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Letter from the Editors

The *Journal of Military and Government Counseling* (JMGC) is an official publication of the Military and Government Counseling Association (MGCA), a division of the American Counseling Association. The mission of the journal is to promote reflection and to encourage, develop, facilitate, and promote professional development for administrators, counselors, and educators working with all members of the Armed Services and their families, whether active duty, guard, reserve, retired, or veteran; civilian employees of the Department of Defense; first responders including EMS, law enforcement, fire, and emergency dispatch personnel; and employees of Local, State and Federal governmental agencies.

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Towards a Trauma-Informed Logotherapy (TIL) for the Treatment of Trauma

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The purpose of this article was to critically examine the theories and praxes of Frankl's (1959) Logotherapy for potential incongruities with the evidence-based principles of trauma informed care (TIC) outlined by the National Center for Trauma-Informed Care in 2018 – intended to protect clients from re-traumatization via the treatment process. The authors examined the extant literature on Logotherapy, trauma-informed care, and a wide array of contemporary research on the treatment of psychological trauma. While aspects of the theory and praxes of Logotherapy were found to be congruent with TIC-based principles, the authors also identified areas for growth. The authors made a series of four actionable suggestions for enhancing Logotherapy's alignment with the principles of TIC (NCTIC, 2018), outlined some limitations, as well as implications for multiculturalism and social justice. The authors conclude with a challenge to mental health professionals to continue critically examining innovative ways of advancing existing interventions that show promise as a treatment for psychological trauma.

Keywords: Trauma-Informed Care, Logotherapy, Post-Traumatic Stress

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Human life can be fulfilled not only in creating and enjoying, but also in suffering (Frankl, 1986, p. 106)

Trauma is ubiquitous – nearly universal across the issues that people present with in counseling, from substance use to social anxiety. For example, according to the Substance Abuse and Mental Health Services Administration (2015), in the United States (US) alone, 61 percent of people identifying as men and 51 percent of people identifying as women report having experienced at least one traumatic experience, as did approximately 90 percent of those receiving mental health services in the US. Perhaps unsurprisingly, trauma has also been found to positively correlate with a number of important indicators of mental distress (e.g., experiential avoidance, depression, suicide, substance use) in key underserved populations, from veterans (United States Department of Veterans Affairs, 2019) to people of marginalized identities (Ratts et al., 2016). It is necessary, then, for all counselors to remain reflexive to the available research on trauma. As recently as 2019, Smith et al. issued a challenge to mental health professionals and researchers to begin adapting pre-existing trauma-focused interventions so that they more closely align with emergent research in trauma. One intervention that is commonly used as both an adjunctive and primary treatment for trauma is Frankl's (1959) Logotherapy.

While Logotherapy's (Frankl, 1959) client-driven, meaning-based approach has remained in common usage since the therapy's earliest inceptions, with nearly six decades of trauma-research since its initial development, it is ripe for advancement. Towards these ends, the authors will first examine scholarship on Logotherapy as a treatment for trauma, followed by some trauma-literature that may call into question some of the treatment's core postulates. These include, among others, Shay's (1994) theory on moral injury in US Veterans of the war in Vietnam and Herman's (1997) conceptualizations of complex (i.e., compounded) and betrayal

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traumas in survivors of incest, Intimate Partner Violence (IPV), and Prisoner of War (POW) camps. Next, the authors will examine whether the underlying theory and praxes of Logotherapy (Frankl, 1959) appear to hold up to the evidence-based principles of Trauma-Informed Care (TIC) outlined by the National Center for Trauma-Informed Care (NCTIC) in 2018 – now considered best practices by the Substance Abuse and Mental Health Services Administration (SAMHSA), the Center for Disease Control (CDC), and others.

The authors will also argue that Frankl's (1959) tragic optimism, while helpful for some, may also manifest as potentially damaging social pressure from counselors and therapists acting on trauma-survivors to adopt redemptive-narratives (i.e., accounts about the traumatic event and its aftermath that insinuate that there necessarily needs to be some type of positive ending). The authors will then make four actionable suggestions for how Logotherapy's (Frankl, 1959) alignment with the principles of TIC (2018) might be enhanced, especially within the context of counseling or psychotherapy work with survivors of trauma. Limitations to a trauma-informed Logotherapy (TIL) will also be noted, and implications for multiculturalism and social justice thoroughly reviewed. We will end with both a testable research hypothesis and a challenge to future practitioner-researchers of Logotherapy (Frankl, 1959) to heed Frankl's (1959) own wisdom by continuing to innovate methods of enhancing care for some of our most vulnerable clinical-populations – survivors of trauma that may be grappling with questions around the meaningfulness of their lives.

Review of the Literature

The struggle of life keeps us in 'suspense' because
the meaning of life depends on whether or not we fulfill
the demands placed upon us by our tasks. (Frankl, 1986, p. 106)

Logotherapy

Logotherapy, an existential-humanistic form of psychotherapy developed by Jewish Holocaust survivor Viktor Frankl (1959), was largely developed as an adjunctive approach to psychological treatment for

populations grappling with, among other things, disruptions to their senses of meaning in life. Not coincidentally, since its development, it has been adopted for use with a number of diverse populations that report having survived traumas, from combat veterans (Lantz, 1992c) to survivors of Intimate Partner Violence (Herman, 1997). Traumas are largely defined in accordance with their lasting impacts on survivors' assumptive-worlds (Janoff-Bulman, 1992; Tedeschi & Calhoun, 2004) – alterations to peoples' foundational instincts regarding who, how, and when to trust (Herman, 1997). These alterations to a person's assumptions about the world (e.g., beliefs that the world is safe or that other people can be trusted, etc.) also often have negative effects on the ways in which people are able to continually construct meaningful narratives of their life-circumstances, making meaning-based approaches like Logotherapy especially advantageous for this clinical population (Frankl, 1959). Logotherapy has three philosophic postulates that form the foundations of its theory and praxes: Meaning-in-life, will-to-meaning, and freedom-of-will (Frankl, 1959). Generally speaking, these values insinuate that meaning-in-life can be discovered or created under all circumstances (i.e., meaning-in-life), that the basic human motivation is the search for meaning (i.e., will-to-meaning), and that humans are free to choose either their actions or their attitudes towards their circumstances (i.e., freedom-of-will) (Frankl, 1959).

Understanding Frankl's (1959) Logotherapy largely requires understanding Frankl himself. Born in Vienna, Austria in 1905, Frankl was a neurologist and a psychiatrist. During his career and prior to World War II, Frankl founded Logotherapy – his therapeutic philosophy that centered around the notion that the primary motivational force of an individual is to find meaning in life. In 1942, Frankl and his family were deported to Czechoslovakia and imprisoned in Theresienstadt, a concentration camp-ghetto hybrid, before being moved to several other concentration camps (Frankl, 1959). Frankl's (1959) book, *Man's Search for Meaning,* details his experiences in the concentration camp and outlining their relevance to Logotherapy. In this book, he poignantly described his position that perceiving a sense of purpose buoys resilience and fortifies mental health – values that ultimately aided his own survival during the Holocaust. Frankl (1959) used this philosophy and the encompassing techniques to survive

and to help other victims of the holocaust endure, noting that when victims visibly lost hope, their death often followed swiftly.

Unsurprisingly, Frankl (1959; 1986) also opined that Logotherapy adopts the stance of tragic optimism, wherefore, human beings remain free to transform pain into human-achievements (e.g., growth, enhanced awareness, etc.), guilt into an awareness for a need to change, and the inevitability of our death into a reminder of our existential responsibility to adopt actions and attitudes that align with meaningful pursuits. It first attempts to help people become aware of the things that they can control and the things that they cannot. Then, it uses techniques like Socratic questioning to walk with clients as they grapple with reconstructing new, and (hopefully) adaptive narratives given now altered-assumptions about the world (Frankl, 1959) – a client-lead cognitive restructuring of their noetic (i.e., existential) worlds. This approach has also been used successfully with survivors of trauma with co-occurring addictions (Smith, 2013). Addictions are viewed from a Logotherapeutic-framework as a normal but maladaptive response to crises of meaning in life, most often tied to traumatic-distress (Frankl, 1959; Smith, 2012; 2013), consistent with contemporary research in addictions (Mate, 2014).

Logotherapy as a treatment for trauma

Given Frankl's (1959) own traumatic experiences in the Holocaust, it comes as no surprise that many clinicians and researchers have identified Logotherapy's capacity as a treatment for trauma. Research into Logotherapy's efficacy as both a stand-alone and an adjunctive treatment is continually ongoing and routinely produces supportive results, and countless researchers and clinicians have utilized the therapy and its meaning-based techniques to good effect over the last half-century. Logotherapy and its accompanying theories have been studied and theoretically modeled across a range of trauma sources and a variety of target populations. However – as is the case with many widely practiced and well-regarded therapeutic orientations – Logotherapy does not yet enjoy the degree of empirical support necessary to receive the endorsement of the APA as an empirically supported treatment for PTSD or any other trauma-related disorder. While the extant literature on Logotherapy and

trauma is rich with theory, treatment manuals, and observational studies, there is a relative poverty of quantitative, empirical research. Randomized Controlled Trials (RCTs) are even more scarce. That said, the empirical literature that *is* available is supportive of Franklian (Frankl, 1959) and contemporary models. Fast-growing bodies of literature documenting the use of Logotherapy as an intervention with combat veterans and with medical patients are advancing the field's understanding. Finally, psychometric measures of Frankl's (1959) constructs (i.e., having meaning in life, meaning-seeking, and meaning-making) provide diagnostic and predictive utility.

Researchers have proposed rationales and clinical guidelines for how Logotherapy can provide value in the treatment of trauma among the general population as individual (Lantz, 1992b, 1996; Tedeschi, & Riffle, 2016) or group (Lantz, 1984) therapy, and provide theoretical frameworks for the integration of Logotherapy into therapeutic orientations already utilized by mental health professionals (Schulenberg et al., 2008), such as mindfulness-based techniques (Garland et al., 2015; Tedeschi & Blevins, 2015) and "Logotherapy-enhanced cognitive behavioral therapy" outlined by Ameli and Dattilio (2013). Researchers and clinicians have also provided treatment manuals for the use of Logotherapy with target populations including: adults who were molested as children (Lantz, 1992a), victims of clergy-perpetrated sexual abuse (Marotta-Walters, 2015), families of traumatized individuals (Lantz, 1991), the traumatically bereaved (Davis et al., 2007), the terminally ill (Jafari et al., 2018), and for the prevention/treatment of burnout among trauma-exposed healthcare professionals (Riethof & Petr, 2019; Sheykhi et al., 2019).

Logotherapy and combat-related trauma

Exploration of the use of Logotherapy to treat combat-related trauma among veterans has been an area of steady growth. Researchers have articulated how logotherapy can serve as either an adjunctive (Ameli & Dattilio, 2013; Southwick et al., 2006) or primary (Lantz, 1992b; Smith, 2012) intervention for combat veterans exposed to combat-related traumas. MacDermott (2010) even posits that meaning-making ability may function

as a protective factor in soldiers exposed to trauma. These theorists posit that Logotherapy is capable of addressing a host of existential concerns common among combat veterans that standard cognitive models cannot. Namely, an externally skewed locus of control, guilt and survivor guilt, loss of meaning, and a foreshortened sense of ones' future (Gilmartin & Southwick, 2004). Southwick et al. (2006) report that by using Logotherapy as a primary therapy, Vietnam-era veterans received successful in- and outpatient treatment for chronic treatment-resistant PTSD and comorbid disorders. In a series of case studies, Southwick et al. illustrated how individual and group Logotherapy promoted a search for meaning, how guilt and awareness of death were recontextualized as calls to action, and how action-oriented interventions such as volunteerism and community engagement stimulated social connection and a greater sense of competency. In a poignant example from one such case study, Southwick and colleagues (2006) report how a Vietnam-era veteran who delivered hot meals to a fearful elderly woman came to see his own experience with hypervigilance and fear as a kind of expertise – his own experiences allowed him to understand the elderly woman's struggles with fear and hypervigilance at a deep level. In this way, the patient's own suffering was brought new meaning. What was once a purely negative symptom of PTSD was recontextualized as a valuable tool for connecting with and healing others. Case studies and theoretical pieces such as these are not uncommon. However, nearly all authors, regardless of target population or trauma type cite the need for further empirical analyses. Between the relative obscurity of Logotherapy and the myriad challenges involved in empirically studying *any* therapeutic orientation, most research has been observational and qualitative (if data-driven at all). Experimental research is rare, and randomized controlled trials are all but absent from the extant literature. We will revisit the need for rigorous empirical analysis in our conclusions.

Logotherapy and medical trauma

One area of study where considerable empirical research *has* been conducted is the rapidly growing body of literature into Logotherapy's effectiveness as a psychological intervention for patients coping with terminal disease and debilitating physical injury – both common

occurrences in veterans and service people. While these researchers do not always name trauma as a central focus in these studies, terminal diagnoses and life-derailing physical injury clearly meet criteria for a traumatic event – that which shatters assumptive roles, threatens to overwhelm the subject's ability to adapt, and endangers the subject's lives and bodily integrity (Herman, 1997; Janoff-Bulman, 1992; Tedeschi & Calhoun, 2004). In this way, even though trauma is not directly studied in much of this literature, Logotherapy's overall success in improving the psychological well-being and minimizing the existential malaise of the traumatically ill and injured still speaks, to some degree, to its fitness in treating trauma-related psychopathology. Most of these studies analyze the effects of Logotherapy on related measures of psychological well-being (e.g., depressive symptoms, hopelessness, anxiety, quality of life, etc.), and observe clinically significant improvements compared to waitlist-controls or alternative treatment groups.

For meta-analyses of Logotherapy as a psychological intervention for subjects with advanced forms of cancer, see Jafari and colleagues (2018) and Kang et al. (2019). For specific studies, see Breitbart et al., (2012), in which subjects with advanced cancer who received individual meaning-centered psychotherapy experienced improved spiritual well-being, meaning, quality of life, and reduced symptom burden and symptom-related distress compared to those in a control therapy group, and Breitbart and colleagues (2015), in which subjects who received meaning-centered group psychotherapy experienced reduced depression, hopelessness, desire for hastened death, and physical symptom distress compared to those who received a control therapy. Given that Logotherapy *has* been successful in improving the psychological well-being of these patients whose life circumstances are, by definition, a potential source of trauma; it is unfortunate that so few of these studies have included measures of trauma and post-traumatic growth. As researchers working in these medical settings take an increasingly interdisciplinary interest in meaning-based interventions – and publish some of the only experimental literature on the topic – we urge researchers like these to include measures of trauma and post-traumatic growth in their studies, where feasible. Our collective

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understanding of Logotherapy and its role in the treatment trauma and trauma-related psychopathology would benefit greatly.

Trauma-Informed Care

In 2018, the National Center for Trauma-Informed Care (NCTIC), a close affiliate of the Substance Abuse and Mental Health Services Administration (SAMHSA) published their principles of trauma-informed care. Commonly mistaken for being *trauma-focused* (i.e., intended to treat psychological trauma), though they are often used for that purpose, they serve the unique task of helping to inform the development and usage of a wide range of interventions and services to help them minimize the risk of re-creating traumatic narratives throughout the treatment process. There are six core principles of TIC (NCTIC, 2018), which include: safety; trustworthiness and transparency; peer support and mutual self-help; collaboration and mutuality; empowerment, voice, and choice; and cultural, historical, and gender issues. The principles of TIC (NCTIC, 2018) are a synthesis of existing research and literature on the impacts of psychological traumas in survivors, within a framework that can be used to guide the usage and development of mental health interventions and services used by a wide range of people, though primarily those clients with histories of trauma(s).

For example, it has long been known that trauma-focused, though not necessarily trauma-informed, approaches like Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) developed from widely celebrated Randomized Controlled Trials (RCTs) conducted in laboratory settings have had prolific problems with client dropout in clinical settings (Najavitz, 2015). A common belief as to the source of these high dropout rates is their shared emphases on having clients approach their traumatic narratives as a core element of the treatment process, exacerbating symptoms (Najavitz, 2015). In contrast, Herman's (1997) postmodern feminist approach to trauma treatment asserts that approaching the trauma narrative is not actually a necessary part of the treatment process. Rather, she promotes processing the *impacts* of trauma(s) on survivors' assumptive worlds (Herman, 1997) – a safer approach that appears to be more closely aligned with the principles of TIC (NCTIC, 2018). Herman (1997) does

note, however, that if the client wishes and is aware of the risks, they can approach the trauma narrative in treatment, but it should always be done in service to a greater therapeutic goal, like better understanding the origins of overgeneralized beliefs about the world (e.g., that they will never be safe again or that no one can be trusted, etc.) that stem from the traumatic event(s). Most interventions will have some aspects that align with the principles of TIC (NCTIC, 2018) to some degree and some that do not. Thus, an examination of Logotherapy's (1959) alignment with contemporary psychological models of trauma and the principles of TIC (NCTIC, 2018) might begin by first focusing on the theory's individual presumptions and techniques.

Challenges to Logotherapy's Alignment with the Principles of Trauma-Informed Care

The authors, in addition to their examination of the research on Logotherapy for psychological trauma and the evidence-based principles of trauma-informed care (NCTIC, 2018), examined two predominant contemporary psychological models of trauma that may expose potential areas of growth or advancement for the theory and clinical praxes of Logotherapy (Frankl, 1959) when used for the treatment of trauma. The first is psychiatrist Jonathan Shay's (1994) *Moral Injury* in veterans of the war in Vietnam – a type of psychological trauma that results in potentially intractable disruptions to meaning-making. The second is Judith Herman's conceptualizations of both betrayal (i.e., traumas committed by people, institutions, or systems in positions of power) and compound-traumas (i.e., repeated traumas, such as from multiple instances of abuse or torture).

Shay's (1994) moral injury in veterans of the war in Vietnam.

Any examination of the kinds of traumas that might negatively impact attempts at meaning-seeking or creation in their aftermaths must also include a discussion on *moral injury*. As review, moral injuries happen when an experience – typically an action carried out by a person – so deeply violates their own sense of ethics, that it causes nearly irreparable damage to the actor's ability to adaptively accommodate the event(s) into

their life-narratives (i.e., meaning-making). Moral injury is distinct from Post-Traumatic Stress (PTS), though it can be a contributing factor. It is important to note that these kinds of injuries do not always happen by choice. Shay (1994) recounts several stories told to him by the Vietnam veterans that he worked with in therapy that reported attacking targets that their command-elements said were enemy combatants; however, after-action assessments later determined that the perished were actually civilians. Moral injuries can occur even when the actor behaves in socially acceptable ways, such as taking the life of an enemy combatant who is aggressing against them – something Grossman (1995) refers to as a lawful killing. Though an action like this falls well within the rules of engagement, they may still deviate far enough from the actor's personally-held values that they might be deemed morally injurious and, hence, deleterious to subsequent efforts at making meaning of these kinds of experiences (National Center for Post-Traumatic Stress, 2019). Next, we turn our attention another type of trauma that has been found to significantly compromise adaptive meaning-making in its aftermath: compound traumas.

Herman's (1997) Betrayal and Compound Traumas in Survivors of Assault.

Herman's (1997) research and clinical work on survivors of compound (i.e. complex) trauma(s) emerged in the 1990s largely thanks to the second-wave feminist movement. Clinicians and researchers began to acknowledge that repeated incidents of trauma had differential effects on psychological wellbeing compared to a single incident of acute trauma, resulting in things like dissociation, depersonalization, complex characterological-changes, and hyper-sensitivity to changes in interpersonal relationships (i.e., for survival, as a means of anticipating the thought-processes and behaviors of abusers), among other symptoms. One of Logotherapy's (Frankl, 1959) main tenets is that meaning can be found or created under all circumstances; however, this should not be presumed – especially with regards to survivors of prolonged or repeated instances of trauma. Common populations that fall within this category include victims of Intimate Partner Violence (IPV) trapped in abusive relationships, prisoners of war exposed to repeated incidents of torture, and survivors of incest having weathered

prolonged terror, among other examples of compounded or complex traumas.

Towards a Trauma-Informed Logotherapy (TIL)

The destiny a person suffers, therefore, has a twofold meaning:
to be shaped where possible, and to be endured where necessary.
(Frankl, 1986, p. 111)

Four Ways to Potentially Enhance Alignment with the Principles of Trauma-Informed Care

The authors suggest four actionable suggestions to potentially advance the practice of Logotherapy (Frankl, 1959) when used with survivors of trauma. Each of these clinical suggestions were formulated with a grounding in the primary works of Frankl (1959; 1986), the evidence-based postulates of trauma-informed care developed by the National Center for Trauma-Informed Care (NCTIC) in 2018, and extant literature on Logotherapy with survivors of trauma. It should be noted that the authors do *not* contend that Logotherapy (Frankl, 1959) is entirely misaligned with TIC-based principles (NCTIC, 2018). Rather, we posit that the framework of Logotherapy might be enhanced when couched within recently emergent literature on the treatment of trauma.

#1: Allowing for but avoiding pressure to adopt redemptive-narratives

A strength of Frankl's (1959) Logotherapy is that it proffers the TIC-based (NCTIC, 2018) notion that counselors and therapists should be relatively neutral fellow-travelers on clients' journeys of grappling with the meanings of their experiences and, more broadly, their lives. Logotherapy, in theory, was intended to be a non-directive approach, placing the client in the role of expert, evidenced largely by its reliance on the clinical technique of Socratic dialogue (Frankl, 1959). This method of questioning intends to 'midwife' clients' own healing knowledge via strategically formulated open-ended questions as the primary tool for which new narratives and meanings are constructed in therapy (Frankl, 1986). Even the best open-ended questions are directive in as much as they affect clients' subsequent

responses – a fact used with great intentionality in approaches like Miller and Rollnick's (2013) Motivational Interviewing (MI) to reinforce neural pathways that lean towards adaptive behavior change. Frankl (1986), too, did not always model this entirely non-directive approach in his primary source texts when recounting work with past clients, often suggesting reframed meanings to clients. For example, in *The Doctor and the Soul*, he (1986) notes having suggested to a spouse grieving the loss of a romantic partner that in some ways, perhaps the client's grief is also a noble sacrifice, in as much as the partner never has to know what it is like to live without the other. This reflects his value that existential suffering (i.e., due to disruptions to previously functioning meaning-systems, like being in a relationship with a romantic partner) is often ameliorated at the moment it is attributed a meaning, such as bearing the burden of grief so a posthumous partner does not have to (Frankl, 1959; 1986). It does not, however, promote an entirely non-directive brand of psychotherapy – not that such a thing exists in as much as all treatments hold the agenda of symptom amelioration.

Consider that the example of the grieving partner is also a textbook example of pressuring a client into adopting a redemptive narrative, asserting that a positive can be derived from even the worst kinds of sufferings. While the authors do not necessarily contend a direct refutation of Logotherapy's (Frankl, 1959) tenet, *meaning-in-life* (i.e., the idea that meaning can be found under all circumstances), we do propose that to protect trauma-survivors from re-traumatization (i.e., alignment with the principles of TIC), clinicians should allow clients to define and empower meaningful possibilities entirely on their own (NCTIC, 2018). Towards these ends, one of the principles of TIC (NCTIC, 2018) is empowerment, voice, and choice. Thus, it might be presumed that at the very least, clinicians should offer minimal potential reframes and when they do, they should offer them in tandem with what the authors refer to as a *nullified reframe* such as, "While my suggestion for a potential meaning is possible, there is not always a significance that emerges from our circumstances. " While *nullified reframes* might seem counter-intuitive, they are intended to alleviate suggestive pressure. Perhaps any reframes should also be offered as mere invitations for open-ended curiosity as opposed to as suggested

edits to clients' post-traumatic life narratives. For example, rather than suggesting how a Marine Veteran of Operation Enduring Freedom (OEF) in Afghanistan might make meaning of survivor's guilt, the trauma-informed clinician might ask, "Given the loss of your Marine to an Improvised Explosive Device (IED) last year and *your* recent insight that you believe that that tragedy gives your life a weightier responsibility, what do you think is being asked of you to remain accountable to this self-appointed obligation?"

#2: Consider differential effects on meaning-making

The risks in proffering a redemptive narrative in work with trauma survivors further affirm the importance for having an awareness that the ways in which survivors might be affected by traumas (e.g., betrayal traumas, moral injuries, institutional trauma, etc.). Trauma is inherently phenomenological (i.e., experienced subjectively by each individual experiencer) making generalizations about how people might therein make meaning of their circumstances an impossibility. As not all traumas effect people in the same way, factors like the type of trauma, the social and cultural contexts in which the traumas took place, the identities of any offenders (e.g., family trauma versus an attack from a stranger), and their frequency, duration, and intensity, among others, become crucial considerations before suggesting to a client that positive "growth" or meaning of any kind might be an expected outcome of the treatment process. Clinicians need only to examine the extant scholarship to appreciate this important clinical implication. For example, it has long been posited (Reker & Cousins, 1979) and somewhat recently evidenced (Garcia-Alandete et al., 2016; Zeligman et al., 2018) that there is a relatively simple yet powerful, inverse relationship between the search for and presence of meaning (i.e., that the search for meaning will result in people actually finding meaning), though the evidence has largely been cross-sectional. Consider, though, that Steger et al. (2008) actually found that the search for meaning does *not* always precede derivation of meaning, in contrast to Reker and Cousins (1979), Garcia-Alandete and colleagues (2016), and others – including Frankl (1959; 1986). Put another way, simply because someone is searching for a new life's meaning in the

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aftermath of trauma does not presume that they will necessarily achieve it. Steger and colleagues' (2006) research underscore the need to continue searching for factors that might be predictive of whether people find meaning in their circumstances and the types and contexts of trauma(s) people experience might be just that.

#3: Consider re-directing meaning-making efforts to the present moment

The third and fourth considerations offered by the authors are a slight pivot from the first and second; however, they are critical to enhancing congruency between the principles of trauma-informed care outlined by the National Center for Trauma-Informed Care (NCTIC) in 2018 and the principles and praxes of Frankl's (1959) Logotherapy. As previously noted, the evidence-based principles of TIC (NCTIC, 2018) reaffirm what Herman (1997), Najavitz (2015), and others have proffered for decades: Approaching (i.e., processing) the actual narrative of what happened during the trauma(s) are not a necessary condition for recovering from psychological trauma and can actually result in negative clinical outcomes from re-traumatization to client dropout. In lieu of approaching narratives directly – a common component of Logotherapy when used with veterans (Lantz, 1992), for example – efforts at meaning-making might be re-directed to the present moment. Put another way, survivors can examine how what happened might have impacted their awareness of or movement towards meaningful pursuits *in the present moment* rather than looking back and discussing the intimate details of what actually happened.

#4: Consider re-directing meaning-making efforts towards future pursuits

Similar to the third consideration, in situations where clients are experiencing repeated traumas and worsening severity of traumatic experiences (to the point where it has become deleterious to meaning reconstruction), the clients may benefit from shifting perspective to a future orientation. While there may not be meaning in the specifics of the trauma that the client has experienced, future-oriented meaning-making means that clients can find meaning in their lives moving forward, beyond and *in spite* of what traumas have been experienced. By making a shift from focusing

on the traumas themselves to the client's future pursuits, the counselor and client can collaboratively set long term goals while empowering the client to pursue their personal meaning in life which may have left focus due to the trauma, or to change the client's goals which may no longer be possible due to the traumatic experience. Frankl (1959) referred to this process of refocusing on future-meanings after traumas as *de-reflection* (i.e., re-direct of focus away from the self and towards external pursuits, as happiness is presumed to be a byproduct of meaningful action). While the suggestion is to look away from the traumatic events towards the client's future pursuits, the authors do not suggest just moving past the traumas entirely; rather, they suggest using the future orientation as a way to indirectly confront aspects and symptoms of trauma, such as the impacts of the trauma on a clients' assumptive world and begin working through symptoms to allow the client to live a more fulfilling post-trauma life.

In Peter Levine's (1997) *Waking the Tiger: Healing Trauma*, Levine identifies needing to work with trauma indirectly, because working directly with traumatic events is like looking directly at Medusa. While Levine gives specific suggestions of ways to work indirectly with trauma, so as not to stare at Medusa, another possible suggestion is to work towards a future that clients identify as meaningful to them. When clients begin identifying how they might continue the fight towards a future of meaning and purpose, clients and counselors now have end goals that they can collaborate on to identify changes that need to happen in the client's life to move the client in the direction of their goals. This step of identifying a client's meaningful future is not only important for promoting agency and choice, per the principles of trauma-informed care (NCTIC, 2018), but also, leverages what Frankl (1959) identifies as the "primary motivation" in an individual: their will-to-meaning. Frankl identifies the will-to-meaning as a motivation so powerful that individuals would live or die for the meaning they are pursuing, and as a force that can allow individuals to experience extreme suffering in pursuit of their meanings.

In situations where future-oriented meaning-making is being used, clients will be experiencing symptoms of their traumas, and suffering in that experience. The task of the client and counselor – in what is now the process of moving towards these identified goals – is to either reduce

symptoms that are barriers to clients reaching their goals, or to find ways for the client to live with the current symptoms and work towards their goals regardless. In working to overcome symptoms, the client and counselor will be indirectly facing the trauma, in as much as they are facing the impacts of the trauma in a way that is supportive, client-directed, empowering, and that, ideally, feels safe to the client. By shifting the focus to future pursuits in lieu of directly approaching a trauma narrative, a framework is set for counselors to provide Logotherapy in a way that adheres to the principles of TIC (NCTIC, 2018), and that could be a more beneficial approach for clients who have experienced repeated, complex-traumas to the point where meaning-reconstruction has been negatively affected.

Conclusions

The following conclusions will begin by examining key limitations and implications for clinical research (including some testable research hypotheses). For the convenience of both clinicians and researchers, this section also includes a summation of the most recent research examining the validity and reliability of various Logotherapeutic measures and some common correlates to mental health. Then, the authors examine some implications for multiculturalism and social justice. Finally, the article concludes with a challenge to current and future mental health professionals and researchers to continue adapting pre-existing interventions used for the treatment of trauma in accordance with emergent scholarship, such as the evidence-based principles of trauma-informed care developed by the National Center for Trauma-Informed Care in 2018.

Limitations and Implications for Clinical-Research

While evidence-based, there is still some debate over how the values of trauma-informed care should be defined (Berliner & Kolko, 2016), which is why the authors chose the well-articulated principles promoted by the National Center for Trauma-Informed Care (2018) discussed in this article. Their pre-operationalization may also allow for greater falsifiability during follow-up research studies. While a conceptual

piece like this article was an important first step in the process of developing a Trauma-Informed Logotherapy (TIL), moving forward, it is deserved of further scientific inquiry, preferably using a between-groups experimental design with random assignment into treatment and control groups, as well as manipulation of independent variables (e.g., levels or types of treatment relative to a control). It might be efficacious to include both meaning and symptom-based dependent variables, measured at multiple time-points for enhanced interpretability (i.e., at least pre- and post-treatment). A valid and reliable instrument with relatively sound psychometrics (tested in a wide variety of cultures and languages) that attempts to measure two of Logotherapy's core tenets (Frankl, 1959) – both the will-to-meaning (i.e., the search for meaning) and the presence of meaning (i.e., meaning-in-life) – is Steger et al.'s (2006) Meaning-in-Life Questionnaire (MLQ).

Testable Hypotheses

Given the extant literature, the authors propose two simple hypotheses that might be tested by clinical researchers: That treatments that evidence in their theories and praxes an awareness and sensitivity to the impacts of trauma (and potential for re-traumatization) will have lower dropout rates (Najavitz, 2015) *and* more positive clinical outcomes pertinent to trauma compared to treatments that do not. The purpose of this article is not to suggest that NCTIC's (2018) principles are without flaw, nor to assert that they can be perfectly integrated into a pre-existing intervention like Logotherapy (Frankl, 1959). It is also not this article's raison d'etre to suggest that Logotherapy is entirely misaligned with the principles of TIC (NCTIC, 2018), because it is not. Rather, it is to promote the idea that Logotherapy has a lot of potential as a treatment for trauma (Lantz, 1992; Southwick et al., 2006), especially as it pertains to the reconstruction of meaning in suffering's aftermath (Frankl, 1959; May, 1975; Yalom, 1980); however, it might be even more effective when wielded within a *trauma-informed* clinical framework that might better protect survivors from re-traumatization.

Measuring Logotherapeutic constructs and common mental health correlates

For the convenience of both clinicians and researchers, the authors examined and summated some recent empirical studies that explored the validity and reliability of measures based on the central constructs of Logotherapy. Researchers have reported strong construct validity and predictive validity of measures based on the central concerns of Logotherapy: presence of meaning-in-life (e.g., the Meaning-in-Life Questionnaire [MLQ]; Steger et al., 2006), purpose-in-life (Purpose-in-Life test [PIL]; See: Crumbaugh & Maholick, 1964), and the search for meaning (Seeking of Noetic Goals test [SONG]; See: Crumbaugh, 1977). In hierarchical regression analyses, Owens et al. (2009) found that greater meaning-in-life predicted lower PTSD severity among combat veterans surveyed. Similarly, Steger, Owens, and Park (2014) reported analyses which revealed that higher ratings of meaning-in-life (MLQ-P) and searching-for-meaning (MLQ-S) were associated with greater stress-related growth among Vietnam-era veterans. The presence of meaning-in-life and meaning-making have been associated with lower depressive symptoms among trauma-exposed emerging adults (Woo & Brown, 2013), has predicted lower post-traumatic stress in a longitudinal study of adults after the September 11th terrorist attacks (Updegraff et al., 2008), and has been shown to facilitate post-traumatic growth among the unjustly and traumatically bereaved (Davis et al., 2007). Thompson et al. (2003) found that among participants who had received spinal cord injuries (all of which resulted in paraplegia or quadriplegia of the subjects), higher purpose in life (PIL) was associated with greater psychological adjustment to injury and that PIL scores mediated the effects of personality variables and health locus of control on adjustment.

Measures used to assess these central constructs of Logotherapy have largely been shown to meet sufficient-to-high degrees of reliability and validity. For reviews of the validity and reliability of the Franklian measures, see MacDonald et al. (2011), Steger et al. (2006), or Melton and Schulenberg (2008). For a critique of methodological and theoretical limitations of Franklian measures, see Park and George (2013). Given the

central importance of their antecedent constructs in the theoretical framework of Logotherapy, the utility of these measures strongly suggests that meaning-based models of psychological wellbeing are both theoretically valid and clinically relevant. In other words, the predictive and diagnostic utility of meaning-based measures strongly suggests that the Franklian constructs they are based upon are meaningful. Insofar as meaning-based measures add predictive or diagnostic power when used in conjunction with well-established measures of psychological well-being (i.e., Beck Depressive Inventory, PTSD Symptom Scale), we may conclude that the Franklian phenomena of meaning-having, meaning-seeking, and meaning-making are distinct experiences which deserve the attention of clinicians and researchers alike.

Implications for Multiculturalism and Social Justice

People with identities that are historically and currently marginalized are perhaps at greater risk for re-traumatization via the treatment process due to the hierarchical nature of mental health work (Ratts, et al., 2016; NCTIC, 2018). As keepers of their clients' intimate experiences and as oft (mis)presumed experts in the human condition, counselors and therapists hold an omnipresent power over their clients – especially when working with those who may already be psychologically vulnerable in the wake of challenging life circumstances. Clinicians that are overly directive, for example, pressuring clients into approaching the specifics of their traumatic experiences, can reaffirm a disempowering-narrative. As such, adopting treatment approaches that remain explicitly sensitive to issues of empowerment, like the principles of TIC (NCTIC, 2018), may be especially efficacious. Any consideration of empowerment might aptly begin with an examination of the role culture may play in the meaning-making process.

Culture and Meaning

Regardless of a trauma-worker's theoretical leanings, they should remain acutely aware of the effects of culture on meaning-making. Cultural aspects such as religion, family structure, and gender roles, among many other

influencers, play a tremendous role in impacting an individual's outlook, including how they make meaning of their experiences. For example, individuals who are part of collectivist cultures may be limited to widely accepted meanings of specific traumas that may or may not be helpful for them in the healing process, such as with regards to curses, displeasing the gods, or dishonoring one's ancestors. Consider the tradition of bridal kidnappings in Kyrgyzstan, which at the present moment is illegal yet still widely practiced (United Nations, 2018). In some instances, this happens strictly according to tradition (i.e., where the woman has no idea who the kidnapper is) and in others, it is more of an honorary practice (i.e., the kidnapping is staged and the woman has consented to marriage) (United Nations, 2018). The victims of the traditional kidnappings are not likely to be supported by individuals in their community and are alienated when having to make sense of their traumas (United Nations, 2018). In this case and with other cultures as well, the process of meaning-making can be collaborative or individual in nature. An individual typically from collectivist cultures may rely largely on the help of their family, elders, and other trusted individuals to make sense of their traumas. In situations where a person is alienated from their cultural group or have conflict with their culture, it may have serious implications for the process of meaning-making. As such, clinicians working from meaning-based frameworks should remain aware of both how culture can positively impact the ability to make meaning of traumatic experiences, as well as how it might compromise survivors' abilities to make sense of, and cope with, their circumstances.

Limitations

Another important take-away for readers is that not only is *meaning* irreducibly nuanced because it is perceived phenomenologically (i.e., subjectively), it can also be operationalized in a multitude of different ways. If meaning-making is only construed cognitively as a way in which survivors must *make sense or find the good that results* from traumatic events, then the search for meaning is often futile. For example, researchers have noted that when *making sense* or *finding benefit* after the traumatic event is understood as *meaning-making*, 80% of parents who lost a child in

car accidents were not able to make sense of it 4-7 years later (Lehman et al., 1987; Wortman, 2004, cited in Armour, 2010). In another example, after the 9/11 attacks, 60% of Americans were not able to find meaning at one year after those events (Updergraff et al., 2008, cited in Armour, 2010). However, meaning-making need not make sense of or find the benefit from traumatic events, nor is meaning-making limited to one's cognitive appraisal of events. Armour (2002, 2003) examined how family survivors of homicide victims employed activity and the intentional engagement in behaviors designed to focus explicitly on the things that matter most after trauma as meaning-making enterprises. Here, meaning was not found in the traumatic event or the suffering that followed after, but was a subsequent result of a person's attending to those actions that were significant in their life after the death of a loved one. In this context, meaning-making was defined as the forming and reforming of intentionality and significance (Carlsen, 1988, cited in Armour, 2010.) Significant and intentional actions inform the individual(s) of what is meaningful and give shape to meaning-making. A trauma-informed Logotherapy can seek to encourage hope in those *significant and intentional actions* undertaken by survivors even as it seeks to assist survivors in making meaning through more cognitive means.

Another important take-away is that while it may be true that for some clients that survive trauma, meaning cannot *necessarily* be found or created, there are a wide multitude that do report finding meaning and Frankl (1959; 1986), himself, notes the importance of holding people to a hopeful standard (i.e., one where meaning can be found into perpetuity, regardless of the severity, frequency, or types of traumas). Look no further than his first tenet of Logotherapy, *meaning-in-life* – that meaning can allegedly be found under all circumstances. Thus, the core thesis of this article is not an admonishment of meaning-based approaches; rather, it is a call to action to advance the therapy’s theories and practices based on apparent limitations in light of emergent best-practices in trauma-counseling.

A Call to Action

Frankl (1959) once opined that, “if there is a meaning in life at all, then there must be a meaning in suffering” (p. 88). The authors contend that

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one way to potentially make meaning from clients' collective trauma(s) are to apply any extant insights from their painful experiences towards the advancement of our teaching, clinical-work and scholarship. The principles of trauma-informed care (NCTIC, 2018) were developed with an evidence base in the reported experiences of survivors of trauma(s), and when couched within a Logotherapeutic-framework (Frankl, 1959), they may offer a potent clinical formula for safer processing of the impacts of traumas of survivors. Consider, though, that the current mental health zeitgeist all too often requires clinicians to adopt an ultra-timebound, manualized approach like Cognitive Processing Therapy (Monson et al., 2006; National Center for PTSD, 2016) shaped less by the needs of clients and more by the weighty influences of managed care and Health and Maintenance Organizations (Yalom, 2012).

A core Frankl (1959) teaching is that people are free to choose either their attitudes or actions towards their circumstances, and given the conditions placed upon modern-day counselors, we must resist the temptation to adopt a passive stance. According to Herman (Smith & Speciale, 2019), just as trauma – as a suffering of powerlessness – is political, so too is the fight for resources needed to adequately treat its various clinical manifestations. Even while working within the systems we have, there are a multitude of choices for how, which, and when to wield the deluge of clinical techniques available to contemporary clinicians. We must challenge the existing culture of a quick or cheap fix in favor of approaches that seek to integrate evidence-based, emergent best practices in the field, such as the principles of TIC (NCTIC, 2018). We must continually examine the theories that underlay our praxes for alignment with embryonic, yet efficacious opportunities for enhancement. And finally, as Frankl (1959) might suggest, we must adopt an attitude towards our circumstances that reflects a reflexivity to the needs of those that we serve, continually advocating for the proper care of those in our charge.

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Counseling the Military Population: Barriers to Mental Health Counselors

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Culturally competent mental health counselors working with the military are needed, however, rarely do counseling programs train counseling students to specialize in treating this population. A recent research study explained the need for more culturally competent counselors and gained insight into what Counselors-in-training need in order to feel competent and confident counseling this population, allowing an increase in numbers equipped to work with this population (Arcuri Sanders & Forziat-Pytel, in press). Findings indicated that barriers may be linked to more than attitudes and training regarding this group and hint that barriers may also be attributed to hiring attitudes and practices. Quantitative findings were able to complement data that arose from the qualitative themes to provide a more comprehensive understanding of the system transformation that needs to occur to ensure more mental health professionals are equipped to work with both the unique cultures of the *military* and *counseling,* as a first step in activism and advocacy.

Keywords: barriers to counseling, military, culture, advocacy, counseling identity

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Medical and mental health providers share similar cultures with regards to promises and training surrounding attention to physical and psychological client welfare. Despite these similarities, the differences (e.g., philosophy, problem solving, and consultation styles) are often the focus and may get in the way of medical and mental health professions working in a collaborative nature (Hamberger et al., 1999). This may also be true for challenges that may exist among the many types of mental health care professionals (i.e., psychologists, licensed clinical social worker [LCSW], licensed professional counselor [LPC]), who strive to serve clients true to their unique principles and identities. Similarly, all mental health professionals work in efforts to assess and provide therapeutic treatment of individuals' surrounding thoughts, feelings, behaviors, and life goals (Zalaquett et al., 2018). Training is even more similar (e.g., same psychotherapy theories being used), however, given cultural differences that stem from philosophy and training, battles occur in opinions among other professionals (Zalaquett et al., 2018) as well as among the clients they serve (Hartman et al., 2018) of who is the best qualified for the job.

Mental health professional groups are counselors (i.e., clinician, therapist, etc.), social workers, psychologists, psychiatrists, and nurse practitioners; however, more often than not, the first three groups provide the therapy and the following two prescribe and monitor medications (National Alliance on Mental Illness [NAMI], 2017). Though degree requirements and licensure credentials vary, roles and responsibilities overlap with regards to client assessment and treatment (NAMI, 2017).

Mental health professionals have been around and working in some capacity with the military population since the inception of the Armed Forces approximately 246 years ago in 1775 (Maslowski, 2007); with the most well documented cases starting in World Wars I and II surrounding screening protocols (Pols & Oak, 2007). Over time, official positions have been created to make this more formalized and in favor of some professions. For example, when browsing the official U.S. Air Force website, mental health career options include (a) clinical social worker, (b) psychiatrist, (c) mental health service, (d) behavioral sciences/human factors scientist, (e) mental health nurse, and (f) clinical psychologist -- none of which specifically addresses the alternative role of the professional counselor, who by training, meets similar qualifications (e.g., "knowledge of theories, techniques, and resources for

clients"; U.S. Air Force, 2019, para. qualifications). This is the same finding when searching across other military branches.

It has been a long journey for counseling organizations, such as the American Counseling Association (ACA) and National Board for Certified Counselors (NBCC) who have advocated on behalf of the counseling profession, to be recognized and granted similar career opportunities within the Department of Defense (DoD) and Department of Veterans Affairs (VA) settings (NBCC, 2010). Fairly recently, the DoD made changes to allow mental health counselors to (a) diagnose and treat TRICARE (i.e., health care program for Service Members, Veterans, and their families; DoD, 2020) beneficiaries and (b) receive reimbursement for services (DoD & VA, 2015). Despite these positive changes, counselors, in comparison to other health professionals, may still experience more barriers to working with military-connected individuals. A recent research study exploring the training experience as well as competence of counselors serving or wishing to work with the military-connected population (e.g., active duty and/or Veterans and their families) uncovered participant perspectives concerning the barriers faced in gaining access to work with this population (Arcuri Sanders & Forziat-Pytel, in press). This article draws attention to this issue. Barriers found extended past training and confidence concerns to counsel this group and uncovered issues related to hiring and other mental health professional groups. The purpose of this exploratory study being to (a) highlight identified barriers that counselors face when trying to work with the military population in a counseling setting when compared to those in like mental health professional fields and (b) discuss possible advocacy efforts needed to reduce these barriers.

Mental Health Field & Counseling

Mental health is "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization [WHO], 2014, para. 1). Therefore, those working in the mental health field have missions to improve individuals' overall well-being (i.e., mental health) (ACA, 2014, A.1.a.) and decrease the negative consequences that develop as a result of poor mental health (e.g., relationships issues, mood changes, job issues, etc.) (American Psychiatric Association [APA], 2013). Many mental health professionals are

trained to do this; focusing on those that do counseling, the major mental health professionals include counselors (i.e., clinician, therapist, etc.), social workers, and psychologists. These professionals are all seen in the military setting, however, some more than others. Currently, according to the United States' Bureau of Labor Statistics' Occupational Outlook Handbook (2019), health care personnel military careers consist of only psychologists providing mental healthcare and/or can conduct research on behaviors and emotions. According to Today's Military (2019), social workers are considered professionals who work in offices or clinics as a commissioned officer for the U.S. Army, Navy, and/or Air Force. Licensed professional counselors are not noted as being recognized for either enlisted or officer occupation opportunities. Furthermore, the DoD/VA Report (2015) to the Congress in Response to Senate Report regarding the National Defense Authorization Act for Fiscal Year 2014 denoted that 2,048 psychologists, 774 psychiatrists, 2,445 social workers, 548 mental health nurses who were registered nurses, 178 mental health nurses who were nurse practitioners, 93 other licensed mental health providers, and 3,339 non-licensed technicians, also known as counselors were staffed to address the mental health needs of active military members and their families. There were 42.1 % civilian positions with the DoD while 12.1% were contracted employees. Of the other Licensed Mental Health Providers, 0 were military, 54 were civilian positions, and 39 were contractors.

Major Mental Health Professionals

Counselors (also known as Clinicians and Therapists)

These professionals are trained at the masters-level to (a) assess a person's mental health and (b) treat any issues found through therapeutic techniques with their focus on the person. Concentration areas related to mental health vary based on the master's degree (M.S. or M.A.). For example, marriage and family therapists (LMFT) fall under this category with professional counselors (LPCs). They follow practice guidelines from the American Counseling Association (ACA). Additionally, there are other specialties of counselors aside from mental health which are school counseling, rehabilitation counseling, and career counseling (ACA, 2019).

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Clinical Social Workers

These professionals are also trained at the masters-level to (a) access a person's mental health and (b) treat any issues found through therapeutic techniques, in addition they are trained in case management services and this has them focus on the person's environment versus individual work. They follow practice guidelines from the National Association of Social Workers (NASW). Concentration areas are only in social work (MSW), however, they work toward clinical social work (LCSW; Licensed Clinical Social Worker) if they want to do mental health counseling (NASW, 2019).

Psychologists

These professionals are trained at the doctoral-level to (a) access a person's mental health through clinical interviews and heavy focus on psychological evaluations and testing and (b) treat any issues found through therapeutic techniques. They follow practice guidelines from the American Psychological Association (APA). Concentration areas slightly differ depending on the Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.) degree which is more clinical in nature (APA, 2019).

Training

As part of clinical training all mental health professionals learn to take a multicultural perspective when addressing client needs (Zalaquett et al., 2018). Often during training competencies or standards ensure this perspective is taught. For example, master-level counselors rely on *Multicultural and Social Justice Counseling Competencies* (Ratts et al., 2016) whereas those in social work utilize the *Standards and Indicators for Cultural Competence in the Social Work Practice* (National Association of Social Worker [NASW], 2015). Additionally, in practice, ethical guidelines remind the provider that diverse groups exist and this, as well as cultural competency, should be addressed before treatment takes place to ensure quality service to all (e.g., counselors ACA 2014 *Code of Ethics* and psychologists APA 2017 *Ethical Principles of Psychologists and Code of Conduct*). Additionally, they are taught to work in many settings (i.e., individual, family, and group) and, in advocacy efforts, to ensure access needed to resources to promote wellbeing is provided (Ratts & Pedersen, 2014). While these mental health professions are

similar in background to one another, they are also different, so it is interesting to see that some are preferred to others in military settings.

Military Culture & Counseling Trends

Military culture is a unique culture that calls for specific attention from counselors so that they understand the functioning and worldview of individuals connected to this culture as it relates to structure and values (Prosek et al., 2018). Advocacy efforts have been growing in the last couple of years, particularly as it relates to the importance of training counselors for military cultural competency. Forziat et al. (2017) have been interested in looking at the advantages and disadvantages of working with the military population as military-connected and not military-connected. They have also been interested in learning methods, – that were effective and not so effective – used in training students to understand and work with this culture (Arcuri Sanders & Forziat-Pytel, in press). Other authors have been curious to see if counselor educators are infusing the military culture into their curriculum to show that it is, in fact, a diverse group (Hayden et al., 2018). Lastly, to help standardize the knowledge and skill needs for working with this particular culture, the *Competencies for Counseling Military Populations* (CCMP) were created (Prosek & Wehrman, 2018). The intention behind them was to provide a guideline for working with military clients in the counseling setting (Prosek et al., 2018).

Counselor Experiences Working with Military-Connected Clients

A long-standing problem has been counselors' recognition to working with military-connected clients in military affiliated settings (Prosek & Wehrman, 2018). The purpose of this article is to advocate for the counseling profession with regards to capability of working with the military population in comparison to their more popular mental health professional counterparts. Counselors at various training levels were asked about the reasons they wanted to work with the military population (a. military/veteran population [i.e., service members and veterans] and b. military/veteran families) and about the barriers they faced when working with this population as a counselor. Open-ended research questions included:

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Research Question 1*:* Reason for interest to work with this population [a then b].

Research Question 2*:* Please explain the barriers you have faced in trying to work with the [a then b] as a counselor.

Research Question 3*:* Do you feel that counselors (e.g., LPCs) experience barriers in reference to working with the [a then b] in comparison to other helping professionals (e.g., Social Workers, Psychologists, etc.)? If so, please indicate the helping professional and explain how so.

Previous literature discussing counselors' experiences counseling this group have found that training programs for cultural competency are lacking and this is providing a barrier to care in terms of number of available providers to service this group (Hall, 2016; Moore, 2012). However, this is only one reasoning for the divide and, therefore, an exploratory mixed-methods approach allowed the researcher to engage in an in-depth examination to identify other key barriers from individuals close to these issues. The researchers believe that this insight and comparison may (a) help advocate for positions in which counselors are qualified for and not currently getting in military settings and (b) contribute to new research ideas for uncovering the access barriers that counselors face when seeking counseling work with the military.

Methods

Concurrent Design

A concurrent mixed methods survey design containing both qualitative and quantitative questions (Creswell, 2014) was utilized to gain participant experiences concerning their training experience to work with the military population. This approach uses quantitative findings as complementary to the evolving qualitative themes.

Researchers used this method to get a more accurate picture of the layers in which participants may experience their barriers (e.g., training, exposure, etc.) to working as a counselor with the military-connected population. The qualitative questions were analyzed using phenomenological inquiry for an understanding of the meaning of participants' lived experiences

in their counseling roles rather than declaring a theory (Moustakas, 1994). The quantitative questions were analyzed using univariate analysis. This mixed method survey was self-administered in Survey Monkey, an online survey tool after receiving institutional review board (IRB) approval to conduct the human subjects study aligned with ethical processes. The IRB allowed for data collection to begin in 2018; the researchers collected data for approximately six months. Six months was enough time to send out two additional "reminders" for participation and it was at this timepoint that it became clear that no new data had been coming in.

Data Collection

A research advertisement was sent out to professional counseling listservs (i.e., CESNET-L, Journal of Military and Government Counseling Association Bi-weekly newsletter) and social media groups (e.g., Mental Health Professionals for Military and Veterans Facebook group), and university graduate programs. The advertisement shared the purpose of the study and inclusion criteria. Interested individuals, who also met the inclusion criteria, clicked on the survey link which took them to the Informed Consent. The Informed Consent provided more detailed information about the study to include (a) time anticipated for completion of the survey, (b) risks and benefits to participation, (c) how participation was voluntary (which included the ability to skip questions), and (d) that no incentive would be provided for participation. Participants who chose to consent and continue on, completed a short survey (through Survey Monkey). The survey started with demographic questions and then presented the multiple choice and essay questions created by the researchers to answer the specific research questions related to participants' interest and, given counseling training, ability to work with the military population (see Appendix B). After the survey was completely answered, participants were provided with a short debriefing after taking this survey to thank them for participating. The survey in total took about 20-30 minutes in an effort to collect both quantitative and qualitative responses.

Sample

Convenience sampling was used to find counselors (*N*= 49) around the counseling field who were (a) at least 18 years of age, (b) a current Counselor-

in-training or counselor interested in working with the military as a counselor. Given that counseling programs seek to develop professional counselors who can improve the quality of life of the clients they serve through culturally-inclusive practices and emphasis on wellness (Kaplan et al., 2014), the researchers were only interested in looking at mental health professionals from this shared mission. Convenience sampling allows the researcher to use all participants who respond to a research request and meet the basic inclusion criteria (Creswell, 2014; Etikan et al., 2016). This was determined an appropriate way to gather a sample, given that participants were recruited through online forums and made the decision to participate in the study, per their interest in counseling the military-connected population.

Study Sample

The sample for this study consisted of both Counselors-in-training as well as professional counselors who were in practice. Demographics of the sample were found comparable to the Data USA's counselor job profile for 2017 (Data USA, 2017) as well as statistics for the DoD (DoD & Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, (2016). Fifty-eight individuals originally agreed to participate, however, of these only 49 participants completed the survey portion and 30 participants completed the qualitative survey portion. Of the 49 participants, 14% were male and 86% were female. Participants serving this population spanned across all five U.S. military branches: Army, Air Force, Marine Corps, Navy, and Coast Guard. A significant percentage of the participants reported being a prior military spouse (29%) or current military spouse (49%). The race/ethnicity breakdown of this sample was slightly off in comparison, showing a smaller percentage (57%) of counselors in the work force to report being Caucasian (versus of 70%; Data USA, 2017). Additionally, the second highest reported group was Hispanic or Latino whereas census data shows this to be Black or African American (Data USA, 2017). Age ranges were as follows, 11 participants were ages 21-29, 17 participants were ages 30-39, 14 participants were 40-49, five were ages 50-59, and two participants were age 60 or older. Participants who were (49%) and were not (51%) current Counselors-in-training were close in numbers. For the 51% who had graduated, graduation dates ranged from 1982 to 2017. The majority of participants had completed this counseling training at a brick-and-mortar university (51%),

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however, many were also involved in online (33%), or hybrid (16%) training programs. The training programs spanned 18 states.

Analysis

First, data was analyzed for the quantitative descriptive statistics (i.e., the univariate analysis) and then for the qualitative codes that were developed and turned into main themes as part of a phenomenological study; which looks to understand a unique group with a shared experience (Maxwell, 2013; Moustakas, 1994).

Quantitative

A set of descriptive statistics were computed on Likert scale agree-disagree questions related to interest and barriers faced as counselors trying to counsel military service members, veterans, or military families. The results are shared in the form of percentages.

Qualitative

Then, the qualitative data were analyzed using thematic analysis procedures where data is moved from (a) raw data review, (b) to initial codes, (c) to themes, before being (d) reviewed by researchers through triangulation, and (e) settling on the final emergent themes (Nowell et al., 2017). Both researchers conducting this study shared identities as counselors who were part of the military connected-population. Bracketing as well as member-checking was used on the participant essay question responses, to protect results from researcher bias during the data analysis process (Maxwell, 2013). Bracketing in phenomenological inquiry is a methodological device that has the researcher remove their own beliefs about the phenomenon under investigation, given prior experience or knowledge about the phenomenological investigation (Chan et al., 2013). In addition to the steps the main researchers took to ensure trustworthiness of the data, a third reviewer (nursing educator) unassociated with the research and military counseling was brought in as a third-party perspective. This reviewer reported similar codes and themes as the researchers.

Given that the mixed-method survey that was analyzed by the researchers was also created by the researchers, the psychometrics of the

quantitative survey questions cannot be provided. However, the questions (see Appendix B) were constructed to align with CACREP's guidance for programs to understand student counselor learning in relation to program evaluation (2016, section 4).

Results

Participants were asked quantitatively and qualitatively about the (a) reasons they wanted to work with the military-connected population and (b) barriers they faced when trying to work with both the military/veteran as well as military family. Additionally, they were also asked quantitatively and qualitatively about their (c) perceptions of the *counselor position* in comparison to other mental health professions to provide additional insight into whether or not it was the type of position trying to access this population or the population itself and difficulties accessing it.

Reason for Interest

Participants were asked about their level of interest to work with the military/veteran population. Of those that responded, the majority of responses (71%) indicated that they were very much interested; 19.35% were quite a bit interested, 9.68% were somewhat interested, 0% were very little interested, 0% not interested. Participants were asked about their level of interest to work with military/veteran families. Of those that responded, the majority of responses (80.65%) indicated that they were very much interested; 12.90% were quite a bit interested, 6.45% were somewhat interested, 0% were very little interested, 0% not interested.

Four main reasons for wanting work with the military population (i.e., service member, veteran, or family) were identified as (1) personal connection, (2) personal desire, (3) patriotism, and (4) underserved. The theme of *personal connection* (PC) was given to those who identified having served or having had a family member serve. One participant shared, "I have grown to respect the military/veteran populations and have some first-hand experience with military life. I have always been drawn to these types of populations and feel it is a good fit with my own personality and skill set." Another theme, *personal desire* (PD) was given to those who mentioned having seen individuals from the military population struggle to receive competent services thus sparking their desire to work with this population. One participant stated, "I see time and

time again lack of understanding of the military culture and how it affects reporting symptoms". The third theme of *patriotism* (P) was given to those who indicated wanting to give back to those who give their lives through duty to the country. Participants named this themselves by saying, "Already worked on 5 bases due to patriotism," or in more subtle ways, such as another participant who shared, "I want to serve those who serve; help establish support for those who support our nation and sacrifice daily." The last theme was *underserved* (U) this code was given to those who expressed an interest in working with population given their 'underserved' status. One participant explained, "They [service members/veterans] seem to be lacking competent resources." These themes derived similar ratings for participants' interest for working with service members and veterans as well as their families (shown in Table 1).

Barriers

It is clear that trends of counselors being invited to work with the military population in counseling settings differs when compared to other mental health professionals. Literature has shown (a) differences in the number of counselors hired (b) that there is no designated position type (DoD/VA Report, 2015), and only have civilian employment opportunities. To better understand barriers from the perspective of the participants, who were in counselor roles, participants were asked about barriers they faced when trying to work with both the military service member or veteran as well as military families and their thoughts about how these barriers (with the above-mentioned groups) compare when thinking of other mental health professionals. Therefore, the structure below shows responses to barriers faced when trying to work with a particular group, followed by their opinions about whether they experience more barriers than others trying to work with the group.

Military Service Member/Veteran

Participants were asked if they faced a lot of barriers in working with the military service member/veteran as a counselor (e.g., LPC). Of those that were currently in the field practicing, the majority of responses (60%) indicated that they agreed; 40% strongly agreed, 20% agreed, 30% were undecided, 10% disagreed, 0% strongly disagreed.

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When asked to explain the barriers participants faced in trying to work with the military/veteran population as a counselor, participants responded with three main themes (a) strict training (i.e., CACREP accredited program) and licensure requirements (i.e., need a specific license), (b) inability to get qualified supervisors for those in training, and (c) counselor license (LPC) is not looked at as favorably as other mental health professionals by the military organizations (DoD and VA); likewise extending to insurance companies, making it more difficult to accept certain insurance types (i.e., TRICARE).

Comparison to Other Helping Professionals. Looking at the perspectives of both Counselors-in-training as well as counselors in the field, the majority of participants (58%) consider counselors *do* (e.g., LPCs) experience barriers in reference to working with the military/veteran population in comparison to other helping professionals (e.g., Social Workers, Psychologists , etc.).

Military/Veteran Families

Participants were asked if they faced a lot of barriers in working with the military/veteran families as a counselor (e.g., LPC). Of those that were currently practicing in the field, the majority of responses (50%) indicated that they agreed; 35% strongly agreed, 15% agreed, 40% were unsure, 5% disagreed, 5% strongly disagreed.

Participants elaborated on the barriers they have faced in trying to work as a counselor with military/veteran families, responding with themes related to (a) access to families is difficult (e.g., civilian counselor), (b) families' lack of awareness of resource, (c) licensure issues, (d) other mental health professionals are the preference, and (e) difficulty establishing rapport (i.e., trust issues).

Comparison to Other Helping Professionals. Half of participants (50%) felt that counselors (e.g., LPCs) *experience barriers* in reference to working with the military/veteran families in comparison to other helping professionals (e.g., Social Workers, Psychologists, etc.).

Those that said they experienced barriers clarified with themes related to (a) organizations interfere (i.e., VA, CACREP, TRICARE) and (b) preference for other mental health professionals (i.e., social work and psychology).

Those that felt barriers were experienced clarified leading to the following themes: (a) counseling needs a stronger identity, (b) counselors are not as respected, (c) other mental health professionals, specifically social workers, are the preference, (d) not recognized or given a specific job description by the VA/other government systems, and (e) counselors are discriminated against.

Looking at the perspectives of both Counselors-in-training as well as counselors in the field, the vast majority of participants (86.67%) felt that counselors (e.g., LPCs) *did not experience advantages* in reference to working with military/veteran families in comparison to other helping professionals (e.g., Social Workers, Psychologists, etc.). They clarified their responses which led to themes surrounding *training*; some participants thought that counselors were better qualified in terms of counseling versus other mental health providers and others who felt they were trained equally as well. However, those that felt counselors do not experience an advantage clarified their response leading to the following overarching theme, *less access to the population* (e.g., employment opportunities and ability to bill for services).

Discussion

Statistics concerning military, civilian, as well as contracted opportunities for licensed counselors to serve the military population suggest possible barriers exist (Kline, 2019; DoD/ VA Report, 2015). Furthermore, a recent study highlights how licensed counselors noted having less access to this population in comparison to other mental health providers (e.g., social workers and psychologists) despite having similar training regarding therapeutic interventions (Arcuri Sanders & Forziat-Pytel, in press). Statistics highlight the DoD's and the VA's preference for other mental health professionals when compared to the counselor. With only recent legislation recognizing licensed counselors as competent to fill positions to provide services to this population, and the insurance company for uniformed service members, veterans, and their families allowing counselors to bill for services, a misunderstanding as to what professional counselors are and do is suggested. Licensed Counselors are obligated to safeguard the well-being of their clients first and foremost (ACA, 2014, A.1.a.), while having the professional responsibility to exercise professional competence (C.2.), and provide clients with effective services

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which include "modalities that are grounded in theory and/or have an empirical or scientific foundation" (C.7.a., p. 10).

Perhaps one barrier the profession faces in regard to access to this population actually is a result of their own due diligence. Counselors have the ethical responsibility of providing culturally competent services (B.1.a.), yet current practicing counselors as well as Counselors-in-training indicate not receiving adequate training to address the unique needs of the military population (Arcuri Sanders & Forziat-Pytel, in press). Ironically, CACREP (2016) requires accredited counseling programs to provide their learners education in social and cultural diversity and considers it one of their eight common core areas. Therefore, questions to be considered are, (a) "how are we, as a profession, failing to provide these graduates with the skills needed to be competent in serving this population?" as well as (b) "how can we, as a profession, ensure hiring agencies recognize counselors to be competent to serve this group?" For instance, all 22 syllabi (as of 2020) that were housed in the ACA's syllabus clearinghouse for social/cultural diversity not one had mention of the military culture (ACA, 2020). While the *Competencies for Counseling Military Populations* (CCMP; Prosek & Wehrman, 2018) are intended to help those in practice establish an identity for working with this unique population, it does not fill the gap that continues to exist at the counselor education master's level where this culture may not be infused into courses.

These considerations should be even more alarming for the profession since many active-duty service members, veterans, and their family members seek services from civilian counselors. In fact, due to stigma, many service members prefer to receive services off-base. In a study of 233 active-duty service members from 2013-2016 serving across the United States and in Afghanistan, South Korea, and Germany, 93% of the participants indicated not wanting to seek military-connected treatment due to fear of reprisal for seeking services and 56% due to mistrust of command (Waitzkin et al., 2018). Just because a service member has mental health services offered to them at their duty stations does not mean that they, nor their families, do not seek services with civilians.

Limitations

This study contained limitations which are noted in this section. First, convenience sampling was used to increase the sample size and include all who responded to the research request and met the basic inclusion criteria (Etikan et al., 2016); however, this method greatly limits the research's generalizability and increases responder bias (Jager et al., 2017). The exploratory concurrent mixed-methods study sought to provide descriptive data and confirmation of the qualitative themes found. The goal was not to uncover statistical relationships. Second, this sample has a very small sample size (*N*=49) who completed the survey portion and *N*=30 participants completed the qualitative survey portion; therefore, findings should be viewed with cautiousness related to transferability. Findings cannot be generalized to the larger population. Third, the online mixed-methods anonymous survey design poses several risks to the data including (a) false answers, (b) missing data, and (c) survey fatigue (Dillman et al., 2014), and (d) misrepresentation of the identity of the respondents. Participants may have falsified answers, perhaps in an effort to protect privacy or please the researchers. Missing data did occur as questions were not "required" in an effort to maintain "participation being voluntary". This participant right allowed individuals to skip questions and ultimately survey portion numbers were misaligned. Lastly, survey fatigue could have occurred, given the number of questions asked of participants requiring both quantitative and qualitative responses. Unique limitations to the qualitative analysis include the inability to (a) verify the results of the qualitative research, (b) investigate causality, since responses are more opinion based, and (c) ensure researcher bias was kept out of the data analysis (Creswell, 2014).

Future Research

This study included a group of counselors, however, it would be important to conduct a follow-up study which included other mental health professional groups to understand their thoughts and feelings related to (a) reasons they want to work with the military-connected population, (b) training for cultural competency related to work with this group, (c) barriers they feel they face when trying to work with service members, veterans, as well as military families, and (d) about their perceptions of the *counselor position* in comparison to other mental health professionals to service this population. This

would allow for more voices and perspectives related to barriers for military mental health professionals, for perhaps counselors are not alone in this issue. Furthermore, understanding military versus non-military connected group differences may be able to provide further insight regarding not only access to employment opportunities but also areas needed to ensure competence of service providers is met. Findings from this study, which aligns with previous studies (Hayden et al., 2018), denotes a vast majority of participants who indicated having a military connection when expressing interest in working with this population. Researchers should start to look to understand (a) "How do we get individuals who are not military-connected themselves interested in working with this population?" and (b) "How do we get individuals who are not military-connected themselves to feel competent in working with this population?" Individuals not connected could help generate new ideas related to training needs (i.e., learning culture from the outside of it) to serve this population and uncover new ideas for decreasing barriers to care for both clients and mental health professionals.

Conclusion

The purpose of this article was to discuss barriers to counselors servicing the military population. Insights gained from this study is an *initial* step towards activism and advocacy, as we now better understand specific areas that can be targeted for social action which include (a) more attention to the counselor identity as it relates to other mental health professionals, (b) program training needs, and (c) bridging gaps between military versus non-military connected counselors in servicing this population. This exploration of experiences for professionals is a start for a conversation that needs to continue if counselors desire to be perceived by employers as providing mental health services to this population. Despite having professional organizations which offer ethical guidance and boards providing legal guidance to ensure the welfare of clients first and foremost, counselors are still not equally represented as a mental health provider for the military-connected population. This manuscript hopes to inspire further research to gain insight concerning reasonings and development of strategies to negate these negative perceptions of the counseling profession.

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Appendix A

Table 1: Number of Participants Responses Per Group for each Theme

Theme	Number of Participants per Group	
	SM/V	*Family*
Personal connection (PC)	23	22
Personal desire (PD)	3	2
Patriotism (P)	2	2
Underserved (U)	2	1

Appendix B

Mental Health Professionals Serving the Military: Access and Barriers Survey

Demographics

1. Age:
   18-20, 21-29, 30-39, 40-49, 50-59, 60 or older

2. Gender:
   Male, Female, Transgender, Other (please specify):_______

3. Ethnicity:
   Caucasian, Black or African American, Hispanic or Latino,
   Asian/Pacific Islander, Native American or American Indian,
   Other (please specify):_______

4. Marital Status:
   Single, Married, Divorced, Widowed, Separated

5. Former/Current military service as Service Member:
   Yes, No

- If yes, indicate Former or Current:
  Former, Current
- If yes, indicate Branch:
  Army, Marine Corps, Navy, Air Force, Reserve Forces, Coast Guard, National Guard
- If yes, years of service
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+

6. Former/Current military spouse:
   Yes, No

- If yes, indicate Former or Current
  Former, Current
- If yes, indicate Branch and years of service
  Army, Marine Corps, Navy, Air Force, Reserve Forces, Coast Guard, National Guard
- If yes, years of service
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+

7. Former/Current military dependent (child):
   Yes, No

- If yes, indicate Former or Current
  Former, Current
- If yes, indicate who all in relation to you was the service member (select all; e.g. If Mother and Father were active duty, check Mother and Father)
  Father, Mother, Stepfather, Stepmother, Grandparent, Other: _____
- If yes, indicate how many years you were a military family?
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+

8. Former/Current civilian employee contract service with the Department of Defense (DoD) other than providing mental health services (e.g., groundskeeper, technological support)?
   Yes, No

- If yes, indicate Former or Current
  Former/Current

- If yes, how long in years?
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+
- If yes, indicate occupation_____

9. Former/Current mental health provider with the Department of Defense (DoD)?
   Yes, No

- Indicate Former or Current employee
  Former, Current
- Indicate mental health provider role as civilian, contractor, or service member (MOS)
  Civilian, Contractor, Service member
- Indicate credential license used:
  Licensed Professional Counselor, Licensed Clinical Social Worker, Psychologist, Other (please specify):____
- If yes, how long in years?
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+
- If yes, who did/do you provide mental health services to active military, Veterans, and/or dependents? (click all that apply; indicate how long for each)
  Active Duty:
  Veterans:
  Dependents:

10. Former/Current employed mental health provider who has military population clients (not contracted or employed by DoD):
    Yes, No

- Indicate Former or Current employee:
  Former, Current
- Indicate credential license used:
  Licensed Professional Counselor, Licensed Clinical Social Worker, Psychologist, Other (please specify): ______
- If yes, how long in years?
  3 or less, 4-6, 7-9, 10-12, 13-15, 16-18, 19+
- If yes, who did/do you provide mental health services to active military, Veterans, and/or dependents? (click all that apply; indicate how long for each)
  Active Duty:
  Veterans:
  Dependents:

- If yes, what type of site?
  Private practice, Agency, DoD or DoD associated site

11. Degree Earned to treat military population as a mental health provider:
    Counseling, Social Work, Psychology, Other (please specify):______

12. Highest Degree Earned to treat military population as a mental health provider:
    Doctorate, Master's, Bachelor's, Other (please specify):_______

13. Former/Current Military Connection other than noted above:
    Yes, No
    - If yes, please explain:

Note: Please note the next questions will be asking about (1) ***Military/Veteran Population and (2) Military/Veteran Families (dependents). Military*** encompasses current service members (i.e., Active Duty and Reserve/ Guard status) where ***Veteran*** encompasses those who have previously served (i.e., Active Duty or Reserve/ Guard status).

Questions Regarding Interest in Working with Military/Veteran Population and their Families

1. Level of interest to work with the ***Military (Active Duty) Population***

   Very much interested, Quite a bit interested, Somewhat interested, Very little interested, Not interested

2. Reason for interest to work with this population (Qualitative response)

3. Level of interest to work with the ***Veteran Population***

   Very much interested, Quite a bit interested, Somewhat interested, Very little interested, Not interested

4. Reason for interest to work with this population (Qualitative response)

5. Level of interest to work with ***Military (Active Duty) Families (Dependents)***

   Very much interested, Quite a bit interested, Somewhat interested, Very little interested, Not interested

6. Reason for interest to work with this population (Qualitative response)

7. Level of interest to work with the ***Military Veteran Families Population (Dependents)***

   Very much interested, Quite a bit interested, Somewhat interested, Very little interested, Not interested

8. Reason for interest to work with this population (Qualitative response)

9. I have faced a lot of barriers in working with the ***Military Connected Population*** *(indicate choice for Active duty, Veteran, Active Duty Dependent, and Veteran Dependent)* as a mental health provider (e.g., LCSW, LPC, Psychologist):

	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
Active Duty					
Veteran					
Active Duty Dependents					
Veteran Dependents					

10. Please explain the barriers you have faced in trying to work with the ***Military Connected Population*** as a mental health provider (e.g., LCSW, LPC, Psychologist) (Qualitative)

11. Do you feel that licensed counselors (e.g. LPCs) experience barriers in reference to working with the ***Military Connected Population*** in comparison to other helping professionals (e.g., Social Workers, Psychologists, etc.)?
    Yes, No

    - If yes, please indicate the helping professional and explain how so......

12. Do you feel that licensed counselors (e.g. LPCs) experience an advantage in reference to working with the ***Military (Active Duty) Population*** in comparison to other helping professionals (e.g., Social Workers, Psychologists, etc.)?
    Yes, No

    - If yes, please indicate the helping professional and explain how so......

Leadership Style and Work Factors as Burnout Predictors in Supervising Deputy Probation Officers

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This study addressed a gap in the literature by investigating burnout in Supervising Deputy Probation Officers (SDPOs). The study examined leadership style, number of probation officers (POs) as direct reports, and tenure. Leadership (i.e., transformational and transactional) and Maslach's burnout theory served as the theoretical framework. The participants included SDPOs from probation agencies within the state of California at the community-based capacity. The sampling approach was randomized and a logistic regression analysis was used to determine predictability. The MLQ and MBI-GS were administered to measure leadership style and burnout. The results indicated a predictive relationship between leadership style and burnout, a predictive relationship between tenure and burnout, and no predictive relationship between the number of POs supervised by SDPOs and burnout. Interventions are needed to address burnout and combat SDPO's disengagement, recurring absenteeism, decrease in effectiveness, and ultimately resignation. Implications for law enforcement and related disciplines are presented.

Keywords: probation officers, burnout, leadership style

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Law enforcement officers are placed in situations where discretionary decisions are made under difficult conditions, subjecting them to heightened pressures and stress resulting in serious mental and physical problems (Woody, 2006). According to Yanan et al. (2014), job-related stress is one of the leading factors associated with job burnout. Burnout in the law enforcement profession is complex with implications for officer safety and health, including psychological and emotional impacts (Genly, 2016). Supervising Deputy Probation Officers (SDPOs) are responsible for the management practices devoted to promoting professional probation officer (PO) conduct and maximizing performance. The experience of burnout can cause officers to contemplate resigning and reduce effectiveness in implementing evidence-based care to clients (Salyers et al., 2015). SDPOs are required to work closely with POs to improve work processes as well as provide feedback to upper management about individual and overall performance (Janes, 1993). SDPOs serve as middle management and balance a wide range of expectations (Hsieh, et al., 2015). Moreover, probation officials take on a crucial role in the restoration of victims, offenders, and communities (Purkiss et al., 2003).

Research on POs has been conducted including officer safety and the impact of violence in their profession, stress and job satisfaction, case and workload management, leadership perceptions and professional support, to job-related burnout (Dale & Trlin, 2007; Denney & O'Beirne, 2003; DeMichele & Payne, 2007; Slate et al., 2000; White et al., 2015). However, it is critical to examine similar areas, particularly related to SDPO leadership styles and their mental and physiological state. An important part of leadership involves listening to concerns expressed by staff members, which is often misinterpreted as resistance (Siegel, 2000). SDPOs are first-level supervisors that represent, communicate, and provide feedback between POs and upper management. SDPOs are critical contributors to policy development and implementation. Although the impetus of implementation is put forth by top management, success or failure depends on middle management as they hold influence at the employee level, suggesting that they could also serve as a barrier to desired outcomes (Janes, 1993). Furthermore, unaddressed burnout puts the organizations at risk of decreased employee organizational commitment and

increased turnover intention (Khera, 2017). With less committed public employees, a culture that serves private interests instead of the public interest is created (Kim, 2015).

This research study examined whether SDPOs' leadership style and work factors (i.e., years serving as an SDPO and number of POs under their supervision) predict burnout. This investigation provided a better understanding to enhance leadership approaches and minimize burnout among SDPOs. It could also serve as a framework to guide practitioners such as Industrial-Organizational (I-O) psychologists in managing competency development and effective training and support (Gibson et al., 2018). Leader-member interactions, behavior, characteristics, and well-being are topics of concern in the study and practice of I-O psychology.

Background of the Problem

SDPOs hold a first-level supervisor position in probation departments, making them a liaison between line staff (POs) and upper management. SDPOs set the tone for ethical conduct, department policy and high standards across the agency (Fortenbery, 2015). Given these demands, it is important to understand the impact on SDPOs mental, emotional, and physiological state and whether the leadership approach contributes to burnout.

Leadership advancement in social agencies dates back to the 1920s when the need for leadership development training in public welfare systems drove the development of specialized fieldwork for probation and other public welfare agencies (Morgan, 1923). The Probation Act was amended by Congress in the 1930s, enabling the probation system to operate as a national organization. In the 1950s, the creation of federal probation training evolved to officer safety training and academies (Ward & McGrath, 2015). However, no training specific to leadership development was offered until January 1992 when the Federal Judicial Center launched a leadership program to overcome what was described as *compelling forces* (Siegel & Vernon, 1994). Leadership development focused primarily on upper management, such as probation chiefs (Vernon & Byrd, 1996). Burnout was investigated relative to leadership in the law enforcement and probation context, being prone to emotional exhaustion, which tends to

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harm the way work accomplishments are viewed (Michinov, 2005). Burnout related research has focused more on POs despite probation managers' critical role in the organization (Whitehead, 1986). Lewis, et al. (2013) indicated POs who experienced specific caseload events scored notably higher on traumatic stress and burnout measures in comparison to POs who did not experience such caseload events. This study raised the possibility that POSs could have underreported traumatic stress as they may attempt to normalize stress reactions based on what they perceive as socially desirable. These responsibilities also weigh on SDPOs since they are responsible for monitoring PO caseload. One of the only empirical studies by White et al (2015) on burnout among juvenile POs, found POs scored high for emotional exhaustion and cynicism, suggesting their daily experiences consisted of feeling emotionally drained while lacking enthusiasm. The findings were significantly higher than studies conducted in the 1980s on POs that were administered using the Maslach Burnout Inventory (MBI). The results indicated that burnout was predictive of stigmatizing views regarding personal mental health treatment and competency to address caseload needs. Thus, the need for burnout interventions tailored to juvenile POs was emphasized due to their dual mandates (rehabilitative and public safety). More rigor is needed in this area of study to understand the multifaceted forces affecting POs' stress levels (Slate, 2000), for which Michinov (2005) describes as a form of occupational burnout. Burnout in POs is due to balancing public safety concerns, rehabilitation, enforcing conditions and sanctions on offenders released from correctional facilities back into society, along with added pressures of large caseloads, high-risk offenders, shrinking budgets, and political and public scrutiny (Pitts, 2007; Salyers et al., 2015). Since job stress has been shown to be related to burnout (Ishaq & Mahmood, 2017), officers could experience a decrease in the quality of life, meaning that burnout can lead to undesirable outcomes at home (e.g., family life and physical health) as well as the way that correctional services are provided as a whole in terms of turnover and absenteeism (Gould et al., 2013). Middle management civil servants hold specialized roles including policy formulation, which requires training in leadership (Raadschelders, 2016). Leaders need the ability to adapt and perform certain functions (e.g.

emotion coaching, effective communication, and conflict resolution skills) as a necessary aspect of achieving organizational objectives (Luo & Jiang, 2014).

Distinctions in probation work could also be made as it relates to PO stress levels (Slate, 2000), which contributes to burnout (Maslach & Jackson, 1981; Maslach et al., 2001; Whitehead, 1986) particularly in SDPOs, given they hold a deputized position with added supervisory responsibilities. Empirical evidence shows there is a relationship between leadership style, emotional regulation, and burnout (Arnold et al., 2015). The National Institute of Justice (2005) indicated that 87% of POs disliked their supervisor and identified this as a source of stress. Work-related stress and burnout cause concern in organizations, which include how leadership styles relate to burnout; given that a leader's emotional competencies are associated with their overarching leadership styles (Arnold et al., 2015). Burnout leads to mental, emotional, and physical fatigue and lowers commitment in the workplace, which could translate into toxic behavior while on duty (e.g. officers have been witnessed insulting subordinates [Ritu et al., 2014]). Previous findings indicated a relationship between seniority and burnout in federal supervisors and POs (Lewis et al., 2013; Thomas 1988), supporting the assumption a greater potential for burnout exists when officers remain in federal service for a longer period of time.

Theoretical Framework

Given an increasing research interest in burnout, measures that assessed a broader scope of the phenomenon such as the MBI-GS were developed (Maslach & Leiter, 2008; Schutte et al., 2000).

Freudenberger (1974) initially defined burnout after observing symptoms of exhaustion in the workplace context as a psychiatrist (Galanakis et al., 2009; Jackson et al., 1986; Maslach et al., 2001). Maslach et al.'s (2001) conceptualization of the term burnout relates to a psychological syndrome resulting from chronic work-related interpersonal stressors. Burnout has been operationalized according to Maslach's theoretical framework (Galanakis et al., 2009; Maslach & Jackson, 1981), which recognizes three components: emotional exhaustion, depersonalization, and reduced personal accomplishment.

Transformational, transactional, and *laissez-faire* leadership are three prominent leadership styles (Bass & Avolio, 1997; Won-Jae et al., 2010). Leary et al. (2013) posited that dysfunctional leadership devastates employee engagement and job satisfaction, thus, significantly contributing to burnout. While much has been said about the need for probation to change its traditional paradigm and employing effective leadership (Paparozzi, 1999; Won-Jae et al., 2010), a gap in the research remains in leadership style and burnout.

Law Enforcement and Probation Burnout

Law enforcement refers to any officer or agent of the state or government that engages in the supervision, detection, and investigation for the prevention of any criminal law violation (Bulletproof Vest Partnership, 2017). Operations within these agencies often require considerable responsibilities and demands from officers, which exposes them to stressful situations. A large body of literature indicates numerous factors that contribute to stress and burnout (Finney et al., 2013). Job stress is identified as being a factor associated with dissatisfaction and burnout, which impacts performance in civil servants (Yanan et al., 2014). Burnout is a response of prolonged interpersonal stressors and is characterized as a syndrome caused by chronic exposure to work related stress (Maslach & Jackson 1981; Maslach & Leiter, 2008). Whitehead (1986) found job satisfaction, role conflict, and role clarity had been reported among probation managers, particularly, with distinctions between the administrator and first-level probation supervisors. It was found that low levels of burnout were associated with having less than 6 years of experience. Results indicated that probation supervisors and administrators experienced all three components of burnout. However, the results showed that feelings of burnout were infrequent among probation managers (Whitehead, 1986).

Thomas (1988) indicated that probation managers ranging from supervisors, deputy chief, and chief in probation pretrial services reported the same stressors as POs, which mainly consisted of two dimensions characterized as occurrence frequency and reaction intensity. However, probation managers' stress focused on how they perceived the stressor affecting POs (Thomas, 1988). Thomas acknowledged literature indicating

stress in relation to burnout but asserted that they are not the same, suggesting probation managers are subjected to stressors leading to burnout.

Griffin et al (2010) investigated the relationship between work related stress, organizational commitment, job satisfaction, and burnout in correctional officers. The study indicated officers holding a leadership position experienced increased levels of burnout. These findings were contrary to Seltzer and Numerof's (1988) study of position and burnout, which indicated certain behaviors in corrections resulting from burnout are unsafe, resulting in turnover, productivity decline, and absenteeism (Finney et al., 2013). Another study examined burnout and organizational commitment in hierarchies of police personnel (Ritu et al., 2014). Findings indicated that head police constables scored higher in affective commitment and significantly higher on three aspects of burnout compared to police officers, suggesting that head police officers tend to develop high levels of burnout. Bakker and Heuven (2006) found a relationship between emotional job demands and burnout. Further, in police work, emotional dissonance refers to the public persona that officers display versus their genuine emotions. This implies police officers manage their emotions in order to maintain a physical demeanor that exudes control and neutrality, which requires suppressing their own emotions, while simultaneously being expected to empathize with victims of crime (Bakker & Heuven, 2006). There is no consensus relative to police officer burnout, which prompts the need to investigate contributing factors (Goodman, 1990). Another study examined burnout in supervising POs working with juveniles and found 32% scored high in emotional exhaustion and approximately 28% scored high in cynicism, where only about 15% scored high in professional efficacy (White et al., 2015). This confirms POs' autonomy in their work provides the opportunity to make independent decisions, which contributes to confidence level. This study was the only known research effort that examined burnout in juvenile POs, however, the researchers recognized that their findings contradicted Whitehead's (1985) thirty-year-old findings. This supports the need to accurately reflect contemporary burnout among the PO population.

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Burnout Predictive Factors

Leadership

Leadership plays an important role in shaping employees' performance and productivity (Hussain & Hassan, 2016). However, leadership in probation is a difficult issue to address, and the balance between leadership and management is often ambiguous (Senior, 2016). Burnout impairs social and personal functioning and leads to the distancing of personal involvement with subordinates (Maslach & Goldberg, 1998). Evidence indicates leadership style is associated with burnout and transformational leaders are cognizant of how their expressions and emotions affect their followers, which could explain the significant results on genuine emotional expression relative to burnout (Arnold et al., 2015). Sereni-Massinger et al. (2015) asserted that self-regulation is crucial in law enforcement, given their role, which requires competencies in problem-solving and decision-making. Andresscu and Vito (2010) found transformational leadership was perceived as the ideal leadership style by police managers. Previous studies show that burnout might be a reason officers make fewer arrests, which compromises the peace and safety of communities, thus, urging the need for leadership that considers followers' perspectives (Andresscu & Vito, 2010).

To understand the influencing behavior between officers and supervisors, Deluga and Souza (1991) examined leadership style in police officers. Previous evidence indicated transactional leadership promoted more influence among subordinates compared to transformational leadership, leading to the hypothesis that results that would generate the same findings within the law enforcement setting. However, their study revealed contrary results. The hypothesis that police officers and supervisors might exhibit different influencing patterns in the law enforcement context compared to other settings appeared reasonable (Deluga, 1988; Deluga & Souza, 1991), and further drives the need for more research.

Skakon et al. (2010) opined that when leaders' well-being is negatively affected by work related stress (a factor known to contribute to burnout), it crosses over to subordinates. High levels of stress in leaders

were associated with high levels of stress among subordinates. Conversely, such crossover includes how followers shape the leader's work experience, which impacts well-being (Wirtz et al., 2017). Although it could not be confirmed that a direct crossover of emotional exhaustion takes place from followers to leaders as indicated by previous findings (Whitehead, 1985), the implication is that the leader's emotional self-efficacy moderates the transfer of emotional exhaustion from followers to leaders, which could also be attributed by their leadership role. Therefore, leadership style not only impacts organizational effectiveness, but also the leader's well-being (Sudha et al., 2016).

Zwingmann et al. (2016) examined direct effects of transformational leadership and *laissez-faire* leadership relative to emotional exhaustion. Their study showed a longitudinal relationship between emotional exhaustion and transformational leadership, implying that although transformational leadership is increasingly effective, in the long run it can hurt the leaders' emotional state by depleting their personal resources and increasing emotional exhaustion. Thus, this lack of self-care undermines the efforts of effective leadership (Zwingmann et. al., 2016) and the chronic experience of emotional exhaustion leads to burnout (Maslach & Jackson, 1981). As supported by research, it is probable that leadership style impacts individuals' psychological relationship to their profession between negative feelings of burnout and positive experiences of efficacy (Arnold et al., 2015; Maslach et al., 2012; Zwingmann et al., 2016), demanding further investigation.

Tenure

Burnout presents itself in various symptomatic forms and degrees, usually occurring around one year in position (Freundenberger, 1974). Seltzer and Numerof (1988) found that subordinates with more years of experience reported higher burnout levels. They showed years of experience directly impacted burnout versus a curvilinear effect for which the researchers had initially predicted, however, they noted that only 15% of their respondents had more than ten years of experience. Lambert et al. (2010) examined burnout among correctional officers and found that depersonalization was associated with increased absenteeism and turnover

intent in correctional officers. However, supervisory status and tenure had a statistical association with absenteeism suggesting that officers with high tenure suffer from the long-term effects of burnout in the prison work environment. These findings were supported by correctional officers working ten years or more scoring higher on emotional exhaustion (Oliveira et al., 2016). Seniority is related to burnout in POs, as officers new to the job reported lower burnout scores. However, findings indicated burnout scores decreased in officers having 15 years or more experience (Whitehead, 1985). As with probation and parole officers, levels of psychological demands increase with job tenure, which impacts physical health due to the psychosocial work environment that they are exposed to (Warren et al., 2015).

Workload

Caseload factors, such as level of clients' need, have been associated with mental health (Walsh & Walsh, 2002). Sharp growth poses serious implications regarding workload (DeMichele & Payne, 2007), which is a decision primarily initiated and executed by first-line supervisors, given that they are critical agents of workload allocation (DeMichele & Payne, 2007; Whitehead, 1986). According to McCarty et al (2019) emotional exhaustion is likely driven primarily by workload. Outcomes could improve if caseload was reduced (Jalbert et al., 2010). Other related trends include the increasing conditions of supervision, which are often mandated by court judges, releasing authorities, and legislators (DeMichele & Payne, 2007). Hsieh et al (2015) posited that awareness could inform policymakers about potential disjunctions that separate the ideology of law versus the reality of practice. Supervisors are expected to oversee the efficiency of operations and the effective handling of concerns to ensure the integrity of the operation as well as enforce the legal system (Cawthray et al., 2013). Balancing these demands is challenging, along with the ever-changing work conditions impacting work related stress (Öhman et al., 2005).

Synthesis of Research Findings and Methodology Justification

Inconsistencies and similarities were noted in the literature as it applied to this study. Within the context of this study's theoretical framework (i.e., burnout and leadership theories), there was vast literature related to organizational factors and burnout. Literature on leadership in the law enforcement setting was limited, particularly how it relates to burnout from the supervisory standpoint. The literature demonstrated consistent results indicating a relationship between workload and burnout (DeMichele & Payne, 2007; Jackson et al., 1986; Jalbert et al., 2010; Walsh & Walsh, 2002), however, an investigation within the supervisory role in law enforcement was extremely rare. The literature also demonstrated consistent findings indicating positive relationships between tenure and burnout (Lambert et al., 2010; Oliveira, Scheneirder et al., 2016; Whitehead 1985), but again, not within the law enforcement setting. However, one study did reveal that officers with greater seniority and lower social support reported greater emotional exhaustion and depersonalization (Whitehead & Lindquist, 1985). These results were contrary to burnout theory, which indicated that favorable perceptions of the job increased with seniority (Whitehead & Lindquist, 1985), further demonstrating the need for further study.

Whitehead's (1986) study was the first to examined burnout within probation management and current research has not explored this specific phenomenon. While White et al (2015) conducted a related study, it focused on potential predictive factors of burnout within the juvenile POs' population. Although it included probation supervisors and managers, the study's intention was not directed on this population. Their findings also generated higher scores of burnout than previous studies by Whitehead (1986) and Whitehead and Lindquist (1985), suggesting the need for further research. Another inconsistency in the research was position status in relationship to burnout. Research emphasized professionals who have the ability to influence others, make work-related decisions, and exercise autonomy in the workplace (as with professionals in a supervisory position) tend to experience greater job engagement and less burnout (Ashforth, 1993; Maslach & Leiter, 2016). Lambert et al (2010) found that

correctional officers in a supervisory position were less likely to miss work, but it was likely due to their greater sense of responsibility and obligation. The concept of limited autonomy experienced by probation supervisors relative to burnout could provide important information, given that subordinates seek leadership guidance with the expectation that the supervisor will be able to act on it, however, they may be unable to do so due to organizational bureaucracy (Gleicher et al., 2013). There may be formalized interventions in place relative to case management. However, these guidelines become useless when the supervisor has limited authority and resources to implement and enforce it (Horsier & Lombard, 2010).

Lastly, a finding worth noting was that research indicated low levels of burnout in probation managers with less tenure. This finding is strongly relevant as it seeks to determine whether tenure could have a predictive relationship to SDPO burnout. Furthermore, it is important given that employee disengagement and burnout can occur over time when work stressors exist (Travis et al., 2016). Both quantitative and qualitative research has been conducted to examine burnout in the workplace, particularly how work overload leads to exhaustion by depleting workers' capacity to meet job demands (Maslach & Leiter, 2008). The research methodology for this study derived from previous studies that examined work factors as predictors of burnout (Jackson et al., 1987; Lee et al., 2009; Maslach & Leiter, 2008; Savaya et al., 2016) as well as leadership (Arnold et al., 2015; Wilson, 2016).

Research Design and Sample

The first research question asked if there was a statistical significance between leadership style and burnout. The second research question asked if there was a statistical significance between number of POs and burnout. The third research question asked if there was a statistical significance between number of years served and burnout. The fourth research question considered if there was a collective statistical significance between predictor variables (leadership style, number of POs; and the number of years) and burnout.

This study employed a quantitative nonexperimental design to test the multiple predictive variables and their relationship to the dependent

variable (burnout) in SDPOs. Standardized and demographic questionnaires were used to collect data, then analyzed by applying the logistic regression model using the data analysis computer software (SPSS 2015, Version 23). The target population was SDPOs from probation agencies within the state of California at the community-based capacity. The study included SDPOs who met the following criteria: actively holding an SDPO position for a minimum of one year; over the age of 21; and, actively supervising at least one PO. The final sample (N = 140) were from Probation Agency A (113; 80.7%), Probation Agency B (18; 12.9%), Probation Agency C (4; 2.9%), and Probation Agency D (5; 3.6%). The mean number of years working as an SDPO was 10.56 years (SD = 8.14). For the number of POs supervised, the mean number of Deputy POs supervised was 8.54 (SD = 4.27). The highest frequencies of the samples were African American/Black (45; 32.1%), Hispanic (42; 30%), and White (26; 18.6%). More men (78; 55.7%) than women (62; 44.3%) were included in the study.

Data Collection

A research request was submitted to the probation departments as the process to obtain data collection approval required authorization to ensure standards of ethical research practice. The anonymity of the probation agencies was protected. The participants were recruited by either an email being forwarded by the agency on behalf of the researcher, or by the agency providing email addresses to the researcher. In either case, an introductory letter was then provided. If the participant met the inclusion criteria and chose to proceed, informed consent, then a link to the survey on the Mind Garden (2019) platform was provided. The researcher was employed by one of the probation agencies that participated. Therefore, the necessary steps were taken not to include any participants that had a direct professional or personal relationship and were not influenced in any way that would undermine the integrity of the study. The demographic survey asked for site location and was intended to facilitate the researcher with data organization and to be sure participants did not have a relationship with the researcher. The methodology was designed to exclude the researcher’s relation to the field, thus, minimizing bias or influence that could interfere with the validity of the research. The study

was approved by the Capella University Institutional Review Board (IRB) and was completed as a doctoral dissertation. The initial approval by the IRB was issued in June of 2016 and data collection began. Additional agencies were added to the data collection plan. This modification was approved in September of 2016 and data collection continued from two additional agencies.

The MBI-GS defines burnout based on the degree of three subscales: Exhaustion, Cynicism, and Professional Efficacy (Maslach et al., 1996). Since burnout is recognized as an important social problem, the MBI is an instrument that has attracted researchers and practitioners around the globe due to its measure and underlying multidimensional model having strong empirical support (Maslach, 1993; Schaufeli et al., 2008). The rating for the MBI-GS consists of a 7-point scale with questions that range from *never* to *every day* (Maslach & Jackson, 1981). The frequency of the feelings experienced (that fall under each item) is then produced into three scores, collectively indicating the extent of burnout. The factorial validity of the MBI-GS was examined with employees of a multinational company, which included total data of *N*=9055 (Schutte et al., 2000). The MBI-GS three-factor model was replicated across various occupations and the internal consistencies are satisfactory (Schutte et al., 2000). The internal consistency met the .70 criterion in every subsample and there was a significant range (.35 to .67 with the highest correlation ranging between .63 to .87 of the total sample) with correlations between factors (Schutte et al., 2000). As an indicator of a good fit as a global model, the MBI-GS ranged between .90 and .94 for five subsamples within occupational groups.

Reliability analysis revealed that it is sufficiently and internally consistent (Schutte et al., 2000). According to Maslach et al. (1996), the reliability internal-consistency estimate (Cronbach's alpha) is based from the 3,727 participants and similar patterns were observed for the three scales: *Exhaustion* (.89, .87, and .87); *cynicism* (.80, .73 and .84); and *professional efficacy* (.76, .77, and .84) (Maslach et al., 1996).

The MLQ measures leadership styles based on three aspects including transactional, transformational, and *laissez-faire*, comprised of twelve full-range leadership style measures. The MLQ consists of a five point scale from *not at all* to *frequently*, if not *always* (Avolio & Bass

2004). A meta-analysis of 33 empirical studies that applied the MLQ indicated a strong positive correlation of all transformational leadership components and including performance measures (Avolio & Bass, 2004). The hierarchal ordering of the constructs for leadership relative to performance was confirmed in the meta-analyses proposing that leadership effectiveness would be highly correlated mostly with transformational leadership, followed by transactional and then *laissez-faire* leadership. The MLQ has been used as a primary tool to reliably differentiate effective from noneffective leaders for over 25 years and has also been used in various rater/ratee groups (Avolio & Bass 2004; Den Hartog et al., 1997; Tajeda et al., 2001).

Data Analysis

Since the outcome was being predicted by more than two independent variables (continuous or categorical), a logistic regression (measured by a statistic *Wald* X^2) was conducted (Wall-Emerson, 2018). This applies given that two independent variables are continuous (years serving as SDPO and number of POs under supervision) and one is categorical (leadership style). There are no restrictions on the explanatory variables, thus making it the most common analysis for categorical data and a model in many fields such as behavioral science, social, educational, and medical (El-Habil, 2012). The *z*-test was used to calculate the *p*-value since standard normal distribution is asymptotic with *Wald* statistics. To test the hypothesis, inferential statistics were applied to test for the *p*-value. To generate a statistically significant result, a *p*-value of .05 or less is required and the logistic regression model's *Wald* statistic has been reported to have a *p*-value of less than .0001, thus exceeding the standard (Wall-Emerson, 2018); therefore, making it a reliable method to test the hypothesis and identifying the significance. The data for this study was retrieved from the Mind Garden (2019) website, where participants took the demographic questionnaire and assessments, then analyzed in SPSS 2015, Version 23.0. Table 1 summarizes MLQ scores for leadership styles of 140 participants. Comparison of the mean scores showed transformational leadership (M = 2.40; SD = 8.14) had the highest mean score while non-transactional leadership (M = 0.90; SD = 0.78) had the lowest mean.

Based on the three burnout subscales, participants were categorized as either experiencing burnout or not, as Table 2 summarizes. The cutoff score for high burnout in terms of cynicism, exhaustion, and professional efficacy should be above 10, 15, and 29, respectively. For cynicism, half (70; 50%) experienced cynicism with a mean score of 12.76 (*SD* = 9.62) and considered in the *high* range (≥ 11). For exhaustion, less than half (58; 41.4%) experienced exhaustion with a mean score of 13.76 (*SD* = 8.93) and considered *moderate*. For professional efficacy, less than half (57; 40.7%) experienced what was considered *moderate* (being between 24 to 29) professional efficacy with a mean score of 25.96 (*SD* = 7.80). Lastly, a single measure of burnout was obtained to be used as a dependent variable in the logistic regression. The majority or 121 (86.4%) out of the 140 SDPOs experienced overall burnout.

A logistic regression analysis was conducted to investigate research question one, and the significance of the relationship between leadership style and burnout using a significance level of .05. A significant relationship exists if the *p*-value of the *Wald* statistic is less than the level of significant value. The results indicated the fit of the logistic regression model ($X^2(3) = 6.23$, $p = 0.10$) generated was insignificant, suggesting it was not an acceptable model fit. The Cox & Snell R Square or measure of the effect size of the logistic regression model was 0.44, which shows a moderate effect size, meaning that the combined effect of the three leadership styles indicated a variance of 44% in predicting burnout. Investigation of the individual effect of relationships of leadership style and burnout showed only one leadership style of non-transactional leadership style (*Wald* (1) = 4.32, $p = 0.04$) had a significant relationship with burnout. Investigation of the coefficient of the odd ratio statistic of Exp (B) showed non-transactional leadership style was 3.74 which implies that a one unit increase in the score of non-transactional leadership style increased the odds of SDPOs experiencing burnout (versus not having burnout) by 2.74 or 274%. This means having a higher frequency of practice of non-transactional leadership would result in greater overall burnout. The null hypothesis for research question one that "SDPOs' leadership style as measured by the MLQ does not have a predictive relationship to burnout in the workplace as measured by MBI-GS" was rejected.

For research question two, a logistic regression analysis was conducted to determine the significance of the relationship between number of POs supervised and burnout, using a level of significance of .05. The results showed the model fit of ($X^2(1) = 0.01$, $p = 0.92$) generated was insignificant indicating that the logistic regression model was not an acceptable model fit. This means the overall effect of the number of POs supervised on burnout was not significant. The Cox & Snell R Square or measure of the effect size of the logistic regression model was 0.00, which indicates no effect size, meaning that the overall effect of the number of POs supervised did not capture any percentage of variance in predicting burnout. Investigation of the individual effect ($Wald(1) = 0.92$, $p = 0.99$) did not have a significant relationship with burnout. Therefore, the null hypothesis for research question two that "Number of POs under SDPO supervision does not have a significant predictive relationship to burnout in the workplace as measured by MBI-GS" was not rejected.

For research question three, a logistic regression analysis was conducted to determine the significance of the relationship between the number of years served as SDPO and burnout using a level of significance of .05. The regression results revealed that the model fit of the logistic regression model ($X^2(1) = 4.51$, $p = 0.03$) generated was significant suggesting that the logistic regression model was an acceptable model fit, meaning the overall effect of the number of years served as SDPO on burnout was significant. The Cox & Snell R Square or measure of the effect size of the logistic regression model was 0.03, which shows a very low effect size, meaning that the overall effect of the number of years served as SDPO captured a very low variance of 3% in predicting burnout. Investigation of the individual relationship of the number of years served as SDPO and burnout showed ($Wald(1) = 3.76$, $p = 0.05$) a significant relationship to burnout. Investigation of the coefficient of the odd ratio statistic of Exp(B) showed the number of years served as SDPO was 1.08 which implies that a one unit increase in the number of years increased the odds of SDPOs experiencing burnout by 1.08 or 8%. Therefore, the null hypothesis for research question three that "SDPO's number of years serving as a supervisor does not have a significant predictive relationship to burnout in the workplace as measured by MBI-GS" was rejected.

For research question four, a logistic regression analysis was conducted to determine the significance of the collective relationship of leadership styles, number of POs supervised, and the number of years served as SDPO with burnout using a level of .05 significance. The results are shown in Table 3, revealing the model fit of the logistic regression model ($X^2(5) = 8.78$, $p = 0.12$) generated, was not significant suggesting that the model did not have an acceptable model fit. This means that the combined effect of the three variables on burnout was insignificant. The Cox & Snell R Square or measure of the effect size of the logistic regression model was 0.44, which is moderate and means the combined effect of the three variables captured a variance of 44% in predicting burnout. Investigation of the individual effect to determine the significance of the individual relationships of each variable and burnout showed that all three leadership styles of transformational leadership (*Wald*(1) = 0.83, p = 0.36), transactional leadership (*Wald*(1) = 0.17, p = 0.68), and non-transactional leadership (*Wald*(1) = 3.50, p = 0.06), number of POs supervised (*Wald*(1) = 0.46, p = 0.50), and number of years served as SDPO (*Wald*(1) = 1.92, p = 0.17) did not have a significant relationship with burnout as the p-values of the *Wald* statistics were all greater than the level of significance value of .05. Therefore, the null hypothesis for research question four that "SDPOs' leadership style, years serving as an SDPO, and number of POs under SDPO supervision, do not have a collective significant predictive relationship to burnout in the workplace as measured by the MBI-GS" was not rejected.

Discussion of the Results

The results showing leadership style does have a predictive relationship to burnout, specifically having a higher frequency of non-transactional leadership will result in greater overall burnout by SDPOs was expected. Leadership behaviors that provide positive encouragement and motivation in difficult situations boost emotional support and encourage personal achievement. Given this finding, creating a more supportive climate would increase engagement by being responsive to important issues voiced by employees (Giovannoni et al., 2015). This significant result is supported by Leary et al (2013), concluding that an ineffective leadership

style confounds employee morale and engagement. An ineffective leadership style is characterized by leaders who treat those that they oversee as nuisances, are detached and distant, and passive-avoidant in important issues (Giovannoni et al., 2015; Leary et al., 2013). An ineffective leadership style ultimately contributes to employee burnout. This is especially significant in supporting the hypothesis given the results showing SDPO's are more likely to experience burnout while displaying non-transactional leadership, an ineffective method in the context of probation (Andresscu & Vito, 2010). Won-Jae et al. (2010) called for further research on probation leadership style and burnout since it has been concluded that leaders who are passive-avoidant in important issues are ineffective in the probation context. Their study was the first empirical leadership study in the probation field and explored leadership style and success, revealing that transformational leadership was consistent among probation directors. Effective leadership style provides a positive work environment resulting in the aversion of burnout (Andresscu & Vito, 2010; Leary et al., 2013).

The finding showing the number of POs under supervision does not have a significant predictive relationship to burnout was not the expected outcome. One of the possible reasons is the sample required actively supervising at least one PO, it did not take into consideration a varying mix in terms of the number of POs under their supervision. Another possible reason for the unexpected finding might be other factors such as individual stressors. According to Thomas (1988), other personal stressors are excessive workload and making dispositional recommendations. The weights of these factors are worth investigating further. While there is a dearth of available literature on leadership in law enforcement, there is little research on how the number of subordinates handled by a supervisor predicts burnout. However, Maslach and Leiter (2016) and Ashforth (1993) concluded professionals who generally have the ability to influence others, make work related decisions, and exercise autonomy in the workplace tend to experience greater job engagement and less burnout. Also, given this study takes a specific position under scrutiny and did not indicate a predictive relationship, this serves as an extension of knowledge to the discipline and contributes to the gap in literature.

The finding showing the number of years serving as a supervisor

does have a significant predictive relationship to burnout was expected. Stressors that are present in the probation setting build over time and impact the physiological well-being of the SDPO, which eventually lead to burnout. Whitehead's (1986) study included participants with seniority that varied up to 15 years of experience in the probation setting from which it showed low levels of burnout are found to be associated with probation managers having five years or less of experience. In addition, this study also supports previous findings by Seltzer and Numerof (1988) that more years of experience is likely to increase burnout. Lambert et al. (2010) and Oliveira et al. (2016) further highlighted specific indicators such as absenteeism and emotional exhaustion, which were highly correlated to burnout. Therefore, this finding is highly significant as it is one of the few studies specific to the law enforcement setting.

The finding showing leadership style, years serving as an SDPO, and number of POs under their supervision, do not have a collective significant predictive relationship to burnout was contrary to the expected outcome. It does, however, present the possibility that other factors would be more predictive as Whitehead (1986) showed that probation supervisors experienced various indicators. As such, this finding serves as groundwork for future research to determine collective factors of burnout in probation management.

Limitations

The sample was constrained to four agencies within the state of California. This limitation poses as a factor to consider when stating conclusive evidence; specifically, the study's scope of sample selection does not suffice to deem it applicable in generalization to a national level. Another limitation to consider in sample selection is that the study only focused on SDPOs working in the field and did not include SDPOs working at the detention or residential treatment facilities. This limitation, consequently, means that the findings are not generalized to all operations. A further limitation could be related to the definition of supervision, including SDPO's in the study who are actively supervising *at least one PO* as the criteria for participation. The study did not take into consideration a varying mix in terms of the number of POs under their supervision, which

may not be conclusive enough to determine whether this factor would impact burnout. A final limitation is the self-report instruments could be a source of bias in terms of perception within the context of leadership.

Conclusions and Recommendations

Practical implications resulting from this study are beneficial to diverse stakeholders in law enforcement settings. Maslach and Jackson (1981) asserted the effects of burnout and how the depletion of emotional resources led to eventual unavailability at a psychological level. Therefore, the findings of the study aid in helping individuals avoid negativity and the development of cynical attitudes. The implications, when translated to practical programs for SDPOs, can assist in addressing personal feelings of unhappiness and dissatisfaction at the individual level (Maslach & Jackson, 1981). If left unaddressed, high stress and burnout levels could result in a potentially dangerous decrease in quality-of-life in officers (Gould et al., 2013). The finding of this study, that indicates a positive correlation of the SDPO's number of years as a supervisor to burnout, indicates the more an employee is exposed to probation work environment variables, the more likely it is to experience burnout. Therefore, lacking intervention to address stress-related variables in the workplace would lead to disengagement, recurring absenteeism, decreased effectiveness, and ultimately resignation. The study provided empirical evidence that leadership style and tenure are relevant in predicting burnout. Through means of determining which factors are most pertinent and should be focused on in order to avert burnout, SDPOs would be more effective in their roles and provide better collaboration and feedback with both upper management and subordinates. At the organizational level, the findings increase awareness for various law enforcement agencies, courts, and attorneys who work closely with POs. Having empirical quantitative data supports the understanding of the job profile and the targeted needs of SDPOs. Although several research studies specific to POs were conducted over the past years, most of these were centered on other factors such as officer safety and the impact of violence in their profession; stress and job satisfaction; case and workload management; leadership perceptions and professional support; to job-related burnout (Dale & Trlin, 2007; DeMichele & Payne, 2007; Denney &

O'Beirne, 2003; Slate et al., 2000; White et al., 2015). SDPO's can increase performance when their mental and physiological needs are addressed. Thus, the desired outcomes in policy development and an overall healthy workplace are more likely to come to pass.

Future researchers may improve the sample selection by including officers with other specific job functions such as detention or residential treatment facilities. Additionally, other various organizational and environmental conditions such as work overload, value conflict, community breakdown, lack of control, fairness, and rewards are shown to be factors of employee stress and thus should be considered as factors to predict burnout in future studies (Maslach et al., 2012). Both collectively and individually, the outcomes were expected to have a strong positive correlation in predicting burnout for SDPOs. Ultimately, it was found that not all factors were strong predictors of burnout, contrary to initial expectations. Effective programs can be developed from the findings that would aid SDPOs' mental and physiological well-being as the literature has shown work stressors that are left unaddressed will likely result in mental disengagement and eventual burnout (Travis et al., 2016). Further, if burnout is unaddressed, it may result in added recruitment and training costs, which would place an additional burden on resources of law enforcement (Salyers et al., 2015). The findings of this study provided further understanding of burnout in law enforcement, which plays a critical role in keeping not only organizations but the larger community safe and productive.

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APPENDIX

Table 1

Descriptive Statistic Summaries for Leadership Styles

Leadership Style	*N*	Minimum	Maximum	Mean	Std. Deviation
Transformational Leadership	140	0.30	4.00	2.40	1.00
Transactional leadership	140	0.40	3.75	2.08	0.66
Non-transactional leadership	140	0.00	3.30	0.90	0.78

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Table 2

Frequency and Percentage Summaries of Categories of Burnout

Category	Frequency	Percent
Cynicism		
Not	70	50
Burnout	70	50
Exhaustion		
Not	82	58.6
Burnout	58	41.4
Professional Efficacy		
Not	83	59.3
Burnout	57	40.7
Overall Burnout		
Not	19	13.6
Burnout	121	86.4

Table 3

Logistic Regression Results of Collective Relationships of Leadership Styles, Number of POs Supervised, and Number of Years Served as SDPO with Burnout

Variable		B	S.E.	Wald	DF	Sig.	Exp(B)
Step 1[a]	Transformational leadership	0.42	0.45	0.83	1	0.36	1.51
	Transactional leadership	0.19	0.46	0.17	1	0.68	1.21
	Nontransactional leadership	1.24	0.66	3.50	1	0.06	3.45
	Number of POs Supervised	-0.05	0.07	0.46	1	0.50	0.96
	Number of years served as SDPO	0.06	0.04	1.92	1	0.17	1.06
	Constant	-0.63	1.81	0.12	1	0.73	0.54

Note. $X^2(5) = 8.78$, $p = 0.12$, Cox & Snell R Square R Square (R^2) = 0.44, N = 140

a. Variable(s) entry on step 1: Transformational leadership, Transactional leadership, Nontransactional leadership, number of POs supervised, Number of years served as SDPO

*Significant at level of significance $\leq .05$