced by the client (Maslach, Jackson, & Leiter, 1996). Working with such clients can be emotionally draining and cause counselors' chronic stress which can lead to burnout (Maslach et al., 1996). Research has confirmed that counselor burnout not only has negative effects on counselors, but their clients as well (Emerson, Shirley, Markos, & Patricia, 1996). There are various proactive steps that counselors can do to prevent burnout and interventions to implement if already burned out (Christopher, Christopher, Dunnagan, & Schure, 2006). This literature will review: the definition of burnout, the causes of counselor burnout among mental health counselors, the implications of counselor burnout, and interventions to both prevent and recover from counselor burnout.

Definitions of Burnout

Maslach et al. (1996) defined burnout as: "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p. 4). There are three aspects of burnout: 1. Emotional Exhaustion, 2. Depersonalization, and 3. Personal Accomplishment (Maslach et al., 1996).

Burnout increases as feelings of emotional exhaustion increase. As emotional resources are depleted, counselors feel that they are no longer able to give of themselves at a psychological level (Maslach et al., 1996).

Burnout also increases as depersonalization of one's clients also increases. Depersonalization is described by Malach et al. (1996) as negative, cynical attitudes and feelings about one's clients. This depersonalization, callous, or even dehumanized perception of others can lead counselors to see their clients as somehow deserving of their troubles. The development of depersonalization appears to be related to the experience of emotional exhaustion, creating a correlation between the two (Maslach et al., 1996).

Lastly, burnout increases as a counselor's sense of personal accomplishment decreases. This reduction in personal accomplishment, refers to the tendency to evaluate oneself negatively, especially with regard to one's work with clients; counselors may feel unhappy about themselves and dissatisfied with their accomplishments on the job (Maslach et al., 1996).

Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling (Maslach et al., 1996). Emerson, Shirley,

Markos, and Patricia (1996) report that burnout is not an end-point, but a process; a thing that you are continually experiencing more or less of.

Causes of Burnout

Research has shown that there are a variety of causes that can lead to counselor burnout among mental health counselors. Savincki and Cooley (1987) suggest that a mental health counselor's work environment often has a direct effect on the extent of counselor burnout. High burnout levels have been linked to: low worker impact on procedural and policy issues, a lack of worker autonomy within the guidelines of the job structure, and uncertainty about work objectives and responsibilities (Savincki and Cooley, 1987). Cummings and Nall (1983) found that counselors within an authoritarian organization had increased levels of burnout.

Another area within the work environment that is associated with burnout is the social climate within the work setting (Savincki and Cooley, 1987). Savincki and Cooley (1987) say that, "In settings where workers feel supported and appreciated by administrators and supervisors, burnout levels are low" (p. 249). Kirk-Brown and Wallace (2004) support this concept by stating that organizational factors that increase burnout among counselors include work group conflict, poor supervisory practices, or job design.

Another way in which organizations contribute to counselor burnout is that these organizations are attempting to reduce spending and thereby expect counselors to deliver services both effectively and economically, which increases counselor stress (DiGiacomo and Adamson, 2001). DiGiacomo and Adamson (2001) state, "In addition to the negative impact of this economic restructuring, some heath professionals may experience

conflict between their professional values and the demands of the organization" (p. 106). A counselor's perceived improper allocation of time, inadequate staff and resources by the organization has also contributed to stress (DiGiacomo and Adamson, 2001).

Coyle, Edwards, Hannigan, Fothergill, and Burnard (2005) agree that organizations contribute to counselor stress. The study by Coyle et al. (2005) showed that counselors experience relatively high levels of both work-related anxiety and trait depression when compared with normative populations and workers in other professions; frequently mentioned stressors were role conflict, role ambiguity and fulfilling statutory responsibilities under the Mental Health Act. Factors linked with an increase in stress included having no sense of personal achievements from work, workload, not feeling valued as an employee and being female (Coyle et al., 2005). Coyle et al. (2005) report that 68 percent of community mental health counselors report being under stress. The sources of stress included: lack of supervision, the lack of peer or organizational support and also a lack of other resources; the main sources of dissatisfaction reported were the way the department was organized, leading to confusion and resentment (Coyle et al., 2005). Coyle et al. (2005) also state that the quality of relations between management and staff had an impact on the counselor's ability to manage the stressors inherent in their job. Coyle et al. (2005) go on to say that mental health counselors experience greater emotional exhaustion than either psychiatrists or psychologists and more depersonalization than psychologists.

Apart from the organization in which a counselor works, the work itself, the work itself contributes to burnout. Romero and Pinkney (1980) said a mental health counselor faces, "emotionally draining hard work that exacts personal costs" (p. 6). Individuals

seek out counselors to meet a human need that they have (Boy and Pine, 1980). Counselors can become discouraged by the demands and pressures placed on them by their clients (Boy and Pine, 1980). Boy and Pine (1980) state, "Such demands and pressures not only place a heavy burden on the counselor's time and energy, but they create a psychological burden which ultimately affects negatively the counselor's professional functioning" (p. 161).

While working with clients, a counselor may also experience secondary traumatic stress also known as STS (O'Hallaran, Theresa, Linton, and Jeremy, 2001). STS can cause emotional distress for a counselor which contributes to higher levels of burnout. O'Hallaran et al. (2001) define STS as, "an outcome or risk that is related to engaging empathically with another's traumatic material" (p. 354). Mental health counselors often meet with clients suffering from PTSD; one of the goals in meeting with such clients involves helping the client tell his or her story of the traumatic events, and providing a safe place for feelings of helplessness, anger, and fear to be released (O'Hallaran et al., 2001). When working with such clients, counselors can develop STS (O'Hallaran et al., 2001).

Skovholt, Grier, and Hanson (2001) identify seven hazards of mental health counseling as a profession that often contributes to counselor burnout. These hazards illustrate just how difficult the job of a mental health counselor can be; the hazards are: "1. Clients have unsolvable problems that must be solved, 2. All clients are not "honors students", 3. There is often a readiness gap between clients and counselors, 4. A counselor's inability to say no, 5. Constant empathy, interpersonal sensitivity, and one-way caring, 6. Elusive measures of success, and 7. Normative failure" (pp. 169-171).

When referring to hazard number one, Skovholt, et al. (2001) state that clients when coming to counseling often are stuck in life and are unable to find a solution, resulting in low self-efficacy and high despair; it is almost always difficult for counselors to have a quick impact on this condition. This can lead to a counselor doubting his or her effectiveness. Hazard number two addresses the idea that when clients possess skills such as motivation, good judgment, and insight change is usually more likely to occur; however, not all clients come into counseling possessing those skills helpful in promoting change and may continually struggle while in counseling (Skovholt, et al., 2001). A counselor may become frustrated and impatient with one's clients if they struggle in counseling.

Skovholt et al. (2001) point out in hazard number three that counselors and clients are not always ready to move at the same pace sometimes making it difficult for a counselor to judge "dose" and "timing". This difficulty in judging "dose" and "timing" can leave the counselor feeling distressed. Hazard number four addresses the tensions between good intentions and the feeling of turning one's back on human need; it may be extremely difficult for a counselor to reconcile the pull on the heart and mind when uncertain about how hard to work within the helping role (Skovholt, et al., 2001).

The concept that counselors put a tremendous amount of effort into the relationship with the client, while perhaps collaborative, is not always reciprocal; the counselor must concentrate, be involved, and work until he or she is often emotionally exhausted, or depleted is identified as hazard number five (Skovholt, et al., 2001). Skovholt, et al. (2001) point out in hazard number six that it is sometimes difficult for a counselor to gage success; in ambiguous helping relationships, a counselor may feel

uncertain about how to describe what was learned, achieved, or changed. Lastly when describing the seven hazards of counseling, Skovholt, et al. (2001) report that a counselor must develop the capacity to accept lack of success, or normative failure, as a component of the work; the counselor must realize this, accept it, and incorporate it into his or her professional self-concept for long-term, high quality professional functioning.

Then there are things that a counselor does himself/herself that contributes to burnout. Gladding (1991) refers to a phenomenon called counselor self-abuse as a precursor to burnout. Counselor self-abuse occurs when counselors, "fail to become helpful healers because of their disposition to abuse themselves by not learning from the past or by not setting proper boundaries for themselves with their clients and colleagues" (Gladding, 1991, p. 414). Often unawareness and a lack of skills cause counselors to fall into the category of counselor self-abuse (Gladding, 1991).

Implications of Burnout

The implications of burnout among mental health counselors are as varied as the causes of it. Romero and Pinkney (1980) state that burnout is characterized in counselors by a reluctance to see clients, difficulty in developing rapport, avoidance of emotional issues within the counseling setting, and counselor reluctance to personally experience high affect levels. It is easy to see how these characteristics can have negative clinical and ethical implications for his/her client. DiGiacomo and Adamson (2001) and Emerson et al., (1996) state that counselors experiencing burnout often manifest negative behavioral changes towards their clients, which include a loss of concern for clients, treating clients with a detached impersonal manner, frequent irritability with clients, and rationalizing failure by blaming clients. Maslach et al. (1996) also state that there is a

deterioration in the quality of care or service provided by counselors to their clients. Miller (2001) states, "Just as counselors can pass on happiness to their clients, so can they pass on unhappiness" (p.383).

Symptoms of a counselor experiencing a high level of burnout manifest themselves while working with clients as a reluctance to check for messages or return calls, and unseemly delight in a canceled appointment; the counselor may even begin to agree with the many clients who seem to be complaining about hopelessness, frustration, pessimism, and doubting the efficacy of counseling (Emerson et al., 1996). Further, counselors experiencing high levels of burnout may fail to meet deadlines, forget appointments, cancel appointments, dramatically change work habits, become extremely critical and abrasive, become unresponsive to client needs, or exhibit inappropriate behaviors.

There are professional implications of counselor burnout. One such implication is an increase in the number of counselors applying for early retirement (Borrrritz, Rugulies, et al., 2006). Riggar, Harrington-Godley, and Hafer (1984) and Maslach et al., (1996) state that counselors experiencing burnout often do not perform effectively which results in a loss of money, time, and effort; there is decreased productivity, and an increase in turnover, and absenteeism.

Apart from implications to clients, as well as organizational, ethical and professional implications, burnout also produces emotional implications. Kesler (1990) reported that, "The road to burnout is scattered with the remnants of a counselor's emotional health" (p. 303). A burned out counselor often feels helpless with a loss of control, guilt, anger, anxiety, incompetent, bored, depressed, and victimized (Kesler,

1990). DiGiacomo and Adamson (2001) also state that these counselors often have a decline in self-esteem.

There are also social implications for the mental heath counselor experiencing burnout. These counselors have increased negative experiences in their ability to meaningfully relate with family and friends (Evans and Villavisanis, 1997). Research has shown that mental health counselors experiencing burnout report a decrease in their emotional investment in their own families and often reduce their circle of friends; a counselor experiencing burnout can lose his/her ability to resolve stressful events in his/her personal and professional life (Evans and Villavisanis, 1997). There is a correlation with counselors experiencing burnout and various self reported indices of personal dysfunction, including marital and family problems, and the increased use of alcohol and drugs (Maslach et al., 1996).

Physical implications of burnout include increased heart attack, cancer, or suicide (Kesler, 1990). Chandler, Bodenhamer-Davis, Holden, Evenson, and Bratton (2001) list some physical reactions to burnout as: increased heart rate, blood pressure, respiration, muscle tension in the forehead, cooler hands due to vasoconstriction of the peripheral blood vessels, and increased pulse rate. A counselor experiencing burnout may also experience chronic fatigue, physical exhaustion, frequent colds, headaches, stomach irritation, sleeplessness, and drug and alcohol use (DiGiacomo and Adamson, 2001 and Malsach et al, 1996).

Preventing Burnout

There are various ways to prevent counselor burnout and ways to intervene once burnout has occurred among mental health counselors. The first area that can be

addressed in preventing counselor burnout revolves around the organization itself. Knudsen, Ducharme, and Roman (2006) report that certain management practices within organizations have the potential to reduce burnout through changes in the social interaction between management and counselors. "Management practices, facilitated within the social interactions of everyday organizational life, develop perceptions among employees about the distribution of power and the presence of workplace fairness" (Knudsen, et al., 2006, p. 176). Evans and Villavisanis (1998) also state that promoting encouragement exchange among counselors in the workplace can combat burnout on an organizational level. Organizations can also encourage mandatory supervision of all mental health counselors; when remaining open to the evaluation of one's work and welcoming feedback about one's performance during supervision, a counselor reduces the chance of burnout (Osborn, 2004). Kahill (1988) found that variety and flexibility in one's job was also important; the need to vary the type of work activity or the type of client and to take time out from front line work and take vacations or days off if needed.

While organizational interventions are useful in preventing counselor burnout, much of the responsibility is placed upon the counselor himself/herself. Kahill (1988) found common ways that counselors counteract burnout; they include: social supports, and social relations with colleagues, supervisors, and administrators, both informally and structured, as well as relations with friends and family outside of work. Also important to counselors in preventing burnout were social interactions with family, friends and the community along with pursuing hobbies, recreation, and in particular physical activities (Kahill, 1988). Gladding (1991) reported that effective ways for mental health

counselors to combat burnout include participating in individual personal counseling as well as group counseling.

Christopher, Christopher, and Dunnagan (2006) report that personal growth opportunities through self-care practices and professional growth through mindfulness practices in counseling can help prevent burnout. Self-care practices are self-initiated behaviors that promote good health and well-being (Christopher, et al., 2006). More specifically Christopher et al. (2006) state that mindfulness practices contribute to a counselors well-being; mindfulness is based on cultivating awareness with the aim of helping people live each moment of their lives, even painful ones, as fully as possible. Through mindfulness, counselors become less reactive to stress-related or anxiety-provoking events such as when clients are in crisis or are discussing painful emotions (Christopher et al., 2006). Counselors also through mindfulness gain new ways of relating to their emotional life that include awareness and tolerance; instead of responding with defensiveness and reactivity, contemplative and mindfulness disciplines can assist counselors to become more present and connect more intimately with themselves, their clients, and their supervisor (Christopher et al., 2006). Myers and Williard (2003) also purport that an essential aspect of wellness includes integrating spirituality into the counselors' framework.

Seven suggestions for counselor stamina to prevent burnout given by Osborn (2004) are: 1. Selectivity, which refers to the practice of intentional choice and focus in daily activities and long-term endeavors; it means setting limits on what one can and cannot do and, in the process, being deliberate in one's tasks and purposeful in one's mission. 2. Temporal sensitivity implies that counselors must be constantly aware of the

given restrictions and limitations of time-in sessions with clients, in determining the appropriate length of overall treatment, and the spacing of sessions to make the best use of time. 3. Accountability, which refers to being able to practice according to a justifiable, ethical, theoretically guided, and research –informed defense; it must make sense not only to the counselor's clients and the counselor, but also the group of professionals that the counselor works with. 4. Measurement and management refers to the preservation and cultivation of particular choices; it entails day to day behaviors that support and protect selected limitations and demarcations. 5. Inquisitiveness which characterizes a sense of wonder or curiosity about human behavior and the unique experiences of individuals. 6. Negotiation which refers as one's ability to be flexible, to participate in give and take without giving in completely. 7. Acknowledgement of agency implies a preference for a productive orientation, one that is sure in the possibility of positive resilient resources, processes, and outcomes.

Skovholt, et al. (2001) believe that continuing to increase ones own self-awareness is useful in preventing professional stagnation and burnout by increasing personal maturity, and enhancing professional effectiveness. This can be done by actively noticing one's self during interactions with clients and supervisors (Skovoholt et al., 2001).

Boy and Pine (1980) state that counselor burnout can be avoided through role renewal. Boy and Pine (1980) reported that role renewal can be achieved through spending the majority of the working day counseling clients; it is believed that an important professional goal should be to be an authentic counselor rather than a superficial one enmeshed in non counseling activities. Knowing your client's authentic

needs and identifying with them rather than the interests of funding agencies, is another way to achieve role renewal (Boy and Pine, 1980).

Role renewal also involves carefully selecting the organization in which the counselor will work, being involved in that organization, and by associating with committed and concerned colleagues (Roy and Pine, 1980). The counselor that has carefully selected his/her organization and is involved in the organization has access to power that determines the goals of the organization. That access allows the counselor to participate in ways that will ultimately improve the organization and benefit the client (Roy and Pine, 1980). Periodically examining the counseling role and being committed to a theory of counseling also helps in role renewal by allowing the counselor to identify with an approach for assisting people in need as well as providing consistency (Roy and Pine, 1980).

When considering what a counselor can proactively do to both recover and prevent burnout, Grasha (1987) suggests several short-term coping techniques for managing stress; he termed them quick relaxation techniques; they are: slow rhythmic breathing, guided imagery, and writing to relieve tension. The idea behind using quick relaxation techniques is that when daily activities become too stressful, muscular and mental tension increases; taking a break to relax helps to decrease such tension (Grasha, 1987). Relaxation devices also restore energy so that people can cope better with stressful events (Grasha, 1987). The quick relation techniques that Grasha (1987) identified can be used in a period of three to five minutes and are most beneficial when used on a regular basis throughout the day.

A high level of burnout among a mental health counselor is a serious issue for the counselor, his/her clients, and the organization in which he/she practices. A counselor that is experiencing high levels of burnout does not arrive at that place in one day; it is a process and one that can be potentially avoided by self care practices if there is awareness on the counselor's part if heading in that direction. My research questions whether levels of burnout among mental health counselors are affected by the awareness of one's own level of burnout, and interventions to combat it. My hypothesis is that when a counselor is aware of his/her burnout level and then incorporates self care practices into his/her life, burnout levels will decrease. To test this hypothesis, a group entitled *Burnout/Self-Care Among Mental Health Counselors* was developed and run for mental health counselors.

Method

Setting

The research for this study was conducted at the Orleans County Mental Health Department in Albion New York. The group was designed by the writer for group activities that were conducted on a weekly basis during the lunch hour for eight sessions lasting 45-60 minutes. The group began on December 4, 2006 and ended on February 12, 2007.

Sample

There was a total of 10 mental health counselors employed at Orleans County Mental Health and three mental health counselor interns when the group entitled *Burnout/Self-Care Among Mental Health Counselors* was run. Out of the 13 individuals able to participate in the group, all were female, except one male. Years of employment at Orleans County Mental Health for the counselors ranged from approximately 25 years

to one month. The writer informed the counselors at Orleans County Mental Health of the *Burnout/Self-Care Among Mental Health Counselors* group and handed out consent forms, located in appendices C and D, to every counselor employed at Orleans County Mental Health, and the counselor interns as well. Those counselors that were interested were asked to return a signed copy of their informed consent form directly to writer, at Orleans County Mental Health.

Participants

Nine counselors from Orleans County Mental Health volunteered to participate in the *Burnout/Self-Care Among Mental Health Counselors* group; there were eight females and one male. Out of the nine counselors that volunteered to participate, one was an intern and eight were counselors that were employed at Orleans County Mental Health. Although nine counselors signed the consent form and began the group, only six ended up completing the group. The six counselors that completed the group by taking both the pre and post tests consisted of five females and one male, all of which were employed at Orleans County Mental Health with the exception of one intern.

Materials

The materials that were used in this group were journals, crayons, the Maslach Burnout Inventory-Human Service Survey Third Edition (Maslach et al., 1996), the film *Baggage* (Neel, 1968), and the CD *Creative Visualization Meditations* (Gawain, 1996).

Evaluation

The Maslach Burnout Inventory-Human Service Survey Third Edition (Maslach et al., 1996) was given to participants during the first and last group sessions. Writer scored the test for each individual and the group as a whole.

Constructs of the MBI-HSS

The test authors described the Maslach Burnout Inventory-Human Service Survey Third Edition (MBI-HSS) as a measure designed to assess the three aspects of burnout: emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach et al., 1996). Each aspect is measured by a separate subscale. The emotional exhaustion (EE) subscale assess feelings of being emotionally exhausted and overextended by one's work (Maslach et al., 1996). Maslach et al. (1996) report that the depersonalization (Dp) subscale measures an unfeeling and impersonal response toward recipients of one's service, care, or treatment. The last subscale, personal accomplishment (PA), assesses feeling of competence and successful achievement in one's work with people. The frequency with which the respondent experiences feelings related to each subscale are assessed using a six-point, fully anchored response format (Maslach et at., 1996).

The test authors conceptualized burnout as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. They did not view it as a dichotomous variable, which is either present or absent (Maslach et al., 1996). A high degree of burnout is reflected in high scores on the emotional exhaustion and depersonalization subscales and in low scores on the personal accomplishment subscale; an average degree of burnout is reflected in average scores of the three subscales, and a low degree of burnout is reflected in low scores on the emotional exhaustion and depersonalization subscales and in high scores on the personal accomplishment subscale (Maslach et al., 1996).

Test authors report that the MBI is available in three forms: the human service survey, the general survey, and the educators' survey. Maslach et al. (1996), state that

the human service survey is designed for individuals employed in a wide variety of human service professions, including health care, social services, mental health, and criminal justice. The general survey is designed for individuals in occupations where there is no direct personal contact with service recipients or with only casual contact with people (Maslach et al., 1996). Lastly, the educators' survey is designed for individuals employed in school settings (Maslach et al., 1996).

Test History of the MBI-HSS

The Maslach Burnout Inventory (MBI) was initially developed by Christina Maslach and Susan Jackson and published in 1981, when there was an enormous amount of interest in the concept burnout, but very little in the way of guiding theory or empirical research (Maslach et al., 1996). As a result Maslach and Jackson developed an instrument to be used as a standardized measure of an individual's experience of burnout. The MBI is now recognized as the leading measure of burnout (Maslach et al., 1996).

Initial research on the MBI was based on data from the United States and Canada however, subsequent studies have been done in many countries around the world, and the MBI has now been translated into several different languages (Maslach et al., 1996).

The third edition of the MBI includes several new developments. The first being, Michael Leiter was added as a new co-author. Michael Leiter helped contribute to the second edition of the MBI manual by compiling the group norms, but was not included as a co-author until the third edition after completing his extensive research on job burnout (Maslach et al., 1996). The second development in the third edition of the MBI was the development of a new version of the MBI, which was adapted for use with occupations other than the human services and education (Maslach et al., 1996). Lastly, the third

edition now has revised titles and forms for the various versions of the MBI, in order to clarify the distinctions between them; there is also added citations to ensure that researchers use the appropriate version in their studies (Maslach et al., 1996).

Practical Features of the MBI-HSS

There are time considerations to the MBI-HSS. Maslach et al. (1996) report that the MBI-HSS takes about 10-15 minutes to fill out, and is self administered. Complete instructions are provided for the respondent. Scoring however, is not conducted during the administration of the test (Maslach et al., 1996).

There are also financial considerations to be aware of when using the MBI-HSS. The non-reusable, hand scorable MBI-HSS is sold in packages of 25 for $34.35, and the MBI scoring key is sold for $17.25 from the CPP website (CPP Publishing, 2007). The MBI Manual is also needed to administer the test, and can be purchased for $51.50 from the CPP website as well (CPP Publishing, 2007). Support materials that may be helpful, but that are not necessary include the MBI-Human Services Demographic Datasheets which are sold in packages of 25 for $21.75 which can be purchased from the CPP website (CPP Publishing, 2007).

General Consideration for the MBI-HSS

According to Maslach et al. (1996), no special qualifications or procedures are required of the examiner who is administering the MBI-HSS; however, the examiner should not be a supervisor or administrator who has some direct authority over the respondents because this could cause respondents to be less candid in their answers. The major responsibilities of the examiner are as follows: minimize response bias and ensure response completion (Maslach et al., 1996). Response bias can be minimized by having

the administrator stress the importance of giving honest answers and reassuring respondents about the confidentiality of the results (Maslach et al., 1996). To ensure response completion, the examiner should carefully check each completed test form as it is handed in to make sure that all items have been answered, as it is critical that respondents answer all of the scale items (Maslach et al., 1996).

Test Items on the MBI-HSS

There are 22 questions on the MBI-HSS; nine of those questions specifically measure for the emotional exhaustion (EE) subscale. Out of the total 22 questions, five questions measure for the depersonalization (Dp) subscale and eight measure for the personal accomplishment (PA) subscale.

Reliability of the MBI-HSS

Maslach et al. (1996), report that internal consistency was estimated by Cronbach's coefficient alpha (n = 1,316). The reliability coefficients for the subscales were following: .90 for emotional exhaustion, .79 for depersonalization, and .71 for personal accomplishment (Maslach et al., 1996). The standard error of measurement for each subscale is as follows: 3.80 for emotional exhaustion, 3.16 for depersonalization, and 3.73 for personal accomplishment (Maslach et al., 1996).

Data on test-retest reliability of the MBI-HSS have been reported for five samples. For a sample of graduate students in social welfare, and administrators in health agency (n = 53), the two test session were separated by an interval of two to four weeks. The test-retest reliability coefficients for the sub scales were the following: .82 for emotional exhaustion, .60 for depersonalization, and .80 for personal accomplishment (Maslach et al., 1996). Although these coefficients range from low to moderately high,

all are significant beyond the .001 level. In another sample of 248 teachers, the two test sessions were separated by an interval of one year. The test-retest reliabilities for the three subscales were the following: .60 for emotional exhaustion, .54 for depersonalization, and .57 for personal accomplishment (Jackson, Schwab, & Schuler, 1986). Lee and Ashforth (1993) found test-retest correlation of .74, .72, and .65, respectively, for an eight month interval. Leiter (1990) found test-retest correlations of .59, .50, and .63 on a six month interval. Leiter and Durup (1996) found test-retest correlations of .75, .64, and .62, respectively for a three month interval. Although the values do not differ strikingly, note that for most of these five studies the highest test-retest correlation is for emotional exhaustion. In general, longitudinal studies of the MBI-HSS have found a high degree of consistency within each subscale that does not seem to diminish markedly from a period of one month to a year (Maslach et al., 1996).

Validity of the MBI-HSS

Convergent validity was demonstrated in several ways. First, an individual's MBI-HSS scores were correlated with behavioral ratings made independently by a person who knew the individual well. A group of 40 mental health workers were each asked to provide an anonymous behavioral evaluation of a designated co-worker who had also completed the MBI-HSS. The critical question on this evaluation, in terms of validating the emotional exhaustion and depersonalization subscales, were ratings of how "emotionally drained" the person was, and how he or she reacted to clients. People who were rated as appearing physically fatigues scored higher on emotional exhaustion and depersonalization (Maslach et al., 1996). It was expected that high scores on depersonalization would be reflected in the behavior of frequent complaints about clients.

Co-worker ratings of this behavior were correlated with depersonalization scores (Maslach et al., 1996). The predicted correlation between co-worker ratings of the individual's satisfaction with the job and scores on personal accomplishment did not provide statistical significance (Maslach et al., 1996).

MBI-HSS scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Based on the findings of Maslach and Pines (1977), it was predicted that the greater the number of clients on must deal with, the higher the burnout scores on the MBI-HSS. Maslach and Jackson (1984b) found this pattern of response in a nationwide survey of 845 public contact employees. When caseloads were very large, scores were high on emotional exhaustion, and depersonalization, and low on personal accomplishment.

Additional validation of the MBI-HSS is provided by data that confirm hypothetical relationships between experienced burnout and various outcomes or personal reactions (Maslach et al., 1996).

In terms of discriminant validity, the MBI-HSS distinguished itself from measures of other psychological constructs that might be presumed to be confounded with burnout (Maslach et al., 1996). For example, it is possible that the experience of burnout may be nothing more than the experience of dissatisfaction with one's job. Although one would expect the experience of burnout to have some relationship to lowered feelings of job satisfaction, it was predicted that they would not be so highly correlated as to suggest that they were actually the same thing. A comparison of subjects' scores on the MBI-HSS and the JDS measure of "General job satisfaction" (n = 91 social service and mental

health workers) provides support for this reasoning (Maslach et al., 1996). Job satisfaction had a moderated negative correlation with both emotional exhaustion (r = -.23, p < .05) and depersonalization (r = -.22, p < .02), as well as a slightly positive correlation with personal accomplishment (r = .17, p < .06) (Maslach et al., 1996).

Scoring of the MBI-HSS

Each respondent's test form is scored with a scoring key containing directions for scoring each subscale. Each score can then be coded as low, average, or high using the numerical cutoff points listed on the scoring key. The ranges for the occupational subgroup for mental health workers were as follows: 1. Emotional exhaustion with a score of less than or equal to 13 is placed in the low range; emotional exhaustion with a score of 14-20 is placed in the average range; emotional exhaustion with a score of greater than or equal to 21 is placed in the high range. 2. Depersonalization with a score of less than or equal to four is placed in the low range; depersonalization with a score of five to seven is placed in the average range; depersonalization with a score of greater than or equal to eight is placed in the high range. 3. Personal accomplishment with a score of greater than or equal to 34 is placed in the low range; personal accomplishment with a score of 33-29 is placed in the average range; personal accomplishment with a score of less than or equal to 28 is placed in the high range (Maslach et al., 1996).

The stand deviations and means for the occupational subgroup for mental health workers were as follows based upon a sample size of 730 (n = 730): 1. Emotional exhaustion- mean equals 16.89 (M = 16.89) and the standard deviation equals 8.90 (SD = 8.90). 2. Depersonalization- mean equals 5.72 (M = 5.72) and the standard deviation

equals 4.62 (SD = 4.62). Personal accomplishment- mean equals 30.87 (M = 30.87) and the standard deviation equals 6.37 (SD = 6.37) (Maslach et al., 1996).

Design and Procedure

The purpose of *Burnout/Self-Care Among Mental Health Counselors* was designed to encourage awareness of possible burnout and present a sampling of possible interventions to prevent it among mental health counselors. It was designed to raise self-awareness, increase self-esteem, facilitate team building and personal growth, increase UPR with clients, and develop ways to cope with stress. The group *Burnout/Self-Care Among Mental Health Counselors* was an eight week group. The group attendance for each session can be found in appendix E.

Session One: Session one was held on December 4, 2006. The group began at 12:00 pm and ended at 1:00 pm. Nine counselors attended the group. The group began by having the writer give an introduction to the group. Group rules, were then developed by the group as a whole. The rules included: 1. Whenever in the building during the group and not with a client, attendance was expected. 2. Confidentiality was expected by everyone. 3. All members of the group were to treat each other respectfully.

Writer then gave each member of the group the MBI-HSS. Writer informed group members that they were not to put their names on the test. When finished each member directly handed writer his or her test. Writer had previously assigned each member a number; once the tests were handed in, writer put the number of that individual on the test for identification purposes. After all of the tests were handed in, the group processed what it was like to take the test. Most members stated that they had to think

longer on the items that were to be scored in reverse. They found the wording more difficult to understand.

Session Two: Session two was held on December 11, 2006. The group began at 12:00 pm and ended at about 12:55 pm. Six counselors attended the second group. Writer began the group by giving each member a printed out copy of their individual and group results of the MBI-HSS. Writer explained the scoring and the meaning of the results in each of their printed out copies for both individual and group results. The group then processed what they experienced after getting their results back. Most counselors were surprised by their results.

After the MBI-HSS was processed, writer handed out journals to each member of the group. Writer then asked each member of the group to write out his or her personal mission statement as a counselor. This was done in hopes of increasing self-awareness among group members. After they completed their individual mission statements, group members then decided that they would like to share their mission statements with the group. Every group member present decided to do this. The group then processed what it was like to have to develop their counseling mission statements. Many group members stated that they had not really thought of it before. Writer told group members that they were allowed to take their journals with them, but asked them to bring them back with them next time. Writer directly handed out the results of the MBI-HSS and journals to the three members of the group who were absent when seen next.

Session Three: Session three was held on December 18, 2006. The group began at 12:00 pm and ended at about 12:50 pm. Six counselors were present during this session. Writer began the group by leading group members in several mindfulness

meditations in hopes of reducing stress by creating a relaxing atmosphere. All of the meditations were meditations on the breath. The first meditation was focused on the breath as you breathe through the nose. The second meditation was focused on your lungs as you breathe. The third meditation was focused on counting as you breathe. All group members stated that they felt very relaxed after completing the exercises. Some group members found it easier when focusing on the breath through the nose, and others found it easier when focusing on the lungs when breathing. All group members found it easier to concentrate on the breath when counting. Writer encouraged group members to continue using the meditations during their work day in the upcoming weeks when they found spare moments.

Session Four: Session four was held on January 8, 2007. There was a two week gap between this group and the last group as the office was closed for two Mondays in a row due to Christmas and New Years. The session began at 12:00 pm and ended at 1:00 pm. Six counselors attended the group.

This group session was centered around team building. Each member of the group was able to give and receive positive feedback from each group member. One group member would sit in chair while all of the other group members covered their ears and closed their eyes. One by one group members would go to that one group member in the chair and state three positive things they experienced from that individual. When a group member was done giving feedback, he or she would go tap the next group member in line, then cover his or her ears and close his or her eyes. The group member that was taped would then go and give his or her feedback in the same fashion and so forth till that one individual in the chair received feedback from every group member. The process

would then begin again until every member of the group received and gave feedback to all other members.

When processing this exercise some group members were thankful for the opportunity to tell each other just how much they are valued as they would not have found the opportunity to do so otherwise. Some group members noted how hard it was to hear the positive feedback; they stated that they noticed how it is easier to hear negative things about themselves. On the whole, the group experienced this as a very positive and powerful exercise.

Session Five: Session five was held on January 22, 2007. There was a one week gap between the last group session and this group session as the office was closed on January 15, 2007. The group began at 12:00 pm and ended at 1:00 pm. Three counselors attended the group. This exercise centered around guided imagery exercises, again with the hopes of reducing stress by creating a relaxing atmosphere. Writer played the CD *Creative Visualization Meditations* (Gawain, 1996). The speaker on the CD, led the group through several guided imagery exercises. The group then processed the exercise. One group members found it difficult to participate in the guided imagery exercises. Another group member dozed off and woke during the middle of the meditation and found it difficult to complete. However, one group member found it very relaxing and insightful.

Session Six: Session six was held on January 29, 2007. The group began at 12:00 pm and ended at around 12:50 pm. Six counselors attended the session. During this session, writer asked group members to draw a picture in their journals to represent how they experience their job as being a counselor. Writer then asked group members to

draw a picture in their journals to represent how they would like to experience their job as being a counselor. The purpose of this exercise was to again increase self-awareness as to how they actually view themselves in their roles as counselors as compared to how they would like to see themselves. When processing this exercise, group members were surprised between the differences in their two pictures. Group members also noted the similarities between their pictures and other group members' pictures.

Session Seven: Session seven was held on February 5, 2007. The group began at 12:00 pm and ended at 12:50 pm. Five counselors attended this group session. Writer showed the group the film *Baggage* (Neel, 1968). The purpose of the film was to help increase UPR for clients. The film is a lyrical portrayal of how humans' carry around their psychological baggage and how they do in fact try to rid themselves of it the best they can. After watching the film, the group processed their experience of it. Many of the group members found the film confusing and hard to interpret. However, some group members stated that they were able to take away some meaning from the film.

Session Eight: Session eight was held on February 12, 2007. The group began at 12:00 pm and ended at 1:00pm. Six counselors attended this last session. Writer handed out the MBI-HSS as she did during the first session. Writer gave the group participants the exact same instructions that were given during the first session. After all of the tests were received by writer the group processed their experiences of the group while eating pizza. Many of the group members commented on their regret for not being able to attend all of the sessions. Other group members stated that they were glad for the experience. Writer asked the group members if they were implementing anything they learned or any activities done in the group during their work day or outside of work.

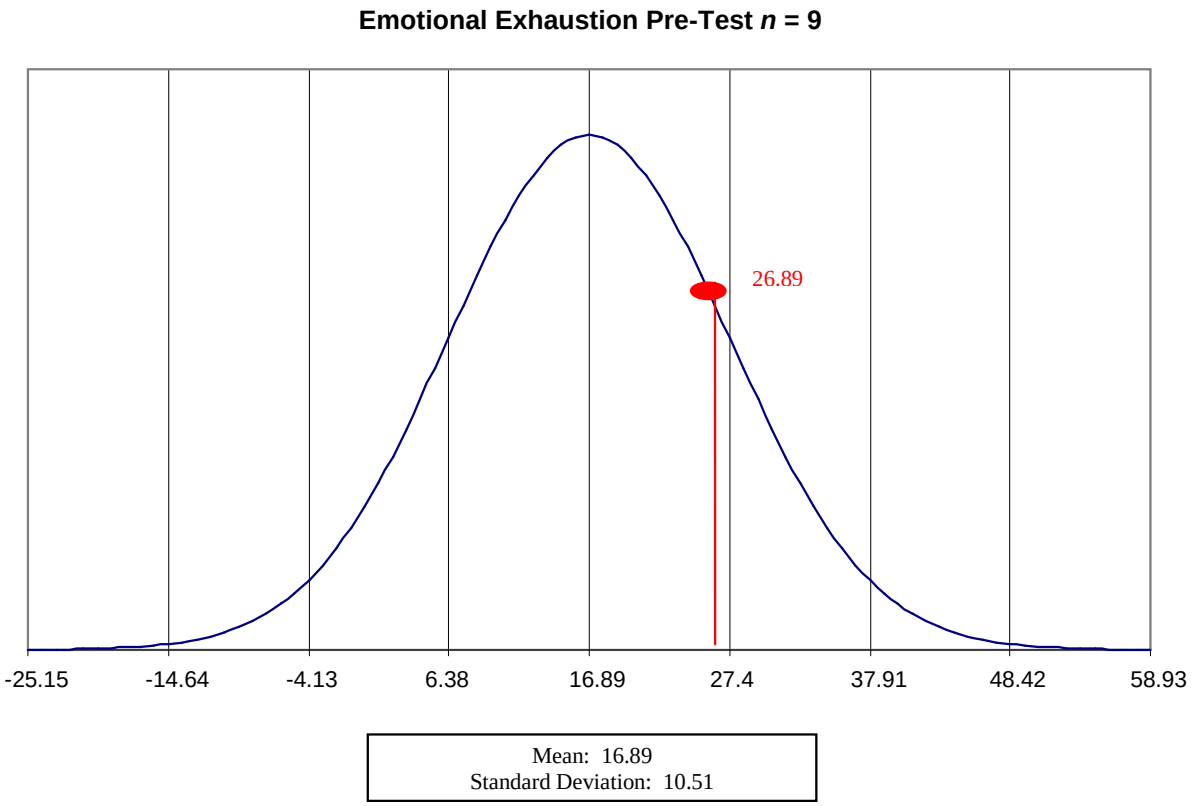
Group members responded by saying that they have not done so outside of the group. Writer ended the group by thanking all group members for their willingness to participate when able.

After the group ended, writer scored the MBI-HSS. Writer handed each member that completed the group a printed out copy of their individual and group results of the MBI-HSS for both the pre and post test. Writer explained the scoring and the meaning of the results in each of their printed out copies for both individual and group results of the pre and post tests.

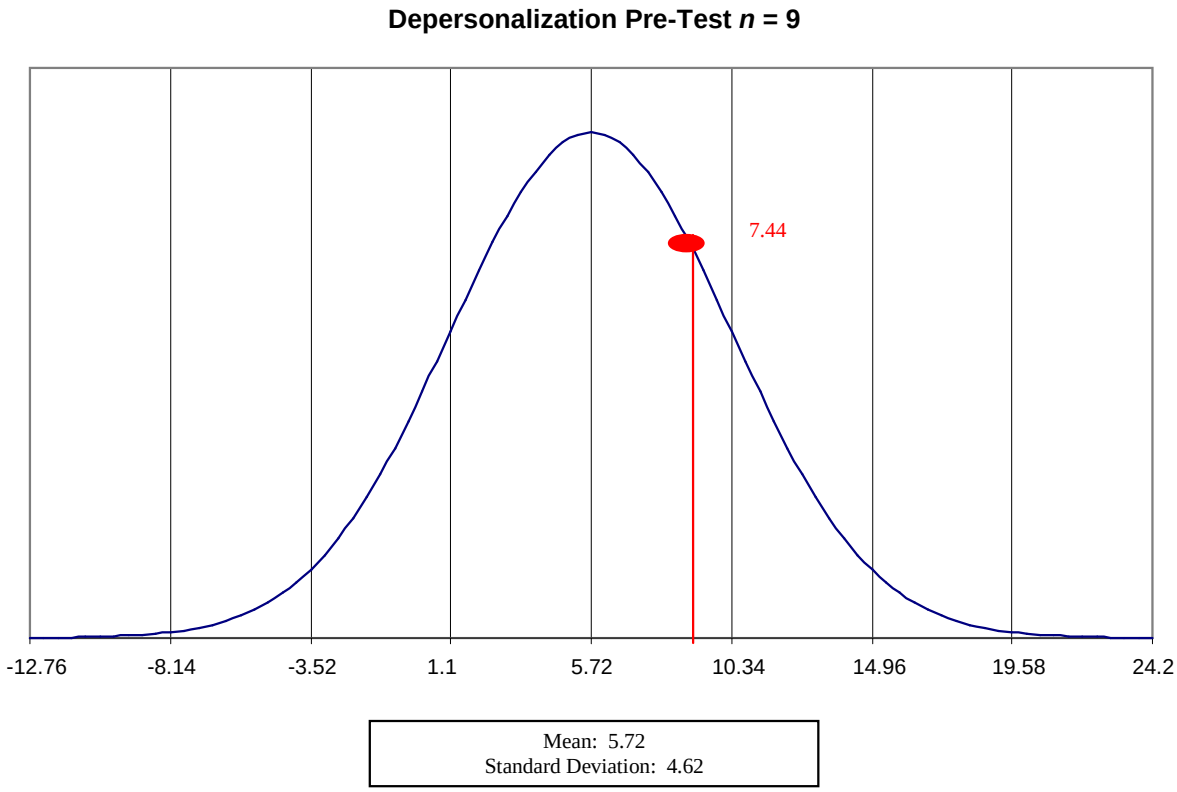
Results

Nine counselors began the group by taking the MBI-HSS as a pre-test. Group results for the nine are presented below. However, only six counselors completed the *Burnout/Self-Care Among Mental Heath Counselors* group by also taking the MBI-HSS as a post-test. You will find group pre and post-test results for the six counselors that completed the MBI-HSS as both pre and post-tests. You will find bell curve graphs with the results of the pre and post-tests for the group of six counselors that completed the MBI-HSS as both pre and post-tests in the list of tables and figures section of this paper. Individual test results will not be presented in this paper as it was stated to all participants that no individual results would be shared due to the professional stigma that can be associated burnout.

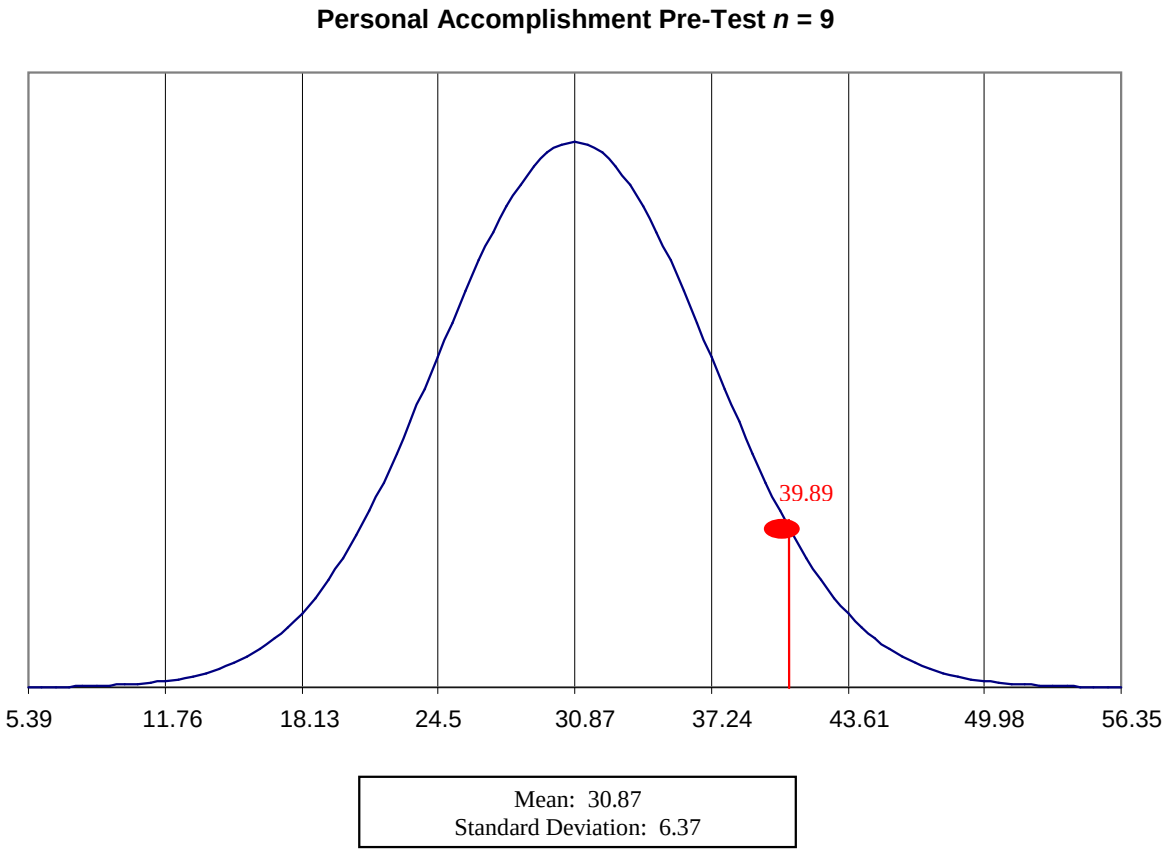
Pre-Test Group Results of the Nine Counselors that Took Only the Pre-Test



Under the emotional exhaustion subscale, the mean for the nine counselors that originally took the pre-test, was 26.89, or $x = 26.89$ for that group. The mean fell in the high category, which indicated that the original group of nine had high feelings of being emotionally overextended and exhausted by one's work. The original group of nine fell within one standard deviation above the mean, which is where most mental health workers fall.

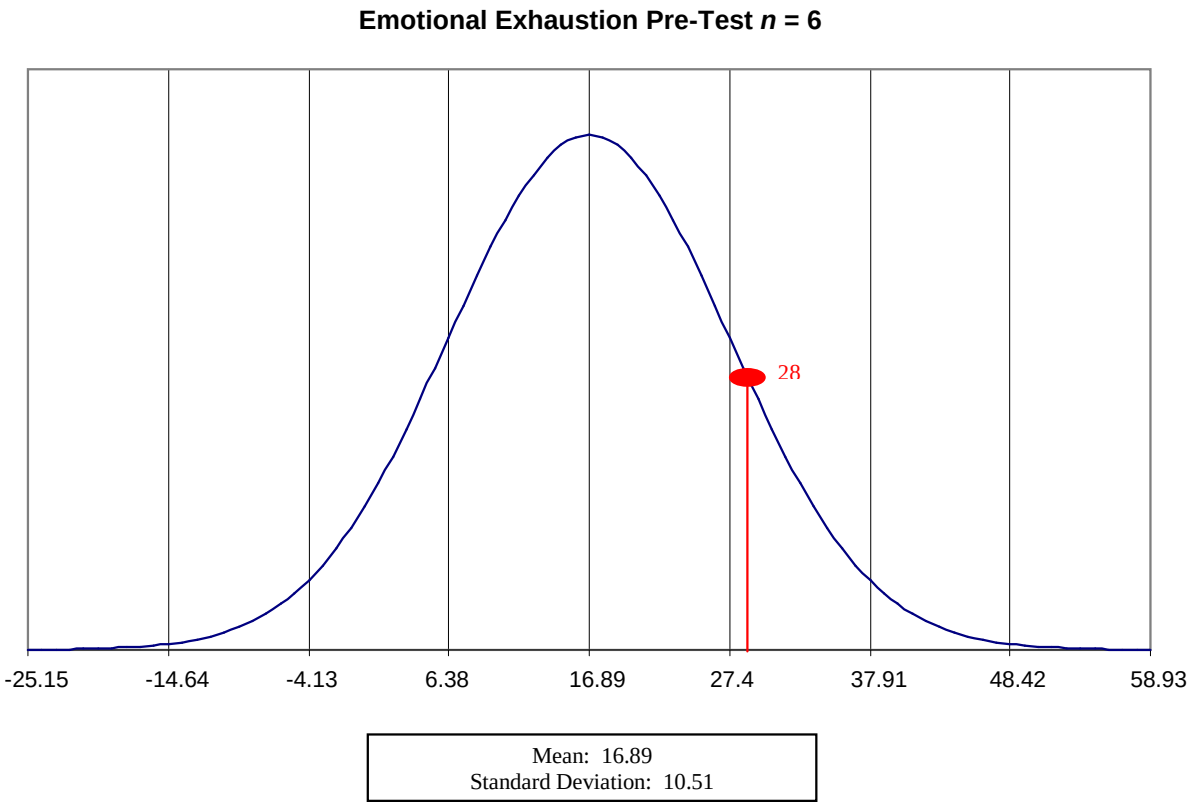


Under the depersonalization subscale, the mean for the nine counselors that originally took the pre-test, was 7.44, or $x = 7.44$ for that group. The mean fell in the average category, which indicated that the original group of nine had average unfeeling and impersonal responses toward recipients of one's service, care, treatment, or instruction. The original group of nine fell within one standard deviation above the mean which is where most mental health workers fall.

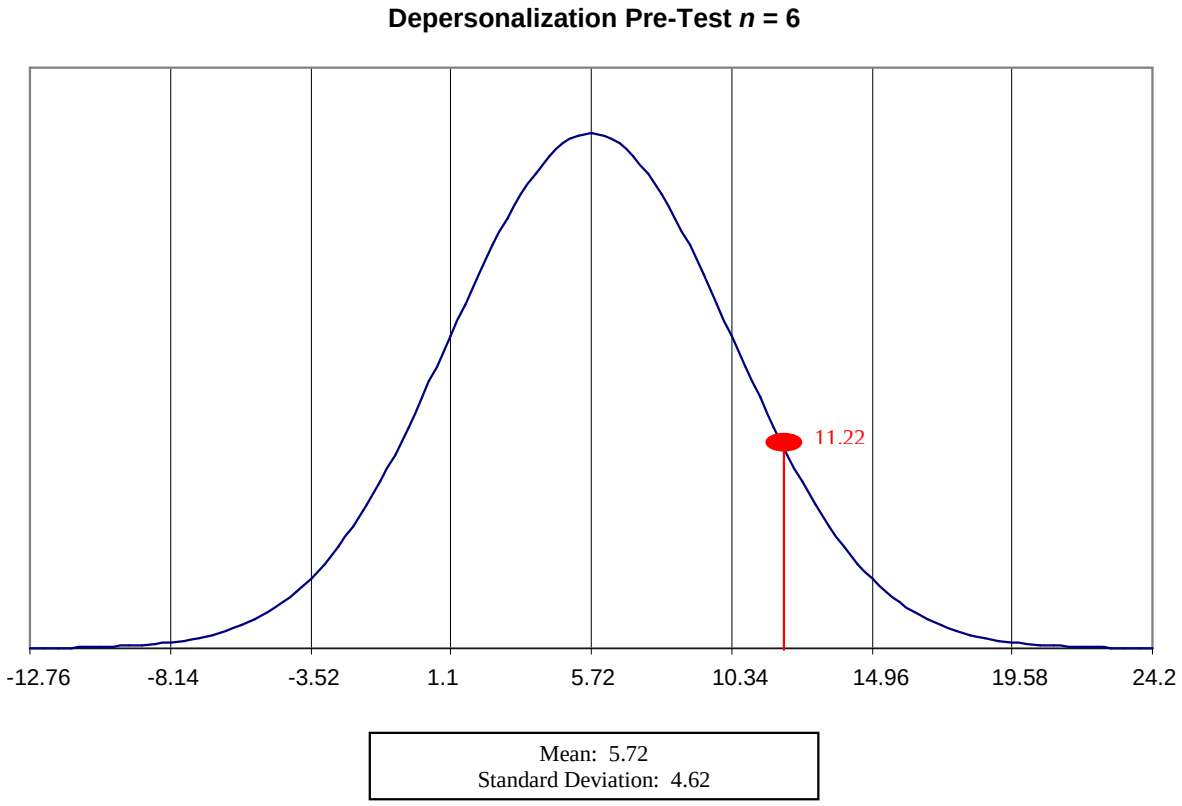


Under the personal accomplishment subscale, the mean for the nine counselors that originally took the pre-test, was 39.89, or $x = 39.89$ for that group. The mean fell in the low category, which indicated that the original group of nine had high feelings of competence and successful achievement in one's work with people. The original group fell within two standard deviations above the mean.

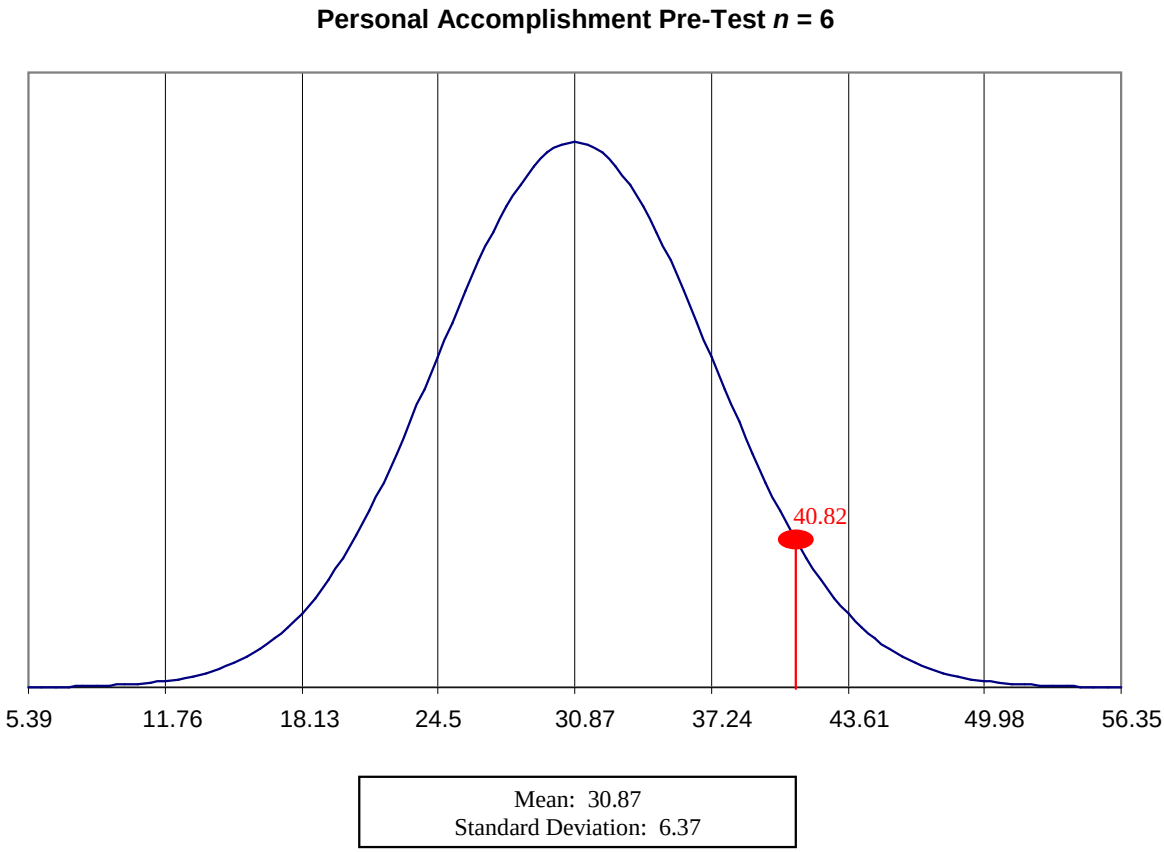
Pre-Test Group Result of the Six Counselors that Completed Both Pre and Post-Tests



Under the emotional exhaustion subscale, the mean was 28, or x = 28 for the six counselors that completed both the pre and post-tests. The mean fell in the high category, which indicated that the group of six had high feelings of being emotionally overextended and exhausted by one's work. The group of six that completed both the pre and post-tests fell within two standard deviations above the mean.

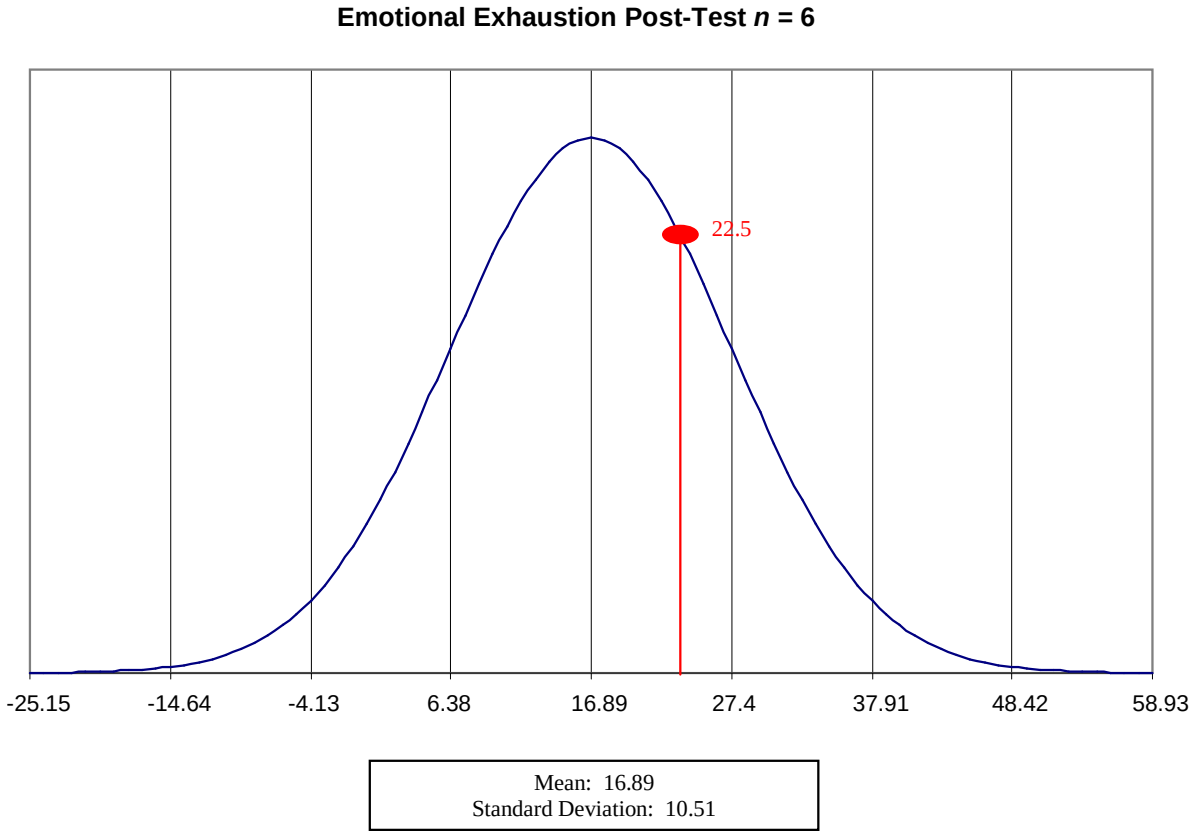


Under the depersonalization subscale, the mean was 11.22, or x = 11.22 for the six counselors that completed both the pre and post-tests. The mean fell in the high category, which indicated that the group of six had high unfeeling and impersonal responses toward recipients of one's service, care, treatment, or instruction. The group of six that completed both the pre and post-tests fell within two standard deviations above the mean.

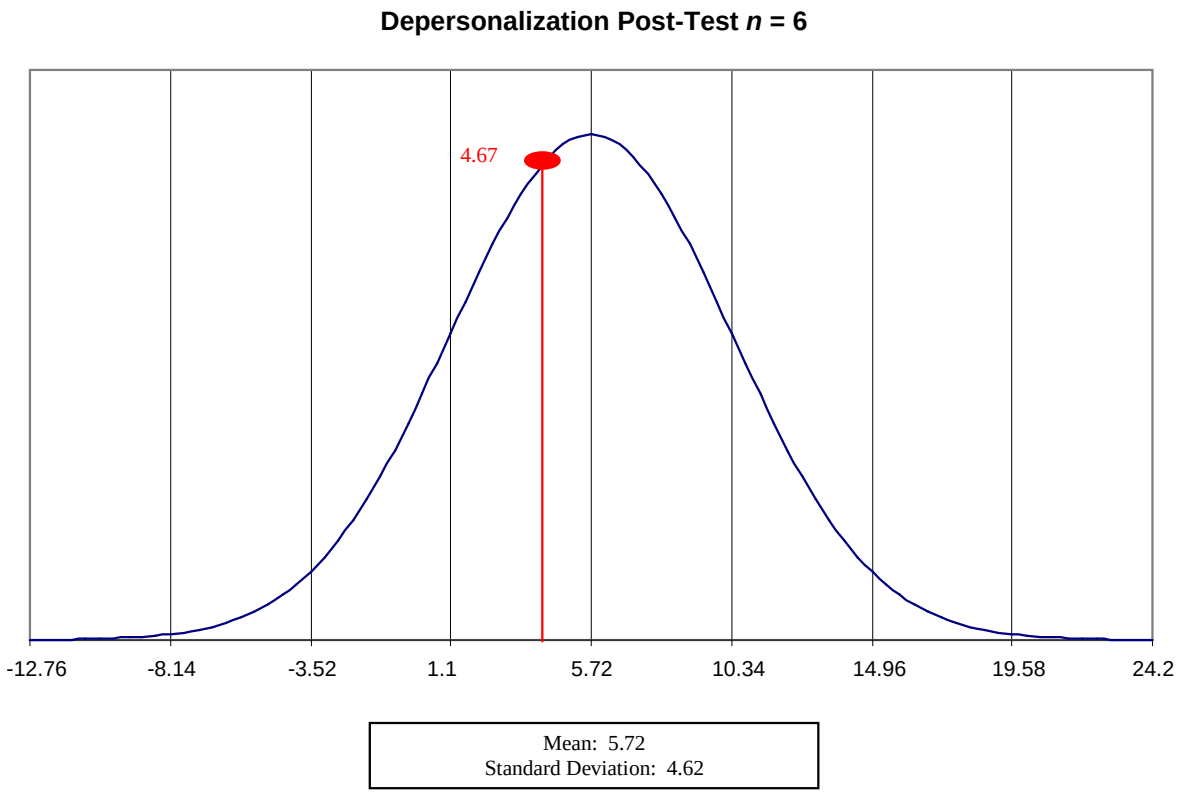


Under the personal accomplishment subscale, the mean was 40.83, or $x = 40.83$ for the six counselors that completed both the pre and post-tests. The mean fell in the low category, which indicated that the group of six had high feelings of competence and successful achievement in one's work with people. The group of six that completed both the pre and post-tests fell within two standard deviations above the mean.

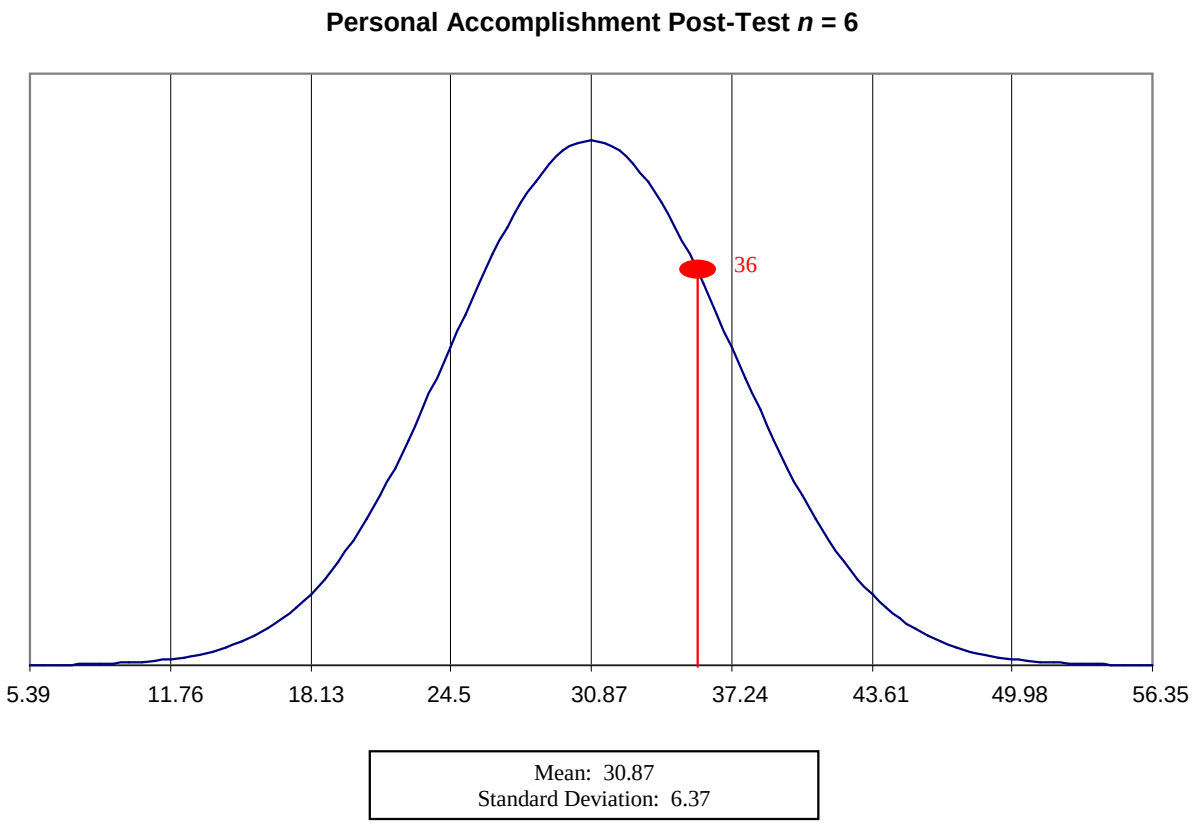
Post-Test Group Result of the Six Counselors that Completed Both Pre and Post-Tests



Under the emotional exhaustion subscale, the mean was 22.5, or $x = 22.5$ for the six counselors that completed both the pre and post-test. The mean fell in the high category, which indicated that the group of six had high feelings of being emotionally overextended and exhausted by one's work. The group of six that completed both the pre and post-test fell within one standard deviation above the mean which is where most mental health workers fall.



Under the depersonalization subscale, the mean was 4.67, or $x = 4.67$ for the six counselors that completed both the pre and post-tests. The mean fell in the average category, which indicated that the group of six had average unfeeling and impersonal responses toward recipients of one's service, care, treatment, or instruction. The group of six that completed both the pre and post-test fell within one standard deviation below the mean where most mental health workers fall.



Under the personal accomplishment subscale, the mean was 36, or $x = 36$, for the six counselors that completed both the pre and post-tests. The mean fell in the low category, which indicated that the group of six had high feelings of competence and successful achievement in one's work with people. The group of six that completed both the pre and post-tests fell within one standard deviation above the mean, where most mental health workers fall.

Differences in the Group Results of the Pre and Post-Tests of the Six Counselors that Completed Both Pre and Post-Tests

Although the group of six fell in the high category on both the pre and post test on the emotional exhaustion subscale, the standard deviation changed. The group of six now falls within one standard deviation above the mean as opposed to two, which is again where most mental health workers fall. In short, the results indicate that while the group

of six still experiences high levels of emotional exhaustion, they experience no more emotional exhaustion than do most mental health workers since participating in the group *burnout/Self-Care Among Mental Health Counselors.*

Previously the group of six fell in the high category and was two standard deviations above the mean on the depersonalization subscale. The group of six now falls in the average category and is within one standard deviation below the mean, which again is where most mental health workers fall. In short the results indicate that the group of six is experiencing less depersonalization than before beginning the *Burnout/Self-Care Among Mental Health Counselors* group, and is now falling where most mental health workers fall.

The group of six fell in the low category on both the pre and post test on the personal accomplishment subscale, but changed in the standard deviation. The group of six now falls within one standard deviation above the mean rather than two, which is again where most mental health workers fall. In short the results indicate that the group of six is still experiencing high feelings of personal accomplishment but is less of an exception since participating in the *Burnout/Self-Care Among Mental Health Counselors* group.

Discussion

There are many things that can be considered after compiling the results of the *Burnout Self-Care Among Mental Health Counselors* group. Things to consider include: the results of the group and its association with the literature, the implications for the counseling profession, and the limitations and possible areas for further research.

Results in Association with the Literature

All group session activities were based upon suggestions found in the literature to help reduce levels of burnout and increase self-care. A large part of the *Burnout Self-Care Among Mental Health Counselors* group revolved around self awareness. Boy and Pine (1980) stress the importance of self awareness for counselors and its impact on burnout. Boy and Pine (1980) state "In self assessment the counselor reaches toward a caring inner core that, when understood, permits a higher level of commitment and effectiveness" (p. 163).

Skovholt et at. (2001) also spoke of the importance of self awareness within the counseling profession. Specifically they state that one way to do this is by increasing one's professional self understanding. This was the premise behind the session that involved creating mission statements. The goal was to challenge group members to consider how they view their mission as a counselor in contrast to how the would like to view their mission as a counselor.

This was done at another point in the group sessions as well. Group members were asked to draw a picture representing how they currently view their job and role as a counselor in contrast to how they would like to view it. As with the mission statements, the picture drawing was done to increase one's professional self understanding.

Malsach et al. (1996) states that an important aspect of burnout, is the depersonalization of one's clients. The session in which the film was shown addressed this issue. Not only is it important for counselors to increase their own self awareness in how they view their role as counselor, it is equally important if not more so to be aware of how they view their clients. The film was meant to challenge participants of the group to become aware and examine how they see their clients.

Grasha (1987) stated that quick relaxation techniques such as slow rhythmic breathing, meditation, and guided imagery exercises can be effective ways to cope with stress; stress can increase burnout levels. He stated that these interventions are best utilized when used regularly. Several sessions were spent learning these techniques. One session was specifically dedicated to exposing participants to guided imagery; another session was spent meditating on the breath. However, the meditation used was not just any meditation. It was specifically a mindfulness meditation. Christopher et al. (2006) states that such mindfulness practices replace less desirable mental and physical states such as stress, anxiety, fear, or pain with more desirable states such as calm, peace, or relaxation. All of which are helpful in reducing levels of burnout.

Witmer and Young (1996) reported on how relationships, community, and team building within an organization can help combat burnout. Specifically they state that increased support among co-workers has been found to be an effective tool for counselors to decrease levels of burnout. This concept was the driving force behind the team building exercise during one of the group sessions.

There are many more techniques and interventions that can be introduced to help combat high levels of burnout. These were just a few suggestions from the literature that were used during the *Burnout/Self-Care Among Mental Health Counselors* group.

Implications for the Counseling Profession

This research can have huge implications for the counseling profession. Results of the *Burnout/Self-Care Among Mental Health Counselors* group shows that burnout levels can be decreased when actively addressed. As of now, few mental health organizations if any, have groups designed specifically for counselors to address these

issues. This research has also shown that counselors are more apt to implement self-care techniques and practices to decrease levels of burnout when there is a designated time to do so. Without such a program in place, most counselors simply do not find the time to implement these practices into their daily lives. Perhaps groups such as the *Burnout/Self-Care Among Mental Health Counselors* group should become requirements or standards for mental health agencies.

Limitations of the Research and Possible Areas for Further Research

The group *Burnout/Self-Care Among Mental Health Counselors* had its limitations. One being that the research did not report upon specific individual results. Although data on each individual's pre and post-tests were gathered, due to the professional stigma that can be associated with burnout, writer informed participants that individual results would not be used. Writer did this with the hopes of allowing participants to answer the pre and post-tests without bias. Writer also decided upon not sharing individual results as the research was done in a small agency with a small number of participants. Most employees at the agency were aware of which counselors were participating in the group. As the results of this study were going to be left with the agency, writer wanted to protect the anonymity of group members as much as possible. Writer wanted to prevent possible speculation by others on whose results were whose.

However, if individual results were presented, correlations between changes in burnout levels and possible group attendance could be presented. During this research writer did not gather individual normative data, data such as specific ages, gender, and length of employment. Again writer did this because individual results were not going to be presented. However, if normative data were collected, correlation between changes in

burnout levels and possible group norms could be presented. Possible future research conducted in which the participants were willing to share individual results and identifying norms, would be beneficial and would provide a more complete and accurate picture of the value of such a group.

Group attendance was also another limitation to the research. Group members volunteered to participate during their lunch hour. Not all of the participants' lunch hours were scheduled for the same time. As a result it was up to the individual group members to block that time off as their lunch hour from week to week. This did not always happen. Also, there were times when group members were unable to attend sessions due to clients coming in for emergency visits. Then there were times when the group members were absent because they were simply not working that day.

As in all groups, inconsistent attendance affects group dynamics. Although each participant did his/her best to attend all of the sessions, it is unclear as to how the spotty attendance affected the group results. In the future, it would be beneficial for such a group to be run when group attendance could be consistent.

Another limitation to the research was the length of time in which the group was run. As this was a group in which all participants that volunteered to participate also voluntarily gave up their lunch hour, the group was only run for eight sessions. More research could be done to determine if a group run for a longer period of time produced more significant results.

An area of possible research to possibly be explored is the lasting effects of the group. The group post-test was taken during the last session. There is no data as to

whether group results have changed again three months after the completion of the group. It is unclear as to whether or not the group produced long term change.

One last limitation to the research and possible area for further research centers around participants' incorporation of learned skills into their daily lives. The group *Burnout Self-Care Among Mental Health Counselors* was meant to be a sampling of possible interventions to decrease burnout levels. Although, time spent during the group was specifically designed to increase self awareness, many of the exercises were designed to be implemented by participants in their daily routines. This however did not happen. It is unclear as to how the results of this group would have differed if participants followed through with the skills that they learned.

Summary

Just as weeds can take away and destroy what a flower garden is meant to do and be, so can burnout take away and destroy what a counselor is meant to do and be. A counselor suffering from high levels of burnout is not, and can not achieve for himself/herself or his/her client what the counseling process is meant to be. Just as gardeners have tools to rid their gardens of the weeds that are crippling to their flowers, so do counselors have the tools to rid themselves of the burnout that is crippling to themselves and their clients. It then becomes a matter of finding and using their tools.

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Appendix A

CHRISTINA MASLACH • SUSAN E. JACKSON

MBI–Human Services Survey

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

Because persons 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.

On the following page there 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 a "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.

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 times a week	Every day

How Often 0–6	Statements:
1. _____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under then 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 a "5."

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Appendix B

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 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.

(Administrative use only)

		cat.		cat.		cat.
EE:	_____	_____	DP: _____	_____	PA: _____	_____

Appendix C

Statement of Informed Consent

Dear Counselors,

My name is Julie Pettit and I am a graduate student pursuing a Master's degree in Counselor Education at SUNY College at Brockport. I will be implementing a program about *Burnout/Self-Care Among Mental Health Counselors*. The purpose of this program is to teach mental health counselors to become aware of possible burnout and interventions to prevent it. It will be designed to raise self-awareness, increase self-esteem, facilitate team building and personal growth, increase UPR with clients, and ways to cope with stress. The program will take place during the lunch hour for eight weeks.

In order for you to participate in this program, your informed consent is required. You are being asked to make a decision whether or not you want to participate in this program. If you want to participate in this program, and agree with the statements below, please sign below. Your participation in this study is completely voluntary. You are free to change your mind or stop being in this program at any time and there will be no penalty.

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions. Participating or not participating will have no impact on work evaluations.
2. My confidentiality of data is guaranteed. Confidentiality will be protected by student researcher as part of the group procedures. The student researcher will continuously discuss and reinforce confidentiality among the group members throughout the eight sessions. All consent forms and documents handed out will be kept in a locked filing cabinet at Orleans County Mental Health. Confidentiality regarding group members will be discussed and strongly encouraged.
3. There will be no anticipated risks or benefits because of my participation in this program.
4. My participation involves eight sessions of discussing various topics, working on inventories, and drawing. Participants will complete the MBI Human Services Survey and take pre and post tests.
5. No individual results used in the research will be shared with anyone other than the individual.
6. All consent forms and documents handed out will be shredded at the end of the project.
7. Approximately 10 counselors will participate.

Appendix D

Statement of Informed Consent Continued

If you have any questions you may contact:

Primary Researcher	Faculty Advisor
Julie Pettit (585) 589-9372	Dr. Pat Goodspeed-Grant (585) 395-5493 Dr. Tom Hernandez (585) 395-5498

I understand the information provided in this form and agree to participate in this program.

_____ _____

Appendix E

Burnout/Self-Care Among Mental Heath Counselors Group Attendance

Session 1

- Counselors Present: #1, #2, #3, #4, #5, #6, #7, #8, and #9

Session 2

- Counselors Present: #1, #2, #3, #4, #5, and #6

Session 3

- Counselors Present: #1, #2, #4, #5, #7, and #8

Session 4

- Counselors Present: #1, #2, #4, #5, #7, and #8

Session 5

- Counselors Present: #2, #4, and #8

Session 6

- Counselors Present: #1, #2, #3, #4, #5. and #7

Session 7

- Counselors Present: #1, #2, #4, #5, and #8

Session 8

- Counselors Present: #1, #2, #3, #4, #5, and #6