
Theses, Dissertations, and Projects

2010

An examination of the relationship between self-compassion and burnout in practicing psychotherapists : a project based upon an independent investigation

Jennifer Ann Thurlow
Smith College

Follow this and additional works at: <https://scholarworks.smith.edu/theses>



Part of the [Social and Behavioral Sciences Commons](#)

Recommended Citation

Thurlow, Jennifer Ann, "An examination of the relationship between self-compassion and burnout in practicing psychotherapists : a project based upon an independent investigation" (2010). Masters Thesis, Smith College, Northampton, MA.

<https://scholarworks.smith.edu/theses/524>

This Masters Thesis has been accepted for inclusion in Theses, Dissertations, and Projects by an authorized administrator of Smith ScholarWorks. For more information, please contact scholarworks@smith.edu.

Jennifer Thurlow
An Examination of
The Relationship
Between Self-compassion
and Burnout in
Practicing Psychotherapists

ABSTRACT

Burnout is particularly a problem among people whose work involves responding to human suffering; therefore, without adequate personal resources to draw from, psychotherapists are especially at risk. Self-compassion is a powerful coping skill, thus therapists may be protected from burnout through the practice. The purpose of this study was to examine how self-compassion is related to burnout in practicing psychotherapists. It was hypothesized that higher total self-compassion scores would be associated with lower scores on the burnout subscales of emotional exhaustion and depersonalization and that higher scores of total self-compassion would be associated with higher scores on the burnout subscale of personal accomplishment.

The participants were 71 practicing psychotherapists who completed an online survey including the Maslach Burnout Inventory, the Self-compassion Scale, and two qualitative questions on coping behaviors. Correlational analyses revealed significant associations between participants' self-compassion and sense of personal accomplishment, and the subscale isolation was associated with emotional exhaustion and depersonalization. Clinicians who were female, had a master's level licensure, and were less experienced also showed significant correlations among burnout and self-compassion. The most popularly used coping mechanisms were connecting with colleagues, personal relationships, slowing down, meditation, breathing, mindfulness,

positive affirmations and healthy distancing. The most effective techniques were personal relationships, exercise, colleagues, slowing down, meditation, breath, mindfulness, and work boundaries. The present study provides evidence that self-compassion practice is related to burnout and supports that future research continue to explore the role of self-compassion in clinicians, as a self-care approach used to foster long-term well-being and resilience.

AN EXAMINATION OF THE RELATIONSHIP BETWEEN SELF-COMPASSION
AND BURNOUT IN PRACTICING PSYCHOTHERAPISTS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Jennifer Thurlow

Smith College School for Social Work

Northampton, Massachusetts 01063

2010

ACKNOWLEDGEMENTS

I would like to thank my thesis advisor, Dr. Mary Beth Averill, for her guidance and feedback. I am also grateful to Christy for a remarkable friendship throughout this experience. Thank you to my family for your unwavering love and encouragement. To Brad, I am so much more appreciative of you than I could ever say. Your support, insight, and helpful perspective made this research possible. Thank you for your immeasurable love and devotion. Finally, I thank Dr. David Ritter for making this all possible.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS.....	iii
LIST OF TABLES	iv
LIST OF FIGURES	vi
CHAPTER	
I INTRODUCTION	1
II LITERATURE REVIEW	5
III METHODOLOGY	42
IV FINDINGS	49
V DISCUSSION.....	76
REFERENCES	103
APPENDICES	
Appendix A: Recruitment Flier.....	112
Appendix B: Demographic Questionnaire.....	113
Appendix C: Self-compassion Survey Instrument.....	114
Appendix D: Maslach Burnout Inventory Human Services Survey	116
Appendix E: Qualitative Questions	117
Appendix F: Suggested Reading	118
Appendix G: Human Subjects Letter of Approval.....	119
Appendix H: Email Sent to Potential Participants	120
Appendix I: Informed Consent	121

LIST OF TABLES

Tables

1. Frequency Distribution by Gender	50
2. Means and Standard Deviations for Age and Years in Practice.....	51
3. Response Frequencies for Age and Years in Practice Demographic Clusters	51
4. Response Frequencies by Ethnicity	52
5. Response Frequencies by License	52
6. Response Frequencies by Setting	53
7. Response Frequencies by Marital Status	53
8. Response Frequencies by Self-compassion Score Category	54
9. Summary of Self-compassion Scores	54
10. Response Frequencies by Burnout Score Category.....	55
11. Summary of Burnout Scores	56
12. Correlations Between Self-compassion and Burnout Measures	57
13. Correlations Between Self-compassion and Burnout Measures in Men and Women.....	60
14. Correlations Between Self-compassion and Burnout Measures by Age Grouping	61
15. Correlations Between Self-compassion and Burnout Measures in Years in Practice.....	62
16. Correlations Between Self-compassion and Burnout Measures by License	64

17. Means and Standard Deviations of Self-compassion and Burnout Scores by License	65
18. Coping Strategies Among Practicing Psychotherapists	68

LIST OF FIGURES

Figures

1. Diagram of Subset Groupings for Identified Coping Strategies 68

CHAPTER 1

INTRODUCTION

The aim of this study was to demonstrate the relationship between self-compassion and burnout in practicing psychotherapists. This study asked the question of how clinicians' levels of self-compassion are related to their levels of job burnout. Burnout is the emotional exhaustion and cynicism that occurs frequently among individuals who work with people in some capacity (Maslach, Jackson, & Leiter, 1996). Burnout often occurs as a result of the interpersonal demands on caregivers by care recipients (Dollard, Dormann, Boyd, Winefield, & Winefield, 2003; Hellman, Morrison, & Abramowitz, 1986; Maslach, Schaufeli, & Leiter, 2001). Burnout has been associated with poor mental and physical health, insomnia, alcohol and drug problems, diminished abilities to perform job functions, deterioration in client care, and job turnover (DePanfilis, 2006; Farber, 1983; Guy, Poelstra, & Stark, 1989; Horner, 1993; Maslach et al., 1996; Raquepaw & Miller, 1989; Sherman & Thelen, 1998; Smith & Moss, 2009; Thoresen, Kaplan, Barsky, Warren, & de Chermont, 2003). Mental health professionals are often required to spend a considerable amount of time in intense involvement with patients struggling with feelings of anger, despair and fear. Solutions to clients' problems are not always obvious or easily achieved, adding ambiguity and frustration. Psychotherapists who work continuously with people in such circumstances often experience chronic stress, become emotionally drained, and are at high risk for burnout (Maslach et al., 2001).

The emergent field of positive psychology leads to a set of potential resources to potentially help mental health practitioners circumvent or minimize burnout. Positive psychology provides a theoretical base in how fostering one's positive self-states and emotions, rather than focusing on one's negative emotions or deficiencies, benefits one's well-being and resilience. When people are happier, more content, and feel they are maximizing their potential, they more easily connect with others, experience joy and find pleasure in their day to day lives (Duckworth, Steen, & Seligman, 2005; Rich, 2001; Seligman, 1998). Positive psychologists believe that by focusing on one's strengths and potential, positive self-states are increased, which builds resilience for individuals to sustain themselves mentally and physically during stressful times (Frederickson, 2001; Lyubomirsky, King, & Diener, 2005).

Based on positive psychology's theory of resilience, the use of self-compassion may be a valuable strategy for increasing a clinician's emotional and psychological well-being, through its resilience enhancing properties, thus buffering against the negative consequences of professional burnout. Empirical studies have shown that self-compassion has been associated with better psychological functioning. Neff (2003a) defined the construct:

Self-compassion entails three basic components: (a) extending kindness and understanding to oneself rather than harsh judgment and self-criticism, (b) common humanity—seeing one's experiences as part of the larger human experience rather than seeing them as separating and isolating, and (c) mindfulness—holding one's painful thoughts and feelings in balanced awareness rather than over-identifying with them. (p. 89)

In other words, self-compassion refers to the ability to accept oneself in spite of one's limitations. Research has shown that self-compassion can be a learned skill (Gilbert

& Irons, 2004; Gilbert & Procter, 2006). Studies have indicated higher levels of psychological health can be created when self-compassion is introduced. For the clinician, the use of self-compassion may be an effective tool for self-soothing and self-care, to avoid the pitfalls of burnout. The practice of self-compassion can be learned and integrated into their lives and work regardless of personal philosophy or professional orientation. Therapists who have buffering agents against the stress of their vocation may be more likely to be happier in their jobs, in their own lives, and be more effective in the clinical setting. While self-compassion has not been studied as a self-care approach against burnout in clinicians, it seems warranted self-compassion's association with positive emotions, well-being and resilience would buffer against the challenges of psychotherapy and the negative states of burnout. Thus, it is reasonable to hypothesize that the presence of self-compassion may be associated with levels of burnout among practicing therapists.

This research used a survey of 71 licensed, practicing psychotherapists in the United States, via email and an online survey. The survey contained two well-known standardized instruments assessing their self-compassion and burnout levels. There were also two open-ended questions to allow the participants to add specifics about what types of coping they used when facing work challenges, and which practices were seen as effective or not effective.

This study explored the relationship between psychotherapists' levels of self-compassion and their levels of burnout. The study aimed to enrich understanding of therapists' self-compassion and the association with the three dimensions of burnout: emotional exhaustion, depersonalization and reduced personal accomplishment in their

work. This thesis explored the hypothesis that burnout, as measured by the three dimensions of the Maslach Burnout Inventory, will vary as a function of level of self-compassion, as measured by Neff's (2003b) Self-compassion Scale. In other words, I sought to demonstrate that higher total self-compassion scores would be associated with lower scores on the burnout subscales of emotional exhaustion and depersonalization and that higher scores of total self-compassion would be associated with higher scores on the burnout subscale of personal accomplishment. I hoped to build on the growing literature on self-compassion and establish the learning of self-compassion as a possible intervention for mental health professionals, by demonstrating a relationship between self-compassion and burnout in mental health practitioners. This study provides insight about the potential protective factors of a practice of self-compassion among therapists in their work context and provides the background necessary to propose interventions aimed at increasing these individuals' quality of work life, and to avoid the perils of job burnout.

This thesis is organized in five chapters. Chapter II reviews the literature pertinent to this thesis. This review will further justify the importance of this study and its implications for clinicians. Chapter III describes the method used to test this study's hypotheses. Chapter IV presents the findings for hypotheses tested. Finally, Chapter V discusses this study's findings in the context of relevant literature, examines the practical implications from these results, and explores suggestions for future research.

CHAPTER II

LITERATURE REVIEW

This chapter begins with a review of the literature on burnout, focusing on how it negatively impacts the mental health profession. Strategies for buffering against the negative consequences are reviewed, with emphasis on person-centered approaches. Positive psychology theory is then discussed, as a base for understanding how individuals who have balanced, positive self-states and emotions are more resilient, have better psychological and physical functioning and increased immunity to stress and life challenges. A review of the growing literature on self-compassion will provide a background on how the practice impacts individual functioning and increases positive self-states that promote resilience, suggesting its potential value in increasing a clinician's emotional and psychological well-being as a strategy for reducing professional burnout.

Burnout

Maslach et al. (2001) conceptualized burnout as a psychological syndrome in response to chronic interpersonal stressors on the job that create overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment. Burnout includes feelings of being overextended, negative, callous, and depleted of one's emotional and physical resources, and having an excessively detached response to various aspects of the job and feelings of incompetence and a lack of achievement and productivity at work. A key aspect of

burnout is increased feelings of emotional exhaustion, where workers feel they are no longer able to give of themselves at a psychological level. Burnout has been expanded to include all occupations, however it was initially conceptualized and researched to reflect the effects of working in human services and people work vocations, such as mental health and human services.

Psychotherapists are especially at risk for increased burnout. There are certain occupational hazards found within the profession that have been shown to increase the prevalence of burnout, including negative client behaviors such as suicidality and aggressiveness, professional and emotional isolation, lack of therapeutic success, and demanding paperwork and administration duties (Farber, 1983; Farber & Heifetz, 1981; Freudenberger, 1990; Hellman et al., 1986; Smith & Moss, 2009).

Burnout has many dangerous consequences for mental health professionals. Burnout impacts the professional and client relationship, decreases job satisfaction, and disrupts personal relationships, increasing psychological distress and harming professional effectiveness (Brookings, Bolton, Brown, & McEvoy, 1985; McCarthy & Frieze, 1999; O'Connor, 2001; Pines & Maslach, 1978; Schulz, Greenley, & Brown, 1995; Shapiro, Astin, Bishop, & Cordova, 2005; Sherman & Thelen, 1998; Stevanovic & Rupert, 2009). The following section will outline how burnout has been shown to negatively impact the mental health profession and the well-being of practitioners.

Burnout Affects the Therapeutic Relationship

Burnout can decrease attention, reduce concentration and reduce a clinician's ability to establish and maintain strong relationships with clients (Guy et al., 1989). Clinicians who are emotionally exhausted, a key component of burnout, can develop a

callous or cynical attitude, leading them to view their clients as deserving of their troubles (Maslach et al., 2001). Burned out clinicians tend to evaluate themselves negatively and criticize themselves harshly in their work with clients and subsequently feel dissatisfied and unhappy with their accomplishments on the job (Maslach et al., 1996).

Investigating how feelings of inadequacy among therapists, an often-overlooked area of research, can negatively impact their work, Thériault and Gazzola (2006) found that therapists' beliefs about their abilities and effectiveness in their role are frequently challenged internally. The researchers found that self-deprecating and critical subjective evaluations of their performances as clinicians were common and personally harmful for the therapist. Therapists also reported that difficult clients increased their feelings of insecurity, which added to their contribution to a lack of stability within the therapeutic relationship, often through countertransference reactions. The findings were collected through a research design consisting of eight semi-structured interviews that tapped into the daily struggles of licensed, practicing psychotherapists with over ten years of experience, currently in full time practice. The researchers used a "theoretical saturation" approach for data analysis (p. 316), where participants continued to be interviewed until no new or relevant data emerged, categories were well developed, and the relationships among themes were well established and validated. Limitations of their study included a qualitative design with a small sample base, limiting the ability to generalize findings, and participant familiarity with the researcher, which may have increased their capacity for disclosure or answers that would help the study.

A study by Farber and Heifetz (1982) with a larger sample size explored burnout and factors that promoted or hindered the therapeutic relationship, through sixty semi-structured interviews with practicing psychotherapists. Results indicated professional satisfaction was achieved through the ability to promote a helpful therapeutic relationship and dissatisfaction stemmed from lack of therapeutic success. Burnout was primarily a consequence of the unreciprocated attentiveness, giving, and responsibility demanded by the therapeutic relationship. The researchers found that therapeutic work was most satisfying and led to less burnout when psychotherapists themselves reported learning and growing while being helpful and involved with their clients. The researchers also discussed how therapists are not encouraged to discuss their failures, fears, and doubts or to express dissatisfaction or boredom with their work, particularly if one's work is judged by society as fascinating and important, as psychotherapy often is, thus contributing to feeling isolated and frustrated.

Glasberg, Eriksson, and Norberg (2007) explored how the demands of the therapeutic relationship often create symptoms of burnout. Their study on healthcare workers revealed that factors associated with the burnout dimension of emotional exhaustion were "having to deaden one's conscience" (p. 392) when working with patients, the stress from lacking sufficient time to provide needed care, work being so emotionally demanding that it influenced home life, and not being able to live up to patients' and others' expectations. Having to lower one's aspirations to provide good care also correlated with higher scores of depersonalization. The researchers found caregivers' abilities to recognize their discomfort and to pay attention to feelings of having a "troubled conscience" (p. 401) were associated with decreased burnout. The researchers

recommended workers need opportunities to reflect on their struggles and that further research was needed to find ways for clinicians to do that. The study outcomes were strengthened by the large sample size and use of multiple inventories to assess burnout, perceptions, stress and resilience. Limitations included a sample that only included Swedish participants and cross-sectional data, making inferences about causality less feasible.

Quality of client care can be affected by clinician burnout. McCarthy and Frieze (1999) found that therapist burnout levels and client perceptions of the quality of their therapy were positively correlated. However, because the results were measured by clients' self-reports, their feelings towards the therapist may have been biased, and their recollections of how and what the therapist did in therapy may not have been accurate.

Söderfeldt, Söderfeldt, and Warg (1995) found mixed results when assessing whether social workers engaged in individual care giving had high burnout levels. The authors conducted a literature search of empirical studies on burnout through Medline, Psychological Abstracts, and Sociological Abstracts, finding only 18 studies that reported higher burnout among social work clinicians, than comparable occupational groups. Only 10 of the reviewed studies measured burnout using standardized instruments and quantitative data, with only two studies finding working with clients correlated with burnout. The researchers concluded that despite the large body of research exploring the concept of burnout, empirical studies did not indicate social workers engaged in client care, on average, suffered excess job burnout. They suggested other causes of stress and organizational factors may lead to burnout and that further systematic investigation was needed. The researchers indicated limitations of their review included small sample sizes

within the studies and that most of the research designs did not account for standardized work situations, with participant work settings ranging from private practice in suburban environments to agencies in large cities.

Organizational Factors

Research has demonstrated that the phenomenon of burnout is related to a wide range of diverse variables, in addition to factors related to working with clients (Ackerley, Burnell, Holder, & Kurdek, 1988; Leiter & Maslach, 2001). The workplace or organizational environment may also play an important role in the development of stress through person-job mismatches, work overload, type of practice setting, value conflicts, low compensation, and lack of control, reward, community, and fairness (Maslach et al., 2001; Rupert & Morgan, 2005). Organizational factors of burnout may be an imbalance of the demands placed on the worker to fulfill their professional obligations and availability of supportive resources. Maslach et al. (1996) provided a conceptual model of burnout that included these workplace factors, where lack of resources such as social supports, coping, skills use, autonomy and involvement in decisions, together with the demands of work overload and personal conflicts, created the psychological symptoms of burnout, with the resulting costs of turnover, absenteeism, physical illness and diminished organizational commitment.

Compassion Fatigue

The literature describes three concepts most frequently associated with the adverse consequences of caring work—burnout, compassion fatigue (secondary traumatic stress), and vicarious traumatization. Compassion fatigue differs from burnout as it occurs with individuals who in the course of working with victims of traumatic events,

themselves fall victim to secondary traumatic stress (STS) reactions brought on by helping or wanting to help a traumatized person (Figley, 1995). Caregivers who work with people who have suffered trauma are subjected to significant stress and are at higher risk of making poor professional judgments than those professionals who do not work with trauma survivors. Figley (2002) defined compassion fatigue:

Compassion fatigue is defined as a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing or reminders of the traumatic events, or persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (p. 1433)

Sprang, Clark, and Whitt-Woosley (2007) researched the relationship between compassion fatigue and mental health providers, finding that therapists with specialized training in trauma work reported higher levels of compassion fatigue than nonspecialists. Collins and Long (2003) conducted a quantitative and qualitative longitudinal study to examine the effects on clinicians of working therapeutically with seriously traumatized people. They measured 13 healthcare workers' compassion fatigue and burnout scores the year after their work in a trauma and recovery team helping people traumatized by the Northern Ireland Omagh bombing on August 15, 1998. Their analysis of the quantitative data indicated that levels of compassion fatigue and burnout in clinicians significantly increased in the year following the event. They also measured compassion satisfaction, the feeling of fulfillment and gratification derived from doing work helping others in need, and found that caregivers with high compassion satisfaction scores were less likely to have high compassion fatigue and burnout scores. The researchers concluded that clinicians who retained a sense of personal fulfillment in helping traumatized clients, may have more resiliency against compassion fatigue and burnout. The results provided

evidence for the argument that not all caregivers succumb to secondary traumatic stress and that there must be a protective mechanism, such as compassion satisfaction, derived from the work of helping others, that helps maintain the caregivers' well-being and the delivery of effective services (Stamm, 2002, p. 107).

In his research on compassion fatigue and psychotherapists' chronic lack of self-care Figley (2002) commented:

It is vital that today's psychotherapist continue to work with empathy and compassion. Yet, there is a cost to this work that is obvious to any one practitioner working with the suffering. As the evidence mounts proving the negative consequences of a lack of self-care and the presence of compassion fatigue, so will the ethical imperative for the suffering practitioner to do something, or something will be done for them. We cannot afford to not attend to the mistakes, misjudgments, and blatant clinical errors of psychotherapists who suffer from compassion fatigue. It is, therefore, up to all of us to elevate these issues to a greater level of awareness in the helping professions. Otherwise we will lose clients and compassionate psychotherapists. (p. 1440)

Person-Centered Prevention Approaches

Burnout is an unpleasant and dysfunctional condition that both mental health professionals and the organizations that employ them would like to change. While the burnout field describes causes or correlates of burnout, less attention has focused on intervention strategies. Greater attention to self-care in the mental health profession is a recurrent theme in the literature (Baker, 2003); however empirically based models of coping strategies remain scarce.

Although there is recognition of organizational level factors and strategies for overcoming and changing workplace stressors, this study will focus on the individual's role in the prevention of burnout. Maslach and Goldberg (1998) noted that there are two main categories of individual prevention strategies—either targeting the person's

relationship to the job, such as changing work patterns and one's relationship to organizational contexts, or focusing on strengthening the person's internal resources, self-care and development of preventive coping skills, thus making one more resilient to the effect of worksite stressors. The goal of intrapersonal strategies is to reduce the impact of work stressors not by changing the stressors themselves, but by changing how the individual responds to them.

Individual coping techniques for mental health professionals discussed in the burnout literature range from social support (personal relationships, supervision), cognition altering approaches (healthy distancing, awareness), behavioral activities (personal therapy, humor, writing, vacations, rest, leisure pursuits) to spiritual practices (meditation, prayer, breathing) and physical care (exercise, nutrition). The following section will focus on individual strategies that emphasize the clinician's inside resources for self-to-self relating and cognitive approaches.

Healthy distancing. The ability to withdraw emotionally when necessary can provide "the self-pacing skill necessary to go deep with another, and most particularly with another who suffers" (Speeth, 1982, p. 156). The ideal of *detached concern* (Lief & Fox, 1963) refers to the ideal of blending compassion with emotional distance. Although the clinician is concerned with the client's well-being and remains caring and sensitive, he or she recognizes that it is necessary to avoid over-involvement and to retain a more detached objectivity, allowing engagement while maintaining healthy boundaries. Clients can often emotionally overwhelm a clinician, triggering difficult emotions and negative thoughts. Therefore, reminding oneself that the stress is inherent in the client and not a reflection of the clinician's skill is a mechanism to maintain emotional balance and to

provide a buffer from the client's problems (Newman, 1997). Kramen-Kahn and Hansen (1998) studied career sustaining behaviors in 208 psychotherapists. Their findings indicated that 68% of respondents stated "maintaining objectivity about clients" (p. 132) was a primary coping mechanism for working with clients. A limitation of the study was that most of those surveyed were Caucasian (92%). Strengths of the study included a stratified random sample by state and inclusion criteria of licensed, full time workers who spent at least 50% of their time with direct client contact.

Self-awareness. Therapist self-awareness is a core element in the management and regulation of one's self as a professional and is one of the factors often associated with therapeutic efficacy. As Baker (2003) stated, "individual psychologists need to stop and look at themselves and notice their behavior and what they are struggling with" (p. 14). Coster and Schwebel (1997) identified self-awareness as the top factor that contributed to psychologists' self-reported ability to function with the stressors of their job. Among 29 self-care items, psychologists were in considerable agreement that they regarded being self-aware and self-monitoring as most important, followed by support from peers, spouses, friends, mentors, therapists, and supervisors, and maintaining one's values and leading a balanced life that included leisure time, vacations and relaxation approaches. While the findings have limited external validity, as all of the participants were from the New Jersey area, a strength of the study was a mixed method research design including both qualitative interviews with 6 well-functioning psychologists as well as quantitative questionnaire responses from 339 randomly selected licensed psychologists. The researchers noted that self-awareness and self-monitoring also enabled

psychologists to recognize the need for assistance beyond that of the peer support and the spouse-others relationships.

Carroll and Gilroy (1999) theorized that therapists who are aware and seek to understand their professional struggles are more likely to believe that a lack of self-care risks harm to their clients, and are therefore more likely to safeguard themselves through a regular practice of self-care behavioral strategies including exercise, meditation, peer supervision, personal time, relaxation, sleep, and good nutrition. In addition, such clinicians are more open to seeking personal therapy. The authors stated that unaware and uncommitted therapists perceive their un-sureness, self-doubt, and confusion in their jobs as personal failures, and do not seek coping resources such as personal therapy.

Positive reappraisal. A cognitive process by which people focus on the good in what is happening or what has happened so that the meaning of a situation is changed in a way that allows the person to experience positive emotion and psychological well-being is called positive reappraisal. Forms of positive reappraisal include actively discovering opportunities for personal growth, perceiving actual personal growth, and seeing how one's own efforts can benefit other people. In a study of end of life caregivers by Moskowitz, Folkman, Collette, and Vittinghoff (1996), positive reappraisal was consistently associated with positive emotions both during care-giving and after the death of a patient. This association remained significant even when other types of coping were statistically controlled. Building on this research, Folkman, Moskowitz, Ozer, and Park (1997) examined how end of life caretakers would consistently create positive events throughout their workdays as a pervasive and significant coping mechanism for working with the dying. They noted caregivers created positive psychological time-outs for

themselves by infusing ordinary events with positive meaning, such as savoring a compliment that was offered or pausing to take notice of nature. Such time-outs provide momentary respite from the ongoing stress.

Meditation. Newsome, Christopher, Dahlen, and Christopher (2006) researched a mindfulness-based stress reduction (MBSR) course among counseling students, which included meditation practices, yoga, and conscious relaxation exercises. Students reported positive physical, emotional, mental, spiritual, and interpersonal changes and substantial effects on their counseling skills and therapeutic relationships. The study's strengths were inclusion of three methods of evaluating the course—a focus group, qualitative reports, and a quantitative course evaluation. Although the results of the study cannot be generalized to other types of mental health professionals beyond student counselors, most students reported intentions of integrating mindfulness practices into their future profession.

Research on the effects of Zen meditation in clinical social workers by Brenner (2009) indicated the practice enhances awareness, acceptance and nurtured a sense of responsibility. Limitations of study were a qualitative design with small sample of ten, and the social workers were all long-term meditators. The objective was to explore the influence of a personal mediation practice on the professional work of clinical social workers through examining if meditation cultivates the therapist's awareness of his or her own feelings, enhancing the clinician's ability to remain in the moment with the client and not be drawn into or possibly project his or her own feelings onto the client. The results of their study indicated meditating clinicians' reporting enhanced abilities to focus on the present moment with a client and reduced tendencies to have preconceived ideas

about the client enter their work. They suggested that further research with larger sample sizes and the inclusion of control groups were warranted. While the limitations of the research design were recognized, the researcher concluded:

The practice of Zen by clinical social workers thereby allows for the development of an authentic presence with the client, in that there is both an increased cognitive flexibility and the ability to be more fully present in the session with the client. (p. 464)

Positive Psychology

The emergent discipline of positive psychology may provide insight for helping professionals about how to mitigate burnout. Positive psychology focuses on the positive aspects of human experience and cultivation of human flourishing, potential, and well-being. The guiding principle of positive psychological theory is the assumption people possess the inner resources necessary for their own emotional well-being, thus they have the capacity to foster their own mental health (Patterson & Joseph, 2007). Well-being has been defined in positive psychology as the presence of positive emotions and a cognitive judgment of satisfaction and fulfillment (Duckworth et al., 2005). Seligman (1998), one of the founders of the positive psychology movement, believed that the good in people and society as whole can be promoted through the science and study of positive emotions and behavior such as compassion, respect, joy, trust, love, empathy and gratitude.

Positive psychology encourages people to maximize their best selves by increasing positive psychological states that promote self-worth and inner-peace, compassion towards self and others, and a sense of purpose and being engaged in life, with the strengths to overcome challenges (Duckworth et al., 2005; Rich, 2001). The experience of frequent positive emotions is often defined in the literature as “happiness”

(Lyubomirsky et al, 2005, p. 806). Positive emotion and happiness have been shown to correlate with desirable outcomes such as greater career success, increased creativity, better relationship functioning, superior coping skills and physical health (Frederickson, 2001; Lyubomirsky et al., 2005; Pressman & Cohen, 2005).

Howell, Kern, and Lyubomirsky (2007) found that subjective accounts of well-being positively impacted health outcomes. After examining objective outcomes from 150 experimental and longitudinal studies with adults, the researchers concluded that when well-being was high, immune system responses and pain tolerance increased.

Similarly, Sin and Lyubomirsky (2009) conducted a meta-analysis of 51 interventions that focused on cultivating positive cognitions and feelings with techniques such as writing gratitude letters, practicing optimistic thinking and self-acceptance, and replaying positive experiences to examine if psychological interventions aimed at increasing positive feelings and cognitions enhanced well-being and decreased depressive symptoms. Data collected from 4,266 individuals showed overwhelming evidence that the positive interventions significantly enhanced well-being and that depressive symptoms were also significantly decreased.

Boehm and Lyubomirsky (2008) analyzed data from cross-sectional, longitudinal and experimental studies regarding positive affect and workplace outcomes. Their results indicated workers who were happier were more satisfied with their jobs, had more favorable perceptions of themselves, were more self-efficacious, performed better on tasks, were more likely to help others, tended to think more flexibly, were less likely to withdraw and have high rates of absenteeism, and were more likely to be employed than

their peers with lower positive affect. The researchers concluded that the happier employees had greater overall workplace success.

Furthermore, workers who experienced positive emotions not only went beyond their required duties at work, but they were more invested and involved in their jobs (George, 1995). The opposite of job involvement, such as burnout, absenteeism, and turnover have been shown to all negatively relate to high positive affect (Thoresen et al., 2003). In other words, happy people show less burnout (Iverson, Olekalns, & Erwin, 1998), less emotional exhaustion (Wright & Cropanzano, 1998), and they are less likely to quit their jobs (Van Katwyk, Fox, Spector, & Kelloway, 2000) than unhappy people. In sum, workers with high positive affect are more engaged in their work and committed to their organization (Thoresen et al., 2003) and do not typically engage in withdrawal behavior as a response to professional challenges.

The research overwhelmingly demonstrates the value of happiness and positive emotions as not only allowing one to feel good but also as valuable public health, social welfare, and career sector investments. Concerned with understanding psychological well-being in its own right, and not simply as the absence of disorder or stress, Folkman and Moskowitz (2003) stated “the focus on positive psychology encourages coping researchers to think more broadly about the nature of coping and the mechanisms through which it helps people sustain themselves mentally and physically during stressful times” (p. 124).

Intentional Activity and the Construal Model of Happiness

According to Lyubormirsky’s model of human happiness (Sheldon & Lyubomirsky, 2004), determinants of happiness and well-being include a genetic set-

point (50%), and one's circumstances such as demographic variables (10%) and intentional activities (40%). Intentional activities are the cognitive efforts such as adopting an optimistic attitude, behavioral practices such as being kind to others, or volitional intentions, such as striving for meaningful goals. Sheldon and Lyubomirsky stated, "intentional activities have the potential to create sustained positive change, because of their more dynamic and varying nature and because of their capacity to produce a steady stream of positive and rich experiences" (p. 9). They stated that circumstances (winning the lottery, getting married or your job) are not as likely to change your happiness level. In other words, investing in how you think or behave, in intentional activities such as cultivating gratitude or kindness, increasing social supports or exercising, are more likely to elevate levels of happiness than objective life circumstances such as whether one is married or an accountant or a city dweller. For clinicians experiencing burnout it seems warranted that choosing intentional coping strategies involving adopting positive attitudes and cognitions would be valuable ways to increase positive states of mind and happiness on the job.

Construal theory further explains the psychological underpinnings of cognitive efforts involved in such intentional efforts, stating that people are actively constantly interpreting and acting on life events, and that happy people respond to events and situations in ways that support positive emotions and self-regard, even when experiencing negative life events (Abbe, Tkach, & Lyubomirsky, 2003). According to Lyubomirsky and Dickerhoof (2010) how people construe and think about objective events and situations in their lives plays an important role in determining how happy they are. Thus, using adaptive strategies to cope with daily experiences and to interpret circumstances in

relatively positive ways raises happiness levels. As the burnout literature shows, clinicians often judge themselves harshly, blame themselves and feel insufficient in meeting client demands. Construal theory suggests that when clinicians feel out of balance, revising internal interpretations of their job stress could bring about greater feelings of happiness and more positive stance towards their work.

Providing a contrasting view, Ehrenreich (2009) stated that positive thinking can lead to self-blame and feeling that one's failures are wholly self-inflicted, creating an unhelpful preoccupation with trying to eliminate negative thoughts. The author theorized that too much emphasis on optimism contributes to an irrational belief that serious obstacles like obesity, relationship problems, poverty and unemployment can be easily overcome, through having the right mindset. She suggested that realism rather than forced optimism is a better approach to life's challenges.

Broaden-and-build Model and The Undoing Effect

Another theory within positive psychology holds that enhancing one's happiness quotient may be the key to resilience (Masten, 2001; Seligman & Pawelski, 2003). According to Fredrickson's (2001) broaden-and-build model of positive emotions, positive emotions function as an antidote and can undo the detrimental effects of negative emotions, helping a person's ability to recover from stressful experiences. The theory holds that experiencing positive emotions broadens people's momentary thought-action repertoires, which builds enduring coping skills (Frederickson, 2006). In other words, personal resources are accrued during states of positive emotion and can be drawn on in subsequent moments and in different emotional states. Frederickson suggested positive emotions are important facilitators of adaptive coping and adjustment to stress and may

underlie the reported beneficial effects of interventions such as mindfulness and relaxation therapies. “Through experiences of positive emotion, then, people transform themselves, becoming more creative, knowledgeable, resilient, socially integrated, and healthy individuals” (p. 90). Thus, the positive affects produced by practicing intentional happiness-enhancing activities as described by Lyubomirsky’s model (2005) of human happiness, compound over time and carry the capacity to mitigate adversity and undo lingering negative emotional arousal. Rather than focusing on disorders, psychopathology, dysfunction, and problems, when people focus on the good things in life and cultivate positive attitudes and happiness, they increase the ratio of positive experiences to negative, building improved coping and emotional well-being, and as a result are more balanced, resilient, successful, and thriving (Duckworth et al., 2005; Radey & Figley, 2007). Thus, it stands to reason that a clinician who consistently strives to cultivate and retain a reserve of positive coping and experiences, would be buffered against future challenging work situations and experiences, and not succumb to the debilitating effects of burnout.

Self-compassion

Self-compassion may be a valuable approach for increasing one’s emotional and psychological well-being, potentially mitigating burnout. Positive psychologists (Abbe et al., 2003) posited that fostering one’s positive self-states and emotions, rather than focusing on one’s negative emotions or deficiencies, provides resilience against life’s challenges. Whereas burnout has a significant negative impact on the physical, psychological and emotional well-being of mental health clinicians, emerging research on self-compassion describes its capability to positively impact the self-states and emotions

of people using these skills. Thus, these positive self-state enhancing properties of self-compassion may be one way to lessen the consequences of burnout among therapists through increasing resilience levels and stronger coping.

The body of literature emerging from Buddhist philosophy and mindfulness-based psychology has been steadily growing. Recognizing Buddhist self-concepts and self-attitudes, Western schools of psychotherapy began to incorporate these teachings into therapeutic practice. Within the last decade, this dialog has expanded into the area of self-compassion. Psychology practitioners questioned how enhancing a sense of self-empathy, radical self-acceptance, kindness and connectedness, along with mindfulness, leads to positive effects on the individual and one's psychological well-being, rather than relying on more Western, egocentric conceptualizations of self-related processes and feelings, like self-esteem.

Neff (2003a) suggested that self-compassion consists of several elements, including a kind and nonjudgmental attitude toward oneself when suffering; recognition that one's experiences are part of the larger, more universal human experience; and the holding of painful thoughts and feelings in balanced awareness, in which they are observed and accepted without judgment, rumination, or self-pity. Three distinct but inter-related components of the construct have been outlined as kindness against self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Neff (2003b) stated:

These aspects of self-compassion are experienced differently and are conceptually distinct, but they also tend to engender one another. For instance, the accepting, detached stance of mindfulness lessens self-judgment. Conversely, if one stops judging and berating oneself long enough to experience a degree of self-kindness, the impact of negative emotional experiences will be lessened, making it easier to

maintain balanced awareness of one's thoughts and emotions. Similarly, realizing that suffering and personal failures are shared with others lessens the degree of blame and harsh judgment placed on oneself, just as a lessening of self-judgment can soften feelings of uniqueness and isolation. (p. 225)

Neff (2003b) argued that self-compassion does not lead to being complacent or passive, or cause one to avoid taking responsibility for one's harmful actions. When feelings of self-compassion are complete and genuine, and one can see their failures clearly without judgment, rather than being ignored or disregarded, the desire for health and well-being gently encourages change when needed and rectifies unproductive patterns of behavior.

The component of self-kindness is the tendency to treat oneself kindly in the face of perceived inadequacy by engaging in self-soothing and positive self-talk. Self-kindness is an ancient Buddhist principal requiring one to first give oneself the love and kindness one would give others. Self-judgment is formed by self-directed criticism and self-loathing, where an individual is unable to give oneself warmth, soothing, reassurance, self-liking, or self-directing. People with high self-compassion do not experience these negative emotions and instead treat themselves with kindness rather than judge or criticize themselves harshly (Neff, 2003a, b; Neff, Hsieh, & Dejittthirat, 2005). In contrast, individuals who criticize and fail to treat themselves kindly find it difficult to get relief (Deniz, Kesici, & Sümer, 2008).

The second component, common humanity, involves recognizing that one's discomfort is an unavoidable part of the human experience—one's perceptions of feeling connected with others rather than isolated. This aspect of self-compassion entails one's tolerance for oneself as well as others, since a sense of common humanity is the essence

of cultural and universal values of justice, equality and tolerance. Feelings of self-judgment often stem from the dimension of isolation and feelings of alienation and disconnection with others (Mongrain, Vettese, Shuster, & Kendal, 1998). Neff (2008) articulated that rather than mere self-love, “people recognize that being imperfect, making mistakes, and encountering difficulties are part of the shared human experience; something that we all go through rather than being something that happens to ‘me’ alone as isolated, separate self” (p. 268).

The last component, mindfulness, involves facing one’s own painful thoughts without avoiding or exaggerating them and managing one’s disappointment and frustration by quelling self-pity and melodrama. Mindfulness is a core value in Buddhist philosophy involving bringing one’s complete attention to the experiences occurring in the present moment, in a sustained nonjudgmental or accepting way (Dimidjian & Linehan, 2003; Kabat-Zinn, 1990). Together, these three qualities encompass one’s self-compassion—the tendency to internalize kindness, remain open and nonjudgmental to one’s experience, and the ability to cultivate soothing thoughts of acceptance and perspective that their experience is part of larger humanity.

Self-compassion and Self-esteem

Research clearly shows that negative self-attitudes are linked to a variety of psychological problems, including attempted suicide and depression (Harter & Marold, 1994; Laufer, 1995). The ability to treat oneself kindly when things go badly without judgment has been shown to promote feelings of well-being, more than self-esteem (Neely, Schallert, Mohammed, Roberts, & Chen, 2009). Neff (2003a) conceptualized self-compassion as distinct from self-esteem in that it is non-evaluative. To believe in

oneself and feel valued by others is related to self-esteem, whereas caring for oneself compassionately has been shown to allow one to be more stable and resilient in the face of adversity. Self-compassion also has a stronger negative association with social comparison, public self-consciousness, self-rumination, anger, and need for cognitive closure. Self-esteem (but not self-compassion) has been found to be positively associated with narcissism (Neff, 2009). Self-esteem stability refers to day-to-day changes in feelings of self-worth, as opposed to trait levels of global self-worth, which tend to remain relatively constant over time. The benefits of self-compassion over self-esteem are explained by Kirkpatrick, Neff, and Rude (2007):

One reason that self-compassion may be more beneficial than self-esteem is that it tends to be available precisely when self-esteem fails. Personal flaws and shortcomings can be approached in a kind and balanced manner that recognizes that imperfection is part of the human condition, even when self-evaluations are negative. This means that self-compassion can lessen feelings of self-loathing without requiring that one adopt an unrealistically positive view of oneself—a major reason why self-esteem enhancement programs often fail. Thus, increasing self-compassion should be an effective and sustainable way to counter chronic self-criticism. (p. 145)

Self-evaluation based on perceived external standards of worth and desired acceptance and approval by others contrasts with the construct of self-compassion, where personal worth is not linked to external, culturally valued goals, but rather is connected with the human community without contingencies, avoiding self-alienation and isolation. When one's sense of worth is based on individual, merit-based accomplishments, self-rejection and shame often result, creating a lack of self-empathy and resulting in a profound sense of separation from others and reduced psychological health.

Benefits of Self-compassion

Research (Kirkpatrick et al., 2007; Neff et al., 2005; Shapiro, Brown, & Biegel, 2007) has shown that self-compassion is associated with life-satisfaction, wisdom, happiness, optimism, curiosity, social connectedness, and emotional resilience. Higher levels of self-compassion are associated with better psychological health and outcomes (Adams & Leary 2007; Gilbert & Procter, 2006; Thompson & Waltz, 2008) and low self-compassion is related to a host of negative psychological issues, such as neuroticism, depressive symptoms, and anxiety.

Research on the effects of mindfulness and self-compassion interventions by Jain et al. (2007) showed reduced physiological consequences of stress through enhancing positive affect. The researchers conducted a randomized controlled trial examining the effects of a 1-month intervention in 83 students who were reporting distress, as compared to a control group. Their results revealed that the intervention groups experienced significant decreases in distress as well as increases in positive mood states over time. Strengths of the study included an integrative training program consisting of cognitive components (such as selective attention skills to focus on one's thoughts and emotions, somatic components (such as Hatha yoga techniques), and self-compassion components (such as practicing self-kindness affirmations and loving-kindness meditations). Participants were also given tapes and manuals, homework assignments, and didactic materials to facilitate practice and reflection at home. Data analysis showed positive affect was inversely related to stress and anxiety, evidence that positive affect independently served as a buffer against deleterious physiological consequences of stress. While the findings cannot be generalized outside of student populations, a major strength

of the study was that post intervention data were collected two weeks after completion of the last intervention class and just before a final exam period, therefore the intervention still increased positive affect and lowered anxiety during a stressful period for participants.

Self-compassion's connection to well-being was further studied by Neely et al. (2009), who examined whether students' self-compassion would contribute to stress management and measured by how participants regulated their emotions and their reactions to the stress of blocked goals. Their aim was to introduce self-compassion as a factor that might contribute to college students' well-being. The researchers were interested in examining what active, conscious coping mechanisms individuals used to cope with negative emotions like disappointment. Their results showed the importance of self-compassion as a predictor of students' well-being. Managing negative emotions in the face of disappointment through self-compassion was a significant contributor to the students' well-being. Self-compassion was seen as an active, approach-oriented view of emotion regulation. Limitations of the study included qualitative self-reports over one semester, among a limited sample.

Neff et al. (2005) also researched benefits of self-compassion in relationship to academic achievement goals and coping with perceived academic failure. Their results indicated self-compassion was associated with adaptive motivational patterns and coping strategies in academic contexts. Kirkpatrick et al. (2007) also found significant changes in undergraduates' self-compassion levels after they participated in a Gestalt two-chair exercise, which involved students voicing self-criticisms and receiving a counselor's guidance to answer these self-disparaging statements. Results indicated that those who

experienced an increase in self-compassion also experienced increased social connectedness, and decreased self-criticism, depression, rumination, thought suppression, and anxiety. Further, the improvement in individuals' self-compassion appeared robust over a three-week period of time.

Williams, Stark, and Foster (2008) built on the self-compassion literature in the academic sphere by examining the links among self-compassionate attitudes, motivation, and procrastination tendency, finding individuals with high self-compassion reported dramatically less motivation anxiety and procrastination tendency than those with low or moderate self-compassion. The researchers indicated that because their sense of identity and worth were not contingent upon performance, highly self-compassionate individuals may be more focused on learning from challenging course assignments, rather than performance-oriented academic goals. Surprisingly, self-compassion was not correlated to academic goal achievements. While the study included a large sample size ($N = 91$), with an even distribution by gender selected through random sampling methods, the participants were mostly Caucasian educational psychology students, limiting the study's external validity.

In contrast, Mitmansgruber, Beck, and Schüßler (2008) investigated avoidance, self-compassion, mindfulness, and emotion on well-being in paramedics with potentially traumatic experiences. They found being stern and contemptuous about one's own feelings and having little self-compassion was beneficial for psychological well-being among this population. Although this is contrary to contemporary theorizing on self-compassion, the authors suggested it might reflect the unique role of paramedics and their need for control. Ignoring one's own emotions to serve others might be protective factors

for paramedics responding to traumatic experiences. However, the researchers noted the long-term consequences of this highly controlled style need further examination.

Thompson and Walz (2008) further examined how self-compassion might aid in lessening the impact of traumatic experiences, through examining the relationship between self-compassion and posttraumatic stress symptoms. Of the three PTSD symptom criteria measured, reexperiencing, avoidance, and hyperarousal, the use of avoidance significantly correlated with levels of self-compassion. The authors concluded that individuals high in self-compassion use fewer avoidance strategies following trauma exposure, allowing for a natural exposure process that increases their coping. Strengths of the study include a large number of participants ($N = 210$) who met the PTSD criterion and participants having a wide variety of trauma experiences such as accidents, deaths or near-deaths of friends and family, sexual assault, or a trauma during which they feared physical injury or death for themselves or another that endorsed a feeling of helplessness. Limitations to this study were self-report measures for meeting trauma criteria rather than a clinical interview and confounding variables—whether trauma exposure and PTSD symptoms lower self-compassion or whether low self-compassion makes one more vulnerable to developing PTSD.

Given that the construct of self-compassion is Buddhist informed, Hsieh, Neff and Pisitsungkagarn (2008) studied whether individuals in Asian societies tend to have more self-compassion than those in the West, by comparing self-compassion levels in the United States, Thailand, and Taiwan. The study was conducted with 181 American, 223 Thai, and 164 Taiwanese undergraduates from major universities in large metropolitan areas in the United States, Thailand and Taiwan. Asian Americans were not included in

the American sample to avoid possible confounds in cross-cultural comparisons. Participants completed six surveys that have shown cross-cultural validity in a variety of nations, measuring self-compassion, self-esteem, depression, self-construal, and satisfaction with life. Self-compassion was significantly associated with well-being in all three cultures; however, it was highest in Thailand and lowest in Taiwan, with the United States falling in between. The variable of interdependence was linked to self-compassion in Thailand only, whereas independence was linked to self-compassion in Taiwan and the United States, suggesting that self-compassion levels in these societies are linked to specific cultural features rather than general East–West differences. The researchers explained Taiwanese cultural tradition holds that self-criticism is a productive motivating force and means for self-improvement, and that a lack of self-criticism amounts to self-indulgence, which may explain the findings. Interestingly, a significant gender by culture interaction was found, indicating that women had less self-compassion than men in the United States, although gender differences were not apparent among Thai or Taiwanese participants. These results confirmed other research findings that U.S. women have lower levels of self-compassion than men—specifically in terms of self-judgment, isolation, mindfulness, and over-identification (Neff, 2003a).

Neff (2003a) also studied how long-term self-compassion practice might contribute to psychological functioning through examining levels of self-compassion among practicing Buddhists of the Vipassana tradition. Results indicated Buddhists had significantly higher total self-compassion scores and psychological functioning than an undergraduate control group, with a significant correlation between self-compassion scores and number of years of practice. In contrast to previous studies on gender and self-

compassion, no significant sex differences were found among the Buddhist participants. Neff suggested that meditation practice or exposure to Buddhist teachings might be a useful means of achieving greater self-compassion and mental health for both women and men who are suffering from a lack of self-compassion.

The relationship between self-compassion and self-evaluation was examined by Kirkpatrick et al. (2007). They created an experimental design of a mock job interview situation in which individuals were asked to give a written answer to the dreaded interview question, "Please describe your greatest weakness." Results indicated participants with higher levels of self-compassion reported less anxiety after writing about their greatest weakness, while higher levels self-esteem were not associated with less anxiety. The study included a measure of negative affect to ensure that the protective qualities of self-compassion were not solely attributable to lower levels of negative affect, therefore reducing redundancy of constructs. Another strength of the study was the method for analyzing the answers to the "greatest weakness" question. A computerized text analysis program that calculates the average use of particular word categories previously categorized by independent judges was used as a means of tapping into underlying psychological characteristics. This method of data analysis has been used to examine how levels of self-acceptance, social integration and connectedness are translated into written language thus warranting its use as a coding strategy of this study. The researchers suggested that further experimental designs would support a link between self-compassion and well-being through comparing outcomes for a randomly assigned experimental group trained in self-compassion to those of a control group.

Results from the study were limited by a middle-class American college undergraduate sample.

Cultivating Self-compassion

Self-soothing, attachment, and introjects. Gilbert and Proctor (2006) noted the connection between attachment systems and self-soothing in the formation of early systems of self-compassion. They suggested that the presence or loss of affection and approval in early life derived from the quality of our attachments to caretakers explains much of our later ability for self-compassion:

All humans want/need to feel loved and accepted, because in our evolved past our very survival may have depended on it. So when this does not happen for us the brain can register this as a major threat—and then our emotional minds try to develop some kind of protection strategies, which can become automatic. Although very understandable these can become unhelpful and prevent us from changing. (p. 362)

Cognitive schemas for self-to-self relating are based on prior interactions with attachment figures. Therefore, experiences with others who are either accepting or critical become internalized and expressed as self-acceptance or self-criticism. These attachment experiences play a role in how individuals are compassionate with themselves. Gilbert and Proctor (2006) explained that because feelings of warmth normally begin via experiencing warmth from others towards the self, they have been internalized as self-objects that act as referents for self-soothing. Gilbert (2000) created a model of self-compassion as a social and neurobiological reaction associated with a deactivation of the threat system associated with feelings of insecurity and defensiveness. He proposed that secure attachments regulate stress arousal within the limbic system and activate a self-

soothing system with increased oxytocin–opiate production, creating feelings of happiness, security and safeness.

Wallin (2007) noted that children who had secure attachments with parents showed substantially greater emotional health, ego resilience, positive affect and social competence than insecurely attached children, and that these levels of resilience were maintained in later development, “what begins as biologically driven interactions register psychologically as mental representations that continue lifelong to shape behavior and subjective experience whether or not the original attachment figures are physically present” (p. 24). In other words, early attachment experiences encoded in the mind influence the quality of relationships with both self and others. Thus, those with poor attachments may have less self-compassionate mental representations to draw from in difficult circumstances. Developing new self-objects and introjects from secure attachment experiences later in life is commonly relied on in the therapeutic relationship, whereby the therapist provides acceptance, warmth, and validation of one’s emotional experience, helping the client internalize a kinder, more accurate and soothing internal self.

Research by Henry, Schacht, and Strupp (1990) linked therapists’ own “introject states” (p. 769) and the interpersonal process in therapy and client outcomes, demonstrating that therapists who lacked self-compassion and were critical and controlling toward themselves, were more critical and controlling toward their patients and had poorer patient outcomes. The researchers stated “therapists whose introjects are self-accepting would be expected to engage their patients in accepting and supportively helpful transactions as compared with therapists with hostile introjects, who would be

expected to behave in a relatively more critical or neglectful manner with their patients” (p. 768).

Self-compassion training. Gilbert and Irons (2005) conducted an early pilot study of self-compassion training to explore the personal experiences of individuals with high self-criticism who followed a system of recording self-attacking and self-soothing thoughts and images. Participants were trained in self-soothing methods and skills to develop more compassionate self-attitudes and self-talk. They noted that a key problem for participants was a lack of access to feeling memories of being affectionately cared for and soothed which was associated with levels of self-care abilities.

In a follow-up study, Gilbert and Procter (2006) created a structured version of compassion training called Compassionate Mind Training (CMT). The study explored the effectiveness of their program aimed at explicitly increasing self-compassion in a group setting with patients having severe mental illness. The program’s educational component involved teaching people how protection and safety strategies such as avoidance, anger, emotional numbing, or denial are survival strategies based on early experience, as well as exploring efforts trying to elicit others’ approval and avoiding being controlled or threatened by others often creates harmful self-criticisms. In a group format, patients then stand back and develop empathy for themselves. Through validation, clients are able to fully appreciate that many of their efforts (including self-attacking) have been safety behaviors as ways to try to protect themselves and regulate their emotions, due to early experiences. The authors noted CMT is rooted in evolutionary psychology based on human developmental processes and attachment systems:

We refer to our approach as compassionate mind training because we are not targeting specific core beliefs or schema per se, but (like mindfulness) seek to alter a person's whole orientation to self and relationships. We seek to change an internalized dominating–attacking style, that activates a submissive defensive response when dealing with setbacks and failures, and replace it with a caring, compassionate way of being with one's distress. (p. 359)

According to their view, “self-compassion can help reduce the sense of threat and create feelings of safeness” (Gilbert & Procter, 2006, p. 357). The researchers found reductions in depression, anxiety, self-criticism, shame, inferiority and submissive behavior; however, correcting self-attacking was not reduced. Participants reported being better able to self-soothe and give themselves warmth and reassurance after the training. While the findings cannot be generalized due to a sample size of only nine participants, the study had strong selection criteria of participants who would commit to attend the daily two-hour, 12 week training and who were initially screened for having clear problems with shame, self-criticism and self-devaluation. While there are important flaws to consider in the research design, the intent was to test a trial program, and provide a starting point for further research. The study provided an initial exploration of group-formatted program aimed at enhancing self-compassion explicitly for patients with chronic mental health issues and an opportunity for the researchers to discover how the training components worked together through receiving feedback on the intervention from participants.

Imagery and metta. Using images for directing warmth, understanding and compassion towards the self has been an integral part of Buddhism for thousands of years. This imagining of compassion flowing to others and from others to self is the basis for compassion loving-kindness meditation, or *metta*, which involves imagining oneself

happy, peaceful and accepted before sending the intentions of wishing well out to others (Salzberg, 2002). In traditional metta practices, phrases of care and love are repeated and visualizing goodwill is imagined towards oneself first, and then extended to include one's family, friends, acquaintances, and even enemies. Through training the mind toward self-kindness during metta, one's own happiness is increased along with a deeper capacity for kindness and empathy for others (Welwood, 2002).

Walsh and Shapiro (2006) noted that unlike western therapies, approaches such as metta and mindfulness aim to cultivate *positive* affects such as joy, love, and self and other compassion, suggesting that loving oneself can raise one's internal happiness set point, which psychologists usually assume is genetically constrained. The use of self-compassionate imagery offers people an alternative through creating their own images of warmth, by imagining their ideal of caring and compassion.

Building on the theory that the degree to which people are able to access warm and supportive, or condemning and critical self-to-self scripts and images, relates to emotional well-being, Gilbert, Baldwin, Irons, Baccus, and Palmer (2006) used an imagery task with undergraduate students (N = 197) to explore how easy or difficult it was to imagine a self-critical attacking part of the self, and a soothing, compassionate part of the self. Those high in self-criticism found it easier to imagine a critical part of the self that was experienced as hostile, powerful and controlling, while low self-critics found it more difficult, suggesting highly critical persons have less automatic access to self-soothing systems. Their findings suggested one's compassionate images influence the degree of positive self-to-self relating and that self-compassionate states can be cultivated via generating self-soothing, compassionate and warm images, as an antidote

for critical and harsh images and lack of self-compassion. A strength of the study included the visualization outcomes being measured in multiple ways. The researchers assessed how typical it was for a participant to be self-critical or self-reassuring, the experienced level of intensity when a self-critical or self-reassuring person was visualized, how easily visualized images were created, and how elaborate, clear and vivid those images were. The researchers acknowledged that their research with the students was illuminative, but further research was needed with clinical populations. However, the responses from the participants indicated the self-critical individuals reported considerable benefits in trying to develop self-compassion through self-compassionate imagery training.

Mindfulness cognitive attitude training. While there has been no research directly studying self-compassion training among mental health professionals, Schenström, Rönnerberg, and Bodlund (2006) conducted a mindfulness cognitive attitude training program for primary health care personnel designed as an intervention to reduce the negative effects of stress on both a personal and professional level, as well as to encourage personal well-being and improved management of the clinician-patient relationship. Participants (N = 52) were doctors, nurses, physical therapists, occupational therapists, and social workers recruited through Sweden's public health care system. All participants demonstrated significant positive changes after completing the course, persisting at a 3-month follow-up assessment, with perceived quality of life increases and stress both in and outside the workplace decreased. While the study design did not include a comparable control group who did not receive the treatment, a major strength of the study was its inclusion of a pre- and post-intervention assessment. The authors

recognized the difficulties in selecting methods for measuring quality of life, as most scales are designed for people with specific diseases and not for healthy individuals. As well, the mindfulness scale was in English; therefore it might have been more difficult for the Swedish participants to express the nuances of their perception of any changes. It was not apparent which variable created the effect, because mindfulness and cognitive approaches were integrated elements of the program.

Commenting on the benefits of mindfulness training with self-compassion, Shapiro et al. (2007) stated, “the effects of mindfulness training on positive affect and self-compassion may help to enhance professional skills, reflected in a greater kindness toward, and acceptance of clients and patients, and this could also be explored in future research” (p. 113). The process of facilitating the cultivation of self-compassion is still in its early phases. While the literature on self-compassion’s benefits has been widely established, the therapeutic vehicles that enhance self-compassion have only begun to be empirically studied and promoted.

Self-compassion and Burnout in Clinicians

Professional burnout arises when people are not functioning at their maximum potential and when negative psychological and physical states arise and positive emotions and experiences are diminished, creating exhaustion, cynicism and feeling one is not fulfilling a sense of personal accomplishment in their work. Clinicians often experience negative emotions such as frustration, anxiety, self-criticism, inadequacy, and failure during their professional life (Deniz et al., 2008). When clinicians enter their work with high goals and expectations and then feel they have failed, they start to feel powerless and hopeless, leading to burnout.

Mental health professionals with high-levels of burnout tend to describe themselves as overworked, have negative self-images, and blame and accuse themselves for difficulties at work (Jeanneau & Armelius, 2000). In order to avoid the perils of burnout, they need to rebalance these negative emotions through effective coping mechanisms. Given the nature of psychotherapy, the use of self-compassion among clinicians seems warranted. Neff (2009) commented:

Although people typically value being kind and compassionate to others, they are often harsh and uncaring toward themselves. The intense self-focus that occurs when people confront their own limitations can sometimes lead to a type of tunnel vision in which people become over identified with and carried away by negative thoughts and feelings about themselves. Feelings of isolation can also occur when people temporarily forget that failure and imperfection are part of the shared human experience, serving to amplify and exacerbate suffering. Self-compassion, on the other hand, involves being kind toward oneself when considering weaknesses, remembering that being human means being flawed and imperfect, and learning from one's mistakes. Self-compassion involves taking a mindful approach to negative thoughts and emotions that acknowledges the reality of personal failings while keeping them in balanced perspective. (p. 29)

Based on the research in self-compassion, it seems reasonable to consider that psychotherapists who practice self-compassion may be more resilient and less burned-out when faced with the unique challenges of their work. The effects of the therapist's developing higher levels of self-compassion would seem to spontaneously bring an embodiment of calmness and presence into the relational process of therapy.

The quality of unconditional presence, of attending fully and non-judgmentally to oneself, a key component of self-compassion, is reminiscent of person-centered therapies founded by Rogers (1951), and has been studied by various authors as a potent factor in the therapeutic encounter. Therapists who practice self-compassion may find relief in the effort of staying present with their clients in the midst of expressions of deep sadness and

pain, may withdraw emotionally when necessary, may understand being an imperfect clinician is part of the human condition, and may be free from self-criticism through self-kindness. Self-compassion may give the therapist a sense of what Crane and Elias (1996) call “OK-ness” in the midst of “not-OKness” (p. 32). In this way the influence of self-compassion can inform a different approach to the therapeutic process, constituting an effective way to empower clinicians to relate to themselves with greater empathy and compassion, mitigating the negative consequences of burnout.

To date, no research has examined the role of self-compassion practice in clinicians and burnout, therefore this study attempts to fill this gap, while adding knowledge to the self-compassion and burnout fields. Additionally, research in self-compassion aligns with the tenet of social work and positive psychology for garnering individuals’ strengths, rather than focusing on psychopathology and maladaptive functioning.

CHAPTER III

METHOD

Research Design

The purpose of this study was to determine if there is a relationship between levels of self-compassion in practicing psychotherapists and levels of burnout. This research was designed with a mixed-method approach with no direct manipulation of variables. Rubin and Babbie (2007) commented that because both quantitative and qualitative research have advantages and disadvantages, research that combines both approaches can be particularly effective. Use of multiple methods in research helps to examine a process or a problem from all sides. Both qualitative and quantitative data were collected concurrently, using quantitative surveys to assess self-compassion and burnout levels. Generating a richer understanding through human experience can be elicited from qualitative research methods; therefore the design included two open-ended questions to gain a more in-depth account of self-compassion practices and coping with burnout from clinicians. Because of non-probability sampling of participants and the lack of experimental control in the research design, cause and effect cannot be drawn from my findings (Weinbach & Grinnell, 2007). However, the relationship between self-compassion and burnout can be explored and findings should be useful to those in the mental health field. In this study, the variables being tested for associations are total self-compassion with three dimensions of burnout—emotional exhaustion, depersonalization, and personal accomplishment.

Participants

This study used a non-probability sample of convenience and snowball sampling through participants' encouragement to pass along the survey to colleagues (Cassell & Symon, 1994). Additionally, a recruitment flier was posted at various mental health agencies, psychotherapy graduate schools and counseling centers throughout San Francisco as a strategy for recruitment to better access a diverse population of psychotherapists (See Appendix A). Participants were identified as mental health professionals with the following criteria: (a) participant has received a master's or doctorate degree, (b) participant is a licensed clinical social worker, marriage and family therapist, psychologist or equivalent, (c) participant has been employed at their current job for more than 6 months, (d) participant provides individual, family or group therapy.

Instruments

Neff's Self-compassion Scale (2003b) was used in this study to measure self-compassion levels. This inventory is a 26-question survey measuring total self-compassion through averaging six subscale scores: mindfulness, over-identification, isolation, common humanity, self-judgment, and self-kindness. The Maslach Burnout Inventory (Maslach et al., 1996) is a 22-item inventory that was used to measure the three dimensions of burnout: emotional exhaustion, depersonalization, and personal accomplishment. In this study, the scores from these inventories were used for analysis for comparing whether a relationship existed between self-compassion and burnout.

Online Questionnaire

The questionnaire in this study encompassed four sections. For purposes of this discussion, the sections will be titled Demographic Questionnaire (Appendix B), Neff's

Self-compassion Inventory (Appendix C), Maslach Burnout Inventory–Human Services Survey (Appendix D), and Qualitative Questions (Appendix E). The online questionnaire participants received did not label these sections or separate them using instructions or different titles, so that they did not make assumptions before answering the questions.

Demographic questionnaire. The first section in this study’s online questionnaire consisted of seven questions to assess the participants’ demographics, including gender, age, marital status, years in practice, type of licensure, primary work setting, and racial/ethnic identity.

Neff’s Self-compassion Inventory. Neff’s Self-compassion Scale (Neff, 2003b) has shown internal consistency of 0.92; test-retest reliability of 0.93 during a 3-week interval; significant positive correlations with social connectedness, emotional intelligence, and life satisfaction; and significant negative correlations with self-criticism, perfectionism, depression, and anxiety (Baer, 2006). The inventory never mentions self-compassion explicitly. Instead self-compassion levels are inferred by examining responses to 26 items designed to tap into the three main components of the construct: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification (Kirkpatrick et al., 2007).

Items were rated on a 5-point Likert scale from 1 (almost never) to 5 (almost always). Subscales self-kindness, common humanity, and mindfulness were scored such that higher scores reflect greater self-compassion. Subscales self-judgment, isolation, and overidentified are reverse scored such that before reverse scoring higher scores reflect lower self-compassion, while after reverse scoring a higher score indicates higher self-compassion. A total self-compassion score is calculated by averaging each subscale,

reverse scoring the latter three subscales, summing all six, and creating a final total self-compassion average (Neff, 2003b).

Maslach Burnout Inventory–Human Services Survey. Recognized for more than a decade as the leading measure of burnout, the Maslach Burnout Inventory–Human Services Survey (Maslach et al., 1996) is a 22-item inventory designed to measure three aspects of burnout: emotional exhaustion, depersonalization, and lack of personal accomplishment. Three factors are measured through these subscales: feelings of being emotionally overextended and exhausted by one’s work, unfeeling and impersonal responses toward recipients of one’s service, care treatment, or instruction, and feelings of competence and successful achievement in one’s work.

Burnout is seen as a multidimensional construct; therefore the sub-scales are not combined to reveal one ultimate burnout score. High levels of emotional exhaustion and depersonalization and low levels of personal accomplishment indicate increased risk of burnout. Maslach et al. (1996) provided cut-off points for a categorical rating of low, moderate, or high burnout; however, they recommended use of the original numerical scores in statistical analyses. Items are scored on a 7-point scale ranging from never (0) to daily (6). These 22-items were the last of the standardized survey questions.

Qualitative questions. Participants were asked two open-ended questions intended to elicit qualitative responses, in the following order: (1) *What coping behaviors, thoughts or self-talk do you practice when you find yourself in challenging and stressful situations at work? Please describe what you do.* (2) *Briefly discuss what works well and what doesn’t work well to bring yourself back in balance.* Following the end of the online

survey, a final page was included, entitled “suggested reading” with a list of seven books about burnout and self-compassion (see Appendix F).

Procedure

Prior to conducting this study, the study’s design and sample population received approval by the Smith College Human Subjects Review Committee (see Appendix G). The survey was presented on the online survey service site Survey Monkey, for data collection. Once data collection was complete, the sample consisted of 71 participants. Three participants chose not to answer the two open-ended questions. Further details on participant demographics are outlined within the next section.

I sent out an email to recruit potential participants (see Appendix H). The email explained the purpose of the project, the goal of the study, the requirements for participation, and the option to participate by clicking on a web link. Email recipients were also asked to forward the email on to notify their colleagues about the research and forward the email, as a basis for providing information to potential participants.

When participants clicked the web link, they were taken to the introduction page of the survey website. The introduction page welcomed the participant and thanked them for their interest, explained the nature of the study and asked the participant the screening criteria in a “yes or no” format. If they said “no” to any of the screening questions, they were thanked but not allowed to go any further. If they said “yes” to all criteria, they were automatically directed to the informed consent page. The Informed Consent (Appendix I) told participants that their responses would be anonymous, and the original data from the survey would be maintained in a locked, secured condition for three years as required by federal regulations, to eventually be destroyed. Participants were informed

a statistical consultant and I would have access to the raw data and that a separate copy of the data in Statistical Package for Social Sciences (SPSS) format would be forwarded to Consulting Psychologists Press, Inc. who retain the rights to use the data within larger data sets for analyses, but not with the data collected from this study alone. They were reminded that no personal identifying information was available once the survey was completed, thus anonymity was guaranteed. Participants were also told of the potential risk of arousing emotional themes and that they had the ability to opt out of the survey at any time. Participants then had the option to opt out of the survey by clicking no, or yes to continue to the survey, confirming their willingness to participate.

Data Analysis

The purpose of analysis was to determine the strength of the relationships between the variable of self-compassion and the three variables of burnout: emotional exhaustion, depersonalization, and personal accomplishment. Level of self-compassion was measured by a total self-compassion score, which consists of six subscales averaged to create one overall score. Three levels of burnout were established via the three separate burnout subscales. In this study, higher total scores of self-compassion were proposed to correlate with lower levels of emotional exhaustion and depersonalization and higher levels of personal accomplishment. The survey was online for five weeks during which time 94 people began the survey and 71 individuals completed the survey. A survey was considered to be complete if all of the quantitative questions were answered.

Quantitative data were collected through the Survey Monkey online tool, electronically coded, and sent to a statistician at Smith College for analysis with the Statistical Package for Social Sciences (SPSS) software. Descriptive statistics were

calculated for each of the variables. The Pearson product-moment correlation coefficient, or Pearson r , was used to measure correlations between the three hypothesized effects: higher total scores of total self compassion associated with lower levels of the burnout dimension emotional exhaustion, higher total scores of self-compassion associated with lower levels of the burnout dimension depersonalization, and higher total scores of self compassion associated with higher levels of personal accomplishment.

The quantitative data were also analyzed using Pearson's correlations to determine if relations between levels of burnout and self-compassion were related to demographic variables among participants: gender, age, years in practice, license, marital status and ethnicity. Further correlational testing of the six separate subscales of self-compassion—mindfulness, over-identified, self-kindness, self-judgment, common humanity, and isolation against the subscales of burnout—emotional exhaustion, depersonalization and personal accomplishment were also included in the analyses performed.

The qualitative data included in the survey were analyzed through the use of open coding, where categories are derived through close examination of the qualitative data, organizing text data thematically (Rubin & Babbie, 2007). Analysis was conducted through transcription of responses into a word document and units of meaning were grouped according to emerging themes found among respondents. Each theme that was found by this researcher is presented in the data section.

CHAPTER IV

RESULTS

The findings from this research project addressed the question of how clinicians' levels of self-compassion are related to their levels of job burnout. These findings were identified through both quantitative based analyses of participant variables from the survey administered and by identifying themes that emerged from two open-ended questions, using content data analysis procedures. This findings chapter will be composed of four parts. First, the demographics of the study participants will be presented. Secondly, findings for each of the three hypotheses will be presented. Third, survey findings of correlations among burnout and self-compassion subscales will be presented by demographic. Lastly, the responses from the two qualitative questions will be presented.

Significant associations between participants' self-compassion and personal accomplishment, and the self-compassion subscale isolation with emotional exhaustion and depersonalization, were found in this study. Clinicians who were female, had an LCSW, MFT or equivalent licensure, and were younger with less experience also showed significant correlations among burnout and self-compassion. Coping mechanisms fell into three main categories: social support, cognitive or behavioral approaches. Connecting with colleagues, personal relationships, slowing down, meditation, breathing, mindfulness, positive affirmations and healthy distancing were the most popular coping mechanisms used by clinicians. The techniques reported as the most effective were

personal relationships, exercise, colleagues, slowing down, meditation, breath, mindfulness, and work boundaries. Being self-judging and critical, ruminating, and focusing on negative emotions were the most cited ineffective responses.

Participant Demographics

Of the 71 participants, only three opted to not answer the two open-ended questions. Of the 71 participants, there were 54 females (76%) and 17 males (24%) (Table 1).

Table 1
Frequency Distribution by Gender

	<i>f</i>	<i>%</i>
Gender		
Female	54	76
Male	17	24

Their ages ranged from 28 to 70 years old, with a mean age of 48 (Table 2). There were three age group clusters containing the highest frequencies of similar ages. Group one, ages 28 – 38 (27%), contained 34 as the most common age, group two, ages 39 – 54 (38%), contained 40 as the most common age and ages 58, 59, and 61 occurred most frequently in a third grouping, 55 – 70 (35%) (Table 3).

The participants reported a variety of years in clinical work, from 1 to 40 years, with a mean of 13 years in practice (Table 2). There were three clusters containing the highest frequencies of similar years practicing—group one, 1 – 7 years (37%), with 1 year the most common reported, group two, 8 – 19 (31%), with 10 and 11 years most common, and participants with over twenty years in practice (32%), with 23 years practicing the most common (Table 3).

Table 2

Means and Standard Deviations for Age and Years in Practice

Variable	<i>M</i>	<i>Mode</i>	<i>SD</i>	Range
Participants (N=71)				
Age	48	34, 40, 57, 58, 61	11.8	28 - 70
Years in Practice	13	1	10.2	1 - 40

Table 3

Response Frequencies for Age and Years in Practice Demographic Clusters

Variable	<i>f</i>	%
Participants (N=71)		
Age		
28 – 38	19	27
39 – 54	28	38
55 – 70	24	35
Years Practicing		
1 – 7	26	37
8 – 19	22	31
20 +	23	32

Racial diversity was poor, with only 13% of the sample identifying as other than Caucasian. Three people identified as Chinese, two as Biracial/Multiracial, two as European, one as Latino/Hispanic and one as Korean. The remainder—62 participants (87% of the sample)—reported their race as Caucasian (Table 4).

The majority of individuals had either a license in clinical social work (29) or a doctorate license (21). Out of the remaining participants, 12 had an M.F.T. license, five were licensed mental health clinicians (L.M.H.C.) and four were licensed as a Psy.D. (Table 5).

Table 4

Response Frequencies by Ethnicity

Variable	<i>f</i>	%
	Participants (N=71)	
Biracial/Multiracial	2	3
Latino/Hispanic	1	2
Chinese	3	4
European (other)	2	3
Caucasian	62	87
Korean	1	1

Table 5

Response Frequencies by License

Variable	<i>f</i>	%
	Participants (N=71)	
PHD	21	30
MFT	12	17
LCSW	29	41
LMHC	5	7
PSYD	4	6

Participants were asked to choose their main place of work when responding to setting type. Of the multiple settings participants worked, 31 individuals (44%) reported working in private practice, 15 in a community mental health center (21%), ten in education (14%), five in a hospital (7%), four in an unspecified mental health agency (6%), three at an HMO (4%), two in residential treatment (3%) and one in a substance abuse organization (1%) (Table 6). Lastly, the participants' marital status included the majority married/committed (63%), followed by single (20%), divorced/separated (11%), and widowed/other (6%) (Table 7).

Table 6

Response Frequencies by Setting

Variable	<i>f</i>	%
Participants (N=71)		
Community Mental Health	15	21
Hospital	5	7
Private Practice	31	44
Substance Abuse	1	1
Residential	2	3
HMO	3	4
Other agency	4	6

Table 7

Response Frequencies by Marital Status

Variable	<i>f</i>	%
Participants (N=71)		
Married/committed	45	63
Single	14	20
Divorced/separated	8	11
Widowed/other	4	6

Self-compassion Levels

On average the sample was highly self-compassionate. Following Neff's (2003a) suggested cutoff points, the participants fell into three overall categories for their current level of total self-compassion: low, moderate, or high in total self-compassion. Those scoring high in total self-compassion made up 61% of the sample. The participants scoring moderate in total self-compassion were 35% of the sample. Only three people (4%) in all 71 participants scored low in overall self-compassion (Table 8). Table 9 presents a summary of participants' self-compassion scores.

Table 8

Response Frequencies by Self-compassion Score Category

Self-compassion (range 1- 5)	<i>f</i>	%
Participants (N=71)		
Low (range 1- 2.5)	3	4
Medium (range 2.6 - 3.5)	25	35
High (range 3.6 - 5)	43	61

Table 9

Summary of Self-compassion Scores

Self-compassion Measure (range 1- 5)	<i>M</i>	<i>Mode</i>	<i>SD</i>	Range
Participants (N=71)				
Total Self-compassion	3.7	2.5, 3.7, 3.9, 4.4	.64	2.0 - 4.8
Self-Kindness	3.7	2.8	.74	2.0 - 5.0
Self-Judgment	3.5	3.6	.83	1.4 - 5.0
Common Humanity	3.8	3.8, 5.0	.88	1.5 - 5.0
Isolation	3.6	3.8, 4.0	.83	1.8 - 4.8
Mindfulness	3.9	3.8, 4.8	.66	2.0 - 5.0
Over-Identification	3.6	4.0	.84	1.5 - 5.0

Burnout Levels

On average the sample had low levels of emotional exhaustion and depersonalization and high levels of personal accomplishment, indicating overall low burnout as measured by the three subscales. Participants fell into three categories for each subscale: low, moderate, or high, determined by Maslach et al.'s (1996) recommended cutoff points for interpreting scores. As presented in Table 10, for the emotional exhaustion subscale, those scoring low (less burnout) in emotional exhaustion made up more than half (54%) of the sample. Moderate emotional exhaustion was reported by

28%, and 18% scored highly in the subscale, indicating more burnout. Participants scores in the second subscale, depersonalization, indicated the majority (85%) were not very burned out along this dimension, with 60 of the 71 respondents falling into the “low” category. Ten people (14%) fell into the moderate range, and only one person scored high in depersonalization (high burnout). For the last subscale, personal accomplishment, a large majority (82%) of participants scored in the high range, indicating *less* burnout, followed by 13% in the moderate range and only four people (6%) of the 71 respondents scoring low in personal accomplishment. Outliers in each burnout component were not always the same people; for example, those participants who fell into the low category for one burnout dimension did not necessarily score in the low categories for the other dimensions. Table 11 summarizes the burnout scores of participants.

Table 10

Response Frequencies by Burnout Score Category

Burnout Measure	<i>f</i>	<i>%</i>
Participants (N=71)		
Emotional Exhaustion (range 0-54)		
Low (range 0 - 16)	38	54
Moderate (range 17 - 26)	20	28
High (range 27 or over)	13	18
Depersonalization (range 0-30)		
Low (range 0 - 6)	60	85
Moderate (range 7 - 12)	10	14
High (range 13 or over)	1	1
Personal Accomplishment (range 0-48)		
Low (range 0 - 31)	4	6
Moderate (range 32 - 38)	9	13
High (range 39 or over)	58	82

Table 11

Summary of Burnout Scores

Burnout Measure	<i>M</i>	<i>Mode</i>	<i>SD</i>	Range
Participants (N=71)				
Emotional Exhaustion (range 0-54)	16.3	7	10.17	2 - 48
Depersonalization (range 0-30)	3.4	1	3.06	0 - 13
Personal Accomplishment (range 0-48)	41.3	43	6.56	8 - 48

Tests of Hypotheses

The survey findings are presented below as they relate to the research hypotheses posed for this study. Table 12 presents the correlation analysis of the total self-compassion and subscales self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification with the burnout subscales emotional exhaustion, depersonalization, and personal accomplishment in an attempt to answer the hypotheses posed. Pearson's Product Moment Correlations were computed to assess the strength and direction of the relationships between overall self-compassion, the subscales of self-compassion and the three dimensions of burnout.

Hypothesis 1

The first hypothesis states that total self-compassion levels are expected to have a negative correlation to the emotional exhaustion subscale of burnout. This hypothesis was not substantiated by the data. Relations between total level of self-compassion and emotional exhaustion were not significantly correlated (Table 12).

Table 12

Correlations Between Self-compassion and Burnout Measures

Self-compassion Measure	Burnout: Emotional Exhaustion	Burnout: Depersonalization	Burnout: Personal Accomplishment
Participants (N=71)			
Total Self-compassion	-.190	-.215	.344(**)
Self-Kindness	-.154	-.179	.480(**)
Self-Judgment	-.218	-.169	.205
Common Humanity	-.006	-.115	.311(**)
Isolation	-.299(*)	-.378(**)	.141
Mindfulness	.020	-.173	.480(**)
Over-Identification	-.225	-.016	.090

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

However, one of the six self-compassion subscales did correlate with emotional exhaustion. The self-compassion subscale isolation was negatively correlated with emotional exhaustion ($r=-.299$, $p<.05$)., This finding can be interpreted as a positive relationship between high self-compassion and low burnout since a low isolation score represents high self-compassion.

Hypothesis 2

The second hypothesis states that total self-compassion levels are expected to have a strong negative correlation to the depersonalization subscale of burnout. Contrary to the hypothesis, correlations between total self-compassion and depersonalization were nonsignificant. Similarly to hypothesis 1, the correlations between the self-compassion subscales and depersonalization were nonsignificant, with the exception of a negative

relationship between subscale isolation and depersonalization ($r=-.378$, $p<.01$) as shown in Table 12.

Hypothesis 3

The third hypothesis states that total self-compassion levels are expected to have a positive correlation to the personal accomplishment subscale of burnout. As expected, total self-compassion correlated positively with personal accomplishment ($r=.344$, $p<.01$). This relationship was significant, allowing the null hypothesis to be rejected. Similarly, personal accomplishment correlated significantly with subscales self-kindness ($r=.480$, $p<.01$), common humanity($r=.311$, $p<.01$), and mindfulness($r=.480$, $p<.01$) as shown in Table 12.

In sum, the analysis showed that one of the three dimensions of burnout, personal accomplishment, was related to total self-compassion, and the three positive self-compassion subscales self-kindness, common humanity and mindfulness also met levels of statistical significance with personal accomplishment. Additionally, the self-compassion subscale isolation was associated with both levels of the burnout dimension emotional exhaustion and depersonalization suggesting that as participants' sense of isolation increased, their levels of emotional exhaustion and depersonalization also increased and as their levels of isolation decreased, their levels of emotional exhaustion and depersonalization also decreased.

Demographic Variable Correlations

In an attempt to expand upon these findings, correlations were performed again according to demographic groupings. The purpose of these analyses was to determine if

demographic variables influenced the relationship between levels of self-compassion and burnout.

Gender

As shown in Table 13, there were significantly different correlations between gender groups male and female. The correlations between the total levels of self-compassion and burnout subscales depersonalization ($r = -.462, p < .01$) and personal accomplishment ($r = .354, p < .01$) were statistically significantly greater for women than for men. All of the six subscales for self-compassion correlated significantly with depersonalization for women, contrasting to no observed relationships for men. Similarly, subscales self-kindness, common humanity and mindfulness all correlated positively with personal accomplishment for women, contrasting with no found associations for men. For men, the only significant correlation among all variables observed was between emotional exhaustion and one subscale, isolation ($r = -.504, p < .05$).

Age Groups

While the correlations between burnout subscale personal accomplishment and self-compassion subscales mindfulness, self-kindness and common humanity were all significant when the therapists were looked at as a whole, when the sample was divided into three age clusters, differences emerged (Table 14). Correlations between self-kindness ($r = -.593, p < .01$), common humanity ($r = .509, p < .05$) and mindfulness ($r = -.715, p < .01$) and personal accomplishment remained significant only within the youngest age grouping, the 28 to 38 year old cluster. The personal accomplishment and self-compassion subscale correlations were not maintained for the other two age groups, 39 to 54 years and 55 to 70 years.

Table 13

Correlations Between Self-compassion and Burnout Measures in Men and Women

Self-compassion Measure	Burnout: Emotional Exhaustion		Burnout: Depersonalization		Burnout: Personal Accomplishment	
	Men	Women	Men	Women	Men	Women
Total Self-compassion	-.333	-.178	.227	-.462(**)	.261	.354(**)
Self-Kindness	-.381	-.130	.149	-.422(**)	.319	.512(**)
Self-Judgment	-.410	-.195	.170	-.415(**)	.453	.126
Common Humanity	.291	-.107	.270	-.289(*)	-.098	.390(**)
Isolation	-.504(*)	-.194	-.227	-.420(**)	.110	.173
Mindfulness	-.025	-.003	.389	-.423(**)	.323	.500(**)
Over-Identification	-.314	-.314	.420	.420	.158	.158

Note. Men (n=17), Women (n=54)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Years in Practice

A similar pattern found in the age grouping differences was found after comparing three years in practice clusters (Tables 15). The least experienced, in the 1 to 7 years in practice grouping, had significant correlations between personal accomplishment and self-kindness ($r=-.519$, $p<.01$), common humanity ($r=.391$, $p<.05$) and mindfulness ($r=.655$, $p<.01$) that were not observed in the 8 to 19 years and 20 or more years groupings, with the one exception of mindfulness reaching significance with personal accomplishment ($r=-.428$, $p<.05$), for the middle years in practice group, 8 to 19 years.

Table 14

Correlations Between Self-compassion and Burnout Measures by Age Grouping

Self-compassion Measure	Burnout: Emotional Exhaustion			Burnout: Depersonalization			Burnout: Personal Accomplishment		
	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3
Total Self-compassion	-.235	-.204	-.093	-.371	-.036	-.291	.370	.276	.311
Self-Kindness	-.125	-.176	-.101	-.390	.027	-.172	.593(**)	.344	.388
Self-Judgment	-.277	-.227	-.124	-.312	.039	-.283	-.015	.231	.358
Common Humanity	-.232	.036	.103	-.144	-.105	-.078	.509(*)	.156	.195
Isolation	-.124	-.447(*)	-.152	-.422	-.308	-.440(*)	.103	.161	.059
Mindfulness	-.059	-.002	.105	-.410	.032	-.198	.715(**)	.304	.367
Over-Identification	-.281	-.132	-.276	-.131	.166	-.156	-.137	.235	.062

Note. Set 1: 28 -38 years old (n=19) , Set 2: 39 - 54 years old (n=27), Set 3: 55 -70 years old (n=25)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 15

Correlations Between Self-compassion and Burnout Measures in Years in Practice

Self-compassion Measure	Burnout: Emotional Exhaustion			Burnout: Depersonalization			Burnout: Personal Accomplishment		
	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3
Total Self-compassion	-.049	-.090	-.180	-.122	-.184	-.191	.329	.320	.159
Self-Kindness	-.053	-.038	-.091	-.190	-.053	-.071	.519(**)	.356	.330
Self-Judgment	-.121	-.110	-.207	-.091	-.119	-.176	.089	.380	.042
Common Humanity	.140	.119	-.001	-.087	-.112	.019	.391(*)	.199	.106
Isolation	-.194	-.304	-.257	-.188	-.463(*)	-.450(*)	.115	.145	-.026
Mindfulness	.100	.308	-.065	-.128	-.216	-.029	.655(**)	.428(*)	.103
Over-Identification	-.084	-.249	-.203	.067	.117	-.147	-.044	.055	.181

Note. Set 1: 1 - 7 years (n=26), Set 2: 8 - 19 years (n=22), Set 3: 20 + years (n=23)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

License

Another set of comparisons addressed the question of licensure differences. Analysis showed there were significantly different correlations between the doctoral and master's level or equivalent, licensure groups (Table 16). When individuals were divided into three main groups, PhD (Ph.D. and Psy.D), MFT (M.F.T. and L.M.H.C) and LCSW (L.C.S.W.) and then compared, correlations between personal accomplishment and total self-compassion($r=.731, p<.01$), subscales self-kindness($r=-.693, p<.01$), self-judgment($r=.605, p<.05$), isolation($r=.671, p<.01$) and mindfulness($r=.595, p<.01$) were significant for the MFT group, as well as emotional exhaustion and self-judgment($r=-.487, p<.05$) and depersonalization and isolation($r=-.512, p<.05$). Similarly, for the LCSW group, personal accomplishment and total self-compassion($r=.376, p<.05$), subscales self-kindness($r=-.569, p<.01$), common humanity($r=.388, p<.05$) and mindfulness($r=.582, p<.01$) were significant, as well as depersonalization and total self-compassion($r=-.464, p<.05$) and subscale self-kindness($r=-.464, p<.05$). In contrast, no significant associations between self-compassion or the subscales and any of the burnout dimensions emerged for the PhD group. While the LCSW group had slightly lower scores in self-compassion and slightly higher scores in burnout than the PhD or MFT groups, the overall differences in scores between groups were minimal (Table 17).

In summary, there were four significant demographic differences in self-compassion and burnout levels observed. Between males and females, female's self-compassion was highly correlated with personal accomplishment and depersonalization, with no correlations indicated for men.

Table 16

Correlations Between Self-compassion and Burnout Measures by License

Self-compassion Measure	Burnout: Emotional Exhaustion			Burnout: Depersonalization			Burnout: Personal Accomplishment		
	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3	Set 1	Set 2	Set 3
Total Self-compassion	-.266	-.417	-.036	-.080	-.128	-.464(*)	.058	.731(**)	.376(*)
Self-Kindness	-.201	-.461	.052	-.007	-.055	-.464(*)	.136	.693(**)	.569(**)
Self-Judgment	-.273	-.487(*)	.046	.010	-.186	-.354	.075	.605(*)	.118
Common Humanity	-.180	.087	-.091	-.197	.135	-.325	-.011	.365	.388(*)
Isolation	-.339	-.470	-.024	-.312	-.512(*)	-.353	-.006	.671(**)	.076
Mindfulness	-.082	-.004	.049	-.005	-.038	-.451(*)	.125	.595(*)	.582(**)
Over-Identification	-.201	-.374	-.201	.123	.180	-.366	.020	.164	.095

Note. Set 1: PhD (n=25), Set 2: MFT (n=17), Set 3: LCSW (n=29)

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table 17

Means and Standard Deviations of Self-compassion and Burnout Scores by License

Measure	<i>M (STD)</i>		
	PhD	MFT	LCSW
Total Self Compassion (range 1-5)	3.8 (.6)	3.8 (.6)	3.5 (.6)
Burnout: Emotional Exhaustion (range 0-54)	18 (12)	17 (12)	15 (8)
Burnout: Depersonalization (range 0-30)	4 (3)	4 (4)	3 (3)
Burnout: Personal Accomplishment (range 0-48)	42 (5)	43 (4)	40 (8)

Note. PhD (n=25), MFT (n=17), LCSW (n=29)

The youngest age group of clinicians with the fewest years in practice also showed correlations for three subscales of self-compassion with the personal accomplishment dimension of burnout, versus their older, more experienced therapists. Lastly, those with a doctoral degree had no correlations between self-compassion and burnout subscales, while the MFT and LCSW groups showed depersonalization correlated with self-compassion subscales and personal accomplishment correlated strongly with total self-compassion and subscales. Similar analyses investigating the relationships between self-compassion and burnout were performed to discern any significant differences due to therapist marital status and workplace setting. There were no significant differences between any of the groups. Additionally, too few participants in the non-Caucasian categories did not allow running a statistically significant test to explore ethnic group differences.

Qualitative Findings

Participants were asked two questions, “What coping behaviors, thoughts or self-talk do you practice when you find yourself in challenging and stressful situations at

work? Please describe what you do” and “Briefly discuss what works well and what doesn’t work well to bring yourself back in balance.” Sixty-eight participants responded to these questions. The findings below will first present what behaviors respondents said they actively practiced as coping strategies. I then present findings which demonstrate what respondents indicated works or does not work as coping strategies.

This study found that participants engaged in various social support, cognitive and behavioral approaches. Social support approaches included connection with colleagues, significant others, supervision and personal therapy. Cognitive approaches included reflection, positive affirmations, healthy distancing, normalizing being human and a therapist, seeing the positive, and developing a wider perspective. Behavioral strategies ranged from spiritually inspired practices such as meditation, focusing on the breath, mindfulness, prayer, 12-step programs, lovingkindness, and gratitude practices, to increasing work boundaries, exercising, yoga, massages and resting, as well as distractions such as vacations, television, reading, journaling, nature, music, hobbies, smoking, and using the computer.

While some practices were seen as more effective than others, when asked which practices worked well, with the exceptions of 12-step programs and gratitude practices, each of the social support, cognitive and behavioral techniques, were listed by at least one respondent as working well. The most popular effective strategies were exercising, colleagues and personal relationships, slowing down and reflecting, meditation, breathing and mindfulness. Two new themes, finding humor and cleaning, were mentioned as working well, but were not cited as strategies actively practiced. When asked which approaches were ineffective, new themes emerged which were also the most popular:

isolating, being critical and blaming, ruminating and dwelling, and focusing on negative self-states (Table 18). Practices mentioned by a few that were both ineffective but also used, were colleagues, personal relationships, positive affirmations, diet, smoking, 12-step programs, and cleaning.

Coping Strategies Practiced

A content and theme analysis was completed on the open-ended question regarding what approaches clinicians' use when they are out of balance in their work. There were three general types of practices: social support, cognitive techniques, and behavioral activities, from which themes emerged (Table 18).

Social support. The top two approaches within all three categories involved social support. The most popular approach was 26 out of the 68 participants (38%) who identified seeking support from colleagues and peers. The second most common was a total of 17 participants (25%) who reported they sought out personal relationships with significant others, family, and friends. Supervision (10%) and personal therapy (6%) were also utilized.

Cognitive techniques. Fourteen participants (21%) reported slowing down and reflecting. Twelve participants (18%) reported using positive affirmations such as "this too shall pass" and "relax" and twelve also used healthy distancing cognitive techniques. One person explained healthy distancing as "removing myself emotionally if overwhelmed; not taking it personally." One therapist wrote:

I try to remember that my clients make their own choices. I try to guide them or show them another way, but ultimately it is their life, free will and own responsibility to make their own choices. I care for these people, but I cannot act for them.

Table 18.

Coping Strategies Among Practicing Psychotherapists

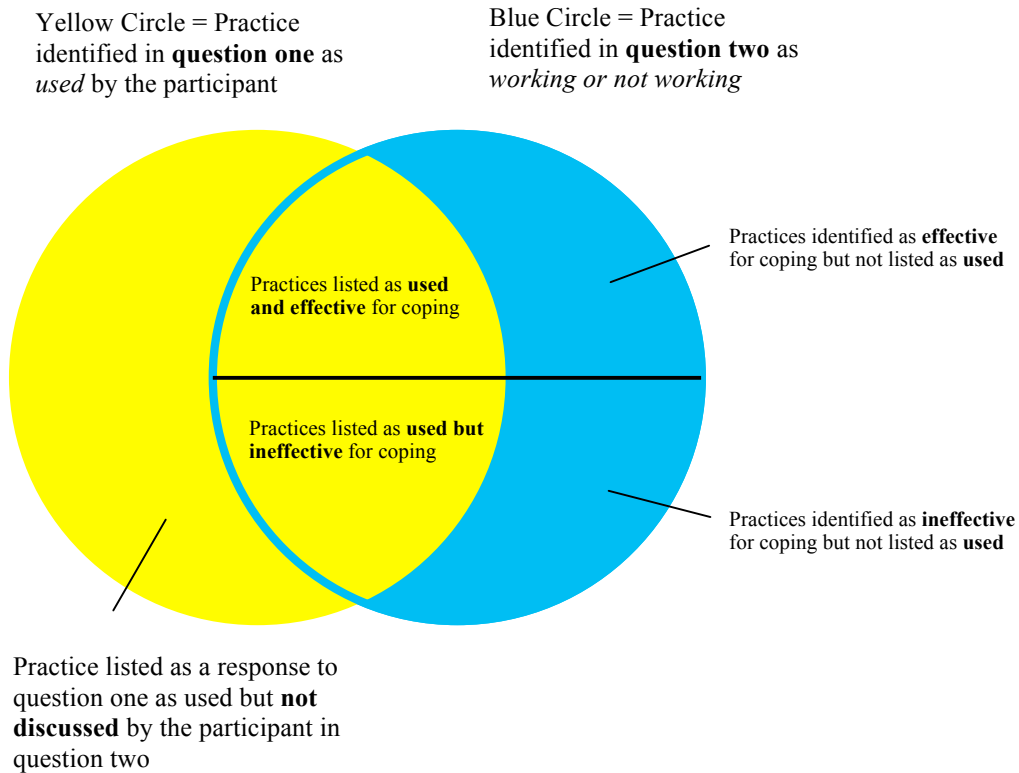
Theme	Q1: Uses	Q2: Works	Q2: DNW	Q2: Works	Q2: DNW	Q2: NC	Q2: Works	Q2: DNW
n =	68 (col2)	68 (col3)	68 (col4)	Col2	Col2	Col2	Col3+4	Col3+4
Social Support								
Colleagues	26	19	4	13	2	11	6	2
Personal relationships	17	20	1	8	0	9	12	1
Supervision	7	9	0	3	0	4	6	0
Personal therapy	4	1	0	1	0	3	0	0
Isolating	0	0	3	0	0	0	0	3
Cognitive Techniques								
Slowing down/reflection	14	14	0	9	0	5	5	0
Positive affirmations	12	1	1	1	0	11	0	1
Healthy distancing	12	10	0	5	0	7	5	0
Normalizing being human	11	1	0	1	0	10	0	0
Seeing the positive	9	3	0	1	0	8	2	0
Normalizing being a therapist	7	2	0	1	0	6	1	0
Wider perspective	5	1	0	1	0	4	0	0
Critical/blaming of self	0	0	10	0	0	0	0	10
Ruminating/dwelling	0	0	7	0	0	0	0	7
Focusing on negative	0	0	6	0	0	0	0	6
Finding humor	0	3	0	0	0	0	3	0
Behavioral Activities								
Meditation	14	14	0	10	0	4	4	0
Breath	14	13	0	8	0	6	5	0
Mindfulness	13	13	0	7	0	6	6	0
Work-life balance/boundaries	9	13	0	6	0	3	7	0
Exercise	7	20	0	3	0	4	17	0
Lovingkindness/mantras	7	2	0	2	0	5	0	0
Diet/nutrition	6	8	4	4	0	2	4	4
Television/movies	6	4	0	2	0	4	2	0
Other hobbies	5	7	0	3	0	2	4	0
Smoking/drinking	3	2	3	2	1	0	0	2
Rest/sleep	3	10	0	3	0	0	7	0
Vacation	3	6	0	2	0	1	4	0
Reading	3	5	0	0	0	3	5	0
Prayer	3	3	0	1	0	2	2	0
Journaling/writing	3	3	0	2	0	1	1	0
Music	3	1	0	1	0	2	0	0
12-step programs	2	0	1	0	1	1	0	0
Yoga	2	6	0	1	0	1	5	0
Massage/muscle relaxation	2	3	0	1	0	1	2	0
Computer	2	2	0	1	0	1	1	0
Nature	1	2	0	0	0	1	2	0
Gratitude practice	1	0	0	0	0	1	0	0
Cleaning	0	2	1	0	0	0	2	1

Note. Q1 = Question 1; Q2 = Question 2; DNW = Does not work; NC = No comment; Col = Column. Yellow columns = Responses in these columns indicate participants evaluation of the effectiveness of practices (question two) which they reported as a practice they use (question one). Thus the n for the three

yellow columns is the number of people who said they used the practice in question 1 (also shown as the yellow circle in figure 1).
 Blue columns = Responses in these columns indicate participants evaluation of the effectiveness of practices which they did not report using in question one. Thus the n for these two columns is the total number of all the people who said a practice was either works or does not work in question 2 who did not mention the practice in question one – as shown in the blue area of figure 1.

Figure 1.

Diagram of Subset Groupings for Identified Coping Strategies



Another added:

Sometimes I imagine developing a teflon shell when I feel like I am absorbing too much of a client's emotional distress and trauma response... I try to focus on listening and having a warm, empathetic approach while also trying not to directly experience the client's intense distress.

Normalizing being human was self-talk eleven participants reported (16%)

engaging in. One therapist shared "I tell myself: we are all bozos on the bus. I do not

expect to be 100%—just my personal best. This allows me to offer what I offer, and when it I make mistakes that trouble me, I forgive, learn, and move on.” Another wrote:

It reassures me and relaxes me to know that I do not have to be anything other than what I am, and that I am not only a collection of theories and techniques. When mistakes happen I remember that I am human and there is always room for repair.

Nine participants (13%) described seeing the positive in their struggle, such as one therapist who wrote “I feel better when I remind myself of successes and think back to where I/the client started together” and another who wrote “I locate small victories; I think of the potential longer term positive impacts of a therapeutic relationship.” Another seven (10%) normalized their stress as part of being a therapist, with one person noting, “I remind myself that stress is part of providing services to populations that really need them” and another who shared, “I tell myself that all therapists experience some challenging and stressful situations.” Lastly, five individuals thought about a larger perspective, such as connecting with their life values.

Behavioral activities. The two most common behavioral approaches, meditation and breathing, were both cited by 14 participants (21%), which was also the third most popular among all three categories, tied with the cognitive technique of slowing down and reflecting. One therapist stated, “Meditation has been life-changing in terms of self-care. I meditate 45 minutes a day for six days a week and couldn’t do this work without it!” Almost as common, thirteen (19%) of the clinicians noted they often utilized mindfulness practices in times of stress, such as “telling myself my feelings are temporary and will pass” and also “I allow myself to feel my feelings.” One clinician explained:

When I feel stressed in session, I self-observe my level of physical and emotional response and may slow my breathing or change my posture. I tell myself to stay present with the client and listen more carefully rather than let my thoughts or associations distract me.

Two other important behavioral approaches were maintaining work-life balance (13%) and loving-kindness practice (10%). Physical care activities, such as exercise (10%) and diet/nutrition (9%) were also notable. Lastly, a few individuals mentioned various escape and distraction techniques such as television, personal hobbies, vacation, and reading or writing.

Effective and Non-effective Coping Strategies

Another theme analysis was completed on the question concerning what participants thought worked well or does not work when dealing with job stress (Table 18). These findings fall into two categories: practices that are espoused to work well and those that were reported to not work well. In some cases participants commented on the effectiveness of behaviors which they also described practicing in their answer to question one. However, in other cases practices were discussed as either working or not working, which were not mentioned as a current practice of the individual. Thus, many respondents noted different strategies they thought worked well or not, that they did not mention as something they did in the first question, as shown in the blue highlighted columns in Table 18, as well as the reverse where some respondents did not comment on their practiced strategies from question one, as working well or not in question two, as shown in the *Q2: NC* titled yellow highlighted column in Table 18.

What works well. Personal relationships and exercise were tied as the most common response on what participants believed worked well to bring them back into

balance, recommended by twenty participants (29%) each. The importance of personal relationships, the second most common activity people engaged in when stressed, was emphasized by one person, “talking to other emotionally mature friends is number one to help bring perspective and balance back to my life and lessen a self critical introject.” Another wrote, “I try to hang out with people who aren’t in this field so that my downtime social conversations do not exclusively revolve around clinical work.” Notably, 17 of the 20 total participants who said exercise works well do not necessarily exercise when out of balance, as they did not mention using it as a technique when asked in question one what they do. This was illustrated by one respondent who wrote, “Should go to the gym more often—that has proven to be the best coping mechanism.”

Talking to colleagues was the second most popular response (28%) for effectiveness, even though it was the most common thing people actually did. Supervision (13%) was the other common social support cited, similar to the number of people who used it as an active coping method.

Slowing down and meditation were tied as the third most common responses for effective approaches, by 14 people each. One respondent wrote, “When I give myself time to breath and slow down even for a few minutes, it always helps me to calm down. If I don’t allow the moment of pause, it tends to escalate my level of stress.” Notably, of the 14 people who mentioned meditation, 10 people who noted it was effective also said they actively practice it. Maintaining boundaries, mindfulness and breathing were all tied as the fourth most popular strategy reported to work well. Similar to those who mentioned meditation, more than half of the 13 respondents in each group also noted they

actively do those activities when stressed. Second to slowing down, among the cognitive approaches healthy distancing (15%) was another common response.

Less commonly mentioned as working well yet popular as something they actually engaged in, was seeing the positive, normalizing being a therapist and human, positive affirmations, and cultivating a wider perspective. While not nearly as espoused as exercise, a few people mentioned rest, nutrition, yoga and massage, personal hobbies, vacation, reading, television and writing.

As presented in Table 18 in the yellow highlighted column titled *Q2: Works*, there were certain items that were believed to be effective by respondents in question number two, who also listed in question one they actually do that particular strategy when stressed. The most common themes with the largest numbers of people who did what they thought was effective, were talking to colleagues (13 out of 26), meditation (10 out of 14), slowing down and reflecting (9 out of 14), personal relationships (8 out of 17), breathing (8 out of 13), mindfulness (7 out of 13), time management/boundaries (6 out of 9) and healthy distancing (5 out of 12). Those participants who did not comment if a particular strategy they engaged in was either effective or not are presented in Table 18 in the yellow highlighted column titled *Q2: NC*; they may have assumed it was effective (or not), however they did not specify either way.

What does not work. When asked to comment on what participants thought was not an effective coping, three new themes were mentioned much more frequently than any others cited: self-blame, rumination, and focusing on negative feelings. These cognitive techniques were the first, second and third most reported responses. The first was being blaming or critical of oneself, reported by ten participants. “Blaming myself or

feeling guilty doesn't usually work well and is counterproductive to growth and understanding/moving forward," remarked one therapist. Another stated "What doesn't work is beating myself up for getting out of balance in the first place." Second was dwelling or ruminating on the situation, reported by seven participants. One person stated "dwelling negatively on the frustration or failure, and wallowing in it, is not helpful." Another person explained "excessive reflection without a reality check with trusted others can lead to over thinking without relief." Six people identified with focusing on negative internal thoughts and feelings. "It does not work well for me to focus on the negative self talk or the fears and anxiety," stated one person, while another shared, "over focusing on anger and frustration does not work well. Nor does blaming. Harsh self criticism does not work either."

Talking to colleagues and poor diet were the fourth most cited ineffective approaches, noted by four people each. Three people also identified isolating as an unhelpful approach. "Isolating and staying to myself can throw me off balance and leave me feeling alone in challenges I face with clients. Feeling like I'm working with a team helps me work more efficiently," wrote one participant. Another noted, "What doesn't work well is keeping everything inside. It doesn't work well to let things build and then have a very emotional reaction in the workplace." Items that had previously been cited as working well were also cited as unhelpful. One therapist commented personal relationships were sometimes unhelpful, specifying "Assuming the role of therapist with friends." Another person cited 12-step programs as a hindrance, "because I often hear more problems and feel this is my time-off."

As presented in Table 18 in the yellow highlighted column titled *Q2: DNW*, some of the items that people believed did not work well were also responses they tended to practice anyway, such as two people who mentioned talking to colleagues, one of whom stated “often their frustration and mine combine to make it not healthy,” one person who smoked and another who attended 12-step programs. Conversely, of the most popular items believed to not work well—being critical of oneself, ruminating and focusing on negative feelings, none identified those strategies as something they tended to actively use or do when stressed, in question number one.

The responses to the questions highlights how a sample of mostly moderate and highly self-compassionate clinicians with low to moderate levels of burnout, use a variety of social, cognitive and behavioral coping strategies to keep themselves in balance. Overall, the sample had high rates of using social support, particularly colleagues and personal relationships and also believed they worked well. They found practices such as mindfulness, meditation and breathing particularly helpful, and actively practiced them. Many gave themselves time to slow down and reflect, created work-life balance and used healthy distancing with clients. Exercise was espoused as helpful but not as commonly practiced. There were a small number of individual physical care behaviors and escape and distraction techniques cited, however none were as common as the aforementioned approaches. This sample of therapists did not report engaging in negative thinking, self-blaming, isolating, or ruminating when struggling, however they these approaches were believed by the majority as responses that would hinder bringing them back into balance.

CHAPTER V

DISCUSSION

The purpose of this study was to explore if there is a relationship between therapists' levels of self-compassion and levels of burnout. As discussed in Chapter I, lack of attention to job burnout can lead to adverse consequences for the clinicians, be costly for the organizations for which they work, and affect the reputation and esteem of the mental health profession (Pines & Maslach, 1978; Shapiro et al., 2005; Sherman & Thelen, 1998; Stevanovic & Rupert, 2009). Coping mechanisms that are associated with buffering against the unique stressors of the mental health profession can be examined in order to find ways to maintain the health and effectiveness of mental health professionals.

The literature shows that self-compassion may be a powerful coping skill for maintaining mental health (Adams & Leary 2007; Gilbert & Procter, 2006; Thompson & Waltz, 2008). Thus the application of self-compassion may be one way therapists can mitigate or minimize burnout. This study was the first to examine whether there is a relationship between self-compassion and burnout in psychotherapists. This chapter reviews the research findings as they relate to the initial research question and relevant research literature. The chapter is divided into three sections: discussion of the findings, limitations of this research, and implications for future research.

Discussion of the Findings

This discussion of the findings comprises four parts. First, the findings for overall self-compassion and burnout levels are discussed. Secondly, I discuss each of the three

hypotheses evaluated in this research. Third, findings from the demographic data are explored. Lastly, the findings from the two qualitative questions are discussed.

Overall Self-compassion and Burnout Levels

Over half of the participants in this study ranked in the high range for total self-compassion, nearly a third, in the moderate range, and only three participants, low in self-compassion (see Table 8). Participants also reported low levels of burnout (see Table 10), with more than half reporting low scores of emotional exhaustion, 85% reporting low depersonalization scores and 81% reporting high personal accomplishment scores, which is associated with low burnout (Maslach et al., 1996). The findings are congruent with Söderfeldt et al.'s (1995) review of empirical studies on burnout in the mental health field finding social workers experienced low degrees of burnout.

The low prevalence of burnout among the participants was unexpected since the literature has suggested that therapists must cope with unique risks and stressors associated with practicing psychotherapy (Maslach et al., 2001; Moore & Cooper, 1996). From the survey responses it seems likely that the therapists participating in this study employ effective coping mechanisms that effectively mitigate the negative consequences of burnout.

Discussion of Hypotheses

The findings of this study show a small set of correlations between the overall self-compassion and burnout variables as reported in the results chapter. There were fewer relationships than expected. This section first discusses the correlations that were identified for Hypothesis 1, 2, and 3. I then explore possible explanations for why overall relationships did not emerge as hypothesized.

Hypotheses 1 and 2. The first hypothesis stated total self-compassion levels are expected to have a negative correlation to the emotional exhaustion subscale of burnout. The second hypothesis stated total self-compassion levels are expected to have a negative correlation to the depersonalization subscale of burnout. Both hypotheses yielded the similar results. In each case the subscale of isolation was the only variable to correlate with the burnout variable.

The self-compassion subscale isolation varied significantly with levels of both emotional exhaustion and depersonalization. In other words, higher levels of a sense of common humanity were associated with both lower levels of feeling depleted and fewer negative/impersonal attitudes towards clients. These findings support the research indicating that feeling socially connected and emotionally supported by other professionals is associated with lower burnout levels (Farber & Heifetz, 1982; Himle, Jayaratne, & Thyness, 1989). Additionally, previous studies have indicated that the individual nature of psychotherapy is a risk factor associated with burnout due to isolation from colleagues and peers (Hellman & Morrison, 1987; Sprang et al., 2007). Berkowitz (1987) discussed the importance of social connectedness:

We must discuss our difficulties, including our failure experiences. There is very little room for vanity. For this we need to look no further than John Bowlby who identified three pertinent dysfunctional human strategies: (1) compulsive care giving; (2) emotional detachment; and (3) compulsive self-reliance. Loneliness is the cost of such protection to therapists who tend to be isolated. This problem is incredibly reinforced when therapists believe that they, themselves, are supposed to be models of mental health. They should not hold themselves out as such, even to their patients. This should not be their purpose as a therapist and it should not be a personal goal in their lives. (p. 88)

The emergence of isolation as variable relating to burnout may have emerged due to the nature of the work environment of survey participants. Nearly half of the

participants were in private practice and many of those in agency settings may have been primarily conducting individual therapy, therefore feeling isolated may have been a particularly salient factor.

Hypothesis 3. The third hypothesis states that total self-compassion levels are expected to have a positive correlation to the personal accomplishment subscale of burnout. The results of this study indicated a significant relationship between participants' total self-compassion and their levels of personal accomplishment. For these participants, feeling skilled and believing they are providing a valuable service is strongly associated with how self-compassionate they are. As the literature suggests, feeling competent can be easily thwarted within the profession, as successes are often not apparent, and the daily emotional demands of clients can overshadow underlying changes. Thériault and Gazzola (2006) highlighted how feelings of inadequacy and reduced feelings of mastery are prevalent among mental health professionals and are detrimental to their effectiveness. This study found that that clinicians' sense of adequacy and achievement is related to how self-compassionate they are. Thus, increasing self-compassion may ameliorate feeling professionally dissatisfied by providing a wider perspective of achievable successes, normalizing a clinician's experiences, and not expecting perfection.

The literature on positive psychology provides one way of understanding why self-compassion and positive subscales mindfulness, self-kindness and common humanity correlated with personal accomplishment. Increasing positivity has been shown to be an important factor in enhancing and sustaining well-being, while negative affect, such as feeling contemptuous or irritable and expressing disdain or disliking, has been

linked to decreased functioning (Sin & Lyubomirsky, 2009). Frederickson's (2006) broaden-and-build model illustrated that bolstering positive emotions and mind-states creates a reservoir or surplus of inner resources and accumulated wisdom that acts as immunity against future challenges that challenge one's ability to manage stress. Frederickson found that positive emotions and mindsets can even undo the detrimental affects suffered when stressed. Unlike negativity, which narrows people's actions that increase their well-being, positivity widens the array of thoughts and actions and generates greater flexibility and innovation for coping. Thus, the positive psychology literature suggests that use of self-compassion, and specifically mindfulness, self-kindness and common humanity, may increase positive self-states, such as happiness, optimism and curiosity, thereby increasing practitioners' physical, cognitive, and social resources for keeping themselves resilient and keeping their sense of personal accomplishment high. Conversely, lowered self-compassion may negatively impact an individual's positive affect, thus lowering personal accomplishment.

As reflected in the literature, those individuals who are happier have been shown to enjoy more workplace success and are seen as more accomplished (Lyubomirsky et al., 2005; Pressman & Cohen, 2005). The use of mindfulness, common humanity and self-kindness among participants in this study may have increased positivity, leading to satisfaction with their work. In other words, increased positive affect and positive attitudes towards clients may have provided an optimal frame for helping themselves and others. In turn, increased self-care through self-compassion may have helped participants find inspiration and happiness in their work, thus increasing their sense of personal accomplishment, rather than seeing their work as insignificant and inconsequential.

Comparison of hypotheses findings. The finding that a relationship exists between self-compassion and personal accomplishment but not the other two aspects of burnout, is somewhat unexpected. One way to understand the finding may be through Gil-Monte, Peiró, and Valcárcel's (1998) alternative model of the burnout syndrome, where response to job stress is understood as a secondary response after initial appraisal and coping strategies are not successful. They depict burnout as progressing from an initial lack of personal accomplishment to emotional exhaustion and then from emotional exhaustion to depersonalization. In contrast to initial conceptions of burnout (Maslach et al., 2001), personal accomplishment is considered an earlier stage of burnout and cognitive assessment that, without sufficient coping, may create an emotional response (exhaustion), leading to depersonalization as a coping strategy. Thus, perceptions of poor performance and feelings of professional failure generate frustration and the emotional exhaustion and depersonalization responses. In this study, participants' self-compassion may be a coping strategy employed during this initial phase of assessing personal satisfaction in their jobs. Thus participants are able to cope without the need for subsequent exhaustion and depersonalization as ways of coping.

Discussion of Findings by Demographic

When participants were examined by demographic groupings, several new key findings emerged, including gender, age, experience, and licensure type differences. This discussion is presented in three sections. First gender differences are discussed. Secondly, age and experience are discussed. Last, licensure type differences are explored.

Gender. This study found a distinct difference between women and men's self-compassion and burnout correlations. Women's scores showed multiple significant

relationships between self-compassion and two of the three burnout dimensions. Female participants' total self-compassion and subscales self-kindness, self-judgment, isolation, common humanity and mindfulness correlated significantly with depersonalization (Table 13). Their total self-compassion and subscales self-kindness, common humanity and mindfulness were also associated with personal accomplishment. In contrast, only one self-compassion subscale, isolation, was associated with only one burnout dimension, emotional exhaustion, for men.

These findings may be due in part to gender differences in self-reporting of self-compassion. Previous research on gender differences in self-compassion found that women score lower in self-compassion than men (Hsieh et al., 2008; Neff, 2003b) Thus, lower reported scores by women could potentially lead to a more distinct relationship between self-compassion and burnout scores, particularly given the relatively small number of participants in this study.

The significant associations between female participants' self-compassion and burnout may reflect women's particular coping styles. Research has indicated women tend to be more self-critical and to have more ruminative coping styles than males (Leadbeater, Kuperminc, Blatt, & Hertzog, 1999; Nolen-Hoeksema, Larson, and Grayson, 1999). This could lead to women's reporting lower levels of self-compassion in relation to burnout. Nolen-Hoeksema (1987) argued that compared to men, women's lower social power and status, and their experience of more negative circumstances in important areas in their lives such as balancing multiple roles (mother, partner, employee) and feeling less valued (lower pay) contributes to their tendency to engage in rumination and focus on negative feelings when they are distressed. Thus, the more female

participants engaged in these kinds responses, the more their burnout scores increased. Conversely, as they were more self-compassionate, they regained balance and their burnout scores decreased. Self-compassion's focus on combating rumination and challenging internal self-criticisms, may have provided a way for women clinicians to feel efficacious about exerting control and not remaining stuck in a style of coping common among females.

Personal accomplishment and self-compassion varied for women but not men. One way to understand this finding is through research indicating female clinicians reported greater use of career sustaining behaviors than male clinicians, particularly self-talk strategies for perspective, relational or support-seeking approaches, and self-awareness (Coster & Schwebel, 1997; Kramen-Kahn & Hansen, 1998; Stevanovic & Rupert, 2004). Thus, female participants in this study may have been predisposed to use the strategies of self-compassion to boost their sense of vocational accomplishment, since the practice entails positive self-talk, mindful awareness, and increasing a sense of connection.

All of the self-compassion subscales, with the exception of overidentification correlated with depersonalization for women. Depersonalization refers to negative, callous, or excessively detached responses to various aspects of the job. Glasberg et al. (2007) noted depersonalization seemed to be related to high levels of *stress of conscience* from sacrificing one's own standards of care to try to meet the demands of the work. Women participants' higher depersonalization scores in relation to lower self-compassion may have reflected this response of trying to perform at their peaks without adequate coping when demands were too high. When self-compassion increased, depersonalization

decreased. Thus, female practitioners may need to actively incorporate an empathetic, compassionate stance towards themselves so that they do not have to work at peak efficiency, over all situations, and with all clients in order to be happy, effective clinicians.

The theory of women's development called *self-in-relation* may also help explain the gender differences. Jordan, Miller, Stiver, and Surrey (1991) explained that women, more than men, function in a context of attentiveness and responsivity to others. For women, well-being is related to the degree of emotional sharing, openness, and sense of understanding and regard with others. Women are also more accommodating to and sensitive towards shifts in feelings of self and others. Thus, women psychotherapists may experience the stressors of their work more intensely than men due to their more attuned internal and relational styles. Self-compassion may have been an instinctive coping mechanism for the women psychotherapists in this study, because it focuses on internal and relational coping. Thus, their use of the practice was related to their levels of burnout. Jordan et al. commented on the connection between women's particular relational style and well-being:

For women, guilt and shame often become tied to the experience of failure in mutual empathy. That is, women suffer if they feel they have not participated in relationships in this way. However, if other growth-promoting mechanisms can be made available, these failures can lead to further relational growth. A sense of self worth becomes involved in a "good enough" understanding and caring for the other. This is a key factor in women's self-esteem though it is often overlooked. (p. 58)

Good enough caring is also an essential part of self-compassion: reminding oneself that mistakes are part of life, being non-judgmental, taking a broader perspective, and letting negative emotions pass.

Age and years in practice. Age and years of experience appear to impact the relationships between self-compassion and burnout. Clinicians in the youngest age group (28 - 38) and with the least number of years of experience (1- 7) showed associations between the self-compassion subscales of mindfulness, common humanity and self-kindness with the personal accomplishment dimension of burnout. In contrast, for clinicians with more experience, the burnout dimensions of emotional exhaustion and depersonalization were only correlated with the self-compassion variable isolation. Farber's (1990) research on young and inexperienced practitioners may provide some insight into these findings. Farber noted that younger, inexperienced therapists have not worked through their own countertransference, and hold on to their feelings of frustration, anger, or bewilderment with difficult clients longer than more tenured therapists. They may not be as adept at drawing boundaries with clients or be as accustomed to the nonreciprocal and drawn out nature of the work. With less time in the field, newer clinicians may have not developed sufficient professional support networks. Additionally, supervisors may provide inadequate feedback for good work and senior staff may tend to give new clinicians the more "difficult" patients. Farber and Heifetz (1981) described how new clinicians often have unrealistic expectations that can create disillusionment and reduced sense of accomplishment:

The expectations of the many students who strive so earnestly to enter the psychotherapeutic field apparently center on the notion that it is a profoundly fulfilling human service enterprise and that it is a unique field, offering immense personal satisfaction, substantial financial compensation, personal autonomy, high status, and unlimited opportunities for personal growth. (p. 629)

The older, more experienced clinicians in this study may feel more confident in their abilities and can rely on their past successes as compared to their younger

colleagues who have accumulated fewer resources to draw on when challenged by their work. The newer clinicians in this study may feel more insecure of their fledgling skills, thus their sense of personal accomplishment may be more tenuous than that of their older counterparts. As well, newer therapists are usually paid less than their senior colleagues; therefore gaining a sense of professional aptitude may be more dependent on more elusive achievements in their work. Thus, as self-compassion was used among younger, newer clinicians in this study, they may have been providing themselves their own positive feedback and self-soothing, which was connected to feeling their work was valuable.

Another possible way to understand this finding is through examination of the qualities of the positive subscales of self-compassion that were associated with personal accomplishment for the young and inexperienced clinicians. The self-kindness, common humanity and mindfulness subscales tend to increase positive self-states. Thus, for younger, newer clinicians, it may be particularly important to build internal resilience not through focusing on alleviating negative self-states (isolation, self-judgment, overidentification), but through actively strengthening pathways of positive emotions through self-kindness, mindfulness and common humanity. As described, younger and inexperienced therapists are especially at risk for burnout; therefore, building a reserve of positive internal resources to offset the unique challenges they face may be a factor in bolstering their sense of feeling competent and accomplished. Lastly, there is the possibility that clinicians whose professional aptitudes and beliefs in the merits of their work are associated with how self-compassionate they are, simply leave the field altogether. This could potentially explain how the older, more experienced participants

remaining had no significant associations between self-compassion and vocational accomplishments.

Licensure. Correlation analysis performed on licensure groups indicated significant positive correlations between self-compassion and burnout for the MFT and LCSW groups, but no significant correlations for the PhD group. The burnout literature did not include research on licensure differences; however, this finding may have been influenced by experience level. While there were no distinct mean age differences among the groups, the PhD participants were more experienced ($M = 17, SD = 11$) than the MFT group ($M = 13, SD = 8$) and the LCSW group ($M = 9, SD = 9$) (Table 19). As previously discussed, relationships between self-compassion and burnout were more prevalent among the inexperienced clinicians.

Table 19

Means and Standard Deviations of Years of Experience by License

Licensure	<i>M (STD)</i>
PhD	17 (11) years
MFT	13 (8) years
LCSW	9 (9) years

Note. PhD (n=25), MFT (n=17), LCSW (n=29)

Another possible explanation for this finding may be that the longer training necessary for the doctoral programs resulted in the PhD clinicians using different coping styles than the master's or equivalent participants. For the PhD clinicians, persisting through the longer span of time in clinical training may have required developing types of coping other than self-compassion. Their stance towards the challenges of psychotherapy may be a reflection of how they endured the challenges of their longer, more extensive programs. Future research is needed to further understand this finding.

Discussion of Qualitative Findings

Participants were asked (1) *What coping behaviors, thoughts or self-talk do you practice when you find yourself in challenging and stressful situations at work? Please describe what you do,* and (2) *Briefly discuss what works well and what doesn't work well to bring yourself back in balance.* The participants in this study overall scored highly in self-compassion and low in burnout, thus when asked these qualitative questions, their responses reflected more specifically *how* participants with high self-compassion act and think when out of balance and *which* particular strategies were believed to work and not work.

Not surprisingly, these responses overwhelmingly reflected the use of self-compassion, as defined by Neff (2003a): a kind and nonjudgmental attitude toward oneself when suffering; recognition that one's experiences are part of the larger, more universal human experience; and the holding of painful thoughts and feelings in balanced awareness, in which they are observed and accepted without judgment, rumination, or self-pity. The responses to the qualitative questions are examined in context of these three main components of self-compassion. First, coping related to isolation and common humanity are explored. Secondly, strategies related to mindfulness and overidentification are explored. Lastly, responses indicating use of self-kindness and self-judgment are discussed.

Isolation and common humanity. Support from other professionals and personal relationships were the most commonly used and most effective approaches. This finding is consistent with the literature (Farber & Heifetz, 1982; Himle et al., 1989) showing social support as a key factor in mitigating burnout. This finding aligns with the

quantitative results indicating the self-compassion subscale isolation varied significantly with depersonalization and emotional exhaustion. It also aligns with the quantitative finding that the subscale common humanity was significantly associated with personal accomplishment.

Participants' comments reflected how feeling connected with others was valuable for keeping them in balance, through gained perspective, feelings of being on a team, being able to problem solve with others, lessening shame that their experiences were unique or embarrassing, and receiving encouragement and reassurance that could then be internalized. These approaches align with literature (Farber & Heifetz, 1981; Rupert & Morgan, 2005) indicating psychotherapy can be an isolating profession, where feedback and perspective are not always readily available, thus connecting with others often needs to be actively pursued and cultivated.

Popular self-talk approaches that enhanced feeling connected to others was seen through the themes of normalizing being human, normalizing being a therapist, and cultivating a wider perspective. Thus, these responses described how participants' used the self-compassion component of common humanity. Participants gave various reminders to themselves that their difficulties were common to being human and a clinician, and that connecting to a larger world outside themselves and their vocation were often used, and useful for regaining balance. As expected, these participants did not report they tended to isolate, however isolating was mentioned as the fourth most believed detrimental response to stress.

Mindfulness and overidentification. The techniques of meditation, breathing, mindfulness and slowing down and reflecting all closely followed social support as the

most common coping strategies practiced. They were also listed as the more popular espoused strategies to work well, with the majority of participants engaging in at least one of these practices. These approaches are all associated with the self-compassion component of mindfulness. Thus, staying present with their experience without judgment, using breath to center, and giving themselves time to acknowledge and stay with their struggles in a quiet, curious manner, were important for their well-being and staying effective in their work.

Meditation and mindfulness were notable strategies because they were each one of the highest rated techniques that were also reported by clinicians as both an active and effective practice. Respondents wrote about a range of meditation practices, including “quick and frequent” meditations between clients, to daily practices. The participants’ comments were consistent with the research on mindfulness and meditation illustrating how the practices increased awareness of countertransference, enhanced perceptions of clients’ projections, and allowed clinicians to remain present with clients, while maintaining a curious, empathetic stance (Newsome et al., 2006; Neff, 2003a; Brenner, 2009). The clinicians in this study stated that mindfulness-based practices allowed them to better concentrate and tolerate difficult emotions when faced with challenges.

The opposite approach, using distractions such as television, hobbies, reading, and computer use, was used by some of the participants; however, these responses were less common and reported as less effective than the mindfulness-based approaches. A possibility why clinicians tended to use mindfulness practices rather than avoidance strategies to face their challenges may be that mindfulness allowed bringing themselves back into balance *during* a difficult situation, thus allowing immediate reparations to

difficult situations. Distractions may have provided momentary respite; however, these strategies may have necessitated additional time to implement (vacations) and the difficulty may have resurfaced afterwards due to a lack of attention for problem solving needed.

Overidentification, the opposite process of mindfulness, was reflected in the second and third most popular found categories of what was believed to work badly—rumination/dwelling and focusing on negative emotions. As supported in the literature (Mongrain et al., 1998) and reflected in the participants' comments, getting caught up in frustrations, irritability, and negativity were thought to be professionally limiting and kept clinicians from managing their well-being. The participants' beliefs that negativity is harmful support the positive psychology literature (Frederickson, 2006) that posits positive affect allows individuals to think more expansively about ideas and problem solving, while keeping emotional stability. Thus, respondents claimed negative affect would restrict their ability to help themselves and their clients.

One way to reduce overidentification appeared to be through the commonly used practice of healthy distancing. This practice was also reported as effective by the majority of therapists that used it. Congruent with the literature on the use of *detached concern* (Kramen-Kahn & Hansen, 1998; Lief & Fox, 1963) among psychotherapists, the participants reported the practice helped keep a balanced stance of both empathy and objectivity with clients. They stated this technique avoided a tendency to become over-involved with intense emotions and overly focused on their own negative reactions. Thus, part of their self-compassion entailed a reduction in overidentification through this

strategy, which required the self-compassion component of mindfulness for maintaining the delicate balance of concern and separation.

Self-kindness and self-judgment. Positive self-talk in the form of positive affirmations was a highly rated response. Looking at the positive in their challenges was also a popular response. This is consistent with Folkman et al.'s (1997) research, which indicated a similar approach, positive reappraisal, was linked to increased functioning in health-care workers. Loving-kindness practice or metta, a form of visualizing and repeating phrases of self-love to oneself and others, was also rated as a popularly used practice. Both metta and positive affirmations primarily involve the self-compassion component of self-kindness: generating self-soothing thoughts, loving images, reinterpretation of situations with positive self-statements and cultivating a caring attitude. Thus, compassionate self-warmth and kindness were often used as practices clinicians turned towards when under stress.

Although these practices were used, they were not noted as either effective or not effective. In contrast to the literature (Gilbert et al., 2006; Jain et al., 2007; Moskowitz et al., 1996), in this study, practices focusing on the self-kindness aspect of self-compassion were actually seen as less effective than the strategies associated with the other components of self-compassion. On the other hand, the number one approach believed to most hinder effective coping was the self-judgment component of self-compassion. Respondents wrote that being critical, blaming and judging of oneself was the least helpful response to their challenges. In other words, even though many participants who used strategies that emphasized the self-kindness aspect of self-compassion generally did not comment their effectiveness, a large number of respondents stated that the opposite

practice of having a harsh internal critic would be the most detrimental response when struggling in their work.

One way to understand the finding that self-judgment was the least effective coping response may be that most psychotherapists are trained to understand developmental theories about how individuals' cognitive schemas for self-to-self relating are based on prior interactions with attachment figures. Having a professional understanding of how experiences with others who are either accepting or critical become internalized and subsequently expressed as self-acceptance or self-criticism may be a factor in why clinicians stated self-judgment was especially harmful. This awareness may have heightened their sensitivity to the perils of unaccepting and harsh internal states, leading them to identify self-judgment as the most harmful practice for coping. After all, as Gilbert and Proctor (2006) suggested, much of the work as a therapist is providing warmth and validation and combating negative cognitions, to help the client internalize a kinder, more accurate and soothing internal self. Another possibility is that these clinicians' positive self-talk and self-soothing introjects are so ingrained in themselves, that when asked about their coping, they overlooked something they do all the time (generating kind internal cognitions), in favor of reporting more action-oriented coping such as meditation and peer support.

Two coping techniques were reported as commonly used, but were not directly related to the use of self-compassion as defined by Neff (2003a). The first was maintaining work-life balance, through such strategies as reduced work hours, not taking on additional clients, and not bringing work home. The second was exercise. Other behavioral activities such as massage, diet, vacations and journaling were also mentioned

by a few. These activities could be considered compassionate acts; however they differ from the majority of the responses that were person-centered, intentional approaches emphasizing self-kindness, mindfulness and common humanity.

A discrepancy was found between actually engaging in exercise and believing it worked well. Somewhat surprisingly, exercise was tied for the most popular strategy believed to work well, but the rates of actually engaging in this activity were less than half of those espousing it, ranking it well below other popularly used approaches. While there are several possible reasons for this finding, no research has explored this area. One reason this may have occurred is that most of the self-compassionate strategies are portable, and can be practiced in most circumstances, including home or at work, with minimal time or requirements. Practically, it may be much harder for therapists with busy schedules and working long hours to find the time and energy for physical activity. On the other hand, it seems that as the number one known effective mechanism from this study, therapists would find a way to use such a failsafe approach when out of balance. Psychotherapy has an intellectual focus and is often sedentary. Transitioning into a more somatic-based coping strategy may be more of a challenge for clinicians than other cognitive approaches. Another possibility is that they may have a hard time giving themselves help, preferring to be the helper to others. They may unconsciously believe they cannot take the extra time away from their job, clients and significant others, for their own self-care for their own healing. Thus, the clinicians tended to use “good-enough” coping strategies as compensation, rather than an approach that may have felt too self-centered or self-indulgent. More research in this area is needed.

Study Limitations

One of the main limitations of this study is the inability of this research to determine a cause-and-effect relationship among the variables in this study. Correlation analysis was performed as necessary first steps to establish self-compassion as relevant to burnout. Determining a cause-and-effect relationship among self-compassion and burnout would strengthen the understanding of self-compassion, as well as provide evidence as to whether self-compassion prevents burnout among psychotherapists.

Another main limitation of this study is the generalizability of the results. The results of this study are only generalizable to participants similar to those that participated in this study and not conclusively applicable to the greater population of therapists. This study looked at 71 clinicians and found overall low levels of burnout. These findings do not support the literature suggesting high levels of burnout among mental health professionals (Farber, 1983; Farber & Heifetz, 1981; Freudenberger, 1990; Hellman et al., 1986; Smith & Moss, 2009). Using snowball sampling and recruitment via flyers in a major metropolitan city of California may have made the sample more homogeneous. Thus, the data in this study suggesting high self-compassion and low burnout among psychotherapists may have reflected a skewed sample, rather than a more general mental health clinician population. Possibly, psychotherapists in private practice may have passed the survey along to their other private practice colleagues. This area of California also has a large community of mindfulness-based practitioners, which may have affected the diversity of participants. Thorough measures ensuring a broader range of clinical settings across a more diverse geography more representative of the mental health field would be valuable in future research.

The participants of this study included mainly white clinicians. Self-compassion may also be associated with burnout among clinicians with different ethnic backgrounds. Too few minority participants made it difficult to detect significant correlations among ethnic groups. This would be important to further explore, possibly in a study exclusive to minority psychotherapists.

The choice to use surveys inherently limits the study to those participants who self select into the survey. Informing the potential participants of the study's emphasis (self care and stress) prior to their decision to participate may have attracted only those clinicians who were particularly satisfied with their current profession and not burned out, who had the time and energy to complete the surveys. Therapists more able to cope with the challenges of their work may remain in the field longer and feel better able to answer questions about their well-being and coping responses. Those clinicians who were burned out, may have not found the time or felt too exhausted to complete the survey. Additionally, having the study online and recruited via email increased the exclusion of possible participants who do not use email or do not have access to computers.

Suggestions for Future Research

An important next step is to carry out similar research in a larger and more varied population of therapists. Conversely, research conducted among mental health specializations traditionally associated with a high prevalence of burnout (Ackerley et al., 1988; Sprang et al., 2007), such as work with trauma-populations and the severely mentally ill, may highlight more clearly how self-compassion and burnout are related.

The findings from this study observed distinct differences among gender groups, years of experience, age and licensure. These are concerning finding that could strongly

benefit from future exploration, including longitudinal studies measuring burnout and self-compassion levels in relation to increased tenure in the field.

Clinicians in the current study reported using a variety of approaches to bring them back into balance, many of which were espoused as effective. These clinicians did not generally note as many ineffective strategies. Future qualitative research could investigate a more in-depth understanding of these effective and non-effective self-compassionate techniques, as well as generate a clearer understanding of how their responses have an impact on their work.

There is a scarcity of empirical studies that address the effectiveness or benefits clients may receive from clinicians with varying levels of burnout, and no research on clinicians' self-compassion levels and client success rates. Future research which compare self-compassion and burnout levels with client outcomes as well as employee retention, might enhance empirical support for the benefits of the practice, motivating employers and schools to increase efforts at implementing compassionate self-care information and programs.

While the interest in self-compassion has increased in recent years, more research and discussion on identifying practical ways to create training and educational programs that integrate self-compassion training and promote understanding of self-compassion needs to continue to advance. Experimental studies could expand on initial research implementing self-compassion training programs (Gilbert & Irons, 2005, Gilbert & Procter, 2006), specifically for psychotherapists. If connections between self-compassion and resilience are continued, integrating self-care practices in the mental health profession and education may become more than hollow words on these crucial issues.

Hopefully, the findings determined from this study will help stimulate much needed further research and discussion on how psychotherapists' treatment of themselves in therapeutic contexts may be associated and influential in enhancing their full potential as professionals and in lessening the serious consequences of burnout.

Implications for Practitioners

The proposed audiences for this study are clinicians, educators, and students within the mental health profession who are interested in reducing burnout. Avoiding the costly and detrimental consequences of burnout is in the best interest of employers, educators and the future of psychotherapy. If clinicians are not retained, and if they are not working efficiently and effectively, then the mental health field will lose in terms of overall reputation and employee productivity and quality of care to clients.

As psychotherapy poses a unique emotional strain and many ethical problems and dilemmas, it is surprising that while studies often focus on the therapist's ability to provide compassion for clients, relatively few studies have fully investigated the impact of how therapists treat themselves. The idea of taking time for self-care may seem a selfish luxury; however, developing strategies for increased resilience is an essential part of the therapeutic mandate, enabling caretakers to care for patients in a sustainable way with greater compassion, sensitivity and effectiveness (Kearney, Weininger, Vachon, Harrison, & Mount, 2009).

Previous research shows no conclusive results regarding prevention of burnout among caregivers. To date, no research has examined the role of self-compassion among psychotherapists, and whether there is an association between therapists' self-compassion and burnout. This study attempts to fill this gap, by providing mental health professionals

with insight into understanding of self-compassion, and specifically how such a practice may be beneficial for minimizing the risk of burnout. Research in self-compassion aligns with the tenet of social work and positive psychology for garnering individuals' strengths, rather than focusing on psychopathology and maladaptive functioning.

Given the implications of this study's findings, the active identification of therapists' lack of self-compassion in therapist training and supervision, with a view to developing a more adaptive, self-compassionate attitude, is essential in maintaining therapists' well-being. The significant findings that isolation was related to emotional exhaustion and depersonalization and that social support was the most widely used and effective approach for well-being are important factors that need to be recognized for how clinicians can be supported to be at their best. For example, the use of case conferences, group and individual supervision, and other means for clinicians to be encouraged to talk about their work, reach out to others and maintain a sense of connection, are critical factors in their success. Agencies must support these initiatives for all clinicians, not only those collecting licensure hours. Clinicians must also advocate for these services themselves, through collective efforts with managers and directors addressing implementation of such staff development protocols within their existing schedules.

This study's findings showing significant relationships between personal accomplishment and self-compassion also have implications for how supervisors, employers and educators can increase morale and retain workers. Employers should show appreciation towards their employees through vocalizing how valuable they are to the company and their clients, allowing flexible schedules to fit the needs of employees, and

providing growth opportunities through internal promotions or cross-functional training. The use of celebrations and outings, regular performance reviews with achievements recognized monetarily or through other means, and keeping the work area clean, bright and organized are also ways employers can boost clinicians' morale.

Supervisors can be a great influence on their supervisees' sense of personal accomplishment through consistent positive feedback and praise for what clinicians are doing right, along with suggestions and focusing on how clinicians' performances can be improved. Educators should provide trainees with inspirational case studies, remind students their mistakes are normal, and provide perspective on achieving goals with clients. In the absence of high salary, positive feedback from employers, supervisors, or even clients, and years of experience from which to draw upon, clinicians themselves need to take initiative for enhancing a positive attitude about their chosen vocation, sense of competency and beliefs they are delivering a valuable service. Clinicians can be proactive in cultivating a self-compassionate stance of mindfulness, feeling connected and self-kindness through self-education, either through reading books on self-care, continuing education courses on increasing enthusiasm for their work, getting inspired through talking to other clinicians, learning new professional skills and techniques, and incorporating a regular self-care practice such as meditation, exercise, yoga, breath-work, metta, or regular positive self-statements.

According to this research, most psychotherapists are highly self-compassionate and not very burned out. While this is good news, there were distinct differences among gender, age and experience and licensure groups. Women, master's levels clinicians and newer therapists appeared to have greater significant relationships between their self-

compassion and burnout levels. Master's graduate programs need to emphasize the dimensions of self-compassion into their curriculums and incorporate self-care workshops specifically for women. Newer clinicians need to hear from more experienced colleagues on how they incorporate self-care and coping strategies into their work, either while they are students or while gaining licensure hours. Licensing boards currently have annual requirements for clinicians to maintain a certain number of continuing education units, which often include specific topic areas like domestic violence and substance abuse. These licensing boards should start requiring self-care and well-being classes as part of the requirements, particularly for those in the pre-licensure stage.

The concept of a self-care plan (Skovholt, 2001) has also gained acceptance in the literature, underlining the need to take practical steps to minimize burnout among therapists. Supervisors and employers should take the initiative to examine their therapists' levels of self-compassion, through standardized tests such as the self-compassion scale. The results could form a central component of individualized self-care plans for employees. Supervisors and their supervisees could then work together to find effective coping approaches for low scorers. Clinicians in a particular agency whose score highly in self-compassion would be beneficial spokespeople to present to other staff how they maintain their resilience.

Based on the findings from this study, exercise, connection with colleagues and personal others, meditation, breathing, mindfulness, slowing down and reflecting, healthy distancing, and maintaining boundaries are the most effective strategies for maintaining emotional balance in clinical work. Strategic planning that includes discussion of these particular techniques within supervision would be fundamental in maintaining the

resilience of psychotherapists in the field. Employers could bring in outside consultants for staff trainings on mindfulness and meditation. Educators would be wise to provide coursework that includes how and when to implement boundaries with not only clients, but with home-life balance. Learning healthy distancing techniques while in training would also be a significant step in establishing protective burnout prevention strategies.

Exercise was unique in that it was seen as effective, yet most clinicians struggled to use it. Making it easier for clinicians to exercise as a way to alleviate job strain should be implemented, such as employers and professional associations offering reduced rates on athletic memberships or sports leagues through organizations. Employers should encourage mental health professionals' physical well-being by offering incentives that include paying more of their health-insurance premiums or through on-site fitness facilities. Implementing walking teams or paring up lunchtime buddies could also be effective ways towards integrating physical health within workplace culture, rather than promoting working through lunch or not taking breaks. Employees should advocate for themselves within management structures, utilizing research showing employees who are more fit are more productive and take less sick time.

In sum, incorporating well-being in education and curricula within graduate training programs, employer support in self-care, and encouraging clinicians to educate themselves via continuing education workshops and books on these topics are essential. Beyond discussion and theorizing of self-care, this study aims to highlight the importance of clinicians simply practicing and engaging in compassionate self-care in order to reduce burnout, and foster happy, healthy, and well-balanced lives.

References

- Abbe, A., Tkach, C., & Lyubomirsky, S. (2003). The art of living by dispositionally happy people. *Journal of Happiness Studies*, 4(4), 385-404.
- Ackerley, G., Burnell, J., Holder, D., & Kurdek, L. (1988). Burnout among licensed psychologists. *Professional Psychology: Research and Practice*, 19(6), 624-631.
- Adams, C. E., & Leary, M. R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social and Clinical Psychology*, 26, 1120-1144.
- Baer, R. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment*, 13(1), 27-45.
- Baker, E. K. (Ed.). (2003). *Caring for ourselves: A therapist's guide to personal and professional well-being*. Washington, DC: American Psychological Association.
- Berkowitz, M. (1987). Therapist survival: Maximizing generativity and minimizing burnout. *Psychotherapy in Private Practice*, 5(1), 85-89.
- Boehm, J., & Lyubomirsky, S. (2008). Does happiness promote career success? *Journal of Career Assessment*, 16, 101.
- Brenner, M. (2009). Zen practice: A training method to enhance the skills of clinical social workers. *Social Work in Health Care*, 48(4), 462-470.
- Brookings, J., Bolton, B., Brown, C., & McEvoy, A. (1985). Self-reported job burnout among female human service professionals. *Journal of Occupational Behavior*, 6, 143-50.
- Carroll, L., & Gilroy, P. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy*, 22(2), 1333.
- Cassell, C., & Symon, G. (1994). *Qualitative methods in organizational research: A practical guide*. London; Thousand Oaks, Calif.: Sage Publications.
- Collins, S., & Long, A. (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric & Mental Health Nursing*, 10(1), 17-27.
- Coster, J., & Schwebel, M. (1997). Well-functioning in professional psychologists. *Professional Psychology: Research and Practice*, 28(1), 5-13.
- Crane, R., & Elias, D. (2006). Being with what is. *Therapy Today*, 17(10), 31-33.

- Deniz, M., Kesici, S., & Sümer, A. (2008). The validity and reliability of the Turkish version of the self-compassion scale. *Social Behavior & Personality: An International Journal*, 36(9), 1151-1160.
- DePanfilis, D. (2006). Compassion fatigue, burnout, and compassion satisfaction: Implications for retention of workers. *Child Abuse & Neglect*, 1067-1069.
- Dimidjian, S., & M. M. Linehan. (2003). Defining an agenda for future research on the clinical application of mindfulness practice. *Clinical Psychology: Science & Practice*, 10(2), 166-171.
- Dollard, M., Dormann, C., Boyd, C., Winefield, H., & Winefield, A. (2003). Unique aspects of stress in human service work. *Australian Psychologist*, 38(2), 84-91.
- Duckworth, A., Steen, T., & Seligman, M. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology*, 1(1), 629-651.
- Ehrenreich, B. (2009). *Bright-sided: How the relentless promotion of positive thinking has undermined America*. New York: Metropolitan Books.
- Farber, B. (1983). Psychotherapists' perceptions of stressful patient behavior. *Professional Psychology: Research and Practice*, 14(5), 697-705.
- Farber, B. (1990). Burnout in psychotherapists: Incidence, types, and trends. *Psychotherapy in Private Practice*, 8(1), 35-44.
- Farber, B. A., & Heifetz, L. J. (1981). The satisfactions and stresses of psychotherapeutic work: A factor analytic study. *Professional Psychology*, 12(5), 621-630.
- Farber, B. A., & Heifetz, L. J. (1982). The process and dimensions of burnout in psychotherapists. *Professional Psychology*, 13(2), 293-301.
- Figley, C. R. (1995). Compassion fatigue as secondary traumatic stress disorder: An overview. In C. R. Figley, & C. R. Figley (Eds.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized* (pp. 1-20). Philadelphia, PA: Brunner/Mazel.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapist' chronic lack of self care. *Journal of Clinical Psychology*, 58(11), 1433-1441.
- Folkman, S., & Moskowitz, J. (2003). Positive psychology from a coping perspective. *Psychological Inquiry*, 14(2), 121-125.
- Folkman, S., Moskowitz, J., Ozer, E., & Park, C. (1997). Positive meaningful events and coping in the context of HIV/AIDS. In B. H. Gottlieb (Ed.), *Coping with chronic stress* (pp. 293-314). New York: Plenum Press.

- Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist*, *56*, 218-226.
- Fredrickson, B. L. (2006). The broaden-and-build theory of positive emotions. In M. Csikszentmihalyi & I.S. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 85-103). New York: Oxford University Press.
- Freudenberger, H. (1990). Hazards of psychotherapeutic practice. *Psychotherapy in Private Practice*, *8*(1), 31-34.
- George, J. M. (1995). Leader positive mood and group performance: The case of customer service. *Journal of Applied Psychology*, *25*, 778-795.
- Gilbert, P. (2000). Social mentalities: Internal social conflicts and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert & K. G. Bailey (Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118-150). Hove, England: Psychology Press.
- Gilbert, P., Baldwin, M. W., Irons, C., Baccus, J. R., & Palmer, M. (2006). Self-criticism and self-warmth: An imagery study exploring their relation to depression. *Journal of Cognitive Psychotherapy*, *20*(2), 183-200.
- Gilbert, P. & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert, & P. Gilbert (Eds.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263-325). New York: Routledge.
- Gilbert, P. & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, *13*, 353-379.
- Gil-Monte, P., Peiró, J., & Valcárcel, P. (1998). A model of burnout process development: An alternative from appraisal models of stress. *Comportamento Organizacional Gestào*, *4*(1), 165-179.
- Glasberg A.L., Eriksson S., & Norberg, A. (2007) Burnout and 'stress of conscience' among healthcare personnel. *Journal of Advanced Nursing* *57*(4), 392-403.
- Guy, J., Poelstra, P., & Stark, M. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. *Professional Psychology: Research and Practice*, *20*(1), 48-50.
- Harter, S., & Marold, D. (1994). Psychosocial risk factors contributing to adolescent suicidal ideation. *Children, youth, and suicide: Developmental perspectives* (pp. 71-91). San Francisco: Jossey-Bass.

- Hellman, I., & Morrison, T. (1987). Practice setting and type of caseload as factors in psychotherapist stress. *Psychotherapy: Theory, Research, Practice, Training*, 24(3), 427-433.
- Hellman, I., Morrison, T., & Abramowitz, S. (1986). The stresses of psychotherapeutic work: A replication and extension. *Journal of Clinical Psychology*, 42(1), 197-205.
- Henry, W., Schacht, T., & Strupp, H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, 58(6), 768-774.
- Himle, D., Jayaratne, S., & Thyness, P. (1989). The effects of emotional support on burnout, work stress and mental health among Norwegian and American social workers. *Journal of Social Service Research*, 13(1), 27-45.
- Horner, A. (1993). Occupational hazards and characterological vulnerability: The problem of burnout. *The American Journal of Psychoanalysis*, 53(2), 137-142.
- Howell R., Kern, M., & Lyubomirsky, S. (2007) Health benefits: Meta-analytically determining the impact of well-being on objective health outcomes. *Health Psychology Review*, 1(1): 1-54.
- Hsieh, Y., Neff, K., & Pisitsungkagarn, K. (2008). Self-compassion and self-construal in the United States, Thailand, and Taiwan. *Journal of Cross-Cultural Psychology*, 39(3), 267-285.
- Iverson, R., Olekalns, M., & Erwin, P. (1998). Affectivity, organizational stressors, and absenteeism: A causal model of burnout and its consequences. *Journal of Vocational Behavior*, 52(1), 1-23.
- Jain, S., Shapiro, S., Swanick, S., Roesch, S., Mills, P., Bell, I., et al. (2007). A randomized controlled trial of mindfulness meditation versus relaxation training: effects on distress, positive states of mind, rumination, and distraction. *Annals of Behavioral Medicine*, 33(1), 11-21.
- Jeanneau, M., & Armelius, K. (2000). Self-image and burnout in psychiatric staff. *Journal of Psychiatric & Mental Health Nursing*, 7(5), 399.
- Jordan, J., Miller, J., Stiver, I., & Surrey, J. (1991). *Women's growth in connection: Writings from the Stone Center*. New York: Guilford Press.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Delacorte.

- Kearney, M., Weininger, R., Vachon, M., Harrison, R., & Mount, B. (2009). Self-care of physicians caring for patients at the end of life. *JAMA: Journal of the American Medical Association*, *301*(11), 1155-1164.
- Kirkpatrick, K., Neff, K., & Rude, S. (2007). Self-compassion and adaptive psychological functioning. *Journal of Research in Personality*, *41*(1), 139-154.
- Kramen-Kahn, B., & Hansen, N. (1998). Rafting the rapids: Occupational hazards, rewards, and coping strategies of psychotherapists. *Professional Psychology: Research and Practice*, *29*(2), 130-134.
- Laufer, M. E. (1995). Depression and self-hatred. In M. Laufer (Ed.), *The suicidal adolescent* (pp. 21–27). Madison, CT: International Universities Press.
- Leadbeater, B., Kuperminc, G., Blatt, S., & Hertzog, C. (1999). A multivariate model of gender differences in adolescents' internalizing and externalizing problems. *Developmental Psychology*, *35*(5), 1268-1282.
- Leif, H. I., & Fox, R. C. (1963). Training for detached concern in medical students. In H. I. Lief, V. F. Lief, & N. R. Lief (Eds.), *The psychological basis of medical practice* (pp. 12-35). New York: Harper & Row.
- Leiter, M., & Maslach, C. (2001). Burnout and quality in a sped-up world. *Journal for Quality and Participation*, *24*, 48-51.
- Lyubomirsky, S., & Dickerhoof, R. (2010). A construal approach to increasing happiness. In Tangney, J. & Maddux, J., (Eds.), *Social psychological foundations of clinical psychology*. New York: Guilford Press.
- Lyubomirsky, S., King, L.A., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin*, *131*, 803–855.
- Maslach, C., & Goldberg, J. (1998). Prevention of burnout: New perspectives. *Applied & Preventive Psychology*, *7*(1), 63-74.
- Maslach C., Jackson S., & Leiter M. P. (1996). *Maslach burnout inventory* (3rd ed.) Palo Alto: Consulting Psychologists Press.
- Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422.
- Masten, A. (2001). Ordinary magic: Resilience processes in development. *American Psychologist*, *56*(3), 227-238.
- McCarthy, W., & Frieze, I. (1999). Negative aspects of therapy: Client perceptions of therapists' social influence, burnout, and quality of care. *Journal of Social Issues*, *55*(1), 33-50.

- Mitmansgruber, H., Beck, T., & Schüßler, G. (2008). "Mindful helpers": Experiential avoidance, meta-emotions, and emotion regulation in paramedics. *Journal of Research in Personality*, 42(5), 1358-1363.
- Moore, K., & Cooper, C. (1996). Stress in mental health professionals: A theoretical overview. *International Journal of Social Psychiatry*, 42(2), 82-89.
- Mongrain, M., Vettese, L., Shuster, B., & Kendal, N. (1998). Perceptual biases, affect, and behavior in the relationships of dependents and self-critics. *Journal of Personality and Social Psychology*, 75(1), 230-241.
- Moskowitz, J., Folkman, S., Collette, L., Vittinghoff, E. (1996). Coping and mood during AIDS-related caregiving and bereavement. *Annals of Behavioral Medicine*, 18, 49-57.
- Neely, M., Schallert, D., Mohammed, S., Roberts, R., & Chen, Y. (2009). Self-kindness when facing stress: The role of self-compassion, goal regulation, and support in college students' well-being. *Motivation & Emotion*, 33(1), 88-97.
- Neff, K. D. (2003a). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity*, 2(2), 85-101.
- Neff, K. D. (2003b). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2(3), 223-250.
- Neff, K. D. (2008). Self-compassion: Moving beyond the pitfalls of a separate self concept. In J. Bauer & H. A. Wayment (Eds.), *Transcending self-interest: psychological explorations of the quiet ego* (pp. 95-105). Washington DC: APA Books.
- Neff, K. D. (2009). Self-compassion. In M. R. Leary & R. H. Hoyle (Eds.), *Handbook of individual differences in social behavior* (pp.561-573). New York: Guilford Press.
- Neff, K. D., Hseih, Y., & Dejithirat, K. (2005). Self-compassion, achievement goals, and coping with academic failure. *Self and Identity*, 4, 263-287.
- Newman, C. (1997). Maintaining professionalism in the face of emotional abuse from clients. *Cognitive and Behavioral Practice*, 4(1), 1-29.
- Newsome, S., Christopher, J., Dahlen, P., & Christopher, S. (2006). Teaching counselors self-care through mindfulness practices. *Teachers College Record*, 108(9), 1881-1900.
- Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: Evidence and theory. *Psychological Bulletin*, 101(2), 259-282.

- Nolen-Hoeksema, S., Larson, J., & Grayson, C. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology*, *77*(5), 1061-1072.
- O'Connor, M. F. (2001). On the etiology and effective management of professional distress and impairment among psychologists. *Professional Psychology: Research & Practice*, *32*(4), 345.
- Patterson, T., & Joseph, S. (2007). Person-centered personality theory support from self-determination theory and positive psychology. *Journal of Humanistic Psychology*, *47*(1), 117-139.
- Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. *Hospital & Community Psychiatry*, *29*(4), 233-237.
- Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin*, *131*, 925-971.
- Prosser, D., Johnson, S., Kuipers, E., & Szmukler, G. (1997). Perceived sources of work stress and satisfaction among hospital and community mental health staff, and their relation to mental health, burnout and job satisfaction. *Journal of Psychosomatic Research*, *43*(1), 51-59.
- Radey, M., & Figley, C. (2007). The social psychology of compassion. *Clinical Social Work Journal*, *35*(3), 207-214.
- Raquepaw, J., & Miller, R. (1989). Psychotherapist burnout: A componential analysis. *Professional Psychology: Research and Practice*, *20*(1), 32-36.
- Rich, G. (2001). Positive psychology: An introduction. *Journal of Humanistic Psychology*, *41*(1), 8.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.
- Rubin, A., & Babbie, E. (2007). *Essential research methods for social work*. CA: Thompson Brooks/Cole.
- Rupert, P., & Morgan, D. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research & Practice*, *36*(5), 544-550.
- Salzberg, S. (2002). *Loving kindness: The revolutionary art of happiness*. Boston: Shambhala.
- Schenström, A., Rönnerberg, S., & Bodlund, O. (2006). Mindfulness-based cognitive attitude training for primary care staff: A pilot study. *Complementary Health Practice Review*, *11*(3), 144-152.

- Schulz, R., Greenley, J., & Brown, R. (1995). Organization, management, and client effects on staff burnout. *Journal of Health & Social Behavior*, 36(4), 333-345.
- Seligman, M. (1998). *Learned optimism: How to change your mind and your life*. New York: Knopf.
- Seligman, M., & Pawelski, J. (2003). Positive psychology: FAQs. *Psychological Inquiry*, 14(2), 159-163.
- Shapiro, S., Astin, J., Bishop, S., & Cordova, M. (2005). Mindfulness-based stress reduction and health care professionals: Results from a randomized controlled trial. *International Journal of Stress Management*, 12, 164–176.
- Shapiro, S., Brown, K., & Biegel, G. (2007). Teaching self-care to caregivers: Effects of mindfulness based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology*, 1(2), 105-115.
- Sheldon, K., & Lyubomirsky, S. (2004). Achieving sustainable new happiness: Prospects, practices, and prescriptions. In A. P. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp. 127-145). Hoboken, NJ: John Wiley & Sons Inc.
- Sherman, M., & Thelen, M. (1998). Distress and professional impairment among psychologists in clinical practice. *Professional Psychology: Research & Practice*, 29(1), 79.
- Sin, N., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology*, 65(5), 467-487.
- Skovholt, T. (2001). *The resilient-practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Boston: Allyn and Bacon.
- Smith, P. L., & Moss, S. B. (2009). Psychologist impairment: What is it, how can it be prevented, and what can be done to address it? *Clinical Psychology: Science & Practice*, 16(1), 1-15.
- Söderfeldt, M., Söderfeldt, B., & Warg, L. (1995). Burnout in social work. *Social Work*, 40(5), 638-646.
- Speeth, K. R. (1982). On psychotherapeutic attention. *Journal of Transpersonal Psychology*, 14(2), 141-160.
- Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss & Trauma*, 12(3), 259-280.

- Stamm, B. H. (2002). Measuring compassion satisfaction as well as fatigue: Developmental history of the compassion satisfaction and fatigue test. In C. R. Figley, & C. R. Figley (Eds.), *Treating compassion fatigue* (pp. 107-119). New York, NY US: Brunner-Routledge.
- Stevanovic, P., & Rupert, A. (2004). Career-sustaining behaviors, satisfactions, and stresses of professional psychologists. *Psychotherapy: Theory, Research, Practice, Training, 41*, 301–309.
- Stevanovic, P., & Rupert, P. (2009). Work-family spillover and life satisfaction among professional psychologists. *Professional Psychology: Research & Practice, 40*(1), 62-68.
- Thériault, A., & Gazzola, N. (2006). What are the sources of feelings of incompetence in experienced therapists? *Counselling Psychology Quarterly, 19*(4), 313-330.
- Thompson, B., & Waltz, J. (2008). Self-compassion and PTSD symptom severity. *Journal of Traumatic Stress, 21*(6), 556-558.
- Thoresen, C., Kaplan, S., Barsky, A., Warren, C., & de Chermont, K. (2003). The affective underpinnings of job perceptions and attitudes: A meta-analytic review and integration. *Psychological Bulletin, 129*(6), 914-945.
- Van Katwyk, P., Fox, S., Spector, P., & Kelloway, E. (2000). Using the job-related affective well-being scale (JAWS) to investigate affective responses to work stressors. *Journal of Occupational Health Psychology, 5*(2), 219-230.
- Wallin, D. (2007). *Attachment in psychotherapy*. New York: Guilford Press.
- Walsh, R., & Shapiro, S. (2006). The meeting of meditative disciplines and western psychology: A mutually enriching dialogue. *American Psychologist, 61*(3), 227-239.
- Weinbach, R. W., & Grinnell, R.N. (2007). *Statistics for social workers* (7th ed.). Boston: Pearson Education, Inc.
- Welwood, J. (2002). *Toward a psychology of awakening*. Boston: Shambhala.
- Williams, J. G., Stark, S. K., & Foster, E. E. (2008). Start today or the very last day? The relationships among self-compassion, motivation, and procrastination. *American Journal of Psychological Research, 4*, 37-44.
- Wright, T., & Cropanzano, R. (1998). Emotional exhaustion as a predictor of job performance and voluntary turnover. *Journal of Applied Psychology, 83*(3), 486-493.

Appendix A

Recruitment Flier

Self-Care and Stress in Practicing Psychotherapists

A Quantitative Research Study

I am seeking participants to complete a thirty-minute online survey for my MSW thesis, exploring how psychotherapists treat themselves when faced with challenges of their work.

You meet the inclusion criteria for this study if you:

- ⇒ *Are a **licensed** clinical social worker, marriage and family therapist, psychologist, or equivalent practicing in the United States.*
- ⇒ *Have received a **master's or doctorate degree.***
- ⇒ *Provide **individual, family or group therapy.***
- ⇒ *Have been employed at your **current job for more than 6 months.***

Participation in this study is completely voluntary and your survey responses will be anonymous. Contact: selfcare_research@yahoo.com for more information.

Thank you!

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

*Self-care and stress in psychotherapists
Research Study Survey
Contact: selfcare_research@yahoo.com*

Appendix B

Demographic Questions

REMINDER: This survey is completely anonymous. Please answer as truthfully and as authentically as you are able.

IMPORTANT: If you work more than one mental health job, please fill out this survey with only one job in mind. Thank you.

Demographic Information

1. Please identify your gender. Choices: male, female, transsexual/other.
2. Please indicate your age. (open-ended)
3. Please indicate years in practice. (open-ended)
4. Please indicate your marital status. Choices: Single, Married, Divorce/Separated, Widowed, Other
5. Please identify your ethnicity. Choices: African, African American, Latino/Hispanic, Asian/Pacific Islander, Chinese, East Indian, Pakistani, Caribbean, Native American/Alaskan Native, Caucasian, Biracial/Multiracial, European (other), Other.
6. Please identify your licensure: (open-ended)
7. Please identify your primary work setting. Choices: Community Mental Health Center, Education setting, Hospital, Justice agency, Private practice, Substance abuse agency, Other.

Appendix C

How I Typically Act Towards Myself in Difficult Times

Please read each statement carefully and decide how often you behave in the stated manner. Indicate how often by choosing the number that best describes how frequently you feel or behave that way, from 1 “almost never,” to 5 “almost always” on the rating scale row.

How Often:	1	2	3	4	5
	Almost never				Almost always

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me, I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me, I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens, I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me, I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me, I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down, I try to approach my feelings with curiosity and openness.

23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens, I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

This scale was developed by Kristin Neff, Ph.D. It is reprinted with the author's permission (Neff, 2010).

Appendix D

Sample Items for the MBI-Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professionals view their job and the people with whom they work closely. The term recipients, refers to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Following are statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, you would choose “0” (zero) from the options on the rating scale row. If you have this feeling, indicate how often you feel it by choosing the number that best describes how frequently you feel that way, from 1 “a few times a year or less,” to 6 “every day” on the rating scale row.

How Often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

I. Depersonalization Sample Item:

5. I feel I treat some recipients as if they were impersonal objects.

II. Personal Accomplishment Sample Item:

9. I feel I'm positively influencing other people's lives through my work.

III. Emotional Exhaustion Sample Item:

20. I feel like I'm at the end of my rope.

Adapted with permission of the Publisher, CPP, Inc. from MBI-HSS. Copyright 1986 by CPP, Inc. All rights reserved. Further reproduction is prohibited without CPP's written consent.

Appendix E

Qualitative Questions

1. What coping behaviors, thoughts or self-talk do you practice when you find yourself in challenging and stressful situations at work? Please describe what you do.
2. Briefly discuss what works well and what doesn't work well to bring yourself back in balance.

Appendix F

Suggested Reading

- Bennett-Goleman, T. (2001). *Emotional alchemy: How the mind can heal the heart*. New York: Three Rivers Press.
- Chodron, P. (2005). *Start where you are: How to accept yourself and others*. London: Element/HaperCollins.
- Germer, C. K. (2009). *The mindful path to self-compassion: Freeing yourself from destructive thoughts and emotions*. New York: Guilford Press.
- Gilbert, P. (2009). *The compassionate mind*. London: Constable.
- Glaser, A. (2005). *A call to compassion: Bringing Buddhist practices of the heart into the soul of psychology*. Berwick, ME: Nicolas-Hays.
- Lyubormirsky, S. (2007). *The how of happiness: A scientific approach to getting the life you want*. New York: Penguin Press.
- Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton & Co.

Appendix G



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

December 10, 2009

Jennifer Thurlow

Dear Jennifer,

Your very careful revisions have been reviewed and are complete. We are happy to give final approval to this interesting and useful study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project. It will be very interesting to see the kind of response you will get to your recruitment. As it is not the usual kind of study and focused to them rather than their clients, you may get a good response.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

Appendix H

Dear Clinician,

My name is Jennifer Thurlow. I am a Smith College School for Social Work student collecting data for my MSW thesis that asks the question: How is self care related to responses to job stress for practicing psychotherapists? I request 30 minutes of your time to fill out a survey for my research on this topic if you meet the following criteria: you received a master's or doctorate degree and are a licensed clinical social worker, marriage and family therapist, psychologist or equivalent, you have been employed at your current job for more than 6 months and you provide individual, family or group therapy. To participate, please click on the link below, which will take you to the informed consent, and to the survey. If you have any colleagues, particularly clinicians of color, whom you think would be interested in this study, please forward this email to them. Link: <https://www.surveymonkey.com/TBD>.

This is an anonymous survey; there will be no record of participants' identities. The confidentiality of the participants will be secured by not having any names or email addresses attached to the surveys. A third party - Survey Monkey - will collect the completed surveys in an anonymous method. Your time, honesty, and thoughtfulness are deeply appreciated. If you have any concerns about this study, please contact me via email (name@smith.edu) or the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Sincerely, Jennifer Thurlow

Appendix I

Informed Consent (on surveymonkey)

Title of Research: Self-Kindness and Stress in Practicing Psychotherapists
Investigator: Jennifer Thurlow, MSW student

Dear Participant,

I am Jennifer Thurlow, a graduate student at Smith College School for Social Work, located in Northampton, Massachusetts. I am conducting a research study about self-care and stress among practicing psychotherapists. The research is for my MSW thesis and may be used for possible publication or presentation.

If you agree to participate in this study you will be asked to fill out a survey that will take about 30 minutes to complete. The survey includes a series of questions designed to elicit some demographic background information about you, a survey regarding self-kindness and job stress, and two open-ended questions regarding the ways you cope with the challenges of your profession.

Since your participation in this study will be anonymous, there are few perceived risks to participating in this study. As with any exercise where self-reflection is requested, there is always the risk that strong feelings may emerge. You will have the option to choose not to participate in the study and click on exit at any time. This project is an opportunity to contribute to the professional knowledge base on how personal coping strategies can buffer against the inherent stresses of the mental health profession. Participants may personally benefit through gaining new or increased awareness of how they tend to treat themselves, and how they are functioning in their job. Through reflecting on their self-care and responses to work stress, they may be motivated to make changes. Compensation for participation will not be provided; however, a resource list of suggested readings will be provided at the end of the survey.

Since there will be no way to trace responses to any individual, your answers are anonymous. Study data will be stored in a secured place and will be maintained for three years as required by Federal regulations, after which time, they will be destroyed, unless I continue to need them in which case they will be kept secured until no longer needed, at which time they will be destroyed. A statistical consultant and I will have access to the raw data. Additionally, a copy of the data will be forwarded to Consulting Psychologists Press, Inc. who retain the rights to use these data within analysis of its larger data set but will not publish any analysis based on these data alone.

Your participation in this study is voluntary. You may skip any question you choose not to answer in the survey. However, once you submit the survey, your responses become part of the study database, and you will not be able to remove your responses. If you agree to the terms and conditions listed above, please click “yes.” If you do not choose to complete the survey, please click “no.” Please print a copy of the informed consent for your records. If you have any questions concerning the research project you

can call me at (xxx) xxx-xxx or email name@smith.edu. Questions regarding your rights in this research project should be directed to the Chair of SSW Human Subjects Review Committee at (413) 585-7974

BY SUBMITTING THIS SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY. THANK YOU.

Yes, I agree to participate, take me to the survey.

No, I do not consent and wish to leave the survey now.

Please print a copy of this Informed Consent for your records.