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Emotional and Spiritual Well-Being as Predictors of Burnout Among Doctoral Clinical Psychology Trainees

Garret L. Blankenship

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by

Garret L. Blankenship

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Garret L. Blankenship

George Fox University

Signature:

Marie-Christine Goodworth, PhD,
Chair

Members:

Rodger Bufford, PhD

Date: 2·4·19

Author Note

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Garret L. Blankenship

Graduate School of Clinical Psychology

George Fox University

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Abstract

It has been observed in prior studies that student spiritual engagement and attribution tends to decline throughout graduate clinical training in psychology (Eisele, 2016; Fisk et al., 2013). This is problematic considering the inverse relationship between spirituality and stress (Calicchia & Graham, 2006) and the protection it provides against burnout. Also protective against burnout, and correlated with spirituality, is Emotional Intelligence (EI; Kaur, Sambasivan, & Kumar, 2013). Both EI and spirituality are related to lower burnout, less depression, and greater life-satisfaction (Kroska et al., 2017). Despite burnout being a common experience for graduate students in medical school (Amir, Kumari, Olivetta, & Mansoor, 2018; Kroska et al., 2017), few studies have considered possible underlying risk or protective factors against burnout among graduate students. This study evaluated the possible roles EI and spirituality may play in student burnout in 76 doctoral clinical psychology students. All but 1 of the 76 students who participated reported experiencing at least some symptoms of burnout over

the course of their studies, though most did not reach a critical risk level. However, students who scored higher on both measures of EI and spirituality reported lower than average levels of burnout symptoms. EI had a large effect size in predicting group membership, while spirituality had a moderate effect size in predicting group membership. The two groups differed significantly in degree of burnout symptoms. Other studies' findings that spirituality was lower in more advanced cohorts than in lower cohorts (Eisele, 2016; Fisk et al., 2013) were not replicated in this study; rather scores were significantly higher for more advanced cohorts, raising the possibility that prior studies may have found cohort differences rather than developmental changes. This study's findings suggest that graduate clinical training programs may wish to increase their focus on enhancing student EI and spirituality as a way to improve clinical training, decrease student burnout, and minimize deleterious student training experiences.

Keywords: spirituality, emotional intelligence, student well-being, graduate clinical training, burnout, doctoral clinical psychology students

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Chapter 1

Introduction

Engaging in a doctoral program requires significant commitment, perseverance, and personal sacrifice to be successful. That sacrifice may take the form of money, social time, sleep, or recreation, relational stress with significant others, and the compounding cost of biopsychological stress. The nature of graduate educational stressors requires students to have sufficient cognitive and emotional coping abilities to navigate and thrive during this demanding process. In addition, doctoral psychology students experience vicarious trauma while providing therapy in clinical practicums. Though trauma is known to stunt developmental growth in the general population (Lamothe, 1999), PsyD/PhD students are expected to engage in intentional developmental growth (i.e., personal therapy, receiving supervision, writing reflection papers, etc.). Spirituality is one of the strongest factors of resilience and provides protection against burnout related to traumatic and normal stress (Brown, 2015). Yet, in a prior studies, more advanced students in doctoral clinical psychology programs reported lower levels of spirituality and spiritual well-being (Fisk et al., 2013). However, their results were not replicated in a second sample.

Spiritual and Emotional Well-Being During Doctoral Education

While spirituality is considered among the strongest factors of resilience (Brown, 2010; Brown, 2015), Emotional Intelligence (EI) is similarly among the strongest predictors of life success (Lanciano & Curci, 2014). EI and spirituality are also predictive factors for positive

treatment outcomes in trauma survivors (Seagraves, 2001). This is possibly related to higher levels of EI being integral in navigating the psychosocial stressors inherent in developmental processes, which are more complex for trauma survivors. The doctoral education process for clinical psychology students is essentially developmental in nature. If clinical psychology students are expected to model healthy behavior for their patients, then in addition to developing knowledge and skills students must also address their own personal development. Graduate students in general have been observed to have higher than average rates of burnout (Hyun, Quinn, Madon, & Lustig, 2006), and risk of developing a mental health disorder increases with the age of the graduate student (Clarke, 2018; Garcia-Williams, Moffitt, & Kaslow, 2014). This decrease in mental, interpersonal, physical, and spiritual functioning (Calicchia & Graham, 2006) is problematic considering that a strong patient-therapist alliance (Ahn & Wampold, 2001) and the emotional intelligence (Kaelber & Schwartz, 2014; Kaplowitz, Safran, & Muran, 2011) of the clinician are two strong predictors of treatment outcomes (Ahn & Wampold, 2001; Wampold, 2001). Increasing the importance of this dilemma is that emotional intelligence and spirituality appear to be positively associated (Lee Flores, Green, Duncan, & Carmody-Bubb, 2013).

Emotional Intelligence

Emotional Intelligence (EI) has historically been a controversial subject due to disagreements over theoretical models. The most widely used and best empirically supported model of EI is the four-branch model of EI (Fan, Jackson, Yang, Tang, & Zhang, 2010; Mayer, Salovey, & Caruso, 2012; Salovey, Mayer, Caruso, & Lopes, 2003). Others contend EI is a construct better explained by various aspects of temperament and personality; there is

substantially less evidence to support this model (Fan et al., 2010). The four-branch model, as cited by (Karim & Weisz, 2010), has also been evaluated and normed in multiple cross-cultural validity studies while other models have not. These findings suggest EI is a distinct and definitive set of measurable cognitive abilities that exists on a normal curve regardless of educational experiences or cultural identity (Karim, & Weisz, 2010).

While EI is considered to be a subset of cognitive abilities, it is distinguished from general intelligence by the fact EI is only partially innate (Arn, 2014; Mayer, et al., 2003). EI is greatly dependent upon the intersectionality of life experiences and developmental stages (Arn, 2014; Karim, & Weisz, 2010). Further separating EI from general intelligence, EI can be altered in positive and negative directions through a variety of means (Salovey, 2008). A few things known to influence growth in EI are learning a musical instrument (Habibi, & Damasio, 2014; Morris, et al., 2005), having and developing secure attachments (Arn, 2014), mindfulness practices (Lanciano & Curci, 2014), intrinsically motivated religious activities (Lee Flores et al., 2013), and psychotherapy (Salovey, 2008). Despite EI's ability to be influenced by environmental factors, it is still observed to have a normal score distribution and can be measured using the four-factor model of EI (Carlson, Geisinger, & Jonson, 2014; Salovey et al., 2003).

The four-factor, or ability model, conceptualizes EI as comprised of four individual abilities of Emotion Perception, Emotional Facilitation of Thought, Emotional Understanding, and Emotion Management. Emotion Perception is the ability to accurately identify emotional information from facial expressions, verbal and non-verbal social cues, and situational contexts (Salovey et al., 2003). In addition to identifying emotions in the self and others, Emotion

Perception also is related to aptitude in identifying emotional valence in art, music, and other inanimate objects (Salovey et al., 2003). The Emotion Facilitation of Thought index measures the ability to create, experience, and utilize emotions in problem solving and interpersonal interactions. Emotional Understanding is a person's capacity to accurately comprehend emotional information. This includes understanding what normal transitions between emotional states are, how to blend emotions together, and the function of specific emotions (Salovey et al., 2003). Lastly, Emotion Management is the ability used when modulating the intensity and form of expression of emotion (Salovey et al., 2003). Emotion Management also considers a person's competence in regulating the emotions of others.

Emotional intelligence and mental health outcomes. Mental health and trauma-related disorders accounted for 125.6 billion dollars of economic burden in 2006 and are expected to increase in financial burden in the future (Soni, 2009). EI is a potential key to addressing this growing societal burden. EI has been evidenced as vital for coping and recovering from mental health disorders and trauma (Carlson et al., 2014; Jahangard et al., 2012). Though EI is not a core consideration of psychotherapy, EI tends to increase in patients following administration of traditional talk therapy (Lanciano & Curci, 2014). Significantly, the EI of a mental health provider is also associated with positive treatment outcomes (Kaelber, & Schwartz, 2014; Rieck & Callahan, 2013). Despite significant evidence suggesting the importance of including EI as part of mental health treatments, it is largely an indirectly addressed aspect of patient care and generally not a consideration of clinical training programs.

Spirituality

Psychological studies on spirituality have recently grown in popularity (Hood, Hill, & Spilka, 2018; Paloutzian & Park, 2013). This burgeoning trend in research implicitly asserts spirituality is involved in mental and physical health outcomes; an assertion which now has a good deal of empirical support. Spirituality should not be confused with Religiosity, which are generally considered as separate theoretical constructs (Sodhi, 2014). Spirituality is defined in this study as the intrinsic set of values that guide behaviors and development of beliefs as part of the human drive towards obtaining existential meaning and self-actualization; in other words, spirituality is the aspect of our being that seeks meaning and purpose through connection to something that is larger than ourselves (Osman-Gani, Hashim, & Ismail, 2013). In contrast, religiosity is, colloquially, more concerned with religious behaviors and beliefs and whether they are motivated by intrinsic or extrinsic reasons.

Motivation and spirituality. Extrinsic versus intrinsic motivation is a significant delineation for both spirituality and religiosity. Higher scores on intrinsic spirituality measures are correlated with better mental and physical health, higher quality of life, and more secure relationships (Kaur, Sambasivan, & Kumar, 2013; Sodhi, 2014). Individuals who score higher on extrinsic religiosity and lower on intrinsic spirituality tend to exhibit less helpful thinking styles, have higher levels of emotional distress, social isolation, and poorer health behaviors (Sodhi, 2014). Additionally, extrinsic religiosity has been inversely correlated to EI, though the correlation was small (Liu, 2010). As cited by Cook, Kimball, Leonard, and Boyatzis (2014), high scorers on intrinsic and extrinsic religiosity and internal spirituality tend to receive the benefits of intrinsic spirituality without incurring the negative effects of high religiosity. Those

who have both internal and external motivations for religiosity and spirituality tend to have the greatest benefit of all the possible score configurations (Osman-Gani et al., 2013). These differences highlight that it is the motivation of one's behaviors and beliefs that matter far more than what behavior or belief is adopted.

Spirituality and stress. Religiosity and spirituality affect the psychological and physiological response to stress (Calicchia & Graham, 2006; Cook, Kimball, et al., 2014). They also affect how life events are interpreted and understood (Kaur et al., 2013; Seagraves, 2001). Spirituality has been suggested as being among the strongest predictors of shame-resilience and buffers against burnout (Brown, 2015; Kaur et al., 2013). It is unsurprising then that an individual's ability to reframe trauma into a narrative of purpose and meaning – the existential meditative factor of spirituality – has been found to be a significant component of trauma treatment and recovery (Seagraves, 2001). However, as Fisk et al. (2013) has noted, spirituality, awareness of God, religious problem solving, and felt importance of religion or spirituality apparently are all negatively correlated to cohort year; one possible interpretation is that spirituality declined during doctoral training in clinical psychology. This is concerning since spirituality has been associated with higher degrees of empathy; a critical component of successful psychotherapeutic outcomes (Maciak, 2002).

Paradoxically, while spirituality is a buffer against stress, it is also negatively impacted by stress (Calicchia, & Graham, 2006). Considering this paradox, there is likely a mediating variable between spirituality and effects of stress. However, no literature was found that could provide a theoretical model or substantiated hypothesis to suggest how spirituality is both protective against stress and yet also negatively impacted by stress. It is known that individuals

with higher EI are more resistant to burnout associated with prolonged stress (Kaur et al., 2013). One possible explanation is EI may play a role in mediating the negative effects to spiritual vitality associated with prolonged stress. This study seeks to explore whether EI has protective effects for spiritual vitality during periods of prolonged stress.

Student Characteristics and Experiences in Graduate Clinical Psychology Programs

Individuals with diverse backgrounds are enrolled in doctoral programs across the country. The APA does a study on the demographic characteristics of students enrolled in accredited doctoral clinical psychology programs each year. While the study considers 6 different categories of institutions (e.g., Universities, Medical school, etc.), I will focus primarily on the demographics of University settings as that accounts for nearly 80% of doctoral clinical psychology programs and is the educational setting in which this study is being completed.

According to the APA Student Demographics study in 2007, men accounted for 24 - 28% of the student population in all academic settings, while women comprised between 72 and 76 percent dependent upon whether the program was a doctoral or master's program respectively (Cope, Michalski, & Fowler, 2017). This gender gap is important to note as it has been found that females tend to have higher general levels of EI than males (Mayer et al., 2012). In respect to cultural demographics, 7%-8% of students were African American/Black, 9% Hispanic/Latinx, 3%-4% Multi-/bi-racial, 7%-8% Asian/Pacific Islander, <1% American Indian/Alaska Native, and approximately 72% were Caucasian/White (Cope et al., 2017). While some differences in normal scores on measures of EI exist between people residing in different countries, performance tends to be normally distributed and no significant differences in the underlying factor structure of EI has been observed between countries (Karim & Weisz, 2010).

Additionally, EI appears to be unrelated to income level, but does have a positive relationship with a parent's level of education (Holmes, 2008).

Burnout. Burnout is something most people experience in their lifetimes, and it can be caused by many things including work, health problems, social stressors, trauma, and vicarious trauma (Fang, Shi, & Zhang, 2009). Burnout has three basic components: emotional exhaustion, depersonalization, and personal accomplishment (Maslach et al., 1981). Emotional exhaustion may be experienced as general anhedonia or felt as a general inability to experience affect; the mind feels fatigued and unable to process affect. Depersonalization occurs as a way to defend against any additional stressors that could be incurred during interactions with others. It is the experience of feeling detached or unemotional towards others regardless of the emotional valence of the interaction with the other person. The last aspect of burnout, Personal Accomplishment, is an inverse measure of burnout.

Graduate students are significantly more vulnerable than the general population to burnout due to the immense mental and physical demands of graduate course work (May, Seibert, Sanchez-Gonzalez, & Fincham, 2016; Wolfe & Rosenstock, 2017). Lack of sleep and limited exercise in particular have been associated with graduate student burnout risk (Kötter, et al., 2016; Wolfe & Rosenstock, 2017). Problem-focused coping styles, obsessive passion (i.e. passion that is exhibited due to external pressures or secondary intrapersonal gains such as ego inflation) (Saville, Bureau, Eckenrode, & Maley, 2018), and the personality trait of conscientiousness (Buick, 2018) were also found to increase risk of graduate student burnout (Powell, 2018). In a study of 10,000 medical students, students who reported feeling burned out more than a few times a month were significantly more likely to report suicidal ideation, making

perceived major intervention errors, dishonest behaviors, having less altruistic attitudes, and had higher rates of attrition (West, Dyrbye, Satele, Sloan, & Shanafelt, 2012). In practicing licensed surgeons rating higher levels of burnout was associated with a greater number of mistakes and suicidality (West et al., 2012).

Physiological and psychological contributions to burnout. A combination of physiological and psychological factors contribute to the phenomenon of burnout. Physiologically, when burnout occurs the body's autonomic nervous system is no longer able to upregulate arousal to new or continued stressors due to adrenal fatigue (Verhaeghe, Van Den Eede, Van Den Ameele, & Sabbe, 2012). Adrenal fatigue leads to hormonal imbalances, metabolic changes, decreased functioning of critical organs, sleep disruptions, and is associated with cognitive and affective changes (Anderson, 1935; Bast, Supernaw, Lieberman, & Munroe, 1928; Castellani et al., 2002). The cognitive changes are attributed to the Hypothalamic-Pituitary-Adrenal (HPA) axis integration into the autonomic and peripheral nervous system (May et al., 2016; Verhaeghe et al., 2012). This makes stressors like sleep deprivation, social conflict, supervisory conflicts, lack of exercise, and high academic demand more deleterious than normal (Clarke, 2018; Colman et al., 2016; Cook, Arora, Rasinkski, Curlin, & Yoon, 2014). Overtime, burnout reduces the vascular and autonomic nervous system's ability to adapt to even large changes in the mental and physical and mental environment (May et al., 2016). In other words, burnout is not just a set of unpleasant psychological experiences, but the biological exhaustion of the entire somatic organism of which the mind is a part.

Because the HPA axis is linked to the associative, limbic, and mesolimbic neural circuits, relational and biological stressors both cause the same physiological and psychological toll on

holistic human functioning (May et al., 2016). The inclusion of rest, time with family and friends, and other basic self-care elements have been shown to be highly effective in mitigating burnout in graduate students (Clarke, 2018); however, most programs design no free space in their curricula for such activities (Clarke, 2018). Most programs strongly encourage students to engage in non-essential extracurricular enrichment activities which further reduces the amount of time students are able to engage in self-care activities (such as sleep), simultaneously removing a protective factor against burnout and introducing another risk factor (May et al., 2016). These processes place EI (Hall-Sandoval, 2017) and spirituality at risk of harm (Coleman, et al., 2016).

Vicarious trauma and burnout. Vicarious trauma is often underestimated as a stressor, and consequently is perceived as having fewer negative consequences than first-hand trauma or other forms of stress (Hall-Sandoval, 2017). As stated by Hall-Sandoval (2017, p. 10), the hallmark symptom of burnout from vicarious trauma was "disruption of spirituality, loss of existential meaning, and hopelessness." It is unsurprising that burnout has been found to be a direct measure of vicarious trauma (Kadambi & Truscott, 2003). While vicarious trauma, such as that encountered by PsyD/PhD clinical psychology students, has the potential to elicit higher levels of resilience, – consistent with stress inoculation theory, – outcomes of vicarious trauma experiences are largely dependent upon highly contextualized variables (Parker & Henfield, 2012). As already discussed, well-processed previous trauma exposure lowers the experienced stress of future trauma and is found to correlate to higher levels of spiritual maturity (Harris & Leak, 2013). However, another study found that the level of clinical and life experience was one of the top three factors predicting whether someone will experience vicarious trauma (Parker &

Henfield, 2012). The same study suggested that organizational support, time away from work/school and education, and awareness of vicarious trauma all help mitigate negative effects.

Empathy and EI in graduate clinical psychology students. A large focus in graduate clinical training for doctoral psychology students is the development of empathy as a professional competency. In popular public literature (e.g., newspapers, news articles, magazines, etc.) empathy is often used interchangeably with EI; however, researchers who study EI and empathy have distinguished these two related concepts. One particular study compared graduate counseling students in master's programs and found that length of training positively correlated with empathy but not EI and showed a weak moderate correlation of EI and empathy (Kaelber & Schwartz, 2014). It has also been found that having high levels of empathy without correspondingly high EI was associated with neutral to negative therapeutic outcomes and higher than average rates of clinician burnout (Bogs, 2012). Another study followed five cohorts at a medical school and measured levels of burnout and facets of empathy; it found that individuals who rated higher on the empathy scale of "personal distress" (i.e., experiencing biopsychological stress in response to another's stress) burned out at significantly higher rates than medical students who only scored high on "empathic concern" (i.e., feeling another's distress without being distressed themselves; Von Harscher, Desmarais, Dollinger, Grossman, & Aldana, 2018). These findings suggest that empathy alone is not enough, and in fact could be a risky skill to impart to students if other aspects of emotional functioning are not concurrently addressed.

Spirituality in PsyD students. One of the top reasons cited for attending faith based doctoral programs is the inclusion of faith and spirituality as part of professional development or in regard to training in diversity. However, it has been found that many students in faith based

Doctoral clinical psychology programs may actually experience a decline in their spirituality (Fisk et al., 2013). It is unclear whether this is due to normal burnout associated with graduate education, vicarious trauma, or is part of some developmental pattern. Regardless of whether it is caused by the stress of graduate study or the vicarious trauma of clinical experience, a decline in such a vital resilience marker as spirituality is problematic.,

Purpose of this Study

Understanding the contributing factors of burnout during the doctoral education of PsyD/PhD clinical psychology students is complex and all possible sources of variance cannot be addressed in this study. However, the overlap of spirituality and EI *a propos* resilience and their established inverse correlation with burnout make the present study an excellent foundation to begin empirical evaluation. For clinical psychology trainees, EI undergirds everything we do. To no lesser extent spirituality is something we all experience; it is the fabric of what binds all of us together and our ability to find existential meaning in adversity. This study is intended to provide a point of origin for further study in EI, Spirituality, and the prevention of burnout especially as it pertains to the health and development of graduate students and treatment providers in care professions. I assert four hypotheses in support for these goals.

Hypothesis 1: EI, as measured on the BEIS-10, will be positively correlated with scores in spirituality, as measured by the SIBS-R, irrespective of time completed in graduate school or cohort.

Hypothesis 2: Cohort year and spirituality will be inversely associated with EI.

Hypothesis 3: A linear combination of EI and spirituality will predict burnout.

Hypothesis 4: Persons with high EI scores and high spirituality scores will cluster together.

Hypothesis 5: Persons with above average scores in EI and spirituality will cluster with those having lower levels of burnout.

In summary, this study seeks to understand the relationship of doctoral students' EI, spirituality, and burnout. Specifically, this study is designed to elaborate upon currently known contributors to graduate student burnout and evaluate whether EI and spirituality may provide some level protection against burnout. Understanding the relationship these variables have is a step towards establishing ways towards improving doctoral student well-being and clinical training outcomes. Additional aspirations of this study include furthering understanding of emotional intelligence and demonstrating the importance of EI in the doctoral education of clinical psychologists and other mental health professionals.

Chapter 2

Methods

Participants

Seventy-six students provided completed surveys. The survey was sent out to 123 participants; this means the response rate was 62%. Twenty-six participants were male (36.1%) and 46 were female (63.9%). Fifty-three individuals (69.7%) identified as a Caucasian ethnicity (i.e., Russian, European, Ukrainian, and/or Jewish) and 23 participants (31.3%) identified themselves as an ethnicity that is colloquially considered in the United States as a person of color (i.e., Hispanic, Latinx, African/Black/African American, Asian, Pacific Islander, Multi-racial, First Nations, and Middle Eastern). Twelve study participants chose not to disclose their ethnicity. Regarding cohort year, 21 first year students, 13 second year students, 14 third year students, 15 fourth year students, and 16 fifth year/intern students participated in the study. The age of participants ranged from 22 – 49 years of age, with a mean of 28 years of age (*SD* = 5.1) and 12 declined to identify their age.

Materials

Brief Emotional Intelligence Scale - 10 (BEIS-10). The BEIS - 10 (see Appendix A) is a 10-item measure of EI based upon the cognitive abilities model of EI developed by Mayers, Salovey, and Caruso (2012). However, Davies, Lane, Devonport, and Scott (2010) differentiate the four factors used by Mayers et al. (2003) into a five-factor model that combines the constructs of Emotion Perception and Emotion Understanding into a single construct called Emotion Appraisal. Another difference between the BEIS-10 and the Mayer et al. (2003) EI

model is that the Emotion Regulation and Emotion Appraisal factors are each divided into two factors; thus, we have the five factors of Appraisal of Own Emotions, Appraisal of Others' Emotions, Emotion Regulation of Self, Emotion Regulation of Others, and Utilization of Emotions; each is comprised of two items. A composite score based on all 10 items may also be computed and is referred to as mean EI. The BEIS takes an average of 1-2 minutes to complete based on the normative data collected during the testing of approximately 1,100 individuals. The test retest reliability of the BEIS – 10 was reported per item with values between .89 and .96 (Davies et al., 2010). The factorial validity was determined using a Confirmatory Factor Analysis (CFA) and was found to have a CFA of .91 ($p < .05$) (Davies et al., 2010). In this sample, the Cronbach's alpha for the composite score of the BEIS-10 was .67, which was judged as acceptable for inclusion considering this value is slightly higher than the norm population value of .64 (Davies et al., 2010). No index level scores on the BEIS-10 achieved a Cronbach's alpha level meeting minimum rules for inclusion. Thus, only a composite score was utilized for analyses in this study.

Spiritual Involvement and Beliefs Scale – Revised (SIBS – R). The SIBS (see Appendix B) was designed with the intent to be considerate towards individuals of all religious and theological persuasions as a cross culturally valid measure of spirituality (Joshanloo, 2012). The alpha levels for the SIBS were .98, .74, .70, and .51 for core spirituality, existential/spiritual perspective, personal application/humility, and acceptance/insight respectively, with an overall alpha of .93 (Hatch, Burg, Naberhaus & Hellmich, 1998). This high level of reliability is among the reasons for choosing the SIBS over the measures used in the Fisk et al. (2013) or Eisele (2016) studies.

The SIBS-R is a 22-item revised version of the SIBS; each item is rated on a seven-point Likert scale from (1) *Strongly Disagree* to (7) *Strongly Agree*. The SIBS – R measures four aspects of spirituality: external spirituality, internal spirituality, existential (i.e. spiritual perspective), and personal application/humility (Hatch et al., 1998). A combined score is also computed and termed Mean Spirituality.

In a second study, the SIBS – R had an overall Cronbach alpha of .92, and the four factors of the SIBS – R were found to correlate with the four factors of on the original SIBS at the level of .98 (Hatch et al., 2006). Test retest reliability was .93 (Hatch et al., 2006). In pilot testing, mean total scores of 124.8 were found for adults, with scores ranging from 46 – 147 (Hatch et al., 2006), suggesting a significant negative skew. In the present study the 22 items of the SIBS-R achieved a Cronbach's alpha of .88, which is slightly lower than in normative studies. Due to failing to yield statistically significant results, in addition to having a low alpha, acceptance/insight was omitted from results. Alpha levels for the remaining subscales had alphas of .90 and .70 for core spirituality and existential/perspective. Personal Application/Humility had an alpha of .36; it was judged to be acceptable in the study despite the low alpha as it was insignificantly lower than the parent scale (Hatch, 2016). Personal Application/Humility was a two-item scale, which are known to have relatively lower alpha levels. Considering other studies have not had psychometric difficulties with this scale and the initial study established the reliability of the Personal Application/Humility scale (Hatch, 2016) it was judged to be acceptable for inclusion in this study.

One-item Burnout Measure. A one item burnout measure was used to evaluate the degree of burnout present in the sample of doctoral students and primary care physicians (Dolan,

et al., 2015; West, Dyrbye, Sloan, & Shanafelt, 2009). The item used (see item 8 in Appendix C) has been found in studies to generally approximate scores on the Maslach Burnout Inventory (West et al., 2012). The one-item burnout measure used in this study was found to produce comparable statistical conclusions when compared to data obtained from administering the full MBI (West et al., 2012). Additionally, Spearman correlations of the 7 point Likert-type burnout item demonstrated a correlation of .83 with the one-item measure and with the MBI full scale domain of emotional exhaustion (West et al., 2009). Other studies using similar one-item burnout measures have supported their use as an acceptable substitute for when the full MBI cannot be administered (Rohland, Kruse, & Rohrer, 2004; Trockel et al., 2017; West et al., 2012). It is, specifically, strongly correlated with emotional exhaustion (Trockel et al., 2017; West et al., 2012). While reliability and validity information were not available for the 7-point Likert -type version used in this study, the same item when measured on a 5-point Likert-type scale has a specificity of .87 for emotional exhaustion and a test-retest reliability of .82 (Rohland et al., 2004).

Biographical data form. Participants were asked to provide basic demographic information, including age, gender, ethnicity, and class standing. Participants will also be asked questions regarding their perceptions of their spirituality, denominational affiliation, and confidence in their beliefs. For further information see Appendix C.

Procedure

This study was conducted with approval through the George Fox University (GFU) IRB. Students in the GFU Graduate Department of Clinical Psychology were offered an opportunity to participate in this study, which was given by providing a SurveyMonkey link. All participants

were informed of the risks of participating and no form of inducement was used to obtain responses or ensure student participation; all participation was entirely voluntary. Additionally, portions of the SurveyMonkey questionnaire which could potentially marginalize a participant's privacy (i.e., age, ethnicity) were demarcated as optional items.

This study measured the spirituality, emotional intelligence, and degree of burnout among graduate students in the doctoral program of Clinical Psychology at GFU.

Chapter 3

Results

The mean score on the BEIS – 10 across the entire sample was 40.28 (*SD* = 3.64). Sample means, standard deviations, and internal consistencies can be observed in Table 1. EI scores obtained in this study were similar in distribution to the mean EI scores observed in another study looking at the emotional intelligence of counseling interns (*n* = 380*, M* = 41.97, *SD* = 3.83*)* (Testa & Sangganjanavanich, 2016), though significantly lower (*t* (110) = -3.662, *p* < .001*)*. Additionally, the mean EI score observed in this study is slightly higher than an undergraduate normative sample (*n* = 111*, M* = 36.8 *SD* = 7.2) and had less variance. The difference between the sample, graduate, and comparison mean (Balakrishnan & Saklofske, 2015) was statistically significant (*t* (172) = 4.35, *p* < .001; Cohen's *d* = -0.45*)*.

The mean score for the SIBS-R in this sample was 117.63 (*SD* = 10.96). Observable SIBS-R mean scores were slightly higher than the general population norm values. Of note was the mean spiritual scores in this sample appeared lower level than the normative score observed in recovering adult alcoholics (M_{sample} = 117.63, *SD* = 10.96; $M_{alcoholics}$ = 124.80, *SD* not reported), though calculating mean differences was not possible since the standard deviation was not reported for the adult alcoholic sample. Adolescent recovering alcoholics received a mean score of 100 (Hatch, 2017).

Table 1

Descriptive Statistics for the Sample

Measure	Sample Mean(SD)	Coefficient Alpha
BEIS-10	40.28 (3.63)	.67
SIBS-R	117.63 (10.96)	.93
Core Spirituality	82.97 (10.24)	.98
Perspective	22.60 (1.95)	.74
Humility	10.83 (1.79)	.70
Acceptance	5.22 (1.21)	.22
Burnout	3.05 (1.41)	--

Females reported higher burnout than males on the one-item burnout measure. An independent samples t-test was computed and found this difference to be statistically significant (t (73) = -3.24, p = .002). There was a large effect size (g = .77) in the relationship between gender and burnout, suggesting that females in this sample had significantly higher burnout scores than men. It should be noted that the one-item burnout measures loaded more heavily on emotional exhaustion than personal achievement or depersonalization – the latter of which tends to be more frequently reported in males experiencing burnout (Maroco & Bonini, 2012; West et al., 2009).

Out of the 75 respondents who completed the burnout item, 30 (40.0%) reported burnout once a month or less, 24 (3.0%) reported burnout a few times a month, 10 (13.3%) reported burnout symptoms once a week, 12 (16.0%) reported symptoms a few times a week, and 3 (4.0%) reported burnout symptoms every day (See Figure 1). In all, 20.0% reported burnout symptoms at least a few times a week, the critical level suggested in West et al. (2012); among

these, 86.7% were women, though women comprised only 61.5% of the sample. This finding is consistent with the mean difference between male and female participants.

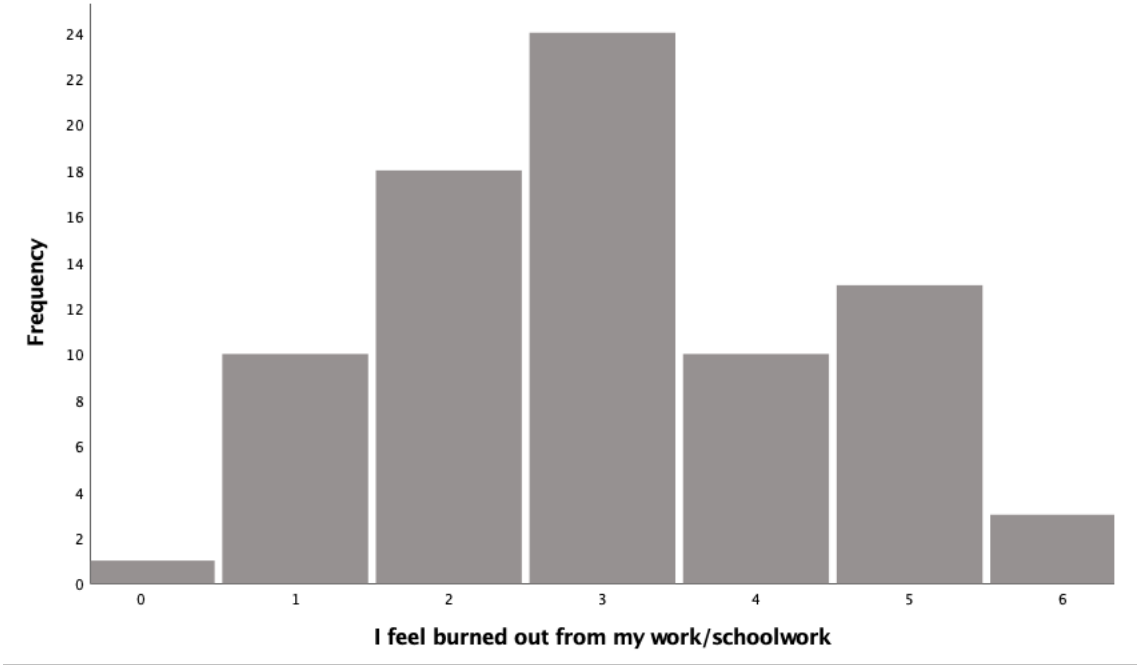

Figure 1. Response rate for each response on the 1-item-burnout measure.

Burnout symptoms were observed to have a statistically significant correlation with female gender ($r(76) = .35$, $p < .001$) and correlated inversely with subjective satisfaction with spiritual wellness and vitality ($r(76) = -.25$, $p < .001$).

Hypothesis 1

Pearson's correlations for the measures with relevant demographic information are listed in Table 2. Because of demographic differences among cohorts, a test of Hypothesis 1 required controlling for gender and cohort effects. To evaluate the relationship between EI and spirituality, a partial correlation was computed which controlled for these.

Table 2

Correlations between test measures and demographic variables

Measure	Female Gender	Person of Color	Cohort/Years in Program	Age
BEIS-10	0.20*	0.16	-0.21*	-0.06
SIBS-R	0.02	0.07	-0.06	-0.09
Core Spirituality	-0.05	0.02	-0.03	-0.11*
Perspective	0.01	-0.07	0.05	0.08
Humility	-0.02	0.07	-0.22**	-0.12
Burnout	0.35**	0.01	-0.06	0.18

*Note: N = 72, p < .05 sig. = *, p < .001 sig. = **, df = 75.*

I observed a significant positive relationship between full scale EI score (BEIS-10) and full-scale score (i.e., mean spirituality) on the SIBS-R (r (75) = .33, p < .05). The effect size (r^2 = .108) for the relationship between the parent scales of BEIS-10 and SIBS-R was moderately strong. Additionally, EI had significant correlations to the SIBS-R indices of humility (r (75) = .41, p = <.001), core spirituality (r (75) = .28, p <. 05), Perspective/Existential (r (75) = .23, p <. 05), and also to subjective self-reported life satisfaction (r (75) = .40, p = .001). These are considered as medium, medium, small-medium, and medium effect sizes respectively.

Hypothesis 2:

Cohort year and spirituality will be inversely associated with EI. No and no. Cohort year was not significantly associated with EI, r = -.06. However, for EI and SIBS-R opposite results was found for with a moderate positive correlation for all SIBS-R subscales (r = .27, .41, .23 and .33) for Core Spirituality, Humility, Perspective/Existential and Mean Spirituality (the total

score). These results suggest no relationship between emotional intelligence and cohort year, and a positive relationship between cohort year and R/S functioning. These findings are inconsistent with Fiske et al. (2013) and Eisele (2016).

Hypothesis 3

A step-wise regression further explored the relationship between EI, SIBS-R, and cohort. The variables in the order in which they were entered were EI and SIBS-R Mean spirituality. EI and Spirituality were observed to have a statistically insignificant inverse relationship with cohort year with a very small effect size ($R^2 = .004$, $F\ (2,75) = .295$, $p = .59$).

Hypothesis 4

A K-means cluster analysis was utilized to explore whether persons with high BEIS-10 and SIBS-R scores clustered together. The SIBS-R Core Spirituality subscale had significant construct overlap ($r = .94$) with and better internal consistency than the composite SIBS-R total score (Mean Spirituality). For these reasons, Core Spirituality was used as the primary measure of spirituality in the cluster analyses. An initial cluster analysis yielded possible one, two, three, and four cluster solutions (See Figure 2). In further forced solutions, a two-cluster solution was observed to be best. In the two cluster solution, EI scores greater than the mean tended to cluster with Core Spirituality SIBS-R scores greater than the mean. The model produced was considered statistically significant ($F_{\text{EI}}\ (2,75) = 52.69$, $p = .001$; $F_{\text{Spirituality}}\ (2,75) = 105.32$, $p = .001$).

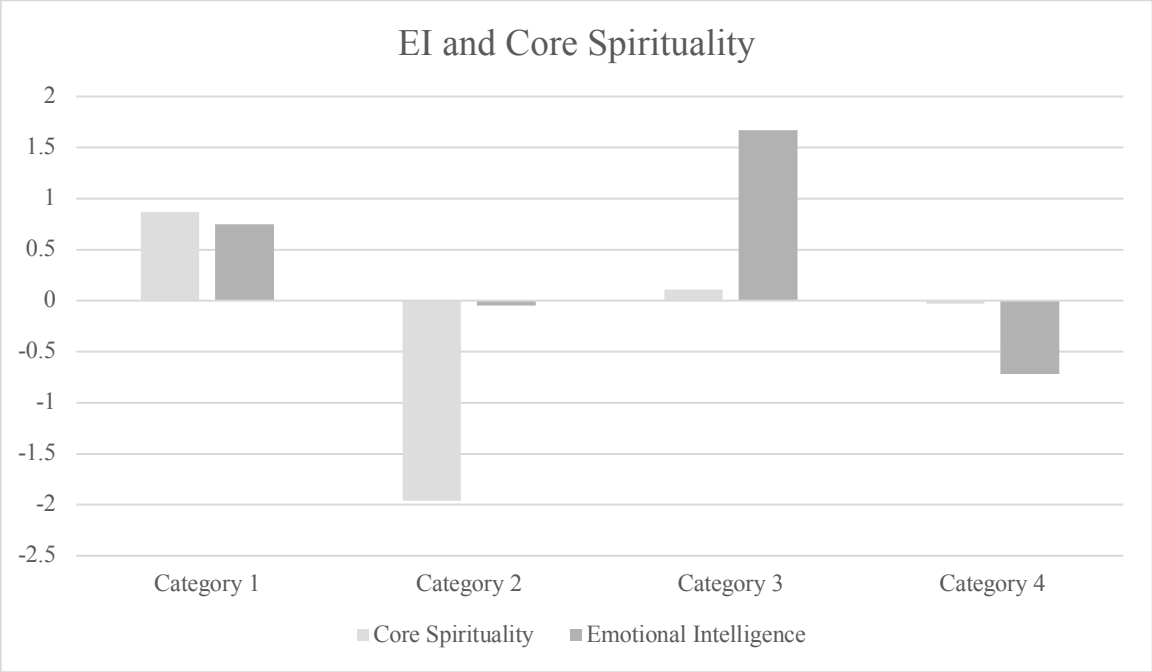

Figure 2. K means cluster analysis of EI and Mean Spirituality.
Note. Values are reported as z-scores.

Hypothesis 5

A second K-means cluster analysis was done to evaluate the relationship of spirituality, emotional intelligence, and burnout. For this analysis SIBS-R, EI, and Burnout scores were converted to z-scores. The standardized scores were then entered into the cluster analysis.

An exploratory two-cluster forced solution was used for this analysis with consideration of the results from the testing of Hypothesis 4. Participants with high levels of Burnout, low EI, and low SIBS-R clustered together (Figure 3). The inverse was also observed; participants with high EI, high SIBS-R, and low Burnout clustered together. The cluster model was found to be statistically significant ($F_{burnout}$ (2,75) = 4.43, $p < .05$; $F_{spirituality}$ (2,75) = 51.31, $p < .001$; F_{EI} (2,75) = 55.44, $p<.001$).

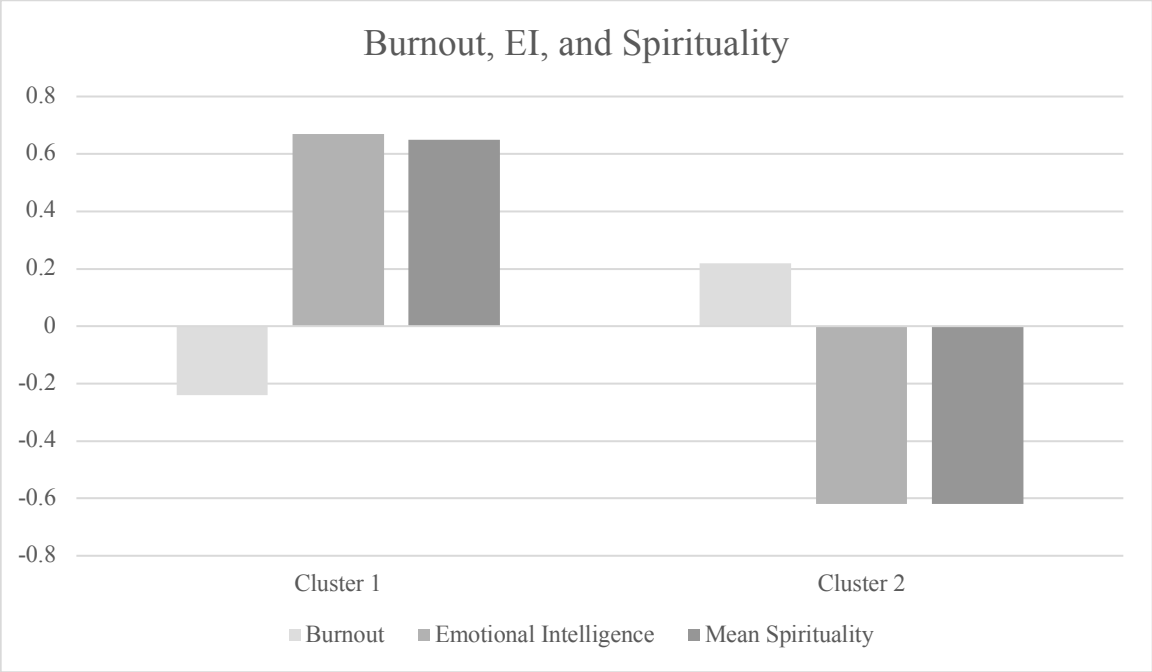

Figure 3. K *means cluster analysis of burnout, EI, and Spirituality scores.*

To further evaluate the relationship between burnout, EI, and spirituality a general linear model was run. The model included these three variables and cohort year as independent variables and the 1 item burnout measure as the dependent variable. The model showed BEIS and SIBS scores were inversely related to burnout scores ($F(75) = 3.89$, $p = .03$), but cohort year did not yield a statistically significant relationship in the regression model. For this reason, cohort was excluded from subsequent analyses.

I completed an ANOVA to evaluate the individual effect sizes of EI, SIBS-R, and Burnout in predicting cluster membership. While in the cluster solutions, high and low burnout appear to cluster separately, degree of burnout had almost no predictive effects in determining cluster membership ($d = -.02$). However, SIBS-R yielded moderate effects in cluster membership ($d = .44$); which means individuals with higher scores on spirituality were more likely to cluster

in Group 1 where individuals tended to score higher on emotional intelligence and lower on Burnout. Emotional Intelligence yielded a large effect size ($d = 0.73$) which suggests that EI is the strongest predictor of cluster membership.

Supplementary Analyses

Cohort differences in SIBS-R. In a post-hoc Pearson correlational analysis, Cohort year was found to have inverse correlation with EI (r (75) = -.21, p <.05) and the Personal Application/Humility subscale of the SIBS-R (r (75) = -.22, p <.001). The rest of the results of the post-hoc analysis can be viewed below in Table 3.

Table 3

Pearson Correlations between EI, Spirituality, Burnout, and Cohort Year

	EI	Mean Spirituality	Core spirituality	Humility	Perspective/ Existential	Burnout	Cohort Year
EI	-						
SIBS-R Mean Spirituality	.33*	-					
Core Spirituality	.27*	.94*	-				
Humility	.41*	.27*	.10	-			
Perspective/Existential	.23*	.40*	.18	.24*	-		
Burnout	-.08	-.08	-.05	-.22*	-.15	-	
Cohort Year	-.21*	-.06	-.08	-.22*	.00	-.06	-

Note: n = 76, df = 75.

The SIBS-R Mean Spirituality score showed only marginally significant differences among cohorts when cohort was treated as categorical data (rather than ordinal) and differences were evaluated using a Kruskal-Wallis test for group differences (χ^2 (4) = 10.63, p = .03). The only significant differences between cohorts was between 1st and 4th year cohorts; the effect size

for the difference in SIBS-R Mean Spirituality scores for these two cohorts was small-medium (r (12,20) = -.24, p <. 05).

Additional measures. In the demographic questionnaire, there were three questions regarding subjective levels of religious knowledge/development, satisfaction with spiritual wellness/vitality, and general life satisfaction. Correlations between these three variables with core test variables yielded several relationships (see Table 4). Self-reported Religious knowledge and development were negatively correlated with humility (r (75) = -.20, p < .001) and positively with SIBS-R Core Spirituality (r (75) = .24, p < .05). The relationship between spiritual vitality and wellness with Burnout (r (75) = -.25, p < .05) and EI's moderately strong relationship with life satisfaction (r (75) = .40, p < .001) were also significant. Satisfaction with spiritual vitality and wellness was somewhat more negatively associated with burnout than life satisfaction. Cohort year was not significantly related to any of these subjective report items. These correlations can all be seen in Table 4 below.

Table 4

Correlation of Research Measures with Likert Style Self-Report Measures.

Item (rated on 7-point Likert scale)	Mean Spirituality	Core Spirituality	Perspective/ Existential	Personal App./Humility	Emotional Intelligence	Burnout
Religious knowledge and development	.17	.24**	-.09	-.20*	-.01	-.04
Current satisfaction in spiritual vitality/wellness	.49**	.50**	.05	.14	.15	-.25*
Present life satisfaction	.22*	.28*	.25**	.01	.40**	-.18^{+}

Note. * = $p \leq .05$, * = $p \leq .001$, $^{+}$ = p = .055.; N = 76, df = 75. Item abbreviations used here, see appendix for actual item wording.

Chapter 4

Discussion

In this sample of doctoral clinical psychology students EI was found to be significantly lower than another sample of graduate level mental health students (Testa & Sangganjanavanich, 2016) and was only slightly higher than an undergraduate student sample (Balakrishnan & Saklofske, 2015). No comparative data could be found regarding scores on the SIBS – R that would allow this sample to be compared to other graduate samples. Available SIBS – R comparison groups were missing data needed to calculate whether observable means differences were significant or not. Observable SIBS – R means differences suggested that this study's sample population performed slightly better than the general population but lower than adult recovering alcoholics (Hatch, 2017).

Results were mixed, supporting Hypotheses 1, 4, and 5, but not Hypotheses 2 and 3. Here we will address the relationship of emotional intelligence and spirituality and the relationship of cohort year to these variables. Then we will examine clusters based on EI and spirituality, clusters involving these two factors and burnout.

Cohort Year and Spirituality

Cohort Year and spirituality did not have the inverse relationship that was hypothesized. Prior studies found that cohort year and spirituality were negatively correlated (Eisle et al., 2015; Fisk et al., 2013). Present findings found that cohort year only accounted for four percent of variance in student EI and spirituality scores in the PsyD students at GFU. However, mean scores

were still below the spirituality mean scores for the general population (Hatch, 2016), though statistical significance between these two means could not be established due to unavailable descriptive statistics on the norm group. One cohort scored an average score that was nearly identical to the mean score of adolescents entering a substance use recovery program (Hatch, 2016).

EI is associated with developmental maturity (Maciak, 2002), relational satisfaction (Arn, 2014), and life success (Bogs, 2012). It is the understood intention of doctoral clinical psychology programs to promulgate the professional and personal development of their students. However, in this study EI was inversely related to cohort year, which suggests that upperclassmen perform lower on EI. The effect size was small and the relationship only accounted for four percent of the variance, though results were significant. EI received equivalent effect sizes regardless of whether cohort year was considered as continuous or categorical data. This may suggest that EI is related to program specific factors and the significance observed is not due to cohort effects. While literature is non-existent regarding EI and doctoral student cohort year, this study's results suggests there may be some overlap.

EI and Spirituality

Prior studies have found that EI and spirituality are strongly correlated (Keshavarzi & Yousefi, 2012). In my results the strongest relationship was between EI and personal application/humility scale; the relationship was moderate in strength. BEIS-10 and SIBS – R composite scores were observed to have a strong direct relationship. This is highly consistent with prior findings studying the relationship of EI and spirituality, which show consistent overlap in construct but also demonstrate divergent validity (Keshavarzi & Yousefi, 2012). However, per

the report of the SIBS-R author, this is the first instance the SIBS-R has been utilized in a study on EI. The findings in this study may suggest that the SIBS-R likely measures similar constructs as other measures of spirituality.

In this study EI had a large effect size in predicting whether someone clustered in a high or low average spirituality cluster. The SIBS-R Personal Application/Humility scale held the strongest relationship with EI and had a small-moderate effect size. This is could be due to intrapersonal reflectiveness, emotional regulation, and perspective taking being constructs shared by both scales (Hatch et al., 1998; Mayer & Salovey, 2004). These three constructs are also reflected in the APA clinical training competencies and are relevant to clinical training goals and outcomes. Thus, EI & humility should be considered as important in the education and training of clinical psychologists.

EI, Spirituality, and Burnout

EI and spirituality have also traditionally been found to be protective factors against burnout (Bogs, 2012; Doolittle, Windish, & Seelig, 2013). Fisk et al. (2013) noted a negative correlation between student spirituality and cohort year, which suggests upperclassmen are more at risk of burnout. In this study, cohort year did not significantly relate to levels of burnout while controlling for age, gender and ethnicity. This suggests other cohort effects, individual factors, or program factors may better explain student burnout than cohort year. No other studies evaluating doctoral student burnout could be found that included cohort year as an independent variable. When EI and spirituality were measured in relation to burnout a significant but very small amount of the variance (8%) was accounted for in degree of burnout. However, EI had a large effect size and spirituality had a moderate effect size in predicting whether an individual would

be clustered in a high or low burnout group. This may suggest that while they explain a small portion of the variance in burnout scores, EI and spirituality are strongly related to other factors which also are protective against burnout. Another explanation for the significant effect sizes despite small variance is the relatively narrow distribution of EI and burnout scores. Other studies have noted moderate to strong relationships between EI and spirituality with burnout (Kaur et al., 2013). Overall, my findings are similar to other experiments looking at EI, spirituality, and burnout and suggests that EI and spirituality are protective against burnout and promote resilience (Doolittle et al., 2013; Kaur et al., 2013).

The SIBS – R personal application/humility scale also had a small-to-moderate inverse relationship with burnout. This finding is consistent with other studies on burnout, life satisfaction, and spirituality (Sodhi, 2014).The moderately strong relationship between EI and personal application/humility has important implications when considered in the context of the small-moderate relationship between burnout and personal/application humility. It may suggest that the construct of personal application/humility holds an important link between EI, spirituality, and burnout.

While there was a gender difference in degree of burnout, there was also significantly more females in this study than males. So, observed differences in burnout rates may not depict actual difference in degree or frequency of burnout between genders and can only be interpreted as a representation of more females than males experiencing burnout. Burnout was not significantly different between white persons and persons of color.

Of particular note with regards to burnout rate was all but one person reported at least some recurring level of burnout. These burnout rates are similar to findings in another study on

graduate clinical psychology students (Zahniser, Rupert, & Dorociak, 2017) and medical students (Kroska, Calarge, O'Hara, Deumic, & Dindo, 2017). This highlights a concern for graduate clinical training programs as they consider the developmental growth of their students.

Implications

EI and spirituality held weak linear correlations to burnout in this study, though EI and spirituality had large and moderate effect sizes in predicting whether an individual would score above or below the mean on the 1-item burnout measure. This indicates significant relationship between EI, Spirituality, and burnout; specifically it suggests that individuals with higher EI and spirituality are more likely to score lower on measures of burnout. While the source of burnout and potential protective factors were only minimally explored in this study, other studies provide possible factors for exploration. Some of sources of burnout noted in other studies have included negative clinical supervisory experiences (Cornér, Löfström, & Pyhältö, 2017), student mistreatment (Cook, et al., 2014a), sleep deprivation (Colman et al., 2016), personality traits (Beduna & Perrone-McGovem, 2016), vicarious traumatization (Kadambi & Truscott, 2003), and poor self-care routines (Zahniser et al., 2017). Student burnout has negative effects on personal and professional development (Lee & Lee, 2018), personal relationships and coping strategies (Lowe, 2002), physical well-being (May, et al., 2016; West et al., 2004), and clinician empathy for patients (Von Harscher et al., 2018). Student burnout has also been correlated with higher rates of suicidality, erroneous clinical decisions, attrition rates, dishonest behavior, and decreased altruistic behavior (West et al., 2012). Burnout has also been found to have significant negative effects on empathy (Von Harscher et al., 2018).

Considering that this and other studies have demonstrated that burnout is something many graduate students experience (Cook, Arora, et al., 2014; Kroska et al., 2017; West et al., 2012) graduate clinical training programs should consider ways to address and reduce student burnout. Clinical training programs should consider how to mitigate effects of vicarious trauma and burnout (e.g., trainings on self-care, maintaining strong social supports, emphasis on processing emotionally difficult clinician-patient interactions, etc.). However, care should be taken to maximize student privacy and consideration given to their dignity and well-being in the development of such policies.

It is problematic that patient attrition rates, but not necessarily treatment outcome, are generally unaffected by clinician burnout (Harvey, 2016). Without apparent external markers of diminished functioning (i.e., patient attrition) it is highly possible for students and clinicians to be unaware of their decreased objectivity and clinical effectiveness placing them at higher risk of malpractice. Burnout's negative relationship with EI could also mean that students' ability to have insight into their own level of functioning is inherently compromised. Doctoral training programs may wish to incorporate protocols that improve identification of students who are becoming burned-out and to implement intervention policies that support and care for students in various states of burnout.

Graduate students in mental health programs experiencing role ambiguity report significantly higher levels of burnout (Powell, 2018). Tolerating and processing ambiguity or uncertainty, especially during life transitions is core to developmental success in advancing from one stage of Fowler's stages of faith to the next (Lownsdale, 1997). In this context, my finding that higher EI and spirituality scores consistently clustered with lower burnout rates could reflect

a developmental process at play. If future studies establish evidence for a developmental basis for differences in EI, spirituality, and burnout, clinical training programs should consider ways to promote successful navigation of the relevant developmental conflicts.

Limitations

While this study represented a decent sample size of 76, results from this convenience sample are limited in generalizability due to all participants being from the same school and the relative homogeneity of certain demographic factors. This may have introduced selection bias into the study. Additionally, the imbalance of gender and ethnicity within the sample may further restrict the application of the study's results where gender and ethnicity are concerned. Variability in the number of students in each cohort, as well as low *n* values for the majority of individual cohorts restricts the statistical power of cohort related analyses. This may cause statistics to over and/or under report different correlations and relationships. While the cross-sectional nature of this study was intended to compensate for the lack of longitudinal data, it may have introduced cohort effects that are not representative of the general population.

Regarding the materials used, the SIBS- R has been normed on a variety of populations and has good psychometric validity. However, the BEIS-10 has a marginal Cronbach's alpha level (.67) and may lack the level of sensitivity necessary to measure smaller degrees of magnitude in EI abilities. This restricts the use of this tool to broadly describe EI and limits utility in discriminating one participant's abilities from another. This lack of instrument sensitivity may cause some relationships to appear weaker than they are.

The one-item burnout measure has limitations related to its brevity and construct validity. While strongly related to emotional exhaustion it is significantly less sensitive to

depersonalization and personal achievement; these scores are both more commonly elevated in men than women (Maroco & Bonini, 2012). This may partially explain the significant gender differences observed in this study. Additionally, the lack of sensitivity to other forms of burnout may cause burnout to appear less prevalent in the sample than in actuality.

An interpretational limitation of this study is the inability to produce a structural model of how each of the variables interact. While EI and spirituality are known factors in resilience and burnout prophylaxis, it would be impetuous to assume they encompass the entirety of these constructs. Some of the variables not included in this study are hobbies, sleep hygiene, temperament, personality traits, and personal values. This is not an exhaustive list, and future researchers of these topics are encouraged to approach variable selection with openness, creativity, and novelty.

Future Directions

Future research should involve the facets of self-care behaviors (especially sleep), developmental stages of faith in relation to spirituality, emotional intelligence, vicarious trauma, resilience, and student mistreatment. While prior research has demonstrated burnout is directly related to vicarious traumatization, burnout's effects on the various components of student well-being are not directly measured here. Though not investigated in this study, vicarious traumatization is known to be deleterious to personal development (Kadambi & Truscott, 2003). Follow-up studies should also include post-graduates in the sample and observe whether the trends observed during graduate clinical training alter in any way.

The creator of the SIBS-R measure used in this study has noted that alcoholics receiving therapeutic interventions have increased levels of spirituality and exhibit more advanced markers

of developmental stages of faith (Hatch, 2016). It is seemingly a paradox that patients would receive healing and growth from interventions that were learned in an educational process that had the opposite effect on the clinicians in training. Future studies may wish to consider the various components of successful substance use treatment programs. Adaptation of relevant components of substance use treatment into doctoral training curricula could have positive effects on the healthy development of graduate mental health trainees.

Another variable unexplored by this study is how attachment styles moderate vicarious trauma's impact on spirituality and EI. Attachment styles are ontologically developmental and teleologically relevant to how a person will experience/interpret an event as vicarious trauma or utilize maladaptive defense strategies to regulate their emotions (Lowe, 2002). Future researchers may wish to account for attachment styles when measuring burnout, EI, and spirituality. Establishment of a relationship between attachment style and these constructs would support a developmental explanation for this study's results. It would also suggest that attachment style should be considered in the evaluation of prospective applicants to mental health profession programs.

One significant risk factor for burnout is sleep deprivation (Bast et al., 1928; Colman et al., 2016). Sleep deprivation is known to have significantly different effects on males than females (Ferrara et al., 2015). Specifically, females display increased egoism and increased tolerance for social inequity following even one night of sleep deprivation (Ferrara et al., 2015). In contrast, Ferrara et al. (2015) noted men tended to make riskier decisions while women tended to be more cautious when sleep deprived. Considering the connection between humility, burnout,

vicarious traumatization, and that the overwhelming majority of psychologists are women, follow-up studies should also consider gender specific issues as moderators of burnout risks.

One significant attachment that all clinical students must navigate is their relationship with their supervisors. This relationship has been tied in previous studies to high levels of student mistreatment, burnout, and negative health outcomes (Corner et al., 2017; Ellis et al., 2014). It is also known that the majority of graduate students (over 64%) will experience significant mistreatment by a faculty member or supervisor during their doctoral training (Cook, Kimball, et al., 2014; Ellis et al., 2014). Conversely, supportive supervisors and faculty are associated with a decrease in risk of vicarious traumatization in studies with medical and doctoral clinical psychology students (Cook, Arora, et al., 2014; Doolittle et al., 2013). Considering the significant role that secure attachment plays in mitigating vicarious trauma and burnout, and also in promoting development of EI and spirituality, future studies should consider the role of strong positive supervisory relationships in preventing EI and spirituality declines in graduate school (Corner et al., 2017).

Something this study did not address directly is the relationship between EI and clinical work. Limited data is available describing how EI of clinicians can affect treatment outcomes; the available data suggests this is a strong positive relationship (Harvey 2016; Kaelber & Schwartz, 2014; Kaplowitz et al., 2011). Clinical training programs should consider pursuing research on how clinician EI impacts patient care. Some possible applications of such research data could be made in the selection process for admissions to doctoral training programs, training goals, and development of EI focused patient interventions.

Conclusion

EI and spirituality were positively correlated with each other. High scores on measures of EI and spirituality were inversely related to burnout. Cohort year was only significantly related to EI. Ultimately, the collective relationships elucidated in this study leave too many gaps to suggest a possible structural model. The present study has provided some evidence to substantiate EI and spirituality as protective factors against burnout. Considering the strong influence environmental factors have on the development of EI and spirituality, training programs should consider ways to foster an environment which nurtures the growth of EI and spirituality. Further research will need to be done to establish other contributing elements to burnout.

Eight days of stress exposure combined with the experience of negative affect has been associated with a significant increase in 5- and 20-year mortality risk (Chiang, Turiano, Mroczek, & Miller, 2018). Doctoral clinical psychology training is 4-7 years in length and, in addition to the stressors of graduate education, students are expected to participate in situations where they will be vulnerable to vicarious trauma on an ongoing basis; a situation colloquially agreed to induce negative affect. Understanding the relationships between EI, spirituality, and burnout is a first step in addressing the ongoing issue of graduate student burnout.

Considering the productivity-centric nature of graduate education, it may be that the emphasis on personal development (i.e., personal therapy, sleep hygiene, emotional intelligence skills development, non-didactic spiritual development, etc.) is more didactic than process and practices. This pattern in and of itself is an eerily similar vignette comparative to the construct of emotional exhaustion or depersonalization (i.e., going through the motions but experiencing none

of it). Perhaps this is part of our solution as well. If the productivity focus of graduate education is related to student burnout– something this study cannot speak to directly– then it is the facet of personal accomplishment that is neglected. Mastery, a highly similar construct to personal accomplishment, has been associated with a decrease in lifetime mortality risk in trauma survivors (Elliot et al., 2018). It stands to reason that one possible solution may be to promote mastery in clinicians by giving them the same interventions that promote health and growth in patients with subsequent didactic work on the underlying theory and process that was used to guide the intervention. Said differently, the personal accomplishment, or mastery, of clinical skills is accomplished through encouraging the personal growth of the clinician.

Finally, addressing student mistreatment by faculty and clinical supervisors will be an important aspect of addressing student burnout. The pluralistic majority of doctoral psychology students will experience mistreatment by faculty and supervisors at least once during their clinical training (Cook, Arora, et al., 2014). Considering the established link between supervisory alliance and student burnout, attrition, and mitigation of vicarious trauma, it will also be important to evaluate aspects of student-instructor dyads to improve student outcomes (Cook, Arora, et al., 2014; Cornér et al., 2017). It may also be useful to provide EI skills training to clinical supervisors and faculty to increase ability in the areas of empathy, self-reflectiveness, emotion regulation, and ability to use emotions constructively.

Considering the negative effects of burnout on personal and professional well – being, including an increased mortality rate (Chiang et al., 2018), the findings of this study underscore the importance of understanding potential protective factors like EI and spirituality. These results also emphasize the importance of investigating and addressing sources of burnout. In addition to

understanding the relationship and individual effects of EI, spirituality, and burnout, developing an understanding of things that promote the growth of EI and spirituality and reduce the risk of burnout, such as self-care activities (Clarke 2018; Colman et al., 2016), will be important in promoting the well-being of doctoral clinical psychology students and other students receiving graduate educations.

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Appendix A

Emotions questionnaire – BEIS 10

A number of statements which people have used to describe themselves are given below. Read each statement and then blacken in the appropriate circle to the right of the statement to indicate how you feel *right now*, that is, *at this moment*. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. I know why my emotions change	1	2	3	4	5
2. I easily recognize my emotions as I experience them	1	2	3	4	5
3. I can tell how people are feeling by listening to the tone of their voice	1	2	3	4	5
4. By looking at their facial expressions, I recognize the emotions people are experiencing	1	2	3	4	5
5. I seek out activities that make me happy	1	2	3	4	5
6. I have control over my emotions	1	2	3	4	5
7. I arrange events others enjoy	1	2	3	4	5
8. I help other people feel better when they are down	1	2	3	4	5
9. When I am in a positive mood, I am able to come up with new ideas	1	2	3	4	5
10. I use good moods to help myself keep trying in the face of obstacles	1	2	3	4	5

Appendix B

Spiritual Involvement and Beliefs Scale – Revised (SIBS-R)
(Hatch RL, Spring H, Ritz L, Burg MA, University of Florida)

How strongly do you agree with the following statements? Please circle your response.

		Strongly Agree	Agree	Mildly Agree	Neutral	Mildly Disagree	Disagree	Strongly Disagree
1.	I set aside time for meditation and/or self-reflection	7	6	5	4	3	2	1
2.	I can find meaning in times of hardship.	7	6	5	4	3	2	1
3.	A person can be fulfilled without pursuing an active spiritual life.	7	6	5	4	3	2	1
4.	I find serenity by accepting things as they are.	7	6	5	4	3	2	1
5.	I have a relationship with someone I can turn to for spiritual guidance.	7	6	5	4	3	2	1
6.	Prayers do not really change what happens.	7	6	5	4	3	2	1
7.	In times of despair, I can find little reason to hope.	7	6	5	4	3	2	1
8.	I have a personal relationship with a power greater than myself.	7	6	5	4	3	2	1
9.	I have had a spiritual experience that greatly changed my life.	7	6	5	4	3	2	1
10.	When I help others, I expect nothing in return.	7	6	5	4	3	2	1
11.	I don't take time to appreciate nature.	7	6	5	4	3	2	1
12.	I have joy in my life because of my spirituality.	7	6	5	4	3	2	1
13.	My relationship with a higher power helps me love others more completely.	7	6	5	4	3	2	1
14.	Spiritual writings enrich my life.	7	6	5	4	3	2	1
15.	I have experienced healing after prayer.	7	6	5	4	3	2	1

		Strongly Agree	Agree	Mildly Agree	Neutral	Mildly Disagree	Disagree	Strongly Disagree
16.	My spiritual understanding continues to grow.	7	6	5	4	3	2	1
17.	I focus on what needs to be changed in me, not on what needs to be changed in others.	7	6	5	4	3	2	1
18.	In difficult times, I am still grateful.	7	6	5	4	3	2	1
19.	I have been through a time of suffering that led to spiritual growth.	7	6	5	4	3	2	1
20.	I solve my problems without using spiritual resources.	7	6	5	4	3	2	1
21.	I examine my actions to see if they reflect my values.	7	6	5	4	3	2	1

22. How spiritual a person do you consider yourself? (with "7" being the most spiritual)

7 6 5 4 3 2 1

Scoring instructions:

Reverse score all **negatively** worded items (3,6,7,11,20)

i.e. Strongly Agree = 1, Agree = 2, ….. Strongly Disagree = 7
or Always = 1, Almost Always = 2, ….. Never = 7

For all other items, the score is the number circled by the subject.

Appendix C

Biographical Data Form[1]

BACKGROUND INFORMATION
***=Required**

1. What is your age in years as of your most recent birthday? (Optional)
_____ Years

2. Gender (Optional):
_____ Male
_____ Female
_____ Other

3. Ethnic Background (Optional)

_____ Asian American (Specify: _____)
_____ Black/African American
_____ European Heritage (Specify:_____)
_____ Jewish
_____ Russian
_____ Ukrainian
_____ Hispanic
_____ Latina/o
_____ First Nations/Native American (Specify: _____)
_____ Not Listed (Specify: _____)
_____ Choose not to disclose

4. Class Standing*

_____ 1st year cohort

_____ 2nd year cohort

_____ 3rd year cohort

_____ 4th year cohort

_____ 5th year cohort

5. How would you describe your current religious knowledge and development? (Optional)

Limited; would need help from others — Extensive; able to help and instruct others

1 2 3 4 5 6 7

6. To what degree are you satisfied with your life at the present time? (Optional)

Not at all satisfied — Completely satisfied

1 2 3 4 5 6 7

7. How would you describe your current spiritual vitality/wellness/fulfillment? (Optional)

Very immature; — Very Mature

1 2 3 4 5 6 7 N/A

8. I feel burned out from my work/schoolwork

0 Never

1 A few times a year or less

2 Once a month or less

3 A few times a month

4 Once a week

5 A few times a week

6 Everyday

[1] Biographical data form is a revised version of a form created by Dr. Rodger Bufford; revisions made by the author.

Appendix D

Curriculum Vitae

Current Placement

Options in Psychology – Private Group Practice **August 2018 – Present**

- Group private practice in a highly remote rural setting.
- I provide comprehensive evaluation services including neuropsychological assessments, diagnostic interviews, forensic evaluations, flight clearance evaluations, substance use evaluations, probationary/court-ordered assessments, and general comprehensive psychological assessments to all ages.
- I specialize in the treatment of trauma disorders, substance use disorders, co-morbid health/medical disorders, family therapy, personality disorders, and neurodevelopmental disorders. I am highly collaborative and provide frequent consultation to medical, school, probation, legal, and mental health professionals.
- **Hours worked per week: 40-60**

Nebraska Psychological Association – Board Member **January 2020 – Present**

- I am an elected board member for the Nebraska State Psychological Association. My duties include reviewing and monitoring legislative initiatives and documents as they pertain to the practice of clinical psychology.
- I am responsible for helping to organize and lead training events and initiatives focused on helping the growth and development of early career psychologists.

Educational Background

George Fox University – APA Accredited

- *Doctorate in Clinical Psychology – PsyD* **July 2019**
- *Master of Arts in Clinical Psychology* **May 2016**

University of Texas at Arlington **Class of 2012**

- *B.A. Biology – Cum Laude*

Clinical Training

Post-Doctoral Fellowship

Options in Psychology **September 2019 – September 2020**

- A group private practice in a rural setting.
- I provide clinical psychology services including individual therapy, play therapy, family therapy,

- I conduct neuropsychological assessment, forensic assessment, comprehensive psychological evaluations, and occupational evaluations.
- Conduct clinical and practice related research.
- I provide consultation with probation officers, school administrators and teachers, medical professionals, and legal professionals.
- **Hours worked per week: 40-60**
  - **Notable Achievements:**
    - Conducted outcomes research and compiled a profile of the demographic and clinical populations served by the clinic over a 3-year period. Results were used to improve marketing, adapt trainings provided to clinicians, and used to push providers towards incorporating the use of outcome measures.
    - Created multiple report templates used and adapted by other providers at the clinic which have shortened psychological report turnaround time by several weeks without compromising the integrity or quality of the report.
    - Helped foster a stronger relationship between the clinic and the district probation office.

Doctoral Internship (APA Accredited)

High Plains Psychology Internship Consortium **2018-2019**

- *Primary Rotation*: Options in Psychology – Private practice, in affiliation with University of Northern Colorado.
- *Secondary Rotation*: Western Nebraska Behavioral Health Integrated Care Clinics in affiliation with University of Nebraska Medical College. Worked as an integrated healthcare psychologist.
- **Notable Achievements:**
  - Helped develop the online database for clinical resources which interns use to share clinical tools, trainings, and information across multiple sites.
  - Wrote the intern handbook/orientation manual for my primary rotation site.
- **Hours worked per week: 40-50**

Clinical (Pre-Doctoral) Practicum Sites

Kaiser Permanente **2017-2018 Academic Year**

- **Responsibilities:** Provided therapy to individuals with medical, mental health, and substance use disorders at Kaiser Permanente. I also engaged in cognitive, neuropsychological, and therapeutic assessment, interprofessional consultation, peer supervision, and group therapy services. Expected to monitor treatment outcome effectiveness using ACORN data. Additionally, I was the co-facilitator for a dual diagnosis group therapy intervention and DBT skills training group.
- **Interventions Utilized:** Time-Limited Psychodynamic Therapy, Motivational Interviewing, Gestalt Therapy, Solutions Focused Therapy, Psychoeducation, Mindfulness Based Cognitive Therapy, Acceptance and Commitment Therapy (ACT), DBT skills training

- **Notable Achievements:**
  - Best treatment outcome rating of any mental health provider at any of the Kaiser Salem locations as measured by ACORN outcome measures. Outcome rating was higher when considering patient severity level.
  - Completed weekly trainings in neuropsychology, diagnostic interviews, consultation, dementia evaluations, and other health, neuro, and primary care related psychology trainings.
- **Hours Worked Per Week: 20-36**

Northwest ADHD Treatment Center **2016-2017 Academic Year**

- **Responsibilities:** Provided short and long-term psychotherapy services, comprehensive assessment, neuropsychological assessments, ADHD evaluations, engaged in interprofessional consultation with physicians, and gave feedback for assessment results.
- **Interventions Utilized:** Integrated Psychodynamic therapy, Gestalt Therapy, Solution Focused Therapy, Client- Centered Therapy, Interpersonal Therapy, DBT Skills Training, & Psychoeducation.
- **Notable Achievements:**
  - Redesigned the digital assessment referral system which connected providers between different practice locations.
  - Developed multiple report templates which allowed for assessment report turnaround times between 1-7 days for basic neuropsychological evaluations.
  - Helped create a digital tracking and logging system for psychological testing materials to maintain record of the location of each assessment tool.
- **Hours worked per week: 16-20**

North Clackamas School District **2015-2016 Academic Year**

- **Site:** *Alder Creek Middle School* – School Psychology
- **Responsibilities:** To provide educational and comprehensive assessment services, special education evaluations, therapy to students, client consultation, teacher and administrative consultation, crisis intervention, crisis consultation, risk assessments, and implementing systems level interventions.
- **Interventions Utilized:** Client-centered therapy, Solution Focused Therapy, CBT, DBT skills training, Systems Interventions, Psychoeducation, Time-Limited Psychodynamic Therapy, Family Systems Therapy.
- **Hours worked per week: 16-25**
- **Notable Achievements:**
  - Instituted a weekly psychoeducational newsletter for teachers and school administrators. Feedback for the newsletter from teachers to school administrators was so positive that the newsletter became circulated to the entire school district.
  - Streamlined and standardized the referral system so that teachers could seek consultation or make referrals to the school psychologist for treatment before students escalated their behaviors to a level requiring an office referral or other disciplinary actions.

- Created a consultation system that allowed SPED teachers and behavior classroom teachers weekly consultation on managing disruptive classroom behaviors.

Supplemental Clinical Experiences

George Fox Behavioral Health Clinic **Summer 2018**

- Provided neuropsychological and comprehensive assessment services to individuals and families and provided consultation to other doctoral students on their therapy and assessment cases.
- **Hours worked per week: 10-25**

Non-Pareil **June 2015 – August 2016**

- *Portland Prep Academy*
- Psychological Assessment and Consulting Services
- Conducted program evaluations, student outcome evaluations, and to provided psychological services to students who were young adults on the autism spectrum.
- **Hours worked per week: 1-5**

Professional Involvement

Nebraska Psychological Association (NPA) **January 2020- December 2022**

- **Position: Board Member-at-Large**
  - Elected to the state Psychological Association Board for a two-year position as of January 1st, 2020.
- **Responsibilities**: legal advocacy of mental health related issues, state psychology ethics concerns, interaction with senators, review of legal documents, and committee specific duties.
- **Committee Membership (Elected Positions):**
  - **Legislative Committee:** Involved in review and revision of proposed legislative documents, grass-roots efforts, coordinating efforts with senators and government officials, and engaged in political advocacy efforts. Will be participating in the legislative defense of the Prescribing Psychologists bill (LB 817) in the Nebraska legislature in 2020.
  - **Early Career Psychology Committee:** Involved in formation of initiatives and programs aimed at helping early career psychologist in their professional development. Goals include creating and advocating for training programs that help early career psychologists establish themselves as well-rounded clinicians with an awareness of their ability to advocate for their patients through various means including political, consultative, and interprofessional collaboration.

Research and Professional Presentations

Blankenship, G., & Sklyarov, O., 2020 (Nebraska Psychological Association) *A Whole New World of Assessment – Assessment in the Age of Mandatory Telehealth* Webinar given during a Nebraska Psychological Association Webinar series to address challenges encountered as part of the COVID-19 crisis

Blankenship, G., Flachsbart, C., Johnson, B., & Haigh, J., 2016, (George Fox University) *Characteristics That Impede Effective Goal-Setting in Young Adults with ASD* Poster session presented at the 2016 annual Western Psychological Association convention in Long Beach, California

Blankenship, G., Besser, E., Shumway, K., Goodworth, M.C., Marston, A., 2016, (George Fox University) *Music, Mind, and Heart: Novel Approaches to Improving Emotion Regulation* Poster session presented at the 2016 annual Oregon Psychological Association convention in Portland, Oregon

Blankenship, G., & Thomas, M., 2017, (George Fox University) *Mindfulness & Self-Defense: Integration of Mindfulness into Everyday Living* Seminar at Portland Krav Maga Self Defense and Fitness, Milwaukee, Oregon

Blankenship, G., Goodworth, M.C., Bufford, R., & Sklyarov, O. 2019 (George Fox University) *Emotional Intelligence as Protection Against Burnout and Loss of Spirituality in Doctoral Training in Clinical Psychology*, Dissertation, Newberg, Oregon.

Clinical Trainings and Continuing Education

Logsden, L., & Hess, R., (2020 April) *Telehealth in the COVID-19 Environment: Tips for implementing effective supervision, support and training for graduate students and provisionally licensed mental health clinicians*. Nebraska Psychological Association, Webinar.

King, S., (2020, March) *Telehealth in the COVID-19 Environment: What Nebraska Mental Health Practitioners Need to Know Now*

Taube, D. (2019, October) *Sequence IX: Ethics &Risk Management in complex Clinical Conundrums*. Nebraska Psychological Association, Lincoln, NE.

Bernhardt, S. (2019) *Circle of Security Parenting Skills*. Options in Psychology, Scottsbluff, NE.

Wetzl, A. (2019, May) *Innovations in Cognitive Behavioral Therapy for Anxiety and Suicide Prevention*. Nebraska Psychological Association, Lincoln, NE.

Michenbaum, D. (2018, October) *Trauma Processing Treatment Approaches*. Nebraska Psychological Association, Lincoln, NE.

Vogel, M. (2018, March). *Integration and Ekklesia*. Colloquium presentation at George Fox University, Newberg, OR.

Taloyo, C. (2018, February). *The history and application of interpersonal psychotherapy*. Grand Rounds presentation at George Fox University, Newberg, OR.

Sordahl, J. (2017, November). *Telehealth*. Colloquium presentation at George Fox University, Newberg, OR.

Gil-Kashiwabara, E. (2017, October). *Using community based participatory research (CBPR) to promote mental health in American Indian/Alaska Native (AI/AN) children, youth and families*. Grand Rounds presentation at George Fox University, Newberg, OR.

Seegobin, W., Peterson, M., McMinn, M., & Andrews, G. (2017, March). *Difficult dialogues*. Diversity Grand Rounds presentation at George Fox University, Newberg, OR.

Warford, P., & Baltzell, T. (2017, March). *Domestic violence: A coordinated community response*. Grand Rounds presentation at George Fox University, Newberg, OR.

Brown, S. (2017, February). *Native self-actualization: Its assessment and application in therapy*. Colloquium presentation at George Fox University, Newberg, OR.

Bourg, W. (2016, November). *Divorce: An attachment trauma*. Grand Rounds presentation at George Fox University, Newberg, OR.

Kuhnhausen, B. (2016, October). *Sacredness, naming, and healing: Lanterns along the way*. Colloquium presentation at George Fox University, Newberg, OR.

SBIRT (Screening, Brief Intervention, and Reference to Treatment) Training at George Fox University, Newberg, OR. 16 March 2016.

CAMS (Collaborative Assessment and Management of Suicidality) Training at George Fox University, Newberg, OR. 11 March 2016.

Jenkins, S. (2016, March). *Managing with diverse clients*. Diversity Grand Rounds presentation at George Fox University, Newberg, OR.

Hall, T., & Janzen, D. (2016, February). *Neuropsychology: What do we know 15 years after the decade of the brain? and Okay, enough small talk. Let's get down to business!* Colloquium presentation at George Fox University, Newberg, OR.

Mauldin, J. (2015, October). *Let's talk about sex: Sex and sexuality with clinical applications*. Grand Rounds presentation at George Fox University, Newberg, OR.

The State of the Art of Gestalt Therapy – Annual American Association of Gestalt Therapy Conference (2015, October). A Professional Conference in Portland, OR.

Hoffman, M. (2015, September). *Relational psychoanalysis and Christian faith: A heuristic faith*. Colloquium presentation at George Fox University, Newberg, OR.

McRay, B. (2015, February). *Spiritual formation and psychotherapy*. Colloquium presentation at George Fox University, Newberg, OR.

Sammons, M. (2015, February). *Credentialing, banking, the internship Crisis, and other challenges for graduate students in psychology*. Grand Rounds presentation at George Fox University, Newberg, OR.

Dodgen-McGee, D. (2014, November). *Face Time in an Age of Technological Attachment*. Colloqium Presentation at George Fox University, Newberg, OR.

Doty, E. (2014, October). *Understanding & Treating ADHD in Children*. Grand Rounds Presentation at George Fox University, Newberg, OR.

Becker. T, (2014, October). *Learning Disabilities DSM5 – A New Approach*. Grand Rounds Presentation at George Fox University, Newberg, OR.

Extracurricular Trainings

Leadership Training Workshop **September 2017**

- A day long intensive training offered for student leaders by Dr. Deborah Dunn of Westmont University. Awarded signed certificate of completed training as proof of participation.

Focused Mentoring and Supervision in Psychoanalytic/dynamic Psychology **2016-2017**

- Attended weekly case presentation meetings supervised by Nancy Thurston, PsyD, ABPP (Psychoanalysis)

Autism Diagnostic Observation Schedule – 2 Competency Training **Summer 2015**

- Two-day intensive ADOS-2 training that included 2 demonstrations of administration and scoring, 2 practice administration and scoring attempts, 1 competency attempt. Clinical level of competency obtained.

George Fox Graduate Department of Clinical Psychology Involvement

Multicultural Committee - Member **August 2014 – June 2015**

- Part of research sub-committee – lead discussions on current research trends in diversity issues in psychology

Community Worship Planning Committee - Member **Academic Year of 2015**

- Helped to organize and plan monthly community social gatherings

Religion and Spirituality Significant Interest Group – Founder & Leader **Fall 2015**

- **Mission Statement:** Fostering religious awareness and spiritual growth.
- Addressed contemporary issues of religious diversity in clinical psychology.
- Assisted in equipping psychologists in training to be professionally and personally competent in issues of religious and spiritual diversity

Teaching and Supervision Experience

Fourth Year Mentor, George Fox Clinical Team **2017 – 2018**

- Provided clinical supervision and mentoring to second year PsyD students. Oversaw clinical work, provided mentorship, guided professional development of 2nd year student under the supervision of Carlos Taloyo, PhD

Consultation, Education, & Program Evaluation - Teaching Assistant George Fox University **August 2017 – May 2018**

- Responsibilities: Provided mentoring, instruction, and oversight to students conducting projects and completing assigned work in addition to grading assignments and helping with course administration.

Cognitive Assessment - Teaching Assistant George Fox University Dec. 2015 – Dec. 2016

- Responsibilities: Helped teach, grade, and mentor PsyD students in the Cognitive Assessment course at George Fox University

Awards, Achievements, and Distinctions

- Founder of Religion and Spiritual Diversity Committee at George Fox University
- Freshman Honors Scholarship 2008-2012
- SMART Grant 2009-2010
- College of Science Dean's List 2010-2012
- Authored a chapter in a cell physiology textbook on glucose metabolism at the system and cellular level. Reviewed and supervised by Dr. Malgosia Wilk at UT Arlington.
- Conducted research on antibiotic resistant strains of *Staphylococcus aureus* under the direction Dr. Julian Hurdle at UT Arlington.

Hobbies

Running, Krav-maga, chess, rock-climbing, outdoor activities with my fiancé, reading, board games, archery, shooting, gardening, dog training, geocaching, and movies.