

Lived Experiences of Mental Health Professionals  
Using Resilience to Resist Burnout

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A Dissertation Presented in Partial Fulfillment  
Of the Requirements for the Degree  
Doctor of Education

School of Behavioral Sciences

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Approved by:

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### **Abstract**

The purpose of this qualitative transcendental phenomenological study was to describe the lived experiences of mental health professionals (MHPs) in California who have worked in private practice settings. The three research questions that framed this study were: what resilience-promoting mindsets do these mental health professionals rely upon, what resilience-promoting behaviors or practices do they demonstrate, and how do these mindsets and behaviors protect MHPs in private practice from experiencing burnout? The theory guiding this study was the metatheory of resilience and resiliency by Glenn E. Richardson (2002; 2016) as it provided a framework to assess how these professionals utilized resilience mindsets and practices to resist burnout. Data collection consisted of demographic questionnaires and semi-structured interviews with 12 mental health professionals. Data analysis strategies consisted of first and second cycle coding procedures, namely, descriptive coding, in vivo coding, and focused coding, as well as bracketing and journal reflections. Data analysis revealed two primary themes of the mental health practitioners' lived experiences of the phenomenon of resilience and nine supportive sub-themes. The findings indicated that these MHPs experience resilience by operating from their optimal self and flowing with temporal fluidity. Recommendations are provided for educational, spiritual, and clinical settings as well as topics for future research.

*Keywords:* resilience, resiliency theory, burnout, mental health professionals, private practice

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**List of Abbreviations**

American Counseling Association (ACA)

American Psychological Association (APA)

Marriage and Family Therapist (MFT)

Mental Health Professional (MHP)

Metatheory of Resilience and Resiliency (MRR)

## **Chapter One: Introduction**

### **Overview**

Chapter One provides an introduction to the dilemma of professional burnout among MHPs, the societal effects that result, and the phenomenon of resilience that counters it. Following the brief background section which introduces humanity's intrigue with stories of overcoming adversity, a historical context for the problem of burnout will be presented, incorporating its causes and consequences. The social implications of burnout are addressed next, highlighting the systemic and individual effects, and the role resilience plays in mitigating negative outcomes. The imminent need for this resilience research will be explored, examining key aspects of resilience research over the decades. The metatheory of resilience and resiliency (MRR) (Richardson, 2002) that shapes the theoretical background of this study will be presented, as well as my motivation for the study, philosophical assumptions, and research paradigm. The final sections of this chapter include the problem statement, the purpose statement, the significance of this study, the research questions, key definitions, and a brief summary.

### **Background**

Life's adversities can hit at unexpected times and in unpredictable ways. They can throw someone's life into utter turmoil by tormenting their mind, pummeling their body, and assaulting their soul (Southwick & Charney, 2018). Adversity, "a state or instance of distress, calamity, hardship, or affliction," can pack a strong punch, sometimes leaving someone down for the count (Moore, 2014, p. 25). But does adversity always win? Does it always get the last word? The plot of many great story lines found in literature, film, and oral tradition highlights individuals who faced adversity and overcame. The human race is greatly inspired by stories of those whose courage and tenacity compelled them to triumph over challenging situations (Moore, 2014; Titus,

2006). Millennia ago, the Biblical writers were stirred by stories of overcoming, referencing victorious individuals throughout the Bible. Though the word *resilience* is not explicitly used, related concepts communicate a similar theme. Terms such as perseverance (James 1:12; Hebrews 12:1-3), endurance (Colossians 1:12, Romans 5:3-5), and steadfastness (James 1:2-4, 2 Thessalonians 3:5) reveal inspiring tales of human fortitude and victory. Although centuries have passed, the strength and adaptability that enables individuals to withstand seemingly impossible circumstances, still inspire. Much can be learned from those who rediscover purpose, beauty, and meaning after adversity. Courage is contagious, and people are strengthened when they hear stories of overcoming from others (Bonanno & Diminich, 2013; Hanson, 2018).

The overcoming power of resilience is the focus that drives this study. MHPs face their own life challenges, and yet still work to help others navigate their hardships. Sometimes this leads to compassion fatigue and burnout. But other times, MHPs exhibit a resilient resolve that helps them resist burnout. Resilience highlights the human spirit's ability to overcome adversity (Calo et al., 2019; Southwick & Charney, 2018). A dynamic capacity that individuals rely upon to weather challenging situations, resilience becomes particularly relevant to helping professionals who work as frontline participants assisting clients through various life crises.

### **Historical**

Burnout is a state of mental and physical exhaustion that professionals often face due to being worn down by the excessive demands placed upon them (O'Connor et al., 2021). It occurs when someone's ability to cope has been overwhelmed because their energy, strength, or resources have been depleted (Freudenberger, 1974). Burnout in the mental health field is a pervasive problem (Morse et al., 2012; Rohland, 2000). "Up to 67% of mental health providers" experience high levels of burnout (Eliacin et al., 2018, p. 388). This exceeds the 62% prevalence

rate among those who work in palliative care (Kavalieratos et al., 2017; Shanafelt et al., 2015; Westwood et al., 2017). Psychologist Herbert Freudenberger (1974) first introduced the concept of burnout into professional literature after experiencing a particular exhaustion that he also observed in those working alongside him in the free clinics in New York City (Hyman, 2021; Samra, 2018). Intrigued, he began to wonder how its effects could be reversed (Freudenberger, 1975). He set out to better understand how living under excessive demands could lead to burnout (Freudenberger, 1974). Soon after, Christina Maslach (1976), a social psychologist, also became interested in the idea of burnout. She devised the Maslach Burnout Inventory, a self-assessment inventory, which is still considered the gold standard in the field (Hyman, 2021; Maslach, 2017). Over the years, professional bodies that oversee practitioners became concerned with burnout trends among MHPs (Maslach, 2017). Researchers developed interest in the symptoms, causes, and effects of burnout (Lowe et al., 2020; O'Connor et al., 2021), turning it into a viable research focus (Acker, 2011; Bahar et al., 2020; Eriksson et al., 2018).

The concept of burnout quickly extended beyond the field of psychology into other disciplines such as aviation (Samra, 2018), nursing (Lowe et al., 2020), medicine (Hyman, 2021), and social work (O'Connor et al., 2021). A greater understanding of what burnout entails was generated and a triad of symptoms emerged: emotional exhaustion (a fatigue that leads to a decrease in work activities), depersonalization (a cynicism or negativity toward clients or the work environment), and decreased personal accomplishment (a negative assessment of one's own achievements) (Hyman, 2021; Lowe et al., 2020; Volpe et al., 2014). Some researchers identify exhaustion and fatigue as the main feature of burnout, naming depersonalization and decreased achievement as its consequences (Kristensen et al., 2005; O'Connor et al., 2021).

Occupational stress and overinvestment in one's workplace have been identified as most strongly correlated with burnout symptomatology (McGhee, 2017; O'Connor et al., 2021). Because this syndrome is triggered by stress, those working in emotionally demanding environments are especially vulnerable (McGhee, 2017; Volpe et al., 2014). MHPs are particularly high risk because of the intense emotional demands associated with their work (Sander, 2017; Serole et al., 2021). Meeting clients in their pain and assisting them in finding solutions to their crises requires high levels of empathy and compassion, leading to practitioner burnout if not monitored (O'Brien & Haaga, 2015; Pack, 2013; Samra, 2018). With the distress, trauma, and tragedy in our modern world, MHPs need help managing the increased workload and severity of cases (Eliacin et al., 2018; Pack, 2013; Pereira et al., 2017). Because burnout is generally associated with poor work—life balance and a lack of support, its effects add more strain to an already stressed individual (Hyman, 2021; O'Connor et al., 2021; Sander, 2017). Some individuals use drugs, alcohol, or other addictive behaviors to cope, while others succumb to anxiety, depression, or stress-induced somatic issues (Lowe et al., 2020; Teran, 2015).

### **Social**

There are costs to society when clinicians experience burnout, evidenced most often by impaired effectiveness and decreased effectiveness with clients (Acker, 2011; Lee et al., 2019). A client's therapeutic process is negatively impacted when the practitioner is struggling with their own depleted resources (Lee et al., 2011; Wang et al., 2017). It results in reduced quality of care (Halevi & Idisis, 2018; O'Connor et al., 2021). When clinicians are battling burnout, they tend to choose a lower quality of interventions and apply them less effectively than when they are working competently (Fahrenkopf et al., 2008; Volpe et al., 2014). This leads to impaired client relations and decreases patient satisfaction with the overall therapeutic experience (Lowe

et al., 2020). When clinicians struggle, their own personal suffering increases, resulting in strain on their primary relationships (Hammond et al., 2018; O'Brien & Haaga, 2015), increased sick leave (O'Connor, 2021; Simionato & Simpson, 2018), and more frequent career changes (Lowe et al., 2020). Some MHPs battle burnout by leaving a specific job (Halevi & Idisis, 2018; Sander, 2017), but many others leave the profession altogether (Hyman, 2021; McGhee, 2017). This exodus out of the profession causes a ripple effect across society, impairing society's confidence in the benefit of therapeutic services (Bubendorff, 2019; Kreitzer & Klatt, 2017).

The Code of Ethics (2014) from the American Counseling Association (ACA) states that MHPs must monitor, maintain, and promote their own well-being in order to best fulfill their professional duties (Sander, 2017). It is imperative for all MHPs to prioritize their own mental and emotional health status regardless of where they work (Herrman et al., 2011). Private practice practitioners are particularly at risk due to the absence of colleagues to rely upon to help shoulder the burdens inherent in this type of work (Lee et al., 2019; Sears, 2017). Resilience has been identified as an antidote to burnout, so much so that recent decades have seen a trend in the development of resilience training programs (Halevi & Idisis, 2018; McGhee, 2017). More resilience training programs have been developed now than during any other time in history (Beaumont et al., 2016; Kreitzer & Klatt, 2017; Moore, 2014). These programs yield effective results. Even the American Psychological Association (APA) proclaims the benefits of resilience, stating that it improves someone's ability "to adapt to stress and adversity" (2016, p. 16) and to effectively recover from exposure to crisis (Masten, 2014; Ungar & Theron, 2020).

### **Theoretical**

While the foundational framework for this study is phenomenology, the metatheory of resilience and resiliency (MRR) helped shape my understanding of resilience (Richardson, 2017;

Waite & Richardson, 2004; Zimmerman, 2013). Defining resilience as a “self-righting force within,” it posits that every person possesses an internal drive that compels them to pursue a higher version of themselves (Richardson, 2002, p. 313). An internal life force awakens within people to propel them beyond survival toward well-being (Waite & Richardson, 2004). The innate capacity for personal growth that each human possesses is paired with an internal drive to actually attain it (Deci & Ryan, 2008; Markland et al., 2005). Therefore, the primary goal of the MRR is to help individuals identify the life force intrinsic within and to lay hold of the energy, vitality, and self-motivation readily accessible to them (Richardson, 2017; Ryan & Deci, 2008). Although positive changes can be made relatively quickly in life, a stable internal drive is necessary to sustain ongoing healthy habits (Duhigg, 2014; Richardson, 2017). The MRR helps people connect to their internal wellspring so they can continue to make the choices consistent with the long-term growth they desire to achieve (Duhigg, 2014). This metatheory undergirds the current study by establishing a comprehensive framework for how individuals can learn to access multiple layers of strength (Richardson, 2002; Richardson, 2016). This includes different biological, psychological, and spiritual resources, as well as intrapersonal, interpersonal, and community sources (Waite & Richardson, 2004; Zimmerman, 2013). The various areas of resource work together to affirm a unique blend of capacity within each individual that helps them overcome hardship (Deci & Ryan, 2008; Kalisch et al., 2019).

### **Situation to Self**

My motivation to conduct a study describing the experiences of marriage and family therapists (MFTs) in private practice originated from my own experiences working in the field. As an intern, I readily observed significant differences in how my supervisors in public agency settings managed the demands of the job from those who worked in private practice settings. As

I became established in my own private practice, I deliberated over how to navigate the stressors such that they did not impose a detrimental cost on my personal or family life. Now, 15 years later, I am still curious as to how MHPs navigate these professional challenges and was therefore inspired to interview my fellow practitioners.

In addition to my personal experiences within the profession, there are three philosophical assumptions that I bring to the research and a paradigm that guides this study. First, the ontological assumption that undergirds the study views reality as subjective. As opposed to quantitative research, which perceives reality as objective, this study defines reality as being internal to the knower (Moustakas, 1994). This study supported the ontological position that humans can share their own thoughts, interpretations, and meanings because their lived experiences are indeed valid (Seidman, 2019). Second, this study reflects the epistemological view that meaning is not discovered but constructed by human beings and shared within their social context (Moustakas, 1994). Exemplifying the interpretive/constructive perspective, this study utilized open-ended questions that invited the descriptive process from the participants' worldview (Van Manen, 2017). Third, the axiological assumption led me to recognize how my own values and biases could influence the interpretation of data. Moustakas (1994) suggested that researchers commit to introspective self-awareness to mitigate researcher bias. Self-reflexive journaling and bracketing of my own assumptions, biases, and viewpoints enabled me to suspend my judgments in order to pursue transcendental subjectivity in the research outcomes.

The constructivist framework is the paradigm that guided interpretation of the findings. It is based on the premise that the learner actively participates in the construction of meaning of their own experiences (Creswell, 2013). The individual's own personal experiences and unique background defines their point of view and influences the manner in which they reflect upon and

reconstruct their own stories (Seidman, 2019). Striving to discover the essence of the participants' lived experiences of the phenomenon of resilience, I prioritized their descriptions of reality while holding my own assumptions and biases in abeyance (Heppner et al., 2016). Gathering their diverse realities together helped me to generate themes of their collective experiences, reflecting insights to address the problem of burnout among MHPs.

### **Problem Statement**

Provider burnout among mental health professionals is occurring at alarming rates (Deville et al., 2009; Morse et al., 2012; Sodeke-Gregson et al., 2013). Despite the proliferation of professional development and skills training that help MHPs accrue specific professional skillsets, disciplines, and habits, helping professionals still face compassion fatigue and burnout at increasing rates (Dombo & Gray, 2013; Kottler, 2010). These problems negatively impact MHPs by inhibiting their professional abilities to compassionately and effectively fulfill their role in helping others (Bratt, 2019), as well as negatively impacting their personal lives with absenteeism, decreased job satisfaction, and reduced job performance (Hammond et al., 2018; Haramati et al., 2017). Recent studies have found that up to 67% of providers have experienced burnout at some point in their career (Morse et al., 2012). Other studies suggest that burnout rates among MHPs occur in more than half (56%) of the respondents, with 50% of them reporting intentions to leave their job because of it (Acker, 2011; Hammig, 2018). Related problems of compassion fatigue and vicarious trauma also haunt the profession (Carrola et al., 2016; Elician et al., 2018; Mattioli et al., 2018), leading to decreased quality of care for patients and increased turnover in the workplace (Dorociak et al., 2017; Lakioti et al., 2020).

Previous research has focused on how burnout impacts clinicians in schools (Boccio et al., 2016; Mullen et al., 2018), hospitals (Kreitzer & Klatt, 2017; Morse et al., 2012), prisons

(Lambert et al., 2015), mental health agencies (Gaal, 2010), and veterans' hospitals (Eliacin et al., 2018). However, the current research is deficient in describing the lived experiences of clinicians in private practice settings (Lent & Schwartz, 2012; Morse et al., 2012; Rupert & Morgan, 2005; Simionato & Simpson, 2018). The private practice setting is unique from other settings because they are isolated from their colleagues and therefore shoulder client burdens all alone (Hanson, 2018; Hendriks et al., 2018). This qualitative study addresses the problem of burnout among MHPs in private practice by exploring their lived experiences in order to highlight the resilience-promoting mindsets and behaviors they utilize (Goubert & Trompetter, 2017; Leaf, 2013) to mitigate against burnout (Moustakas, 1994; Seidman, 2019).

### **Purpose Statement**

The purpose of this transcendental phenomenological study was to describe the lived experiences of resilience for MHPs who work in private practice (Simionato & Simpson, 2018). At this stage of research, resilience was defined as the ability to bounce back after adversity (Buzzanell, 2010; Fletcher & Sarkar, 2016). This definition does not suggest that one is immune to the effects of hardship and crisis (Garmezy, 1991; Santamaria-Garcia et al., 2017; Weine, 2017), but rather, that one is able to carry on in spite of these challenges (Rao & Mehra, 2015; Rees et al., 2015). The theory shaping my understanding of resilience was the metatheory of resilience and resiliency (Richardson et al., 1990; Richardson & Waite, 2002). Because the MRR is a strength-based ideology (Bonanno & Diminich, 2013; Fletcher & Sarkar, 2016), it established a solid foundational for pursuing what resilience-promoting mindsets and behaviors the MHPs utilize to resist burnout (Nissen-Lie et al., 2013; Simionato & Simpson, 2018). In developing a deeper understanding of the phenomenon of resilience, practical insights will be generated to address the problem of burnout in the profession.

### **Significance of the Study**

This study describing mental health clinicians' experiences with resilience provides empirical significance to the research on clinician burnout, theoretical significance to the metatheory of resilience and resiliency, and practical significance to the mental health field.

#### **Empirically**

Empirically, this study contributed to research on clinician burnout. Because burnout syndrome is triggered by stress, those working in emotionally demanding environments are especially vulnerable (McGhee, 2017). Mental health practitioners are particularly high risk for burnout because of the intense emotional demands associated with their work (O'Connor et al., 2021; Sander, 2017). This study is related to research previously conducted regarding burnout among mental health professionals (Acker, 2011; Aronsson et al., 2017; Bianchi et al., 2014; Boccio et al., 2016; Eliacin et al., 2018; Gaal, 2010; Kim & Lambie, 2018; Lee et al., 2019; Morse et al., 2012; Mullen et al., 2018; Ortiz-Fune et al., 2020; Rohland, 2000), but addresses the population of professionals who face the unique pressures found in the private practice setting.

Previous research has been done on the benefits of resilience in other helping professions such as in nursing (Ashby et al., 2013; Brown et al., 2018; Hegney et al., 2015), school counseling (Boccio et al., 2016; Kim & Lambie, 2018; Mullen et al., 2018), social work (Montero-Marín et al., 2016; Newell & Nelson-Gardell, 2014), and in agency-based programs (Bubendorff, 2019; Lowe, 2012; Morse et al., 2012). However, there is a dearth of research focused on the population of MHPs in private practice. Prior studies have had a similar focus on identifying strategies to aid in the reduction of burnout symptomology in mental health providers (Eriksson et al., 2018; Lamb & Cogan, 2016; Maslach, 2017; Ortiz-Fune et al., 2020; Wood et

al., 2017). This study contributes knowledge to the field by addressing the pressures and stressors that are unique to private practice clinicians.

Research reveals that MHPs demonstrate a practice of learning effective coping skills from dealing with crisis situations, thereby adapting themselves to act accordingly in subsequent crises (Buzzanell, 2010; Morse et al., 2012). This quality guided the assumptions in this study and revealed the significance in understanding how resilience-promoting mindsets and behaviors can become instrumental in helping MHPs assuage compassion fatigue and burnout (Buzzanell, 2010; Nissen-Lie et al., 2013; O'Brien & Haaga, 2015; Pedersen, 2018). Prior studies sought to develop theories highlighting the dynamic relationship between professional resilience, identity, and practice (Ashby et al., 2013; Halevi & Idisis, 2018; Lakioti et al., 2020). Similarly, this study enquired into the lived experiences of MHPs regarding the resilience-promoting mindsets and behaviors that have assisted them in mitigating the professional pressures that lead to burnout. Resilience emerges through the process of facing adversity and overcoming it (Bennis & Sample, 2015; Kent et al., 2015; Pedersen, 2018). Process models of resilience emphasize what factors aid in the development of resilience (Kent et al., 2015; Reed & Blaine, 2015). This offers insight when dealing with helping professionals who need to withstand extreme emotional pressure and still move forward both personally and professionally. Resilience directly impacts how helping professionals manage their own adversities as well as how they advise others through crises (Boullion et al., 2021; Moore, 2014; Nemecek et al., 2015). This study adds to the literature by highlighting the perspectives, stressors, and coping skills of MHPs in private practice.

### **Theoretically**

This study contributes to Richardson's metatheory of resilience and resiliency (Richardson, 2002, 2017). The MRR posits that every person possesses an internal drive that

helps them pursue a higher version of themselves (Richardson, 2002; Waite & Richardson, 2004) and this is paired with an internal drive to attain it (Deci & Ryan, 2008; Markland et al., 2005). The goal is to help people connect to the wellspring of life within them so they can engage in healthy decision-making that facilitates long-term growth (Duhigg, 2014; Waite & Richardson, 2004). This draws from self-motivation theory which posits that humans can live from a proactive and engaged stance, or passive and isolated (Ryan & Deci, 2000). Innate psychological needs can influence whether someone lives with activated intrinsic motivation or not (Deci & Ryan, 2008; Kalisch et al., 2019). Competence, autonomy, and relatedness “yield enhanced self-motivation and mental health” but when thwarted, lead to “diminished motivation and well-being” (Ryan & Deci, 2000, p. 68). Richardson’s metatheory reflects similar findings that support facilitating optimal functioning in individuals through supporting that which fosters positive processes (Richardson, 2016).

The MRR supports identifying different areas of strength to rely upon during challenging times. Individuals will utilize a blend of strengths that is unique for each person (Treptow, 2014; Zimmerman, 2013). People can draw energy and input from their biological (Treptow, 2014; Tugade & Fredrickson, 2004), psychological (Teran, 2015; Trigueros et al., 2019), spiritual (Smith et al., 2012; Titus, 2006), interpersonal (Smith, 2015; Walsh, 2016), and community resources (Ungar et al., 2013; Waite & Richardson, 2004; Zohar & Marshall, 2000). These different areas of resource work together to form a unique capacity that is synergistic and that contributes to positive outcomes (Ungar & Theron, 2020; Zimmerman, 2013). The various sources of strength recognized by the metatheory of resilience and resiliency (Richardson, 2002; 2016) are supported by previous research, namely in the field of positive psychology (Niemiec, 2014; Niemiec & McGrath, 2019; Peterson & Seligman, 2004). Resilience reflects the capacity

of the human spirit to confront and overcome hardship, drawing from resources of bravery, hope, and self-efficacy to overcome (Pangallo et al., 2015; Russo, 2012; Seligman & Pawelski, 2003). When people can find meaning in their struggles, then they are positioned to withstand the hardship and find ways to overcome (Park, 2017; Van Agteren et al., 2021; Yates et al., 2015). This study contributes additional insights to Richardson's theory (2016) through emphasizing the resilience-oriented mindsets and behaviors that MHPs rely upon.

Richardson's theory (2002) highlights resiliency processes and outcomes. Using adversity as a fuel to move through hardship is a theme endorsed in other studies (Silverstein et al., 2017; Southwick & Charney, 2018). Life disruptions can lead people to discover internal strengths they did not know they had, but that help them to grow stronger through their struggles (Waite & Richardson, 2004). Resilience also reveals that individuals can become emboldened with skills that they did not possess prior to the hardship (Richardson et al., 1990). This theory emphasizes the common experiences of humanity to better understand the life forces that help people develop adaptive attitudes and behaviors (Schmidt & Shumow, 2020; Sisto et al., 2019). The current study contributes to the MRR by highlighting details from the participants' narratives that reveal the mindsets and behaviors that led to positive outcomes.

### **Practically**

This study provided practical assistance to the mental health profession by offering insights into the stressors that private practice clinicians experience. Resilience separates those who adapt and overcome from those who do not (Forbes & Fikretoglu, 2018). Therefore, supporting resilience research strengthens the mental health field because it provides strategies and solutions for the chronic problem of burnout that has plagued the field (Bouillon et al., 2021). Research indicates ongoing benefits from resilience, specifically that those who exhibit

resilience in their thoughts and actions become less vulnerable to the ill effects of subsequent stressors (Calo et al., 2019; Pedersen, 2018). These insights can benefit helping professionals by warning them of the potential struggles that are common in the private practice setting.

Exploring how MHPs experience burnout helps to reduce provider fatigue and susceptibility to burnout (Ashby et al., 2013; Rupert & Dorociak, 2019; Russo et al., 2012). By identifying the potential problems, it encourages MHPs to engage in preemptive actions toward good self-care (Titus, 2006; Treptow, 2014; Ungar & Theron, 2020). This leads to more sustainable work-life balance, which translates into better standards of care for clients (Sisto et al., 2019; Trigueros et al., 2019; Wald, 2015). Highlighting the phenomenon of resilience in the lived experiences of MHPs in private practice invites insight into what mindsets and practices have assisted them in overcoming adversity. This study reveals the need for professional self-care in the private practice setting (Newell & Nelson-Gardell, 2014). The specific tools identified can become coping strategies that other MHPs utilize to strengthen their own self-care regimens (Vanhove et al., 2016; Wang et al., 2017; Wood et al., 2017). This study can inspire other MHPs to proactively fulfill their professional duty of ethical self-care through applying similar principles (Rupert & Morgan, 2005; Shrivastava & Desousa, 2016).

### **Research Questions**

The research questions provide a framework to understand the phenomenon of resilience among private practice clinicians. This study explored three research questions:

**RQ1:** What mindsets that promote resilience do these mental health professionals rely upon?

**RQ2:** What behaviors or practices that promote resilience do these participants demonstrate?

**RQ3:** How do resilience-promoting mindsets and practices help mental health professionals resist burnout?

### Definitions

1. *Adversity* - difficult experiences that “have the potential to disrupt or challenge adaptive functioning and development,” threatening an individual’s homeostasis and initiating the potential for less desirable outcomes (Yates et al., 2015, p. 774).
2. *Bracketing* - a scientific process where the researcher suspends any presuppositions, biases, assumptions, theories, or previous experiences in order to see the phenomenon as described by the participants (Gearing, 2004).
3. *Burnout* - negative personal impact caused by job-related stressors that create excessive demands on an individual’s energy, strength, or resources leading to emotional exhaustion (Freudenberger; 1974)
4. *Compassion fatigue* - the caregiver experiences exhaustion by failing to protect their own energy, resulting in an accumulative depletion (Mattioli et al., 2018).
5. *Epoche* - the process wherein researchers set aside their own thoughts, experiences, or preconceived understandings (Moustakas, 1994).
6. *Phenomenological reduction* - each experience is described in its total form, with all the thoughts, feelings, perceptions, and sensory stimuli included. The goal is then to reduce the data to language that most accurately reflects what the participants described, offering texture to the descriptions and synthesizing the meanings (Saldana & Omasta, 2021).
7. *Resilience* - the ability to bounce back after adversity (Buzzanell, 2010; Fletcher & Sarkar, 2016) and demonstrate successful adaptation to obstacles and hardship (Truffino, 2010; Van der Meulen et al., 2019; Zolkoski & Bullock, 2012).

8. *Resilience Mindset* - thought processes proven to create “effective pathways to improved functioning and well-being” (Mongrain & Anselmo-Matthews, 2012, p. 382).
9. *Resilience Behaviors* - observable actions proven to be effective in facilitating recovery, health, and well-being (Moore, 2014).
10. *Resiliency Process* - harnessing adversity as fuel to facilitate movement through hardship in order to gain new insights, strength, or growth (Moore, 2014).
11. *Resilience Outcomes* - adaptive attitudes and behaviors evidenced after exposure to challenging life events that allow someone to regain or exceed previous levels of functioning (Sisto et al., 2019).
12. *Vicarious Trauma* –therapists can experience negative effects from working with the difficult stories that survivors of trauma share during treatment (Devilly et al., 2009).

### **Summary**

Provider burnout is a pervasive problem that impacts the mental health profession because of the deleterious effects it has on MHPs, both personally and professionally (Morse et al., 2012). Despite years of education and training, the stressors associated with working in the mental health profession can exact a harsh price on clinicians who fail to posture themselves toward health and well-being (Teran, 2015). The mental and physical exhaustion that occurs during burnout impacts clinicians personally, but also impacts their clientele by reducing their clinical effectiveness (Eliacin et al., 2018). This results in reduced satisfaction with the therapeutic experience (Lee et al., 2011; Wang et al., 2017). Burnout symptoms can manifest as decreased job satisfaction (Acker, 2011), increased absenteeism and sick leave (O’Connor et al., 2021), increased job turnover, or early retirement (Fahrenkopf et al., 2008; Volpe et al., 2014).

The purpose of this transcendental phenomenological study was to describe the experiences of MHPs in regard to the problem of burnout in private practice settings. The metatheory of resilience and resiliency (Richardson, 2017) was selected to describe the experiences of clinicians. My motivation for the study generated from my personal experiences within the profession and curiosity as to how other clinicians resist the pressures leading toward burnout. The research questions were created to elicit MHPs' insights into the resilience-promoting mindsets and behaviors they utilize. Since qualitative studies offer valuable insight into populations that have not yet benefited from systematic study (Bonanno et al., 2010; Moustakas, 1994), this study applied the extant literature to MHPs who work in private practice, a population that has been largely neglected in research (Lent & Schwartz, 2012; Morse et al., 2012; Rupert & Morgan, 2005). The study added empirical significance to the research on clinician burnout, theoretical significance to the metatheory of resilience and resiliency, and practical significance to the mental health field.

## **Chapter Two: Literature Review**

### **Overview**

Chapter Two begins with a review of the theoretical framework for this study and associated literature on burnout and resilience. The theoretical framework section introduces the metatheory of resilience and resiliency which was selected to guide this study (Richardson, 2002). The related literature section includes a description of burnout, its prevalence, causes, and effects. Resilience is discussed next, beginning with a history of resilience research and evolving into current research. Four common components of resilience will be explored. Finally, research into MHPs will be discussed, leading into resilience-oriented mindsets and behaviors. This chapter provides a backdrop for the existing gap in the literature and provides a rationale for this study. The chapter concludes with a short summary and research questions.

### **Theoretical Framework**

The three main principles of the MRR are significant to establish the foundation for this study. First, every person has an internal life force that functions as a self-righting force within, provoking them toward survival and well-being (Richardson, 2002). This internal force is innate in humans, making resilience accessible to every human being (Richardson, 2016). The primary goal of the MRR framework is to identify the sources of strength that people can access to overcome adversity (Richardson, 2002). It involves a motivational drive compelling people to engage in practices that support their own well-being (Waite & Richardson, 2004). Drawing from self-determination literature, this metatheory affirms that the “fullest representation of humanity shows people to be curious, vital, and self-motivated” (Ryan & Deci, 2000, p. 68). Intrinsic motivation prompts people to receive vitality from sources that inspire them (Flannery, 2017), helping them to sustain their efforts supporting healthy functioning (Ryan & Deci, 2008).

Second, resilience draws from multiple layers of strength. The MRR establishes a broad framework including mental, emotional, physical, and spiritual components as viable resources (Richardson, 2002; Waite & Richardson, 2004). This holistic approach, rooted in the wellness movement, promotes whole person health (Richardson, 2017). Cognitive, behavioral, spiritual, and affective pathways can be accessed for personal development even during crisis (Mehrotra & Tripathi, 2017; Richardson, 2016). Those with higher levels of “religious faith and spirituality were associated with more adaptive coping responses, a more optimistic life orientation, greater perceived social support, lower levels of anxiety, and thus, higher resilience” (Ajawani, 2017, p. 72). In fact, many researchers highly value spiritual intelligence. Multiple studies name spiritual intelligence (SQ) at the top of the hierarchy, with emotional intelligence (EQ) and cognitive intelligence (IQ) following in importance (Ajawani, 2017; Zohar & Marshall, 2000). Waite and Richardson (2004) postulated that every individual’s innate resilience is connected to a transcendent reality that brings out the best in them. Spiritual virtues transcend typical human limitations (McMinn, 2017; Park, 2017) and the impetus toward “self-actualization, altruism, wisdom, and harmony with a spiritual source of strength” creates transcendent possibilities for growth (Waite & Richardson, 2004, p. 178). Neurological studies reveal that the human brain is biologically and developmentally wired toward spirituality as evidenced when specific regions of the brain light up on brain scans when the individual is exposed to spiritual ideas or experiences (Ajawani, 2017; Newberg et al., 2001; Panksepp, 2014). Even though it is biologically congruent with human nature, spiritual strength does not develop on its own. It must be mindfully nurtured (Niemiec & McGrath, 2019; Zohar & Marshall, 2000). When faced with situations of struggle and despair, many people report feeling stretched beyond themselves and unable to cope (Mehrotra & Tripathi, 2017). This is when faith becomes a vital source of

strength. It helps people transcend their self-serving interests (Park, 2017). Healthy spiritual pursuits empower people to endure hardship and discover hope beyond what is normally within their reach (Dweck, 2006; Niemiec, 2014). When spirituality is actively pursued, stabilization against distress occurs and meaningful outcomes result (Titus, 2006; Worthington, 2017).

Emotional regulation plays a significant role in navigating emotionally distressing situations because crises demand healthy emotional responses (Duckworth, 2018; Richardson, 2017; Richardson et al., 1990; Smith et al., 2012). When done well, it results in increased strength, determination, and grit (Moore, 2014; Rendon, 2015). Learning to modulate emotional distresses while in the midst of adversity demonstrates “competence in decision making and resilience in action” (Young & Rushton, 2017, p. 580). The MRR incorporates emotional regulation into its foundational goals. Since resiliency is stimulated when someone is pushed to disruption by a stressor, change, or adversity (Richardson, 2017), resilience enables them to grow stronger through the disruption, achieving reintegration at levels beyond what they had previously possessed (Rendon, 2015; Waite & Richardson, 2004). Instead of following the medical model’s focus on psychopathology, the MRR has established itself within the positive psychology field with its strength-based ideology (Richardson et al., 1990).

Third, the MRR entails both resiliency processes and outcomes. MRR defines resiliency as “the process and experience of being disrupted by change, opportunities, stressors, and adversity, and, after some introspection, ultimately accessing gifts and strengths (resilience) to grow stronger through disruption” (Waite & Richardson, 2004, p. 178). Disruptions occur throughout life, but resiliency is the process of learning to deal with the disruptions by viewing them as opportunities for growth (Richardson et al., 1990; Young & Rushton, 2017). Harnessing the concept of Flach’s law of disruption and reintegration, the MRR affirms that falling apart is a

“necessary prelude to personal renewal” (Richardson et al., 1990, p. 34). This is because when disruption occurs, a temporary state of confusion and anguish occurs. This demands that someone look for new skills to regroup. These new skills embolden individuals toward adaptive outcomes (Markland et al., 2005; Richardson et al., 1990). After crisis, there are four possible levels of reintegration. Dysfunctional integration is the lowest level of reintegration; it shows unhealthy coping skills that are suboptimal and often add additional negative outcomes due to the poor choices. The second level of reintegration includes maladaptive reintegration. This represents functioning back at a level lower than the level of previous homeostasis prior to the crisis. The third level of integration is homeostatic reintegration, which is a return to the same level of functioning as prior to when the disruption occurred. Finally, the fourth and most optimal level is resilient reintegration. At this level of functioning, people demonstrate new adaptive capacities beyond what they possessed prior to the disruption (Richardson et al., 1990). This model affords the possibility that people can learn how to reintegrate back to the highest level and supports resilient outcomes as the optimal goal. Because of these three core principles, the MRR establishes a solid theoretical foundation for this study investigating the benefits of resilience. A review of literature on burnout and resilience now follows.

## **Related Literature**

### **Burnout Research**

Burnout involves a depletion of someone’s emotional resources and manifests with symptoms of emotional exhaustion, decreased energy, and lack of motivation (Hammond et al., 2018; Lambert et al., 2015). The term burnout is credited to Freudenberg (1975) who defined it as an exhaustion from excessive demands on someone’s energy, strength, or resources. However, it is important to note that burnout is not a mental disorder (APA, 2013). The World

Health Organization (2015) describes burnout as a life management problem. It can develop from the accumulated effects of compassion fatigue and vicarious trauma (Beaumont et al., 2016), pointing to a “biopsychosocial syndrome of being overloaded” (Lent & Schwartz, 2012, p. 355). Compassion fatigue occurs when one’s sensitive attempts to alleviate another person’s distress are overwhelmed (Beaumont et al. 2016; Craig & Sprang, 2010). Vicarious trauma refers to the effects of ongoing exposure to traumatizing stories (Lee et al., 2011; Maguire & Byrne, 2017; Mullen et al., 2017). For the purposes of this study, the word burnout will be used to refer to any suboptimal effect upon the clinician, even if it initially began due to compassion fatigue or vicarious traumatization. Burnout will be defined as an emotional exhaustion caused by job-related stressors that impose excessive demands on an individual’s energy, strength, or resources (Kim & Lambie, 2018; Maslach, 2017).

### *Prevalence*

Burnout is common among many types of helping professionals, including military personnel (Johnson et al., 2014), prison guards (Carrola et al., 2016; Gallavan & Newman, 2013), teachers (Bianchini, 2017), pastors (Chan & Wong, 2018; Elkington, 2013; Luedtke & Sneed, 2018), nurses (Mattioli et al., 2018; Montero-Marin et al., 2016; Seery & Corrigan, 2009), healthcare professionals (Montero-Marin et al., 2016; Van Mol et al., 2015), and childcare workers (Lambert et al., 2015; Seery & Corrigan, 2009). In these populations, burnout is linked to negative outcomes such as reduced job satisfaction, decreased commitment to the job, a greater desire to quit, and reduced life satisfaction (Lambert et al., 2015). MHPs also show a propensity toward burnout due to the emotionally intense nature of their work (Carrola et al., 2016; Dombo & Gray, 2013; Kim & Lambie, 2018). Researchers discovered that 21% - 67% of MHPs reported experiencing high levels of burnout (Lee et al., 2019; Morse et al., 2012).

Significant levels of burnout also occurred in community mental health outpatient counselors (Lent & Schwartz, 2012; Neswald-Potter & Simmons, 2016), school counselors (Boccio et al., 2016; Kim & Lambie, 2018), and trauma counselors (DeFigueiredo et al., 2014; Devilly et al., 2009; Sodeke-Gregson et al., 2013).

### *Causes*

Even for well-seasoned clinicians, regularly experiencing other people's emotional stressors demands a high intensity of emotional presence that can become exhausting over time (Frajo-Apor et al., 2016; Maguire & Byrne 2017). This job leads them to confront complex interpersonal situations involving a variety of traumatic situations, overwhelming pain, and suffering (Morse et al., 2012). Those who choose a career as an MHP frequently do so because they endeavor to relieve the suffering of others (Dvash & Shamay-Tsoory, 2014; Elkington, 2013). Often ranking high in character strengths and virtues of empathy, wisdom, and service (McMinn, 2017; Petersen & Seligman, 2004), MHPs fill a unique role in the deeply personal and private moments which requires highly developed skills of empathy and compassion (Craig & Sprang, 2010; O'Brien & Haaga, 2015). Empathy, the expressed "capacity to resonate with and reflect upon the feelings and mental states of others" (Levy et al., 2019, p. 4), is what makes MHPs professionally successful, but it can be drained when relied upon consistently (Beaumont et al., 2016; Warren et al., 2016). When available resources fail to meet the emotionally-laden demands of the work (Lee et al., 2011), the pending pressures can overwhelm even the most sensitive of clinicians (Devilly et al., 2009; Ferdinand, 2011). MHPs must learn how to apply that same compassion and empathy toward themselves that they share with others in order to resist the pull toward burnout (Maslach, 2017; Montero-Marín et al., 2016; Mullen et al., 2017).

### *Effects*

The effects of burnout can cause serious problems if not readily corrected (Beaumont et al., 2016; Maguire & Byrne, 2017). This may include a variety of psychological, behavioral, and physical symptoms, including chronic negative affect (O'Brien & Haaga, 2015), heavy emotional stress (Chan & Wong, 2018; Kerig, 2019; Sodeke-Gregson et al., 2013), deleterious mental strain (Morse et al., 2012; Mullen et al., 2018), exhaustion and fatigue (Rao & Mehra, 2015; Simionato & Simpson, 2018), detachment and depersonalization (Lent & Schwartz, 2012), and increased depression and anxiety (Acker, 2011; Maguire & Byrne, 2017). Reduced motivation, productivity, and accomplishment have also been identified as effects from burnout (Hammond et al., 2018; Lee et al., 2011). The emotional exhaustion of burnout leads to “serious inadequacies in workers’ job performance” including lack of “professional efficacy, intent to quit, and turnover” (Acker, 2011, p 477). It infringes on the professionals’ ability to adequately perform clinical tasks (Mullen et al., 2017), resulting in negative implications for clientele due to reduced quality of care (Beaumont et al., 2016). Entrusted with advising people on important decisions during critical moments of stress and vulnerability, MHPs need to effectively equip those asking for assistance (O'Brien & Haaga, 2015). Those who are experiencing burnout tend to be less effective in their assistance of clients (Elkington & Breen, 2015; Frajo-Apor et al., 2016; Hunt, 2020), missing more work, switching jobs more frequently, and retiring prematurely from the field (Maslach, 2017; Morse et al., 2012; Rupert & Morgan, 2005). Burnout is a leading cause of work-related problems for psychotherapists and adversely impacts the psychotherapy profession as a result (Bears et al., 2013; Lee et al., 2011).

### ***From Burnout to Resilience***

The opposite of burnout is passion, characterized by energy, efficacy, and purpose (Hammond et al., 2018; Maslach & Leiter, 1997). When burnout is the problem, resilience is the

antidote. Resilience enables individuals to persevere through challenges that have the potential to exhaust their resources (Brown et al., 2018). Resilience provides a buffer between the harsh world of traumatic information and the personal effect it has upon mental health professionals (Lakioti et al., 2020; MacGuire & Byrne, 2017). The helping profession requires a professional to use their “sense of self” in ways that draws not only from professionally developed skillsets, but also from personal reservoirs of strength and wisdom generated from their own journey through adversity (Carrola et al., 2016; Dombo & Gray, 2013; Mattioli et al., 2018). When resilience is present, symptoms of compassion fatigue and burnout decrease (Bianchini, 2017; Luedtke & Sneed, 2018; Van Mol et al., 2015). Therefore, it is imperative that researchers seek to understand the phenomenon of resilience in order to contribute to the body of knowledge that will successfully assist practitioners in developing resilience.

### **Resilience Research**

Resilience research is a burgeoning field of study with over a half million research articles available on the topic (Dvash & Shamay-Tsoory, 2014; Kalisch et al., 2019). A viable construct in the social sciences, especially in social work and psychology (Erikson, 1994; Mullen et al., 2017; Newell & Nelson-Gardell, 2014), it has also become popular in other disciplines such as education, business leadership, disaster relief, and environmental sustainability (Cohen et al., 2016; Kerig, 2019; Obrist et al., 2010; Truffino, 2010), as well as in policing, medicine, epidemiology, and nursing (Van der Meulen et al., 2019; Yuan et al., 2011).

### ***The Beginnings***

Resilience is a dynamic concept dating back to the 1620s. The etymology of the word “resilience” is the Latin root *resiliens* and a Latin verb, *resilire*, meaning “to rebound, recoil” (Garcia-Dia et al., 2013; Zolkoski & Bullock, 2012). The term first appeared in a scholarly

discussion by Tredgold in 1818 when he used it to explain why some trees managed adverse conditions while others succumbed to severe conditions (McAslan, 2010). When applied to humans, resilience is most commonly referred to as the ability to bounce back from adversity, and this is the definition used for this study (Adamu et al., 2019; Garcia-Dia et al., 2013).

Resilience first emerged as a viable construct in the field of psychology in the 1960s when Norman Garmezy, who worked with patients with schizophrenia and their families, observed how certain patients fared better than others despite the presence of precarious risk factors (Bell et al., 1959; Garmezy, 1964). Although he initially studied the risk factors that were precursors for the onset of schizophrenia, as well as the deficits in functioning that were evident both individually and in the family unit, he quickly became intrigued with those who excelled despite the presence of risk factors (Garmezy, 1964; Hanson & Gottesman, 2012). Contemplating the positive mental and behavioral adaptations that some individuals demonstrated that helped them bounce back from adversities, he identified the presence of certain psychosocial resources (Garmezy, 1971). His work increasingly became centered on identifying competencies instead of psychopathology (Garmezy, 1987; Masten et al., 2011). He found that biological predispositions and psychosocial elements both played a role in resilience (Garmezy, 1971). The stress-resistant factors that led to adaptive coping behaviors in high-risk populations led him to pioneer empirical studies on resilience, establishing valuable precedents that became foundational for subsequent research (Masten & Cicchetti, 2012).

### ***Evolving Research***

Garmezy's (1991) pioneering role left an indelible mark, trailblazing a field replete with new potential that other researchers have followed (Hanson & Gottesman, 2012; Masten & Cicchetti, 2012). Subsequent researchers pursued the study of risk factors and protective factors,

particularly how individuals differ based on the unique combination of both (Bonanno et al., 2010; Kent et al., 2015; Moore, 2014). Ideally, minimizing the risk factors while enhancing the protective factors is the best way to move forward on a trajectory of competence and growth (Lakioti et al., 2020; Werner, 1995; Zolkoski & Bullock, 2012). In real life, risk factors cannot be so easily erased. They must be part of the discussion when exploring how resilience is actually modulated (Truffino, 2010; Zolkoski & Bullock, 2012).

**Risk Factors.** Risk factors are variables, whether personal or environmental, that increase the likelihood of negative reactions to adversity (Kwong & Hayes, 2017; Truffino, 2010). They are factors that impede an individual's ability to effectively manage stressors and often result in maladaptive coping mechanisms (Bai & Repetti, 2015). They include childhood emotional, physical, or sexual abuse; childhood neglect; poverty; neighborhood or domestic violence; personal or parental substance abuse; personal or family illnesses; being a victim of a crime; discrimination; or other chronic personal or family stressors (Barger et al., 2017; Bellis et al., 2018; Kwong & Hayes, 2017). Almost half of the children in the United States will face at least one of these factors while 22% will face at least two (Barger et al., 2017). The more factors someone experiences equate to a greater potential for negative outcomes (Barger et al., 2017; Zolkoski & Bullock, 2012). These negative outcomes may interfere with normal intellectual, social, and emotional development (Zolkoski & Bullock, 2012). The ongoing negative effects can include serious physical, mental, emotional, spiritual, sexual, social, or financial impact that could interfere with someone reaching their full potential in adulthood (Zimmerman, 2013; Zolkoski & Bullock, 2012). However, research shows that risk factors are not deterministic. They function more like probability statements that increase only the likelihood of experiencing negative effects. Many factors, like the time, place, type of crisis, duration of crisis, and the

support of others impacts this likelihood quotient and must be taken into account to balance otherwise dire projections (Kwong & Hayes, 2017; Samra, 2018; Sander, 2017).

**Protective Factors.** Protective factors enhance someone's ability to resist the negative effects of adversity (Lakioti et al., 2020). They transcend ethnic, geographic, and socio-economic boundaries (Hyman, 2021; Lietz, 2011). They "ameliorate a person's reaction to a stressful situation or chronic adversity" so that their ability to adapt is more successful (Werner, 1995, p. 82). Protective factors compensate for stress through modulation, reduction, or elimination of the threat and are often exhibited through the care, commitment, and social support from significant others (Leitz, 2011; Morice-Ramat et al., 2018). During the early developmental years, warm and responsive parenting or consistent support from at least one caregiver buffers the negative effects of chronic stressors (Bai & Repetti, 2015; Masten, 2014). In adulthood, a good support system of colleagues and supervisors assists in resilient responses among helping professionals (Maquire & Byrne, 2017; Mattioli et al., 2018). Training programs for helping professionals often include classwork on strategies of self-care, self-compassion, and healthy boundaries to properly navigate professional demands (Liu et al., 2017; Morse et al., 2012). Maintaining a strong sense of faith that one's actions can make a positive difference in the world is a protective factor (Kwong & Hayes, 2017). Social connectedness that emphasizes trust, autonomy, and initiative has also been identified as an important predictor of adaptive coping (Bonnano et al., 2010; Bryan et al., 2019; Kent et al., 2015). Ongoing resilience research has continued to identify additional "biological, psychosocial, structural, and cultural resources" that can be harnessed for an individual's well-being (Panter-Brick & Leckman, 2013, p. 333).

### ***Current Research***

At the turn of the 21<sup>st</sup> century, the field of positive psychology established roots (Pawelski, 2018; Petersen & Seligman, 2004; Seligman & Pawelski, 2003; Wong, 2019). Growing interest in strength-based models of development continued over the deficit-based models that previously dominated the field (Akos & Galassi, 2018; Ivtzan et al., 2016). As subsequent researchers became interested in the construct of resilience, interest moved beyond the basic dyad of risk factors versus protective factors. Ideas continued to center on well-being, on how, when, and why certain people possess resources that help them to overcome hardship (Panter-Brick & Leckman, 2013). Studying the qualities that make resilience a biophysiological reality became a popular pursuit (Erickson et al., 2011; Shrivastava & Desousa, 2016). Multidimensional constructs revealed a focus on the biological, intrapersonal, physical, and social dimensions of resilience (Bryan et al., 2019; Kent et al., 2015). Insights from psychoneuroimmunology which revealed noticeable linkages between an individual's state of mind, emotions, and physical well-being (Grafton et al., 2010; Karatsoreos & McEwen, 2013) only strengthened interest in understanding stability and well-being, especially in the contexts of extreme adversity such as in situations of chronic illness, war, natural disasters, abuse, violence, and trauma (Bonanno & Diminich, 2013; Eliacin et al., 2018).

Despite the variety of circumstances in which resilience could be manifest, the common denominator is the presence of an adversity that was overcome (Hanson & Gottesman, 2012; Moore, 2014). Instead of getting stuck in patterns of under-functioning, resilient individuals push through challenges and emerge with new skills (Morice-Ramat et al., 2018; Southwick & Charney, 2018). An upward spiral is created where resilience begets more resilience, spurring people to move forward in positive ways (Bosworth, 2011; Tugade & Fredrickson, 2004). Higher levels of resilience can lead to more successful coping behaviors in the future (Arslan,

2016), to fewer behavioral and emotional problems (Wingo et al., 2010), and to less depression and other emotional struggles (Seok et al., 2012). Adaptive behaviors learned from previous adversities help in subsequent challenges because people can continue to access the learned behaviors which have now become a reservoir of strength (Lakioti et al., 2020). These high-functioning capacities might include qualities such as adaptability, psychological well-being, and social competence (Dias & Cadime, 2017; Luthé & Wyss, 2015), or might be represented by the absence of negative traits such as psychopathology, self-destructive tendencies, and persistent negative outcomes (Bonanno & Diminich, 2013; DePierro et al., 2017).

### *Defining Resilience*

As researchers delved deeper into the construct of resilience, they began to ask more detailed questions about what resilience is. While research agrees that resilience empowers people to overcome adversity, the details of how resilience actually works varies in significant ways. There is no gold standard for defining resilience (Liu et al., 2017; Panter-Brick & Leckman, 2013). Because resilience is impacted by many factors, confusion occurs over whether resilience could best be explained as a trait, a state, or an outcome (Johnson & Tottenham, 2014). Large bodies of research have identified resilience according to each of these categories (Garcia-Dia et al., 2013; Liu et al., 2017). An overview of these three perspectives will now be explored.

**Resilience as a Trait.** The first way that resilience was defined was as a trait (Luthar & Brown, 2007; Masten et al., 1990). Developmental psychology propagated this view. It capitalized on the early years of infancy through adolescence and defined resilience as a trait that was observable when these individuals met the important milestones of each life stage (Masten, 2001; Murphy & Moriarty, 1976; Werner, 1995). Certain characteristics in children, mainly temperamental characteristics, elicited positive responses from caregivers and these were

considered resilient traits; these included being affectionate, cuddly, easy to soothe, and good natured (Werner, 1995). Theorists tried to isolate the individual qualities as personality traits, identifying resilience as cognitive and emotional skills (Moore, 2014; Warren et al., 2016). This promulgated a trait-based framework, positing the belief that certain traits, whether it be a high intelligence, an optimistic mindset, or a prosocial personality, predisposed some individuals to deal better with adversity and experience more positive outcomes (Beetham, 2018; Masten, 2014). From this view, resilience was seen as a trait that some people possessed while others did not (Buzzanell, 2010; Fletcher & Sarkar, 2016). Resilience studies later morphed from looking only at children and adolescents into considering how an adult's history shaped them to become successful in achieving normal developmental milestones throughout their lifespan (Berk, 2017; Erickson, 1994). Speculation arose over what led certain individuals to possess resilient traits while others displayed reduced emotional and prosocial functioning (Beetham, 2018; Kalisch et al., 2019).

Many contend that research failed to indicate a causal link between personality traits and resilient outcomes. Because personality variables are most often measured concurrently with outcomes, it is difficult to determine if the traumatic event helped to create the specific personality variable or if that personality trait was present prior to the adverse event (Southwick & Charney, 2018). It is well known that personality changes occur throughout life, therefore; resilience as a personality trait could be more accurately attributed to the stable traits found in adults versus those found in children (Luthar & Brown, 2007; Morin, 2014). Considering this variability in personality traits over time, many suggested that identifying resilience as a personality trait only provides one piece of the overall puzzle of predicting who might be resilient in a given situation (Bonanno, 2004; Bonanno & Mancini, 2008). In short, personality

traits are overestimated in their influence as they seem to be far more correlational versus causal in regard to resilience (Nguyen et al., 2016; Pangallo et al., 2015). As Mischel (1969) observed, “personality rarely explains more than 10% of the actual variance in people’s behavior across situations” (Bonanno, 2004, p. 26). Furthermore, trait resilience is limited because it doesn’t account for within-person variation, which means that individuals might display the innate, vibrant, personality characteristics to rise above in some situations but not in others (DeRosier et al., 2013; Harvey, 1996; Nguyen et al., 2016; Pangallo et al., 2015). This defies the one-dimensional suggestion that someone is either resilient or not and identifies any inborn personality trait as more of a predictor of future resilience versus proof of innate personal resilience (Garmezy, 1991; Hanson & Gottesman, 2012; Ivztan et al., 2016).

**Resilience as a State.** The second wave of resilience research viewed resilience as a state. As questions emerged over the limited perspective that resilience was a fixed personality trait, views shifted beyond the trait-based conceptualization (Liu et al., 2017) toward a perspective that resilience was not predetermined (Leys et al., 2018; Treptow, 2014). Instead of assuming that those who does not display resilience are incapable of it, which blames the individuals for their lack (Liu et al., 2017), this perspective supports the view that resilience can be learned (Buzzanell, 2010; Duckworth, 2018). From this view, resilience is an adaptive process that anyone can practice (Elkington & Breen, 2015; Kent et al., 2015). Individuals are not simply born resilient; rather, they are made resilient through positive interactions with their environment (Masten, 2014; Ungar et al., 2013). Practicing certain skills leads people toward improved levels of functioning and well-being (Reed & Blaine, 2015; Southwick & Charney, 2018).

This view initiated possibilities to better understand how to create systems that set resilient processes into motion (Bennis & Sample, 2015). Instead of assuming someone was naturally an

expert at something, this view invites a growth mindset (Dweck, 2006; Miller, 2017). People can orient themselves toward continually learning, growing, and overcoming previous limitations (Elkington & Breen, 2015; Kim et al., 2019; Reed & Blaine, 2015). This requires a sustained effort to learn and grow, propelling people toward new knowledge, understanding, and skills that will help them to prevail (Kent et al., 2015). The reciprocal nature of resilience is revealed in this process, evidenced through the ways in which someone interacts with their environment (Walsh, 2016). Those who grow in grit most readily meet their goals by specifically working on areas of weakness. Developing new skills and utilizing new resources rather than simply repeating only the tasks that comes easily to them is central to growth (Duckworth, 2018). In summary, resilience as a state highlights the importance of intentionally pursuing a dynamic, skill-building process that can be cultivated through intentional efforts till the state of resilience is achieved (Maslach, 2017; Morse et al., 2012; Obrist et al., 2010).

**Resilience as an Outcome.** The third wave of resilience research identified resilience as an outcome. When defined in this way, resilience is viewed from a long-term perspective. Because early resilience research looked at the developmental observations of children who were forced to manage chronic forms of adversity, many theorists looked at resilient outcomes as “favorable adjustments over a broad sweep of time” (Bonanno et al., 2010, p. 40). Therefore, individuals would be deemed resilient, if, after having endured long-term poverty or chronically abusive relationships, they still met normal developmental milestones and psychological adjustment (Bonanno, 2004). The goal of outcome-oriented resilience is to observe whether someone developed into a competent, confident, and caring adult (Bonanno & Diminich, 2013; Werner, 1995). There are three main outcomes of resilience to be sought: the ability to achieve positive

results after adverse situations, the ability to function competently amidst acute or chronic stressors, and the ability to recover from adversity or trauma (Masten et al., 1990).

Resilience counteracts weaknesses and enhances strengths (Jones et al., 2007), empowering the development of autonomous, nurturing, and emotionally sensitive adults (Werner, 1995). A long-term resilient outcome could be evidenced by more than the absence of pathology (Bonanno, 2004; Bonanno et al., 2010). A resilient outcome is also reflected when someone who experienced extreme adversity still maintained “a relatively stable trajectory of healthy functioning and positive adaptation in its aftermath” (Bonanno, 2010, p. 36). This perspective does not suggest that individuals will not experience a stress response because resilience does not preclude transient stress. Rather, even while experiencing negative stress responses, this individual still presses onward, maintaining the ability to function well despite adversity (Southwick & Charney, 2018). Researchers differ over what constitutes a resilient outcome. Some define a resilient outcome as a return to normal functioning, others look for positive adaptations, and still others suggest there needs to be the presence of growth that wasn’t evident prior to the adversity (Pangallo et al., 2015). Again, as with all things related to resilience, there are many aspects to defining and embracing this outcome-oriented perspective.

**A Comprehensive Model of Resilience.** After considering the three aforementioned perspectives on resilience—resilience as a trait, as a state, and as an outcome—it becomes evident that resilience is a complex construct that cannot be adequately understood from a single perspective. Southwick and Charney (2018) stated it well when they confessed: “To truly understand resilience, researchers must approach it from multiple perspectives, and examine it through a number of different scientific lenses” (p. 10). This leads us to a fourth option: creating a comprehensive model. It is advantageous to consider resilience as a phenomenon that results

from many levels of interpretation. It is wise to recognize any traits the individuals innately possess while also considering the many layers of influence that coalesces into the moments of adversity wherein they muster up resilient choices. This process is beautifully envisioned as a “dynamic person-environment phenomenon” (Pangallo et al., 2015, p. 2). Resilience can be multi-final (having many resilient outcomes), multidimensional (having many aspects), and multifaceted (achieved in many ways) (Liu et al., 2017). A multi-tiered system is sourced from multiple dimensions, including an internal trait resilience, a developing state resilience, and an outcome-oriented resilience evidenced over a longer course of time (Liu et al., 2017). Because individuals and their environments mutually influence each other, it “culminates from an individual’s interaction with their environment, which, in turn, is influenced by developmental factors, situational constraints, and sociocultural processes” (Pangallo et al., 2015, p. 2). In summary, evidence suggests that resilience not only changes over time, but that it also requires adjustments of one’s operational definition as perspectives shift through the different stages of life. Resilience is, in and of itself, a dynamic process that morphs and develops across one’s lifetime, combining periods of loss, maintenance, and growth into its ongoing trajectory across different stages of life (Truffino, 2010).

The working definition of resilience for this study refers to the ability to bounce back after adversity (Kim et al., 2019; Pangallo et al., 2015; Zolkoski & Bullock, 2012), displaying the ability to recover from extreme stressors or trauma and demonstrating successful adaptive behaviors (Truffino, 2010; Van Agteren et al., 2021; Van der Meulen et al., 2019; Zolkoski & Bullock, 2012). This definition does not limit resilience to a trait, state, or outcome, but invites input from each perspective depending on each participant’s description of their lived experience with the phenomenon of resilience. Allowing resilience to be defined by each participant’s

descriptions will broaden the research findings and ascribe validity to their narratives because it comes from the participants instead of from researcher-imposed limited definitions.

### *Defining Four Common Components of Resilience*

This study encompasses four common components of resilience: the necessary role of adversity, positive adaptations, the temporary nature of setbacks, and unlimited potential (Connell et al., 2018; Crane et al., 2018; Fletcher & Sarkar, 2016).

**Component One - The Role of Adversity.** The first common component is that adversity is a necessary precursor in the definition of resilience (Southwick & Charney, 2018). Without adversity, there is no resilience (Bonanno, 2004; Herrman et al., 2011; Ungar & Theron, 2020). Adversity is a necessary ingredient in the recipe of resilience; it can become a fuel for resilience when harnessed toward effective, transformative ends (Moore, 2014). The mysterious journey of navigating this barren land between adversity and resilience is a place of vulnerability, but not a place of weakness, shame, or defeat. Brene Brown, a well-known shame researcher, states that vulnerability is “our most accurate measurement of courage - to be vulnerable, to let ourselves be seen, to be honest” (Brown, 2015, p. 38). The courage that is necessary to live vulnerably in the midst of adversity is a formative fact of resilience. Strength does not develop based on what people can accomplish within their comfort zones; rather, it develops when new difficulties that were initially beyond one’s sights, daunting and untouchable, have been overcome (Bryan et al., 2019). Adversity is a natural part of life, and most people will inevitably face at least one violent or life-threatening event during their lifetime (Bonanno, 2004; Brunwasser & Gillham, 2018). The presence of adversity is what sets resilience apart from similar concepts like hardiness or strength, which are not predicated upon any difficulty for their existence. By definition, resilience demands adversity to be present because that is the only way someone is able to

effectively bounce back to positive functioning (Connell et al., 2018). Adversity can boost someone's immunity against future difficulties by building within them something beneficial that was not present prior to the adversity (Garcia-Dia et al., 2013; Liu et al., 2017).

**Component Two - Positive Adaptations.** A second point of commonality in the varying definitions of resilience is positive adaptation. Human beings possess a capacity for positive adaptation in the face of acute or chronic stressors or traumas in ways that promote, rather than threaten, their own health, safety, and psychological well-being (Domhardt et al., 2015; Moore, 2014; Shrivastava & Desousa, 2016; Truffino, 2010). Although the ability to adapt to changing environments is a survival skill that every animal possesses, the unique aspect of resilience among humans reveals the ability to consciously reflect upon growth in ways that can be measured and intentionally developed (Blackie et al., 2017; Connell et al., 2018; Waite & Richardson, 2004). Those who are deemed resilient have demonstrated an ability to succeed not because they have been spared hardship, but because they have overcome it (Hanson, 2018; Kent et al., 2015; Southwick & Charney, 2018). Learning to cope is different from developing resilience. Coping is not always adaptive because individuals can display unhealthy or destructive coping behaviors such as angry or violent behaviors, substance abuse, or self-destructive tendencies (Connell et al., 2018). The end goal of resilience is positive outcomes. Resilience points to something that exists beyond coping. It is about thriving (Carver, 1998; Masten, 2011; Zolkoski & Bullock, 2012). Those who have navigated challenging circumstances have developed a know-how that enables them to successfully overcome obstacles (Arslan, 2016; DePierro et al., 2017). Successful adaptation is difficult to quantify, and, yet this is precisely what defines a resilient individual (Criss et al., 2015; Kent et al., 2015). Resilience is learning to practice positive or adaptive outcomes in the presence of some type of challenge

(Criss et al., 2015). *Webster's New Universal Unabridged Dictionary, 2<sup>nd</sup> ed.*, (1979) offers a colorful definition: resilience is “the ability to recover strength, spirits, good humor quickly; buoyancy” (p. 1540). It is bouncing back when you have every reason to shut down (Moore, 2014). It does not suggest negative or neutral outcomes but highlights a trajectory of functioning that “defies the expectation of negative outcomes” (Liu et al., 2017, p. 114). Resilience reflects a dynamic, ever-evolving system of adaptation with identifiable growth trajectories (Arslan, 2016; Kent et al., 2015). In spite of threatening circumstances, resilient individuals become adaptive, facing challenges, negotiating negative effects, and displaying positive life outcomes (Fergus & Zimmerman, 2005; Luthar & Brown, 2007; Zolkoski & Bullock, 2012). A full perspective on the adaptability of resilience includes the difficulty of what someone experienced, the negative effects it caused, and the adjustments they made to persevere despite it all (Afifi & MacMillan, 2011; DiCorcia & Tronick, 2011).

**Component Three - Setbacks are Temporary.** A third component of resilience is the temporary nature of setbacks. Resilience is not a magical resistance to hardship, nor does it imply immunity to struggle (Garmezy, 1991). It does not promise that adversity will have zero impact or that someone becomes invulnerable to adverse life situations (Crane et al., 2018; Earvolino-Ramirez, 2007). Instead, it points to the rebound and recovery that eventually occurs despite adversities and setbacks (Bonanno & Diminich, 2013; Shrivastava & Desousa, 2016). It reflects the regaining of mental health or emotional stability that was temporarily compromised during adversity (Herrman et al., 2011; Moore, 2014). Resilience offers the possibility that the temporary defeats that accompany challenges need not be permanent (Dorociak et al, 2017; Gooding et al., 2012). Better-than-expected outcomes can ultimately be enjoyed (Panter-Brick & Leckman, 2013). While adverse events often cause short-term disruptions in an individual's

functioning, the long-term effects of these events can create disruptions that might take years to recover, but recover they will (Bonanno et al., 2010; Ungar et al., 2013; Zolkoski & Bullock, 2012). Resilient individuals will eventually move beyond their initial reactions toward goal-directed, positive adaptations, and successfully negotiate the challenges to rebuild their lives (DeRosier et al., 2013; Kent et al., 2015; Panter-Brick & Leckman, 2013).

**Component Four - Unlimited Potential.** A fourth component of resilience is the idea of unlimited growth potential. Resilience reframes the possibility that individuals can do more than just survive hardship; they can actually thrive in the midst of it (Ivtzan et al., 2016; Leys et al., 2018). Successfully emerging from adversity with enhanced strength or capability (Blackie et al., 2017; Panter-Brick & Leckman, 2013) or with completely new resolve, rigor, or resources (Hanson, 2018; Jin et al., 2014) suggest resilience is at work. Those who rank high in resilience often display copious, active coping skills, cognitive flexibility, and reliable social support (Gooding et al., 2012; Shrivastava & Desousa, 2016). These qualities help individuals to buoy themselves up during challenges with a vision beyond previous levels of functioning (Carver, 1998; Jayawickreme & Blackie, 2014). Many call this aspect of resilience post-traumatic growth (Dicinson, 2020; Jin et al., 2014; Silverstein et al., 2017) and a plethora of studies have researched its mental, emotional, and physiological implications (Huang & Gan, 2018; Joseph et al., 2012; Tedeschi & Calhoun, 2008; Walsh et al., 2018). It suggests that an individual's limits are self-determined and that shifting focus to the growth possibilities that flow out of hardship can transform someone's functioning toward greater meaning and purpose. Southwick and Charney (2018) said it well: "The forces of fate that bear down on man and threaten to break him also have the capacity to ennoble him" (p. 2). Resilience offers a new lens to view difficulty, carving new pathways on the other side of hardship where new horizons of possibility emerge.

Now that I have identified four common components of resilience, we turn to apply resilience to the specific context of helping professionals. In the next section, research on resilience in mental health professionals will be reviewed to establish how resilience has been associated with a decrease in professional burnout in MHPs. This establishes the gap in research that necessitated the focus of this current study.

### **Resilience in Mental Health Professionals**

Human beings are created with a capacity for resilience (Karatsoreos & McEwen, 2013; McEwen & Getz, 2012; Russo et al., 2012; Shrivastava & Desousa, 2016). Extensive research reveals the positive mental, emotional, physical, and relational benefits of resilience (Brown et al., 2018; Kerig, 2019; Pereira et al., 2017; Wang et al., 2017). By directing people away from the maladaptive coping mechanisms that keep them stuck in under-functioning, resilience empowers people to learn adaptive responses that lead to health and well-being (Duckworth, 2018; Miller, 2017; Smith, 2015). It is for this reason that resilience has been studied across many care-giving disciplines such as nursing, pastoring, emergency medical work, disaster services, and childcare (Hegney et al., 2015; Luedtke & Sneed, 2018; Morice-Ramat et al., 2018; Rees et al., 2015) and has assisted professionals in maintaining optimal functioning even in the midst of emotionally-demanding jobs (Pereira et al., 2017; Van Mol et al., 2015; Wahab et al., 2017). The helping professions place extreme demands upon professionals' emotional availability, and MHPs are on the frontline of the emotionally draining work that leads to high rates of compassion fatigue and burnout (Frajo-Apor et al., 2016; Rabu et al., 2016). It is for this reason that resilience is necessary for MHPs.

### ***Resilience is Imperative for MHPs***

Resilience is imperative for MHPs so that instead of succumbing to burnout, they can adequately assist others who rely on them in times of crisis. MHPs who are constantly exposed to the traumatic experiences of others, whether perpetrators or victims, are more at risk of becoming negatively affected by these exposures (Maguire & Byrne, 2017), particularly those who work closely with trauma (Beaumont et al., 2016; Sodeke-Gregson et al., 2013). MHPs tend to rate high in the trait of empathy (Morice-Ramat et al., 2018; Santamaria-Garcia et al., 2017), which assists them in intuiting and experiencing the feeling states of others (Dvash & Shamay-Tsoory, 2014; Parlar et al., 2014). Wishing to alleviate another's pain and helping others to flourish in the face of adversity is one of the appealing aspects that draws many clinicians into the field (Ashby et al., 2013; Frajo-Apor et al., 2016). Referred to as compassion satisfaction (Craig & Sprang, 2010), it is a meaningful part of what many MHPs say they enjoy about their work (Dvash & Shamay-Tsoory, 2014; O'Brien & Haaga, 2015). However, it is also that same tender sensitivity that can make these professionals vulnerable to compassion fatigue and burnout (Craig & Sprang, 2010; Levy et al., 2019; Mattioli et al., 2018). Since individuals who utilize resilience to adapt to adversity are better equipped for success and effectiveness (Elkington & Breen, 2015), MHPs benefit by learning how to navigate professional pressures in resilient ways (Maguire & Byrne, 2017; Morse et al., 2012).

Because MHPs are trusted to help others navigate morally and ethically through the intensely emotional, private, and painful trials in their lives, they are confronted with unique professional challenges (Bennis & Sample, 2015; Kim et al., 2019; Mohler, 2014). It is important that clinicians maintain their own mental and emotional health for their personal quality of life as well as for their clients' well-being. Their resilience helps to prevent burnout, which is vitally important for the quality of care that they provide to their clientele (Lee et al., 2019). MHPs

need to maintain composure in the face of emotional crises so that they can model a stable presence with their clients. Since people are more likely to develop strength to face their struggles when they are in settings where they feel safe and loved (Elkington & Breen, 2015), it is important that MHPs create these safe spaces for others. Helping professionals need resilience because it is a protective factor against burnout; it also aids them in successfully fulfilling the demands of their job (Kim et al., 2019; Lent & Schwartz, 2012; Reed & Blaine, 2015).

### ***Previous Research on Resilience With MHPs***

Researchers have conducted studies with MHPs when trying to understand how to turn trials and hardships into adaptive coping skills and resilient outcomes (McAslan, 2010). Much research has occurred into how specific work settings (e.g., community agencies, inpatient settings, or private practice) influence the level of burnout amongst MHPs (Bonanno, 2004; Lent & Schwartz, 2012; Pack, 2013). The majority of this research has focused upon MHPs working in settings of psychiatric hospitals (Chang et al., 2019; Fergus & Zimmerman, 2005), crisis care (Little, 2015; Tugade & Fredrickson, 2004), or in outpatient or inpatient treatment facilities that rely upon teams of professionals to collaboratively manage patient caseloads (Frajo-Apor et al., 2016; Lee et al., 2011). These settings create their own challenges for employees, such as regular agency meetings, paperwork, and trainings, as well as other protocols that divide the time clinicians spend on their own caseloads (Lent & Schwartz, 2012). Lee et al. (2011) completed a meta-analysis, including 17 studies that assessed the burnout rates of MHPs in various work settings; while their results indicated common stressors across various work settings, private practice professionals were not included in these sample populations.

Because there is a dearth of research on clinicians working in private practice (Lee et al., 2011; Lent & Schwartz, 2012), little is known about how therapists who function in isolated,

private practice settings experience resilience and overcome burnout (Lent & Schwartz, 2012; Rupert & Morgan, 2005; Teran, 2015). There are unique pressures that private practice clinicians face. One of the biggest challenges is a pervasive sense of isolation that occurs due to a combination of factors: the requirement for client confidentiality, limited opportunity to share about their professional work with others, the ethical demands that the therapist not rely on clients for their own support, and limited daily interactions with professional peers (Clark, 2009; Dattilio, 2015; Halevi & Idisis, 2018). The literal physical isolation that therapists endure by spending the majority of their work hours behind closed doors with a series of revolving clientele also adds to the problem of isolation (Rabu et al., 2016; Wood et al., 2017). Access to colleagues in a field where the majority of time is spent one-on-one with clients' challenges MHPs in private practice. They often feel professionally unsupported due to insufficient peer assistance in dissipating the mental and emotional stressors that accompany this type of work (Rupert & Morgan, 2005; Teran, 2015). Clinicians working in solo practices also experience "over-involvement and constantly feel responsible for their clients" (Rupert & Morgan, 2005, p. 345) because they are not part of a team where multiple professionals review each case file (Neswald-Potter & Simmons, 2016; Newell & Nelson-Gardell, 2014). A qualitative study of six private practice practitioners in Australia recently concluded these same causes for burnout in their participants (Hammond et al., 2018).

Studies on private practice from 20 years ago found therapists in private practice experienced less burnout than those in the public sector (Dupree & Day, 1995; Lent & Schwartz, 2012; Van Morkhoven, 1998; Vrendenburgh et al., 1999). Those participants stated they felt greater control and flexibility over their schedules which permitted them freedom over when they would accept new clients and which clients they would accept (Rupert & Morgan, 2005).

Unfortunately, the majority of these studies on MHPs in private practice are outdated, stretching back to 20 years or longer (Ackerley et al., 1988; Farber, 1985; Hellman & Morrison, 1987; Raquepaw & Miller, 1989). The mental health field has faced many changes in the last two decades, necessitating updated research into this dynamic that solo practitioners experience.

Building upon previous burnout research and resilience research in mental health practitioners (Bianchini, 2017; Haramati et al., 2017), this study focuses on resilience in professionals who operate in private practice settings. Because a thorough review of the literature failed to show adequate understanding of resilience research with private practice clinicians, this study was deemed necessary to fill that research gap (Hammond et al., 2018). Previous studies have suggested that future research focus more upon the unique pressures of specific work settings, such as the private practice setting (Hammond et al., 2018; Mullen et al., 2017), so that protective measures can be implemented in order to assist private practice practitioners with proper self-care and ethical provision of services (Maguire & Byrne, 2017; Morse et al., 2012). It is imperative to identify the best practices and strategies promoting resilience in MHPs in private practice so that their unique concerns may be recognized (Goldhagen et al., 2015; Haramati et al., 2017; Kreitzer & Klatt, 2017; Wald, 2015). In focusing on MHPs in private practice, this study concentrates on an overlooked demographic who have not been adequately represented in resilience literature (Hammond et al., 2018; Lent & Schwartz, 2012; Mullen et al., 2017). Studying how these MHPs develop resilient mindsets and implement resilient habits contributes knowledge to the field on how to bolster MHPs in resilient living (Elkington & Breen, 2015; Lakitoti et al., 2020), protect them from professional burnout (O'Brien & Haaga, 2015; Reed & Blaine, 2015), and lend towards more successful outcomes among clientele (Maguire & Byrne, 2017; Raquepaw & Miller, 1989).

### *Mindsets and Behaviors*

This study focuses on assessing resilience in the mindsets and behaviors of MHPs in private practice. This section identifies aspects of resilience-oriented mindsets and behaviors.

**Mindsets That Promote Resilience.** While the field of psychology was initially built upon the appraisals of negative cognitions as the reasons for psychopathology, a shift from this deficit model of pathology towards a strengths-based ideology later emerged (Bonanno & Diminich, 2013; Fletcher & Sarkar, 2016; Zimmerman, 2013). This shift replaced a problem-oriented, negative focus with positive, growth-oriented possibilities. This marks the essence of resilience (Masten, 2014; Zolkoski & Bullock, 2012). Resilient individuals possess mindsets that allow them room to grow. A growth-oriented mindset serves as a protective factor during hardship because it posits that overcoming adversity is possible. This opposes a fixed mindset that suggests resilience is a fixed trait that cannot be developed (Dweck, 2006; Kreitzer & Klatt, 2017). The ability to bounce back after adversity reveals a cognitive flexibility that is inherent within the mental processes of resilience (Barger et al., 2017; Hendriks et al., 2018). Other cognitive factors include a positive attitude, a healthy self-concept, and a willingness to learn new ways to cope (Zolokski & Bullock, 2012). Reed & Blaine (2015) found that resilient individuals do not languish in the mental role of victim. Instead, they actively adapt themselves to the situation at hand by assuming personal responsibility and pursuing new understanding that facilitates solution-oriented thinking. This involves developing cognitive skills of personal responsibility, mental flexibility, courageous decision making, and active coping styles (Arslan, 2016; Dweck, 2006; Truffino, 2010). Passive coping styles, on the other hand, characterized by denial and avoidance, correlate with increased internalizing behaviors like depression, anxiety, and other mental health struggles. This correlates with substance abuse, violence, and decreased

resilience scores (Haglund et al., 2007; Seok et al., 2012). Resilience-oriented mindsets make room for growth. They do not lose hope because a solution is not immediately available. Instead, a resilient mindset invites someone to embark on the journey of learning how to overcome. It includes making a decision to confront a challenge without judging oneself as a failure or giving up when a resolution does not quickly materialize (Barger et al., 2017; Hendriks et al., 2018).

**Behaviors That Promote Resilience.** Resilience must include behavior for it to become manifest. Individuals with high resilience scores make proactive choices and look for strategies to effectively overcome their shortfalls instead of denying or avoiding their struggles (Haglund et al., 2007; Luthans et al., 2007). The belief that individuals can be malleable by either targeted intervention or by interaction with new aspects of their environment points to the heart of resilient habits that can be studied and replicated (Papazoglou & Anderson, 2014; Van der Meulen et al., 2019). Research on the disciplines involved in developing successful habits dovetails into identifying how individuals can create resilience-promoting habits by implementing predictable routines in their daily lives (Kim et al., 2019; Perella, 2017). Resilient behaviors reflect a dynamic process that offers an evolving capacity for insight and growth (Obrist et al., 2010). Resilience is a source of strength that can be consistently accessed. Individuals can observe how resilience enabled them to overcome past adversities while looking ahead to apply those same strategies to new challenges (Criss et al., 2015). The behaviors demonstrated by resilient individuals reflect creative responses to hardship, encompassing “more complex and nuanced aspects of responding” to situations that result in noticeable personal growth (Kent et al., 2015, p. 278). Researchers have identified four choices that facilitate resilience, including meaningful social connections, health-promoting behaviors that reflect self-

care (e.g., healthy diet, sleep, self-compassion, exercise), healthy emotional self-regulation, and a balanced cognitive style (the way someone interprets their own successes and failures) (DeRosier et al., 2013). Self-reflection and mindfulness are also resilience-promoting practices, leading to stress reduction, pain management, increased empathy, and well-being (Goldhagen, et al., 2015; Perella, 2017; Treptow, 2014).

Research on therapists who emerged well from professional difficulties differed from those who did not according to their commitment to practice resiliency behaviors (Dombo & Gray, 2013). Therapists who engage in regular self-reflection and who maintain consistent self-care regimens fared well in resilience studies (Hammond et al., 2018; Rupert & Dorociak, 2019). Spiritual practices, meditation, and mindfulness were also helpful habits among therapists; they promote self-control instead of surrender to ongoing pressures (Mullen et al., 2018; Pereira et al., 2017). Despite these insights, more research needs to be done with MHPs, specifically those working in private practice, in order to understand how resilience-oriented mindsets and practices can strengthen them against burnout (Haramati et al., 2017; Kreitzer & Klatt, 2017).

### **Summary**

How do mental health workers in private practice fare in regard to burnout? How do MHPs in private practice utilize resilience as a buffer to protect against burnout? Despite previous research that identified the problems of burnout in mental health professionals, MHPs are still facing compassion fatigue and burnout at increasing rates (Carrola et al., 2016; Devilly et al., 2009; Dombo & Gray, 2013; Kottler, 2010; Mattioli et al., 2018). This problem negatively impacts the mental health field by inhibiting MHPs' ability to fulfill their role compassionately and effectively in helping others (Lamb & Cogan, 2016; Lowe, 2012). This qualitative study of phenomenological design addresses this problem of burnout by offering an in-depth

understanding of MHPs' lived experiences of resilience (Lakioti et al., 2020; Lamb & Cogan, 2016; Rupert & Dorociak, 2019). This research seeks to fill the gap in research on MHPs in private practice, granting those working within the mental health profession a more concrete understanding of how resilience promotes resistance to burnout (Jones et al., 2007; Mullen et al., 2017; Young & Rushton, 2017). It is imperative to understand the phenomenon of resilience in MHPs in order to contribute to the body of knowledge that will successfully assist practitioners in developing sustainably healthy habits of resilience that will offset vulnerabilities to burnout (Bahar et al., 2020; Bratt, 2019; Lakioti et al., 2020; Nguyen et al., 2016; Rabu et al., 2016).

### **Research Questions**

This current study answered these research questions:

**RQ1:** What mindsets that promote resilience do these mental health professionals rely upon?

**RQ2:** What behaviors or practices that promote resilience do these participants demonstrate?

**RQ3:** How do resilience-promoting mindsets and behaviors help mental health professionals resist burnout?

## **Chapter Three: Methods**

### **Overview**

The purpose of this transcendental phenomenological study was to describe the lived experiences of mental health professionals (MHPs) working in private practice settings in California. This study revealed the participants' descriptions of their experiences of resilience, highlighting the mindsets and behaviors they use to prevent professional burnout (Lakioti et al., 2020; MacGuire & Byrne, 2017). Phenomenological methodology was justified because in-depth interviews naturally invite an immersion into the lived experiences of participants in order to better understand the phenomenon of interest (Bevan, 2014; Charmaz, 2014; Crotty, 1998). This chapter reviews the methodology utilized in this study, describing the design and specific procedures (Corbin & Strauss, 2015; Roberts & Hyatt, 2018). It details the research questions, setting, participants, procedures, and my role as researcher. Finally, data collection and data analysis are discussed, as well as trustworthiness, ethical considerations, and a brief summary.

### **Design**

As previously stated, this study was designed with the purpose of achieving a rich description of the lived experiences, mindsets, and behavioral practices of clinicians in private practice. The most appropriate type of design for the research questions was a qualitative, phenomenological, transcendental approach. The details of this research design follow.

### **Qualitative Research**

With roots in sociology and anthropology, qualitative research has been used for centuries in many disciplines of study as a naturalistic approach to the world (Denzin & Lincoln, 2017). Even though many quantitative studies have been conducted on clinicians' professional lives (Ashby et al., 2013; Babbie, 2016; Bryan et al., 2019), the dearth of qualitative research

about MHPs reveals a critical gap of understanding in the field. Qualitative research offers unique insights beyond the numerical statistics that quantitative studies provide (Bryan et al., 2019; Conger, 1998) because it seeks to understand the complexity of individuals' lives by addressing the tensions and contradictions of those who have lived certain experiences (Heppner et al., 2016). The range of human experiences is valued by compiling firsthand descriptions (Creswell, 2013). Relying on language versus numerical data, qualitative researchers build a complex, holistic picture of people's lives by interacting with the participants and the material presented (Charmaz, 2014; Denzin & Lincoln, 2017; Yeh & Inman, 2007). While quantitative research embraces a premise that an objective truth must be discovered through observing independent realities (Roger et al., 2018), qualitative research, strongly influenced by an interpretivist-constructivist tradition, is undergirded by assumptions that contradict this premise. Instead, it reflects the processes that individuals undergo when creating meaning of their lived experiences (Conger, 1998; Denzin & Lincoln, 2017; Heppner et al., 2016). Capitalizing on the specific points of view of each participant, this type of study provides deeper insights into an intangible phenomenon of interest (Ang et al., 2018; Ashby et al., 2013). This study gives a voice to the participants by inviting them to share their stories about the phenomenon of resilience (Bevan, 2014; Brunero et al., 2015). A number of qualitative studies conducted on resilience have revealed how resilience empowers professionals toward adaptive responses during adversity (Ang et al., 2018; Elkington & Breen, 2015; Reed & Blaine, 2015). This study was unique because it sought to reveal insights into the phenomenon of resilience in mental health clinicians working in private practice who had not yet been adequately represented in the literature. The data reveals insights into the phenomenon of resilience by highlighting the meaning that these MHPs ascribe to their lived experiences (Higginbottom & Lauridsen, 2014).

### **Phenomenological Research**

Phenomenological research began with Edmund Husserl, an innovative thinker, who proffered an entirely new field of experience that valued subjective insights (Husserl, 2004). He stated that a transcendental perspective allows the natural world to unfold, embracing an “absolutely independent realm of direct experience” (Husserl, 2004, p. 11). Offering a transcendental phenomenological perspective highlights the essence of inquiring into the subjective experiences of one’s soul where the nuances of meaning take form (Husserl, 2004; Moustakas, 1994). Husserlian phenomenology respects the subjective openness of an individual to move beyond everyday experience in order to become fully present in one’s own experiences, entering them anew and perceiving them “freshly, as if for the first time” (Moustakas, 1994, p. 34). Phenomenological research prides itself on the premise that understanding the essence of a phenomenon arises from the data itself (Glaser & Strauss, 1967; Heppner et al., 2016). It describes what the participants have in common in relation to the same phenomenon, revealing the universal experience communicated via the individual experience (Creswell, 2013). This approach offers insight into the essence of what something means to a specific set of participants (Saldana & Omasta, 2021; Van Manen, 2017). The goal is not to get into the participants’ minds, but, rather, to observe how these individuals reveal their mindsets in the lived experiences that they choose to reflect upon (Vagle, 2018; Van Manen & Van Manen, 2021). Husserl posits that the world itself should be bracketed so the experience of the phenomenon can be highlighted without being tainted by the world’s influence (Moustakas, 1994; Vagle, 2018). Prioritizing the consciousness of an individual’s lived experience resides in the forefront of this research method.

Founded upon Husserlian transcendental phenomenology which highlights *lebenswelt*, or lived experience, this study seeks to capture the essence of the phenomenon of resilience (Bevan,

2014; Husserl, 2004; Moustakas, 1994). A descriptive phenomenological design was valuable for this study because the rich, multifaceted texture of resilience could be explored through this inductive, open-ended design (Brunero et al., 2015; Charmaz, 2014). Husserl's phenomenology, epistemological in orientation, links reality with subjectivity while questioning knowledge: How do we know what we know (Taipale, 2015)? This study did not assume to know the lived experiences of these MHPs, nor did it expect to find one universal experience of resilience among the participants. Instead, by setting aside preconceptions about resilience, this study sought to reflect "a transcendental state of freshness and openness, a readiness to see in an unfettered way" (Moustakas, 1994, p. 41). The essence of a phenomenon can be communicated in explicit detail from firsthand accounts, revealing the meanings made by those who have experienced it (Van Manen, 2017). This retrospective appraisal of the phenomenon of resilience based on experiences that already occurred in the lives of these professionals revealed the constructed reality of resilience in the workplace (Van Manen, 2017). This design was relevant for this study because it invited a deeper dive into the phenomenon of resilience in the lives of these MHPs. This research design acknowledges that participants construct differing meanings about a phenomenon based on their own unique experiences (Ang et al., 2018; Crotty, 1998). While phenomenological research describes the common experiences that participants share in relation to a phenomenon, it also seeks to understand the nuanced meanings made by the participants, thus uncovering the essence of the human experience (Moustakas, 1994). After gathering the data, the data itself generated insights into the phenomenon of resilience as conceived in the mindsets and expressed in the behaviors of these participants (Ang et al., 2018; Denzin & Lincoln, 2017; Heppner et al., 2016). How individuals chose to narrate the story of their lives bred insight into the mindsets and behaviors that helped them to overcome the

adversities they have encountered (Elkington & Breen, 2015). Since the aim of the transcendental phenomenological researcher is to allow the essence of participants' lived experiences to arise without being influenced by one's own belief systems, embracing the meanings that participants ascribe to their experiences is of prime importance (Bowie et al., 2016; Husserl, 2004). By investigating the lived experiences of these participants, this study prioritized the participants' meanings (Adams & Van Manen, 2017; Saldana & Omasta, 2021), revealing their resilience-promoting mindsets and behaviors, and the meaning they ascribe to resilience that helps them mitigate professional burnout (Bevan, 2014; Eliacin et al., 2018).

I chose the phenomenological transcendental approach because it was well-suited to explore the varied thoughts and feelings of clinicians in private practice who function in a high stress environment every day, confronting their own limitations while assisting clients who are seeking advice and relief. The complicated world of mental health reflects the internal realities of both therapist and client. Therapists are trained to prioritize the clients' concerns instead of their own. Therefore, therapists bracket their own thoughts and feelings in order to enter their clients' world much in the same way that transcendental phenomenological researchers do when approaching their research participants. The parallels between the profession's modus operandi and the transcendental approach excited me. I utilized a research journal, making plain my own thoughts, perceptions, and biases in order to set those things aside (Moustakas, 1994). The purpose of this study was to investigate and document the lived experiences of MHPs in private practice in order to identify their resilience-promoting mindsets and behaviors. While acknowledging that the researcher is an instrument in the study, I made every effort to set aside my preconceived ideas and personal biases in order to prevent influencing the participants' responses, tainting the data, its analysis, or its subsequent interpretation (Yin, 2011).

### **Research Questions**

These research questions were formulated to define the purpose of the research, to reflect the gap in literature, and to focus the target of inquiry to frame the analysis and findings (Crotty, 1998). Honoring an inductive approach, the questions explored the complex processes involved in clinicians' experiences of resilience in relation to the professional stressors they confront that could lead to burnout. Purposing to richly describe the lived experiences of MHPs in private practice, I designed the research questions to reflect this scope of interest. This study focused on answering these research questions:

**RQ1:** What mindsets that promote resilience do these mental health professionals rely upon?

**RQ2:** What behaviors or practices that promote resilience do these participants demonstrate?

**RQ3:** How do resilience-promoting mindsets and behaviors help mental health professionals resist burnout?

### **Setting**

This study focused on the lived experiences of MHPs in private practice in California. The participants came from personal and professional contacts. The interviews were conducted at the participants' office (seven), at a participant's home (one), and remotely, via a telehealth platform called Doxy.me (four). These settings provided neutral environments that allowed the participants to feel comfortable in expressing themselves freely while also preserving their privacy. Conducting the interviews in a natural setting, one indigenous to the participants, instead of in a controlled setting, invited a comforting familiarity to the participants (Billups, 2021). The participants chose which setting they preferred.

### **Participants**

Twelve participants who have experienced the phenomenon of resilience were selected through purposeful sampling (Patton, 2015). Purposeful sampling is a technique that identifies participants who meet the research criteria and who have a depth of knowledge of the phenomenon (Patten, 2012). Qualitative research relies on a small sample size because it creates a depth of knowledge about the phenomenon being analyzed (Saldana & Omasta, 2021). Thus, the focus of participant selection is not on numbers, but on certain qualities that represent the study's purposes (Patten, 2012). Through selective sampling, I elicited participants known to me who fit the research criteria based on their position as a marriage and family therapist (Patton, 2015; Saldana & Omasta, 2021). I initiated contact through a phone call and conducted a recruitment screening to correctly determine eligibility. These specifications included: they must be 18 years of age or older, they must have a qualifying degree of master's level or higher, they must be licensed as a marriage and family therapist in the state of California, they must have worked in a private practice therapy setting, and they must have faced professional stressors that could lead to burnout. After the verbal recruitment screening (see Appendix B) ensured the inclusion criteria was met, each potential participant communicated his or her willingness to participate. I emailed the informed consent form (see Appendix C). After receiving the signed consent, I emailed a demographic questionnaire to gather an overview of characteristics of interest (see Appendix D). Basic demographic questions such as age, gender, length of time in the profession, and length of time in private practice were asked to assess the range of homogeneity among research participants. Other demographic questions were asked to assess each participant's self-appraisal of his or her own level of burnout, priming them for self-reflection prior to the interview.

The initial sample proved substantial in providing enough data for a trustworthy analysis (Saldana & Omasta, 2021; Saunders et al., 2017). An exact data collection plan cannot be pre-determined because it is dictated by what emerges out of the data itself (Corbin & Strauss, 2015; Glaser & Strauss, 1967). The goal of phenomenological research is to interview new participants until data saturation is achieved (Bevan, 2014; Moustakas, 1994). Saturation is valued as a methodological principle in qualitative research (Saunders et al., 2017), occurring “when the complete range of constructs that make up the theory is fully represented by the data” (Starks & Trinidad, 2007, p. 1375). This study sought to establish optimal data saturation, the point when no new concepts emerge from the data and when sufficient relationships are demonstrated between the emerging categories (Saldana & Omasta, 2021; Saunders et al., 2017; Yeh & Inman, 2007). Once an excellent standard of substantive claims and robust categories was noted, affirming the goal of saturation, then data collection ceased (Charmaz, 2014; Corbin & Strauss, 2015). The process by which new data simply reveals information that has already been collected is referred to as “informational redundancy” (Sandelowski, 2008, p. 875). When this occurs, the focus shifts from collecting more content to analyzing what has already been collected (Saunders et al., 2017). This shift occurred after the twelfth interview.

### **Procedures**

An application was submitted to the Institutional Review Board (IRB) to seek approval for this study. Upon receiving the approval letter (see Appendix A), I began eliciting participants through purposeful sampling. I initiated contact via telephone with individuals whom I knew through personal and professional contacts. During this contact, I read aloud the recruitment letter (see Appendix B), verifying each individual’s eligibility for participation. After receiving a verbal consent to participate, I emailed a consent form (see Appendix C).

Participants were assured their participation in the study was purely voluntary and that they could withdraw from the study at any time with no negative ramifications resulting from their non-involvement (Babbie, 2016; Glaser & Strauss, 1967). After receiving the signed consent form, I emailed the demographic questionnaire (see Appendix D). Participants emailed the completed questionnaire back prior to our scheduled interview times.

When the interview was over, I emailed the completed transcript (Englander, 2012). I invited them to provide any corrections or further reflections (Groenewald, 2004). While many participants offered affirmations that the transcript looked accurate, none of them offered corrections or further insights. The audio recordings have been stored separate from the printed data to preserve participant confidentiality and will be deleted after the required three-year waiting period (Heppner et al., 2016). Detailed data analysis involved reviewing each transcript for repetitious words and phrases utilized by the participants. Themes emerged for each person that reflected their experiences with resilience. The iterative process of combing repeatedly through the data revealed common themes between participants. These common themes represented the collective experiences and became significant in synchronizing the findings.

### **The Researcher's Role**

Qualitative research purposes to describe a person's experiences in the way that they experience it instead of being influenced by the researcher's viewpoints or judgments (Bevan, 2014; Charmaz, 2014). Therefore, understanding my role as researcher was essential so that I could bracket my own perspectives, enabling me to engage in the research process more transparently (Roger et al., 2018). I understand that I was intricately involved in each phase of the study, playing an integral part in the entire process. While I acknowledge that I could not be value-free, I still committed to fulfill my role as researcher throughout the study in as clear and

unbiased ways as was possible (Brunero et al., 2015; Yeh & Inman, 2007). This involved regular and consistent journaling so that I could remain aware of my own pre-research leanings, opinions, and biases. To the degree that I bracketed my own biases through journaling, I allowed the phenomenon of resilience to make itself visible in its own way through the data instead of it being biased by my own preconceived notions (Heppner et al., 2016; Thompson, 2018).

Use of self is a term that applies to a process that MHPs professionally engage in which helps them put themselves aside in order to enter the clients' world. This concept parallels the researcher's role in phenomenological studies in many ways (Brunero et al., 2015). By being purposeful with my use of self during the interviews, I was able to set my own assumptions and biases aside and enter the participants' worlds more easily, uncovering the meanings of their lived experiences and more accurately interpreting the meanings they expressed through their narratives (Charmaz, 2014). I did this by being intentional with my verbal and nonverbal communications during the interviews (Roger et al., 2018). While the researchers do shape the data collection process through their verbal and nonverbal communications during the interview (Saldana & Omasta, 2021; Seale, 1999), I was careful in my follow-up comments and questions so to not influence the flow of the interview away from where the participant was leading it (Patten, 2012; Patton, 2015).

I wanted to use my sense of self to build a bridge of trust with the participants that allowed inquiry into the gaps of information that required further exploration (Roger et al., 2018; Vagle, 2018). Dynamic outcomes arose when I came alongside the data and committed to interact with it in ways that allowed patterns and themes to emerge instead of positioning myself above the data in a top-down approach (Creswell & Creswell, 2018). I sought to capture the most authentic representations from these participants so that their lived experiences with

resilience appear true to form (Roger et al., 2018). Epoché, derived from a Greek word which means “to refrain from judgment,” is an ongoing goal in the phenomenological process. Epoché occurred by putting aside my own views of the phenomenon of resilience and focusing on the views of the participants (Moustakas, 1994). I committed to maintaining this vantage point throughout the process through bracketing, specifically by updating new entries and reviewing previous entries in my research journal (Babbie, 2016; Tufford & Newman, 2010). The reflexive journal that I maintained enabled me to record my personal thoughts, feelings, and reactions to the data. The journal served as an incubator for my reflections, playing an integral role in the interpretative process by removing the influences of my preconceived biases from the data collection and analysis. This journal will be included as part of the research data (Engward & Davis, 2015). Reflexive journaling was a valuable contribution to this research process and to the research data itself as it helped to inform the active analysis process and interpretations reached in the study (Billups, 2021). Journaling offered me a way to reflect upon the research process, to collect observations and insights, and to expedite the analytical work by infusing new insights into the flow of data collection, eliciting more authentic results (Charmaz, 2014; Corbin & Strauss, 2015). Because journaling captures the researcher’s thoughts and observations in raw form, revisiting what I wrote allowed my questions and uncertainties to accelerate productivity in the interpretative process by allowing me to glean insights that otherwise could have been forgotten (Brunero et al., 2015; Charmaz, 2014).

### **Data Collection**

Two data collection methods were used to elicit MHPs’ stories of their lived experiences of resilience to resist burnout: a demographic questionnaire and an individual interview. Participants completed the demographic questionnaire prior to the interview.

### **Semi-Structured Interviews**

The interview is the most common method of data collection in qualitative research (Corbin & Strauss, 2015; Roger et al., 2018; Saldana & Omasta, 2021). Interviews are a basic mode of inquiry that connect individuals by offering opportunities for insight and meaning-making as they make sense of the experiences being shared (Seidman, 2019). Because this research sought to understand the lived experiences of MHPs and the meaning these participants ascribe to their experiences of resilience, the interview was the ideal modality for this study (Crotty, 1998). Through delving into an in-depth exploration of participants' experiences, these interviews invited individuals to select important details, reflect on them, and share them in an order that helped them to make sense of what they encountered (Van Manen, 2017). I communicated their worth and value as professionals who have navigated the interpersonal landscape of the therapeutic world with all of its unique and challenging circumstances by actively listening to their life stories (Seidman, 2019). To do this work takes individuals who are grounded in the conviction that the lived human experience is worth prioritizing. MHPs are often people who reflect upon their own lived experiences and that self-reflection equips them to assist clients who come to them for help. Before each interview, I reminded participants that a pseudonym would be assigned to their data to maintain their confidentiality (Rubin & Rubin, 2012). I also reminded them that the interviews were being audiotaped to ensure accuracy during the transcription process (Moustakas, 1994; Saldana & Omasta, 2021).

The semi-structured interview was the chosen method of inquiry for this study because this study purposed to elicit direct insights into the phenomenon of resilience (Saldana & Omasta, 2021; Seidman, 2019). Semi-structured interviews offer consistency between participants by using the same questions, eliciting relevant information about the same topics.

This loosely guided format allowed “respondents ample opportunity for offering richer and more personalized responses” (Heppner et al., 2016, p. 374) without externally imposed structures that might redirect where they are otherwise naturally inclined to go (Brunero et al., 2015; Charmaz, 2014). Because they were semi-structured, these interviews invited targeted follow-up questions on areas of inquiry for further exploration (Charmaz, 2014). Open-ended questions were used because they prompted focused answers but also allowed new insights to emerge (Corbin & Strauss, 2015). The gentle guidance of open-ended questions created ample space for participants to speculate on their own experiences, freely offering their own stories as they felt led (Billups, 2021). I utilized interviewing techniques designed to honor the participants without trying to help them or change their narratives (Ashby et al., 2013). While the purpose of questioning in a therapy context is to help someone by providing healing responses, the goal of research interviewing is to collect information for the purpose of better understanding the topic at hand (Seidman, 2019). By committing to active listening skills throughout the interview, I highlighted the meanings, both explicit and nuanced, that the participants ascribed to their lived experiences of resilience (Charmaz, 2014). To the degree that I listened attentively, tracked well, used self-reflectivity, and pursued understanding over the gaps of information that arose, the data collected can be viewed as authentic representations of the participants’ intentions (Heppner et al., 2016; Roger et al., 2018).

### **The Interview Guide**

The interview guide helped me direct the interviews, navigating through the questions without limiting the discussion to those exact questions and topics (Charmaz, 2014; Corbin & Strauss, 2015). The guide helped catalyze the interview into unique places of conversation as facilitated by the participant’s choosing. Asking them to recount their own life stories offered a

powerful way to understand how they have made sense of their own experiences, affirming what researchers have posited to be true: “The best stories are those which stir people’s minds, hearts, and souls and by doing so give them new insights into themselves, their problems, and their human condition” (Rubin & Rubin, 2012, p. 50). I worded the interview questions specifically to elicit their subjective points of view, reflecting the phenomenological philosophy that undergirds this study (Seidman, 2019; Van Manen & Van Manen, 2021). In crafting the questions in this guide, I followed Seidman’s (2019) data collection techniques which emphasize that inquiries should be closely related to the topic of interest and represented by a smooth sequence. This facilitates deeper explorations into the lived experiences of the participants. Preparing the guide helped me order the questions to maximize the best narrative sequence, navigating between open-ended questions that invited detailed explanations and follow-up questions that led to unique discoveries in participants’ unplanned stories. Probing questions dove deeper into targeted areas of interest that allowed participants to further their own thought process and reflection upon the nuances they were trying to communicate (Corbin & Strauss, 2015; Rubin & Rubin, 2012). Gathering the participants’ here-and-now perspectives on adversity and resilience highlighted important themes and insights that will be shared in the findings section of this research.

### *Interview Questions*

#### **Self-Identification and History:**

1. Please introduce yourself to me, as if we just met one another.
2. Tell me about your work title and how long you have been employed in this capacity.
3. What other professional settings have you worked in besides private practice?
4. What led you to pursue a career as a mental health professional?

5. What are your favorite aspects to your job? What are your least favorite?

**Professional Burnout:**

6. How would you define the concept of burnout?
7. What professional challenges do you face as an MHP working in private practice?
8. How many of those challenges are unique to the private practice setting itself?
9. Please describe as detailed as possible a situation in which you experienced professional burnout?

**Resilience-Promoting Mindsets:**

10. How do you define the concept of resilience?
11. What does a resilience-promoting mindset mean to you?
12. What are the important characteristics of a resilience mindset?
13. Do you believe that a resilience mindset can be taught or practiced? If so, how?
14. How do you personally work on developing a resilience-promoting mindset?

**Resilience-Promoting Behaviors or Practices:**

15. What resilience-promoting behaviors do you personally practice?
16. What aspects of these resilience-promoting practices are most helpful to you?
17. Do you believe resilience-promoting behaviors or habits can be taught? If so, how?

**Personal Adversity:**

18. How do you define the concept of adversity?
19. Please describe an example of a personal adversity that you have confronted.
20. What helped you overcome that adversity?
21. What did that adversity teach you or deposit within you that you have been able to access during subsequent hardships?

22. How are you different because of the adversity that you overcame?

23. Please describe a situation when you experienced resilience.

**Personal Resilience to Resist Professional Burnout:**

24. Do you think a resilience-promoting mindset is necessary in your line of work to resist burnout?

25. Do you think resilience-promoting practices are necessary in your work to resist burnout?

26. How do you develop or sustain resilience-promoting behaviors to overcome burnout?

**Promoting Resilience in Others Through Your Work:**

27. How do you draw from the resilience you have developed in your personal life experiences to assist others in overcoming their own adversities?

28. What advice would you give to other clinicians working in private practice about how to use resilience to manage professional burnout?

**Conclusion:**

29. Looking ahead to the next few years, how do you expect your mindset or behaviors to change in relation to resilience?

30. One final question: What else do you think is important for me to know about your lived experiences with resilience-producing mindsets or behaviors?

**Question Explanations:**

Questions 1 through 5 were experience questions that relied on direct recall and were intended to build rapport with the interviewee (Patton, 2015). They focused on gaining information about the participant's history, specifically the choice to pursue a career in the mental health field (Harrison et al., 2014; Norcross & Farber, 2005; Zhong et al., 2016).

Question 6 was a knowledge question to elicit the participant's cognitive perspective on burnout, while questions 7 through 9 sought insights into their experiences with professional burnout (Englander, 2012). Questions 10 through 14 were knowledge questions designed to target the cognitive aspects related to resilience and how much the participant considers mindset to be important to the construct of resilience (Duckworth, 2018; Dweck, 2006). A growth mindset is a formidable mediator between adversity and outcome, facilitating favorable psychological adjustments and resilience in individuals (Boullion et al., 2021). Grit, resilience, and mindset have been identified as success-promoting factors that promote subjective well-being when faced with challenges (Calo et al., 2019). These questions were designed to elicit the participant's perspective on mindsets (Schmidt & Shumow, 2020).

Questions 15 through 17, related to resilience-promoting behaviors, were designed to elicit the participant's perspective on whether resilience could be practiced and developed (Lally & Gardner, 2013). Habits are dispositions that can create empowering changes when consistently applied (Nemec et al., 2015; Pedersen, 2018). Staying congruent with a descriptive phenomenological orientation, questions 18 through 22 probed deeper into the participant's experiences of adversity and resilience (Englander, 2012). I situated this section later in the interview to allow ample time for rapport to be established (Seidman, 2019). These questions asked the participant to reconstruct and reflect upon a challenging situation in their own lives. Reflection precedes meaning making. Because the phenomenological approach seeks to understand the essence of someone's lived experience, this series of questions enquires not just the facts of what they experienced, but the essence of what the experience meant to them (Seale, 1999). Question 23 asked about a situation when the participant experienced resilience. The meaning that humans assign to challenging circumstances determines the amount of fortitude

they demonstrate (Bouillon et al., 2021; Calo et al., 2019). Questions 24 through 28 were designed to link their personal experiences to the topic of burnout (Rubin & Rubin, 2012). Resilient individuals tend to display common behaviors across different circumstances (Ang et al., 2018; Duckworth, 2018; Dweck, 2006; Reed & Blaine, 2015). Research shows that resilience that has been developed in one area of life becomes a resource that assists people in subsequent challenges (Criss et al., 2015; Fletcher & Sarkar, 2016). By identifying the common factors, mindsets, and behaviors, that assisted the participants in overcoming adversity, common value-based beliefs revealed similar internal loci of control (Aysegul et al., 2015; Mayhew et al., 2014) that fostered resilience against professional burnout (Kerig, 2019; Kim et al., 2019). Questions 29 and 30 were closing questions that allowed the participant to provide any final thoughts or to return to a previous answer for additional information (Patton, 2015; Seidman, 2019).

### **The Transcripts**

The transcription process is a necessary part of the data collection phase because it informs the researcher about progress toward theoretical saturation. Each interview was transcribed within two days of completing the interview. This timing ensured that the interview was still fresh in my memory. A copy of the transcript was emailed to each participant. They were told to review the transcript and inform me of any corrections (Seidman, 2019). Creating the transcripts was time-consuming, but I am proud I chose to do it myself because it allowed me to interact with the data in a very slow, methodological way. The process enabled me to become intricately familiar with the details of each interview.

Theoretical saturation is the point at which new samples offer no new insights (Babbie, 2016; Charmaz, 2014). Data collection and data analysis are interrelated in descriptive

phenomenological research (Englander, 2012). The interdependent relationship between data collection and data analysis reveals the importance of the simultaneous tasks of collecting, coding, and analyzing data. This benefits the researcher because the data guides the next step of the descriptive process (Glaser & Strauss, 1967). Because the initial analysis of the data occurs simultaneously with its retrieval, small adjustments and corrections can be made along the way that enable the data to shape itself into emerging themes and patterns (Englander, 2012; Glaser & Strauss, 1967). This allows for theoretical saturation to occur as an unfolding process instead of at a definitive point (Corbin & Strauss, 2015). This means that the researcher becomes aware that the interviews are offering no new data but are reinforcing the codes and themes that have already begun revealing themselves. As this process unfolds, each new transcript offers more insight into the dominant codes and themes (Corbin & Strauss, 2015; Creswell & Creswell, 2018). Significant statements within the transcripts begin to reveal meaningful units of thought or overarching themes about the essence of the phenomena (Moustakas, 1994).

The transcription process included word-by-word transcriptions to inform me of key words that correlated with each interview question. As I processed through the unfolding data (Charmaz, 2014; Corbin & Strauss, 2015; Glaser & Strauss, 1967), I added code words in the left-hand column of the transcript, while highlighting in yellow key phrases or sentences that best exemplified the participant's main point. Because the initial data was based on the general subject area of resilience rather than any preconceived theoretical framework that I was hoping to endorse or prove (Charmaz, 2014; Glaser & Strauss, 1967), I maintained a theoretical sensitivity towards the data. I was able to continually ask myself, "What is occurring in this data?", "How can this be conceived?", and "What kind of models does it imply?" (Glaser & Strauss, 1967). To commit too soon to a detailed perspective would have meant that I was

placing myself at risk of losing theoretical sensitivity by developing tunnel vision around what I hoped to see come from the data. This would have inhibited my ability to see the data from how it presented itself, potentially short-circuiting the discovery process, and negatively affecting the quality and credibility of the data's spoken messages (Glaser & Strauss, 1967).

The current study purposed to achieve theoretical saturation through approaching the phenomenon of resilience with a broad lens, allowing the data to speak for itself and directing the next steps of data collection in naturally occurring directions. When I observed that no new categories were being created by additional interviews, but that the existing categories, founded on more substantial evidence instead of weak associations (Charmaz, 2014), were becoming more robust, I knew that theoretical saturation was occurring. I continued interviewing until saturation, the point where maximized opportunities to develop categories and see relationships between concepts is most fully established, and then interviews ceased (Corbin & Strauss, 2015; Glaser & Strauss, 1967).

### **Data Analysis**

Data analysis is an essential step in descriptive phenomenological research because it facilitates arrival at a new understanding of the phenomenon being studied (Heppner et al., 2016). Starks and Trinidad (2007) assert that the researcher plays a central role in data analysis throughout the entire research process. In phenomenological research, the analysis process is iterative, multidirectional, and creative (Saldana & Omasta, 2021). Although the process is not rigid, its flexibility does not sacrifice the reliability and validity of the data, something upheld by standard protocols and rigorous methodological approaches (Charmaz, 2014; Heppner et al., 2016). Maintaining a commitment to “produce an exhaustive description of the phenomena of everyday experience” will yield insight into the essence of resilience (McLeod, 2001, p. 38).

Allowing the data to speak in the manner most authentic to the participants results in the most congruent interpretations to the story the participants want told (Babbie, 2016). This is where phenomenological research gains its dynamic edge (Craig & Sprang, 2010). By avoiding the superficiality of data that quantitative studies provide, phenomenological research invites novel insights into the deeper realities of the topic under investigation (Corbin & Strauss, 2015).

### **First and Second Cycle Coding**

There is no single systematic process that each researcher must undergo in order to arrive at an appropriate interpretation (Van Manen, 2017). I chose a combination of coding procedures to identify the best patterns in the data. I began data analysis with two first cycle coding procedures: descriptive coding and in vivo coding (Saldana, 2021). Descriptive coding enabled me to index a database of key words and concepts that I recorded along the left column of each transcript. In vivo coding entailed highlighting exact quotes from the text so that I could easily locate the best examples. These coding procedures kept me grounded in the voice of each participant, which is an essential part of phenomenological research (Moustakas, 1994). Next, I engaged in second cycle coding. This is where focused coding allowed for categorization of the coded data. By charting the data according to categories, I grouped questions together that contained similar information. For instance, I grouped all the questions that focused on personal traits of the participants under one chart and created a separate chart for questions about the private practice setting. A third chart featured questions that focused on burnout and resilience specifically. Consolidating answers from each transcript onto the same document took hours, but it proved worthwhile. It enabled me to view answers side by side instead of flipping through a dozen transcripts. The juxtaposition of answers allowed me to draw points of connection visually, which led to identifying dominant themes in each category. I listed them in order of the

most common responses to the least (Saldana, 2021). The patterns became easily apparent, revealing rich insights into the lived experiences of resilience (Heppner et al., 2016). This entire coding process serviced different ways of thinking about the data. The visual prompts revealed different connections between the participants' voices and viewpoints (Saldana, 2021).

### **Husserl's Phenomenological Philosophy**

Husserl's phenomenological philosophy is the foundation of this methodology. It influenced the research questions and techniques utilized (Heppner et al., 2016; McLeod, 2001). Intentionality is a key concept; it "is about the orientation of the mind to its object" (Moustakas, 1994). It refers to the perceiving, judging, and valuation of something (Husserl, 2004). It points to developing an internal awareness (Moustakas, 1994). Since phenomenology is about encounter, it is about living life in such a way that one is fully present to experiences and learns to purposefully relate to them (Vagle, 2018). This begets the concepts of *noema* and *noesis*, the textural and structural dimensions of a phenomenon, because both comprise intentionality. The noema refers not to the real object, but to the phenomenon, and the noesis refers to the meanings explicated from the intentional processes (Moustakas, 1994). Husserl's philosophical insights guide the principles underlying the research design, data collection, and analysis, while also explicating the themes, meanings, and essences of the human experiences under study (Englander, 2012). Husserl's steps of data analysis include bracketing, epoché, phenomenological reduction, and imaginative variation, culminating in an understanding of the essence of the participants' lived experiences (Heppner et al., 2016).

### ***Bracketing***

Because phenomenological researchers are active participants in the study, by acknowledging one's own personal assumptions and biases, one is more capable of entering the

data collection process with an open mind (Heppner et al., 2016). Adopting a phenomenological attitude includes becoming vigilant to protect the research process from any personal influence that could contaminate it (Finlay, 2002; Tufford & Newman, 2010). Bracketing is a “scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon” (Gearing, 2004, p. 1444). Bracketing is not a onetime decision that occurs at the beginning of the research process; rather, it is a self-reflexive process of discovery that occurs throughout the entire process and the researcher actively monitors it through journaling (Starks & Trinidad, 2007).

### ***Epoché***

It is essential that the phenomenological researcher enter the research process with an open mind. This can be accomplished through epoché. Epoché requires “the elimination of suppositions and the raising of knowledge above every possible doubt” (Moustakas, 1994, p. 19). It is a process that sets aside the researcher’s own thoughts, experiences, and preconceived understandings in order to have fresh eyes with which to view the phenomena of interest (Moustakas, 1994). Husserl said epoché, was necessary so that the researcher could arrive at a new understanding of the phenomenon (Heppner et al., 2016). Throughout this research journey I actively engaged in epoché, documenting the process to remain open to the incoming data (Moustakas, 1994; Saldana & Omasta, 2021). I included this process in my written results.

### ***Phenomenological Reduction***

Phenomenological reduction begins with experiences described in their total form, with all the thoughts, feelings, perceptions, and sensory stimuli. This method leads to “the source of meaning” (Moustakas, 1994, p. 34). The goal is to reduce the data to language that most accurately reflects what the participants described, offering accurate texture to the descriptions

and meanings (Saldana & Omasta, 2021). By seeking the essence of the lived experiences of resilience, the essential components of this phenomena emerged throughout this study.

### *Imaginative Variation and Synthesis of Meanings*

The last step in the data analysis process, imaginative variation, entails grasping the “structural essences of experience” by considering every aspect of the imagination, sense, and memory to view the infinite possibilities of actual and possible cognitions, viewing it from every angle in order to understand the essence of the phenomenon (Moustakas, 1994, p. 35).

### *Presenting Data*

The goal of the data analysis process is to effectively synthesize the data so that it may speak for itself with little influence from my bias as the researcher. Eliciting a transcendental state of openness to see and experience the world anew resulted in new insights into resilience (Heppner et al., 2016; Groenewald, 2004). Once the prior steps have been completed and the categories and themes have been identified, the results are ready to be presented (Creswell & Creswell, 2018). I provided excerpts from the interviews as well as charts of the themes in order to adequately represent the findings while preserving the originality of each participant’s unique voice (Saldana, 2021; Saldana & Omasta, 2021). The rich, thematic descriptions offer insights into the lived experiences of the phenomenon of resilience for MHPs (Starks & Trinidad, 2007).

### **Trustworthiness**

It is of utmost importance to preserve the credibility and interpretation of data as that reflects on the study’s primary validity. Trustworthiness refers to “the authenticity and consistency of interpretations grounded in data” (Yeh & Inman, 2007, p. 386). This study sought to allow the data to remain authentic to its emerging voice, building trustworthiness as it unfolded (Corbin & Strauss, 2015). Trustworthiness was established through applying inter-rater

reliability. In an effort to mitigate interpretative bias, multiple coders coded the same data set using the same codebook. Results proved an inter-rater reliability of 81% between coders, indicating an acceptable standard of establishing rigor within the interpretive process (Heppner et al., 2016).

### **Credibility**

This study ensured validity by providing direct quotations from the participants. It includes rich descriptions of the participants' answers, increasing the likelihood that readers will have clarity to understand the answers in their original contexts (Charmaz, 2014). Credibility of the analysis has also been supported through implementing a four-step analysis process. This included reading each transcript multiple times in order to arrive at the gestalt of it, dividing the transcripts into smaller units based on meaning, transforming the meaning units into more general terms through imaginative variation, and then synthesizing these units into the essences of what they represent (Heppner et al., 2016).

### **Dependability and Confirmability**

Providing the full transcript to each interviewee assured that participants were accurately represented (Charmaz, 2014). Member checking was employed to confirm the validity of specific quotes from the participants, ensuring their opportunity to provide clarification (Roger et al., 2018). Utilizing an external editor to review the data to ensure the study's overall logic, coherence, and consistency were stable also established the dependability (Charmaz, 2014).

### **Limitations**

The limitations of this study were evident due to the specific research setting and participant pool. These MHPs work only in suburban settings and represent experiences in only one state of the country: California. Therefore, these results might not be generalizable across

mental health clinicians working in urban settings or to those who are located in other parts of the United States or internationally. This study relied upon interviews because it was not legal nor possible to directly observe therapists while in session with clients. Therefore, the information provided as data was firsthand, personal accounts of the participants. Interpretations may differ from how the interviewer might have relayed examples if direct observation or field study had been possible, but since it was not, the results were limited to the self-reporting of the participants (Creswell & Creswell, 2018). Lastly, these results reflect the viewpoints and experiences of MHPs who are still currently working in private practice. The viewpoints included here represent those who have managed any potential burnout symptomology to the point that they have maintained their employment status. MHPs who have succumbed to burnout symptoms or who have already retired were not represented in this sample.

### **Ethical Considerations**

Albert Schweitzer asserted, “The first step in the evolution of ethics is a sense of solidarity with other human beings” (Roberts & Hyatt, 2018, p. 138). Ethical researchers commit to safeguard the rights of the subjects who participate in their studies (Saldana & Omasta, 2021). Using informed consent and confidentiality are two methods to verify volunteers’ protections (Roberts & Hyatt, 2018). I established the safety considerations for these participants in multiple ways.

### **Nonmaleficence and Beneficence**

Ethical standards focus upon the rights of volunteers and the need to protect them from all types of harm (Moustakas, 1994). This central principle, often referred to as the “principle of nonmaleficence,” is popularized by the phrase “above all, do no harm” (Babbie, 2016; Roger et al., 2018). IRB committees ensure that research studies are designed with careful planning to

eradicate all risks. The participants were protected from overt harm and also from the “stress, discomfort, embarrassment, invasion of property, or potential threat to reputation” that also could result (Moustakas, 1994, p. 80).

The principle of beneficence extends beyond nonmaleficence by prioritizing goodness, healing, or growth. Ultimately, it entails doing good to others (Heppner et al., 2016). True ethics does not simply prevent harm. It also leaves a positive legacy, actively contributing to the health, well-being, or development of others (Billups, 2021). This study sought to provoke positive influences. Enhancing MHPs’ resilience counteracts the threat of burnout that clinicians confront and increases the likelihood that their longevity in practice benefits the communities in which they work because their well-being is sustained (Westwood et al., 2017).

### **Informed Consent**

Informed consent involves clearly communicating the procedures and the risks involved before participants affirm their willingness to continue (Roberts & Hyatt, 2018). After evaluating the potential harm associated with this study, this study preserved the dignity of each participant by assuring their participation could be terminated at any time without negative repercussions (Heppner et al., 2016). The informed consent offered explicit clarity regarding the obligations, risks, and responsibilities involved in the study. Each participant signed and returned the consent prior to involvement in any of the procedures (Corbin & Strauss, 2015; Saldana & Omasta, 2021). This ensured that the principles of freedom and autonomy prevailed for the participants throughout the duration of the study (Roberts & Hyatt, 2018).

### **Confidentiality**

Confidentiality refers to protecting the identity of the participants in order to safeguard their well-being (Heppner et al., 2016). Because the information provided in this study involved

personal information of a sensitive nature, it was important to remind the participants about the use of pseudonyms in order to increase the likelihood of honest responses. Confidentiality stretches beyond the identity of the research subjects; it also refers to what will be “done with their data” (Sieber, 1992, p. 35). All data from the participants was held in confidence, with only the researcher having access to the collected data, including the participant forms and audiotaped interviews (Babbie, 2016; Roberts & Hyatt, 2018).

### **Summary**

Chapter Three included the essential features of the transcendental phenomenological design. Because qualitative studies investigate a broad perspective of the lived experiences of a specified phenomenon, the phenomenological research design was an excellent choice for this study. Clarity about utilizing resilience to resist burnout in MHPs emerged (Babbie, 2010; McLeod, 2001). This chapter identified how this phenomenological study was conducted, aligning with the principles for transcendental, phenomenological research, and upholding the ethical standards required (Saldana & Omasta, 2021). The next chapter will account for the collected data. It will offer a detailed discussion and explanation of the findings, an analysis of the data, and the final results (Charmaz, 2014).

## **Chapter Four: Findings**

### **Overview**

Chapter Four contains the findings of the study that were gathered for the purpose of describing the participants' lived experiences of resilience. These three research questions guided this study:

**RQ1:** What mindsets that promote resilience do these mental health professionals rely upon?

**RQ2:** What behaviors or practices that promote resilience do these participants demonstrate?

**RQ3:** How do resilience-promoting mindsets and behaviors help mental health professionals resist burnout?

This chapter describes how 12 participants perceived their lived experiences of resilience through the stories that they chose to share. It begins with a description of the participants' demographics. It then moves on to the results, focusing first on the primary themes and then highlighting the supportive sub-themes. The chapter presents a general narrative and then culminates with a chapter summary.

### **Participants**

The twelve MHPs who participated in the study shared their lived experiences of resilience. Pseudonyms were used to protect their confidentiality. Individual portraits of each of the participants, listed in the order of their interviews, are included in Appendix F. The descriptions provide context for each of the participants as well as the predominant essence of the information emphasized during each interview.

The demographic information of this group of participants is provided in Table 1.

**Table 1**

*Participant Demographics*

Characteristic	Male (n= 4)	Female (n=8)	Total (n=12)
<b>Age</b>			
25 - 35 years	0	1	1
36 - 45 years	1	0	1
46 - 55 years	1	3	4
56 - 65 years	1	3	4
66 - 75 years	1	1	2
<b>Ethnicity</b>			
White	4	7	11
Black	0	0	0
Asian	0	1	1
Latino	0	0	0
Native American	0	0	0
<b>Years in private practice</b>			
1 - 5	0	1	1
6 - 10	1	1	2
11 - 15	1	3	4
16 - 20	0	1	1
Over 20	2	2	4
Retired			
<b>Currently working per week</b>			
1 - 10 hours	0	1	1
11 - 20 hours	1	3	4
21 - 30 hours	1	2	3
31 - 40 hours	0	2	2
Over 40 hours	2	0	2

According to the demographic data, more females participated in the study (females 67%, males 33%). The two age groups most represented were the 46-55-year olds and the 56-65-year olds (33% each). Eighteen percent of the participants were in the 66-75 age range, 8% were in

the 25-35-year old range, and 8% were in the 36-45-year old range. Ninety-two percent of the participants were White, and 8% were Asian. The most common groupings of years spent working in private practice were found in 11-15-year range and the over 20-year range, with each representing 33%. The 6-10-year range represented 18% of the participants. The remaining two groupings, (1-5 years and 16-20 years), represented 8% each. Thirty-three percent of the participants work between 11-20 hours per week, while 25% work 21-30 hours per week. Seventeen percent work 31-40 hours per week and another 17% work over 40 hours. The remaining 8% work 1-10 hours per week.

### **Results**

The qualitative data were transcribed, organized, and analyzed as outlined in detail in Chapter Three. The participants' first-person reports provided understanding of the meanings and essences of their own lived experiences, validating the scientific investigation according to phenomenological principles (Moustakas, 1994). Reviewing the transcripts and applying the coding procedures led to the revelation of the meaning units that best captured the lived experiences of MHPs who have utilized resilience to resist burnout (Saldana, 2021).

### **Primary Themes**

The 12 participants interviewed reflected on their lived experiences of resilience. According to the step-by-step procedures detailed in Chapter Three, these individuals completed a demographic questionnaire and individual interview as part of the data collection process. The data from each participant was analyzed and every sentence investigated to identify the words most frequently used to represent the phenomenon of resilience. After listing them together, I coded the repeated words and phrases, and then I merged the similar codes to consolidate terms. While descriptive coding enabled me to index a database of key words and concepts, in vivo

coding entailed highlighting exact quotes from the text (Saldana, 2021). These coding procedures kept me grounded in the voice of each participant, which is an essential part of phenomenological research as it reflects the essence of the phenomenon of interest (Moustakas, 1994). Two primary themes emerged that reveal the transcendent essence of the phenomenon of resilience: “Operating from Their Optimal Self” and “Flowing in Temporal Fluidity.”

### ***Theme One: Operating from Their Optimal Self***

The theme “Operating from Their Optimal Self” derived from a phrase from Dylan’s interview that revealed a sense of transcendence. Something that is transcendent is something that exists beyond the normal range of human experience. It exceeds the typical physical experience. The idea of living from one’s optimal self means living from the best, or most favorable, level. Dylan used the phrase when asked how he defines burnout. He replied:

Burnout is losing some vigor and zest for the work. Losing some passion for it. It feels burdensome. Like I don’t have enough energy for it. I feel fatigued. Like I don’t have as much compassion or empathy. I know what the *optimal me* is in this field and I know when I’m feeling like I have less than that. I have indicators. I’m more tired. I’m less empathic. I don’t have as much capacity. I don’t have as much interest to grow. That’s a big one for me. If I’m not learning, then I’m not doing well. When the curiosity is strong in me, then I feel like I am growing. But burnout starts to rob me of that.

Dylan’s answer reflected a holistic perspective about his sense of his optimal self. He incorporated a physical component (I’m more tired). He included an emotional component (I’m less empathic). He referred to a mental component (If I’m not learning, then I’m not doing well). The lack of motivation to grow and develop (I don’t have as much interest to grow) highlights the deficiency that burnout induces. Resilience, on the other hand, reverses that pull and

empowers individuals toward living from a fullness that helps people to overcome hardship.

This theme presents a multi-dimensional aspect to the phenomenon of resilience that reveals the gestalt of it, that the lived experience of resilience is greater than the sum of its parts. This same reality is revealed in the other narratives.

Bob values balance and internal stability as key ingredients of living from his best self. He sees “internal stability as a huge component of resilience.” He likens it to driving down the freeway. “Resilience is staying in your lane. Unless someone comes veering into it and then resilience is avoiding them... The whole idea is don’t hit anything and don’t get hit... Sometimes there’s nothing you can do. But you do your best.”

Eva’s sense of her best self culminates when she reminds herself that she is worthy and valuable. And yet, that does not mean she will avoid pain and suffering in life. When she prayed about it she felt she heard the Lord say, “If you are trying to eliminate any adversity or challenge for your child or yourself, it’s impossible.” This led her to wrestle through it, coming out the other side with a new “confidence to sit through it and not let it limit me.” She is at peace with the unknowns of life now because she has learned to “identify where I am most afraid, and it forces me to look at what my faith is in.”

Dylan attributed his current strength to the challenges he overcame in the past. Learning how to overcome difficulty brought out the best qualities in him. He values the resilience he learned through facing and overcoming hardship.

There’s something in me that says I want the challenge of seeing if the odds are against me and if I can overcome them. That’s probably part of my upbringing. All the dysfunction and all the different stuff that happened and all the moving around we did... How can I make a good hand out of this hand of cards even though it’s been kind of

hard? Life made me do that because life was hard. I have had some advantages in life that others don't have, but I think life made me resilient.

Susie values the best qualities in herself by referring to them as the qualities that come naturally to her when she is living from her "zone of well-being." It is where "I can operate from my Spirit-led self." Living from this zone is not easy, but it is possible. She is committed to making that her daily aim. "I have a choice. It is the commitment because I am responsible to get back into my zone. It won't just happen for me. I have to go get it."

Kate identifies herself as a positive person, and she also sees resilient people as positive people. "They are confident that they can persevere, have good self-care, see things positively. They always see the light at the end of the tunnel even when things are tough." By doing this, she has built confidence in herself that she can overcome difficult things. The joy of her job is that by pulling from her own past, she can encourage her clients to have hope for their future:

I use a lot of things that work for me personally, and that has been helpful with other clients... A part of our job is to lend clients our confidence until it becomes true for them... I love giving that to people. That is the beginning of instilling hope, which is supposed to be one of the first steps of therapy.

Ang is purposeful to live in such a way that she can resist burnout because she chooses to not empower adversity in her life to have the final word. Instead, she maintains her "mental perspective and choice" about situations. She gets to choose how she looks at struggles and finding solutions allows her to live feeling empowered instead of victimized. Helping others "facilitate acceptance" in their own lives encourages people to "take action" instead of allowing themselves to "feel stuck" in undesirable circumstances.

For Ben, the key ingredients of resiliency include a “can-do, don’t ever quit, don’t ever stop attitude.” He credits his perspective to having to overcome many challenging situations living as a missionary kid in a foreign country where he did not speak the language. He learned how to “adapt and overcome” and learned that he just had to “figure it out.” These mantras are ones he frequently uses in the counseling room when trying to call forth the latent resilience presiding inside his clients.

Sam is grateful that he “has a natural optimism and natural resilience.” He credits some of it to situations he faced as a child. “The choice was become a victim or overcome it. So I overcame it.” Because of his early victories, he has learned how to tap into that and call it forth from within others. “The value is growing and learning and moving forward. I enjoy growing and I anticipate it is going to be difficult.” But that difficulty does not stop him. It becomes contagious when working with others because it makes his own resilience “more robust” and compels him “to help other people thrive in their lives too.”

Pat looks back on her life and sees that she “more naturally walked in a resilient” way of life. She has always had a positive bent toward her and prefers to live with a focus on hope and she tries to “help people see hope and have hope” as that “helps them overcome hard stuff now for something better to come.” However, she does “intentionally maintain a growth mindset” and this empowers her to live from the best self she can be. She does not think her optimism is naïve. Rather, in the face of knowing that “things in life aren’t going to play out according to expectations or norms, there’s still blessing in it.”

### ***Theme Two: Flowing in Temporal Fluidity***

The second theme, “Flowing in Temporal Fluidity,” refers to the ability to access the past, present, and future time frames, making coherent sense of them in ways that draws from the

wisdom that each time segment holds within it. Accessing the input of past experiences as well as of future hopes and dreams and integrating them into one's present moment decision making maximizes what it means to flow in temporal fluidity. These participants spoke frequently of learning from past events and of being motivated by future dreams. The resilience they developed through overcoming past adversities came shining to the surface. The phrase temporal fluidity came to mind when I reflected upon part of Dylan's narrative. He represented what I have termed *temporal fluidity* beautifully:

I've often thought that healthiest people I know use all the tenses: past, present, and future. So, you understand parts of your past that influence you, but you aren't living in your past. You pull things out of it. You are living in the moment with an eye on the future. You know about where you are trying to get to. I don't think you can be very resilient if you are not focused on the future a bit because it is easier to become stuck in the circumstances. But if I can see the future then I want to change that. If I'm gaining weight and I don't want that then I can see a really unhealthy version of me up there in the future and I need to be resilient now to makes changes to avoid that.

Sam also represented the concept of temporal fluidity so exquisitely when he spoke about how his future goals assisted him in making a big career decision and fighting through the attending challenges.

What kept me resilient? I had a value to do something different with my life. I want to be able to help people in a way that is better and to have some autonomy in my schedule. Because of these values, I set these goals: I'm going to complete school, I'm going to become a therapist, I'm going to own my own business. That was just what I was going to do. Because I had these goals, I could almost borrow from the future... yes, borrow

the joy and meaningfulness and satisfaction. The confidence from the future to keep me engaged in the difficulty right now.... Why do I do it? Because I have these values and goals and they kept me going. Not only was I able to borrow from the future, but looking back, now I can borrow on the past. I realize that the resilience I had in the past is also a resource for me today. I am confident that I can overcome this struggle today because of what I overcame in the past.

Meg tries to help her clients stay in the present while not fearing the future. She tries to keep them from “projecting into the future that because you feel this now you will always feel this way.” When clients do that, she feels they are putting her in a box. This means she “can’t make it better for them” because they color their future with their present woes.

Pat endeavors to help people develop hope for their future because then they have the strength to deal with today. “If I can help them see and have some hope... have something to attach to, based on something they have already overcome, then I can help them overcome now too.” By stirring up hope for the future, Pat sees her clients develop confidence that whatever they are currently dealing with will, at some point, indeed pass.

Tia encourages her clients to “draw on the good things that have happened in the past.” She said, “It offers proof that good things happened once to you, they can happen again, in the future.”

Bob is adamant about living in the present, but he draws from the past to learn how to “not drift one way or another” away from the balance you are trying to achieve. He looks to the future to set goals for who he wants to become. By using future-oriented thinking to visualize what his current values will lead him toward, he builds his confidence in what to live for in the

here and now. “Resilience has a part of mindfulness and awareness that is proactive, that allows you to notice potential problems sooner so that you can respond to it sooner.”

Char overcomes the current self-doubt she faces with challenging cases by reminding herself of God’s faithfulness in the past. “Perseverance now comes from knowing that God did not make a mistake in putting me in this job.” She also draws comfort from knowing that she is only called to “do your best and leave the rest up to God.” His faithfulness in the past provides the framework for how He will be faithful again in the future. This builds confidence that she can share with her clients, and they too can learn to rest in the truth that God is the same yesterday, today, and forever (Hebrews 13:8).

Sam draws from his past to encourage himself in the present while he purposefully creates his future.

I’m ok reflecting on my own experiences in the past and gleaning strength from that. I also continually have, just because I have reached my goal now based on my values, doesn’t mean I don’t have any more goals. I continue to focus on my values and continue to create new goals for myself. This allows me to borrow on the future. What will it be like when?... There’s always a new goal to look toward.

Sam sees his best self as one who lives up to his values, adversity notwithstanding. He faces challenges head on instead of being defeated by them:

Adversity is situations that make it more difficult to reach your goals and honor your values.... You are on a path to honoring your values and meeting your goals and adversity is something that interrupts that. I have to decide if I going to break through that, go around that, or change direction?

Making decisions in real time about things that will impact his future is a serious endeavor for Sam, but he takes it in stride.

When all of a sudden out of left field it comes and you ask yourself what you are supposed to do with that? You have to figure it out. You can borrow on the past. I've been in this situation before. I've not had the skills I needed before. I've not known what to do before. I can figure this out. It'll take a little brain work. I may just need to let it sit for a while. Or I may need to actively get some training or consultation.

Each participant shared personal stories of adversity that had impacted the journey of their lives. The adversities they faced confronted them with moments of decision that became formative for what followed. In deciding how to manage the challenging situations they faced, they were forced outside their comfort zone and had to find strength, wisdom, and input from other sources. Those moments of decision wherein they drew from previous experiences and from future hopes helped them to develop permeable boundaries between the past, present, and future, equipping them with the ability to flow between them in ways that reflect their well-fought for resilience.

### **Supportive Sub-Themes**

The coding processes implemented through the data analysis phase led to the development of those two primary themes, as well as the emergence of nine sub-themes that supported those primary themes. Preliminary meaning units were generated from the participants' narratives. The nine sub-themes reflect the specifics of the lived experiences of resilience for these participants. These sub-themes include setting boundaries to protect themselves, implementing time limits to guard their energy, anchoring in relationships to enrich their hearts, practicing physical self-care to ensure health, connecting spiritually with what is

sacred, attuning to internal shifts to respond quickly, adjusting and adapting to pressures to minimize stress, using self-talk to calm themselves, and refreshing themselves by taking time off. Each sub-theme will now be discussed. They are ordered from the most common to the least common, as reflected by the numbers in parentheses. Each sub-theme is generously supported by quotes from the participant interviews.

### ***Setting Boundaries to Protect Themselves (12/12)***

All twelve participants indicated that boundaries were an essential focus in their lives. People engage in boundaries to protect themselves or their possessions from the negative impact of others (Cloud & Townsend, 2017). In this research, boundaries consisted of identifying emotional limits: what is the therapist's responsibility versus the client's responsibility, what are the limits of the job, what is within the therapist's control, what justifies having given one's best efforts even without positive results, what qualifies offering enough solutions, and what is the appropriate amount of empathy without letting client problems weigh excessively upon them.

Bob referred to boundaries as "the ability to cope with what is going on in your environment, life, and work." He continued, "In private practice, it is about emotional boundaries. My load is lighter if I don't take on stuff I don't need to. Being clear about what my responsibilities are and what the client's responsibilities are helps you not take on so much."

Char agreed, affirming that healthy boundaries are essential for her to function well in this job.

You can only do what you can, do your best, and leave the rest to God. If you don't know how to make that separation, I don't think you can be resilient. It's about good boundaries.... I can't be worried that my client is going to get high. There has to be good

boundaries in my heart to say I know I did my best. There's 24 hours in a day. I was only able to impact them for 45 minutes. Hopefully, that was enough.

Eva notices that while she used to blame herself for lack of client progress, now she refuses to take that on. "If clients weren't opening up, I would blame myself and think what am I doing that is making them uncomfortable? Now, I realize they can tell me if I am doing something that they don't like. I don't have to pry." Eva discovered the benefits of establishing emotional boundaries. "The same clients that used to drain the lights out of me I can now sit with easier because I have more differentiation and boundaries with them. The more you settle into who you are, you find confidence and rest in that."

Susie acknowledged that establishing healthy boundaries with clients is part of her ongoing work. She endeavors to have "a mindful awareness of what is happening inside of me. I have to track what is happening inside... I have to take care of myself." Part of her self-care involves boundaries: "Boundaries! I have to be really aware of where I stop and where somebody else starts. I have to check in with myself to make sure I'm not taking on someone else's stuff that isn't mine."

Ang reported that boundaries help her to honor herself while refusing to accept responsibility for her clients, for their successes, and for their failures.

Things will come and go. Clients will come and go. I'm not responsible for their successes or failures. I just don't take that on... what they do with this is up to them. I don't give myself credit for either. I want to be attentive and aware with how I can be better, but what they finally choose to do is not up to whether I am good or bad. I'm not responsible for them. I'm responsible to them. It reminds me to not work harder than the client, and to put responsibility back on them. If I am carrying the larger part of the load

then it doesn't move toward resiliency, but towards heaviness.... I don't have to step in to solve this. I try to keep shifting the onus back on them. That's part of it.

By interacting with her clients from this space, Ang is inviting them to practice resilience alongside her. They might not yet be aware that they can handle the struggles that they are looking for her to resolve, but by holding that space for them, she is giving them the gift of resiliency because she knows that there is something that they can learn to do. She referenced the Bible verse in 2<sup>nd</sup> Peter 1:3 which says, "His divine power has given us everything we need for life and godliness, through the knowledge of Him who called us by His own knowledge and excellence." Ang uses this verse with clients, saying that she aims to identify within her clients "that sense of agency and solution. For myself, I ask, "What is my agency in this?" And then I ask, "What is theirs?"

Eva made a simple remark that relates perfectly and sums up this theme beautifully. Quoting Brene Brown (2015), Eva said, "Boundaried people are the most generous." This means that people who honor their own boundaries are free to give generously to others because they are aware of what their yeses and no's need to be. When they say 'yes,' others can trust that they mean it. This applies to MHPs who can hold the space of healthy boundaries for their clients. In doing so, they are preserving their own energy to be the best therapist they can be, and they are also offering a generous gift of growth to help spur their clients on toward improved health and wellness.

### ***Implementing Time Limits to Guard Their Energy (12/12)***

All twelve participants mentioned implementing healthy time limits with their clients so that they could remain fresh and unembittered. This included ending sessions on time, limiting session frequency, restricting interactions with clients between sessions, limiting the amount of

preparation done prior to sessions, scheduling only a certain number of clients each day or week, and allowing sufficient time to pass before returning calls or texts.

Bob establishes a tight schedule instead of overworking. “I keep my schedule from 10-7 so that I can get up in the morning and spend an hour in nature.” He also limits his client caseload to 20 hours per week plus five hours of paperwork. This ensures that he is not fighting exhaustion from juggling too many stressful cases at a time.

Dylan also limits his work hours each week because he is acutely aware of his own ambitious tendencies. “There’s the siren call of more work but that would lead to more opportunity for burnout. When you have a fixed salary you don’t have that enticement. But, when I work more, there’s more that I can make.” He keeps a spreadsheet documenting his weekly and monthly hours and purposefully adjusts his weeks accordingly. “If I know I’m not going to work as much next week because we are hosting family, then I will hit it harder this week.”

Eva established new scheduling limits with clients due to her newborn’s sleep schedule. “I am a lot more firm with what I can and cannot do with people.” Many clients do not like her new schedule, but she is holding firm. “I am able to acknowledge my limits and not apologize for my lack of flexibility with my availability or my fees.”

Susie acknowledged the importance of setting time limits on her pre-session preparation for clients. “I’m going to give this client an hour of thought outside the room for treatment planning, and then I’m going to go with that. I’m not going to get lost in the perfect solution. I’m going to time frame this.”

Kate commits to ending her sessions on time so that she can enjoy a few minutes between sessions. “I nourish myself even if I only have a few minutes in between sessions. I make sure I

take a restroom break or grab a quick snack.” Honoring her own time limits ensures that she is not running frantically from one client to the next as the day progresses. She also has had to implement limits with clients who show up at her office outside of their scheduled meeting times, demanding more of her efforts and interrupting her time with other clients.

Ang allows a little time to pass before she replies to calls or messages. “I remind myself I don’t have to call them back in five minutes. I’ll let them sit with it longer. What do you need to do about it? I don’t have to step in quickly and solve this. I try to keep shifting the onus back on them.”

Meg utilizes phone calls instead of texting with clients because she realizes her tendency to overthink how to reply to client texts. “I can spend 30 minutes trying to figure out how to reply in a text. So I’ll make myself stop. I’ll take all that time I spent, erase it, and just make a call.” When she realized that she was not getting paid for the 30 minutes it took to think about how to reply to a difficult text, she decided she needs to protect her time and energy. She then decided to utilize text messaging only to quickly confirm appointments and uses phone calls for any serious or in-depth questions.

### ***Anchoring in Relationships to Enrich Their Hearts (12/12)***

Anchoring in relationships refers to valuing placed on relationships as an important part of enriching one’s heart. All 12 participants referenced the important role that family, friends, colleagues, and the general community held in their lives. These included things like quality time with family, fun times with friends, consistent interactions with co-workers, case consultations with colleagues, interactions with neighbors, socializing in the community, and social time involving clubs, hobbies, and other relaxing activities.

Bob expressed a basic value for meaningful “social connections, and for healthy and happy relationships with family, friends, and colleagues.” His marriage anchors him: “Going on long walks” with his wife and “spending hours watching the waves hit the rocks at their favorite beach” is part of how he grounds himself away from the stressors of the job.

Dylan emphasized how his marriage also grounds him when work feels tough. “Making sure I’m getting enough quality time with my wife and things like that... Making sure the marriage feels like it is in a good place.”

Ang echoed the marriage sentiments and how central that relationship is to keeping life light-hearted for her. “My husband and I go to movies, have a small group at church, have fun and laugh. I’m married to a comedian. So that keeps it fun.”

Meg mentioned her daughter as someone who helps her unwind and reboot when the work stressors begin to build. “A conversation with my youngest daughter always helps me destress. She unlatches from her stress by asking about my day. I spend a lot of time with her on her stressors so it’s nice to watch her shift and reciprocate a bit.”

Eva relies on friends and colleagues to help her. “I have a couple people that I reach out to often. I have a couple of friends who are not therapists and a couple of friends who are therapists who can hold me accountable... I don’t have a problem asking for help. I sometimes feel needy, but I can’t do life alone.”

Pat enjoys the strength that her mom brings to her when she is feeling drained: “It’s having people where I can unload everything with and lean on, who show up... my mom would show up and bring life to me and that really helped.”

Bob referenced the value that colleagues bring to him: “Obviously, a support system matters. Having professional colleagues to bounce stuff off of instead of carrying the full weight of difficult situations.”

Dylan lamented about the isolation of the job. “My least favorite is the isolation. I try to be intentional about relationships and balancing time. Because I’ve been in settings where I had more built-in co-worker interactions.”

Char also agreed with this, commenting on the loneliness that sometimes hits her due to privacy concerns. “I feel like it is really helpful to go to conferences of people who are like-minded, like the AACC, because I feel like we are not alone.” She elaborated on the unique stressors of the job that creates demand for colleague support:

We carry so much, all these heavy topics. There’s no one to share it with. Sometimes it is a huge painful burden to carry. Who are you going to share it with? Even if you have a group at church or something, no one really understands quite as much. I feel like there is limited support as therapists because we are talking about very confidential things.

### ***Practicing Physical Self-Care to Ensure Health (12/12)***

Physical anchors include any bodily or behavioral practices that ground people in peace and calm when they are feeling deficient, down, or defeated. All 12 participants referred to the essential healthy habits that are vital to their ongoing well-being. These activities included eating healthy on a regular basis, grabbing nourishment between sessions, getting enough sleep, engaging in grounding exercises, practicing breathwork, getting plenty of exercise, spending time in nature and at the beach, bodywork and massage, and giving themselves time to write, paint and sing.

At the end of the interview, almost as an afterthought, Tia commented, “Do I need to mention the obvious things like exercising and eating well? Because if you feel bad, then you won’t feel resilient.”

Ben said that being in nature recharges him; “Even before I was in this field I knew the outdoors did that for me.” Bob schedules his hours later in the morning so that he can get an hour of hiking in before work. “Nature and exercise” refresh him so much so that he prioritizes them daily. Meg values “rest, cooking, baking, and trying new things. Right now, this year, my big thing is Shabbat and trying to understand Shabbat rest.”

Eva engages in daily habits to invest in herself physically: “I make sure I wake up and make myself a cup of coffee and take a moment to just breathe. There was one week I went on a walk every day and listened to a podcast while I walked.”

Kate shared the self-care practices that she implements on a regular basis. “I nourish myself between clients, especially if I have back-to-back sessions all day.” When she notices she is starting to run dry emotionally, she “plans lunches with friends. I plan things where nobody needs anything from me.”

Ang takes a creative approach to her physical self-care. “I don’t want to go home and hang out with the Debbie Downers and the crisis-based folk. I keep that very minimal... Also, I write. I do a lot of creative writing. I’m in a writer’s group.”

Susie relies on breathwork to keep in touch with her body. For her, “exercise promotes resiliency... taking care of my body promotes health. Exercise, eating well, self-care. I try to do massage at least every other week... Those are all resiliency-building realities for me.”

Dylan keeps a spreadsheet to track his regular behavioral choices. His tracking efforts are for the purpose of building solid habits and a meaningful existence.

I keep a spreadsheet that I update every day, so I know what is optimal for me. I know how many people to see in a week or a day. I know what good health looks like...

Wanting to collect data was because I wanted to get a sense of what are my busiest months? What are my healthiest weeks? I track that work stuff daily. How did I sleep last night? How many steps did I take? Did I exercise? Did I read the Bible and pray?

Dylan continued:

Personally, I am always looking at stuff for the life-giving meter. What things make me happy and make me feel like I'm thriving? Finding ways to make sure that I'm inserting those in life and don't let them go too long without doing them. That's why I keep my spread sheet about exercise. I didn't exercise that day. Ok, two days in a row. Then I know I make sure I go do something. I love to bike so this year I'm going to bike 2,000 miles. I check how many per month/per week and that helps direct me. I stay resilient when I'm doing certain things. For me, it's exercise. It's curiosity. It's reading. If I couldn't listen to podcasts, I would die... A good sermon, a good interview. I'm also very much an introvert. Going out on a ride and listening to a podcast is when I feel life coming back inside of me.

Although Dylan's commitment to maintaining his daily spreadsheet takes self-care and anchoring to a new level not represented by the other participants, the theme of intentionally seeking that which is edifying and meaningful, that which brings relief and refreshment, joy and recentering, was evident by all.

### ***Connecting Spiritually with What is Sacred (11/12)***

Connecting spiritually with what is sacred to them was a significant way that these MHPs anchored themselves despite the storms of life. Eleven of the twelve spoke extensively about the

central role their faith played in their daily lives. Their spirituality provides a sense of connection, meaning, and relief. This included spiritual practices that focused on relating to God, Jesus, and the Holy Spirit. Reading the Bible and engaging in prayer and meditation were also prioritized. Practicing mindfulness and other Christian virtues like patience and kindness, were mentioned as well.

Every morning Susie tries “to do meditation and reads Scripture.” Her “spiritual fitness” matters to her: “meditation, prayer, and Scripture, and trying to connect with the things that fill my tank, with things that bring me joy.” Spirituality is integrated into how Susie thinks about all aspects of her life: “her body reality, her thinking reality, her feeling reality, and her behavioral reality.”

Char actively relies on her faith, “If it is really heavy, then I take a mental and emotional shower. I pray for God to cleanse my mind and my eyes, my ears, my heart... I think of it as cleansing prayer.”

Tia is committed to her daily quiet time. “Almost every morning, I have my quiet time. I meditate. I trade off writing in my little gratitude journal, or sometimes I’ll just have my bench time with Jesus where I just sit and listen. Sometimes I’ll read my Bible.”

Bob’s relationship with God is of central importance to him. He thinks of “the idea of constant prayer as an open channel,” but also finds comfort in the spiritual disciplines because they have been around for a long time.

Meg agreed, sharing her love of meditating on Bible passages: “Meditation came from the Bible. You see it all over the Psalms.”

Char leans on her faith in the context of the day-t- day pressures of doing this type of work. “I don’t know how people do it without the Lord. It’s so heavy. I don’t know how we

could do it. We have to know that God has a bigger plan.” Her faith directs what she does in the therapy room:

I believe that counseling is like a deliverance. We are doing deliverance work with words. So we can come up with all these different goals and whatever, but at the end of the day we need to speak Jesus over it... I speak Jesus over anxiety, over fear, and depression. The song “Speak Jesus” by Charity Gale is like my anthem. I listen to it on my drive to work. I have to. The song says when your presence is there, there’s peace. There’s a peace in your presence and all sorts of things.

Ang echoed Char’s ideas about her faith in God serving as an anchor in the counseling room:

Resilience has a spiritual component to it which I rely on. I may show up on a day and that day is going to take this much- and I only have this much. So God, you are going to have to fill that gap, somehow, someway. Part of my resiliency is I have to have a faith and a trust that I can rely on something other than myself, and that God always shows up.

Pat’s faith helps her to apply Scripture to her own struggles and the struggle she watches her clients make:

I don’t do a lot of incongruency... If I get something, then I’m compelled to do it. But I know a lot of people who say, “Oh, I get this but I’m doing this.” I get how people have a difference, but I have to step out of myself. I still relate to Paul in Romans 7:15, “For what I want to do, I do not do, but what I hate, I do.” I think we can guide people to practicing different types of behaviors and it would bridge the gap between what you want and what you believe and what is actually coming out in your behavior.

Bob relies on his faith to provide a worldview which grounds him in his identity in Christ instead of feeling constantly swayed by others. “In dealing with people. I guess the word in all of this is patience. Kindness. I have to apply that as consistently as possible regardless of how other people might behave. I guess that is the idea of differentiation.”

***Attuning to Internal States to Respond Well (9 of 12)***

Attunement refers to maintaining a focus on one’s internal barometer that regulates healthy coping and balance in one’s life. Nine participants referenced this idea which includes paying attention to one’s internal state of being, remaining aware of small changes within oneself, and intentionally maintaining an internal balance. They regularly pause to consider the internal perceptions or feeling states that they are sensing or experiencing.

Dylan described attunement as “an internal gauge” and said that he could easily notice when he was functioning sub-par. He can feel it when his curiosity is lacking, and this alarms him because it is a marker for his overall motivation levels. “Burnout is losing vigor and zest for work. Losing some passion for it. It feels burdensome, like I don’t have energy for it. I feel fatigued. I don’t have as much compassion or empathy.” He purposefully stays attuned to his own pain so that it does not overcome him when he is with clients. “I think, in some way, shape, or form you have to know what pain is. You have to navigate through some circumstances on your own... If you do, you can leverage it to do this job well.”

Eva notices her internal warning signs, saying it is like “preparing for a storm.” Instead of getting battered by the storm, this awareness leads her to ask herself, “What do I have to do to survive this storm?”

Bob reflected on a time when he became aware that the pressure he felt to work more was so that he “could afford a bigger lifestyle.” Ultimately, his attunement led him to resist that pull and the pressures that would have placed on him to overwork in order to buy worldly goods.

Tia’s attunement led her “to notice feelings of apathy and tiredness,” traits she typically does not have, and this helped her identify that she had been overworking.

Meg’s internal attunement monitors her feelings of heaviness at the end of a long workday. “I give myself time in the office after clients are done. I want to get done with whatever duties came up during the day... If I know my heart is heavy, then I deal with it.”

Bob’s attunement leads him to maintain a healthy balance in life. He believes in preventative living, meaning that he aims to stay aware that “things are coming at you that could potentially push you off balance. But, you are tuned into it, and you can respond to it, so you are not so far out of balance, out of range.” To him, resilience “has to do with having some reserves, paying attention to what you are dealing with and maintaining that balance... the basic ability is to maintain your balance.” He used the metaphor of walking to explain the necessity of balance:

In terms of walking and keeping your balance and internal stability. There’s a lot of overlap there. Internal stability is a huge component of resilience. One has to ask what is destabilizing me internally: other people’s judgments, my own expectations, my own self-criticism? All these things tear me down. The idea of being able to establish myself and who I am in God is an anchor point. Then the other stuff doesn’t affect me so much.

Ang used the metaphor of tipping the scales to explain her internal modulator that alerts her when she has done too much. “Burnout is when I know I’m not at a performance level or balance level. It has tipped so I’m feeling way off my game.”

Pat said, “it takes intentional effort” to manage her professional responsibilities and to keep connected in “collaboration and consultation with other professionals.” Because she is attuned to her internal stress levels, she knows she would “miss that chance to decompress” with other therapists, and therefore keeps peer consultation as a priority in her regular schedule.

Sam said there is a virtue found in balance. He explained that while it is impossible to avoid all adversity and difficulty in life, his goal is to “avoid unnecessary adversity, to not invite it” into his life. He advised, “When necessary or prudent, engage in it and know that it is worth it, even if it takes a toll on you, but in the long run it will give you that strength to regain your balance and move ahead.”

Dylan agrees and sees value in maintaining a healthy balance in life. “Are you living by design or by default? Am I letting life to just happen to me?” Tia’s internal attunement centers on “cultivating gratitude.” She endeavors to teach people to “intentionally think about the positive that is going on in their life as evidence that they can expect more good things to come their way.”

Kate recognized the role that balance plays: “When I start to notice burnout, I start to integrate balance again. All work and no play is not good.” She said, “As much as I love my husband, kids, and clients, I intentionally plan activities where nobody needs anything from me.”

### ***Adjusting and Adapting to Pressures to Minimize Stress (6/12)***

While becoming aware of an internal state of being is helpful, it is often not enough unless it leads to action. Six participants spoke of the need to adjust or adapt themselves to whatever situations life throws their way. While adjusting to something refers to typically small changes that can occur relatively quickly and are temporary, adapting to something suggests bigger changes that typically take more time and effort to make. When it comes to the topic of

burnout, these professionals were quick to take action. This included making small changes, committing to take action steps instead of staying stagnant, learning to cope with what they don't like about situations or people, learning new skills that will help them or others, and committing to grow into being a better person despite the discomfort involved.

Susie struggles with addressing burnout when she first recognizes it. "It feels very oppressive at times... Where I could be better at it is with the awareness of the internal apathy... I need to battle it with action before it shows up in a bigger way."

Pat has learned from experience to battle burnout as soon as she notices it, because her internal monitor alerts her. For her, it presents as utter exhaustion, where she has nothing more to give. "I need a break... I guard against it on the front end... I will only book 20 a week, only five clients a day. Yesterday, I did six, and I'm spent. So, I don't consistently do that."

After being diagnosed with MS nine years ago, Ang made adjustments to protect her energy and health. She had to talk herself into making changes "so that work could be sustainable for her." Otherwise, she might burn herself out and not be able to work at all. She reduced her work week from five days down to two days. Ang adapts to the limits of her chronic illness because she wants to keep working for as long as possible.

Kate also makes adjustments quickly. "I try to keep my day to no more than seven clients. Eight is too many... I know I just can't do more in one day."

Dylan admitted that he struggles with taking on too much. A few years ago, he worked at three office locations. "I was spreading myself out too much... and I had to make some cuts." This led him to drop two locations. By adjusting to the warning signs of feeling spread too thin, he made healthy changes and prevented burnout.

The motivation to make changes for these clinicians often came from realizing the danger of what could happen to them if they did not make adjustments. They displayed an acute awareness that to ignore internal warning signs could lead to “a slow fade,” or “a subtle drift” toward inattention and inaction (Dylan). Kate caught her “slow fade” due to a demanding client.

This was a lesson well-learned because I didn’t know how much I was burning out until I discharged her. It was a huge relief. Then I noticed my enjoyment for the work coming back. It sounds ridiculous that one client could cause that, but it was a crazy situation.

When Meg lets things slide, “it starts off slow with fatigue levels, but it builds if it is not tended to.” Aware of her warning signs of burnout, she admitted that “all the caregiving in my life meshes and it turns into one mass of caregiving. It becomes a blob of intensity, a lot of tears. I’m feeling overwhelmed and tearful and can’t turn anything off.” She tries to prevent this by committing to “not take the stress home with her.” After hard days at work, she adjusts her evening routine to make sure she can dump her emotions on the way through listening to worship music, stopping to take a walk, or engaging in a meaningful prayer time. She has learned that she must adjusting to the stressors quickly instead of letting them accumulate.

Bob also recognizes the signs of burnout in his own life. “Burnout involves the energy it takes to put toward something. Either I can lose the source of the energy or the task itself can become overwhelming. Either one can tip the balance and then you are running on fumes.” For Bob, life is about “maintaining the balance, being able to monitor where you are, and making adjustments before the scale tips.”

And finally, Dylan, who used a driving metaphor to explain his warning signals:

What happens when you drive is you hit things and the car goes out of alignment. When you let go of the steering wheel the car just begins to drift to the right. So, resilience is,

when I let go of the steering wheel, how do I pull back straight because I'm starting to drift, and I need to get back on track? Life pulls. Life does not want me to go straight. It pulls me so you have to be really intentional about saying no and how do I overcome that pull... If I don't address it, it is going to pull me in more and cause me to drift more.

### *Using Self-Talk to Calm Themselves (6/12)*

This theme reflected in the participants' narratives about resilience-oriented mindsets focused on self-talk. Self-talk refers to internal dialogue, the things that individuals say to themselves (Kendall & Treadwell, 2007). Though self-talk varies from person to person in terms of content and frequency, it is universally recognized as a regular cognitive process in which people engage (Kendall & Treadwell, 2007; Senay et al., 2010). When these MHPs shared their stories, their narratives were often peppered with moments of self-talk. It was a naturally occurring process. This included engaging in positive self-talk, practicing affirmations, catching negative self-talk, changing critical self-talk, practicing self-compassion, talking aloud to oneself, asking oneself hard questions, taking their own advice, shutting down perfectionism, and aiming for good enough.

Ang affirmed, "I'm a very prayerful person. So, when I am dry or flatlining, then I think okay, "If I was sitting on the couch, what would I say to myself? What advice would I give to Ang, and then I do the things that I know nurture and replenish me."

Char used self-talk to encourage herself when she doubted whether she had what it took to continue in this job. She would remind herself "that God did not make a mistake in putting me in this job." She reminds herself to "focus on facts, not on feelings" and that keeps her oriented in the right direction during tough moments.

As Tia spoke, examples of her self-talk slipped out. “Somehow construct a narrative for yourself that makes some kind of sense to you. And it leads you to make a new plan.” She said she talks herself into “a can-do attitude... I think it is a belief. It’s a pre-determined belief that somehow it will all work out.” Positive self-talk empowers her to keep her head up when she is feeling discouraged. Other times, self-talk jolts her out of complacency. “There was a time when I didn’t have peer consultation in place for a period of time, I woke up one morning and said to myself, you are not being very smart just skating all by yourself.” This led her to make some calls and find safety in the support of colleagues.

Kate struggled to finish college when she was younger; she took a semester off two different times hoping to ignite “a want to” within herself. Although extremely discouraged about it, she used self-talk to shift herself into a different mode. “I said to myself, I know I won’t ever feel like it [finishing school], but do it anyway. I’m gonna get there some way, somehow. Chip away at it, just chip away at it.” This constructive self-talk got her through the hard months, and eventually she graduated.

Eva uses self-talk when she feels overwhelmed. She has to pay “attention to that small voice in your body that says, ‘Hey, I’m good. We need to chill out a little bit. We need to take a minute and reflect.’” Self-talk reminds her to pause and to engage in self-care, which results in the self-soothing that she desperately needs.

When in a tough moment, or when confronted with self-doubt that paralyzes his professional decision-making skills, Sam also relies on self-talk.

When I clinically encounter a situation where I am not fully equipped for, which happens all the time, not because I’m a bad therapist but because every situation is that unique. I need to say to myself, “What do I need to do for it? Is it close enough that I can figure

this out?” I think the resilience comes into my ability to maintain confidence in myself without going, “Oh, what’s wrong with you? Why didn’t you know how to handle that better?” Negative self-talk that might occur. But, resilience says, “No, this is normal. What your job demands of you is extremely difficult... Inevitably, there is gonna be something that comes up.” I would expect that will happen the rest of my life. Where in life, generally, you go, okay, I think I got this. This is pretty good. Then all of a sudden out of left field it comes, and you are like, “What? What am I supposed to do with that?” Then you have to figure it out. You can borrow on the past and say to yourself, “I’ve been in this situation before. I’ve not had the skills I needed before. I’ve not known what to do before. I can figure this out. It’ll take a little brainwork.”

Sam demonstrated an entire conversation where he moved himself from discouragement toward hope. By giving words to his doubt, he talked himself out of it. Through self-talk, he stirred up a growth mindset that empowered him to learn what he needed to learn in order to do his job well. Each of these participants used self-talk to move themselves from a place of doubt or discouragement toward hope and possibility.

### ***Refreshing Themselves by Taking Time Off (5/12)***

There is a cost to taking time off when you work as a therapist because there is no one who can fill in for you in your absence. These participants cited this pressure as part of the relentless demands that make this job challenging. Their answers about the best characteristics and the hardest characteristics of working in private practice emerged as unexpected themes and are located in Appendix H. Despite the pressure, five of these participants reported that taking time off was an important part of their resilience-building behaviors. These behaviors included going on vacation with their spouse, going on vacation alone, and taking extra days off.

Vacations are a meaningful investment in Meg's ongoing sanity: "It has to be the right type of vacation. You can't go with just anybody. You have to be able to get enough time alone." What she enjoys most about the right vacation is "getting utterly lost in nature and getting alone time... In March, I went to the Galapagos Islands with my daughter. We spent time together, but she took classes, so it was perfect. I got some time alone. I just got to be."

Ben is committed to taking vacations with his wife because it is a chance for him to completely unplug and recharge. They have a favorite city up the coast that they frequent 3-4 times a year. "Sometimes we take another couple with us. We go on long walks, sit on the rocks, look at the ocean. I find that incredibly restorative for me."

Dylan likes to plan in vacation days and occasional trips because it motivates him to work hard on the in between. "If we have people coming into town and are hosting them, then I like the freedom of taking off a few days to show them around."

The flexibility of taking time off is appealing to Tia right now too. Her husband recently retired, and she is finding it increasingly difficult to get up and leave for the office when she sees him sitting at home in the morning enjoying his coffee. She loves her job and has never faced burnout before, so this lack of motivation to go work is shocking to her. "I am not sure if I am experiencing burnout or if my lack of wanting to come to work is because my husband is at home now and I want to stay with him... It's such an odd feeling." Because of this, she is reworking her schedule so that she can reduce the number of days she is the office.

Sam loves running his own private practice precisely because he can decide to take off a few days next month and he doesn't have to ask anyone for permission. "I just let me clients know this week that I will be gone in two weeks, and we schedule around those dates. And then I just go. It's wonderful."

The nine aforementioned sub-themes reveal the lived experiences of these MHPs and the stories they decided were important to tell in regard to the phenomenon of resilience. The stories shared in phenomenological research include the sometimes mundane, often ordinary, experiences of each person's life. However, in pausing to listen to what is being shared, it gives value to it and reveals the meaning that it holds for the person speaking. Table 2 displays the nine sub-themes according to the participant responses.

**Table 2**

*The Supportive Sub-Themes*

<b>Themes</b>	Bob	Dylan	Eva	Kate	Susie	Ang	Ben	Sam	Char	Meg	Tia	Pat
Setting boundaries to protect themselves (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Implementing time limits to guard their energy (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Anchoring in relationships to enrich their hearts (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Practicing physical self-care to ensure health (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Connecting spiritually with what is sacred (11/12)	X	X	X		X	X	X	X	X	X	X	X
Attuning to internal states to respond well (9/12)	X	X	X	X		X		X		X	X	X
Adjusting and adapting to pressures to minimize stress (6/12)	X	X		X	X	X						X
Using self-talk to calm themselves (6/12)			X	X		X		X	X		X	
Refreshing themselves by taking time off (5/12)		X		X			X			X	X	

### **General Narrative**

Collectively, the participants' interviews revealed insights into the pervasive experience of burnout that thwarts mental health professionals in private practice from excelling in their craft. The constant pressures they confront due to being the sole proprietor responsible for the entirety of the business demands as well as for the mental and emotional care of various clients in desperate or fragile states extols costs of burnout upon these practitioners that must be adequately addressed in order to protect their valuable resource in the mental health community. The phenomenon of resilience answers the call of burnout and offers a viable solution for the varied presentations of burnout that assaults MHPs in private practice. Synthesizing these narratives painted a picture of the phenomenon of resilience and how it can operate as an evidence-based construct beneficial to the MHPs who work in a private practice setting.

In the same way that the burnout syndrome has common components that affect people, impacting their mental, emotional, and physical capacities, resilience also addresses those same capacities in people but resources them in ways that bolster the strength it takes to withstand the deleterious effects of burnout symptomology. Resilience empowers clinicians to live from their best sense of self. This includes living with a defined sense of purpose that attributes meaning and direction to their lives. Resilience enables MHPs to engage in a healthy amount of risk-taking that expands one's positive contributions in the world, both personally and professionally. When combined with a motivating impulse to learn and grow, it leads to new opportunities that challenge their comfort zones and compel them toward new adaptive responses (Duckworth, 2018).

Resilience invites clinicians to access valuable lessons based on their past victories with the goal of applying those insights to current struggles. This postures them to remain grounded in

the reality of today with an open stance of how to respond authentically and accurately to current situations instead of according to previous habits of responding (Miller, 2017). This is a valuable professional skill so that personal experiences do not dictate the counsel given to others during their stressors and crises (Smith, 2015). When combined with a future-oriented perspective, this fuels them to fight the good fight now for the sake of future promises based on the person they want to become and the goals they want to achieve. Keeping their past, present, and future time segments permeable ensures their ongoing ability to flow fluently between them, drawing from the wisdom held within each and maximizing their ability to cope with the predictable stressors and strains of their career more effectively.

Regular habits of self-reflection lead to positive outcomes and enhanced self-worth for mental health practitioners because it leads to a healthy work-life balance. The World Health Organization (WHO) labels burnout as a life management problem (2015). Since burnout is highly correlated with occupational stress and overinvolvement in the workplace (McGhee, 2017; O'Connor et al., 2021), these habits of establishing boundaries to protect their physical energy and implementing time limits to guard the energy they expend on work-related demands decreases clinicians' vulnerability to burnout. By anchoring themselves in healthy relationships with loved ones and prioritizing time spent with colleagues and friends, MHPs can enrich their hearts in ways that equip them to share care and compassion more effectively with clientele. By connecting spiritually to what is sacred to them, clinicians can live more fully attuned to that which invigorates their souls, enabling them to help others navigate their own spiritual journeys. By learning how to adjust to the ongoing pressures of life, they learn how to minimize their own stressors, using positive self-talk as an effective coping skill that promotes both positivity and possibility. Refreshing themselves by taking time off assists MHPs in sustaining the internal

stability, both mentally and emotionally, that is necessary so that they can meet the high demands of compassion and empathy that are required in this profession (Eliacin et al., 2018). This directs them away from maladaptive coping mechanisms that would otherwise keep them stuck in under-functioning, and shifts them toward adaptive responses that lead to better health and well-being.

Resilience-promoting mindsets and behaviors do indicate resilience, but do they comprise the totality of the essence of resilience? The gestalt theory states that the whole is greater than the sum of the parts. When applied to the phenomenon of resilience, it would suggest that resilience is more than the sum of the resilient mindsets and behaviors that people practice. Many people engage in those same mindsets and behaviors without developing resilience in their lives. So what is the difference? These findings revealed that the phenomenon of resilience transcends merely practicing mindsets and behaviors. Participants described moments when they made a conscious decision, a moment when they paused. There was the presence of a possibility, a hope, or a nudge that percolated some sort of ‘what if.’ Something unspoken occurred. There was a transfer of energy from *what was* to *what could be*? They responded to that nudge with a willingness to try a different way of thinking or a different way of behaving. This decision to pivot from stress toward solution, from pain toward possibility is part of the essence of resilience. Resilience includes not just the mindset or behaviors acted upon, but also that moment of awareness when they paused in the midst of the trajectory that they were already positioned to fulfill. This pause invited them to entertain a new thought, a stirring of possibility, a tinge of hope, a quirky “what if?” This pause then led to make a conscious decision to pivot toward a different trajectory. Their ongoing use of resilience-building mindsets and behaviors was then evidence that they had already responded to that internal nudge that led them to pause,

to pivot, and to seek new inputs. Therefore, resilience is more than the sum of mindsets and behaviors. The phenomenon of resilience includes a pause and a pivot. It helps people exceed their past limitations of thinking, choosing, and behaving, helping them to reset their future trajectories and reach new horizons.

### **Research Experience**

The participants shared descriptions of their lived experiences, revealing unique and exquisite details of the stories of their lives. After gathering their data and analyzing it, the two primary themes and the nine sub-themes emerged. Through synthesizing their individual experiences, coalescing them into a collective whole, the transcendent nature of the phenomenon of resilience emerged. Just as Moustakas (1994) writes, “Phenomenology, step by step, attempts to eliminate everything that represents a prejudgment, setting aside presuppositions, and reaching a transcendental state of freshness and openness, a readiness to see in an unfettered way” (p. 41).

Freshness and openness are powerful words that reflect my experience of this group of participants and the energy exchanged during the interviews. As I asked them questions pertaining to resilience and observed their responses, I was struck by more than just their words that flowed forth. Of course, the narratives matter because they convey the meaning ascribed to the pivotal experiences in their lives. But the real essence of the topic of resilience extended beyond their spoken words into an unspoken realm. It is possible to feel the energy shift when someone begins to share about an emotionally challenging situation in their lives. The unspoken heaviness that hangs in the air can be perceived despite an attempt to sound positive or upbeat. Body language and other non-verbal behaviors communicate strong messages that will either support or oppose the verbal message the speaker chooses to use to describe their experiences.

Although I asked these participants difficult questions which compelled them to revisit their own private moments of pain, trauma, and adversity in their lives, no emotionally heavy moments ensued. Instead, as I bracketed my own expectations, I was intrigued by the outcomes. Although each participant shared personal stories of challenging or traumatic experiences, the emotions attached to their stories did not reflect overwhelming pain. Instead, hope emerged. Each participant began to noticeably engage at a higher level of energy as the interviews continued. They began to lean forward, anticipating subsequent questions, while also thoughtfully concocting long, eloquent answers in return. Instead of noticing an energy drain as they reflected on the darkest and hardest moments of their lives, I witnessed a stirring up of something, albeit a passion of some sort, which ignited them to share their heartaches but from a happy place. By asking them to share their hardship through a filter of resilience, an empowerment occurred. I heard them reframe what they learned and how they grew as a result of the hardest experiences in their lives. It evoked an excitement in me that this topic of resilience was so life-giving.

The heart of resilience is indeed positive. It celebrates the strength of the human spirit to endure horrendous experiences and to come out the other side stronger from the victory. It is one thing to read about it, or even to experience it personally in my own life, but to watch individual after individual, 12 in a row, reflect on the life-infusing power of the phenomenon of resilience was profoundly unique. I felt like my own battery of hope for humanity had been recharged when I exited each interview. The light-hearted but rich exchanges empowered a radical sense that nothing was impossible for the human spirit who embraces resilience. I exited each interview feeling strengthened by the incredible stories I heard. The contagious power of resilience was evident. The essence of resilience is reflected in its life-giving presence. The

afterglow of positivity and hope that remains after hearing stories of overcoming demonstrates the transcendent power of resilience.

The phrase “growth mindset” was not something I used with the participants, but two participants used the phrase themselves. Dylan recalled, “I think you have to have a growth mindset about life... If you are not forward thinking then it is easier to become complacent in your life and just let circumstances happen.” Pat also referenced a growth mindset. She admitted that she “intentionally maintains a growth mindset.” She does so by finding lessons “in the hard stuff... To take from it and use something for the positive. Being able to see something that’s positive in it that I can use in the future.”

Although they did not use the term growth mindset, the other interviewees spoke of the importance of having a positive, hope-filled, optimistic mindset. They were actively looking for lessons to learn and ways to grow from the struggles they faced.

Kate described it as, “positivity, as simple as that. I do think that resilient people find the silver lining. They don’t get into a victim mentality.”

Tia explained that a positive, optimistic mindset has helped her, personally: “Yes, that kind of worldview that it is going to be okay. It’ll be okay. That thinking is a gift.”

Meg posited that while a growth mindset doesn’t come naturally for most people, she is intentional to pursue it herself because she values internal growth over internal comfort zones.

Sam said that values are the precursor to mindset because what someone values determine what they are willing to work for. “You have to know your values which help you know your goals which help you have your mindset.”

Eva values personal growth over the false comfort of thinking she has life all figured out. Because of her desire for growth, she listens to weekly podcasts that reveal uncomfortable truths to her so she can identify her blind spots and become a more whole person.

Ben continually learns from those who have gone before, who have faced significant tragedies because he believes their stories teach us how to develop similar mindsets: “I have a pretty strong belief system that human beings are far more resilient than people believe they are.”

Ang’s perspective encapsulated the idea of a growth mindset by limiting the power that someone gives to an adversity by not actually naming it an adversity. To Ang, “adversity is a perception... that something is going against what I like, what I want. Adversity can come in a variety of formats and situations. But mainly, it is getting in the way or stopping me from balance or health, and it keeps me off track.” By not naming hardships as adversities, it helps Ang to not feel victim to hardships. She does not give her power over to them. Adversity is not a fixed reality. Rather, it is a perception based on her mindset. This enables her to find solutions instead of feeling stuck.

Someone with a fixed mindset could feel overwhelmed by hardship because the situation holds the power, but someone with a growth mindset believes that whatever skills are necessary to overcome the adversity are well within reach. This allows for hope in the midst of hopeless situations. It invites solutions. It compels action. It stirs life. This is resilience. It is multi-faceted. It reflects the beauty and capability and unlimited capacity of the human spirit to grow and thrive despite disparaging defeats that seek to make people feel small or incapable. The collective experience across all of these narratives communicates quite the opposite. Adversities do not get to have the final say. They do not get to win. Instead, adversities can offer people the opportunity to twist and turn, to wrestle and stretch, and ultimately, to overcome. Resilience can

produce new traits in them that were not there before. Resilience is a creative, life-giving force that overturns destruction and defeat. It creates champions who rise out of fiery trials. It enables people to become an unstoppable force because they build their own belief in what is possible. By expanding their capacity to confront challenges, they become infused with solution-focused forces of hope and possibility that multiples their resources for subsequent struggles.

### **Summary**

This chapter presented the research findings from 12 mental health practitioners who have experienced the phenomenon of resilience. Though diverse in their backgrounds and life situations, their experiences were individually and holistically assessed to reveal the essence of the phenomenon of resilience. This transcendental phenomenological study sought to describe phenomenon of resilience among these MHPs. Resilience-promoting mindsets and behaviors were shared that highlighted their lived experiences of resilience. But the true essence of resilience extended beyond the stories they told. It was also revealed through the experience of their storytelling. Their presence reflected resilience beyond the words they chose. Resilience is a complex topic, one that has perplexed researchers over the decades. These findings set aside those debates and focused instead on the refreshing winds that percolate when the topic of resilience is discussed. Resilience is not a dead construct. Rather, it is a living reality that empowers people with energy, hope, and action. Watching these participants come alive as they described difficult experiences emphasized the fact that resilience is a profoundly life-giving subject, one that titillate its hearers with the hope and possibility that still exists among humanity even amidst dark seasons of adversity. Their stories of overcoming sparked levity and laughter as they reflected upon how their toughest challenges produced vital character strengths and virtues within them that they deeply value and cherish today. Their collective ability to reflect

upon and reframe their darkest life moments into beacons of hope revealed the power inherent within resilience, and the contagious quality of its essence when shared with others.

## CHAPTER FIVE: CONCLUSION

### Overview

The purpose of this phenomenological study was to describe the lived experiences of resilience in MHPs working in private practice. There is a dearth of previous research on clinicians in private practice who confront burnout. In light of the extant literature, a discussion of the findings is examined, followed by implications, delimitations, and limitations. Finally, recommendations for future research concludes the chapter.

### Summary of Findings

This phenomenological investigation into the lived experiences of the phenomenon of resilience among MHPs working in private practice revealed two primary themes, “Operating from Their Optimal Self” and “Flowing in Temporal Fluidity” as well as nine supportive sub-themes. This study’s three research questions provided a framework to understand the phenomenon of resilience presented through the participants’ “reflections on their pre-reflective experiences” (Adams & Van Manen, 2017, p. 784). These research questions were thoroughly answered by the content provided from the primary and supportive themes. Appendix I includes the Interview Data Summary by Research Question.

### **Theme 1: Operating from Their Optimal Self**

The primary theme “Operating from Their Optimal Self” reveals the participants’ desires to live from their best sense of self. This involves living with purpose, attributing meaning to one’s life, and investing in oneself in ways that maintain one’s full capacities and capabilities. An optimal sense of self is also marked by a confidence that facilitates risk-taking that expands one’s positive contributions in the world. Optimal self-esteem has been defined as “genuine or authentic self-esteem” and is characterized “by a lack of defensiveness, strong interpersonal

relationships, and a realistic positive self-evaluation” (Stronge et al., 2016, p. 58). In contrast to a narcissistic sense of self, which reflects entitlement and superiority, an optimal sense of self is accompanied by “low levels of psychological entitlement” (Stronge et al., 2016, p. 59). This authentic self-esteem was evident throughout the responses from these participants.

These participants possess habits of self-reflection that compel them to make deliberate decisions in their daily lives that lead to positive outcomes and enhanced self-worth. These habits include establishing healthy boundaries to protect their physical energy and health, detaching their minds from negative spirals that escalate stress and distress, and guarding their hearts from heavy emotions that breed anxiety and despair. These participants are not immune from hardship; they are well aware of the constant stressors that press in upon them that carry the potential to overturn their stable functioning if allowed. Instead, they have learned how to identify these pressures from afar and they position themselves a safe distance away. This grants them the breathing space to deliberately choose how to handle the different stressors instead of feeling overwhelmed by them. This reflects a proactive resilience that enables them to resist the symptoms of burnout that could otherwise easily encroach.

Collectively, these participants spoke of attuning to their own internal, emotional states. This enabled them to adjust and adapt to the pressures they faced. Showing compassion toward their own limitations instead of overextending themselves in ways that did not serve them well, they spoke about doing the best they could in tough situations, maintaining a positive outlook despite hardship, and sustaining internal stability mentally and emotionally. Using self-talk to calm themselves, they challenge their own negativity and don’t allow themselves to sink into passivity. Taking action instead of staying stuck in inaction, their answers revealed a motivating impulse to learn and to grow. These individuals are industrious to feed themselves information

that satisfies their inquisitive minds and that helps them move forward in life. Driven by a dream to live from their optimal self, it is not for selfish ends. They desire to model it in ways that encourages others to embark on their own discovery of their optimal self too.

### **Theme 2: Flowing in Temporal Fluidity**

The second primary theme reflected in the data was “Flowing in Temporal Fluidity.” It included ideas of learning how to live in the present moment, fully available for all that is transpiring. It also involved not being disconnected from the past because valuable lessons can be gleaned to help navigate current struggles. This theme also included preventing oneself from projecting current woes onto the future because much can transpire to shift future outcomes based on wise present-moment decision making. These participants displayed a fluidity among the timeline of life, offering hope by drawing insights from the past to energize themselves again. This was particularly helpful when they rehearsed God’s faithfulness in the past as it invigorated them to trust Him again for their future.

This group revealed an adept ability to think of time not in a linear way, where they felt trapped by the past or disconnected from their future. To be humble enough to learn from past mistakes, while also envisioning future goals, capitalizes on this idea of temporal fluidity. They can synchronize themselves through accessing the past, present, and future in this way and it leads meaningful outcomes. MHPs also revealed intentionality with short-term and long-term goal setting. Whether it was for personal or professional ends, they spoke often of the future and of the person they wanted to become as well as the goals they want to achieve. These goals did not reflect a half-hearted belief. Rather, they were rooted in the deeply held values they have cultivated in their hearts and lives. Their reliance on physical, spiritual, and relational anchors helps them to access wisdom from their past that grounds them in the present through reminding

them of the previous hardships they have overcome. They project those victories onto the future through visualization techniques, fueling themselves to fight the good fight now for the sake of the future promise of what it could lead to in the future. This ability of accessing both the past and future in the present moment maximizes their ability to effectively cope with stressors and strain, propelling them toward a trajectory of growth and success.

### **Discussion**

The purpose of this discussion is to compare the findings from the current study to the empirical and theoretical research presented in Chapter Two. The empirical research and pre-study literature regarding burnout and resiliency among MHPs provides context for the discussion of this study's findings. A theoretical discussion related to these findings concludes this section.

### **Empirical Literature**

#### ***Confirming Previous Research***

Previous burnout research indicated a threat to MHPs due to the emotionally intense nature of their work and the serious and chronic demands placed upon them (Elician et al., 2018; Sodeke-Gregson et al., 2013). Work-related stressors impose a cost upon mental health providers, often resulting in decreased job satisfaction, lowered job performance, and hindered client interactions (Dorociak et al., 2017; Halevi & Idisis, 2018; Hammond et al., 2018). The personal lives of MHPs are also negatively impacted, plagued with reduced quality of life, as well as increased burnout, sick leave, and frequent turnover (Haramati et al., 2017; Lakioti et al., 2020). The professional and personal costs of burnout are even more far reaching, negatively influencing the surrounding community by failing to provide adequate standards of care for those coming to receive services. Since burnout is a common problem among mental health

professionals (Bouillon et al., 2021; Dorociak et al., 2017; Fletcher & Sarkar, 2016), this study sought to address this problem by identifying the resilience-promoting mindsets and behaviors that clinicians can utilize to resist burnout (Nissen-Lie et al., 2013; O'Brien & Haaga, 2015; Pedersen, 2018). This study is significant because it fills the gap in research regarding MHPs in private practice, a setting that has been largely neglected in previous research.

This study corroborated the extant literature in two ways. First, this study discovered that burnout extols a noticeable mental and emotional cost to the clinicians, negatively impacting their professional and personal lives (Eliacin et al., 2018; Gaal, 2010; Hammond et al., 2018; Lee et al., 2019). These participants acknowledged that their professionalism waned when they were stretched too far by the unrelenting demands of work. Part of the unique stressors echoed by all twelve of the participants was the fact that in private practice, every aspect of the work fell on their own shoulders. There was no assistance to schedule appointments, return phone calls and emails, interact with insurance agencies, procure payment, or manage crisis moments. The full weight of responsibility consistently rested upon themselves. Missing days due to sickness, emergencies, or vacation just meant there was more to catch up on when they returned. Upon synthesizing the data from all of the interviews, this stressor was found to be pervasive and constant. This highlights even more the need for resilience research for private practice clinicians in order to buffer the incessant demands they confront. However, even with these struggles notwithstanding, the unanimous sentiment was a resounding commitment to remain in the private practice setting. These clinicians have counted the costs. Despite the pressures, they choose to still position themselves in a career that regularly confronts them with persistent pressures leading to burnout.

This study's findings indicated that the participants were astutely aware of their personal indicators that precede burnout and were intricately attuned to the subtle shifts within themselves. They had developed mental and behavioral habits to attend to themselves carefully to prevent accumulated strain. Strikingly, they reflected upon how burnout causes their own professionalism to wane. It led to relying on more basic interventions with clients, such as workbooks and skills training exercises instead of pressing in to do the deeper work that they were typically motivated to engage in with clients. Because the idea of presence is a standard skill practiced throughout clinical training, these participants monitor their use of self in the room in ways that facilitate progress instead of becoming a roadblock to where the session needs to go. They felt less present in the room with their clients. They noticed they were less proactive with clients, resulting in less noticeable results. Their capacity for empathy was limited; they could not hold emotional space as effectively as they could when they were not battling burnout. Ultimately, these clinicians were well-acquainted with the burnout risks unique to their professional setting. And yet, they were still motivated, proactive, and thriving in their practices. This leads to the second revelation that confirms prior research.

Second, this study confirmed previous research highlighting the use of resilience to remediate burnout symptomology (Haramati et al., 2017; Lamb & Cogan, 2016; Maslach, 2017; Morse et al., 2012; Ossege & Sears, 2017). Resilience has been identified as an essential aspect to sustained mental and emotional health, effectively buffering the negative influences of stress, crises, and traumatization (Pack, 2013; Pereira et al., 2017; Rupert & Dorociak, 2019; Wood et al., 2017). Even after many decades of resilience research, no gold-standard definition for resilience exists (Liu et al., 2017; Panter-Brick & Leckman, 2013). The findings from this study affirm the prior research which states that resilience is viewed as a trait, a state, and an outcome.

While most researchers advocated for one of the three positions, Liu, Reed, and Girard (2017) advocated for a multi-tiered system sourced from all three perspectives; they suggested the most comprehensive definition is multi-final (having many resilient outcomes), multi-dimensional (having many aspects to it), and multi-faceted (having many ways to achieve it). The findings from this study affirm their multi-tiered system. These participants referenced resilience from all three origin points, as well as through a multi-final, multi-dimensional, and multi-faceted lenses. They defined resilience by mixing ideas of hardship and adversity with ideas of overcoming and triumph. Finding victory after adversity was the common denominator despite the variety of adversities these participants faced: childhood abuse, family of origin dysfunctions, addiction, divorce, trauma, sickness, disease, and loss. Curiously, when asked how they would define resilience, the actual definition did not matter to them. Resilience was not a stand-alone concept to them. Instead, they interwove it into a larger picture of goal setting and new growth. While a few therapists affirmed that they seek to intentionally build a framework for resilience with their clientele (Dylan, Susie, Char, Ben, Sam), others said resilience is not a term they would ever intentionally use (Kate, Pat). The remaining participants appeared neutral about the topic; although conversant about it, they did not confirm that resilience would become a focal point of their future work (Bob, Eva, Ang, Tia).

I found their initial thoughts about resilience intriguing, especially considering that they get paid, in part, to help others develop resilience so that they may find victory over their challenges. But I bracketed my perspective of the essentialness of resilience in this profession, and instead listened to what was being shared. By doing so, I found myself sitting longer with their pauses. I witnessed how the participants were re-experiencing parts of their own story as they were telling it. The situatedness that they currently found themselves in can work to limit

the depth and breadth of the current vantage points. When sitting comfortably in the present moment of one's life, past struggles can seem distant and less influential. But through the series of questions, I observed these participants start to connect to their earlier selves by reliving the details of the struggles that were the defining moments that undergird the strength and perspective in which they currently live. Through reconnecting with the desperation, they felt in those previous difficult seasons, their current role as a capable clinician started to soften, revealing raw accounts of living through tumultuous times of suffering, doubt, and despair.

When asked what helped them move past their adversities, ideas like hope, balance, boundaries, strength, perseverance, vision, values, goals, and untiring work ethic, were highlighted. Interestingly, as the discussion on resilience continued, I witnessed their horizons shift. I watched one clinician's horizon transform throughout our interview. At the beginning, she remarked multiple times that she had never considered the idea of resilience, much less would she have paired it with the idea of burnout. Instead, she considered balance and boundaries as antidotes to burnout. However, by the end of the interview, she revisited the idea of resilience, actively reconsidering it from new angles. She said she discovered a new perspective on resilience and a new motivation to actively pursue understanding it. Her journey revealed what resilience research has shown over the years; resilience is often confusing yet still intriguing. Reflecting upon it often expands one's horizons so that new insights begin to emerge.

### ***Expanding Prior Research***

Findings from this current study expanded previous resilience research by emphasizing the value contributed by these two categories: resilient mindsets and resilient behaviors. Approaching resilience according to these two categorizations leads the resilience discussion beyond the etiology focus that much of the previous research concentrated upon. The trait, state,

or outcome debate on the origins of resilience creates a solid introduction into the construct of resilience but one must seek to understand the experiential aspects of resilience through experiential means, like mindsets and behaviors. Prior research labelled certain identifiers that facilitate resilient mindsets. The lists included a focus upon the growth mindset; a growth mindset suggests that an individual's attributes are malleable and can be improved upon through focused effort (Boullion et al., 2021). A growth mindset has been paired with grit and resilience as qualities that are "conducive to optimal learning, thriving, and overall well-being" (Calo et al., 2019, p. 317). The findings from this study confirmed this, but also found a collective experience of mental openness, willingness to learn, proactive curiosity, and consistent pursuits of mental stimulation, deliberate growth, and intentional balance, among the participants. Prior research has also revealed certain identifiers that facilitate resilient behaviors. These included physical practices like maintaining consistent schedules of sleep, exercise, and work, while also maintaining adequate time to unwind and relax (Schmidt & Shumow, 2020). While participants in this study affirmed that those behaviors were priorities in their schedules, they also mentioned spiritual habits like prayer, meditation, Bible reading, and mindfulness, as well as relational practices of spending quality time with their spouses, children, loved ones, friends, colleagues, and church community. These behavioral practices were purposeful because they grounded these individuals in ways that helped them regain feelings of calm, comfort, connection, and confidence when they were otherwise feeling stressed, overwhelmed, or disconnected.

The aforementioned descriptive lists detailing resilience-promoting mindsets and behaviors are helpful to consider, but they lack the depth to really describe what the lived experience of resilience is really like. From the vantage point of the transcendental phenomenological perspective, the descriptive lists merely serve as on-ramps into the lived

experiences represented by those qualifiers. They are tools that assist the participants in experiencing resilience. The lived experiences of the phenomenon of resilience transcends merely participating in the lists of mindsets and behaviors previously mentioned. It is better explained as an orientation. To orient oneself toward something is to align with it. There are many people who can practice items from the above lists but that does not equate to resilience becoming evident in their lives. Resilience is more than the sum of these choices. The gestalt of resilience involves the presence of a possibility, a hope, that percolates as the result of engaging in certain mindsets and behaviors. While engaging in the mindsets and behaviors aforementioned, these participants become attuned to their inner selves in ways that prompt them to detach from and rise above the external pressures encircling around them. This new perspective empowers them to exert a counterpressure upon the demands. Something unspoken occurs. It involves a transfer of energy. They are acutely attuned within themselves to perceive it, and they have learned how to capitalize upon it. Instead of continuing to absorb the impact of the stressors and strains upon them, they begin to develop an impenetrable shield that provides them with the necessary breathing space to inhale and exhale, expanding their internal self to push back the forces that felt crushing to them. The new insights and strength garnered from this transaction, exchanging negative thoughts, feelings, and energy for their positives, translates into the dissipation of the debilitating impact of the stressors. New possibilities and solutions arise.

Storytelling entails an extremely subjective process. When someone revisits their past memories, they are simultaneously deciding which details are important to share aloud in the current telling of their story all the while being bombarded with a barrage of images, thoughts, and feelings through which they must quickly mentally navigate. Their perceptions mix with their current bodily experience of being in the world in this present moment, in this present

location, and they ultimately choose a telling of their story that is unique. This unique telling is a collaboration of their present mental and physical realities colluding with their past ones. They begin to access the sensory, mental, and emotional frameworks they had previously constructed to help them survive previous adversities. Their initial imprints are elicited when the old memories are recalled. Observing the participants experiencing these interactive dynamics while introducing the idea of resilience (a new construct for some of them) into the picture created opportunities for me to observe them experiencing the phenomenon of resilience in real time. A thoughtful posturing became evident in both their verbal and non-verbal communication. I observed them act on their internal promptings, leaning into the intrigue of resilience, and assessing their own story according to a resilience framework.

Collectively, the phenomenon of resilience became apparent as I experienced resilience through them. Instead of reflecting a heaviness while revisiting the painful memories of their lives, I witnessed happy and hopeful anticipations of getting to share the hardest seasons of their lives. Though the details of their stories were harsh and the suffering evident, resilience provided a positive filter through which the summary of their stories shone through. While they spoke of the cognitive and behavioral actions that they engaged in that helped them grow through challenging circumstances, the holistic presence that emanated from their personhood became warm, positive, and hopeful. It was energizing. Resilience began to reveal itself not as the practices they engaged in, but as the often-subtle prompting that preceded those practices. I heard them describe internal cues that prompted them to turn and seek the input that would then lead them to engage in the resilience-promoting choices. Resilience was like a pre-step. It was the nudge that led them to pause, to turn, to seek. Once acted upon, positive results occurred. Then through positive reinforcement, because they experienced a relief, strength, or insight that

was helpful to them, a habit of turning to those resilience-promoting mindsets and behaviors developed. The commitment to engage in these mindsets and behaviors were merely the evidence that they already experienced the internal nudge and pivot that caused them to pause, turn, and seek.

This is where the two primary themes discovered in this study beautifully intersect. As a child, one's horizon is limited by personal experiences and by what is learned from others. The ability to envision a future self or situation that has not yet occurred was an incredibly impactful practice that these participants demonstrated. To envision their optimal self is a future-oriented task that requires them to step into an imagined future and put skin on that dream. They then shift back into the present tense to configure the steps necessary to help that optimal self-come into existence. Sam's example of childhood adversity reflected this process. He said he had a choice "to become a victim or to overcome it, and I overcame it." Now, as an adult, Sam can look back and reflect on the choices he made to overcome adversity. His adult horizon incorporates all of his adult understanding of choice and the journey he has since walked that has gotten him to where he is today. But, his childhood perspective did not have all of the future insight at his disposal. He would not have been able to foresee the details of how certain choices would play out in his favor. As a child, all he could foresee was a future that was somehow different than what he was living. It was a future beyond his current circumstances. But, that was enough to compel him to seek out that which would help him move forward. Collectively, these participants communicated story after story of future-oriented thinking that would help to catapult them beyond their worst moments. They purposely used challenging moments as resets to consider what future self they wanted to become. Once they could envision that self, they

would ask themselves the question of what choice did they need to make now in order to arrive at their goals one day.

These participants experienced an internal prompting to dream beyond their present difficulties. Their struggles pulled on cords of hope, of desperation, and of determination that elicited within them the effort to try something new. Once they made the decision to try for something better, then they discovered different people and resources along that journey that assisted them in developing the new mindsets and behaviors that put their efforts into motion. No single formula of resilience became evident. Just as Ang said, some people think their way into new behaviors, and others behave their way into new thinking. It is a unique journey for each person. But the synergism across all of the findings revealed a common reality for the participants. They each had a moment when they paused in the midst of the trajectory that they were already positioned to fulfill. This pause allowed them to consciously pivot toward a new future. Inspired to discover their optimal self and a better future, they followed these promptings and positioned themselves to overturn the tide of pain and despair in their lives.

The lived experience of the phenomenon of resilience exceeds the mindsets and behaviors that I was initially intent on identifying. The mindsets and behaviors were evidence that the internal prompting had already done its work in nudging them toward something new. The phenomenon of resilience precedes what we can see or quantify in people's lives. It is that quiet whisper, that internal nudge, which beckons them to take the risks of an unknown journey in exchange for the predictable existence they had already known. In that exchange, something new is transacted. Something transcendent occurs as they dare to believe that they can transcend their past limitations and reset new future horizons. In doing so, they catapult themselves toward

a new future reality that engaging in the resilience-promoting mindsets and behaviors then helps to create.

### **Theoretical Literature**

The theoretical framework for this study was the metatheory of resilience and resiliency (Richardson, 2002; Richardson & Waite, 2002). The MRR established a foundational understanding of resilience and how it is experienced (Richardson et al., 1990). The MRR reflected a shift in perspective in the field of psychology from a deficit-based model focused on psychopathology toward an asset-based ideology (Bonanno & Diminich, 2013; Fletcher & Sarkar, 2016). Now, surrounded by decades of positive psychology research (Dattilio, 2015; Peterson & Seligman, 2004; Seligman & Pawelski, 2003) involving interest in character strengths and virtues (McMinn, 2017; Niemiec, 2014; Niemiec & McGrath, 2019; Titus, 2006), post-traumatic growth (Blackie et al., 2017; Dicinson, 2020), and happiness paradigms (Hanson, 2018), the mental health field has undeniably evolved. It is not uncommon to contemplate that we can retrain our brains to make them more pliable, more calm, happier. It is not just mental health professionals suggesting this. Medical professionals provide neurological scans to prove that mental conditions can be improved through practicing new habits that retrain cognitions and behaviors (Breuning, 2016; Leaf, 2013). The phrase *mental illness* has been replaced with a focus on *mental health*, revealing the psychological shift in the field at large that is more hope-filled and more strength-based (Dweck, 2006; Peterson & Seligman, 2004).

The MRR built a bridge between the old and new psychological perspectives, ushering in dynamic ideas of possibility, potential, and growth. Richardson's MRR framework defines resilience as a self-righting force within, suggesting that every human being is imbued with an internal motivation compelling them toward survival and well-being (Deci & Ryan, 2008;

Markland et al., 2005; Richardson & Waite, 2002). The findings from this study affirm the MRR's perspective. Pursuant to the tenets of transcendental phenomenological research, I bracketed my pre-judgments and biases during data collection and data analysis in order to remain open to the participants' described experiences. It is only now, in revisiting the theoretical orientation that undergirded the study, that I see the incredible confirmation that these findings offer to the MRR model. The internal promptings toward a future-oriented sense of self or situation that could improve one's current reality was evident in the stories and affirms the self-righting force within from Richardson's model (2016). The ability to learn from the past and envision the future while living in the present reveals an adaptability that affirms the asset-based ideology also reflected in the MRR model.

These mental health professionals seek to elicit that same self-righting force within their clients that they themselves have experienced. They know the power and possibility inherent within the journey that helped them move forward in their own lives. In this sense, resilience is contagious. It inspires others in ways that exceeds its initial function in an individual's life. The opportunity to be part of that pivot for others is a satisfying perk of the job for these participants. Their own lived experience of resilience inspires them to assist others, which ultimately serves to nudge them forward toward a better, more generous version of themselves as well. Resilience is infectious. It multiples itself. It is a much-needed, empowering force in today's world.

### **Implications**

The current study's findings reflect several implications regarding resilience and burnout. The three types of implications: theoretical, empirical, and practical, are described below.

#### **Theoretical Implications**

Richardson's MRR model looks at resiliency as "a process of interaction" between an individual and their environment (Richardson et al., 1990, p. 33). The key to protecting oneself from the negative effects of the disruptions of life is found in learning how to navigate the stressors and challenges that arise (Richardson et al., 1990). The goal of this model is to rebound from the initial impact of a crisis or trauma, reintegrating into life with new wisdom, strengths, or skills that help people to exceed their level of functioning prior to the disruption. Since this model does not require the use of specific coping skills or strategies, individuals can personalize their own resiliency journey according to what works for them while overlaying it on this model to indicate how their journey from crisis to resilience occurred. The coping skills and life strategies that can be use with this model are limitless, synchronizing well with the findings from this current study which discovered two primary themes and nine supportive sub-themes.

Without seeking to elicit any information that would support the MRR's tenets through the interviews, I bracketed my biases and recorded them in my field journal. The participants freely offered information about their lived experiences with resilience while overcoming their adversities. The data analysis phase of the research revealed that the findings supported Richardson's resiliency model (2016). The two primary themes that emerged out of this study, operating from their optimal self and flowing in temporal fluidity, coincide with Richardson's model in implicit and explicit ways. Implicitly, the focus on a growth-oriented mindset carries with it the assumption that humans can choose to be teachable at all points in life, even when facing difficult circumstances (Dweck, 2006). This idea of teachability is fueled by the unlimited possibility of growth as part of the normal human experience. Explicitly, gaining a vision of the optimal self includes a sense of the future self that incites motivation to make present-day choices that support that envisioned future. Hope is not wasted. Hope is not

transient. It can be forged as a substantial ingredient of someone's character with time and effort (Schmid, 2019). This is the task of bringing the optimal self into being, particularly in the resilient reintegration marked by wisdom. This epitomizes the ultimate outcome of the resilient journey, something explored in Chapter Two when discussing post-traumatic growth. Post-traumatic growth bears fruit not just for the individual, but also for those around them (Phillips et al., 2008). In Richardson's model, resilient reintegration multiplies itself, bringing hope to others when resilience is demonstrated. Through this, hope is part of the fuel for the journey but it also becomes a beautiful by-product that inspires the journey for others.

### **Empirical Implications**

Based on the current study's empirical findings, this research has implications for the fields of education and mental health. These implications apply to those tasked with teaching and training MHPs, as well as for the students frequenting those programs. The faith development of the administrators and professors of mental health programs in colleges and universities impacts their students. Entrusted with training the next generation of MHPs, this research benefits the educators by equipping them with insights on designing programs that integrate a Biblical worldview and faith-oriented topics into the learning (Quinn et al., 2012). Findings from this study reveal the import of spiritual practices for MHPs. This has implications for those train Christian counselors. Inculcating a Christian focus matters even in a field that is otherwise dominated by secularism. A recent Gallup poll revealed that almost 80% of the United States population claims to identify with some form of religious identity, with 73% claiming a Christian faith (Newport, 2017). Religious individuals often prefer a counselor who shares their faith orientation, and many clinicians also prefer to integrate faith-related issues in their clinical work (Evans et al., 2021; McMinn et al., 2010). Therefore, training Christian MHPs is a high

calling. Proper spiritual formation trains helpers “to distinguish instincts and to trust one’s gut. This lingo attempts to boost counselor confidence to act on one’s interpersonal (heart) impulses” that have become Biblically aligned (Greggo, 2016, p. 27). The counselor who embraces a Christian identity is one who “exemplifies a total commitment to Jesus Christ and the Gospel” (Greggo, 2016, p. 27). Spiritual formation and soul care are imperative for those training others because they can model and replicate their own journey (Boa, 2001). The students who attend these programs can benefit from the results of this study because the reality of compassion fatigue, vicarious trauma, and burnout are pervasive among helping professionals, even for those in private practice (Bianchi et al., 2014; Eliacin et al., 2018; Gaal, 2010). This study invites dialogue over these concerns and highlights the importance of integrating faith-based approaches for counselor development. It also offers solutions to assist students in establishing resilience-oriented proficiencies during their careers (Clark, 2009; Dattilio, 2015; Haramati et al., 2017).

The findings from this study also have implications for those already working in the mental health field. Merleau-Ponty (2012), in his book *The Phenomenology of Perception*, confirmed that a true phenomenological study honors the perceptions of participants because their participants shape the meaning they ascribe to their experiences. By silencing other thoughts, biases, and perceptions, that which the individual perceives to be true is valued. Research indicates that an individual’s perception of support matters more than the actual support that is offered; when someone perceives support from others, even when there is none, it still engenders courage and strength to effectively manage the tasks at hand (Cutton & Hochstetler, 2021; Zourbanos et al., 2011). This insight reflects the ultimate benefit of phenomenology and the essence of this study. It behooves the mental health profession to develop a rich appreciation of the narratives of MHPs in order to garner strength and wisdom to

assist others. The power inherent in storytelling is revealed through this research as the individual's perceived gains becomes part of their reality when they intertwine it into their life story. These participants modeled an ability to identify their past victories, their current stressors, and the future hopes. This cultivated within them the insight and strength necessary to continue onward despite the difficulties that accompany their current struggles. The mental health field will be strengthened by these findings, not just for the health and well-being of its clinicians, but also for all the clientele whom the clinicians seek to serve.

### **Practical Implications**

The practical implications of this study apply to those in multiple sectors of society, including the educators, the clinicians, and the spiritual advisors. Those who are tasked with educating future MHPs must be acquainted with research that empowers identifying the skills, principles, and processes to encourage therapy students to commit to their own courageous journey of mental health and emotional well-being while also integrating faith-based perspectives. Developing personal mastery over these complex skills will enable them to assist others along similar challenging journeys. Counselor educators fill a unique role because they shape the future of the mental healthcare field. To allow dialogue between different worldviews is imperative in order to meet the widest breadth of need. Creating a holistic pedagogy means that educators in faith-based settings must “purposefully address” all that arises between professional identity development and one's Christian faith (Greggo, 2016, p. 24). The work of integrating Biblical faith with professional development is essential for the next generation of Christian counselors.

Next, those working in the mental health field can benefit from this research. Positive mental health outcomes have been reported from “discussing clients' religion and spirituality in

clinical practice” (Oxhandler and Parrish, 2016, p. 295). Up to 80% of adults reported religion as “at least somewhat important in their lives” (Oxhandler & Parrish, 2016). Therefore, addressing it in their mental health treatment reflects an ethically responsible decision. MHPs who have committed to their own spiritual formation are better equipped to assist clients in fulfilling similar wishes as they are more capable to devise strategies for spiritual development (Phillips et al., 2008). This study endeavors to equip readers toward that end.

Lastly, those who work in the spiritual development field are uniquely positioned to offer spiritual formation and soul care for MHPs. The majority of the participants in this study indicated that the local church to which they belong is an important part of their support system. Those working in these settings have a unique opportunity to invest in these Christian counselors by intentionally co-mingling faith development during time spent with them (Greggo, 2016). This research equips spiritual leaders to understand the reality of what their counseling colleagues face and encourages them to build a space to minister to the unique needs of mental health professionals. Cross-pollinating between the mental health field and the church world could mutually strengthen both since they share a common goal of serving to heal God’s people. This research hopes to reveal that integration is indeed possible and beneficial. Sharing the conviction that “God is actively doing good in the world through the Son and the Holy Spirit to bring about a consummation of history that will reveal his glory” is a common bond that both sectors can embrace, imputing a shared vision of prioritizing Jesus in both fields (Greggo, 2016, p. 27). Resilience is not a psychological construct devoid of heart and soul. It emerges as a resource that draws forth from one’s mental, emotional, physical, and spiritual capacities, unifying them in ways that brings strength and resolve. Spirituality is a rich ingredient.

### **Delimitations and Limitations**

A study's delimitations and limitations must be explored to establish the accuracy and trustworthiness of its findings. The dependability of a study's results relies upon understanding the parameters a researcher purposefully sets, as well as those which were naturally occurring.

### **Delimitations**

Delimitations are decisions the researcher purposefully identified prior to the study in order to define the parameters of the study. The delimitations planned prior to conducting this study related to the research design and the selection of the participants. This transcendental phenomenological framework was selected because it is the methodology of choice for topics as richly layered as burnout and resilience because the firsthand accounts of overcoming hardship invites unique perceptions (Conger, 1998; Wahab et al., 2017). Through bracketing, I set aside my own preconceptions, biases, and judgments, allowing myself to listen with fresh ears to the shared narratives about the phenomenon of resilience (Moustakas, 1994). The research questions were answered according to the core processes that facilitate the acquisition of knowledge in transcendental phenomenology: epoché, transcendental reduction, and imaginative variation (Moustakas, 1994). Epoché helped me to suspend my assumptions, biases, and judgments as the researcher that could otherwise influence the description or interpretation of the individual's experiences (Adams & Van Manen, 2017). This protected the participant descriptions in as pure a fashion as possible and offered unique insights into the meaningfulness of everyday experiences that they shared about adversity, burnout, and resilience. This allowed me to attend more fully to "the subtleties of lived meaning" as the participants experienced it (Adams & Van Manen, 2017, p. 781).

A hermeneutical phenomenological design could have been chosen, but since that would have involved the researcher's interpretation as an observer, the transcendental design proved a

better fit to allow the natural world of the participant to unfold through the sharing of direct experience, bracketing my own observations so to not bias the results (Husserl, 2004). This helped to uncover the participants' nuanced meanings regarding the human experience of resilience (Ang et al., 2018). Husserl's focus on epoché provided the standard which I followed in order to bracket my own perspectives and biases, allowing a new way of seeing things through the perceptions of the participants (Moustakas, 1994). I kept a field journal to record my personal thoughts and biases, providing a valuable resource to document my judgments so to not allow them to influence the findings. With that being said, I could not bracket my own horizon. Therefore, not everything could have been realized by me. At the time of interviewing participants and analyzing data, my own horizon was limited by what I had presumed to find, with details providing origin stories of developing resilience and practical tools relied upon to maintain it. But as I sat with the participants I found myself becoming increasingly able to step back and approach them and their narratives from a wider lens. This change of horizon led to a greater ease with where their narrative was leading and a curiosity over the meaning that they would ascribe to their experiences. The larger horizon enabled me to settle in and be comfortable with being led into the essence of the resilience instead of taking the lead.

Other research designs could have included input from family members, friends, or colleagues, in order to compare and contrast the burnout scores that clinicians self-reported with those attributed to them by their significant others. Personal bias could be revealed in this way, leading to more pure insights. But pursuant to the phenomenological goals of identifying the lived experiences of MHPs themselves, no family members, friends, or colleagues of the clinicians were included in this study. The phenomenological basis of this study revealed unique

first-hand insights from the individuals themselves because eliciting their personal accounts reveals the unique aspects of this phenomena (Higginbottom & Lauridsen, 2014).

A second delimitation for this study involved the selection of the participants according to specified inclusion criteria. The specification of having private practice work experience did not limit participation to only those currently working in private practice, though 100% of the participants were currently employed therein. Seeking out participants who had prior private practice experience but who chose to leave it, would have provided another angle of insight into this problem of burnout. Furthermore, the sample did not seek participants who previously worked in a private practice setting but who were currently retired. Seeking input from those who previously worked in private practice but who chose to leave, either through seeking employment in another setting or through retirement, would have offered rich counter-analysis against which to compare the findings from those currently employed in private practice.

### **Limitations**

Limitations are those elements that arose during the course of the study that affected its results but that could not be controlled. These limitations include participant variables that may have influenced the type of participants' experiences and insights that were gleaned during data collection and include participant demographics and participant spirituality. The first variable that the sample did not control was the demographics of the participants. While age and gender were evenly displaced across groupings, ethnicity was not. Eleven of the twelve participants happened to be Caucasians, though that was not intentionally sought out in sampling. Perhaps that is the accurate representation of the demographics of professional MHPs located in the suburbs of this region of Southern California. While decisions could have been made to control for ethnicity, ensuring the same representation across groupings, that would have limited the

sample by imposing peripheral limitations not reflected in previous research on the problem of burnout. By not limiting the inclusion criteria to a specified number of participants across ethnic groups, the widest range of possible responses was sought. However, the sample was heavily weighted to Caucasian. The results might not be reflective across other ethnicities. Future research could apply this same study to other ethnic groups, comparing the results.

The second variable that was not controlled for but that came out heavily weighted toward a certain grouping was spiritual orientation. Eleven of the twelve participants communicated a practice of the Christian faith, though that was not part of the inclusion criteria. The remaining participant did not identify a faith orientation. One question on the demographic questionnaire asked, "On a scale of 1-10 (1 being a little and 10 being a lot) how much do you rely on your faith to assist you in handling professional stressors?" Nine participants scored themselves with a score of an 8, 9, or 10. Two respondents replied with a 3 out of 10. The remaining respondent scored herself with a 1 out of 10. This study's findings, delimitations, and limitations are utilized to provide recommendations for future research.

### **Recommendations for Future Research**

Several recommendations for future research regarding clinicians in private practice follows. The first recommendation is to include married couples who work in private practice together. Because one of the biggest challenges of the private practice setting is isolation from like-minded peers, it would be insightful to assess the results from couples who have peer interaction easily accessible. This sample population would also afford the opportunity to include both spouse's perspectives on burnout in each other. The spouse's report might evoke insights about biases in the self-reporting of the other spouse. No research has been done with the subset of couples who both run their own private practice. A second recommendation for

future research involves the population of practitioners who retired early from private practice. In contrast to this current study which sought input from those who have not yet retired due to burnout, future studies could focus on those who retired early due to burnout; their input would expose the stressors of the private practice setting that did push them toward early retirement. While research has been conducted on physicians (Riley et al., 2018) and other health professionals (Hammig, 2018) who retired due to burnout, there is a dearth of research on MHPs who retire early. A third recommendation for future research would compare MHPs in private practice with agency-based clinicians (Bianchi et al., 2014). This would provide a real time comparison between burnout levels. Previous research has been done on the impact of work setting on burnout scores among professional counselors (Lent & Schwartz, 2012; Rupert & Morgan, 2005), but the studies were quantitative. They lacked the rich input that qualitative research offers. The common hypothesis in the work-setting studies was that professionals in agencies have higher burnout rates compared to those in private practice (Gaal, 2010; Lent & Schwartz, 2012). A mixed-methods, comparative study would measure burnout scores while also digging into the lived experiences of the professionals in both settings to round out the experiential differences of the professionals working in the field.

### **Summary**

The purpose of this phenomenological study was to describe the experiences of 12 mental health practitioners who have worked in private practice and who have utilized resilience to resist burnout. Previous research on MHPs had not yet revealed insights into how the clinicians in private practice fared regarding resilience to burnout. Prior research assessed how work settings specifically impacted burnout, but the private practice setting was omitted. This study adds to the extant literature and fills that research gap. It assists those who are educating future

therapists, those who are training to become therapists, and those who currently work in the field with empirical, theoretical, and practical insights in the phenomenon of resilience.

This chapter revealed that the participants relied upon resilience-promoting mindsets and behaviors to buffer against burnout. These professionals acknowledged a regular practice of resilience-promoting skills such as establishing boundaries to protect themselves, implementing time limits to guard their energy, anchoring in relationships to enrich their hearts, practicing self-care to ensure health, and connecting spiritually with what is sacred. The respondents also commit to attuning to their internal states, frequently adjusting themselves to the pressures to minimize the stress they experience. They use self-talk to calm themselves and refresh themselves by taking time off. These nine skills comprised the sub-themes that supported the two primary themes from this study.

The first primary theme, operating from their optimal self, enabled them to prevent large scale burnout because they sought to live from a posture of navigating life from their best sense of self. This served as an antidote to burnout because they did not allow themselves to get so depleted that they could not function effectively. Their internal meter allows them to catch themselves before they hit zero. They respond quickly with the tried-and-true skills they have honed that help them to refill and refresh themselves. They confidently implement the mental and physical practices that cultivate self-compassion and self-care. The second primary theme, flowing in temporal fluidity, enables these MHPs to conform their regular habits toward health and well-being. They did not report lives free of the struggles and trials of daily living. On the contrary, each one reported life-changing challenges that shaped the course of their lives. They continue to draw on the lessons they learned from those struggles as they navigate current challenges. They also actively feed a future-oriented vision of themselves and their situation that

helps to move them toward the outcomes that they desire. Their future-oriented vision compels them to set goals to reach the future that they so beautifully envision. By drawing strength and insight from both the past and the future, these clinicians more capably negotiate the present-day stressors and challenges that they face. Their ability to flow between the past, present, and the future keeps them light-hearted and hope-filled because new solutions frequently emerge.

In conclusion, these professionals are not superheroes. Instead, they have learned how to listen to those subtle nudges, the internal promptings that beckon them to lean toward the mindsets and behaviors that will help them live from the optimal self that they actively develop. They have developed a well-honed habit of listening to those nudges, empowering themselves to not remain stuck in tough situations for longer than is necessary. The sense of hope, desperation, or grit that compels them to step out of an adversity and pause to look toward new possibilities is an invaluable ingredient in their recipe of resilience. This helps them pivot toward a new future. That would not have occurred had they remained stuck in their former circumstances. They are inspired by their own journey of overcoming, and they reflect a contagious quality of possibility that can't help but stir up hope in their hearers. They hope to infect their clients with a similar inspiration for strength and perseverance. These MHPs have deliberately shaped their lives toward a version of their best self that compels them to make daily choices to manifest the future they hope to create. These participants have learned how to maintain an optimal level of functioning, managing their personal and professional stressors well. Despite the numerous professional challenges inherent in the world of private practice, and the consistent stressors that have the potential to lead to burnout, these professionals have demonstrated an adept skill of practicing resilience-promoting mindsets and behaviors that have facilitated their health and well-being and led to satisfying and prosperous professional careers.

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## Appendix A

### IRB Approval Letter

November 10, 2021

Re: IRB Exemption - IRB-FY21-22-262 Lived Experiences of Mental Health Professionals Using Resilience to Resist Burnout

Dear Kristen Cummins, Jaesook Gho,

The Liberty University Institutional Review Board (IRB) has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application, and no further IRB oversight is required.

Your study falls under the following exemption category, which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:104(d):

Category 2.(iii). Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by §46.111(a)(7).

**Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB.** Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Please note that this exemption only applies to your current research application, and any modifications to your protocol must be reported to the Liberty University IRB for verification of continued exemption status. You may report these changes by completing a modification submission through your Cayuse IRB account.

If you have any questions about this exemption or need assistance in determining whether possible modifications to your protocol would change your exemption status, please email us at [irb@liberty.edu](mailto:irb@liberty.edu).

Sincerely,  
**G. Michele Baker, MA, CIP**  
*Administrative Chair of Institutional Research*  
**Research Ethics Office**

## Appendix B

### Recruitment Letter - Verbal (In Person or By Phone)

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Hello Potential Participant,

**Intro-** As a doctoral Student in the School of Behavioral Sciences, the Community Care and Counseling Program, at Liberty University, I am conducting research as part of the requirements for a doctoral degree.

**Purpose-** The purpose of my research is to explore the lived experiences of mental health professionals and how they utilize resilience to resist burnout. I am looking at what resilience mindsets and practices therapists in private practice rely upon in order to resist professional burnout. If you meet my participant criteria and are interested, I would like to invite you to join my study.

**Participation-** To be eligible to participate:

- 1- You must be 18 years of age or older,
- 2- You must have a qualifying degree of masters level or higher,
- 3- You must be licensed as a Marriage and Family Therapist in the state of California,
- 4- You must have worked in a private practice therapy setting,
- 5- You must have faced professional stressors that can lead to burnout

Do you meet these qualifications? If so, then you are eligible for participation in this study. If you would like to participate, then I will email you a consent form today. It contains additional information about my research. If you choose to participate, you will need to type your name and date on the consent document, returning it to me via email, as soon as possible. It is due before our scheduled interview time. Upon receiving the consent form, you will be cleared to participate in the following procedures. The procedures are meant to take place in person when possible. Due to Covid precautions, some participants might choose to participate remotely. Appropriate accommodations will be made for those who choose to remain remote.

**Procedures-** The procedures include:

1. A questionnaire- this should take approximately 5 minutes. If you are participating in person, then you will complete this questionnaire when we meet, prior to the interview. If you are participating remotely, then I will email the questionnaire to you upon receiving your signed consent form. After completing the questionnaire, you will return it to me via email at kcummins1@liberty.edu prior to our scheduled interview time.
2. An interview- this will take approximately 60-75 minutes. If you are participating in person, then we will schedule a meeting time for the interview. If you are participating remotely, then I will email you a link to my Doxy.me telehealth account, which we will use for the interview.
3. Transcript review- this will occur by email.

Names and other identifying information will be requested as part of this study, but the information will remain confidential. Pseudonyms will be used so that the information remains confidential.

**Compensation-** Participants will be compensated with a \$25 gift card to either Starbucks or Coffee Bean as a “thank you” for their involvement. Do you have any questions?

**Would you like to participate?**

1. Yes- Great. Please let me know your email address so I can email you the consent form. I must receive the consent form prior to you participating in the questionnaire and the interview. Would you like to participate in person or remotely? If you know your schedule now, then can we set up a time for the interview?

2. No- I understand.

Thank you for your time.

## Appendix C

### Consent Form

**Title of the Project:** Lived Experiences of Mental Health Professionals Using Resilience to Resist Burnout

**Principal Investigator:** Kristen Cummins, LMFT, Doctoral Candidate, Liberty University

#### Invitation to be part of a research study

You are invited to participate in a research study. To be eligible to participate, you must be 18 years or age or older, you must have obtained a qualifying degree of masters level or higher, you must be licensed as a Marriage and Family Therapist in the state of California, you must have worked in a private practice therapy setting, and you must have faced the professional stressors that can cause burnout. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

#### What is the study about and why is it being done?

The purpose of the study is to explore the lived experiences of mental health professionals regarding resilience. The researcher is looking at what resilience mindsets and practices therapists in private practice rely upon to resist professional burnout.

#### What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete a demographic questionnaire. This will take 5 minutes to complete. If you are participating in person, then you will complete this questionnaire at the beginning of our scheduled meeting, prior to the interview. If you are participating remotely, then I will email the questionnaire to you upon receiving your signed consent form. After completing the questionnaire, you will be asked to return it to me via email prior to our scheduled interview time.
2. Participate in an audio-recorded interview. The interview will take 60 minutes to complete. If you are participating in person, then we will schedule a meeting time for the interview. If you are participating remotely, the I will email you a link to my Doxy.me telehealth account, which we will use for the interview.
3. Review the interview transcript. This will occur through email.

#### How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include assisting practitioners in developing improved protocols for clinician self-care to decrease vulnerability to burnout, a more sustainable work-life balance amongst therapists, better standards of care for clients, and increased awareness of the benefit of resilience to bolster the helping professional's resilience-promoting mindsets and habits as it relates to society's experiences with therapeutic services in general.

**What risks might you experience from being in this study?**

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. As a mandatory reporter, I am required to report child abuse, child neglect, elder abuse, or intent to harm self or others if I become privy to information that triggers the mandatory reporting requirements.

**How will personal information be protected?**

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and in a locked filing cabinet. The data may be used in future presentations. After three years, all electronic records will be deleted and all physical records will be shredded.
- Interviews will be recorded and transcribed. Recordings will be stored on a password-locked computer for three years and then erased. Only the researcher will have access to these recordings.

**How will you be compensated for being part of the study?**

Participants will be compensated with a \$25 gift card and will be able to choose a gift card from from either Starbucks or Coffee Bean as compensation for participating in this study. The gift card will either be mailed to you or handed to you at the completion of the interview.

**Is study participation voluntary?**

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

**What should you do if you decide to withdraw from the study?**

If you choose to withdraw from the study, please contact the researcher at the email address/phone number included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

**Whom do you contact if you have questions or concerns about the study?**

The researcher conducting this study is Kristen Cummins. If you have questions, **you are encouraged** to contact her. You may also contact the researcher's faculty sponsor, Dr. Jaesook Gho.

**Whom do you contact if you have questions about your rights as a research participant?**

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board.

*Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.*

**Your consent**

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions after you sign this document, you can contact the study team using the information provided above.

*I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.*

\_\_\_\_\_ (please initial) The researcher has my permission to audio-record me as part of my participation in this study.

\_\_\_\_\_  
Printed Subject Name

\_\_\_\_\_  
Signature & Date

**Appendix D**

**Demographic Questionnaire**

1. Age: \_\_\_\_\_
2. Gender:        Male            Female
3. Ethnicity:    White    Black    Asian    Latino    Native American    \_\_\_\_\_
4. Educational Qualification:    Masters            Post-graduate            Doctorate
5. Type of Professional Licenses (LMFT, LPC, etc.) & # of years you have had each
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
6. Total years of work-related experience in the Mental Health Profession
  - a. 0-5 years
  - b. 6-10 years
  - c. 11-15 years
  - d. 16-20 years
  - e. Over 20 years
  - f. Retired
7. Are you currently working in private practice    Yes        No
8. Number of years you have worked (either currently or previously) in a private practice setting \_\_\_\_\_
9. Currently working how many hours per week
  - a. 0-10 hours
  - b. 11-20 hours
  - c. 21-30 hours
  - d. 31-40 hours
  - e. Over 40 hours
10. On a scale of 1-10, how close to burnout do you rank yourself?
 

(no burnout) 1    2    3    4    5    6    7    8    9    10 (burned out)
11. On a scale of 1-10 (1 being a little and 10 being a lot), how much do you rely on your personal support system of family/friends to assist you in handling professional stressors?
 

1    2    3    4    5    6    7    8    9    10

12. In what ways do you rely on your personal support system to help you manage work-related stress?

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13. On a scale of 1-10 (1 being a little and 10 being a lot) how much do you rely on your faith to assist you in handling professional stressors?

1      2      3      4      5      6      7      8      9      10

14. In what ways do you rely on your faith to help you manage work-related stress?

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15. Work-life balance is central to the topic of burnout. What percentage of each contributes to the current stress you experience? (ex: 50% to 50%, 30% to 70%)

Personal life stressors \_\_\_\_\_%      Professional stressors \_\_\_\_\_%

16. Have you ever experienced professional burnout where you needed to take some time off?

Yes                      No

If yes, how much time did you take off? \_\_\_\_\_

If yes, what contributed most to the burnout you experienced? \_\_\_\_\_

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If yes, what helped you most to rebound from burnout? \_\_\_\_\_

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## Appendix E

### Interview Questions

#### **Self-Identification and History:**

1. Please introduce yourself to me, as if we just met one another.
2. Tell me about your work title and how long you have been employed in this capacity.
3. What other professional settings have you worked in besides private practice?
4. What led you to pursue a career as a mental health professional (MHP)?
5. What are your favorite aspects of your job? What are your least favorite?

#### **Professional Burnout:**

6. How do you define the concept of burnout?
7. What professional challenges do you face as an MHP working in private practice?
8. How many of those challenges are unique to the private practice setting itself?
9. Please describe, in as much detail as possible, a situation in which you experienced professional burnout.

#### **Resilience-Promoting Mindsets:**

10. How do you define the concept of resilience?
11. What does a resilience-promoting mindset mean to you?
12. What are the important characteristics of a resilience mindset?
13. Do you believe that a resilience mindset can be taught or practiced? If so, how?
14. How do you personally work on developing a resilience-promoting mindset?

#### **Resilience-Promoting Behaviors or Practices:**

15. What resilience-promoting behaviors do you personally practice?
16. What aspects of these resilience-promoting practices are most helpful to you?
17. Do you believe resilience-promoting behaviors or habits can be taught? If so, how?

**Personal Adversity:**

18. How do you define the concept of adversity?
19. Please describe an example of a personal adversity that you have confronted.
20. What helped you overcome that adversity?
21. What did that adversity teach you or deposit within you that you have been able to access during subsequent hardships?
22. How are you different because of the adversity that you overcame?

**Personal Resilience to Resist Professional Burnout:**

23. Please describe a situation when you experienced resilience.
24. Do you think a resilience-promoting mindset is necessary in your work to resist burnout?
25. Do you think resilience-promoting practices are necessary in your work to resist burnout?
26. How do you develop or sustain resilience-promoting behaviors to overcome burnout?

**Promoting Resilience in Others Through Your Work:**

27. How do you draw from the resilience you have developed in your personal life experiences to assist others in overcoming their own adversities?
28. What advice would you give to other clinicians working in private practice about how to use resilience to manage professional burnout?

**Conclusion:**

29. Looking ahead to the next few years, how do you expect your mindset or behaviors to change in relation to resilience?
30. One final question: What else do you think is important for me to know about your lived experiences with resilience-producing mindsets or behaviors?

## Appendix F

### Individual Portraits

The following descriptions offer glimpses into the life context of each participant.

Assessing their patterns of language revealed their unique perceptions.

#### **Bob**

Licensed as an MFT for over 25 years, Bob is a quiet, unassuming man but has constructed his adult life with an intentionality unmatched by the other participants. He used the word *intentional* a half dozen times, but his spirit of intentionality was reflected throughout the interview. Bob's pursuit of balance (20 usages) permeates his approach to faith, life, and work. An outdoor enthusiast who revels in hiking and biking, these activities remind him to prevent burnout by being intentional with his work schedule. When in nature, he feels "so connected to God and can hear Him so easily." His faith is an anchor. He relies on it to manage life's stressors about 80% of the time. What he can't control in life, he lifts up to God: "That's where one's trust in God becomes an anchor point. The whole idea of trusting something enables letting it go." Bob encapsulated his faith with the parable of the house on the rock in Matthew 7:

Am I going to build the house of my self-worth on the sand of everyone else's opinion of me or am I going to build it on the rock of God's view? So that idea of stability, balance, and a firm foundation. God loves me all the time, just the same. No matter what.

This 58-year-old extrovert loves God and loves people: "I really enjoy getting to meet people, getting to know people. People matter to me." He desires to live a balanced life and "makes adjustments before the scale tips." He lives preventatively in regard to burnout. He lives "with reserves" so he can "respond quickly" to life and "maintain the balance" he craves.

#### **Dylan**

Dylan presents as a well-spoken man in his late 40s, bursting with creativity and confidence, but not arrogance. Inspired to be transformed like Jesus, he approaches life with a holistic understanding of health and wholeness. Speaking of his love for this profession and for the entrepreneurial spirit that running a private practice requires, his work ethic sets him apart. He logs his choices on a daily spreadsheet, including work, exercise, Bible reading, prayer, and sleep. This enables him to intentionally build his daily, weekly, and annual goals. This eye on the future helps him direct his decision-making in the present. “Work ethic, discipline, and living by design instead of by default” sums up what compels him to be proactive in both who he wants to become and what he wants to accomplish. He believes it is essential to have a growth mindset and to be forward thinking, lest complacency set in. This idea was best represented in his repetitive use of the idea of being pulled out of alignment by life (eight usages) or being left to drift away little by little (five usages). Since life has a tendency to pull us out of balance, we must beware the drift, the slow fade, like the fire that slowly burns out. He blames inattention as the culprit that causes people to gradually slide away from their ideal. He is purposeful to remind himself “what health looks like. If I am doing this, then I’m not letting the subtle drift happen.” Remarkably, Dylan does not have a mindset that forbids error. Ten times Dylan repeated words that reflected an allowance for second chances. It is time to “restart, redo, reset, remake, rebuild or re-engineer” the model of what you want your next step to look like. He does not think mistakes create failure. Instead, they are opportunities to know what pain is, to learn how to navigate it, and to more readily relate to clients who have struggles of their own.

### *Eva*

Eva immediately captures one’s attention with her bubbly personality and energy for life. She recently finished a hectic life season. She got licensed, turned 30, and had her first baby all

within the same year. This was on the heels of working three jobs as the sole financial provider in her household while she finished her licensing hours and passed her clinical exams. The demands of the current season include adjusting to life as a new mom and getting established in private practice. Emotional boundaries (five usages) were a major theme in describing her most recent growth curve. Differentiating “what is my responsibility and what is not” (four usages) as well as “it is my job to do this... it is not my job to do that” (four usages), has created a major victory in her struggle for balance between her job and home life. She has found “confidence” (three usages) in accepting her own limitations, acknowledging when she is “at capacity” (three usages), and not making apology for it (three usages). She has developed a “higher tolerance for discomfort” and has learned how to “just be okay” (three usages) with however clients respond to her new boundaries. She loves this job: “I love getting to go right there with people. I can ask the deep questions that people usually don’t ask... I enjoy the deep, meaningful conversations.”

### *Kate*

In her early 50s, Kate presents with a casual, unassuming air. She admitted that she would have not put the concepts of burnout and resilience together, “Prior to this interview, I don’t know if I would have come up with that. I think I would have said self-care and balance are really important.” She did not believe self-care and balance were synonyms for resilience, but did think that both promote resilience. Resilience is meant to “buffer the stress” (two usages) and it helps to keep her in her healthiest place (three usages). Kate’s strategy for burnout is to prevent it by remaining aware (three usages) and attuned (four usages) within herself so that burnout cannot build-up. She knows her daily limits. “I try to keep my day to no more than seven clients. Eight is too many. My office mate does over 40 a week, and I just don’t get it.” She is intentional about good self-care (12 usages). Taking time for meals in the middle of her

workday, exercise, and going to lunch with friends are all activities that contribute to her wellness. Those activities restore balance in her life. Smaller, regular adjustments are key: “For me, that’s daily burnout. I know I can’t do more in one day.” Monitoring her daily schedule so she does not overextend herself prevents burnout. “If you have good enough self-care and balance then you never need to bounce back because you stay in your healthier place.” She continued, “When I start to notice burnout, I start to integrate balance again.

### *Susie*

At 60 years of age, Susie is one who takes her work very seriously, but who is also so relational that she can draw you into her thought processes with astounding clarity. She sees resilience as “the ability to bounce back and get back into my zone of well-being... resiliency is my ability to recover and get back in my zone.” She describes this zone in numerical terms, as a 4 to 7 on a scale of 1 to 10. She labels it as her “relational zone... where I can operate from my Spirit-led self.” This metaphor provides a focus where Susie remains steadfast, “this means that I stay, because I have a choice. It is a commitment. I am responsible to get back into my zone. It won’t just happen. I have to go get it.” Owning her personal responsibility (six usages) to maintain her zone (14 usages), she credits her faith and hard work at growth as essential in her life. Overcoming adversity has grown her resilience and that has made her more useful in helping others. Her intention (four usages) to rely on God (nine usages) and to remain mindful (10 usages) and motivated (four usages) help her to stay out of shame (10 usages). Shame is “the biggest obstacle to resilience.” Therefore, it is necessary “to track what is happening inside.” Personal responsibility is necessary because we are responsible for the behaviors we choose in our daily lives. We are meant to live responsibly with health, meaning, and purpose.

### *Ang*

After a 20-year career as a licensed MFT, Ang still maintains the initial zest and purpose that led her to begin this second career. Though devastated by an injury that ended her first career as a tennis pro, she felt led by God into this field where she could utilize her innate giftings and offer something meaningful to the world. Motivated by things that are deep and meaningful (five usages), she values balance (seven usages) and approaches her personal and professional life with positive resources (five usages). Her faith in God (six usages) is the key focus of her life. When she has nothing left to give, He's got to "fill the gap, somehow, someway... I have a faith and trust that I can rely on something other than myself, and that God always shows up." Looking at personal responsibility (eight usages) and personal choices (eight usages) as the main determinants of how she sustains (two usages) a healthy life, she believes that much of the struggle people face are linked to the perception (2 usages) they hold about their troubles. Her perspective helps her to not feel victim to the chronic health disease that has attacked her life, forcing her to work one-third of the amount that she would like to. Maintaining her sense of agency (two usages) is a significant part of her positive outlook and her future hope.

### ***Ben***

A 70-year-old man with a 25-year history in youth ministry prior to his 36 years as a licensed MFT, Ben is a deeply committed Christian who relies on God (six usages) daily. He is well-seasoned in both the vicissitudes and virtues of life. Growing up as a missionary kid in South America and living in a boarding school through his teenage years exposed him to life lessons in resilience. "As an adult I now see how tough that was, but I just had to figure it out. No one handed me a book. It's just in the category of you have to figure it out... There's no Plan B." Not surprisingly, one of Ben's most prolific phrases was the phrase "you gotta figure it out." Interweaving that phrase 11 times throughout the course of our meeting created an obvious

theme. Internal fortitude and a “don’t quit” attitude screams resilience to Ben. An avid researcher of autobiographies from those who learned how to adapt and overcome (five usages), he is energized by the stories of Corrie Ten Boom and Viktor Frankl. Ben surmises, “human beings are far more resilient than people believe that they are.” In fact, “More of our society and world need to know this instead of being fragile as snowflakes.” Because of his personal experiences, he knows that he pushes people “to try to help them acknowledge and believe that they can push themselves and do more than they think they can. No, you can. And you need to.” Though he believes that resilience is a mix of nature and nurture and that not everyone will “have what it takes to get back up after they’ve been knocked down,” he does believe some things that can be taught. This is mental health (six usages). It includes the basic emotional and relational skills that each person should learn in order to be fully functioning human beings.

### *Sam*

Sam is a 42-year-old man with only three years of licensing experience but speaking with him belies his short tenure in the field. Presenting with a fluidity of presence, thought, and speech, he confidently (four usages) shared the challenging journey of switching careers. Motivated by goals and gusto, Sam is supercharged to create a tangible vision of what his mental vision says is possible. Driven by values (12 usages) and goals (12 usages), he puts a big emphasis on healthy decision making (five usages) and learning how to just figure it out (six usages). Although much of his focus (four usages) throughout the interview was on the mental aspect of how he moves forward in life, he emphasized the role that behaviors play in developing healthy life skills 22 times. “When you change your behaviors then you can change your perspective on the world. You can start to lead your emotions in a different way. You can start to lead your thoughts in a different way too.” Knowing your values is essential because values

are the foundation for goals. Goals then dictate new behaviors and daily routines. Daily routines enable him to move forward toward the future (eight usages) that he ardently envisions: “I continue to focus on what my values are, and I continue to create new goals for myself.”

### *Char*

Char is a vibrant, faith-filled 46-year-old pastor’s wife who has been a licensed therapist for 13 years. Inspired by her faith in God (13 usages), she embraces her position in this field as a calling (10 usages). If you think of it as a job, she explains, “you will burnout.” There’s a difference between a God-focus and a self-focus. “If you think you are going to go help people, it isn’t going to work. But if you think that God has called you, then you won’t quit, and you’ll be successful.” This differentiation between a job and a calling is essential to Char: “That’s the thing. I don’t think it’s a job. It’s a calling, to carry peoples’ pain” (four usages). The heavy (four usages) weight of pain is not something she takes lightly. Char equips her clients to deal with offenses (three usages) by overcoming (two usages) the victim mindset (three usages) that impedes their growth. “Some people never get out of the victim mindset. Instead of overcoming adversity, they are just victims. That kind of mindset won’t let you become successful at all in any situation.” Char finds success (three usages) through focusing on facts over feelings (three usages). “I know therapists are very empathetic, intuitive, feeling-oriented. But to be resilient, I think we have to pay attention to the facts. Facts over feelings - that’s one that I practice.”

### *Meg*

Meg is a 58-year-old female who has worked for 25 years in private practice. Motivated by the deep parts of the therapeutic process, she loves “watching people grow. Watching them get it. Seeing the look in their eyes. Sometimes it’s sad. Sometimes sadness overcomes them. But you get the sense that they are understanding that they are being understood in a new way.”

Utilizing a metaphor that burnout is like a slippery slope, she explains the early stages of burnout where she notices she is carrying it home (four usages). The demands of caregiving (three usages) start to make her feel like she can't get a break. Everywhere she turns the intensity increases and things are left undone. Then not caring (eight usages) about some aspect of life starts to happen. This is the wake-up call "right before you crash and burn." She has learned to watch for these warning signs and take time off when needed. Resiliency is "the ability to have a hard time, a really hard time, have really bad things happen that are out of your control... but still being able to keep on, not miss a beat in terms of your responsibilities." When someone spirals (17 usages), they get stuck in a thought process that good stuff is never gonna happen (seven usages). In those instances, she has learned how to keep the hope (six usages) and not let herself spiral with them. "You have to put aside any hope to help them until they are out of it. You let them be in their spiral, but you help yourself, so your own hopelessness doesn't set in."

### *Tia*

Tia is a 70-year-old female who has been licensed for 22 years. She loves her job and feels privileged that she gets to do it. She maintains professional connections and meets regularly for peer consultations (three usages), reflecting her value on relationship. Her faith is an anchor, keeping her grounded. Meditation, Bible reading, and prayer are regular habits for her. She acknowledges that good habits (three usages) are essential in walking out the steps required to live resiliently. A firm believer that resilience-promoting mindset and practices can be learned, a "can-do" attitude is vital in overcoming hardship. "I think it is a belief. It's like a predetermined belief that somehow, it will all work out." Another phrase, "it'll be okay" (four usages), reflects the positive demeanor that she takes on for others. She tries to help others "intentionally think about the positive that is going on in their life as evidence that they can

expect good things to come their way. They are forgetting about the good things that already came their way.” Pointing people toward a larger perspective than what they were living in is important. Stretching beyond the “now” is a powerful tool that helps people work on their mindset and get new behaviors in place. “Good habits create resiliency.”

### *Pat*

Pat is a 48-year-old who has worked in private practice for nine years, but in the field for over 20. Delightful in her demeanor and positive in her outlook, she came into the field after discovering that there were “very good approaches that are current and future-focused, and we don’t have to just go back and live in your past.” A forward-thinking individual, Pat prides herself on her optimistic outlook. In fact, positivity (10 usages) was the main theme of her interview. Joking about her disposition toward all things positive, she laughed, “I like my rose-colored glasses. I like to look at the world that way. I don’t want to give them up.” Going through her own adversities led her to realize that she must accept “that things in life aren’t going to play out according to expectations or norms and yet, there’s still blessing in it.” She is motivated to intentionally (three usages) maintain a growth mindset (two usages). This involves preventing burnout by “guarding it on the front end.” She only books a certain number of clients per week. She typically keeps it at five clients a day because when she does six, she feels it. She is not willing to sacrifice her own balance by overworking. Aspiring to bring hope (five usages) to people’s lives, she is diligent to keep her own hope and positivity alive through cultivating a daily walk with the Lord (eight usages). When speaking of what God has done in her life, as well as how He helps her in the therapy room, she bubbles over with excitement. “Discover the power of hope” is the tagline for her professional website and a main theme of her life.

**Appendix G**

**Group Portrait**

Representing a diverse group of individuals with an average of 17 years of experience working in the mental health field. Seven of the participants moved into this field as a second career after working in business (four), ministry (two), and professional sports (one). The common thrust in their career move was to pursue something more meaningful (four), and to become better equipped in helping others (three). The remaining five participants began in the field early on, pursuing studies in psychology in high school or college and continuing on in the field from there.

Table 3 outlines some commonalities that arose among the participant pool.

**Table 3**

*Common Characteristics of Participants*

<b>Common Characteristics</b>	Bob	Dylan	Eva	Kate	Susie	Ang	Ben	Sam	Char	Meg	Tia	Pat
Early hardship (10/12)	X	X	X	X	X		X	X	X	X	X	
Personal therapy (6/12)		X	X	X	X					X	X	
Innate gifting (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Proactive learner (12/12)	X	X	X	X	X	X	X	X	X	X	X	X
Visual communicator (11/12)	X	X	X	X	X	X	X	X	X	X	X	

These individuals share characteristics that were not included in the questioning but that nonetheless reflected interesting commonalities. The empty squares in Table 3 represent topics

not discussed by the interviewee, while the squares marked with an “X” reflect topics that the participant initiated on their own. For those who did not reference these topics, their silence does not suggest that these items do not apply to them. Rather, when unprompted, their train of thought did not lead them to reference these ideas. Although I saw these patterns begin to emerge after the first few interviews, I chose to not ask them in subsequent interviews because I wanted the results to remain organic. I documented my observations in my field journal instead. When I later tabulated the results after the data collection was complete, I was intrigued with the results. There are noticeable trends. Three commonalities (i.e., early hardship, personal therapy, and innate gifting) reflected similarities in their personal histories, while the last two (i.e. proactive learner and visual communicator) revealed observable communication styles.

#### ***Early Hardship (10 out of 12)***

Ten of the 12 respondents referenced early hardship in their life that became part of their personal quest to learn and grow. Sam said, “As a kid I had to overcome or not, and I did, but my brother did not.” Meg affirmed that she had many hardships: “I got a lot of them. It’s just which one to pick out to share with you.” Char also referenced multiple early difficulties, “I think really, my whole life, it’s been one lesson in adversity after another.” Nine participants referred to childhood family difficulties, discord, or parental divorce, while the other one referenced personal addiction. While the remaining two participants did not freely reference any childhood stories of hardship, both mentioned a chronic hardship as an adult that impacted them greatly; for Angie, it was a health diagnosis, and for Pat, it was singleness. The ten participants who experienced an early, life-changing, personal event said that it shaped their life and that they learned certain skills because of having to wrestle through that early hardship.

#### ***Personal Therapy (6 out of 12)***

Six of the 12 interviewees referenced their own personal therapy as part of a significant pivot point in their lives. Three of these six portrayed the relationship with their counselor as highly meaningful: “I really bonded with the guy” (Dylan), “I was so lucky she was a good fit for me” (Eva), and “my experience with him was just so good... life-changing... I still see him 20 years later” (Kate). Five of these six stated that their own positive experiences in therapy became part of their internal motivation to work as a clinician because they wanted to offer the same life-changing experience with therapy to others that they had personally enjoyed.

### *Innate Gifting (12 out of 12)*

All twelve participants referenced a certain moment in time when they became aware that they needed to work in this field. Sam’s colleague suggested he look into becoming an MFT. When he looked it up on the internet, “it went ding, that’s it” and he knew that was his next career. When Ang looked into becoming a therapist, her friends and family affirmed her, saying, “That’s it! That’s what you were meant for.” Four people said that it was God’s calling upon them: “God was calling me” (Dylan), “I knew it was what God created me to do” (Ben), “These natural giftings that God had designed in me” (Ang), and “I didn’t have a relationship with God at the time but, looking back, I see that He was directing me” (Pat). Nine of them said their innate gifting emerged during their teenage years. The roles they played in their family of origin or in their high school friend groups taught them how to be good listeners. Kate acknowledged, “I had a highly angry, narcissistic father. So I feel like I’m naturally trained to navigate them.” Others spent hours talking to friends about tough situations. Eva recognized early on that she was different than her family in terms of how she processed things. “I feel very deeply. I think a lot. I would try to take those things to my family members, but they experience life very

different than me and, it felt very lonely.” Many of them know they are in the right field because the enjoyment they feel over the work is proof itself (Bob, Ben, Ang, Kate, Sam, Char, Tia, Pat).

***Proactive Learner (12 out of 12)***

A proactive learner is somebody who avidly seeks out opportunities for new learning and intellectual growth. All 12 participants represented this quality. They mentioned book titles, names of authors, and popular podcasts as reference points when they spoke, emphasizing something important they had learned. Four interviewees cited podcasts as regular sources of information. Dylan said his goal was to bike over 2,000 miles this year, humorously adding that he “bikes for the podcasts” rather than for the exercise. Ben admitted that when his son joined the Marine Corps, he “wanted to be well-versed in it” so he “read 40 to 50 books about it.”

Continual streams of input feed their internal cravings to learn. Each one had discovered this about themselves and knew how to self-feed in ways that worked in their daily lives (i.e., during their morning routine, while driving, during exercise). This commitment to proactive learning was a significant part of their self-care routines: “If I couldn’t listen to podcasts, I would die” (Dylan), “I love podcasts. There are a couple podcasts I listen to that show me my blind spots” (Eva), “I find I do more reading and studying on a particular issue when I’m not well-informed on it” (Ang), and “As a lifelong learner, I love that I can pursue different topics... it rejuvenates me” (Tia). Six participants referenced Bible reading as a regular activity that helped them to stay grounded (Bob, Susie, Ang, Meg, Tia, Pat). Movies, songs, conferences, and research studies were also commonly referred to as part of how they continued to grow in their everyday lives. Curiosity to learn was a marker for their mental health and losing their curiosity signaled burnout. Sam described it this way, “The value is growing and learning and moving forward.” Dylan affirmed, “If I’m not learning, then I’m not doing well. When the curiosity is

strong in me, then I feel like I am growing, but burnout starts to rob me of that... I need to keep the faucet turned on. It's a steady stream of input."

### *Visual Communicator (11 out of 12)*

A visual communicator is someone who uses metaphors and word pictures to emphasize a point. This trait was reflected in eleven of the twelve participants. I first noticed this when my first two interviewees used the same metaphor of driving a car to illustrate their answers. The close proximity of those examples caused me to journal it in my field notes, and I questioned whether I would find this quality in other interviews. Each participant utilized multiple similes, metaphors, and word pictures to paint ideas in vivid ways. Dylan used seven different similes, metaphors, and word pictures in our interview: "Private practice is like an accordion, it can expand or shrink to your schedule," "It's like the right ingredient in food- the right amount flavors it well, but too much ruins it," "I need to keep the faucet (of new learning) always turned on like a steady stream," "Everyone is subject to life wanting to pull their car off course," "It's like an uninvited guest who shows up and you have to figure out how to deal with it," "When someone feels suffocated by life, then I try to help them expand the walls out to see past the now," "Burnout is like a fire in your house, a roaring fire." At the end of our interview, I presented Dylan with my observation that he utilized many metaphors and word pictures to communicate. He replied, "That's probably one of the giftings that God gives to people who come into this field: the ability to create constructs that makes sense to people." He was right. Eleven of the twelve participants peppered their conversation with rich and colorful language that painted tangible word pictures for intangible realities.

## Appendix H

### Unexpected Codes and Themes

The data were collected and condensed into codes according to two major categories: the private practice setting and the problem of burnout.

#### *Private Practice-Related Codes and Themes*

Although these 12 participants currently work in private practice, each of them had previous work experience in other settings. Working in various community agencies was the most prominent setting represented by these clinicians (eight), while college counseling centers came next (six). Church, school, and foster care or group home settings were listed next frequently (three each). A psychiatric hospital and juvenile detention center round out the list (one each). Ten of the 12 interviewees recounted that their experiences in other settings played a significant role in the decision to work in private practice. Agency protocols (eight), extensive paperwork (six), and excessive meetings (four) were the most cited reasons why they were pleased to depart from other settings and position themselves in private practice instead.

**Two Favorite Aspects of Private Practice.** Table 4 documents the two favorite aspects unique to the private practice setting.

**Table 4***Favorite Aspects of Private Practice*


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Code	Frequency
<hr/>	
Meaningfulness of client relationships (45 total responses)	
Seeing people take steps to grow	6
Asking deep questions and going deep with people	5
Seeing people feel understood and validated	5
Getting to know people	4
Seeing lives change	4
Helping people	3
Providing something meaningful	3
Feeling the Holy Spirit flow through me in session	3
Feeling replenished, inspired, and challenged by clients	3
Feeling it is a good fit and it's rewarding	3
Being trusted with important things in people's lives	2
Figuring it out and providing understanding	2
Creating therapeutic repair	1
Watching kids feel loved, contained, and cared for	1
Autonomy of running the business (28 total responses)	
Flexibility in scheduling my hours	9
Reading and learning what I want to professionally grow	6
Entrepreneurship, independence, working for myself	4
Putting my family first	2
Making business decisions quickly	2
Having my own private office exactly how I want it	2
Choosing the types of clients I see	1
Choosing the number of clients I see	1
Choosing to work with children	1

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As indicated by the results found in Table 4, two primary aspects surfaced that explained the perceived benefits of working in a private practice setting: The Meaningfulness of Client Relationships and The Autonomy of Running the Business. Both benefits include related ideas, nuanced by the phrases most often utilized by these clinicians.

***The Meaningfulness of Client Relationships.*** When asked about their favorite aspect of private practice, all 12 participants mentioned the idea that their work was deeply meaningful. Forty-five responses pointed to the benefits of developing deep and meaningful relationships with their clients. They offered varied responses, but each described some aspect of the beauty of the therapeutic relationships that private practice enabled them to create. At first glance, I thought these responses could relate to any clinician working in any professional setting, but further consideration revealed that the specific parameters of the private practice setting afford the time required to help these relationships evolve. This is because the private practice setting is not subjected to agency protocols that limits session visits, requiring clinicians to follow short-term therapy models. It is not uncommon for agency, college, school, and church settings to limit clients to four to eight sessions. The freedom in private practice to offer unlimited sessions allows the therapist-client relationship to develop deep and enduring bonds over the course of an extended time in treatment, often lasting many months or even years. Because it takes time to identify inner motivations and coping strategies, as well as to break through well-formed defense mechanisms, in-depth progress can only occur through unhurried therapeutic work.

***The Autonomy of Running the Business.*** The second answer that emerged when asked their favorite aspect of working in private practice was the great sense of autonomy they felt over running their own business. Mentioned in 28 different responses, the enjoyment they feel over being the sole proprietor focused primarily on the flexibility of scheduling their days and weeks.

Because they are in charge of their own business, they retain decision making over the types of clients and the number of clients that they accept. Other settings do not offer such flexibility because clinicians are appointed clients based on a rotational basis, preventing them from choosing specific cases they prefer to work with, nor the number of clients they desire in their daily or weekly caseload. Because other settings also require team meetings and office responsibilities, clinicians spend a portion of their work week completing tasks or administrative duties that are devoid of client interaction. In private practice, a larger percentage of work hours are spent in session. They can make decisions quickly to expand or shrink their business, to shift their scheduling, or to adjust to their clients' changing scheduling needs, which proves to be a benefit for clients as well. Dylan explained this by saying that private practice "is like an accordion. It can expand or contract depending upon what my life looks like. If people are visiting, I don't have to work so much. It feels nice to have more control over it." Furthermore, with a fixed salary you don't have the ability to earn more. "If I have a big expense coming up, then I can work more to pay for that." The ability to adjust his amount of work, and likewise his amount of income, according to his wishes is a unique benefit of the private practice setting.

**Two Challenges of Private Practice.** The MHPs also reported unique challenges they experience in the private practice setting. Two main categories emerged. These included the Sole Responsibility to Keep Your Business Alive and the Tendency Toward Isolation. Both aspects include related ideas, nuanced by the phrases most often utilized by these clinicians.

**Table 5**

*Challenges of Private Practice*

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Code	Frequency
<b>Sole responsibility to keep your business alive (47 total responses)</b>	
Business administration	9
Paperwork	9
Staying on top of things in timely manner	6
Legal / ethical requirements	6
Dealing with insurance companies	5
Enticement to overwork hours	4
Technology and texting because no office staff to help	3
Live in small community so possibility for dual relationships	2
Marketing / website maintenance	2
Clients complain about paying because you are Christian	1
<b>Tendency toward isolation (37 total responses)</b>	
Carrying client concerns and burdens alone	8
Isolation, lone wolf feeling, aloneness	7
Need to pursue peer consultation on cases	6
When clients are unmotivated or stuck	6
Client threats of suicide	5
Spiritual battles in the sessions	3
No one to share client stories with	2

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As indicated by the results in Table 5, the two challenges of working in private practice were clustered under the main categories of the Sole Responsibility to Keep Your Business Alive and the Tendency Toward Isolation.

***Sole Responsibility to Keep Your Business Alive.*** When asked about the challenges of working in a private practice setting, all 12 participants stated that the responsibility of being the sole person responsible for their business often felt overwhelming. Forty-seven responses supported this idea. Ten subcategories revealed more detailed explanations. There is no safety net of other professionals who can cover the responsibilities when these professionals are sick, fall behind, or are on vacation. None have office staff who answer or return calls, who read and return emails and texts, who create insurance statements, or who do the billing. A few hired an accountant, but the others felt they do not work enough to justify that expense. More than a third of the responses reflected struggles with the administrative aspects and the paperwork involved in case notes and treatment planning. These clinicians said they do very little paperwork because they prefer to maximize their time with clients instead.

***Tendency Toward Isolation.*** Just as all 12 participants cited struggles with the sole responsibility of ownership, likewise, all 12 participants reported the Tendency Toward Isolation as a significant problem of the private practice setting. Thirty-seven responses pointed to this struggle and are nuanced into seven different subcategories. Forty percent of the responses bemoan the struggle of carrying the client's burden alone and feeling isolated because of it. The next largest struggle involves their need to pursue peer consultation over cases. This reflects a wise investment in time as it mitigates the feelings of isolation that might otherwise creep in.

Ironically, two valuable insights appeared regarding the relationship between the two favorite aspects of working in private practice and the two predominant challenges of this setting. Table 6 below reveals them.

**Table 6**

*Comparison of Favorite Aspects and Biggest Challenges of Private Practice*

	<b>Favorite Aspects of Private Practice</b>	<b>Biggest Challenges of Private Practice</b>
#1	Meaningfulness of client relationships	Sole responsibility to keep your business alive
#2	Autonomy of running the business	Tendency toward isolation

These two columns represent the most favorite and least favorite aspects of working in private practice. In studying this chart, it becomes apparent that the two columns cross-reference each other. For example, the favorite aspect of the Meaningfulness of the Client Relationships also registers as the challenge of Tendency Toward Isolation, wherein one is burdened by the weight of client stories and feels isolated from other professionals who could help. Likewise, the second favorite aspect, the Autonomy of Running the Business, cross-references with the biggest challenge, the Sole Responsibility to Keep Your Business Alive. This reveals that what makes working in private practice appealing is also what makes it difficult. The upside of running one’s own business becomes a burden that weighs too heavily at times. The autonomy can become challenging when the demands become too great. The idea of balance applies here. Private practice clinicians are drawn to the freedom and autonomy afforded in this setting, but that freedom and autonomy carries with it a level of responsibility that can become too much to handle. Likewise, in private practice, the deep relationships with clients are appreciated, but too much responsibility for clients who are suicidal or struggling can feel overwhelming. Awareness of the best and worst aspects of this setting become applicable to the next discussion on burnout.

***Burnout Codes and Themes***

Burnout is not a new concept, nor is it unique to the world of mental health providers. Lent & Schwartz (2012) discovered significant differences in frequency of burnout between work settings. Many studies have addressed the problem of burnout among those who work in foster care agencies (Rienks, 2020; Salloum et al., 2015; Verheyden et al., 2020), prisons (Lambert et al., 2015), and schools (Mullen et al., 2018), but little focus has occurred on private practice. Therefore, this setting was specifically chosen for this study in order to understand how private practice practitioners experience burnout and how resilience might remedy that.

**Participants' Burnout Symptomology.** This group of participants answered questions about burnout, specifically about how they would define the concept of burnout and how they personally experience it. Table 7 shares the results from the participants' responses.

**Table 7**

*Mental Health Professionals' Burnout Symptomology*

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Code	Frequency
<b>Emotional symptoms - (35 total references)</b>	
Lose the want to/vigor and zest/vision/passion	8
Carrying pain	5
Tipping the balance	4
Feeling overwhelmed	3
Less enjoyment/joy	3
Feeling burdened	2
Less feeling	2
Less empathy	2
Feeling heavyhearted	2
Feeling of guilt and responsibility	1
Feeling of failure	1
Less excitement	1
Less compassion	1
<b>Physical symptoms - (32 total references)</b>	
Lack of energy	13
Spread too thin	4
Tiredness	4
Fatigue	3
Apathy	3
Exhaustion	2
Oppressiveness	1
No vibrance	1
Feeling spent	1
<b>Mental symptoms – (30 total references)</b>	
Aware of limited internal capacity and resources	16
Rethink the why	6
No Interest to grow	3
Inattention	2
No learning	1
No motivation	1
Nothing more to give	1

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Table 7 documents the burnout symptomology as amassed from the interviewees’ responses. The frequency of occurrence of each code was tabulated, showing the frequency of data outcomes in the column on the right. Without leading the interviewees to share in any particular manner, the concept of burnout was naturally reflected in three groupings: emotional symptoms, physical symptoms, and mental symptoms. While these three groupings display almost an equivalent number of references for each, 35 references, 32 references, and 30 references, respectively, analyzing the sub-groupings reveal distinct details that fall under each.

**Participants’ Self-Report Burnout Scores.** Participants were asked in the demographic questionnaire to rate their own burnout level on a scale of 1 to 10. Table 8 records each participant’s self-report scores, as well as their self-report scores on how much they rely on their support system and/or their faith to assist with feelings of burnout.

**Table 8**

*Participant Self-Report Burnout Scores*

<b>Participant</b>	<b>Burnout Score (10 high/1 low)</b>	<b>Years Licensed</b>	<b>Hours Working Per Week</b>	<b>Rely on Support System (1-10)</b>	<b>Rely on Faith (1-10)</b>
Eva	8 of 10	1.5 years	31-40 hours	8 of 10	3 of 10
Susie	7 of 10	6 years	21-30 hours	8 of 10	9 of 10
Char	7 of 10	13 years	21-30 hours	9 of 10	10 of 10
Meg	6 of 10	24 years	0-10 hours	8 of 10	9 of 10
Tia	6 of 10	22 years	31-40 hours	7 of 10	10 of 10
Angie	5 of 10	17 years	11-20 hours	9 of 10	10 of 10
Dylan	3 of 10	11 years	Over 40 hours	9 of 10	10 of 10
Sam	3 of 10	3 years	Over 40 hours	2 of 10	3 of 10
Ben	3 of 10	36 years	21-30 hours	9 of 10	10 of 10
Kate	2 of 10	10 years	11-20 hours	2 of 10	1 of 10
Pat	2 of 10	12 years	11-20 hours	10 of 10	9 of 10
Bob	1 of 10	25 years	11-20 hours	5 of 10	8 of 10

In Table 8, the participants reported scores based on their own assessment. Previous resilience research reveals the two most valuable contributors to resilience in the workplace include a strong social support network and a strong faith (Maslach, 2017). This study will apply a “more often than not” stance; this means that at least six out of ten times, or more often than not, this statistic is true for this participant. This provides a common denominator across the three self-report scales, assisting in comparing and contrasting the results. These insights will compare the degree to which these clinicians utilize the two primary pillars of support that are available to them and how that correlates with their burnout scores.

Forty-two percent of participants (five of the 12) reported a burnout score of at least a 6 out of 10, meaning that they experience noticeable burnout “more days than not.” Fifty-eight percent of respondents (seven of the 12) reported a burnout score in the range of 1 to 5 out of 10, suggesting that they experience noticeable symptoms of burnout less than half of the time. When looking at the reliance of their social support network, seven of 12, or 58% of respondents rely on this pillar more often than not. Of those positive respondents, one participant rated herself as 10 out of 10, four participants chose 9 out of 10, and four participants reported a 7 or 8 out of 10. This shows a strong awareness of the need for support networks and an intentional pursuit of relationship to help mitigate stress. When looking at how much these participants relied upon their faith for support, a strong showing also ensued. Nine of the 12 respondents, or 75%, reported relying on their faith more often than not. Five of those nine respondents reported that their faith was a resource to them 10 out of 10 times. That means that they are turning to their faith every day. Three of those nine respondents chose 9 out of 10, and one reported an 8 out of 10. A look at the eight respondents who scored themselves as a 9 or 10 on the faith scale does not reveal corresponding low burnout scores as I hoped to see. Instead, the eight respondents

who reported 9s and 10s on faith support also indicated levels of burnout from 7 out of 10 and all the way down to 2 out of 10. This suggests that while it is evident that this group strongly leans on faith for support, it does not correlate to particularly low burnout scores.

Results also indicated no significant correlation between length of time licensed and burnout level. Instead, two of the newly minted therapists (1.5 years and six years) scored themselves in the high burnout range (with scores of 7 and 8 out of 10) while the other two newest clinicians (three years and 10 years) self-reported in the low burnout range (with scores of 2 and 3 out of 10). The same split pattern proved true for the more seasoned therapists: three of the most seasoned therapists (24 years, 22 years, and 13 years) scored themselves in the high burnout range (with scores of 6 and 7 out of 10), while the other three most seasoned clinicians (36 years, 25 years, and 17 years) scored themselves in the low burnout range (with scores of 1, 3, and 5 out of 10). Lastly, when comparing burnout levels with hours worked per week, other studies suggested that more hours worked equated to higher burnout rates among clinicians (Acker, 2011; Aronsson et al., 2017). However, this did not prove true for this population. The two therapists who reported working the most, over 40 hours per week, scored themselves in the low range of burnout (both reported 3 out of 10). Four out of the five who reported working between 31-40 and 21-30 hour workweeks rated themselves with high burnout (at least 6 out of 10), while three of the five working in the 11-20 and 1-10 ranges reported low burnout (with scores of 1 and 2 out of 10). These results reflect no significant correlation between work hours and burnout rates. This means that according to the data, there is no viable way to predict who is more likely to burnout based on the raw data of self-report burnout scores, hours worked, or reliance on relational or spiritual support systems.

**Appendix I**

**Interview Data Summary by Research Question**

**Research Question 1: What mindsets that promote resilience do these mental health professionals rely upon?**

Interview questions 10, 11, 12, 13, and 14 sought insights from the participants into what factors contribute to resilience-promoting mindsets.

<b>Contributing Factors</b>	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
<b>Boundaries (12/12)</b> -What is my responsibility and what is not -What is my job and what is not my job -What is within my control and what is not -I believe that I did my best -I figured out solutions -I empathized an appropriate amount but did not let it weigh on me excessively	X	X	X	X	X	X	X	X	X	X	X	X
<b>Time Limits (12/12)</b> -End sessions on time -Limit session frequency -Limit preparation time before sessions -Limit interactions by phone or text between sessions -Limit number of clients per day/week -Allow time before replying	X	X	X	X	X	X	X	X	X	X	X	X
<b>Attunement (9/12)</b> -Pay attention to one’s internal states of being -Remain aware of small changes within oneself -Intentionally maintain an internal balance	X	X	X	X		X		X		X	X	X
<b>Adjust and Adapt (6/12)</b> -Make small changes -Take action steps -Learn to cope with	X	X		X	X	X						X



-Write, paint, sing -Bodywork, massage												
<b>Spiritual Anchors (11/12)</b> -Rely on God -Faith in Jesus -Seek Holy Spirit filling -Read the Bible -Consistent prayer time -Meditate on Bible verses -Mindfulness practices -Practice virtues like love, patience, or kindness -Serve others in need	X	X	X		X	X	X	X	X	X	X	X
<b>Time Off (5 /12)</b> -Go on vacation with spouse -Go on vacation alone -Take extra days off		X					X	X		X	X	

**Research Question 3: How do resilience-promoting mindsets and practices help mental health professionals resist burnout?**

Interview questions 23, 24, 25, and 26 sought to elicit responses regarding their perception on using resilience-promoting mindsets and behaviors to resist professional burnout.

Answers	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12
<b>Optimal Self (11/12)</b> -Do the best you can do -Maintain internal stability -Value and prioritize balance -Believe you are worthy and valuable -Don't avoid pain and suffering. Instead, grow confidence to sit through it. -Maintain a positive outlook -Be confident you can persevere and lend others that confidence -Resilient through hardship	X	X	X	X	X	X	X	X	X		X	X

<ul style="list-style-type: none"> <li>-Live from your zone of well-being</li> <li>- Take action instead of feeling stuck in inaction</li> <li>-Adapt and overcome</li> <li>-Help others thrive</li> <li>-Maintain hope because blessing still comes through hard times</li> </ul>												
<p><b>Temporal Fluidity (10 /12)</b></p> <ul style="list-style-type: none"> <li>-Future-oriented living</li> <li>-Live in the present</li> <li>-Don't project current woes onto the future</li> <li>-Offer hope for the future based on the past</li> <li>-Use resilience to be proactive</li> <li>-Respond to potential problems sooner</li> <li>-God's faithfulness in the past</li> </ul>	X	X	X		X	X		X	X	X	X	X