

Evidence-Based Practice as a Potential Solution to Burnout in University Counseling Center Clinicians

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The purpose of this study was to evaluate the impact of changes in perceptions about patient volume and severity of clinical presentations in university counseling centers (UCCS) on burnout. It was hypothesized that perceptions of increased workload and severity of conditions treated would be positively correlated with burnout. It was also hypothesized that self-reported use of evidence-based practice (EBP) would be negatively correlated with burnout. Counseling center clinicians ($n = 80$) completed the Copenhagen Burnout Inventory (CBI), the Evidence-Based Practice Attitudes Scale (EPBAS), and reported on factors that have been shown to impact burnout. In this sample, the following percent of respondents were at or above a level indicating potential burnout on each scale: Personal 19%, Work 15.2%, and Client 2.5%. Years of work was correlated with Client Burnout ($r = .25, p < .05$). Perceived increases in severity were correlated with each CBI Scale: Personal ($r = .33, p < .001$), Work ($r = .32, p < .001$), and Client ($r = .33, p < .001$). Self-reported use of evidence-based practice was negatively correlated with Client burnout ($r = -.30, p < .001$). The EPBAS Divergence Scale, which measures perception that one's usual practice is different than research based practices, was also correlated with burnout ($r = .27, p < .05$) and Divergence was negatively correlated with self-reported use of EBP ($r = -.25, p < .05$). Respondents were also asked if they treat PTSD and obsessive-compulsive disorder and which therapies they use for these diagnoses. Findings suggest that dissemination and implementation of EBPS may be beneficial for UCCS.

Keywords: evidence-based practice, burnout, university counseling, PTSD, OCD

Recent literature highlights what has been referred to as a “crisis” in university counseling centers (UCCS) that are faced with increases in both the amount of work and severity of presenting conditions of students (American Psychological Association [APA], n.d.; Grasgreen, 2012; Novotney, 2014). In The Association of University and College Counseling Center Directors (AUCCCD) Survey (2015) 73.1% of respondents indicated that the severity of mental health problems and related behavior had risen. The AUCCCD Survey has also shown an increasing trend in suicidal ideation and behavior, alcohol abuse and dependence, and self-injury (Grasgreen, 2012). Suicide remains the second leading cause of death for college students and deaths related to substance use ranked in the top five (Turner, Leno, & Keller, 2013). For these reasons, assessment and treatment of at risk students is a major role of UCC clinicians. Grasgreen (2012) highlights the increase in the volume of students with severe

mental health concerns, and expectation that UCC clinicians take on duties in addition to traditional therapy. UCCS are not always able to meet the increased demand for service; 32% of centers report having a wait list and AUCCCD data show that the average number of students on waiting lists increased from 35 to 62 students from 2010 to 2012 (Novotney, 2014). Additionally, Finno, Michalski, Wicherski, and Kohout (2010) reported that the mean annual salary for psychologists in UCCS who had 15 to 19 years of experience was \$69,055. This is notably less than psychologists in other settings with the same amount of experience whose mean salaries were reported as follows: Veterans Affairs (VA) Medical Center psychologists \$92,600, independent practice \$84,891, and group practice \$93,844.

In the last two decades, the role of counseling center professionals has changed from providing support for developmental and identity concerns and problems in everyday living to treating students with psychopathology (Watson, 2013). Therefore, providers who have spent many years working in UCCS and experienced dramatic changes in workload, and clinical severity may now be experiencing burnout. This study aimed to measure the level of burnout in UCC providers and assess potential predictors of burnout. It was hypothesized that perceptions of increased workload and greater severity of presenting conditions would be positively related to clinician burnout. It was also hypothesized that dissatisfaction with salary would be related to burnout.

Evidence-based practice (EPB) is defined by the American Psychological Association (2012) as “the integration of the best

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available research with clinical expertise in the context of patient characteristics, culture and preferences” (see Definitions section, para. 1). It was hypothesized that as UCC providers perceive increasing workload and severity of presenting conditions among students, use of evidence-based practice would be inversely related to burnout. This hypothesis was related to the idea that EBP’s offer short-term effective ways to treat psychopathology and therefore address both increased workload and severity. To examine this, we asked clinicians to provide information about their attitudes toward of evidence-based practice. Respondents were also asked about the work that they do. Although UCCS provide services for students with a wide variety of disorders, it was beyond the scope of this study to ask about all diagnoses treated. Instead, respondents were asked if they treat students who have posttraumatic stress disorder (PTSD) or obsessive–compulsive disorder (OCD) and which treatments they utilized for these diagnoses. The authors chose to focus on PTSD and OCD because there are limited treatments that are indicated as having strong empirical support for these disorders (APA Presidential Task Force on Evidence-Based Practice, 2006). These diagnoses were also chosen because their treatments have been widely disseminated and available to clinicians for several decades (DeAngelis, 2008; Greist & Abramowitz, 2016). Additionally, PTSD and OCD do not typically remit on their own and can become chronic conditions when not treated. This article will elaborate on our methods and findings for the reported level of burnout in UCC providers, and their self-report about treatment of PTSD and OCD, attitudes about evidence-based practice and self-reported use of evidence-based treatment. Limitations of this study and suggestions for future directions will also be provided.

Background

Changes in University Counseling

The first university counseling center was established in 1910 (Bingham, 2015). The Educational Guidance Movement in the United States during the 1930s spurred the growth of UCCS that provided support for students who were often living away from home for the first time. UCCS also provided counseling for students who had developmental concerns appropriate to late adolescence/early adulthood. Other services included career and academic counseling (LaFollette, 2009). In the last several years, UCC clinicians have been tasked to provide services for a changing student population (Watson, 2013).

Burnout

The term *burnout* was first used independently by two individuals, Maslach and Freudenberger, in the 1970s in reference to the experience of social services volunteers (Maslach, Leiter, & Jackson, 2012; Tage, Kristensen, Borritz, & Christensen, 2005). Burnout has been conceptualized by Maslach using three dimensions: emotional exhaustion, depersonalization (or cynicism toward clients), and reduced personal accomplishment (Maslach & Leiter, 2008; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). This model demonstrates that burnout encompasses the realms of both work and personal life. The Maslach Burnout Inventory was introduced to measure the construct of burnout based on this model in 1981 (Maslach & Jackson, 1981). There is a now well-

established relationship between workload and burnout (Maslach & Leiter, 2008). Providers of mental health services in public settings are at risk for burnout, and this risk can be costly for agencies (Paris & Hoge, 2010). Morse et al. (2012) reviewed studies of burnout in mental health providers and found that between 21 and 67% may be experiencing high levels of burnout. Given the dramatic changes in workload and provision of crisis work, UCC clinicians maybe at risk for burnout.

The perception of having too much clinical work to complete was found to be predictive of burnout in a sample of VA mental health providers (Garcia, McGeary, McGeary, Finley, & Peterson, 2014). Predictors of “mental health days taken” in this study included perceptions that there was too much clinical work to finish and that the clinic was not adequately staffed. Similarly, UCC clinicians may share the same perceptions and maybe at risk for burnout.

Burnout can have a deleterious impact on both mental and physical health (Morse et al., 2012). Maslach and Jackson (1981) discuss consequences such as increased substance use and marital problems. It can also result in lowered morale in the workplace and feeling less committed to an organization. Clinicians experiencing burnout may have decreases in empathy. Burnout can also create negative feelings for one’s clients (Holmqvist & Jeanneau, 2006), which can result in worse clinical outcomes and lower quality of care. Burnout can ultimately lead to mental health providers leaving their jobs (Maslach & Leiter, 2008; Paris & Hoge, 2010). Burnout can also lead to other negative consequences for clinical work. For example, absenteeism and job turnover disrupt care. Associated financial impacts on agencies include job searches and training new staff. For UCCS that often have limited budgets, this can be a serious challenge.

Method

Emails containing a link to an online survey were sent to counseling center directors across the country who were listed in the AUC-CCD directory. They were asked to forward the survey request to all providers in their centers. Participants were not asked to provide any personally identifying information about themselves and no incentives were offered to complete the survey. A total of 80 UCC providers completed the survey. They were asked to provide information about the highest degree they earned, role in the counseling center, salary, perceived opportunities for promotion, amount of on-call work, perceived changes in amount of clinical work, and perceived changes in severity of clinical presentations they treat. They were also asked if their centers *Diagnostic and Statistical Manual (DSM)* diagnoses. If their center does diagnose students, they were asked if they treat or refer students with PTSD and OCD. They were also asked to provide a self-report about which types of treatments they use for these disorders.

Measures

Respondents completed the Copenhagen Burnout Inventory (CBI; Kristensen, Borritz, Villadsen, & Christensen, 2005). The CBI is a publicly available instrument that has been widely disseminated to assess burnout in mental health clinicians. The CBI was developed to assess stress related specifically to clinical work and also, stress related to work in general. This is ideal for UCC clinicians whose roles have expanded beyond traditional counseling and include presentations, consultation, and risk assessment

among other duties (Tage et al., 2005). The CBI has three scales: Personal, Work, and Client. The Personal Burnout Scale measures feelings of both physical and emotional exhaustion that have been occurring over a long period of time. The Work Burnout Scale measures both physical and psychological exhaustion related to one's job over a long period of time. The Client Burnout Scale measures both physical and psychological exhaustion related to working with clients. Scale psychometrics for this sample are as follows: Personal ($\alpha = .91$), Work ($\alpha = .89$), and Client ($\alpha = .84$). Each scale has a possible range of 0 to 100. Scores of 50 or above on any scale indicate the potential for burnout in that area.

Respondents were also asked to complete the Evidence-Based Practice Attitudes Scale (EBPAS; Aarons, 2005). The EBPAS is a brief, 15-item scale that has also been widely disseminated. This version of the EBPAS has four scales: Appeal, Requirements, Openness, Divergence, and a total score can also be computed. Scale psychometrics for this study are as follows: Requirements ($\alpha = .91$), Appeal ($\alpha = .82$), Openness ($\alpha = .84$), and Divergence ($\alpha = .56$). Aarons (2005) described each of the domains measured by the EBPAS scales. Appeal can be seen as how attractive different sources of information about EBP are to clinicians. Requirements were described as how likely clinicians are to comply with regulations about using EBP based on the source of these requirements and the individual clinician. Openness is described as a willingness to try new innovations which reflects adaptability and positive attitudes about EPB. Divergence is the perception that current practice is different than new methods and that new methods which are based on research may not be clinically useful. Divergence can create problems with dissemination and implementation of new practices.

Respondents were also asked if their centers use *DSM* diagnoses. If respondents indicated that they do use diagnoses, they were asked if they treat or refer students with PTSD and OCD. They were also asked which types of treatments they use for PTSD and OCD. Finally, respondents were asked if they use evidence-based treatment.

Results

Demographics

Respondents reported their professions as follows: psychiatrist ($n = 1$; 1.30%), psychologist ($n = 35$; 43.8%), social worker ($n = 8$; 10.0%), licensed professional counselor ($n = 23$; 28.7%), psychology intern ($n = 5$; 6.3%), psychology practicum student ($n = 1$; 1.30%), and other ($n = 7$; 8.8%). Other responses are as follows: case manager ($n = 1$), educational counselor ($n = 1$), licensed therapist and art therapist ($n = 1$), LMHC limited permit ($n = 1$), online programs/outreach coordinator ($n = 1$), post-mater's fellow ($n = 1$), psychiatric clinical nurse specialist ($n = 1$). Respondents indicated their highest degree as follows: EdD ($n = 4$; 5.0%), PhD ($n = 24$; 28.7%), PsyD ($n = 13$; 16.3%), MD ($n = 1$; 1.3%), MSW ($n = 8$; 10.0%), BS ($n = 1$; 1.3%), BA ($n = 2$; 2.5%), MA ($n = 14$; 17.5%), MS ($n = 7$; 6.4%), MED ($n = 4$; 3.6%), other ($n = 3$; 2.7%). Other responses are as follows: post-MA certificates ($n = 1$), MA/EdS ($n = 1$), and MSN ($n = 1$). Most, 83.8% of respondents ($n = 67$) indicated that they are licensed in their respective fields and the remaining 16.3% ($n = 11.8$) were not licensed.

There was a wide-range of experience for respondents in this sample ($n = 7$; 8.8%) had worked at a UCC for less than a year ($n = 29$; 36.3%), between 1 and 5 years ($n = 16$; 20.0%), between 6 and 10 years ($n = 8$; 10.0%), between 10 and 15 years, and the remaining ($n = 20$; 25%) over 15 years.

More than half of respondents did not feel that there were opportunities for promotion within their centers ($n = 51$; 63.7%). Over half also felt that their salaries are not adequate for the work that they do ($n = 52$; 65%). More than half also indicated that they do not routinely receive raises ($n = 45$; 56.3%). Nearly a third of respondents indicated that they work at a second job ($n = 25$; 31.6%). Respondents provided information about their annual salaries (see Table 1).

Respondents were also asked to provide information about their work expectations. Over half reported that their jobs require them to be on-call evenings and weekends ($n = 49$; 61.3%). Daytime on-call work was also required by more than half of respondents ($n = 53$; 66.3%).

As expected, when asked how the amount of clinical work that they do has changed, the majority of respondents indicated that it has increased either somewhat ($n = 30$; 38.0%) or dramatically ($n = 35$; 31.8%). Similarly, when asked about change in the level of severity of presenting problems of students they treat, the majority of respondents indicated that they had increased either somewhat ($n = 34$; 43%) or dramatically ($n = 34$; 43%).

Burnout Results

Respondents had a mean of 42.58 on the Personal Burnout Scale (range = 4.17–100; $SD = 20.44$.) In this sample, 19% had a score of 50 or above indicating the potential for burnout in this area. Respondents had a mean of 38.47 on the Work Burnout Scale (range = 3.57–89.29; $SD = 18.14$.) In this sample, 15.2% had a score of 50 or above indicating the potential for burnout in this area. Respondents had a mean of 27.10 on the Client Burnout Scale (range = .00–58.33; $SD = 14.47$.) In this sample, 2.5% of respondents had a score of 50 or above indicating the potential for burnout. See Table 2 for participants' Copenhagen Burnout Inventory scores.

Attitudes Toward Evidence-Based Practice Results

The EBPAS measures attitudes toward evidence-based practice using four scales: Requirements, Appeal, Openness, and Divergence. Scores for this sample are shown in Table 3.

Table 1
Participants' Annual Salaries

Salary range	<i>n</i>	%
<\$30,000	6	7.6
\$30,000–\$40,000	5	6.3
\$40,000–\$50,000	12	15.2
\$50,000–\$60,000	19	24.1
\$60,000–\$70,000	10	12.7
\$70,000–\$80,000	8	7.3
\$80,000–\$90,000	6	7.6
\$90,000–\$100,000	9	11.4
\$100,000–\$110,000	3	3.8
>\$120,000	1	1.3

Table 2
Participants' Burnout Scale Scores

Scale	Range	<i>M</i>	<i>SD</i>
Personal burnout	4.17–100	42.58	20.44
Work burnout	3.57–89.29	38.47	18.14
Client burnout	.00–58.33	27.10	14.47

Respondents were also asked to self-report if they use evidence-based therapies. The great majority of respondents reported that they use evidence-based therapies ($n = 71$; 91%); the remaining ($n = 7$; 9%) responded that they do not use evidence-based therapies.

Burnout Predictors

All of the following were hypothesized to be predictors of burnout: lack of opportunity for promotion, lower salary, working two jobs, weekend and evening on-call work, number of years at one's center, increasing amounts of work, and increasing severity in clinical presentations, endorsing not using evidence based practice. Lower scores on the EBPAS scales that indicate willingness to use evidence-based practice and higher scores on the Divergence Scale were also thought to be potential predictors of burnout.

As predicted, Client Burnout was negatively correlated with self-reported use of evidence-based therapies ($r = -.30$, $p < .001$). Client Burnout was positively correlated with higher scores on the EBPAS Divergence Scale ($r = .27$, $p < .05$). As expected the Divergence Scale of the EBPAS was also negatively correlated with self-reported use of evidence-based therapies ($r = -.25$, $p < .05$). No other scales on the EBPAS were found to correlated with any areas of burnout.

As predicted, years of working in a UCC was positively correlated with client burnout ($r = .25$, $p < .05$). Also as predicted, perceived increases in the severity of clinical presentations of students treated was correlated with each type of burnout: Personal ($r = .33$, $p < .001$), Work ($r = .32$, $p < .001$), and Client ($r = .33$, $p < .001$). Perceived increases in severity were also correlated with length of time working in a UCC ($r = .40$, $p < .001$).

Respondents were asked if their centers use *DSM* diagnoses for students. Over half indicated that their centers do use *DSM* diagnoses ($n = 47$; 60.3%); the remaining ($n = 31$; 28.2%) do not. The 47 respondents whose centers use *DSM* diagnoses were asked if they treat PTSD and OCD or if they refer students who have these conditions. Respondents who provided treatment for these conditions were then ask which treatments they use.

Table 3
Participants' Evidence-Based Practice Attitudes Scale Scores

Scale	Range	<i>M</i>	<i>SD</i>
Requirements	.00–12	7.56	2.86
Appeal	4–16	11.78	2.40
Openness	3–16	8.99	3.07
Divergence	1–13	5.37	2.62

PTSD

Of the 47 respondents who endorsed the use of *DSM* diagnoses, 46 (97.9%) reported that their center provides treatment for students with PTSD. Providers were allowed to choose as many treatments as apply and were also given the option of an "other" response. Results are shown in Table 4.

OCD

Providers indicated a slightly higher tendency for their centers to refer students with OCD to outside providers for treatment ($n = 40$; 85.1%) indicated that their centers treat students with OCD. Providers were then asked if they personally treat OCD and asked to endorse which treatments they use for this condition. Providers were allowed to choose as many treatments as apply and were also given the option of an "other" response. Results are shown in Table 5.

Discussion

University counseling center providers have experienced a great deal of change over the last 2 decades. As students with more severe psychopathology are treated in UCCS, providers are often in roles that require day and evening on-call, and many providers in this sample indicated that there were not routine raises or opportunities for promotion in their current jobs. The majority of respondents also reported that they did not feel that their salaries were adequate for the work that they do and many reported having second jobs. The number of years working in a UCC was positively correlated with client burnout. Perception of one's own practice as being different than research-based practice was correlated with client burnout as was self-reportedly not using evidence based practices.

Notably 28.2% of respondents reported that their centers do not use *DSM* diagnoses. For this reason, it was not possible to ask them what types of therapy they are using for presenting conditions. The remaining participants who endorsed treating clients with PTSD or OCD provided information about which types of therapy they use for these conditions. Nearly all respondents

Table 4
PTSD Treatments Provided by Centers

Response	<i>n</i>	%
I do not treat people with this condition	2	1.8
Acceptance and commitment therapy	14	12.7
Eye movement desensitization and reprocessing	5	4.5
Family systems approach	5	4.5
Prolonged exposure	6	5.5
Cognitive processing therapy	2	1.8
Cognitive-behavioral therapy	37	33.6
Dialectic behavior therapy	16	14.5
Psychoanalytic therapy	4	3.6
Humanistic therapy	25	22.7
Short-term psychodynamic therapy	10	9.1
Interpersonal therapy	14	12.7
Other	7	6.4

Note. Other treatments include art therapy, integrative approach, mindfulness, "psychopharm," relational-cultural, seeking safety, somatic experiencing, support staff, and yoga.

Table 5
OCD Treatments Provided by Centers

Response	<i>n</i>	%
I do not treat people with this condition	4	3.6
Acceptance and commitment therapy	8	7.3
Exposure and response prevention	22	20
Family systems approach	2	1.8
Cognitive therapy	18	16.4
Cognitive-behavioral therapy	30	27.3
Psychoanalytic therapy	4	3.6
Humanistic therapy	11	10
Short-term psychodynamic therapy	5	4.5
Interpersonal therapy	7	6.4
Other	4	3.6

Note. Responses indicated for providers who choose the other option were: Yoga, Mindfulness, Referral to a Psychiatrist, and Referral to Support Staff.

whose centers use *DSM* diagnosis endorsed treating PTSD (97.9%). Although prolonged exposure (PE) and cognitive processing therapy (CPT) are listed as having strong evidence to support their use for PTSD (APA Presidential Task Force on Evidence-Based Practice, 2006), less than 6% of respondents who treat PTSD in this sample endorsed using PE and less than 2% endorsed using CPT. Fewer respondents endorsed treating OCD (85.1%), and of these, 20% indicated that they use Exposure and Response Prevention, which is the therapy that has the largest body of evidence to support its use for OCD (Greist & Abramowitz, 2016).

Given the findings of this study, it stands to reason that UCCS could benefit from providing training for clinical staff in the use of evidence-based practice. Students who seek services at UCCS could benefit from time-limited, evidence-based treatment. Use of EBP could also assist with workload for clinicians as clients have been shown to improve with these treatments which are often time-limited. Burnout among providers in public agencies is costly in terms of time, finances and clinical outcomes.

Limitations and Future Directions

Limitations of this study include using an online survey method to gather the data. Respondents in this study were completely anonymous, and therefore, it is unknown if the respondents are a truly representative sample. Respondents may have been more likely to complete a survey about burnout if they were interested in this topic. Moreover, the time the survey was completed might impact the perception of burnout as it might fluctuate throughout the year for UCC staff. Breaks and summers may not be as busy as the academic year.

Additional limitations include that information about the types of therapy provided were gathered using only self-report. To ascertain if providers are using therapies in a way that is consistent with the models that they report using a study of their model fidelity would need to occur. This was beyond the scope of this study. Data about changes in clinical severity and working condition for UCC providers were all also self-report. It is noted that this study is about perceived changes. This is similar to other studies about burnout which have also focused on perceived working

conditions (Garcia et al., 2014). Additional research comparing perceived to actual changes would be valuable.

This study only asked about treatment for two disorders OCD and PTSD. Reporting on all disorders that clinicians in UCCS treat would have created a response burden on participants and been beyond the scope of this article. Additional research examining use of empirically supported therapies for other disorders in UCCS would be beneficial.

Additionally, this study did not examine UCC providers having increased administrative duties or lack of administrative support. As UCC clinicians are employed in university settings and often have duties outside of traditional counseling, an examination of the impact of these responsibilities on burnout would be helpful. Finally, an examination of self-care practices of UCC clinicians could also offer valuable information about burnout. A study of the promotion of self-care by UCCS could also provide helpful information.

At this time, research about the use of evidence-based therapies in UCC settings is scarce. Cooper (2005) authored a text highlighting potential uses of evidence-based therapies in UCC. Research is needed to demonstrate the effectiveness of evidence-based care in UCC settings. Future studies examining how provider attitudes toward evidence-based practice impact their implementation in UCCS would also be helpful.

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