MILITARY SPOUSE COUNSELORS: EXPLORING MENTAL HEALTH, RESILIENCE, COPING, AND BURNOUT

By

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Department of Counselor Education and Family Studies, Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Philosophy in Counselor Education and Supervision

School of Behavioral Sciences

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ABSTRACT

Military spouses (MLSPs) are an integral part of the military family and key mental health providers in military community. This study explores the mental health, resilience, coping, and burnout of MLSP counselors, counselor educators, and supervisors (CES). This study was grounded in resilience theory, investigating relationships between mental health and burnout, mediated by resilience, and conditioned by coping. An online survey was distributed through social media and email, open to MLSP counselors/CES of all branches and components of service ($N = 68$). This quantitative, descriptive, cross-sectional correlational research designed utilized PROCESS Models 4, 58, and 59, which determined that resilience mediates the relationships between anxiety and burnout as well as posttraumatic stress disorder (PTSD) and burnout. Participants indicated significant mental health challenges, including depression, anxiety, and PTSD. Additionally, poorer mental health was predictive of higher rates of counselor burnout. The sample size was not large enough to provide moderated mediation analysis, providing no information on how coping moderates these relationships. These results indicate the importance of targeted occupational support for MLSP counselors/CES to mitigate burnout, as they face unique personal and professional adversities due to military affiliation.

Keywords: military spouse, counselor, counselor education, mental health, resilience, burnout, coping

Dedication

This dissertation is dedicated to the United States military community and our families. From the spouses who hold families together, to the service members are out the door, to the children who grow up knowing the sacrifices of their parents, I dedicate this work to each of us.

To the men I have known who left and came home, but different, I salute you. Your sacrifice is not forgotten. To the spouses I know who have held on by a thread, I am with you. You have often inspired me to keep going. To the children who miss their parents, I see you. Your resilience is remarkable.

May we all find the strength to carry these burdens together. We are not alone.

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There are so many individuals I would love to thank for their love, dedication, and support to finish this marathon. First and foremost, I want to thank my husband, Caleb, without whom none of this would be possible. I am immeasurably grateful for the life we have made together and cannot wait to see where this amazing life takes us. Together, we make our dreams come true. Thank you for making this incredible achievement a priority for our family.

To my incredible parents, Scott and Jane, thank you for supporting my educational goals throughout my life and encouraging me to "shoot for the moon and reach the stars." Thank you for the countless hours of childcare, editing, and support you have unconditionally given to me. I would never have considered this without your inspiration and constant encouragement that I can achieve my dreams.

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Finally, to my son Declan River, thank you for giving me the best title I never knew I wanted: Mommy. Thank you for giving me the perseverance, the faith, and the purpose to finish this journey. May my small accomplishments serve to inspire you to "shoot for the moon and reach the stars," too. I love you, and our family, with all my heart.

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List of Abbreviations

American Counseling Association (ACA)

American Psychiatric Association (APA)

Army Community Service (ACS)

Blue Star Families (BSF)

Brief Resilience Scale (BRS)

Coping Strategies Inventory- Short Form (CSI-SF)

Counselor Burnout Inventory (CBI)

Counselor Educators and Supervisors (CES)

Department of Defense (DOD)

Diagnostic and Statistical Manual of Mental Disorders- 5th edition (DSM-5)

Emotion-Focused Coping (EFC)

Expiration Term of Service (ETS)

Generalized Anxiety Disorder 7 (GAD-7)

Global War on Terror (GWOT)

Institutional Review Board (IRB)

International Classification of Diseases (ICD)

Military Family Life Counselors (MFLC)

Military Spouse (MLSP)

Non-Commissioned Officer (NCO)

Operation Tempo (OPTEMPO)

Outside the Continental United States (OCONUS)

Patient Health Questionnaire (PHQ-9)

Permanent Change of Station (PCS)

Posttraumatic Stress Disorder (PTSD)

Posttraumatic Stress Disorder Checklist (PCL-5)

Problem-Focused Coping (PFC)

Service Member (SM)

World Health Organization (WHO)

Work-Family Conflict (WFC)

CHAPTER ONE: INTRODUCTION

Overview

The United States has the largest military in the world, dedicating 16.8% of its fiscal budget ($2.01 trillion) to the Department of Defense (DOD) in 2023 (USA Spending, 2023). A substantial amount of research explores military readiness, a critical aspect of the United States military. In recent years, military spouses (MLSPs) have taken their place in the literature, as their contributions to service members (SMs) and the military family are untold (Corry et al., 2019; Sinclair et al., 2019). The experience of the MLSP underscores the importance of resilience in the military community and how overcoming adversity and challenges can strengthen the individual and the community (Sinclair et al., 2019). As MLSP resilience is now a feature of the literature (Sinclair et al., 2019), and MLSP experiences differ greatly across occupational and demographic areas (Sullivan et al., 2021), it is time to explore specific intersectional identities within MLSPs. This study explores mental health, resilience, coping, and burnout in MLSP counselors and counselor educators and supervisors (CES), an integral part of the military community's mental health providers.

This study intends to fill a gap in the current body of literature (Lee et al., 2019), and this chapter lays the foundation of the historical, social, and theoretical underpinnings to thoroughly explore MLSP counselors/CES. Through the theoretical framework of resilience, mental health, resilience, coping, and burnout will be explored, addressing a critical gap in current literature, and contributing to the understanding of resilience within the military and mental health communities. This study seeks to answer several research questions. First, does a higher rate of mental health issues, including depression, anxiety, and post-traumatic stress disorder (PTSD), increase the prevalence of burnout in military spouse counselors/CES? Second, does resilience

mediate the relationship between mental health and burnout in military spouse counselors/CES? Third, what moderating effects, if any, does coping have on mental health and resilience? Fourth, what moderating effects, if any, does coping have on resilience and burnout? Finally, what moderating effects, if any, does coping have on mental health and burnout? This study utilizes snowball sampling to gather a sample of counselors/CES who are MLSPs, and then explore the results using a quantitative, descriptive, cross-sectional correlational research design with moderated mediation analysis to answer these questions. This chapter also explores the problems addressed through the study, the purpose of the proposal, hypothesized models, and relevant definitions.

Background

Research regarding psychological distress and resilience within the military community has focused on the SM, and with good reason (Anderson et al., 2013). However, over the past 20 years, MLSPs have secured the attention of researchers, as their contributions to military readiness and SM well-being—and retention—have been established as critical to the military mission (Dolphin et al., 2015; Sinclair et al., 2019). The U.S. military has recognized the contributions of the MLSP to the military family and SM, establishing additional systems to support MLSPs, including ways to improve family resilience (Dodge et al., 2022).

Historical Background

During the eighteenth and nineteenth centuries, MLSPs worked alongside their husbands in war, often performing vital tasks on the battlefield such as cooking, taking care of horses, providing medical services, and supervising camp (Covkin, 2023). Following the Civil War, the Army began enacting policies to deter married men from enlisting in the Army, including denying married soldiers separate housing and family transportation. This continued through

World War I, where marriage could be cited as the reason for deferral from the frontlines (Alt & Stone, 1991). The adage, "If the Army wanted you to have a wife, they would have issued you one," remained true until the beginning of World War II, when wives were significant help for the war efforts at home (Alvah, 2007, p. 62). Wives were now responsible for bolstering "military readiness" and persuading husbands to reenlist and maintain an Army career (Alvah, 2007, p. 63).

From the 1950s to the 1970s, wives were expected to create communities with other MLSPs, teach etiquette to new spouses, and support large families (Alvah, 2007). In addition, MLSPs were expected to maintain the social programs provided to dependents, such as childcare programs, literacy initiatives, financial counseling, and programs for disabled children (Mittelstadt, 2015). The Army Community Service (ACS) relied on volunteer labor from MLSPs to offer these programs to dependents, requiring unpaid labor from MLSPs to sustain itself, insisting the military life was a "two-person career," (Mittelstadt, 2015, p. 126). However, at the end of the Vietnam War and the end of the draft, SMs were now staying in the military by choice, and MLSPs began to refuse the two-person career model the Army had utilized for so long (Alvah, 2007). MLSPs launched a grassroots movement to press the Army to provide better for their families and no longer take advantage of free labor, as they were burned out (Mittelstadt, 2015).

At the first Army Family Symposium in 1980, MLSPs stated two principles: first, that they did not constitute "neither passive nor dependent extensions of their husbands or the Army itself," and second, that "the decades-old Nancy Shea 'two-for-one' model of the Army wife" was unsustainable (Mittelstadt, 2015, p. 137). This movement led the Army Chief of Staff John Wickham Jr. to write, "The Army Family," outlining the importance of the family to the overall

military mission, acknowledging how the spouses and families of military personnel had been largely ignored in the past but would now be protected and considered through Army programs, initiatives, and funding (Wickham, 1983). This recognition has continued, as the Reagan administration supported the Army wives' new relationship with the military: "that the Army work for the good of Army wives and families," (Mittelstadt, 2015, p. 145). Today, the military recognizes and acknowledges the importance of the MLSP and their contributions to the Armed Forces, exploring areas to provide additional support through programs and initiatives for MLSPs (Corry et al., 2019).

The historical relationship between the Army and SM's spouses has outlined areas of continued improvement, as MLSPs still carry additional stressors in day-to-day life due to the military lifestyle. The military has recognized several areas where MLSPs need support, including mental health, education, employment, and relationship support (DOD, 2023). Exploring these topics has led to substantial research in tangential areas, such as resilience, social support, stress, and familial challenges with deployments (Pflieger et al., 2020).

Empirical Background

The past decade has produced significant research regarding MLSP mental health and resilience, exploring protective factors, identifying social support, family communication, physical health and well-being, SM mental health and well-being, and children as key contributors to military family satisfaction (Pflieger et al., 2020; Sinclair et al., 2019). Most recently, MLSP literature has explored mental health (Senior et al., 2023), resilience (Richer et al., 2022), work-family conflict (WFC; Park et al., 2023), and impacts from the COVID-19 pandemic (Fanari et al., 2022). Rates of depression and anxiety, and their connection to SM deployment, have been an important area of study with mixed results, as some studies have

indicated an increase in mental health utilization during deployments (De Burgh et al., 2011; Mansfield et al., 2010). Additionally, post-traumatic stress disorder (PTSD; Gorman et al., 2011), suicidality (Cole et al., 2021), and substance use disorders (Kulak et al., 2019) have been identified as MLSP mental health challenges.

Resilience, protective factors, and adaptive coping strategies have been provided as possible solutions for MLSPs struggling with their mental health. Resilience has been long explored in military literature and is a known protective factor for military families (Burgin & Prosek, 2021). MLSPs are uniquely positioned in military families to experience the brunt of many adversities, including deployments (Mansfield & Engel, 2011; Pflieger et al., 2020), reintegration (DeVoe et al., 2020; Ross et al., 2020), SM mental and physical health challenges (Cozza et al., 2022; Sharp et al., 2015), permanent change of station (PCS; Corry et al., 2022; Ribeiro et al., 2023), WFC (Park et al., 2023; Woodall et al., 2020) and employment changes during times of military separation or PCS (Park et al., 2023). Equipping MLSPs to exhibit resilience during these adversities is an integral part of military readiness, and while some resilience training and resources exist, they are still new to the community and underutilized (LaCroix et al., 2021).

MLSPs experience unique challenges within their careers where resilience can prove beneficial (Park et al., 2023). One's ability to overcome challenges and stress, particularly in the workplace, is essential to avoiding burnout. Burnout has been identified as the most important measure of occupational distress, particularly within helping professions (Maslach & Jackson, 1981). Today, it is defined as an individual's response to chronic occupational stress (Montero-Marin, 2016). Burnout uniquely impacts MLSPs, as they experience burnout at higher rates than civilian populations (Lester et al., 2016). Burnout is an occupational hazard for all counselors

(Bardhoshi et al., 2019), with a recent meta-analysis indicating that over 50% of therapists experience burnout in the profession (Lee et al., 2020). These statistics, combined with the challenges MLSPs face securing licensure in the profession (Ballard & Borden, 2020; Maury & Stone, 2014) denote the importance of exploring how MLSP counselors and counselor educators utilize resilience and practice coping to avoid burnout in the profession. However, scant research exists regarding MLSP counselor/CES mental health, resilience, coping, and burnout, illustrating a substantial gap in the literature, as MLSP counselors/CES fill a critical role in the military community (The Counsel of State Governments, 2022).

Theoretical Background

The theoretical framework for this study is resilience theory. Historically, resilience theory came to the field of psychology exploring how children from high-risk environments thrived, outlining specific factors that contributed to their success (Garmezy, 1991; Rutter, 1987). From these studies, researchers began applying this theory to additional phenomena, including the World Wars and events like September 11, 2001 (Masten, 2018). After application to major catastrophic events, researchers explored this concept in everyday adversity, investigating the concept of resilience more thoroughly. This has, however, been ripe with challenges, as resilience does not have a clear definition (Meredith et al., 2011). The main debate centers around the core processes of resilience, whether resilience is an innate trait or a state that can evolve and develop (Van Winkle & Lipari, 2015; Verdeli et al., 2011; Yates et al., 2015). This study will operate within the understanding of resilience that does not focus explicitly on risk factors but considers how the individual will navigate adversity and challenge.

Many theorists regard resilience as a bounce back from adversity through adaption to the circumstance, harnessing personal growth from the experience (Richardson, 2016; Rutter, 2012).

This perspective of resilience can be found throughout resilience literature, as this perspective includes both trait and state components and can be applied broadly in many settings. There are three core components to resilience: the presence of adversity, protective factors to overcome the challenge, and adaptive growth from the experience (Stainton et al., 2019). Some assert that resilience is a developmental process and a learned behavioral response that grows over time after exposure to challenge (Verdeli et al., 2011). This perspective makes resilience theory an ideal lens to explore the MLSP counselor/CES experience, as both populations are known for their abilities to experience challenges and overcome them. Exploring populations with high levels of adversity and exposure to stress, such as MLSPs and counselors/CES, can continue to highlight the positive adaptations that resilience can foster.

Problem Statement

MLSP mental health and resilience have been illustrated as a significant area of research in previous literature (O'Neal et al., 2020; Sinclair et al., 2019), but burnout and coping constructs are less present in MLSP studies (Lucier-Greer et al., 2020). Counselor/CES mental health is often shrouded in extant literature by coping and burnout, both of which maintain feature focus in research settings (Bardhoshi et al., 2019; Rosenberger & Bang, 2023). The dearth of literature regarding counselor/CES mental health is a cause for concern for the future of the profession, as it is known that mental health significantly impacts coping and burnout rates (Zhang et al., 2021; Zhang et al., 2023). The problem is that MLSP mental health issues (Lester et al., 2016) and counselor/CES burnout (Fye et al., 2021) continue to increase in severity, and the MLSP counselors/CES who hold this intersectional identity are impacted by both military and professional adversities (The Counsel of State Governments, 2022). At the intersection between MLSP and counselors/CES, there is a gap that, when filled, would provide vital

information in protecting a group whose presence is vital to the military community (The Counsel of State Governments, 2022).

There are multiple, shared intersections in MLSP and counselor/CES literature. WFC has shown significant impacts in both MLSP and counselor/CES populations, with each study identifying areas of further exploration in both populations (Eckhart & Ziomek-Daigle, 2019; Park et al., 2023). WFC, or the conflict between work demands and family responsibilities that cause an inability to fulfill both roles (French et al., 2018), has been outlined as a key contributor to mental health in both populations (Eckhart & Ziomek-Daigle, 2019; Sinclair et al., 2019). As MLSPs report higher WFC levels than their civilian peers (Blue Star Families [BSF], 2021), exploring occupational challenges for MLSP counselors could provide critical information for burnout prevention.

Burnout is another intersection in MLSP and counselor/CES literature. Burnout among military mental health providers is a historical challenge, as they often carry high caseloads, have limited resources, and are consistently exposed to traumatic events and information (Ballenger-Browning et al., 2011; Clifford, 2014). While burnout interventions have been utilized in various disciplines to assist providers through coping skills, peer support, and resilience training, these interventions have provided mixed results (Coleman et al., 2020; Delaney et al., 2023; Keyser et al., 2021; Weidlich & Ugarriza, 2015). Military mental health providers must learn the history, skills, and contributions of a military unit to provide effective services (Delaney et al., 2023). While training and cultural competency is an important way for civilian mental health providers to build trust with SMs seeking treatment (Collins et al., 2023; Powers & Lajoie, 2023), MLSP counselors are uniquely positioned to provide services to SMs, as they have their connections with military culture (The Counsel of State Governments, 2022). The problem is that both MLSP

mental health challenges (Lester et al., 2016) and counselor burnout (Fye et al., 2021) continue to increase at alarming rates, creating a need for targeted support for MLSP counselors to bolster resilience through coping skills. Addressing this challenge will subsequently strengthen the U.S. military and their families as well as the mental health community. This study seeks to address these key areas by providing a thorough, quantitative analysis of a sample of MLSP counselors/CES.

Purpose Statement

The purpose of this quantitative, descriptive, cross-sectional correlational research study grounded in resilience theory is to fill the current research gap in MLSP and counselor/CES literature by exploring the relationships between mental health and burnout through resilience moderated by coping in a sample of MLSP counselors. Relevant findings from this study could create opportunities for targeted interventions for military mental health providers who are also personally affiliated with the military and experience the adversities that come with the military lifestyle. MLSPs who provide counseling in private practice settings may also benefit from a better understanding of how military-related challenges and adversity influence their perceived resilience, occupational burnout, and coping skills. This study may also provide support for SMs and their families as they seek mental health services from counselors who understand their unique challenges. Resilience is a complex facet of the human experience and has multiple adaptive factors associated with it throughout the literature (Meredith et al., 2011). This study explores how resilience can mitigate burnout in both the personal (MLSP) and occupational (counselor/CES) spheres of this population. Findings from this study inform how MLSP counselors/CES utilize resilience to maintain careers in the counseling profession and how they cope with the challenges they face.

While resilience is normal, or experienced by most individuals who face adversity (Rosenberger & Bang, 2023), there are known factors, often in the form of coping, that can contribute to its growth, including appropriate physical and mental care, hobbies, and social support (Mullenbach & Skovholt, 2016; Sinclair et al., 2019). When specific populations experience increased adversity and challenge, it is important to assess these factors and the environment that contributes to an individual's resilience (Weathers et al., 2013). Understanding how MLSPs grow in resilience via coping mechanisms and how this contributes to their work as counselors would provide the foundation for specific interventions to equip both MLSPs and counselors experiencing burnout in their lives. Equipping MLSPs and counselors/CES to address their mental health would provide protective factors for burnout, an occupational risk for all counselors (Bardhoshi et al., 2019). This would also serve to bolster SM mental health and readiness, as SMs whose spouses struggle with mental health also experience additional vulnerability and stress (Sinclair et al., 2019).

MLSPs are an essential component of the military family, and those who provide mental health services serve the military community in another sacrificial way (Sinclair et al., 2019). Providing the best resources for our MLSP counselors and CES is essential to the military's health and well-being (The Counsel of State Governments, 2022). Thus, by analyzing the relationships between mental health, burnout, coping, and resilience, specific interventions can be identified to provide support for this important facet of the military community.

Significance of the Study

The importance of MLSP mental health and resilience to the military family, particularly the SM, is well documented (Green et al., 2013; Lester et al., 2010). The MLSP is essential to maintaining military families, particularly in the SM's absence, and is crucial to supporting the

military mission (Dimiceli et al., 2010). The well-being of MLSPs not only increases SM retention (Dolphin et al., 2015) but also assists SMs in healthier ways of coping with their adversities (Skomorovsky et al., 2022).

Counselors/CES have the unique position of learning to cope with their own challenges while also carrying the weight of others' challenges from daily exposure (Bray, 2020). In addition to the professional challenges of the counseling field, MLSP counselors/CES also face licensure portability, credentialling, and legislation challenges when moving from military stations (Ballard & Borden, 2020; The Counsel of State Governments, 2022; Maury & Stone, 2014). Even more challenging is how MLSP counselors must juggle their own military-related adversities while maintaining efficacy as a counselor/CES (The Counsel of State Governments, 2022), an area widely ignored in extant literature.

No studies have combined these two populations, both of which signify a strong presence in military installations and communities, into a cohort to explore this intersectional identity. Findings from this study provide critical information for MLSP counselors/CES to increase resilience and mitigate burnout in their employment. Without proactive interventions or systematic support, the military's current operation tempo (OPTEMPO) will continue to negatively impact military families and the counselors who serve them (Powers & Lajoie, 2023). Increased resilience will support MLSP counselors/CES with a healthier work-life balance and an increased ability to bounce back after the challenges the U.S. military can provide.

Research Questions

RQ1: Does a higher rate of mental health issues, to include depression, anxiety, and post-traumatic stress disorder measured by the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), the Generalized Anxiety Disorder 7 (GAD-7; Spitzer et al., 2006), and PTSD Checklist

(PCL-5; Weathers et al., 2013), increase the prevalence of burnout, measured by the Counselor Burnout Inventory (CBI; Lee et al., 2007), in MLSP counselors/CES?

Figure 1.1

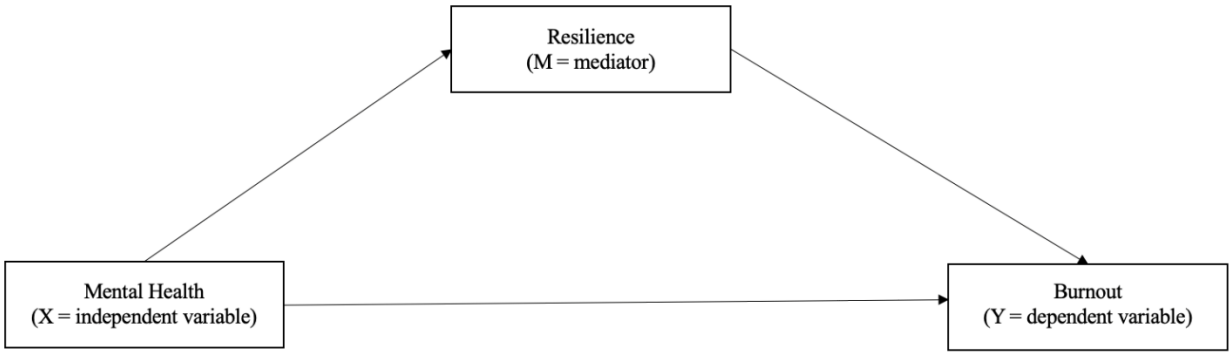
Hypothesized Theoretical Model One

This question seeks to explore how mental health contributes to the presence of burnout within this intersectional identity. The impacts of mental health are well documented in both MLSP (O'Neal et al., 2020; Sinclair et al., 2019) and counselor/CES (Voon et al., 2022; Zhang et al., 2021) literature. As MLSPs experience unique stressors associated with the military lifestyle (Padden et al., 2011; Wilson & Murray, 2016) and counselors/CES experience unique occupational stressors (Zhang et al., 2021; Zhang et al., 2023), understanding MLSP counselors/CES mental health and burnout rates would contribute to MLSP, counselor/CES, and military mental health research.

RQ2: Does resilience, as measured by the Brief Resilience Scale (BRS; Smith et al., 2008), mediate the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI) in MLSP counselors/CES?

Figure 1.2

Hypothesized Theoretical Model Two

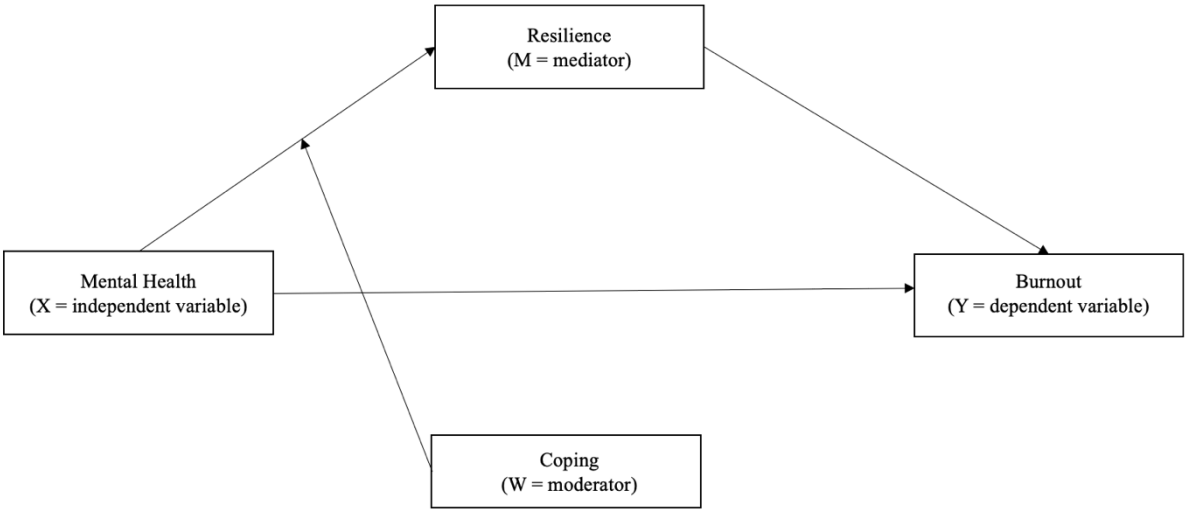


Resilience has become a focus of literature in both MLSP (Sinclair et al., 2019) and counselor/CES (Hou & Skovholt, 2020; Rosenberger & Bang, 2023) contexts. Resilience has been shown to mitigate both mental health challenges (LaCroix et al., 2021; Sinclair et al., 2019) and burnout (Litam et al., 2021), proving essential to the design of this study. Additionally, a thorough examination of how resilience may mediate the relationship between mental health and burnout could prove beneficial for insulating MLSP counselors/CES from burnout in the profession.

RQ3: What moderating effects, if any, does coping, as measured by the Coping Strategies Inventory- Short Form (CSI-SF; Addison et al., 2007), have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and resilience (BRS)?

Figure 1.3

Hypothesized Theoretical Model Three

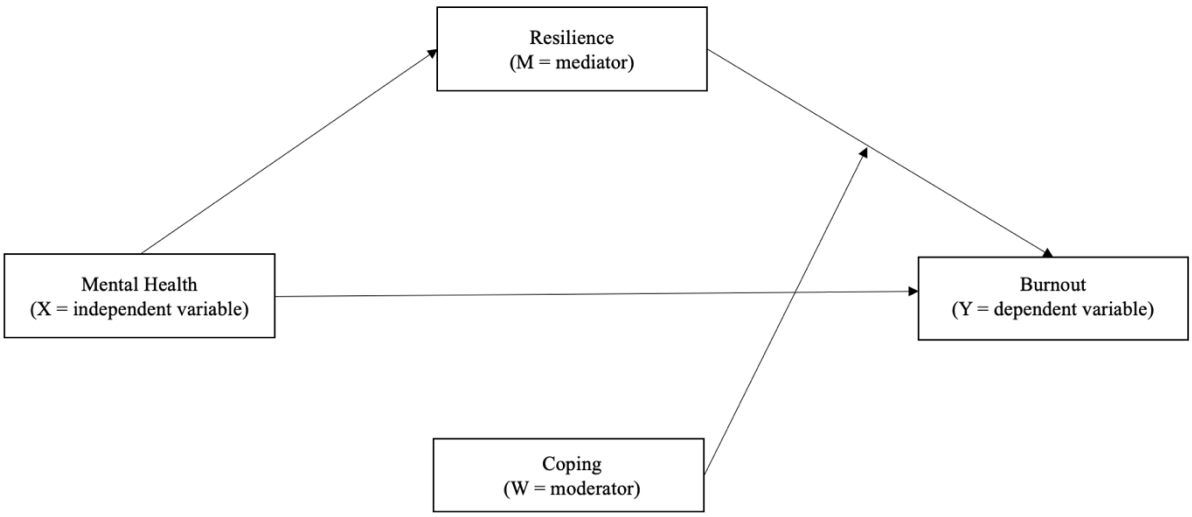


This study also explores any potential moderating effects that coping may exert on the relationship between mental health and resilience. Coping has been shown to improve mental health outcomes (Lambert & Lawson, 2013; Wang et al., 2018) and positively contribute to an individual's response to adversity (Folkman & Moskowitz, 2004). This indicates the importance of incorporating coping into this study's research design.

RQ4: What moderating effects, if any, does coping (CSI-SF) have on the relationship between resilience (BRS) and burnout (CBI)?

Figure 1.4

Hypothesized Theoretical Model Four

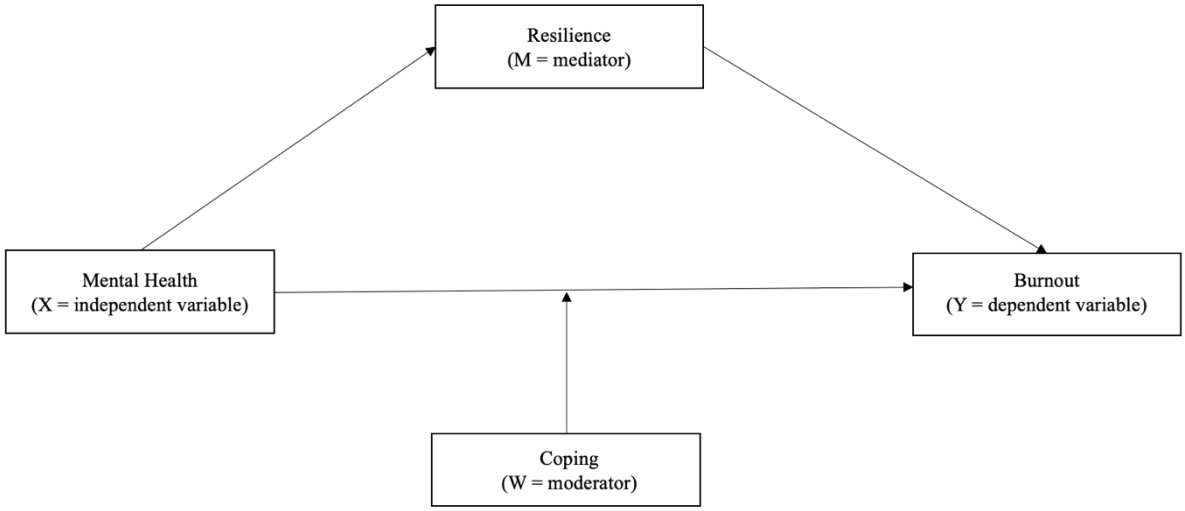


This study also explores the potential moderating effects coping could apply to the relationship between resilience and burnout. As individuals who exhibit resilience typically practice coping skills in adversity (Folkman & Moskowitz, 2004; Skomorovsky & Bullock, 2017), it is important to explore this relationship and how coping may exert moderating effects on the relationship between resilience and burnout.

RQ5: What moderating effects, if any, does coping (CSI-SF) have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI)?

Figure 1.5

Hypothesized Theoretical Model Five



Finally, this study seeks to explore any extant moderating effects coping may exhibit on the relationship between mental health and burnout. Coping skills have been shown to improve mental health (Lambert & Lawson, 2013; Wang et al., 2018) and improve burnout symptoms (Boland et al., 2019; Lee et al., 2016), indicating the possibility of moderating effects.

Definitions

1. *Adversity* refers to a situation or event that is stressful in nature (Greene, 2017) and has the potential to become a risk factor for negative outcomes (Yates et al., 2015).
2. *Anxiety* is an emotion characterized by tension, racing thoughts, and somatic symptoms, such as increased blood pressure or sweating; excessive prevalence of anxiety may lead to an anxiety disorder, characterized by recurrent intrusive thoughts and concerns (American Psychological Association, 2022).
3. *Burnout* is an occupational condition where an individual experiences emotional exhaustion, depersonalization, and reduced efficacy at work (Maslach & Jackson, 1981).
4. *Coping* is defined as cognitive or behavioral efforts that individuals utilize to overcome problems or attempt to minimize the stress associated with their environments (Zhang et

al., 2020) when events or environments exceed the resources of a person (Lazarus & Folkman, 1984).

5. *Counselors* are individuals who have completed a master's or doctoral degree in mental health counseling and obtain a license granted by a state or national licensing body, including licensed professional counselors, clinical mental health counselors, social workers, and marriage and family therapists (American Counseling Association [ACA], 2023).
6. *Counselor Educators and Supervisors (CES)* are professional counselors engaged in educating and supervising counselors-in-training or pre-licensed counselors; these individuals oversee clinical skill development and operate within formal relationships to prepare counselors for professional practice (ACA, 2014).
7. *Deployment* is a military operation that may occur stateside or internationally where the SM leaves for a varying amount of time; deployments may serve the purposes of combat, training, disaster relief, or diplomacy (Allen et al., 2011; Dimiceli et al., 2010; Fields et al., 2012; Richer et al., 2022).
8. *Depression* is a common illness that negatively affects feeling, thinking, and action; depression causes feelings of sadness and a loss of interest in previously enjoyed activities and causes challenges in occupational and interpersonal functioning (American Psychiatric Association [APA], 2020).
9. *Emotion-focused coping (EFC)* refers to ways an individual may learn to cope with negative emotional reactions (Boland et al., 2019; Lazarus & Folkman, 1984).
10. *Expiration term of service (ETS)* refers to when a service member's enlistment, reenlistment, or extension of enlistment expires (United States Air Force, 2023).

11. *Mental health* can be defined as an individual's emotional and mental well-being and life satisfaction (Salsman et al., 2015).
12. *Military spouses (MLSPs)* are individuals married to service members in the United States military, with most of these individuals being female (BSF, 2023).
13. *Permanent change of station (PCS)* is a longer-term assignment, generally between two to four years, that results in moving between military installations (DOD, 2023).
14. *Post-traumatic stress disorder (PTSD)* is a psychiatric disorder that can occur in individuals who have experienced or witnessed a traumatic event or circumstance; PTSD may cause intense, disturbing thoughts and feelings and may cause avoidance of stressful stimuli or reminders of the event (APA, 2022).
15. *Problem-focused coping (PFC)* represents ways an individual may act in a stressful situation to enact change (Boland et al., 2019; Lazarus & Folkman, 1984).
16. *Protective factors* mitigate the risk associated with adversity and increase the likelihood of position impact by buffering potential negative outcomes. (Yates et al., 2015); it is also considered aspects of a person or community's environment that support positive outcomes (Sullivan et al., 2021).
17. *Resilience* is a complex phenomenon where an individual exhibits positive growth and adaptation through adverse experiences or environments (Richardson, 2016; Southwick et al., 2014).
18. *Service members (SMs)* are individuals who serve within the United States military, including the Army, Navy, Coast Guard, Marine Corps, Air Force, and Space Force, and their guard and reserve components (United States Department of Justice, 2010).

19. *Work-family conflict (WFC)* exists when the obligations of work and family are incompatible (French et al., 2018), creating inter-role conflict that leads to lower satisfaction in both areas (French et al., 2018).

Summary

MLSPs are an integral part of the military community and represent an important contribution to military readiness. MLSP mental health challenges, including depression (Mansfield et al., 2010), anxiety (Fields et al., 2012), suicidality (Cole et al., 2021), post-traumatic stress (Gorman et al., 2011), vicarious trauma (Diehle et al., 2017), and substance use (Kulak et al., 2019), have been identified as key areas to address to address military readiness and retention of SMs and their families (Mailey et al., 2018). These mental health challenges are exacerbated by the adversities of the military lifestyle, such as deployments and frequent relocations, that occur in addition to normative life and occupational stressors.

MLSPs face additional occupational stressors, as frequent relocation impacts career opportunities (BSF, 2017). Over 50% of MLSPs pursue careers that require licensure, such as professional counseling (Maury & Stone, 2014). Counselors/CES fill essential roles in the military community, providing mental health services to SMs and their families (The Counsel of State Governments, 2022). Extant literature, which will be thoroughly investigated in the coming chapter, has indicated that it is time to explore more thoroughly the factors that contribute to MLSP and counselor mental health, resilience, coping, and burnout. This study fills this gap by combining these two populations and exploring these factors in MLSP counselors/CES utilizing a survey with a snowball sampling of respondents to determine possible interventions moving forward. Insight from this study contributes to both the counseling profession and the military community at large.

CHAPTER TWO: REVIEW OF THE LITERATURE

Overview

The DOD has outlined military readiness as one of its key purposes, dedicating a substantial amount of research to SM readiness and the differing factors that contribute to military success (McLemore et al., 2021). In recent years, the contributions of MLSPs to SMs have exhibited greater impacts and earned a place within military readiness literature (Borah & Fina, 2017; Cole & Cowan, 2022; Sinclair et al., 2019). Several factors contribute to MLSP resilience and quality of life, including mental health (Corry et al., 2022), perceived social support and community (Corry et al., 2021; Wang et al., 2015), marital satisfaction (Gilbert, 2020), employment (Godier-McBard et al., 2020), substance use (Kulak et al., 2019), and communication with spouse during deployments (Villagran et al., 2013). This study seeks to explore the factors that positively contribute to MLSP counselors and CES, as military mental health providers face specific challenges with burnout and coping (Clifford, 2014; Leners et al., 2014). Utilizing resilience theory as a theoretical framework, the following review of the literature will explore the factors that impact MLSP counselors' resiliency, including the challenges of WFC, burnout, and coping specifically outlined in the literature. Additionally, this review will explore the areas of impact for military readiness, SMs, and the counseling profession.

Theoretical Framework: Resilience Theory

This study is grounded in resilience theory, established in the field of psychology and psychotherapy as well as multiple sociological disciplines (Goldstein & Brooks, 2013). Resilience research continues to expand, as does its operational definition, which now includes characteristics and context regarding age, gender, socioeconomic status, genetics, and cultural

and developmental characteristics (Connor & Davidson, 2003). These characteristics work together to illustrate that resilience cannot necessarily be measured as a binary entity, but rather a multidimensional continuum or spectrum (Joyce et al., 2018; Van Breda, 2018). Thus, creating an operational definition for resilience can be challenging but essential for the purposes of this study.

The framework for resilience theory considers how promotive factors may assist positive development while resiliency models explore processes and relationships, analyzing strategies to test resilience and operationalize resilience within participants (Zimmerman, 2013). Resilience theory explores positive contextual, social, and individual variables, called *promotive factors,* that inform and disrupt trajectories of development that cause problematic behavior, poor mental health outcomes and distress (Fergus & Zimmerman, 2005). These variables are identified through the means of phenomenological inquiry and the identification of factors that contributed to survivors' strength in adversity (Richardson, 2002).

Resilience theory found its roots in the figures and events of the 19th century, including Charles Darwin and Sigmund Freud, as well as the Great Depression and World Wars I and II, causing researchers to explore why some survivors exhibited positive coping skills while others could not adapt after their experiences (Masten, 2018). Werner & Smith (1982) began a longitudinal study of a community for 30 years, exploring children in high-risk environments and categorizing the factors that contributed to success. This study laid the foundation for other research, leading to the identification of specific factors that contributed to improved outcomes after adversity (Garmezy, 1991; Rutter, 1987).

During the 1990s, researchers began exploring specific influences that contribute to positive adaptation and coping. This identified clear protective factors that promote resilience

while also creating a process by which individuals can overcome challenges (Fletcher & Sarkar, 2013). Research expanded to include communities that experience adversity in multiple levels and spheres of life, now contributing to the research of the 21st century (Masten, 2018). Resilience research increased significantly in the 2000s, as psychologists began recognizing that resilience has positive impacts on mental health outcomes. Now, resilience theory incorporates multiple demographic and focal areas, including age, employment, community, socioeconomic, and military affiliation (Masten, 2018).

More recently, defining resilience and outlining its processes has become more challenging, as research has indicated differing contributing factors to overcoming adversity (Van Breda, 2018). For example, authors have explored distinctions between trait, or dispositional resilience, and state resilience, indicating potential dichotomies regarding the development of resilience, including if resilience is developed as a trait, as an outcome of facing adversity, or a product of development over time (Stainton et al., 2019). Some researchers assert that resilience is a process of development and a learned behavioral response that can grow over the lifespan, leading to the complexity of identifying its key processes (Verdeli et al., 2011).

While some have vocalized skepticism about utilizing resilience theory as a theoretical framework (Van Breda, 2018), the body of research has indicated the validity and importance of resilience in mental health outcomes and indicates further areas of exploration (Yates et al., 2015). Though no singular framework of resilience theory exists, it is important to recognize that resilience occurs on a spectrum, as no individual is considered resilient or not resilient (Van Breda, 2018). This is of particular importance when evaluating the resilience of a specific population with multiple adverse experiences, such as MLSPs and counselors/CES.

Defining Resilience

While no singular definition for resilience exists, resiliency is commonly characterized as an individual's ability to bounce back after experiencing risk or adversity (Rutter, 2012; Southwick & Charney, 2012). This bounce-back concept includes exhibiting signs of positive adaptation after going through significant hardship (Fikretoglu & McCreary, 2012). More recently, research has indicated three core components of resilience: the presence of adversity, protective factors that overcome this adversity, and subsequent positive growth and outcomes (Stainton et al., 2019). Historically, however, the origins of resiliency theory are complicated, with differing perspectives and disciplines contributing to its development. Understanding the way resilience impacts populations that experience high levels of adversity, particularly military families and, more specifically, MLSPs, can continue to shed light on the functions and outcomes of resilience in day-to-day life.

Related Literature

MLSPs are an integral factor in considering military readiness, as they support SMs throughout their military careers (Corry et al., 2019). Thus, exploring the challenges facing MLSPs that impact personal, marital, and familial well-being as well as factors that insulate and support resilience is important for the future of the military at large (Sinclair et al., 2019). Spousal mental and physical health, perceived stress, coping skills, quality of life, marital satisfaction and warmth, social support, and resilience have all shown significant impacts on the SM (Lester et al., 2010; Mansfield et al., 2010; Sinclair et al., 2019), indicating the importance of MLSP literature in the military zeitgeist.

Military Spouse Demographics

As indicated in the literature, multiple factors influence MLSP resiliency, including but not limited to age, gender, socioeconomic status, cultural or ethnic background, as well as their trauma history (Sinclair et al., 2019). MLSPs are diverse and have a variety of experiences in their military journeys (BSF, 2023). Thus, exploring these demographic variations between MLSPs is essential to investigate resiliency for the population.

In 2019, there were 605,716 active-duty MLSPs and 363,462 selected reserve spouses, with 64% of these individuals being less than 36 years old (Clearinghouse for Military Family Readiness, 2021). Active-duty spouses are typically younger than reserve spouses, with approximately 71% of active-duty spouses reporting an age of less than 36 years old and 49% younger than 30 years old. Over 91% of active-duty spouses and 86% of reserve spouses are female (DOD, 2020). Most active-duty MLSPs are Caucasian (79%), followed by Hispanic/Latino (16%), African American (15%), Asian (9%), American Indian/Alaskan Native (3%), and Native Hawaiian/Pacific Islander (2%; Office of People Analytics, 2019). Approximately 67% of active-duty MLSPs report having children under the age of 18 in the home, 57% have children under the age of five, and 25% have a child aged two or younger (Office of People Analytics, 2019). Additionally, 25% of active-duty spouses report having a child with special needs (Office of People Analytics, 2020), which is significantly higher than the most recent national average (4.3%; Young, 2021).

MLSPs have unique needs and positions regarding education and employment. In 2019, 23% of active-duty MLSPs were enrolled in school or post-high school training while 41% reported they were not enrolled but wanted to pursue enrollment (Clearinghouse, 2021). The unemployment rate for MLSPs has increased in the last 10 years, from 26% in 2010 to 29% in 2022, with more than half of active-duty MLSPs reporting employment as an issue (BSF, 2021;

BSF, 2023). Several factors lead to the higher-than-average unemployment rate, including relocations due to permanent change of station (PCS), children in the home, age, education, and minority status (Office of People Analytics, 2020). Of the active-duty MLSPs who are employed, only 56% have a job in their area of education or training and 32% are working part-time (Office of People Analytics, 2020).

The Current Military Landscape

The Global War on Terror (GWOT) has been the longest United States military engagement and has significantly changed the outlook of the military lifestyle (Saab, 2022). During the last 20 years of military presence in the Middle East, the United States engaged in Operations Iraqi Freedom, New Dawn, Inherent Resolve, Enduring Freedom, and Freedom's Sentinel (Saab, 2022). While military operations in Afghanistan have unexpectedly concluded, SMs still experience deployments to maintain a presence in Iraq to represent American interests (Lockett et al., 2023; Saab, 2022). Additionally, special operations SMs continue to deploy around the world and represent a key component of our military readiness (Lockett et al., 2023).

These deployments undoubtedly come with a cost for the military family. While all military family members experience stressors and challenges during deployments (Mansfield et al., 2010; Skomorovsky & Bullock, 2017), the MLSP is uniquely positioned to maintain the stability of the military family during this time. Military culture influences spouses in that they feel responsible for the care of the whole military family unit, often leading to hesitancy in taking care of themselves (Mailey et al., 2018). Studies have shown that rates of MLSP depression, anxiety, and substance use increase during deployments (Eaton et al., 2008; Mansfield et al., 2010; Mansfield & Engel, 2011). As MLSPs continue to face adversities related to the current military lifestyle, research regarding how resilience, coping, and other protective

factors impact the MLSP will continue to provide support for the military family and the American soldier.

Military Spouses and Adversity

MLSPs face challenges and adversity that are unique to the military experience. First, and perhaps most complex, the MLSP is faced with challenges specific to military deployments, including physical separation from their SM, increased stress due to SM endangerment, fluctuating logistical and emotional stability for the family unit, and the subsequent impacts on MLSP mental health (Blakely et al., 2012, Green et al., 2013). In addition to the challenges present during deployment, MLSPs experience other impacts, such as increased distance from families of origin, including overseas duty stations (Cozza, 2014; Eubanks, 2013). These difficulties usually lead MLSPs to pursue careers with flexible schedules, or forego traditional careers entirely, to accommodate the MLSP lifestyle (Borah & Fina, 2017). Military-specific stressors are a daily aspect of the MLSP lifestyle, and exploring these challenges provides additional insight into key contributors to MLSP mental health.

Deployment

The GWOT has been the longest military conflict in American history, now surpassing the Vietnam War (Saab, 2022). Although American operations in Afghanistan have recently concluded, American SMs are still deployed in the Middle East to accomplish new mission objectives. The deployments of Operational Iraqi Freedom and Operation Enduring Freedom have been some of the longest in recent history, often spanning nine to 12 months in length (Saab, 2022). While all military family members experience the stress of deployments (Kudler & Porter, 2013; Mansfield et al., 2010; Paley et al., 2013), deployments are specifically challenging for the MLSP and his/her mental health (Mansfield & Engel, 2011). MLSP rates of anxiety and

depression increase during deployments (Baer, 2019), and they utilize mental health services at an increased rate during SM deployments (Eaton et al., 2008). Mansfield et al. (2010) found that approximately 36% of MLSPs had at least one mental health diagnosis during a deployment.

Deployments often exacerbate stress in spouses due to their last-minute changes or notice for the family to make arrangements (Gribble & Fear, 2022). SMs often report positive outcomes from deployment, such as social support and self-mastery, while spouses report loneliness and disconnection (Pflieger et al., 2020). In the current generation of MLSPs, SMs would occasionally experience another deployment within 12 months of returning home (Paley et al., 2013). This creates significant challenges in establishing a "battle rhythm" at home, as a lack of consistency and predictability causes increased stress on the MLSP and family (Villagran et al., 2013, p. 778).

While all MLSPs are at risk for increased levels of stress, newer, less experienced MLSPs may struggle to utilize available resources, particularly during times of military separation (Monney, 2019). However, some younger spouses experience increased coping during deployments in comparison with older spouses, particularly if they are not parenting young children, contemplating significant career decisions, and experiencing cumulative military stress over time (Greene, 2017). As all MLSPs experience stressors during SM deployments, the continued stress of reintegration often leads to increased challenges for the military family.

Reintegration

The reintegration of SMs into the home environment post-deployment has been an area of significant study for military-specific adversity. Research suggests that reintegration stress reaches its peak about four to nine months after the SM's return (Marek & D'Aniello, 2014). MLSPs face multiple challenges during the reintegration period, experiencing significant stress

(Ross et al., 2020). Spouses of National Guard or Reserve SMs may experience increased challenges of reintegration, as these families may have reduced access to support systems in comparison to their active-duty counterparts (Ross et al., 2020). Reintegration stress can impact the SM and the family's well-being for months or years to come (Marek & D'Aniello, 2014).

Multiple factors impact the military family during reintegration, and each military family and spouse can experience reintegration differently. Financial stress has been a consistent factor that creates difficulties for military families during reintegration (Allen et al., 2011). Deployment communication and the associated challenges with communication frequency and quality have been historical issues for military couples (Mallonee et al., 2020). Consistent communication between SM and spouse is an important way to prevent emotional distancing during deployment (Sayers et al., 2018). Poorer mental health, or changes in mental health, among both SMs and MLSPs, increases reunion stress post-deployment (Aducci et al., 2011; De Burgh et al., 2011; Mallonee et al., 2020).

More challengingly, even the SM's or MLSP's positive growth may result in increased difficulties during the reintegration period (DeVoe et al., 2020). Restructuring family roles, redistributing decision-making, and returning to interdependence between partners all contribute to increased reunion stress (Drew et al., 2022; Knobloch & Theiss, 2012). Returning SMs often experience challenges in managing household needs or feeling needed in the family unit after returning home (Drew et al., 2022). Similarly, spouses often report SMs having negative reactions to adaptive growth during the reintegration period (Aducci et al., 2011). MLSPs may feel overprotective of schedules they have established in the SM's absence, while others wish the SM would take over some responsibilities more quickly (DeVoe et al., 2020).

Others experience challenges with SM communication, as communication may be harsher and can place additional strain on child-rearing (DeVoe et al., 2020). This often leaves MLSPs with the task of teaching the SM the children's updated preferences and how parenting is most effective (Drew et al., 2022). After all these transitions, the military couple must also navigate reconnection both emotionally and physically, often reporting challenges with sexual intimacy after deployment as well (Knobloch & Theiss, 2012). These factors contribute to the overall stressors of reintegrating after deployments, an often taxing experience that can negatively impact SMs and their mental health (Mobbs & Bonanno, 2018).

Mental Health Stigma

Mental health stigma presents challenges for both SMs and MLSPs. Stigma can have a significant impact on SMs by preventing them from seeking help when they need it (Roscoe, 2021). This can lead to untreated mental health issues, which can negatively affect their performance on the job and their overall well-being (Hom et al., 2017). Mental health disorders are often a taboo topic in the military community, increasing extant stigma for SMs (Acosta et al., 2014; Roscoe, 2021). Additionally, the fear of being stigmatized for seeking help can discourage SMs from disclosing their mental health issues, which can create a culture of silence and shame around mental health in the military (Sharp et al., 2015). SMs may also try to protect MLSPs and family members by choosing isolation and silence around their mental health difficulties (Skomorovsky et al., 2020).

Military personnel have long been known to have beliefs that make it exceedingly difficult to seek mental health services (Mansfield et al., 2010). These beliefs have also impacted the MLSP, who report concern over how their mental health may impact the SM's career (Eaton et al., 2008; Mansfield et al., 2010). While the military family is provided TRICARE and mental

health coverage, these resources are widely underutilized due to stigma (Amato et al., 2017). Additionally, military moves make continuity of care a challenge for SMs, MLSPs, and the military family (Amato et al., 2017), discouraging effective utilization of these services.

Permanent Change of Station (PCS) and Expiration Terms of Service (ETS)

Most active-duty military families experience a PCS during their military service, with little input on their station choice (Ribeiro et al., 2023). These changes create disruption in the family's lifestyle, particularly within the MLSP's social support networks (Corry et al., 2022; Knobloch & Theiss, 2012). A PCS is even more mentally and emotionally challenging for MLSPs who are parents, as they seek to establish new normal routines and build new networks (Blakely et al., 2012). In fact, Ribeiro and colleagues (2023) found that service-related moves increased spousal distress and accounted for PTSD symptoms in greater severity than SM deployments.

Military families may also experience an outside the contiguous United States (OCONUS) PCS, increasing the risk of psychological stress (Ribeiro et al., 2023). Due to separation from family systems, MLSPs often must make challenging decisions regarding employment, childcare, and housing to accommodate these differences and facilitate military relocations (Farrell et al., 2014). This often includes managing the logistics required for maintaining the household and occasionally even completing military relocations without the assistance of the SM, as SM obligations preclude them from being available during business hours to handle important logistical steps (Blakely et al., 2012). Additionally, the MLSP is often responsible for enrolling family members in appropriate activities and schools (Farrell et al., 2014; Mailey et al., 2018). These responsibilities often take priority over the MLSP's mental health needs (Eubanks, 2013). It can be challenging for spouses to connect with new local

supports within a community, and it can be difficult for spouses to create new communities for their children and themselves (Cole & Cowan, 2022; Lewy et al., 2014).

Each year, approximately 200,000 SMs leave the military, or experience an expiration term of service (ETS; Government Accounting Office, 2019). Veterans who ETS struggle with the changes in schedule, home life, income, and the change from military to civilian life (Mobbs & Bonanno, 2018). Bond and colleagues (2022) found that veterans experience less life satisfaction, poorer mental health, increased depression and PTSD symptoms, financial distress, and excessive opioid use in comparison to commensurate civilians. Alongside these challenges for the SM, the MLSP also experiences a loss of military identity and a sense of community intrinsic to the military life (Thompson et al., 2017). Older MLSPs may also feel additional stress from the SM's decision to ETS to seek additional opportunities (Cooper et al., 2017). Spouses of SMs who have ETS'd experience increased WFC, or situations where the demands of work and family coincide (French et al., 2018), and challenges within marriage satisfaction than those who have remained in the service (Corry et al., 2022).

Military Transition Theory

Creating meaningful connections after military service can be challenging and can impact the veteran's well-being. Military Transition Theory (Castro et al., 2015) explores the causal impact of civilian communities on a veteran's transition. This theory also supports veteran spouses and how they are also affected by their spouses' ETS, as MLSP support systems are often connected to the SM's unit and its connected families (Dodge et al., 2022). The military/civilian gap (Taylor, 2011) is the divide present between military and civilian culture, typically created by a majority of the civilian public having little to no experience with SMs and their families, thus exhibiting a lack of understanding of military service. This gap often impacts

veteran spouses' ability to integrate into new communities and create social support after ETS (Dodge et al., 2022). Keeling and colleagues (2020) discuss the dearth of literature regarding veteran spouses and provide a call to action into the experiences of veteran spouses.

Caregiver Burden

An unfortunate reality of war is that not all SMs return home in the same condition they left, leaving the MLSP with the multi-faceted challenge of caring for their wounded, sick, or injured SM (Thandi et al., 2018). Caregiving for a wounded spouse often causes increased stress, depression, or anxiety for the MLSP (Eubanks, 2013). During American operations in the Middle East, over 60,000 SMs have been critically injured since 2001 (Defense Casualty Analysis System, 2023). PTSD and depression have both been shown to negatively impact health-related quality of life in SMs with a physical injury from combat (Harbertson et al., 2023). This, in turn, impacts MLSP mental health (Cozza et al., 2022; Thandi et al., 2018). In SMs with illness or injury, SMs psychological health can predict the psychological health of the spouse (Skomorovsky et al., 2022). However, the number of MLSPs caring for wounded SMs is significantly lower than the MLSPs experiencing the bulk of caregiving for children in the military community (BSF, 2023; Defense Casualty Analysis System, 2023).

Work-Family Conflict (WFC)

More active-duty SMs are married with children in the home than in previous military conflicts (Lester et al., 2010). Social isolation during deployment with young children in the home can be the most difficult challenge for civilian MLSPs (Strong & Lee, 2017). Over two-thirds of MLSPs report that recreational activities with provided childcare are not available during deployment, with 38% citing this as a critical need for support (BSF, 2021). MLSPs are

often left to manage their mental health to fulfill the demands of parenting and the military lifestyle (Lara-Cinisomo et al., 2020).

WFC refers to situations in which the demands of work and family roles are incompatible, such that fulfilling one role makes it difficult to fulfill the other role (French et al., 2018). The challenges of WFC for MLSPs are one of the greatest barriers to mental stability for the MLSP (Sinclair et al., 2019). MLSPs who leave the workforce by choice report higher marital quality than spouses who are working part-time, full-time, or are looking for work due to the stressors of WFC (Woodall et al., 2020). WFC is largely related to each family's military-specific stressors rather than family-specific stressors, such as the number of children in the home (Park et al., 2023). While employment is typically associated with positive outcomes for MLSPs, balancing a career and full-time parenting due to the SM's OPTEMPO can overload spouses as well (Pflieger et al., 2018).

Military Spouse Employment

MLSPs have high levels of education but are often un- or underemployed due to military relocation and face challenges to maintain a career during their spouse's military service (BSF, 2017; Lim & Schulker, 2010). In 2022, 21% of active-duty spouses reported being unemployed but actively seeking employment (BSF, 2023). Additionally, MLSPs face lower wages, employer buy-in, and earning power due to these challenges while having higher than average levels of education than their civilian counterparts (Maury & Stone, 2014). Approximately 50% of MLSPs work in a field that requires state licensure, certifications, or credentials for employment (Ballard & Borden, 2020; Maury & Stone, 2014). In addition, 40% of MLSPs have faced challenges with licensure portability after a military move (Ballard & Borden, 2020; BSF, 2023). However, 37% of state boards who have legislation supporting expedited licensure applications for MLSPs did

not offer them, and accommodations for MLSPs are not always publicly announced or displayed, thus increasing challenges of licensure portability for spouses (Ballard & Borden, 2020).

Licensure portability for MLSPs has significantly impacted the counseling profession, as the licensure process remains state-based and varies widely from state to state (The Counsel of State Governments, 2022). This creates employment challenges for the MLSP, as reciprocity for licensure due to military relocation does exist in some states but not all (Ballard & Borden, 2020; Owen & Combs, 2017). For active-duty spouses requiring a new professional license after PCS, the time required to obtain a license was less than one month for 12% of spouses, one to four months for 42% of spouses, four to seven months for 19% of spouses, seven to ten months for 7% of spouses, and over ten months 20% of spouses (Office of People Analytics, 2020). These time requirements create significant impacts on the family system in addition to the challenges and adversity of the PCS itself.

An important factor in MLSP employment is the challenge of finding flexible and affordable childcare (Owen & Combs, 2017). The responsibilities of the MLSP fluctuate depending on the SM's operational requirements. While the SM is stateside, for example, childcare may not be needed consistently as the SM is home after deployment to care for children (BSF, 2023). However, these needs change when the MLSP is the primary parent during the next deployment cycle, requiring the spouse to operate as a single parent during the deployment, thus impacting his/her career and need for childcare (Blakely et al., 2012).

Most recently, 33% of military families are unable to find childcare that works best for their situation (BSF, 2023). Approximately 12% of active-duty MLSPs who work part-time report that childcare is the primary factor for working less than full-time, and 14% of active-duty MLSPs who are not seeking employment report the cost of childcare as the main reason (Office

of People Analytics, 2020). Additionally, 34% of active-duty MLSPs who are unemployed but seeking employment report that the cost of childcare is too expensive, preventing them from working (BSF, 2021).

Employment for MLSPs is an integral part of military family readiness, as partner employment and financial stability contribute to well-being, both for the spouse and the family (Hawkins et al., 2018; Pflieger et al., 2018). Employed active-duty spouses report higher relationship satisfaction than MLSPs who want or need work (BSF, 2023). Employment support for MLSPs is beneficial, as it increases confidence in job seeking while also improving spousal perceptions of the military lifestyle and community (Godier-McBard et al., 2020).

As SMs consider ETS, partner employment increases the likelihood of a positive transition to civilian life (BSF, 2017). While aspects of ETS were previously believed to only impact SMs, such as finding employment, health care, and an overall sense of purpose, research has indicated that veteran spouses experience these challenges much in the same way (Thompson et al., 2017). Veteran spouses often take on the role of the breadwinner for their families in times of transition, as the veteran may experience longer unemployment than planned after ETS or may decide to utilize educational benefits for a short-term income replacement rather than finding long-term employment (Keeling et al., 2020). Veteran spousal employment prior to ETS has been shown to improve overall family outcomes as well (Richardson et al., 2023). The challenges veterans experience in their military transition significantly impacts both the active-duty and veteran communities and families, as SMs may not feel equipped to end their military service and secure employment, leading to a lack of morale and trust in the military long-term (Thompson et al., 2017). Thus, exploring the present challenges for MLSPs to retain employment supports both our active-duty and veteran communities and their families.

Social Support

Building community and social support is a consistent challenge for military families (Skomorovsky, 2014). The unpredictable nature of PCS (Cole & Cowan, 2022; Corry et al., 2022; Lewy et al., 2014) and ETS (Thompson et al., 2017) interrupts the entire family's community, causing significant ruptures within the MLSP's social networks. The role of social support in the MLSP community has shown significant predictive factors for psychological well-being (Ross et al., 2020; Skomorovsky, 2014). Most social support studies have examined how the presence of social support alleviates stressful life events, leading to a subsequent decrease in mental health symptoms (Ross et al., 2020). Social support from family, civilian friends, and partners during deployment is a significant predictor of lower levels of depression as well as overall better psychological health (Skomorovsky, 2014). Support from close family members also leads to greater resilience and self-efficacy (Pietrzak et al., 2010). However, the time constraints present due to the military lifestyle can serve as barriers for MLSPs to access these supports (Corry et al., 2022).

Connection to the military community, when possible, does help MLSPs develop a sense of mastery and control within the oscillating environment of the military (Wang et al., 2015). Individuals within the military community can provide helpful support and camaraderie due to shared experiences unique and specific to the military lifestyle (DeGraff et al., 2016). Active-duty spouses who report more connection to their military community often report greater levels of family support, exhibiting greater coping with military-related stressors (O'Neal et al., 2020). Social support for MLSPs is also correlated with increased marital satisfaction (Gilbert, 2020).

Recently, the COVID-19 pandemic exacerbated challenges for MLSPs with social support, causing greater difficulty for spouses to make new friends at new duty stations and

escalating the isolation that MLSPs experience during an already difficult time (Banerjee & Rai, 2020). While spouses often already rely on virtual support and online relationships with family and friends who have moved (McMaster et al., 2017), reliance on virtual relationships for support is a predictor of depressive symptoms and decreased overall well-being (Chen, 2019). Considering the role of social support, both in-person and virtual, is important when evaluating military-related stressors and how MLSPs access resources that bolster resilience.

Military Spouse Counselors and Counselor Educators

Mental health and stigma have long been a focus of military mental health research for SMs, MLSPs, and families. Recently, there has been increased interest in the mental health of counselors/CES as those who facilitate and provide mental health services (Pow & Cashwell, 2017). As previously discussed, MLSPs often pursue careers that require licensure, including careers such as nursing and counseling (Ballard & Borden, 2020). While there has been a focus on resilience and mental health services for military personnel in the past decade (Georgescu et al., 2023), there has been little exploration into those who provide these services and are MLSPs themselves or a part of the military family (Clifford, 2014). Thus, a focus on providing competent care for military communities from those within the military community is an important area of further exploration.

Mental health is more present in day-to-day language than ever before, with the demand for professional counselors increasing by the day. Mental healthcare utilization has been associated with improved outcomes in psychosocial functioning and improved well-being across multiple diagnostic areas, particularly for veteran and SM populations (Peter et al., 2023). As access to care continues to be a focus of military research and legislation (Abiero et al., 2020), it is critical to consider the professional counselors providing this care and how they contribute to

the well-being of the military community, including the barriers MLSP counselors/CES may experience.

Work-Family Conflict (WFC) in MLSP Counselors/CES

Female counselors/CES may be more likely than their male counterparts to experience WFC (Eckhart & Ziomek-Daigle, 2019). Female counselors/CES may face challenges related to WFC due to societal expectations around gender roles and caregiving responsibilities (Eckhart & Ziomek-Daigle, 2019). For example, women may be expected to take on a greater share of household and caregiving responsibilities, which can make it difficult to balance work demands with family responsibilities (Christensen, 2013). In addition, female counselors/CES may also face challenges related to workplace policies and practices, such as inflexible work schedules, limited maternity leave, and lack of support for childcare needs (Eckhart & Ziomek-Daigle, 2019). These factors can contribute to feelings of stress, burnout, and reduced job satisfaction among female counselors/CES (Eckhart & Ziomek-Daigle, 2019). This literature explores issues specific to female counselors/CES without considering women who are also MLSPs. These WFC challenges, combined with the difficulties of managing WFC as a MLSP (Park et al., 2023; Sinclair et al., 2019; Woodall et al., 2020), underscore the importance of exploring this intersectional identity.

Military Mental Health Counselors

Military mental health providers may face high caseloads, exposure to traumatic events, frequent deployments and relocations, and limited resources, all of which can contribute to feelings of stress and burnout (Clifford, 2014). However, prior exposure to military-related stressors can mitigate the impact of burnout over time (Clifford, 2014; Delaney et al., 2023). In a study of military mental health providers, increased caseload, more personality-disordered

patients, being a psychiatrist, and being a female were predictive of increased burnout scores (Ballenger-Browning et al., 2011). Having more clinical experience, confidants at work, more traumatic brain injury patients, and being a psychologist predicted lower burnout rates (Ballenger-Browning et al., 2011).

Military mental health providers, in general, may be at higher risk of burnout due to the unique demands of their work (Clifford, 2014; Delaney et al., 2023). Unfortunately, there is limited research on burnout rates specifically among MLSP mental health providers. Currently, there is no specific data on burnout rates among MLSP mental health providers; thus, the current study seeks to fill this gap in the literature. MLSPs who work as mental health providers may face additional challenges related to their own personal and family experiences with military life as they seek to prioritize their work and military lifestyle (The Counsel of State Governments, 2022). Additionally, prior exposure to the military and its challenges can be beneficial for counselors in training. Prior experience with the military and its challenges is beneficial for counselors and training, as they already have increased awareness of military culture, training, the chain of command, military language, and the stigma of mental health (Collins et al., 2023). Exhibiting cultural competency in military mental health produces improved counseling outcomes (Collins et al., 2023), but most counselors report they did not receive enough training in their master's programs to confidently provide services to SMs and families (Arcuri-Sanders & Forziat-Pytel, 2024). MLSPs fill a critical gap in military mental health by providing competent services to military families, SMs, and fellow MLSPs (The Counsel of State Governments, 2022).

Military Spouse Mental Health

Mental health is comprised of the "thoughts and feelings" that contribute to an individual's psychological well-being (Salsman et al., 2015, p. 3770). MLSP mental health has been an area of exploration in the past several years, as MLSP mental health has been linked to increased military readiness and SM well-being (O'Neal et al., 2020; Sinclair et al., 2019). MLSPs have been classified as a vulnerable population due to the increased stress and adversity they experience day to day (Padden et al., 2011; Wilson & Murray, 2016). Rates of MLSP depression and anxiety as well as mental health care utilization increase during deployment (De Burgh et al., 2011), with some studies indicating at least 36.6% of MLSPs have at least one mental health diagnosis during SM deployment (Mansfield et al., 2010).

Types of Military Spouse Mental Health Challenges

According to the 2020 Military Family Lifestyle Survey, 24% of active-duty MLSPs report a current diagnosis of generalized anxiety disorder, 9% of major depressive disorder, 7% of PTSD, and 6% for sleep disorders. In addition, 4% of active-duty MLSP report experiencing suicidal thoughts in the past year (BSF, 2021). MLSPs with the highest rate of mental health diagnoses express the lowest levels of protective factors (Sullivan et al., 2020).

While most studies explore individual risk factors associated with mental distress in MLSPs, exposure to cumulative risks is important and can be addressed by supporting the MLSP with other protective factors (Sullivan et al., 2021). Examining depression, anxiety, and PTSD individually and how they impact the MLSP is important, but studies also suggest that higher levels of stress exacerbate symptoms in MLSPs with mental health diagnoses (Sullivan et al., 2020). Sullivan and colleagues (2020) suggest that high levels of stress may be the "underlying mechanism" that affects mental health regardless of symptom presentation (p. 382). The

presence of mental health-related challenges for MLSPs is an important area of further investigation.

Depression and Anxiety

MLSPs may experience depression and suicidality due to a range of factors related to military life, such as frequent relocations, separation from their partner, financial strain, and exposure to trauma or violence (Mansfield et al., 2010). Other risk factors for depression and suicidality among MLSPs may include a prior history of mental health problems (Mansfield et al., 2010), social isolation (Chen, 2019), and lack of social support (Ross et al., 2020). MLSPs are up to three times as likely to experience depression in comparison to their civilian counterparts (Mansfield et al., 2010). Deployment status also impacts depression levels in MLSPs, as depressive symptoms may rise before deployment and increase during deployment with moderate to severe prevalence ranging from 25% (Mansfield et al., 2010) to 33% (Faulk et al., 2012).

Limited contact with SMs during deployments is often linked to MLSP depression, increased relationship distress, and decreased family functioning (Ormeno et al., 2020). Spouses also experience poorer physical health and well-being during deployments, as well as carrying a disproportionate mental load during deployments, making all household decisions in the absence of the SM (Lara-Cinisomo et al., 2020). During the reintegration period, approximately one-third of MLSPs report moderately severe depressive symptoms (Dolphin et al., 2015).

Some demographic factors may also impact depression rates among MLSPs. Spouses of enlisted SMs are more than twice as likely to experience clinically significant levels of depression in comparison to officer spouses (Donoho et al., 2018). Additionally, spouses of special operations forces SMs have a higher prevalence of decreased mental health than spouses

of other Army units (Richer et al., 2022). Spouses of SMs who experience post-traumatic stress or alcohol use disorder are at greater risk of clinically relevant depression (Donoho et al., 2018), with SM PTSD predicting new-onset depression in one MLSP study (Walter et al., 2020). MLSPs experience added stress and emotional burden when their partner experiences mental health problems, such as PTSD, traumatic brain injury, or depression (Senior et al., 2023). However, spouses with higher positivity have been able to moderate stress levels and subsequent depressive symptoms regardless of deployment status (Faulk et al., 2012).

MLSPs may also undergo experiences that cause anxiety and fear, such as military training exercises, deployments, or military separations for training (Wilson & Murray, 2016). According to BSF in 2021, 25% of MLSPs report a diagnosis of generalized anxiety disorder, with rates previously ranging from 17% (Eaton et al., 2008) to 44% (Fields et al., 2012). However, prevalence rates for anxiety and depression vary greatly depending on sampling, which speaks to the importance of convenience samples and other methodologies (Steenkamp et al., 2018).

Treating MLSP depression and anxiety can prove challenging. Prosek et al. (2023) found that providing community-based mental health services showed no statistical improvement in MLSP symptoms, while Peck & Parcell (2021) discussed the importance of providing mental health services during and post-deployment. Additional research is needed to explore the best treatment possibilities for MLSPs experiencing mental health challenges.

Suicidality

While SM and veteran rates of suicide are explored at length in the literature (Thomas et al., 2015), MLSP suicide rates are less commonly explored and is the least researched area of MLSP mental health. In 2021, 114 MLSPs died by suicide, with a rate of 11.2 deaths per

100,000 individuals (DOD, 2022). BSF (2021) found that 4% of both active-duty SMs and MLSPs experienced suicidal ideation. Unfortunately, studies have found that MLSPs may be at increased risk for suicidality, particularly during periods of high stress such as deployments or relocations (Cole et al., 2021). MLSPs cite a loss of control and identity, as well as challenges with seeking mental health services as key themes impacting suicide in the community (Cole et al., 2021). It is also key to explore the connection between SM and MLSP suicide, as SM suicide rates were previously lower than civilian rates but have now surpassed civilian numbers substantially (Thomas et al., 2015). Continued exploration of suicidality in the MLSP community is indicated as a critical area of further research.

PTSD and Vicarious Trauma

PTSD is an essential area of study for our military populations, including MLSPs. While research has typically focused on the SM's exposure to combat-related traumatic stress (Mobbs & Bonanno, 2018), PTSD can also affect members of the military family (Giff et al., 2019; Kudler & Porter, 2013). Reported rates of PTSD in MLSPs can vary, ranging from 7% (BSF, 2021) to 17% (Gorman et al., 2011) in some studies. Spousal PTSD is still widely under-researched (Yambo et al., 2016), as exploring how MLSPs can support SM PTSD has been a critical focus of extant literature (Powling et al., 2024; Zwanziger et al., 2017).

MLSPs can experience psychological distress because of their SM's distress, often mirroring each other in studies of both members of the dyad (Erbes et al., 2012; Mansfield et al., 2014). This also speaks to the possibility of vicarious trauma, as MLSPs are exposed to trauma survivors and experience their difficulties (Diehle et al., 2017). Spouses of SMs who experience comorbid PTSD and depression are statistically more likely to experience poor mental health outcomes themselves (Donoho et al., 2018). Additionally, MLSPs with a history of childhood

trauma are more likely to experience posttraumatic stress symptoms due to their SM's experiences (Sullivan et al., 2023). More literature regarding MLSP PTSD and vicarious trauma is needed to explore the correlations between SM and MLSP PTSD (Sullivan et al., 2023; Yambo et al., 2016).

Substance Use

Substance use among MLSPs has been an area of clinical concern but lacks substantial literature and research (Kulak et al., 2019). MLSPs are at risk of adopting maladaptive coping strategies during times of stress, particularly during SM deployments, which may include substance use (Ahmadi & Green, 2011). However, Kulak and colleagues (2019) found that SM deployment status did not play a role in a spouse's alcohol or tobacco use. This indicates the possibility that the MLSP lifestyle, regardless of the SM's deployment history, is a stressor in and of itself that can lend the MLSP to maladaptive coping strategies.

MLSPs are at an elevated risk of experiencing substance use problems due to several factors. Individuals with mental health disorders are more likely to have comorbid substance use disorders (Eaton et al., 2008; Mansfield & Engel, 2011). Additionally, the profound influence of their SMs choices places MLSPs at an increased risk of substance use disorders, as SM's substance use behaviors influence the spouses' patterns of behavior (Craddock et al., 2015), and problematic alcohol and prescription drug use has long been an area of issue in military populations (Blow et al., 2013; Bray et al., 2010). MLSPs in relationships where both SM and MLSP report alcohol use exhibit higher levels of depressive symptoms (Erbes et al., 2012) and are at an increased risk of experiencing domestic violence (Blow et al., 2013).

MLSPs are also more likely to drink alcohol and binge drink than their nonmilitary counterparts, indicating that alcohol misuse in MLSP populations is approximately double what

is typical in civilian populations (Steenkamp et al., 2018). As a result, SMs and MLSPs who binge drink increase the likelihood of separation from the military (Porter et al., 2020). Overall, research suggests that MLSPs face unique challenges related to military life that can impact their mental health (Corry et al., 2019). Thus, it is important for military organizations and communities to provide resources and support to help MLSPs maintain their well-being and resilience.

Counselor/CES Mental Health

Counselor mental health is often explored in the literature regarding burnout, compassion fatigue, and vicarious/secondary trauma (Bardhoshi et al., 2019; Voon et al., 2022). Exploring these concepts, however, can be challenging due to a lack of clarity in methodology and terminology, resulting in difficulty exploring how counselors manage the challenges of the profession (Leung et al., 2023). Counselors deal with the diverse and intensive psychological needs of others day to day, experiencing heightened work pressure that impacts mental health and well-being (Zhang et al., 2021; Zhang et al., 2023). Self-compassion has been identified as a predictor of psychological well-being in counselors (Voon et al., 2022), and when applied within counselor education curriculum, can help manage stress, reduce burnout, provide coping skills, and increase self-care (Coaston, 2017). While extant literature does not thoroughly explore MLSP counselor/CES populations explicitly, this study will discuss relevant findings that shed light on MLSPs and counselors/CES separately to illustrate the need for further exploration into this intersectional identity.

Resilience

In a review of the literature, including both military and civilian studies, Meredith et al. (2011) identified over 100 definitions for resilience, clearly indicating the challenge of both

defining and quantifying resilience as a measurable outcome. Britt et al. (2016) outlined the need to distinguish between the *potential capacity* for resilience and the *demonstrations* of resilience that are measurable while maintaining that both have important implications within research settings and should be explored as separate variables in further study. In contrast, Smith et al. (2008) considered resilience as a changeable, dispositional trait that is impacted and influenced by the presence of other resources, such as optimism, strength through difficult challenges, or other supports that assist individuals' capacity. This operational definition of resilience led to the creation of the Brief Resilience Scale (BRS; Smith et al., 2008), which will be utilized in the present study, as it is the precedent in military-related resilience studies (Sinclair et al., 2019). For the purposes of this study, resilience is defined as a complex phenomenon where an individual exhibits growth and adaptation through adverse experiences (Richardson, 2016; Southwick et al., 2014).

History and Background of Resilience

Historically, resilience has been explored in major catastrophic events, including the Great Depression, World War I, World War II, and catastrophic events like September 11, 2001 (Boss, 2013; Masten, 2018) as well as in high-risk populations, such as children in adverse environments (Rutter, 1987). Researchers explored the contributors to how individuals bounced back from adversity, leading to debates regarding the nature of resilience, whether resilience is a state that can develop with time or if it is an innate trait within a person (Van Winkle & Lipari, 2015; Verdeli et al., 2011). While a concrete definition of resilience has not been created (Meredith et al., 2011), theorists have identified core components that can be identified and measured: the presence of adversity, protective factors that help the individual overcome, and

adaptive growth from the challenge (Stainton et al., 2019). Exploring how these components are expressed in MLSP counselors/CES is a core component of the current study.

Resilience in MLSP Literature

Resilience in military communities has become central to military readiness literature, as resilience is a core ethos in military culture and a significant protective factor (Burgin & Prosek, 2021). MLSPs are no exception, with the majority of recent MLSP research exploring resilience and how individuals weather the storms of the military lifestyle (Sullivan et al., 2020). In fact, psychological resilience is a key protective factor for MLSPs to successfully cope with the challenges integral to the military lifestyle (Lee et al., 2013; Monney, 2019). The role of resilience in women has been explored since the foundation of resilience literature (Werner, 1997). As the majority of MLSPs are female (Borah & Fina, 2017), further exploration into how resilience frames the MLSP experience is beneficial.

The challenge arises when exploring resilience in the MLSP community, as spouses can demonstrate resilience during adversity or experience substantial mental health impacts from military stressors (Lucier-Greer et al., 2014; Marek & D'Aniello, 2014). There are multiple contributing factors that impact a MLSP's resilience and personal growth, producing cumulative effects (Sullivan et al., 2021). Sinclair et al. (2019) explored the connections between dispositional resilience, mental health, and well-being as well as other psychosocial and demographic factors associated with levels of resilience. Their results indicated several characteristics associated with increased levels of resilience, including having more children, being a non-minority, having increased social support, less WFC, and better SM mental health. These factors also predicted improved health outcomes, including reduced psychological

distress, improved sleep quality and relationship functioning, as well as general health and well-being (Sinclair et al., 2019).

Sinclair and colleagues (2019) emphasized that the SM's number or lengths of deployments were not associated with the MLSP's resilience. This speaks to the importance of resilience as a key protective factor for MLSPs who experience high stress due to the military lifestyle. This study contrasts the findings of Van Winkle & Lipari (2015), who found that MLSPs experienced increased stress during the SM's first deployment, with stress levels waning for the next few deployments, then showing an increase in levels again.

Increased resilience is also exhibited when access to military resources within the community are available and when military families have the perceived support of leadership (BSF, 2020). Additionally, MLSPs cite self-mastery, positive outlook, family communication, spirituality, and organizational patterns as key factors in their resilience (Pflieger et al., 2020). MLSPs transferred some "resilience practices" during the COVID-19 pandemic (Fanari et al., 2022, p. 2). MLSPs crafted normalcy, maintained communication with family and social networks, reinforced positive emotions by downplaying negative feelings, and intentionally communicated with their SM to address the challenges related to the pandemic (Fanari et al., 2022). While resilience has been identified as a key area for MLSP mental health, resilience interventions are still in the infancy stages and are not universally applied (LaCroix et al., 2021).

Resilience in Counselor Literature

Therapists who exhibit resilience have several important characteristics: they are drawn to strong interpersonal relationships, they engage with introspection and the self, they desire to learn and grow, and they have an integrated belief system with values (Hou & Skovholt, 2020). In sum, resilient counselors exhibit a connection to self and others (Hou & Skovholt, 2020).

Resilience enables counselors to navigate clients' mental health issues while maintaining their own stability (Rosenberger & Bang, 2023).

David (2012) explored the relationship between compassion fatigue and resilience in trauma-focused counselors, indicating that levels of resilience were correlated with compassion fatigue and satisfaction as well as burnout. Hernandez et al. (2007) also explored counselors' resilience when working with clients experiencing trauma, indicating the possibility of "*vicarious resilience"* (p. 307). *Vicarious resilience* refers to a process where therapists who work in traumatic contexts may learn how to cope with adversity from their clients, having positive secondary effects for the therapist (David, 2012; Hernandez et al., 2007). Litam and colleagues (2021) explored resilience in counselors during the COVID-19 pandemic, finding that resilience protected counselors from burnout and increased compassion satisfaction. While the literature for counselor resilience has focused mainly on trauma counselors or resilience related to the COVID-19 pandemic, less is known about the factors that contribute to resilience across the counselor's career.

Protective factors for counselors are commonly explored, providing counselors with action-based resources to protect against burnout, such as self-care principles, choosing positive cognitions, and interpersonal relationships, as these are often cited as ways to protect counselors from stress (Mullenbach & Skovholt, 2016). Self-care has maintained a prominent feature in the literature, exploring the roles of balanced personal and professional lives, and physical and mental health, including nutrition, sleep, exercise, and hobbies as ways to cope with stress (Figley, 2002). Counselors who manage stress through self-care activities experience post-traumatic growth (Lambert & Lawson, 2013), higher job satisfaction, and lower job-related stress (Bellamy et al., 2019).

Like MLSP literature, social support has also shown predictive power in resiliency for counselors (Hou & Skovholt, 2020). Rønnestad and Skovholt (2013) found three themes related to counselor development and resilience: the integration of personal and professional identity, the utilization of self-reflection, and the value of personal character traits, such as empathy or patience. Elder (2021) explored compassion and empathy in counselors, finding that higher levels of compassion towards self and others, less empathetic personal distress, and fantasy (imagining self as another person), as well as Republican political affiliation were predictive of counselor resilience. The ability to practice self-compassion and utilize therapeutic knowledge towards the self also improves resilience and outcomes (Voon et al., 2022). Understanding the factors that contribute to counselors' resilience throughout their careers will assist in understanding the contributive factors of burnout, an essential area of research focus.

Burnout

Occupational and professional environments, when disorganized, mismanaged, or draining, can impact employees and erode their satisfaction and mental resources over time (Maslach & Jackson, 1981). This phenomenon has become known as burnout, one of the most significant job challenges today (Edú-Valsania et al., 2022). Burnout was originally conceptualized for helping professions (Maslach & Jackson, 1981), but later research indicated that burnout could develop in any professional setting (Salanova et al., 2005). Burnout has earned the attention of the World Health Organization (WHO), which included burnout syndrome in the most recent International Classification of Diseases (ICD-11) as an occupational hazard impacting public health (WHO, 2019).

Burnout syndrome refers to an individual's response to chronic work stress that, over time, can eventually cause chronic health impacts (Montero-Marin, 2016). These health impacts

are multifaceted, causing harm at the cognitive, emotional, and attitudinal levels due to work activities and requirements (Maslach, 2006). Literature has explored how burnout is not a result of personality or work ethic but is a result of certain characteristics of work activity (Bouza et al., 2020). Exploring the history of burnout, including its growth from a theoretical concept to a measurable phenomenon, and its presence in MLSP and counselor/CES literature provides further context for this study.

History and Background

Burnout was introduced to the field of psychology in 1974 when Freudenberger (1974) described burnout as exhaustion, frustration, and fatigue due to professional obligations. Maslach (1976) introduced the concept of burnout into the scientific literature, then later provided an operational concept, characterizing burnout as a syndrome with emotional exhaustion, depersonalization, and reduced professional efficacy (Maslach & Jackson, 1981). While others have worked to reformulate Maslach & Jackson's original work (Salanova et al., 2005), their operational definition of burnout remains the most utilized within the literature.

Burnout has become one of the most important measures of occupational distress (Edú-Valsania et al., 2022). Initially, burnout was applied in helping professions, including psychology and mental health (Maslach & Jackson, 1981). Today, burnout syndrome is defined as an individual's response to chronic occupational stress that develops progressively and can lead to chronic health impacts, both physical and mental (Montero-Marin, 2016). From a mental health perspective, this can lead to damage at the cognitive, emotional, and attitudinal levels, leading to negative behavior in the workplace (Maslach, 2006). These changes are attributed to work-related activities rather than the individual's personal problems (Bouza et al., 2020).

MLSP Burnout

Historically, the MLSP was expected to volunteer and serve the needs of the military as a part of the "two-person career" model (Mittelstadt, 2015, p. 126). MLSPs were not only encouraged to support their husbands and raise large families, but they were also expected to teach etiquette to new spouses, create communities, and maintain Army programs for military families (Mittelstadt, 2015). After the end of the compulsory draft in 1973, MLSPs began a grassroots movement to advocate for Army support, citing their exhaustion from providing free labor for the military's social programs (Covkin, 2023; Mittelstadt, 2015). As a result, the Army began providing programs and initiatives for the military family, focusing on protecting the new, volunteer military family force (Covkin, 2023).

Today, MLSPs often face unique challenges that can contribute to burnout in their careers. Frequent moves and the demands of supporting a SM and family can make it difficult for MLSPs to establish and maintain a career (Owen & Combs, 2017). In addition, the stress of navigating the military lifestyle and the constant uncertainty of deployments and relocations can take a toll on mental health and well-being (Corry et al., 2022).

Research has shown that MLSPs do experience higher rates of stress and burnout compared to their civilian counterparts (Lester et al., 2016). MLSP nurses experience burnout at higher levels than their peers, with 35% indicating they considered leaving their professions due to military-related relocation and licensure challenges (Brannock & Bradford, 2021). The nursing and counseling professions have similar challenges, as they are both helping professions with state licensure that MLSPs tend to pursue (Maury & Stone, 2014). Generally, however, most studies have not explored burnout as a construct in MLSP literature, illustrating a gap in extant literature that requires further exploration.

Counselor Burnout

Burnout is an occupational risk to all counselors (Bardhoshi et al., 2019; Fye et al., 2021; Lee et al., 2011). This foundation inspired the creation of burnout's operational definition in the literature, as counselors and other helping professions experience burnout in their respective professions (Maslach, 1976). Distinguishing vicarious trauma, secondary traumatic stress, and burnout has become challenging when interpreting study results of mental health professionals, as research designs use different measurements and operational definitions (Leung et al., 2023). Today, particularly after the COVID-19 pandemic, understanding burnout and its impacts on the workplace is more relevant, especially in mental health professions (Edú-Valsania et al., 2022). Clinicians may feel pressure to carry a higher caseload and spend more hours working, thus increasing their work-related challenges (Bray, 2020). A recent meta-analysis revealed that approximately 55% of psychotherapists experience burnout (Lee et al., 2020). Addressing burnout in the counseling profession is critical, as counselors who experience burnout are at risk of leaving the field (Mullen et al., 2018).

Risk Factors

Several factors of employment have been related to burnout, such as the number of hours worked and an unhealthy work environment (O'Connor et al., 2018; Rossi et al., 2012). More recently, age, caseload, work setting, COVID-19-related anxiety, and trauma-informed supervision predicted burnout levels in pre-licensed counselors (Cook & Fye, 2023). Specific to mental health providers, therapists with higher needs for control in the therapeutic environment are likely to experience greater impacts from burnout (Emery et al., 2009). Clinicians who report a belief that full understanding is required for successful therapy outcomes and reported fewer personal resources were the most likely to experience burnout (Emery et al., 2009).

Managing countertransference has also been linked to increased interpersonal stress for the counselor (Choi et al., 2014) and increased burnout rates (Houshangi et al., 2023). Additionally, therapists who may find challenges in engaging in self-care may also suffer from burnout at higher rates (Coaston, 2017). Ethical dilemmas (Mullen et al., 2017), self-doubt (Zeeck et al., 2012), and counselor impairment (Figley, 2002) have also been identified as significant occupational hazards that contribute to counselor burnout. These challenges are all present and accounted for in military mental health providers (Clifford, 2014). More specifically, MLSP counselors/CES, who share similar experiences with their military clients, may experience increased challenges with countertransference (Houshangi et al., 2023) and professional challenges related to PCS or ETS (The Counsel of State Governments, 2022).

Protective Factors

While several studies have explored the occupational hazards of burnout for counselors and work-related behaviors that contribute to burnout rates, few have examined the intrinsic characteristics that can serve as protective factors for counselors. Browning et al. (2019) examined gratitude and spiritual experiences as significant negative predictors for burnout, highlighting that hope also predicts compassion satisfaction in seasoned, resilient counselors. Elder (2021) found that counselors with increased empathy toward clients and decreased self-compassion experienced higher levels of burnout. These findings illustrate the importance of considering the occupational and personal dimensions that contribute to counselor burnout.

Moderator: Coping with Military Spouse Counselor Burnout

Exploring how MLSP counselors cope with their day-to-day personal and occupational stressors is an important consideration in this study. Coping has been shown to play an important role in the mitigation of burnout (Boland et al., 2019; Lee et al., 2016), thus requiring

investigation. While coping may seem similar to resilience, coping strategies can be both positive and negative, but resilience is a process that yields positive adaptation (Poudel-Tandukar et al., 2020). Investigating coping and its findings in both MLSP and counselor/CES literature will provide helpful context for this study and how resilience and burnout impact MLSP counselors/CES.

History and Background

Coping with stress plays an important role in how an individual experiences and overcomes a stressful event (Folkman & Moskowitz, 2004). Lazarus & Folkman (1984) formulated a model of coping as an interaction between the individual's perception of the stressor, the environment, and the available resources to manage the stress. They proposed that most people employ several approaches to deal with stressful events until they develop effective coping strategies. Successful coping strategies require both pragmatic problem-solving and emotional regulatory skills applied during a stressful situation or event. While coping has been classified in several different ways, the most important distinction is between problem-focused coping (PFC) and emotion-focused coping (EFC), which was first showcased in the Theoretical Model of Stress and Coping (Lazarus & Folkman, 1984).

Problem-Focused Coping

PFC represents efforts to act on the stressful situation to gain control (Delahaij & Van Dam, 2017). PFC strategies directly address the problem, such as researching the problem or creating a plan of action (Littleton et al., 2007). PFC is preferable in situations where the individual can exhibit control, particularly in high-risk organizations such as the military or police (Baggett et al., 1996). PFC is often effective in addressing burnout but may increase

frustration in circumstances outside of the individual's control (Costa & Pinto, 2017). Utilizing PFC is associated with lower levels of distress in difficult circumstances (Littleton et al., 2007).

Emotion-Focused Coping

EFC involves active attempts and strategies for dealing with the emotional distress of a situation or scenario (Delahaij & Van Dam, 2017). EFC provides ways to change negative emotional reactions to stressful events, working towards self-regulation (Boland et al., 2019). EFC is most effective in situations that are outside of an individual's control, reinforcing the need for the individual to address their perspective and cognitively restructure their perspective (Baggett et al., 1996; Delahaij & Van Dam, 2017). Some EFC strategies—social support-seeking, reappraisal, and religious support—protect from burnout (Boland et al., 2019), while most emotion-focused efforts tend to exacerbate burnout levels. Thus, coping in the military community should include a combination of both problem-focused and emotion-focused strategies.

MLSP Coping

Coping may be experienced differently in MLSP populations, and understanding these differences is critical, as coping impacts MLSP satisfaction with the military lifestyle and, in turn, SM retention (O'Neal et al., 2020). While SMs utilizing PFC experience better coping outcomes (Delahaij & Van Dam, 2017), the effects of PFC and EFC in MLSPs are not as clear. Some studies have indicated that both EFC and PFC had negative impacts on the MLSP's physical and psychological well-being (Padden et al., 2011), while others report that both EFC and PFC strategies, when utilized, produce results (Dimiceli et al., 2010). Skomorovsky & Bullock (2017) found that active distraction coping techniques contributed to resilience during deployment in many MLSPs. However, extant literature does not thoroughly explore specific

coping strategies MLSPs have utilized and how the unique factors of the military lifestyle play a role.

Wang and colleagues (2018) explored coping in MLSPs, indicating that PFC yields better mental health outcomes than EFC, leading to a reduction in depressive symptoms and improved overall functioning. Spouses do, however, consistently employ social support as an EFC strategy, including connecting with other MLSPs and maintaining relationships to reduce the impact of stressors (Everson et al., 2017; Strong & Lee, 2017). MLSPs report that they use social media to cope with military lifestyle stressors (Rossetto & Owlett, 2022), but online communities may increase negative mental health outcomes (Chen, 2019). Negative coping mechanisms, such as alcohol use (Kulak et al., 2019), have been an area of challenge for MLSPs and highlight the need for productive coping strategies (Porter et al., 2020; Steenkamp et al., 2018). As MLSPs indicate similar levels of coping as their SMs (Lucier-Greer et al., 2020), exploring how MLSPs utilize coping is another important way to provide support for the military family unit.

Counselor Coping

Identifying coping strategies for counselors has been an area of substantial research as it relates to counselor burnout, a historical issue for the profession (Maslach, 1976). Holistic self-care practices (Lambert & Lawson, 2013), as well as spiritual and religious activities that are congruent with the individual's values (Coaston, 2017), have been shown to improve counselors' outcomes. Litam and colleagues (2021) explore wellness coping strategies, such as emotional self-expression, awareness, and reflection to assist counselors in coping with job-related stressors. Additionally, healthy physical activity, eating, sleeping, and journaling were all supportive coping strategies for building counselor resilience (Litam et al., 2021). Adaptive coping is also shown to bolster resilience, contributing to a counselor's attitudes during life

challenges (Jeong et al., 2015). This hardiness contributes to the successful counselor's ability to cope with stress (Rosenberger & Bang, 2023).

Coping literature has often centered around counselors who provide disaster-related services (Lambert & Lawson, 2013; Pow & Cashwell, 2017). These counselors provide services to those impacted by traumatic events, often compromising their own mental health and well-being (Lambert & Lawson, 2013). EFC strategies have proven vital in protecting these counselors from traumatic reactions and have increased the likelihood of post-traumatic growth after providing mental health services (Linley et al., 2011). Disaster mental health counselors report higher levels of compassion fatigue (Lambert & Lawson, 2013), similar to military mental health providers (Clifford, 2014; Delaney et al., 2023). Providing mental health treatment to military populations often leads to higher job turnover and reduced job satisfaction (Delaney et al., 2023). Exploring how MLSP counselors cope with both the occupational stressors of counseling and the personal stressors of the military lifestyle would provide vital information in bolstering support for MLSP counselors/CES within the profession at large.

Summary

Fostering a strong and resilient military has long been a focus of the United States, and exploring areas of growth within the military community is a continued area of importance for accomplishing the military's objectives. Constant overseas intervention and engagement have significantly impacted the military family, particularly the MLSP. These impacts affect the MLSP's mental health (Mansfield et al., 2010), occupation (Park et al., 2023), family balance (Mailey et al., 2018), social support (Corry et al., 2022), and resilience (Sinclair et al., 2019), all of which also impact the American soldier. However, the intersection between the MLSP and the professional counselor provides a critical component of the military community that has not been

researched (The Counsel of State Governments, 2022). By exploring the resilience of MLSPs mental health counselors, we can support not only MLSPs but also the providers who offer mental health care and services for American SMs and their families (The Counsel of State Governments, 2022).

Resilience, mental health, coping, and burnout have all made their mark in today's academic literature. Previous literature illustrates the connection between mental health, resilience, coping, and burnout in military populations (Sinclair et al., 2019) and counselor populations (Lee et al., 2019) separately. The study sought to explore these phenomena specifically within MLSPs who are counselors, as they represent a unique subset of the military and counseling community. Lee et al. (2019) laid the academic foundation for this study, as stress, burnout, and resilience in emotional workers indicated areas of further exploration in the literature. Now, research should explore the intersectional identity of a MLSP counselor (The Counsel of State Governments, 2022). More specifically, exploring the potential correlational relationship between mental health and burnout, and how resilience may mediate this relationship, could provide important insight into how MLSP counselors/CES cope with the occupational stressors of their professions combined with the military lifestyle stressors they experience. MLSP counselors/CES are key contributors to both the military and mental health communities (The Counsel of State Governments, 2022), and they play essential roles in military readiness and vitality. The contributions of the findings within this quantitative, descriptive, cross-sectional correlational study contribute to MLSPs, counselors, counselor educators, and the military at large. Details surrounding the methodology to accomplish that goal are presented in Chapter Three.

CHAPTER THREE: METHODS

Overview

This study utilized a quantitative, descriptive, cross-sectional correlational research design with moderated mediation analysis to investigate the designated variables. The methodology of this study explored the relationship between mental health (independent variable) on burnout (dependent variable) through resilience (mediator) conditioned by coping (moderator). This chapter expounds on the research design, questions, and hypotheses as well as the methodology for the study, including participants and setting. Participants were selected through an online, nonexperimental survey utilizing snowball sampling with selected incentives for participation.

The instrumentation for this study includes demographic questions for inclusion, the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001), the Generalized Anxiety Disorder 7 (GAD-7; Spitzer et al., 2006), the Posttraumatic Stress Disorder Checklist (PCL-5; Weathers et al., 2013), the Brief Resilience Scale (BRS; Smith et al., 2008), the Counselor Burnout Inventory (CBI; Lee et al., 2007) and the Coping Strategies Inventory- Short Form (CSI-SF; Addison et al., 2007). The procedures section outlines the research process in detail and includes multiple regression data analysis. The hypotheses tests investigate the relationship effects of coping (moderator) and resilience (mediator) on MLSP counselors/CES mental health and burnout to provide information for interventions and recommendations for counselors, military leadership, and licensure policymakers.

Design and Methodology

This study utilized a quantitative, descriptive, cross-sectional correlational research design. The conceptual model for this project explored the relationship effects between mental

health (independent variable) and burnout (dependent variable) through the mediator of resilience (M) conditioned by coping (W). Selecting a complex research design is best when researching within the fields of counseling and psychology, proffering information in several variables and areas of interest (Heppner et al., 2016).

The variables utilized in this study are complex and could influence the relationships between the independent and dependent variables, indicating the importance of analyzing all existing relationships and their effects (Frazier et al., 2004). Thus, exploring each path for relationships of multiple variables utilizing both descriptive and analytical approaches could improve the interpretation of results (Baron & Kenny, 1986; Heppner et al., 2016). As mental health, resilience, and burnout are all complex variables, investigating the existing relationships, their strength, and directions are essential to data interpretation, making this research design most advantageous for the purposes of this study. The sample includes MLSP counselors/CES, which was gathered utilizing snowball sampling methods in online social media groups and through the researcher's local contacts. The online, nonexperimental survey includes demographic questions as well as the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), PCL-5 (Weathers et al., 2013), BRS (Smith et al., 2008), CSI-SF (Addison et a., 2007), and CBI (Lee et al., 2007) to measure the aforementioned variables. This survey has been analyzed utilizing IBM SPSS to explore descriptive statistics, bivariate correlations, and linear regressions.

Research Questions

RQ1: Does a higher rate of mental health issues, to include depression, anxiety, and post-traumatic stress disorder measured by the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al.,

2006), and PCL-5 (Weathers et al., 2013), increase the prevalence of burnout, measured by the CBI (Lee et al., 2007), in MLSP counselors/CES?

RQ2: Does resilience, as measured by the BRS (Smith et al., 2008), mediate the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI) in MLSP counselors/CES?

RQ3: What moderating effects, if any, does coping, as measured by the CSI-SF (Addison et al., 2007), have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and resilience (BRS)?

RQ4: What moderating effects, if any, does coping (CSI-SF) have on the relationship between resilience (BRS) and burnout (CBI)?

RQ5: What moderating effects, if any, does coping (CSI-SF) have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI)?

Hypotheses

The alternate hypotheses for this study are as follows:

H_a1: MLSP counselors who report poorer mental health via the PHQ-9, GAD-7, and PCL-5 will demonstrate statistically significant higher instances of burnout as measured by the CBI.

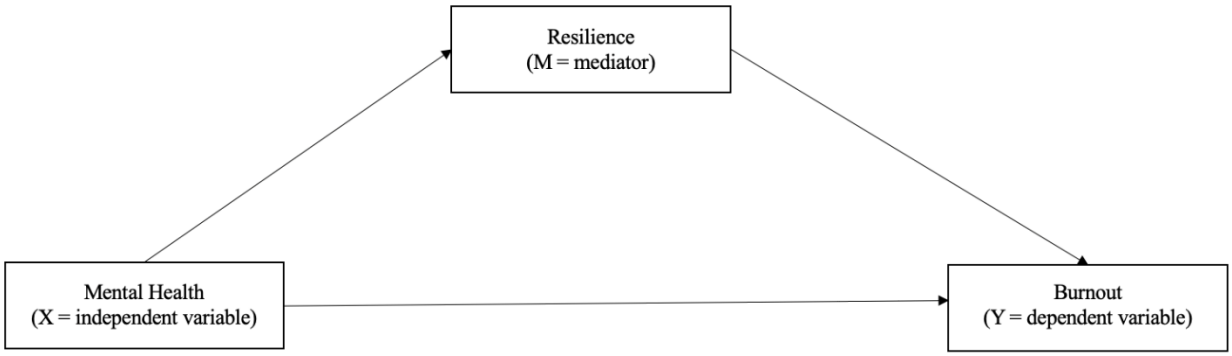
Figure 3.1

Hypothesized Theoretical Model One

H_a2: As measured by the BRS, resilience will mediate the relationship between mental health and burnout in the sample population of MLSP counselors/CES, indicating an inverse relationship.

Figure 3.2

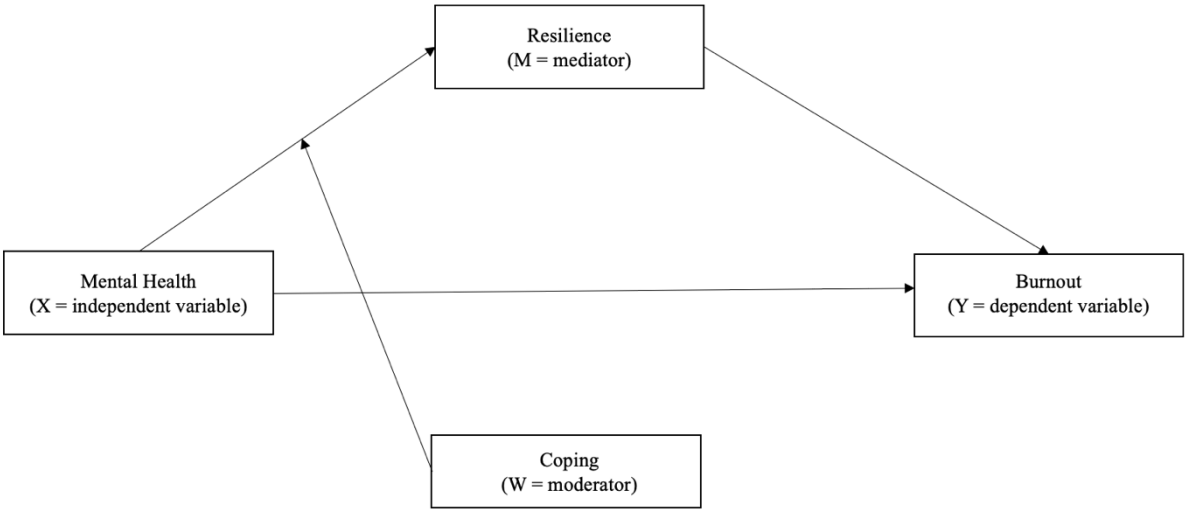
Hypothesized Theoretical Model Two



H_a3: As coping (moderator) measured by CSI-SF increases, the relationship between mental health (PHQ-9, GAD-7, PCL-5) and resilience (BRS) will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).

Figure 3.3

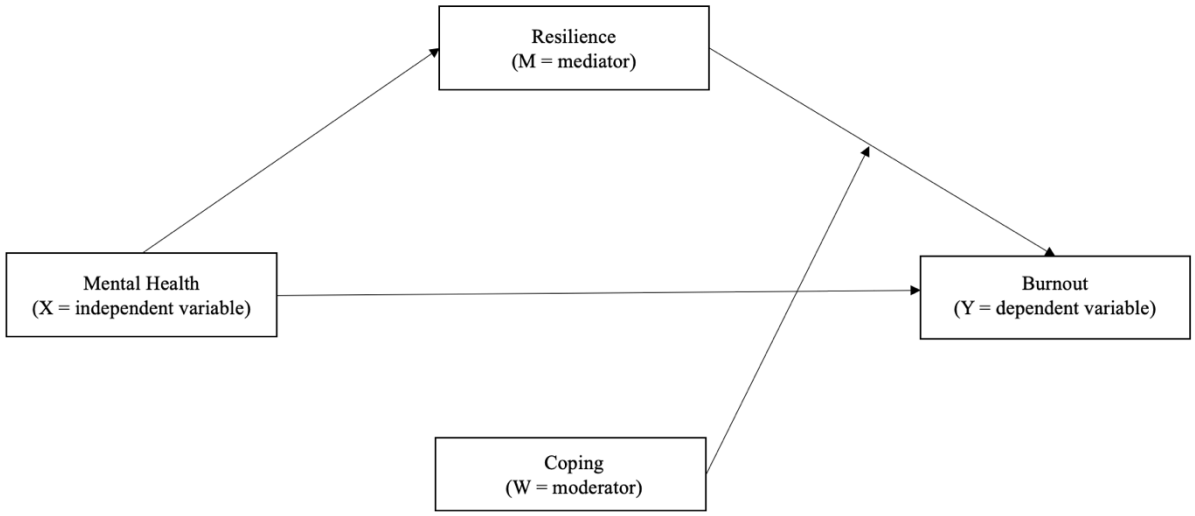
Hypothesized Theoretical Model Three



H_a4: As coping (moderator) measured by CSI-SF increases, the relationship between resilience (BRS) and burnout (CBI) will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).

Figure 3.4

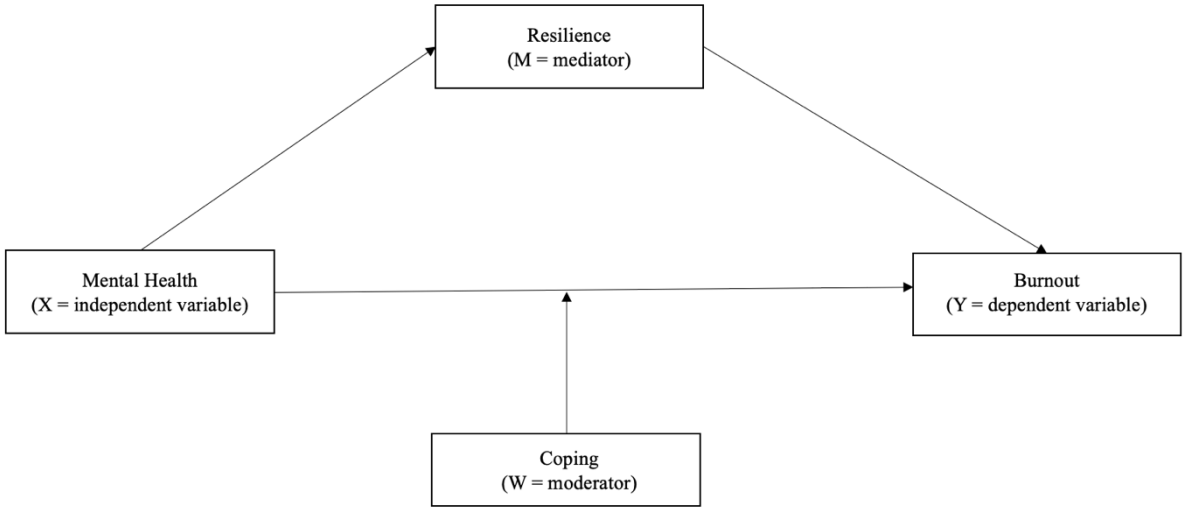
Hypothesized Theoretical Model Four



H_a5: As coping (moderator) measured by CSI-SF increases, the relationship between mental health (PHQ-9, GAD-7, PCL-5) and burnout (CBI) will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).

Figure 3.5

Hypothesized Theoretical Model Five



Participants and Setting

The participants for this study were drawn from a non-probability, convenience sample of online MLSP counselors from all military branches (Army, Air Force, Marine Corps, Navy, Coast Guard, and Space Force), all components of military service (active-duty, National Guard, Reserves, retired, and Expiration Term of Service) spouses, and all ranks (junior enlisted, non-commissioned officers, senior enlisted, warrant, company grade, field grade, and general officers). Participants were required to be at least 18 years old and married to the SM for at least six months while practicing counseling. Participants must have a master's degree in a counseling-related field, including professional counseling, clinical mental health, social work, or marriage and family therapy, must be provisionally or fully licensed in their state for inclusion in this study.

Participants were recruited from two large online groups, one MLSP group and a counselor/CES group, with which the researcher is affiliated. Additional sampling occurred by recruiting from other associations for professional counselors and military mental health providers. The researcher disseminated the survey to other mental health practices near Fort Liberty, North Carolina by direct email. Spouses who participated were encouraged to share the survey link with their respective online networks to increase the sample size for the study. Snowball sampling with MLSPs has been successful in previous studies (Knobloch, 2021; Mailey et al., 2019). Online surveys assist in sampling due to the movements of MLSPs and the average military, transient lifestyle (McMaster et al., 2017). MLSPs are typically active online, as their communities fluctuate consistently, and MLSPs utilize online networks to maintain their relationships (Chen, 2019; Knobloch & Theiss, 2012; McMaster et al., 2017).

After completion of the survey questions, respondents were presented with an option to be redirected to a survey link where they can complete an optional incentive (20 $25 Amazon gift cards) entry form. Any provided identifying information (including name, email address, and phone number) was disconnected from their initial survey responses on the incentive form, as outlined within the informed consent document to maintain anonymity. Incentive recipients were randomly selected twelve weeks after the conclusion of the data collection and screening period and were notified by email of their award. All remaining entrants for the incentive were informed by email (blind carbon copied) that they were not selected but were invited to join an email list for a follow up of the study results.

While small sample sizes in multiple regression analyses are common (Maxwell, 2000), this study provides a modest dataset, producing ample effects to observe. Maxwell's (2000) guidelines indicate that a sample of 218 is needed to conduct a moderated mediation analysis. In

order to provide ample statistical power to the study, the researcher added 44 participants to the sample size to account for a 20% attrition rate, thus requiring 262 participants in total for moderated mediation. However, the researcher was unable to collect 262 responses required for moderated mediation analysis, closing the survey with a total of 68 valid responses. The researcher utilized G*Power (Faul et al., 2007), a statistical power analysis software, to determine the appropriate sample size for mediation analysis. With a medium effect size and statistical power of 80% (Frazier et al., 2004), G*Power indicated a sample of 55 participants would be appropriate (see Appendix C). The researcher included an additional 11 participants to account for 20% attrition, thus requiring 66 participants for mediation analysis. The data analysis includes the statistical significance of unstandardized regression coefficients, variation (R^2), all significant relationships, and direct/indirect effects.

Instruments

The quantitative survey was created via Qualtrics. Informed consent was presented, followed by a prompt to acknowledge the informed consent and answer inclusionary questions to confirm they meet the study requirements. Assessment questions included 13 demographic questions, 36 mental health questions (PHQ-9, GAD-7, and PCL-5), six questions from the BRS, 16 coping questions from the CSI-SF, and 20 questions regarding burnout (CBI). These assessments measured mental health, resilience, burnout, and coping in the surveyed sample.

Demographic Questionnaire

Demographic information about the participants MLSP history included gender, age, SM branch, SM component, length of military service, rank, years married, children, number of PCSes, professional counseling credential (social work, professional counselor, marriage and family therapist, counselor educator), length of time in the profession, and populations served.

The survey included two written questions, asking each respondent to type their professional counseling credential as well as their most recent duty station to mitigate spam or inauthentic participants. This is important information to aid in data screening, exclude potential spam respondents, and analyze correlations between the relationships between mental health, resilience, coping, and burnout.

PHQ-9

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) includes nine items to assess for depressive symptoms. Each item includes a four-point, Likert-type scale ranging from 0 (*not at all*) to 3 (*nearly every day*) and is scored by the total sum of responses. The assessment begins by asking, "Over the last two weeks, how often have you been bothered by any of the following problems?", providing nine items, such as "feeling down, depressed, or hopeless" and "poor appetite and overeating". The PHQ-9 has shown ample consistency ($\alpha = 0.89$) and total-score reliability (Bianchi et al., 2022; Kroenke & Spitzer, 2002). The PHQ-9 has also been utilized in literature to explore MLSP depressive symptoms (Sinclair et al., 2019).

GAD-7

The Generalized Anxiety Disorder 7 (GAD-7; Spitzer et al., 2006) utilizes seven items to assess an individual's anxiety symptoms. Like the PHQ-9, each question utilizes a four-point, Likert-type scale ranging from 1 (*not at all*) to 4 (*nearly every day*), and the sum indicates the severity of anxious distress. The assessment asks the respondent, "Over the last two weeks, how often have you been bothered by the following problems?", providing options such as "feeling nervous, anxious or on edge" and "trouble relaxing". The GAD-7 demonstrates strong internal consistency ($\alpha = 0.92$), test-retest ($r = 0.83$) and procedural reliability ($r = 0.83$; Spitzer et al.,

2006). The GAD-7 has been previously utilized in military and MLSP studies to explore anxious distress and mental health challenges (Sinclair et al., 2019; Wright et al., 2012).

PCL-5

The PTSD Checklist (PCL; Weathers et al., 1993) is one of the most utilized measurements of PTSD. Its original form followed the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders (4th ed; *DSM-IV*; APA, 1994), included three different versions of the assessment (PCL-Military, PCL-Civilian, and PCL-Specific), and utilized 17 self-report items that indicated symptomology for the past month on a five-point, Likert-type scale. The PCL-5 (Weathers et al., 2013) was developed according to the diagnostic criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders and now contains 20 items, utilizing a Likert-type scale from zero to four, scored by summation of the respondent's answers (5th ed; DSM-5; APA, 2013).

The assessment begins by asking, "In the past month, how much were you bothered by:" and provides items such as "repeated, disturbing, and unwanted memories of the stressful experience" and "avoiding memories, thoughts, or feelings related to the stressful experience." The PCL-5 has one version with three differing formats, including one without Criterion A, one with a Criterion A component, and one with the Life Events Checklist for *DSM-5* (Weathers et al., 2013). Criterion A is the traumatic event that precipitated the PTSD symptoms and is utilized in the assessment for diagnostic purposes (Weathers et al., 2013). For the purposes of research, the PCL-5 without Criterion A was utilized in the present study. The PCL-5 demonstrates strong internal consistency ($\alpha = 0.94$) and test-retest reliability ($r = 0.82$; Blevins et al., 2015). It has been utilized in similar research designs (Litam et al., 2021; Sinclair et al., 2019).

Prior military studies have utilized the PHQ-9, GAD-7, and PCL-5 to create a composite mental health score, indicating the presence of anxiety, depression, or posttraumatic distress (Sinclair et al., 2019; Sullivan et al., 2021; Wilk et al., 2010; Wright et al., 2012). This study seeks to explore mental health symptom levels rather than diagnostic criteria, as is consistent with research designs (Sinclair et al., 2019). The inclusion of these three assessments provided the baseline for ascertaining the mental health of participants, and analysis of each mental health variable is included in the results.

BRS

The Brief Resilience Scale (BRS; Smith et al., 2008) is one of the most reliable measurements for resilience and has had popular application in military communities (De la Rosa et al., 2016) and some application in MLSP literature (Knobloch, 2021; Sinclair et al., 2019). The BRS includes six items with Likert scales ranging from 1 (*strongly agree*) to 5 (*strongly disagree*) and includes three positively worded and three negatively worded questions, which are averaged together to create a mean resilience score. The BRS specifically measures one's ability to overcome adversity, one sample item being "I tend to bounce back quickly after hard times," (Smith et al., 2008).

The BRS is one of the more thoroughly investigated resilience measurements, showing significant reliability (both test-retest and internal consistency), factor structure, validity, and application across diverse populations (Windle et al., 2011). The BRS has an alpha coefficient ranging from $\alpha > 0.70$ and $\alpha < 0.95$ (Smith et al., 2008; Windle et al., 2011) and an interclass correlation coefficient of 0.69 and 0.62 in two samples (Windle et al., 2011). This assessment has illustrated consistency and reliability when measuring resilience and is appropriate for utilization in this study.

CSI-SF

The Coping Strategies Inventory- Short Form (CSI-SF; Addison et al., 2007) is a brief version of the original Coping Strategies Inventory (Tobin et al., 1989). The original CSI utilized eight subscales to address the Lazarus & Folkman (1984) model of burnout, using 72 items to explore coping strategies. Addison and colleagues (2007) utilized 16 of the original items of the CSI to explore coping strategies in patients with chronic coronary disease and their caregivers, creating the CSI-SF.

An engagement strategy would require acting to directly confront a stressor, thus limiting the long-term psychological impacts of a stressor (Speyer et al., 2016). A disengagement strategy would require avoiding a stressful stimulus, thus providing short-term relief. A problem-focused coping strategy would emphasize areas where action can be taken to manage a stressor. Finally, an emotion-focused coping strategy would seek to explore the emotions of the individual and provide regulation or stability. These strategies are represented through four subscales, with each item answered using a 5-point Likert scale (1 = *never*, 2 = *rarely*, 3 = *sometimes*, 4 = *often*, 5 = *almost always*). Example items include "I make a plan of action and follow it," and "I try to let my emotions out."

The psychometrics of the CSI-SF have been evaluated in several applications. Addison et al. (2007) normed the metrics on a large cohort of African American respondents in the Jackson Heart Study, where it indicated internal consistency and appropriate levels of fit. More recently, the CSI-SF has been applied in mental health and stress studies, indicating appropriate fit for these applications (Litam et al., 2021; Poudel-Tandukar et al., 2020). The CSI is considered one of the two best measurements for coping in adults due to its utilization of multiple coping styles and strategies (Poudel-Tandukar et al., 2020). The CSI-SF scale exhibits marginal to acceptable

levels of reliability (α = 0.58 – 0.72) for the four subscales included in the original cohort (Addison et al., 2007). The inventory has, however, shown improved reliability in mental health applications, such as counselor stress (α = 0.56 – 0.82; Litam et al., 2021), immigrant coping (α = 0.78 – 0.89; Poudel-Tandukar et al., 2020), emotional regulation (α = 0.73 – 0.83; Awad et al., 2022) and in additional translations of the model (α = 0.56-0.80; Speyer et al., 2013; α = 0.82 – 0.87; Tous-Pallarés et al., 2022).

CBI

The Counselor Burnout Inventory (CBI; Lee et al., 2007) specifically assesses burnout symptoms in professional counselors, measuring burnout across five dimensions specific to counseling: emotional exhaustion, depersonalization, feelings of reduced personal accomplishment, negative work environments, and deterioration of personal life. These five dimensions informed the five subscales—Exhaustion, Incompetence, Negative Work Environment, Devaluing Client, and Deterioration in Personal Life—present in the CBI. This assessment utilizes 20 self-report items with a 5-point, Likert-type scale (1 = *never true*, 2 = *rarely true*, 3 = *sometimes true*, 4 = *often true*, 5 = *always true*), and scores are summed for each subscale, with results ranging from 4 to 20 per subscale, and total score from 20 to 100. Sample items include “Due to my job as a counselor, I feel tired most of the time,” and, “I have become callous towards clients.” The CBI has been tested across multiple samples (Bardhoshi et al., 2019; Lee et al., 2023) and has indicated strong reliability, with internal consistency (ranging from 0.73 to 0.85), test-retest reliability (ranging from 0.72 to 0.85), and alpha coefficients ranging from 0.66 to 0.89 for the five subscales (Bardhoshi et al., 2019; Lee et al., 2007).

Procedures

Prior to data collection, the researcher thoroughly explored extant literature, including previous relationships between independent and dependent variables, the mediator, and the moderator. A draft of the survey was created, reviewed, and edited in Qualtrics, utilizing the specific instruments and assessments mentioned in the instrumentation section. All chosen assessments demonstrate satisfactory levels of internal consistency, reliability, and validity for use in this study. The demographic portion of the questionnaire ensured anonymity for all participants, collecting personal contact information separately from survey data through site redirection.

Liberty University Institutional Review Board (IRB) approval was sought to ensure a thorough investigation of ethical implications. The data from each survey was stored in two separate online locations and not linked to any personal or sensitive information. This information was included in the participant's informed consent, provided at the beginning of the research questionnaire. After IRB approval was obtained, the survey was finalized, and the researcher began participant recruitment.

Each participant completed the informed consent document, confirmed their eligibility to participate in the study, and completed all survey items. Upon completion, they were eligible to complete the incentive information form, which was decoupled from the survey, and redirected them to another website to provide contact information. Due to the transient nature of the military lifestyle (Mailey et al., 2019), participants were recruited online utilizing snowball sampling. Participants were invited to complete a survey by social media posts on Facebook and Instagram, email campaigns, and the utilization of the researcher's personal MLSP connections. Links to the survey were available in online MLSP groups for approximately twelve weeks. This additional time did not produce the required number of participants for moderated mediation.

Upon completion of the survey, the researcher examined the results to screen out potential inauthentic entries or spam participants, removing incomplete entries, straight-lined answers, and text responses that did not answer the questions appropriately. After this initial screening was completed, the researcher distributed the incentives ($25 Amazon gift cards) to 20 randomly selected participants within twelve weeks after data analysis. Respondents who were not selected received an email thanking them for participation and informing them that they were not selected but will be invited to access study results once available. Data was analyzed and interpreted utilizing IBM SPSS and PROCESS Models 4, 58, and 59 (Hayes, 2018), and results are presented in the forthcoming chapter. Additionally, the author explored limitations and areas of further research that could contribute to the body of literature.

Data Analysis

The data gathered through the online survey was analyzed through a quantitative, descriptive, cross-sectional correlational process. IBM SPSS was utilized to process the collected data and analyze bivariate correlations, linear regressions, and descriptive statistics. Multiple regression analysis was applied, as this is the best method of analysis (Frazier et al., 2004; Heppner et al., 2016). Analyzing each path, or relationship, of multiple variables utilizing both descriptive and analytical approaches provided the clearest results for all hypotheses (Baron & Kenny, 1986).

Each hypothesis was analyzed using the appropriate PROCESS model (Hayes, 2018), including basic linear multiple regression for H_a1, Model 4 for H_a2, Model 58 for H_a3 and H_a4, and Model 59 for H_a5. These PROCESS Models were used in SPSS to establish any present relationships, direct or indirect effects between mental health, resilience, coping, and burnout. The researcher considered potential research errors, including Type I and Type II errors as well

as inappropriate sample size, researcher bias, and skewed data as a result of self-report measurements. The researcher reviewed the data for screening purposes, exploring frequency data to ensure that straight-lined or incomplete responses were removed to avoid inauthentic data. After this screening, the data was assimilated through IBM SPSS into results, which is interpreted and discussed in the upcoming chapters.

Summary

This study utilizes a quantitative, descriptive, cross-sectional correlational research design with multiple regression data analysis to explore the relationships and effects of mental health (independent variable) on burnout (dependent variable) and how this may be mediated by resilience (mediator) and conditioned by coping (moderator). The researcher has compiled questions and stated hypotheses for the anticipated outcome of the online survey of MLSP counselors, which was gathered utilizing snowball sampling and online military and mental health networks. Upon completion of this survey, the researcher thoroughly screened the data to ensure only authentic participants were utilized, and then completed data analysis utilizing IBM SPSS. Results are discussed in the following chapters, exploring this study's limitations and implications for further research.

This study's contributions to the extant literature gap regarding MLSP counselors/CES are explored, including the relationships present between mental health, resilience, coping, and burnout. This gap illustrates an area of essential investigation, as MLSP counselors/CES provide vital care for military families, contributing to military readiness and communities (The Counsel for State Governments, 2022). The upcoming chapters review the results from this survey as well as a thorough discussion of these results and their implications for further research.

CHAPTER FOUR: RESULTS

Overview

Data was collected over a twelve-week period to obtain participants for this quantitative, descriptive, cross-sectional, correlational design. This study explored the mental health (X) of MLSP counselors/CES and their rates of burnout (Y) through resilience (M) conditioned by coping (W). Once the IRB approved the Qualtrics survey, study specifications, and informed consent documents, the online survey was distributed through email and social media to recruit participants using non-probability, convenience sampling. This chapter reports the data screening and filtering processes as well as the descriptive statistics, including the sample size, demographics, and bivariate correlations. Additionally, the results of the analyses, determined utilizing IBM SPSS via PROCESS Models 4, 58, and 59 (Hayes, 2018) are reported, including several combinations between variables. Results are presented in various formats, including tables and figures, to represent conditional effects of the multiple regression analyses.

Data Screening & Filtering

The survey was open for approximately twelve weeks to collect as many participants as possible. When the survey was first published to social media, participant data was largely authentic, with each written, “honey pot” question answered appropriately and each respondent meeting the criteria for inclusion in the study. After two weeks, the survey received a suspicious number of responses that did not correctly answer the written questions and proceeded to the incentive survey numerous times, providing multiple emails for the incentive survey. Specific fraud detection measures in Qualtrics did include bot detection (reCAPTCHA), prevent indexing, and relevant ID, but spam respondents were able to infiltrate the survey regardless of these measures.

The data collected included 173 total responses. Data was then filtered for illogical answers in the written questions, such as “Please write your most recent duty station, including title and state (ex. Fort Liberty, North Carolina).” Data with illogical answers, such as Chinese characters, “no,” or “Newton,” were excluded from the data sample. Additional written questions such as, “Please type your counseling credential,” provided additional spam detection. These filtration measures left 68 responses remaining. These responses demonstrated consistent duration times to complete the survey and variations in answers with no straight-lined responses. Demographic information was also screened for authenticity, ensuring each response branch/component and service-length responses were logical (i.e. a Senior NCO in the Space Force with three years of service would be illogical). All 68 participants responded with logical answers to the demographic questions, yielding the final sample size result. This sample size met the requirements for mediation analysis but did not meet the required size moderated mediation (Maxwell, 2000).

The decoupled incentive survey screening proved essential, as the incentive survey received 204 total responses with multiple, easily detectible spam entries. The incentive survey required a name, email, and written response for the respondent’s most recent duty station. The inaccurate responses to this were nonsensical (e.g. Eiwyn, 3vllcadx48clm@sina.com, and “3351 New York, Manhattan”) and were removed from incentive inclusion. Based on observation and unofficial feedback from participants on social media, not all participants chose to answer the incentive survey. Overall, incentive data yielded 204 total responses with 44 authentic cases.

Descriptive Statistics

The MLSP respondents in this sample showed a variety of ages and military lifestyles. An essential component of this study requires an exploration of demographic data to explore

descriptive statistics within the measurements of the study. After exploring these demographics, inferential statistics from the multiple regression analyses are explored.

Demographics

A gender analysis of total MLSP responses ($N = 68$) indicated that 92.6% of respondents are female ($n = 63$) and 7.4% male ($n = 5$). This sample resembles other MLSP studies whose respondents are approximately 95% female (Knobloch, 2021; Lara-Cinisomo et al., 2020). The age of participants was normally distributed, with most participants between ages 26 and 45 ($n = 57$). See Table 4.1 for specific data regarding respondent age.

Table 4.1

Military Spouse Age

Age	*n*	%
18 – 25	2	2.9
26 – 35	34	50.0
36 – 45	23	33.8
46 – 55	9	13.2
56+	0	0

Participants also reported their SM's branch, component, and rank, indicating a wide variety of experiences. Respondents indicated 50.0% ($n = 34$) from the Army, followed by Air Force 19.1% ($n = 13$), Navy 13.2% ($n = 9$), Marine Corps 10.3% ($n = 7$), Coast Guard 7.4% ($n = 5$), and Space Force 0% ($n = 0$). Approximately 75% ($n = 51$) indicated their SMs were active-duty, with the remaining 13.2% ($n = 9$) identifying as Veteran, 7.4% ($n = 5$) Reserves, and 4.4% ($n = 3$) National Guard.

This survey included time served in the military, SM rank, number of children, and PCSs for the purposes of data screening and verification. Time served in the military ranged from four-to-six years to over 20 years. A substantial number of MLSPs, 45.6% ($n = 31$), reported that their SM was a Senior Non-Commissioned Officer (NCO; see Table 4.2). Respondents had been

married from six months to over 25 years. Respondents indicated that 86.8% of MLSPs had experienced at least one PCS, with 17.6% reporting six or more military moves (see Table 4.3). Additionally, 85.3% of the sample were parents (see Table 4.4).

Table 4.2

Service Member Rank

Rank	*n*	%
Junior Enlisted (E1 - E4)	2	2.9
Non-Commissioned Officer (E5 - E6)	15	22.1
Senior NCO (E7 - E9)	31	45.6
Warrant Officer (W1 - W5)	2	2.9
Company Grade Officer (O1 - O3)	9	13.2
Field Grade Officer (O4 - O6)	8	11.8
General Officer (O7 - O9)	1	1.5

Table 4.3

Reported PCSes

PCSes	*n*	%
0	9	13.2
1	14	20.6
2	12	17.6
3	8	11.8
4	7	10.3
5	6	8.8
6+	12	17.6

Table 4.4

Number of Children with SM

Children	*n*	%
0	10	14.7
1	22	32.4
2	25	36.8
3	7	10.3
4+	4	5.9

Respondents were asked to select their counseling credential from licensed clinical mental health/licensed professional counselor (48.5%, *n* = 33), licensed marriage and family

therapist (19.1%, *n* = 13), licensed social worker (32.4%, *n* = 22), or counselor educator (1.5%, *n* = 1). Participants reported a range of time in the profession, with most respondents spending 10 years or less in the profession. See Table 4.5.

Table 4.5

Time Practicing Counseling

Years	*n*	%
0.5 – 2	15	22.1
3 – 5	25	36.8
6 – 10	14	20.6
11 – 15	9	13.2
16 – 20	4	5.9
20+	1	1.5

An additional item asked respondents to select the populations they serve as a counselor, including the instruction "mark all that apply." Participants reported that 60.3% (*n* = 41) work with children and adolescents, 88.2% (*n* = 60) work with adults, 70.6% (*n* = 48) with service members, 69.1% (*n* = 47) with military families, and 20.6% (*n* = 14) with substance use. Most respondents served a variety of clientele, and most of them indicated a diverse caseload.

Measures and Variables

This section explores the data obtained from the sample and report the descriptive statistics of the scales for each variable, including the independent variable (MLSP mental health = X), dependent variable (MLSP burnout = Y), mediator (resilience = M), and moderator (coping = W). This section will explore each mental health variable (depression, anxiety, and PTSD) individually, reporting their frequencies within the sample. Additionally, burnout subscales will be thoroughly investigated due to significant outcomes for MLSP counselors/CES.

MLSP Counselor Mental Health

Respondent mental health was measured utilizing the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), and PCL-5 (Weathers et al., 2013). Prior to analysis, each scale was mean centered to provide most accurate results. The PHQ-9 measured depression from the past two weeks, with 51.5% (n = 35) indicating normal and 23.6% (n = 16) indicating mild depression levels. In this sample, 19.1% (n = 13) reported moderate depression symptoms, 4.4% (n = 3) reported experiencing moderate/severe symptoms, and 1.5% (n = 1) reported severe depression symptoms.

The GAD-7 (Spitzer et al., 2006) measured anxiety in this sample of MLSP counselors/CES within the past two weeks. In this survey, 47% (n = 32) reported minimal levels of anxiety, with another 36.8% (n = 25) reporting mild anxiety. Additionally, 14.7% (n = 10) reported experiencing moderate anxiety symptoms, and 1.5% (n = 1) reported severe anxiety symptoms. PTSD was measured utilizing the PCL-5 (Weathers et al., 2013) in this study. The PCL-5 requires a minimum score of 51 to meet the criteria for PTSD. Approximately 16.2% (n = 11) met the criteria for PTSD using this scoring method.

Military Spouse Counselor Resilience

The Brief Resilience Scale (BRS; Smith et al., 2008) includes six items to assess resilience. The Likert-type scale measures resilience using three positively worded questions and three negatively worded questions. To provide an accurate BRS mean, the negatively worded items (two, four, and six) were reverse coded to match the positively worded items, as instructed by the scale guidelines. Possible resilience answers ranged from 1 to 5 (M = 21.85, SD = 4.53) and scores were categorized as low, normal, and high resilience (Smith et al., 2008). Respondents indicated that 1.5% demonstrated low resilience (n = 1), 54.4% demonstrated normal resilience levels (n = 37), and 44.1% reported high levels of resilience (n = 30).

Military Spouse Counselor Coping

Coping, the moderator for this study, was assessed using the CSI-SF (Addison et al., 2007), a shortened version of the original Coping Strategies Inventory (Tobin et al., 1989). The CSI-SF includes 16 items and explores four main coping strategies: problem-focused versus emotion-focused and engagement versus disengagement. Options ranged from never (1) to almost always (5) in response to what coping strategies are typically utilized when under stress. Results indicated the following averages in this sample: problem-focused engagement (M = 15.03, SD = 2.38), problem-focused disengagement (M = 10.34, SD = 2.26), emotion-focused engagement (M = 14.24, SD = 2.85), and emotion-focused disengagement (M = 11.96, SD = 2.08).

Military Spouse Counselor Burnout

Burnout, the outcome variable for this study, was assessed using the CBI (Lee et al., 2007), a measure utilized to assess burnout in counselors. The 20-item, five-point Likert scale is divided into five subscales: exhaustion, incompetence, negative work environment, devaluing client, and deterioration in personal life. Results indicated a variety of burnout total scores (M = 46.68, SD = 13.40). The CBI does not provide a cutoff measure for counselors experiencing burnout or not experiencing burnout. The severity of each subscale provides more thorough information regarding the burnout symptoms experienced by respondents.

The CBI subscales provided insight regarding the impacts of burnout in the sample, with exhaustion (M = 11.65, SD = 3.62) and incompetence (M = 10.37, SD = 3.29) as the most prevalent burnout symptoms. Respondents reported deterioration in one's personal life (M = 9.50, SD = 3.30) and negative work environment (M = 8.44, SD = 3.86) less frequently, with devaluing client (M = 6.72, SD = 3.11) as the least frequent symptom. These subscales provide

additional insight into the prevalence of symptoms for each mental health variable explored in this study.

Results

Data analysis was conducted using IBM SPSS Version 29. In this section, bivariate correlations, linear regression, and multiple regression analyses will be reported and interpreted. The PROCESS macro extension (Version 4.0; Hayes, 2018) was installed in SPSS to assess mediation and moderation in the models presented. Each statistical test and correlation will now be reported alongside its corresponding hypothesis.

H_a1

The first hypothesis stated the following: "MLSP counselors who report poorer mental health via the PHQ-9, GAD-7, and PCL-5 will demonstrate statistically significant higher instances of burnout as measured by the CBI." See Figure 4.1.

Figure 4.1

Hypothesized Theoretical Model One

Before computing statistical analyses of any variables, a comparative reliability analysis was conducted on all variables to determine internal consistency. Cronbach's alpha for each mental health scale indicated acceptable levels, with the PHQ-9 yielding $\alpha = 0.87$, the GAD-7 yielding $\alpha = 0.84$, and PCL-5 yielding $\alpha = 0.95$. Additionally, the CBI yielded acceptable reliability, with $\alpha = 0.92$. Zero-order correlations were then considered to determine possible connections between the independent variable and dependent variable. The complete correlation matrix of all variables in this study is presented in Table 4.6.

Table 4.6

Zero-Order Pearson Correlations Between All Variables

	1	2	3	4	5	6	7	8	9	10	11
Depres (1)	—										
Anx (2)	.80**	—									
PTSD (3)	.72**	.76**	—								
Resil (4)	-.57**	-.46**	-.49**	—							
Burn-Tot (5)	.69**	.63**	.54**	-.46**	—						
Cope (6)	-.23	-.22	-.35**	.27*	-.19	—					
Burn-Exh (7)	.46**	.52**	.27*	-.27*	.74	.02	—				
Burn- Inc (8)	.56**	.58**	.45**	-.43**	.77**	-.23	.42**	—			
Burn-NW (9)	.70**	.54**	.52**	-.45**	.85**	-.18	.56**	.55**	—		
Burn-De (10)	.51**	.35**	.50**	-.36**	.70**	-.29*	.21	.56**	.54**	—	
Burn-Det (11)	.46**	.45**	.39**	-.27*	.83**	-.06	.65**	.51**	.60**	.48**	—

Note: N = 68

Note: Depres = depression, *Anx* = anxiety, *PTSD* = PTSD, *Burn-Tot* = burnout total, *Cope* = coping strategies, *Burn-Exh* = burnout exhaustion, *Burn-Inc* = burnout incompetence, *Burn-NW* = burnout negative work environment, *Burn-De* = burnout devaluing client, *Burn-Det* = burnout deterioration in personal life.

*Correlation significant at the $p < 0.05$ level (2-tailed)

**Correlation significant at the $p < 0.01$ level (2-tailed)

The correlations between the mental health measurements in this study were statistically significant ($p < .001$), demonstrating a large positive effect size between depression and anxiety ($r = .80$), PTSD and depression ($r = .72$), and PTSD and anxiety ($r = .76$). The zero-order correlation between the independent variables (depression, anxiety, PTSD) and the dependent

variable (burnout) were statistically significant, indicating moderate, positive effects (r = .69, r = .63, r = .54, respectively).

A basic linear regression analysis of depression on burnout produced $F(1, 66) = 61.40$, $p < 0.001$, $R^2 = 0.48$. Depression demonstrated high variance on burnout and a strong relationship between the two components. Depression was a predictor of burnout ($p < 0.001$), indicating that, with each unit increase of depression, burnout increases by 1.79 units (see Table 4.7).

Table 4.7

Linear Regression Results: Depression (X) on Burnout (Y)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	20.43	3.55	<0.001	13.34	27.52
Depression	1.79	0.23	<0.001	1.33	2.24

Note. CI = confidence interval; *LL* = lower limit; *UL* = upper limit.

A basic linear regression analysis of anxiety on burnout produced $F(1, 66) = 43.14$, $p < 0.001$, $R^2 = 0.40$. Anxiety demonstrated high variance on burnout and a strong relationship between the two variables. Anxiety was a predictor of burnout ($p < 0.001$), indicating that, with each unit increase of anxiety, burnout increases by 2.08 units (see Table 4.8).

Table 4.8

Linear Regression Results: Anxiety (X) on Burnout (Y)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	21.38	4.06	<0.001	13.29	29.48
Anxiety	2.08	0.32	<0.001	1.45	2.71

A basic linear regression analysis of PTSD on burnout produced $F(1, 66) = 27.60$, $p < 0.001$, $R^2 = 0.30$. PTSD demonstrated high variance on burnout and a strong relationship between the two components. While the unstandardized coefficient indicated PTSD was a

predictor of burnout ($p < 0.001$), this relationship was less than the relationships between burnout and depression or anxiety, as each unit increase of PTSD caused burnout to increase by .50 units. See Table 4.9 for further details.

Table 4.9

Linear Regression Results: PTSD (X) on Burnout (Y)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	29.31	3.58	<0.001	22.16	36.46
PTSD	0.50	0.10	<0.001	0.31	0.69

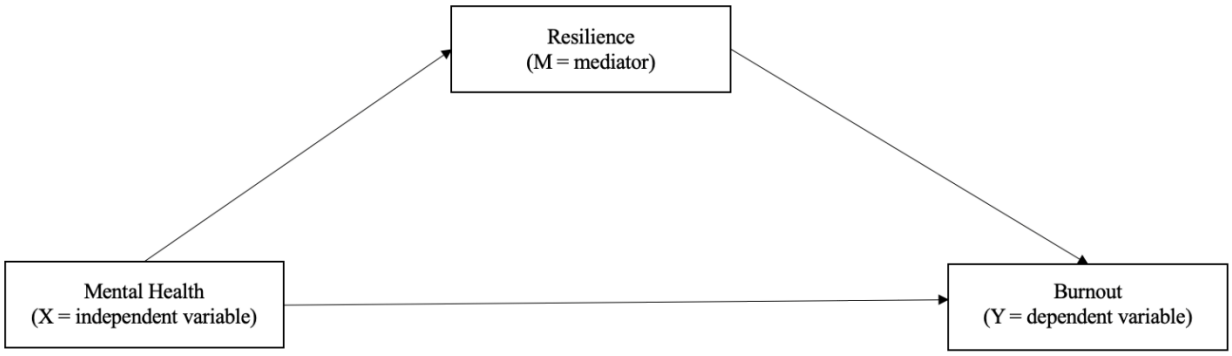
Based on the bivariate correlations and linear regression analyses, the null hypothesis is rejected and H_a1 is supported. Each mental health measure—depression, anxiety, and PTSD—exerted significant effects on MLSP counselor burnout. These results support the alternate hypothesis that MLSP counselors who have a higher prevalence of mental health issues will demonstrate higher rates of burnout in the profession.

H_a2

The second hypothesis stated, "As measured by the BRS, resilience will mediate the relationship between mental health and burnout in the sample population of MLSP counselors/CES, indicating an inverse relationship." See Figure 4.2.

Figure 4.2

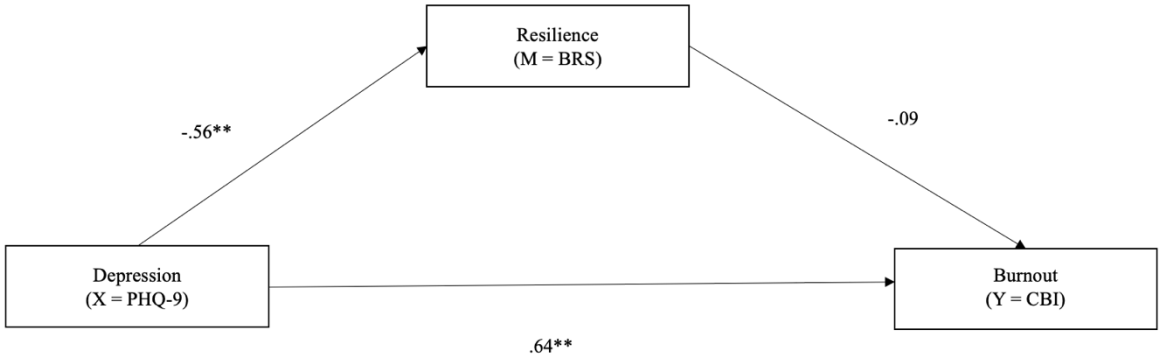
Hypothesized Theoretical Model Two



Before computing the analyses with these variables, comparative reliability analysis was conducted to determine reliability. The BRS indicated an alpha of $\alpha = 0.88$, demonstrating ample reliability for this survey. The correlations between each mental health variable and resilience were significant, demonstrating inverse relationships with medium effects (depression: $p < 0.001$; $r = -0.57$; anxiety: $p < 0.001$; $r = -0.46$; PTSD: $p < 0.001$; $r = -0.49$). The correlation between resilience and burnout was also statistically significant ($p < 0.001$; $r = -0.46$), indicating an inverse relationship but demonstrating a medium effect size. PROCESS Model 4 (Hayes, 2018) was utilized in IBM SPSS to explore the relationship of the three mental health variables (X) on burnout (Y) through resilience (M). Figure 4.3 shows the results of analysis and strengths of model pathways, beginning with depression.

Figure 4.3

PROCESS Model 4 Results: Mediation Model of Depression



A mediation model was calculated in SPSS utilizing the Model 4 PROCESS. The relationship between depression, resilience, and burnout were significant in this model, with an overall variance of $F(1,66) = 31.22$, $R^2 = 0.32$ and a $p < 0.001$. Depression significantly predicted resilience outcomes, indicating participants with greater depression scores experienced less resilience ($B = -0.49$, $p < 0.001$). Additionally, depression significantly predicted burnout, indicating that with each unit increase of depression, burnout score increased by 1.64 units ($B = 1.64$, $p < 0.001$). Resilience did not, however, significantly predict burnout ($B = -0.28$, $p = 0.38$). Because this association was not significant, it violates the assumptions for mediation, indicating that resilience does not mediate the relationship between depression and burnout. See Tables 4.10 and 4.11 for more thorough results.

Table 4.10

PROCESS Model 4 Results: Depression (X) on Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	29.10	1.37	<0.001	26.36	31.85
Depression	-0.49	0.09	<0.001	-0.67	-0.32

Table 4.11

PROCESS Model 4 Results: Depression (X) on Burnout (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	20.43	3.55	<0.001	13.34	27.52
Depression	1.65	0.28	<0.001	1.09	2.20
Resilience	-0.28	0.32	0.38	-0.92	0.35

In addition, mediation models were calculated in SPSS using PROCESS Model 4 to explore the subscales of burnout. Depression was found to be a predictor of all subscales of burnout, demonstrating an increase in depression increases each burnout symptom in this sample. Resilience did not significantly predict any burnout subscale or mediate the relationships between depression and burnout (either total or subscale measures) in this sample. See Table 4.12 for further results.

Table 4.12

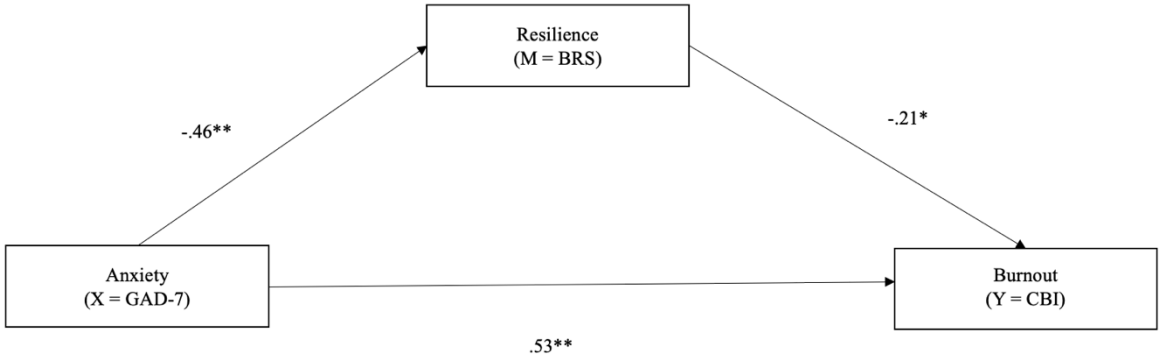
PROCESS Model 4 Results: Depression (X) on Burnout Subscales (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Depression on Exhaustion					
Constant	7.14	3.32	.04	.51	13.78
Depression	.32	.09	<.001	.13	.50
Resilience	-.01	.11	.95	-.22	.21
Depression on Incompetence					
Constant	8.58	2.78	<.001	3.02	14.14
Depression	.30	.08	<.001	.14	.45
Resilience	-.12	.09	.19	-.30	.06
Depression on Negative Work Environment					
Constant	2.74	2.85	.34	-2.94	8.43
Depression	.49	.08	<.001	.33	.64
Resilience	-.65	.09	.48	-.25	.12
Depression on Devaluing Client					

Constant	4.42	2.75	.11	-1.08	9.92
Depression	.27	.08	<.001	.11	.42
Resilience	-.07	.08	.40	-.25	.10
Depression on Deterioration of Personal Life					
Constant	5.72	3.04	.06	-.36	11.79
Depression	.28	.09	<.001	.11	.45
Resilience	-.02	.10	.86	-.21	.18

Figure 4.4

PROCESS Model 4 Results: Mediation Model of Anxiety



A mediation model was run in SPSS utilizing the Model 4 PROCESS to explore the relationships between anxiety, resilience, and burnout in this sample. There were significant associations in the model: $F(1,66) = 18.01$, $p < 0.001$, $R^2 = 0.21$. The GAD-7, measuring anxiety, significantly and negatively predicted resilience scores ($B = -0.52$, $p < 0.001$). Additionally, anxiety was found to be a predictor of burnout ($B = 1.75$, $p < 0.001$), which infers that as anxiety increases by one unit, burnout also increases by 1.75 units. Resilience predicted burnout scores as well ($B = -0.62$, $p = 0.05$). All assumptions for mediation were met and indirect effects were significant ($B = 0.09$, $LL = 0.00$, $UL = 0.25$). Therefore, resilience provides statistically significant mediation between anxiety and burnout. See Table 4.13 and 4.14 for more thorough results.

Table 4.13

PROCESS Model 4 Results: Anxiety (X) on Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	28.15	1.56	<0.001	25.03	31.28
Anxiety	-0.05	0.12	<0.001	-0.76	-0.27

Table 4.14

PROCESS Model 4 Results: Anxiety (X) on Burnout (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	39.05	9.64	<0.001	19.80	58.31
Anxiety	1.75	0.35	<0.001	1.05	2.45
Resilience	-0.63	0.31	0.05	-1.25	0.00

Additional mediation models were explored in SPSS using PROCESS Model 4 to explore the subscales of burnout and any possible relationships. Anxiety predicted exhaustion ($B = 0.44$, $p < 0.001$), incompetence ($B = 0.39$, $p < 0.001$), negative work environment ($B = 0.40$, $p < 0.001$), and deterioration of personal life ($B = 0.34$, $p < 0.001$). Resilience significantly predicted the relationships between anxiety and negative work environment ($B = -0.21$, $p = .03$), also providing significant indirect effects ($B = 0.11$, $LL = 0.01$, $UL = 0.28$). Resilience also predicted the relationship between anxiety and devaluing client ($B = -0.18$, $p = .05$), but it did not produce significant indirect effects. See Table 4.15 for more detailed results.

Table 4.15

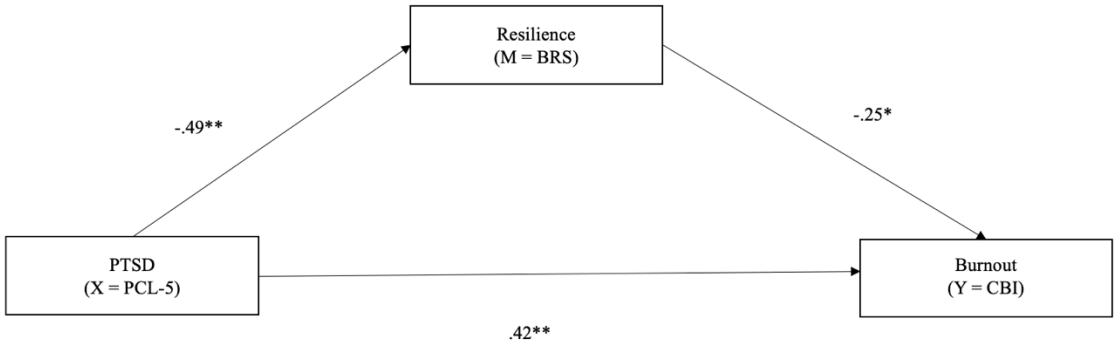
PROCESS Model 4 Results: Anxiety (X) on Burnout Subscales (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Anxiety on Exhaustion					
Constant	6.80	2.95	.02	.92	12.68
Anxiety	.45	.12	<.001	.24	.66

Resilience	-.03	.10	.77	-.22	.16
Anxiety on Incompetence					
Constant	8.85	2.50	<.001	3.85	13.84
Anxiety	.39	.09	.<.001	.21	.57
Resilience	-.15	.08	.07	-.31	.01
Anxiety on Negative Work Environment					
Constant	8.20	2.98	.01	2.24	14.16
Anxiety	.40	.11	<.001	.19	.62
Resilience	-.21	.10	.03	-.41	-.02
Anxiety on Devaluing Client					
Constant	8.48	2.70	<.001	3.09	13.86
Anxiety	.17	.10	.08	-.02	.37
Resilience	-.18	.09	.05	-.35	-.01
Anxiety on Deterioration of Personal Life					
Constant	6.73	2.80	.02	1.13	12.32
Anxiety	.34	.10	<.001	.14	.54
Resilience	-.06	.09	.51	-.24	.12

Figure 4.5

PROCESS Model 4 Results: Mediation Model of PTSD



IBM SPSS and PROCESS Model 4 was utilized to explore the mediation model between PTSD, resilience, and burnout. There were significant associations in the model: $F(1,66)$ =

21.01, $p < 0.001$, $R^2 = 0.24$. PTSD significantly predicted resilience ($B = -0.15$, $p < 0.001$). Additionally, PTSD significantly predicted burnout ($B = 0.38$, $p < 0.001$). Resilience also significantly predicted burnout scores ($B = -0.74$, $p = 0.03$). All assumptions for mediation were met and indirect effects were significant ($B = 0.12$, $LL = 0.00$, $UL = 0.30$). Therefore, resilience mediates the relationship between PTSD and burnout. See Table 4.16 and Table 4.17 for details.

Table 4.16

PROCESS Model 4 Results: PTSD (X) on Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	27.17	1.26	<0.001	24.66	29.68
PTSD	-0.15	0.03	<0.001	-0.21	-0.09

Table 4.17

PROCESS Model 4 Results: PTSD (X) on Burnout (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
Constant	49.54	9.90	<0.001	29.76	69.32
PTSD	0.38	0.11	<0.001	0.17	0.59
Resilience	-0.74	0.34	0.03	-1.43	-0.06

Additional mediation models in SPSS explored the five CBI subscales: exhaustion, incompetence, negative work environment, devaluing client, and deterioration of personal life. There were significant associations within several models. PTSD was found to be a predictor of incompetence ($p = .01$), negative work environment ($p < 0.001$), devaluing clients ($p < 0.001$), and deterioration in personal life ($p = .01$). Resilience mediated the relationship between PTSD and incompetence ($B = -0.20$, $p = .03$), producing indirect effects ($B = 0.13$, $LL = 0.02$, $UL = 0.28$). Resilience also mediated the relationship between PTSD and negative work environment

(B = -0.22, p = .03), producing significant indirect effects (B = 0.13, LL = 0.01, UL = 0.29). See Table 4.18 for more detailed results.

Table 4.18

PROCESS Model 4 Results: PTSD (X) on Burnout Subscales (Y) Through Resilience (M)

				95% CI	
Source	*B*	*SE*	*p*	*LL*	*UL*
PTSD on Exhaustion					
Constant	13.19	3.13	<.001	6.93	19.45
PTSD	.45	.03	.18	-.02	.11
Resilience	-.14	.11	.19	-.36	.07
PTSD on Incompetence					
Constant	12.14	2.58	<.001	6.99	17.30
PTSD	.07	.03	.01	.02	.13
Resilience	-.20	.09	.03	-.37	-.02
PTSD on Negative Work Environment					
Constant	9.60	2.91	<.001	3.79	15.40
PTSD	.10	.03	<.001	.04	.17
Resilience	-.22	.10	.03	-.42	-.02
PTSD on Devaluing Client					
Constant	5.93	2.43	.02	1.08	10.78
PTSD	.09	.03	<.001	.04	.14
Resilience	-.11	.08	.21	-.27	.06
PTSD on Deterioration of Personal Life					
Constant	8.68	2.76	<.001	3.16	14.20
PTSD	.07	.03	.01	.02	.13
Resilience	-.08	.09	.39	-.27	.11

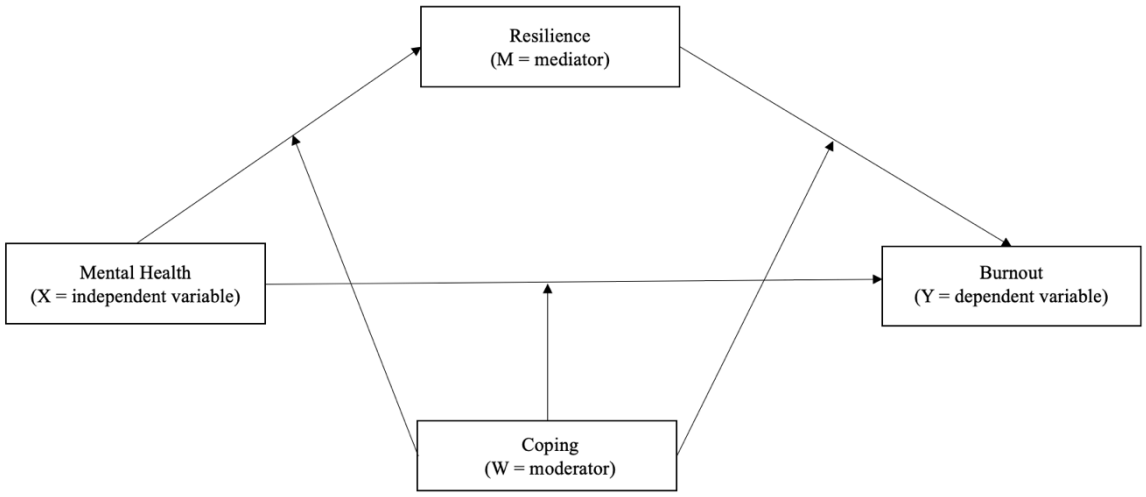
H_a3, H_a4, and H_a5

The third hypothesis stated the following: "As coping (moderator) measured by CSI-SF increases, the relationship between mental health (PHQ-9, GAD-7, PCL-5) and resilience (BRS)

will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).” The fourth hypothesis stated, “As coping (moderator) measured by CSI-SF increases, the relationship between resilience (BRS) and burnout (CBI) will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).” The final hypothesis stated the following: “As coping (moderator) measured by CSI-SF increases, the relationship between mental health (PHQ-9, GAD-7, PCL-5) and burnout (CBI) will become stronger, thus exerting an inverse (decreased) prevalence of MLSP counselor burnout (CBI).” See Figure 4.6.

Figure 4.6

Hypothesized Theoretical Model Three



Before analyzing this model, reliability was analyzed for the CSI-SF measuring coping. Cronbach’s alpha indicated a reliability coefficient of $\alpha = 0.43$, indicating unacceptable reliability in this study. The results of PROCESS Models 58 and 59 did not produce significant results, but exploratory analysis provided R^2 change values that were notable when analyzing anxiety and PTSD. The interaction between anxiety and resilience, when moderated by coping,

produced R^2 = .026, indicating that 2.6% of the variance in this relationship is determined by coping. The relationship between PTSD and burnout, when moderated by coping, produced R^2 = .033, demonstrating that 3.3% of the variance in burnout scores is determined by coping. No notable changes were observed when exploring depression as the independent variable.

Coping did not condition the relationships between the variables and was not a reliable and valid measure for further investigation. Thus, H_a3, H_a4, and H_a5 are rejected, and the null hypotheses are accepted. The requirements for moderated mediation were not met in this study due to low sample size. This occurred due to time constraints of the study as well as the limitations of nonprobability convenience sampling in this population.

Summary

This study gathered data from 68 MLSP counselors/CES through nonprobability convenience sampling via social media recruitment and online connections with MLSP and counseling organizations. Falsified entries from spam bots were excluded from the data sample through intentional data screening measures. The final sample yielded relevant statistics regarding the participants, including their demographics, military life experiences, mental health, resilience, coping strategies, and burnout. The results provided several notable correlations and statistically significant components with differing variable outcomes. Mental health repeatedly predicted burnout levels, as respondents with a higher prevalence of depression, anxiety, or PTSD indicated higher rates of burnout. Resilience mediated the relationships between anxiety, PTSD, and burnout. Resilience did not mediate the relationship between depression and burnout, including the total burnout score or any subscale results. Additionally, the requirements for moderated mediation were not met, thus requiring the rejection of H_a3, H_a4, and H_a5. The data

collected from this sample of MLSP counselors/CES provides new information for the profession, with ample areas for discussion and application.

CHAPTER FIVE: CONCLUSIONS

Overview

The final chapter of this study offers an opportunity to explore the interactions between the information gathered from this sample, including the statistically significant relationships between variables, parallels from extant research, and considerations from these findings. This chapter discusses the notable findings from the study and includes answers to the proposed research questions. Following this discussion, the implications from this study regarding MLSP counselor/CES mental health, resilience, and burnout are explored. These implications are particularly important for the military community, the counseling profession, counselor education, and other researchers exploring these areas. Additionally, the limitations of this study and recommendations for further research will discuss topics to explore within MLSP mental health and burnout in counselors/CES based on the results of this study.

Discussion

MLSPs have been a focus of increased consideration in recent literature, as their impacts on the U.S. SM are critical (Corry et al., 2019; Sinclair et al., 2019). MLSP mental health and resilience have become features of the literature (Knobloch, 2021; Sinclair et al., 2019), providing a foundation for further exploration into differing occupational and demographic areas that impact the MLSP. The purpose of this study was to fill a gap in the literature by exploring MLSP who are counselors and CES, including how their mental health (depression, anxiety, and PTSD) impacts burnout, mediated by resilience, and conditioned by coping. The hypotheses presented in this study were partially supported, and the findings of the study warrant further discussion and exploration, beginning with demographic findings that prove relevant.

MLSP Counselors: Demographics

Demographics from this sample ($N = 68$) represented a modest selection of MLSP counselors/CES. As this study is the first to explore the intersectional identity of MLSP counselors/CES in a cohort, the modest sample size provides unique data on this population. A vast majority of MLSPs are female (BSF, 2023), and most counselors, approximately 75%, are female (Data USA, 2017). This trend was supported in this study, with 92.6% of respondents being female and 7.4% male. The age distribution of this sample was normally distributed, with most participants aged between 26 and 45, which was expected due to the professional and educational requirements of counselors/CES.

This sample was representative of several key adversities in the military lifestyle. Half of respondents reported their SM was in the Army, and about 75% indicated their SMs were active-duty. Additionally, over two-thirds of respondents reported that their SM was enlisted, with 45.6% reporting their SM was a Senior Enlisted NCO. SM rank has shown significant impact on MLSP outcomes, including mastery of the military lifestyle (Ziff & Garland-Jackson, 2020) and moderating effects for mental health outcomes (Knobloch, 2021). Approximately 87% of respondents had experienced at least one PCS, a key military stressor (BSF, 2023). Those who had not experienced a PCS are likely either too early in their military career to be relocated, are in the National Guard or Reserves, or are assigned to a unit that is based in one location. Additionally, 85.3% of respondents were parents, another stressor in the military lifestyle (BSF, 2023) and challenge for women in the counselor/CES profession (Eckhart & Ziomek-Daigle, 2019).

These MLSP counselors/CES also work with a significant percentage of SMs and their families. In fact, 70.6% of participants reported working with SMs and 69.1% with military families, information that warrants further exploration. Working with SMs can increase

vicarious/secondary trauma (Ballenger-Browning et al., 2011; Clifford, 2014), creating additional occupational adversity. In addition to working with a highly traumatized population, working with individuals with similar experiences, such as other MLSPs and military families, increases the likelihood of countertransference, a contributing factor for burnout (Houshangi et al., 2023). Thus, MLSP counselors/CES working with military families may exacerbate burnout symptoms, which can decrease counselor quality of life (Hayes et al., 2015). This intersection of MLSP and counselor/CES adversity is an important area of further exploration to better understand how the military lifestyle, and providing for other MLSPs and their families, impacts the professional life of MLSP counselors/CES.

MLSP Counselor Tendencies: Mental Health

This study sheds light on the mental health experiences of MLSP mental health professionals. According to the assessments utilized in this study, MLSP counselors/CES demonstrate similar levels of mental health challenges as other MLSPs who are not counselors. According to results from the PHQ-9 (Kroenke et al., 2001), 25% of respondents report moderate to severe depressive symptoms. In recent studies, MLSPs report depressive symptoms ranging between 6.1% to 10.7% (Steenkamp et al., 2018; Sullivan et al., 2021). Historically, MLSP literature indicates that moderate to severe depressive symptoms can range from 25% (Mansfield et al., 2010) to 33% (Faulk et al., 2012), indicating that this study's participants are commensurate with historical MLSP samples, underscoring the need for further investigation.

The results for anxiety in this sample were slightly different than previous literature regarding MLSP anxiety. According to results from the GAD-7 (Spitzer et al., 2006), 83.8% report minimal or mild anxiety with 16.2% reporting moderate to severe anxiety levels in this study. Recent literature indicates that MLSPs experience anxiety prevalence rates between 6.5%

to 12.1% (Mailey et al., 2018; Sullivan et al., 2021) while historical literature reports anxiety prevalence between 17.4% (Eaton et al., 2008) to 44.2% (Fields et al., 2012). This study's sample falls between these ranges, indicating significant anxiety prevalence in the sample.

This study provided noteworthy data regarding PTSD in MLSP counselors/CES. According to the results from the PCL-5 (Weathers et al., 2013), 16.2% of respondents met the inclusion criteria for PTSD. The prevalence of PTSD in prior literature indicates that 6.9% (BSF, 2021) to 7.4% (Knobloch, 2021) of MLSPs have PTSD, showing that this sample reports over two-times higher levels of PTSD than other MLSP populations. This result warrants more thorough investigation into the prevalence of PTSD in MLSP counselors. Vicarious/secondary trauma is commonly explored in counselor mental health literature (Bardhoshi et al., 2019; Voon et al., 2022), but counselor's own experiences of trauma have not been thoroughly and consistently investigated in the literature (Leung et al., 2023).

The results of this study were consistent with previous findings from other MLSP cohorts (Knobloch, 2021; Sinclair et al., 2019), indicating that mental health challenges are present in the MLSP counselor/CES community at similar rates to other populations. Military lifestyle factors do impact MLSP mental health, and these stressors illustrate areas where continued support is needed (Lara-Cinisomo et al., 2020; Mansfield et al., 2010; Ormeno et al., 2020). The current study shows more specifically how mental health impacts occupational outcomes for MLSP counselors/CES, but additional investigation into the causational factors that contribute to their mental health challenges would prove beneficial. Additionally, this study underscores the prevalence of MLSP counselor/CES mental health challenges and emphasizes the importance of resilience to consider implications.

MLSP Counselor Tendencies: Resilience

Resilience has been identified as a key protective factor for MLSPs to navigate the difficulties of the military lifestyle (Lee et al., 2013; Monney, 2019; Sinclair et al., 2019). Understanding the relationship between mental health and resilience can answer some questions about how some MLSPs bounce back differently than others. Measuring resilience can prove challenging (Meredith et al., 2011), but previous research has indicated success in identifying resilience in MLSPs and providing practical ways to bolster resilience in this population (Sinclair et al., 2019).

This study utilized the BRS (Smith et al., 2008) to operationalize resilience, which has proven difficult to quantify (Meredith et al., 2011; Van Winkle & Lipari, 2015). In this study, 1.5% of participants demonstrated low resilience, 54.4% demonstrated normal resilience levels, and 44.1% demonstrated high resilience. These results indicate relatively high levels of resilience in comparison to other samples of MLSPs (Knobloch, 2021). These outcomes may be contributed to self-mastery, positive outlook, religion/spirituality, or access to resources that are specific to counselors/CES (Pflieger et al., 2020). Resilience mediated the relationships between anxiety, PTSD, and burnout in this study, indicating areas of further exploration into the protective role of resilience in mitigating counselor/CES burnout.

MLSP Counselor Tendencies: Burnout

Burnout has been identified as an area of significant concern in both MLSP literature (Lester et al., 2016) and counselor/CES literature (Bardhoshi et al., 2019; Fye et al., 2021). This study also underscores the concerns regarding counselor/CES burnout and how MLSP counselors/CES, more specifically, manage burnout symptoms. This study utilized the CBI (Lee et al., 2007) to explore burnout in this sample. Exploring results of the CBI subscales produces further data for investigation.

Participants in this study reported moderate levels of burnout (M = 46.88), validating other studies about counselor/CES burnout and that 55% of counselors experience this phenomenon (Lee et al., 2020). Exhaustion (m = 11.68) and incompetence (m = 10.37) were the most prevalent burnout symptoms reported in this sample, with devaluing clients (m = 6.72) as the least prevalent symptom of counselor burnout. These results mirror other literature that indicates feelings of exhaustion as the central quality of burnout (Maslach & Leiter, 2008) and devaluing clients as the "final stage" of counselor burnout (Lee et al., 2023, p. 171). These results indicate areas of targeted support for MLSP counselors/CES and how they can mitigate burnout.

RQ1

The first research question asked, "Does a higher rate of mental health issues, to include depression, anxiety, and post-traumatic stress disorder measured by the PHQ-9 (Kroenke et al., 2001), GAD-7 (Spitzer et al., 2006), and PCL-5 (Weathers et al., 2013), increase the prevalence of burnout, measured by the CBI (Lee et al., 2007), in MLSP counselors/CES?" To answer this question, the bivariate correlations were significant between each mental health measure—depression, anxiety, and PTSD—and MLSP counselor burnout, indicating significant relationships.

Beyond bivariate correlations, basic linear regression analysis also indicated statistically significant relationships between depression, anxiety, PTSD, and burnout, as each mental health variable was found to be a predictor of burnout. These results support prior literature that explores mental health (Sinclair et al., 2019) and burnout (Litam et al., 2021) in other populations, indicating that poorer mental health is predictive of occupational burnout. These

results indicate that MLSP counselors who have poorer mental health will demonstrate higher rates of burnout in the profession, as expected in this study.

Mental health has shown predictive relationships to burnout in previous literature (Sinclair et al., 2019), but distinguishing vicarious trauma, secondary traumatic stress, and burnout has become an issue for accurately exploring mental health professionals' reported outcomes (Leung et al., 2023). A personal trauma history is associated with poorer mental health outcomes but is not necessarily predictive of burnout (Leung et al., 2023). This study provides similar insight, as PTSD explained the least variance of burnout scores in this sample. Results from the current study contribute to this literature and explore how resilience may mediate these relationships.

RQ2

The second research question asked the following: "Does resilience, as measured by the BRS (Smith et al., 2008), mediate the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI) in MLSP counselors/CES?" This study explores the possible mediation of resilience on the relationship between mental health and burnout. The results did indicate the presence of significant, inverse correlations between resilience and the three mental health measures in this sample.

The results of the PROCESS Model 4 (Hayes, 2018) regression analyses indicated that resilience does partially mediate the relationships between anxiety and burnout as well as PTSD and burnout. In contrast, the regression analysis indicated that resilience does not mediate the relationship between depression and burnout. This finding is surprising, as resilience is touted to provide protective effects for individuals experiencing military stressors and depressive symptoms (Sinclair et al., 2019). This result may be due to depressive symptoms falling outside

of the protective roles of resilience. For example, individuals experiencing depressive symptoms may experience a loss of motivation (APA, 2013), thus not experiencing the bounce back effect of resilience. Resilience may also speak to one's abilities in a positive, performative way, which may not translate to individuals feeling a loss of motivation or purpose due to depressive symptoms. Further investigation into the relationship between depression and resilience may provide additional insight into this study finding.

Exploring the subscales present in the CBI (Lee et al., 2007) provided relevant discussion regarding how mental health challenges may exacerbate specific burnout symptoms. While depression did predict burnout within the subscales, resilience did not mediate these relationships. Anxiety predicted exhaustion, incompetence, negative work environment, and deterioration in personal life subscales, and resilience only mediated the relationship between anxiety and negative work environment. PTSD predicted the outcomes of incompetence, negative work environment, devaluing clients, and deterioration in personal life, but resilience only mediated the relationships between PTSD and incompetence and negative work environment.

These outcomes are important, as these results indicate that resilience directly effects MLSP counselors/CES' perceptions of their work environment when experiencing anxiety and PTSD. Negative work environment can be based on external factors outside of the counselor's control, such as an excessive caseload, and has been shown as the potential beginning of the causal sequence of burnout (Lee et al., 2023). Thus, bolstering counselors' resilience could mitigate negative work environment factors and, consequentially, assist in burnout reduction, particularly for clinicians experiencing anxiety and PTSD.

Resilience also mediated the relationship between PTSD and feelings of incompetence. Feelings of incompetence have been shown to grow from exhaustion (Lee et al., 2023), so addressing emotional and physical exhaustion for counselors with PTSD is key in promoting resilience growth, decreasing burnout in the profession. Examining these subscales can provide a more thorough discussion for specific interventions and practices to support MLSP counselors/CES experiencing mental health challenges and burnout.

RQ3, RQ4, and RQ5

The final three research questions explored possible moderating effects between coping and the other variables in this study. The third research question asked, "What moderating effects, if any, does coping, as measured by the CSI-SF (Addison et al., 2007), have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and resilience (BRS)?" The fourth research question asked, "What moderating effects, if any, does coping (CSI-SF) have on the relationship between resilience (BRS) and burnout (CBI)?" The final research question asked, "What moderating effects, if any, does coping (CSI-SF) have on the relationship between mental health (PHQ-9, GAD-7, and PCL-5) and burnout (CBI)?" Due to the modest but inadequate sample size, moderated mediation could not be analyzed in this study. The measurement for coping produced unreliable results, and the relationships between coping and the other variables were insignificant. However, notable connections between anxiety, PTSD, resilience, coping, and burnout were present in exploratory analysis of the R^2 change values, indicating a need for further investigation. Coping demonstrated notable interactions on the relationships between anxiety and resilience as well as PTSD and burnout, illuminating the need for an increased sample size to explore these effects. Coping did not produce noteworthy interactions with depression in this sample. Future research should attempt to explore these

connections, as coping and resilience have previously shown significant relationship (Mahoney, 2010; Masten, 2018). Understanding how coping strategies assist MLSP counselors/CES in managing their mental health would have provided additional insight into what types of coping are most beneficial to build resilience, manage mental health symptoms, and mitigate burnout. Coping has been shown to help counselors maintain wellness in the profession (Litam et al., 2021), and further exploration into how specific coping strategies impact MLSP counselors/CES would be an area of further investigation.

Implications

This study offers significant implications for the counseling profession, counselor educators, MLSPs, and the military community as a whole. Findings from this study produce additional insight into MLSP and counselor/CES mental health, areas that have been identified as important for further investigation (Knobloch, 2021; Voon et al., 2022). Exploring these implications can provide outcomes for supporting MLSP counselors/CES and mitigating their burnout, as they are essential providers for the military mental health community.

Within this sample of MLSP counselors, the prevalence rates of depression, anxiety, and PTSD are notably concerning. MLSPs have reported higher than average rates of both depression (Mansfield et al., 2010) and anxiety (BSF, 2021) compared to civilians. In this study, MLSP counselors/CES reported commensurate rates of depression and anxiety as other historical MLSP studies completed during the GWOT surge (Eaton et al., 2008; Faulk et al., 2012; Fields et al., 2012) and higher rates than most recent results (Mailey et al., 2018; Steenkamp et al., 2018; Sullivan et al., 2021). This sample also reported over two-times the amount of PTSD than other MLSP studies (BSF, 2021; Knobloch, 2021). Additionally, it is notable that participants indicated the same prevalence of anxiety (16.2%) and PTSD (16.2%) in this study. It is known

that counselors who manage their stress and attend to their needs exhibit post-traumatic growth (Lambert & Lawson, 2013), and counselors who can utilize their therapeutic knowledge in their personal lives demonstrate increased resilience (Voon et al., 2022). While mental health in counselor/CES populations is not thoroughly explored in the current literature, these results emphasize the importance of understanding how MLSP counselors/CES are experiencing PTSD.

Personal trauma history has historically been shown to impact compassion satisfaction in counselors (Leonard, 2008) and increase the likelihood of secondary traumatic stress (Sodeke-Gregson et al., 2013), but exploring personal trauma history as a predictor for burnout outcomes is still an area of further study (Thompson et al., 2014). Most recent meta-analysis indicates the variation of measurements in counselor/CES literature leads to a lack of universally applicable results (Leung et al., 2023). This study explores occupational burnout and its symptoms distinctive from secondary or vicarious trauma, a distinction that has become muddied in the body of literature. Results from this study highlight these areas and how, even when facing additional stressors in the military lifestyle, MLSP counselors/CES can demonstrate resilience and manage their mental health.

The role of resilience in this study offers significant insight as a key protective factor for MLSPs (Lee et al., 2013; Monney, 2019). Over 98% of participants reported normal or high levels of actual resilience in this sample, significantly higher than other MLSP studies (Knobloch, 2021; Sinclair et al., 2019). These findings may support that MLSP counselors/CES may experience vicarious resilience (Hernandez et al., 2007) from their clinical work or may retain protective factors and practices from the profession (David, 2012). Counselors who exhibit resilience show connection to self and others (Hou & Skovholt, 2020), enabling them to navigate other's challenges while managing their own stability (Rosenberger & Bang, 2023). The ability

to apply one's therapeutic knowledge to themselves also bolsters resilience and positive outcomes (Voon et al., 2022). The counselors in this sample provide an opportunity to explore how resilience can manage mental health symptoms and mitigate burnout.

Burnout in the profession is a concern for all counselors (Bardhoshi et al., 2019; Fye et al., 2021), and MLSPs experience burnout at higher rates than their civilian peers (Lester et al., 2016). The results of this study indicate professional burnout as a challenge for MLSP counselors/CES as well, with those experiencing their own mental health challenges reporting increased burnout symptoms. The findings of this study underscore the importance of support for professional counselors/CES, as those experiencing burnout are at risk of leaving the profession (Mullen et al., 2018).

This study explores an intersectional identity where several aspects of burnout are present in both one's personal and professional spheres. First, managing countertransference has been shown to improve burnout symptoms (Choi et al., 2014), but MLSP counselors have a unique challenge when serving their military clients, as military adversities (such as deployment, reintegration, and PCS) may impact both the client and the counselor, increasing the likelihood for countertransference. Military stressors, particularly the PCS, negatively impacts MLSP counselors/CES, as licensure portability is still not available for all counseling licenses (The Counsel of State Governments, 2022). This is a significant challenge for MLSP counselors who wish to retain employment throughout their SM's military career (Ballard & Borden, 2020), and a key occupational stressor (The Counsel of State Governments, 2022). Establishing steps forward with the interstate compact would reduce employment challenges for MLSP counselors/CES, decreasing occupational stress and subsequent burnout.

Examining burnout more thoroughly using the CBI subscales in this study prove helpful for determining implications. MLSP counselors/CES who are experiencing comorbid anxiety and burnout report increased negative perceptions of their work environment. Resilience, however, mediates this relationship. By bolstering resilience, MLSP counselors could mitigate the impacts of a negative work environment, interrupting the causal sequence, and subsequently improve burnout symptoms (Lee et al., 2023). Additionally, MLSP counselors/CES who have comorbid PTSD and burnout report challenges with feeling incompetent in the profession and negativity towards their work environment, but resilience also mediates these outcomes. Increasing resilience would prove beneficial in managing and mitigating burnout symptoms for these MLSP counselors/CES, who are essential providers in the U.S. military mental health community. Exploring areas of adversity and ways to mitigate these challenges is an important way forward to bolster support for the military community at large.

Limitations

While this study has several strengths and important insights, it also has limitations that can possibly impact internal and external validity. The greatest internal threat to the data was the infiltration of spam respondents. Although extra precautions were taken and additional data screening occurred, a small portion of falsified responses may remain, and some authentic responses may have been removed. While the researcher made every effort to manage bias throughout the screening process, it is possible that not all authentic data remained in the final data set.

One of the most notable limitations of this study is the small sample size of participants, resulting in no moderated mediation. This produced inconclusive results for three of five research questions, thus accepting the null hypotheses. The lack of reliability regarding coping is

a significant limitation in this study, as coping and burnout have shown significant relationships in the literature (Boland et al., 2019; Lee et al., 2016). Further research with larger sample sizes should explore the effects of coping strategies on MLSP counselors/CES and how this contributes to resilience and mitigates burnout.

Another limitation of this study is how the participants were collected, using social media and email exclusively to obtain the participants. While utilizing social media, particularly Facebook, can provide effective samples (Mailey et al., 2019), it also may only reach specific populations of MLSPs. The researcher directly contacted other participants by email, which provided more participation, but may have also neglected other populations of MLSP counselors/CES with whom the researcher is not affiliated.

The results of this sample are most representative of active-duty Army and Air Force couples. While participation from other branches and components did occur, most responses were representative of female spouses of active-duty SMs. For results that apply to specific branches or components, further research should specifically target these populations. Additionally, some of the definitions present in the language of the survey may not translate across different branches (e.g., ETS or PCS). Some of the language was also not specific, such as questions about children "shared with your service member." Different demographic questions could have included additional follow up questions for clarity and more thorough insight into the participants' stressors (e.g., coparenting with stepchildren, marriage satisfaction data, etc.).

This study specifically explored three mental health issues: depression, anxiety, and PTSD. The survey did not include official diagnoses or prior history questions, so universal application of the mental health data may not be appropriate. Additional research is needed to draw conclusions about how mental health affects burnout rates in MLSP professional

counselors/CES and how other mental health challenges, such as bipolar disorders or substance use disorders, contribute to these rates. Additionally, the survey did not ask participants if they believe their mental health contributes to their occupational burnout. Self-report survey questions could have provided more thorough insight into how MLSP counselors/CES report burnout in the profession and what sources they believe contribute to their occupational distress.

Finally, this study has the propensity to commit a Type I error of rejecting a true null hypothesis. The sample size served as a control against Type I error in the mediation models, and the bivariate correlations indicated significance levels of $p < .001$. Additionally, most of the linear regression and PROCESS Model 4 (Hayes, 2018) results also provided significance levels of $p < .01$, however several models did include $p < .03$ to $p < .05$, increasing the likelihood of Type I error. Further research should explore this population with an increased participant size to draw more substantive conclusions.

Recommendations for Future Research

The recommendations for future research regarding MLSP counselor/CES mental health, burnout, and resilience are substantial. This study has encouraged additional research questions, several of which could be answered utilizing this data set. The first recommendation for future research would be to collect more thorough demographic data, including race, ethnicity, political affiliation, marriage, and religion. Additional demographic variables could be explored to better understand MLSP mental health and how religious coping and marriage satisfaction may play a role in counselor burnout. Finally, questions regarding how the military has affected respondents' licensure portability would prove beneficial, as this challenge has become a focal point of advocacy in the profession (Ballard & Borden, 2020; The Counsel for State Governments, 2022). The findings from this study produced results that warrant additional

opportunity for understanding how this population manages mental health challenges, the military lifestyle, and occupational burnout in the counseling profession.

Future studies in this area should explore WFC, a key area of challenge in both MLSP and counselor/CES literature. MLSPs are often left to manage the demands of parenting while SMs respond to the duties of the military (Lara-Cinisomo et al., 2020). MLSPs report that WFC is one of the top stressors of the military lifestyle (Sinclair et al., 2019). Counselors/CES also report challenges with WFC and managing the demands of the profession and the family (Eckhart & Ziomek-Daigle, 2019). Exploring how WFC impacts the mental health outcomes of MLSP counselors/CES would provide a foundation for advocacy for continued change and growth in this area.

Future research should also explore larger samples to provide enough data for reliable coping measures. Due to data collection constraints, this study could not produce enough participants to provide statistically significant results for moderated mediation. Additional studies could explore this population more thoroughly to determine how coping, particularly the distinctions between problem-focused coping and emotion-focused coping, impacts burnout outcomes (Boland et al., 2019; Costa & Pinto, 2017). Results in this area would provide tangible recommendations for coping strategies to assist MLSP counselors/CES in managing the challenges of the military lifestyle.

While this study provided military lifestyle questions that are commonly related to adversity and resilience within the literature, future research should explore other predictors of resilience or mental health challenges, such as deployment information, special operations identifiers, or dual military couple questions. These specific situations, while less common, do impact mental health, resilience, and coping outcomes (Sinclair et al., 2019). Potential surveys

should offer options for Military Family Life Counselors (MFLC) to self-identify as well, as military-provided counselors who are MLSPs may provide additional insight into professional burnout.

Providing respondents an option to report if they have been diagnosed with a mental health disorder would have added generalizability to this study's results. Additionally, asking MLSP counselors/CES if they attend counseling themselves and how they would self-report the effectiveness of counseling in their own lives would be an important area of further exploration. Research regarding counselors/CES' utilization of counseling services is scant, and insight in this area would be helpful for further insight into the mental health profession and how providers utilize their own mental health supports.

Finally, exploring other sources of resilience, such as social support, extended family support, and religion would be helpful in future research for this topic. While this study acknowledges the factors that contribute to resilience when reviewing the literature, data regarding this information was not collected to prevent time constraints for participants. In the future, further exploration into how these supports bolster resilience and increase coping would be essential to providing more comprehensive support for MLSP counselors/CES.

Summary

The MLSP has become one of the most important factors of the military home front in recent years (Blakely et al., 2012). The MLSP has been acknowledged as the cornerstone of the military family (Green et al., 2013), while simultaneously experiencing vulnerabilities and challenges unique to this position (Borah & Fina, 2017; Cole & Cowan, 2022). The prevalence of mental health challenges in the MLSP community is concerning, and these rates have continued to increase after the GWOT. This study highlights the challenges that MLSP

counselors/CES face as providers who are facing their own mental health issues and military stressors. MLSP counselors/CES are an essential piece of the military mental health community and provide essential, informed care for SMs and families while facing their own personal and professional challenges. This study sought to lay the foundation for further exploration into supportive measures for MLSP counselors/CES and how advocacy within the profession can strengthen mental health outcomes across the military community.

Supporting the mental health of SMs and MLSPs is paramount for the success of the military community (Dolphin et al., 2015; Eaton et al., 2008). Those MLSPs who provide mental health support to others are at risk of occupational burnout and need to address their own mental health needs. This underscores the importance of providing additional supportive measures and protective factors to MLSPs who are counselors/CES, such as additional peer support, portable licensure, and informed supervision to maintain the demands of the military lifestyle. The findings of this study demonstrate the importance of identifying mental health challenges and assisting MLSP counselors/CES in managing these challenges to prevent burnout in the profession. This demographic is uniquely positioned to support the military community both personally and professionally, sacrificing in multiple areas throughout their lives. Providing targeted support for MLSP counselors/CES to bolster resilience and mitigate professional burnout will prove essential for the future of the counseling profession and the growth of the military mental health community.

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Appendix A: IRB Approval Letter

Thursday, March 14, 2024 at 14:52:34 Eastern Daylight Time

Subject: [External] IRB-FY23-24-654 - Initial: Initial - Exempt
Date: Thursday, November 2, 2023 at 10:02:37 AM Eastern Daylight Time
From: do-not-reply@cayuse.com
To: Brinkley, Melinda Poteet, Knobloch, Sharita G (Community Care and Counseling)
Attachments: ATT00001.png

[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

November 2, 2023

Melinda Brinkley
Sharita Knobloch

Re: IRB Exemption - IRB-FY23-24-654 Military Spouse Counselors: A Quantitative Study of Mental Health, Resilience, Coping, and Burnout

Dear Melinda Brinkley, Sharita Knobloch,

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.(i). 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 cannot readily be ascertained, directly or through identifiers linked to the subjects;

For a PDF of your exemption letter, click on your study number in the My Studies card on your Cayuse dashboard. Next, click the Submissions bar beside the Study Details bar on the Study details page. Finally, click Initial under Submission Type and choose the Letters tab toward the bottom of the Submission Details page. Your information sheet and final versions of your study documents can also be found on the same page under the Attachments tab.

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.

Sincerely,

Appendix B: Informed Consent Form

Consent

Title of the Project: Military Spouse Counselors: A Quantitative Study of Mental Health, Resilience, Coping and Burnout
Principal Investigator: Melinda Brinkley, Doctoral Candidate, School of Behavioral Sciences and Counselor Education, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. Participants must be 18 years or older, married to a United States military service member and have a master's degree in a counseling-related field, including professional counseling, clinical mental health, social work, or marriage and family therapy. Military spouses of any branch (Army, Air Force, Marine Corps, Navy, Coast Guard, Space Force) and service component (Active Duty, National Guard, Reserve, Expired Terms of Service/Separated, and Retired) are eligible. Participants must be provisionally or fully licensed in their state and must have practiced counseling for at least six months while married to their service member for inclusion in this study. 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?

I am conducting research as part of the requirements for a PhD in Counselor Education and Supervision. The purpose of this study is to explore military spouses who are counselors and their mental health, resilience, coping and burnout. This study will not only fill a gap in current literature, but it will also provide a potential opportunity for creating more targeted interventions for military spouse counselors to increase support and assistance.

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:

- Participate in an online survey that will take approximately 15-25 minutes.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study. However, this study has the potential to impact the military spouse counselor community. Information participants provide could prove critical to the counseling profession for understanding how one's mental health may contribute to occupational burnout for military spouse counselors, providing vital insights into the military mental health community.

What risks might you experience from being in this study?

The expected risks from participating in this study are minimal, which means they are equal to the risks you would encounter in everyday life.

How will personal information be protected?

The records of this study will be kept private. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses to the online survey will be anonymous.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.

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

Participants will have the option to enter an incentive drawing to receive one of 20 ($25) Amazon gift cards. Email addresses will be requested for compensation purposes; however, they will be pulled and separated from your responses to maintain your anonymity. Upon closure of the survey window, an online number generator will randomly select the gift card recipients. The researcher will then contact the recipients for them to claim their prize.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether to participate will not affect your current or future relations with Liberty University or any military spouse or counseling organizations or affiliations. If you decide to participate, you are free to not answer any question or withdraw at any time prior to submitting the survey.

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

If you choose to withdraw from the study, please exit the survey and close your internet browser. Your responses will not be recorded or included in the study.

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

The researcher conducting this study is Melinda Brinkley. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at mbpoteet@liberty.edu. You may also contact the researcher's faculty sponsor, Dr. Sharita Knobloch, at sknobloch@liberty.edu.

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 IRB. Our physical address is

Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA, 24515; our phone number is 434-592-5530, and our email address is irb@liberty.edu.

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

Before agreeing to be part of the research, please be sure that you understand what the study is about. You can print a copy of this document for your records. If you have any questions about the study later, you can contact the researcher using the information provided above.

Appendix C: Permissions for Counselor Burnout Inventory

Subject: [External] RE: Counselor Burnout Inventory
Date: Thursday, July 20, 2023 at 3:07:06 AM Eastern Daylight Time
From: Sang Min Lee
To: Brinkley, Melinda Poteet
CC: Knobloch, Sharita G (Community Care and Counseling)
Attachments: Bardhoshi_et_al-2019-Journal_of_Counseling_&_Development (1).pdf, Counselor Burnout Inventory_permission.doc

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[EXTERNAL EMAIL: Do not click any links or open attachments unless you know the sender and trust the content.]

You have my permission to use CBI.

Best,

Sang Min Lee.

> ----------Original Message----------
> **Subject :** RE: Counselor Burnout Inventory
> **Date :** 2023-07-20 02:53:57
> **From :** Brinkley, Melinda Poteet [redacted]
> **To :** [redacted]
> **Cc :** Knobloch, Sharita G (Community Care and Counseling) [redacted]
> Good afternoon Dr. Lee,
>
> My name is Melinda Brinkley and I am currently completing my doctoral dissertation at Liberty University. I am conducting a study of counselors who are military spouses and exploring their rates of burnout. I would love to utilize the Counselor Burnout Inventory (CBI) for my study, if possible. How could I pursue licensing permissions to use the CBI in my online Qualtrics survey?
>
> Thank you so much in advance!
>
> **Melinda Brinkley, MA, LCMHC, NCC**
> Doctoral Student
> Department of Counselor Education and Family Studies
> Chi Sigma Iota- Rho Eta Chapter
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> Liberty University

Appendix D: G*Power Sample Size Test