3-10-2023

Relationships Between Burnout, Isolation, Secondary Trauma, and Self-Compassion in Mental Health Providers

Michael Underriner

Relationships Between Burnout, Isolation, Secondary Trauma, and Self-Compassion in Mental Health Providers

Michael Underriner

Presented to the Faculty of the

Graduate School of Clinical Psychology

George Fox University

in partial fulfillment

of the requirements for the degree of

Doctor of Psychology

in Clinical Psychology

Newberg, Oregon

Approval Page

Relationships Between Burnout, Isolation, Secondary Trauma, and Self-Compassion in Mental Health Providers

by

Michael Underriner

has been approved

at the

Graduate School of Clinical Psychology

George Fox University

as a dissertation for the PsyD Degree

Committee Members

Roger Bufford, PhD, Chair

Mary Peterson PhD

Daniel Rodriquez, PsyD

March 10, 2023

Abstract

Experiencing burnout as a mental health provider is a growing concern with a number of personal and professional issues related to it; organizational and self-directed interventions are often used to combat the issue (Morse et al., 2012). With the onset of coronavirus (COVID-19), mental health providers face more isolation at work due to social distancing measures and more instances of hearing trauma reports from their patients. Self-compassion might be a solution to address the concerns stated above (McCade et al., 2021; Richardson et al, 2018). Participants in this study were members of a state psychological association, many of whom are in private practice. They completed surveys on loneliness, isolation, self-compassion, burnout, and secondary traumatic stress. Results showed a relationship between isolation, certain factors of self-compassion, burnout, and secondary traumatic stress. Loneliness/Isolation was predictive of burnout (ß = 0.77) and secondary traumatic stress (ß = 1.05) in mental health providers; self-compassion did not add incremental predictive validity; loneliness/isolation also predicted these outcomes but did not add incremental predictive validity due to collinearity (r = .77). The results of this study have important implications for individuals, organizations, and populations treated by and containing mental health providers. Present findings suggest that within the population of mental health providers interventions and actions focused on decreasing isolation may be more beneficial to prevent and treat burnout than interventions and actions focused on self-compassion.

Keywords: burnout, isolation, secondary traumatic stress, self-compassion, loneliness

Table of Contents

Table of Tables

Relationships Between Burnout, Isolation, Secondary Trauma, and Self-Compassion in Mental Health Providers

Chapter 1

Burnout is a major problem in the mental health profession and is the main catalyst for work-related problems in the profession (Morse et al., 2012). It is widespread, with expectations for many mental health providers to experience some level of burnout during their careers (Simionato & Simpson, 2018). The prevalence and severity of burnout depend on a number of factors including: age, experience, clinical demands, clinical setting, personality, personal beliefs, coping style, and social supports (Simionato & Simpson, 2018). High rates of burnout lead to a wide range of issues among mental health providers. Mental health providers who experience burnout are more likely to use substances, deliver suboptimal and unethical care, develop physical and mental health concerns, and report decreased professional satisfaction (Simionato et al, 2019). This makes burnout a troubling and ongoing problem that needs to be addressed. The problem has been exacerbated in the past 3 years; the coronavirus (COIVD-19) pandemic has impacted professional lives of mental health providers in a number of ways. A main impact of the pandemic has been the rapid shift in how therapy is delivered, the change from in-person visits to remote teletherapy visits with some mental health providers who reported only limited training or prior experience providing teletherapy (Bell et al., 2021; Sampaio et al., 2021). Although research on how this shift has affected mental health providers is not extensive at this time, certain challenges mental health providers face working remotely during COVID-19 have been identified (McBeath et al, 2020). These include ethical concerns, increased clinical demands, reduced ability to assess clients' interpersonal cues or risk factors, and increased feelings of fatigue and isolation (Inchausti et al., 2020; McBeath et al., 2020). This

increased isolation can be partially attributed to social distancing laws which have been implemented across the world including the United States to help reduce the spread of COVID-19. Social distancing decreases one's ability to access social support and negatively impacts family systems (Prime et al., 2020; Sampaio et al., 2021). Social distancing limits the ability to engage with social supports and causes shifts in workplace demands; burnout prevention during this time may need to focus more on person-directed interventions rather than organizationally-directed interventions. Additionally, mental health providers face increased exposure to secondary traumatic during COVID-19, which is linked to burnout (Mcbride et al., 2020; Shoji et al., 2016). This is where self-compassion presents as a solution to address burnout. In a study involving Veterans Affairs mental health staff, self-compassion was shown to be associated with resilience to burnout (Atkinson et al, 2017). As mental health providers shift to more remote work with the rise in teletherapy, research is needed to examine the relationship between burnout, isolation, and self-compassion. Furthermore, this could provide evidence to support interventions that promote self-compassion in order to decrease burnout, feelings of isolation, secondary traumatic stress, and defend against the negative personal and professional consequences related to it.

Burnout

Definition of Burnout

Burnout can be described as a chronic stress from working in the medical field that can appear in mental health providers as emotional exhaustion, low personal accomplishment, or depersonalization (Simionato et al., 2019). Mental health provider burnout has been measured in studies using The Maslach Burnout Inventory, a questionnaire which measures emotional exhaustion, low personal achievement, and depersonalization (Maslach & Jackson, 1981).

Emotional exhaustion is defined as feelings of being overworked and drained of your individual emotional and physical energy (Simonato et al., 2019). Low personal accomplishment is related to the mental health provider's professional performance and perceived feelings of incompetence regarding their professional achievements and ability at work (Simonato et al., 2019). Depersonalization can be used to describe the cynicism a physician or other medical provider feels, and can show up as negative feelings and attitude towards the patient's mental health provider treatment (Simonato et al., 2019). Burnout can present itself emotionally, physically, behaviorally, and cognitively, with each posing different negative consequences for the mental health providers (McCormack et al., 2018; Simonato et al., 2019).

Effects of Burnout

Burnout has been a topic of growing concern in the mental healthcare field due to high prevalence of burnout within the profession, with reported rates between 21% to 67% (Morse et al., 2012). This concern has grown during the COVID-19 era as increased clinical demands potentially put mental health providers at a higher risk of experiencing burnout (Sander & Bauman, 2020). A direct result of the high rate of mental health provider burnout is the number of negative consequences involved both for the mental health provider experiencing burnout and for the patients they serve (Yang & Hayes, 2020). Burnout can negatively impact a mental health provider's physical health in a number of ways; studies show burnout may be responsible for sleep disturbances, flu-like symptoms, and gastrointestinal symptoms in mental health providers (Hammond et al., 2018). Furthermore, Hammond et al's (2018) study found the connection between physical health issues and burnout are cyclical in nature. For instance, a number of mental health providers endorse sleep difficulties when feeling burnout, which increases difficulties concentrating and regulating moods, which could lead to increased feelings of

burnout in mental health providers. Additionally, mental health providers who experience burnout have a tendency to sacrifice self-care to continue to meet clinical demands, which can increase their risk of developing adverse physical health symptoms (Kaeding et al., 2017; Yang & Hayes, 2020).

Burnout not only affects a mental health provider's physical health but their mental health as well. Research has shown mental health providers who experience burnout are at a greater risk for developing depression, anxiety, and post-traumatic stress disorder, and are more likely to have decreased psychological well-being and increased secondary traumatic stress (Hammond et al., 2018; Yang & Hayes, 2020). Additionally, mental health providers who experience burnout report increased interpersonal difficulties and reduced willingness to reach out socially (Simionato et al., 2019) Furthermore, an increase in clinical demands and constant exposure to traumatic stress leads to a decrease in resources integral to coping with personal and professional issues, making mental health providers more susceptible to mental health concerns.

In addition to effects for the mental health providers, burnout also may harm the organizations they work for and the patients they serve. Mental health providers who experience burnout have higher rates of workplace turnover and ethical issues, and are more likely to move to part-time work and retire from the profession early (Simionato et al., 2019; Yang & Hayes, 2020). All of these can lead to an increase in financial costs for organizations, which makes finding a way to combat burnout in mental health providers a prominent issue for the organizations that employ them. Additionally, research has indicated depersonalization, reduced sense of personal accomplishment, and emotional exhaustion as symptoms of burnout that can lead to worse clinical outcomes (Hammond et al., 2018; Yang & Hayes, 2020). Depersonalization effects a mental health provider's empathy toward their patients and their

ability to build rapport and feel connected to their patients (Yang & Hayes 2020). Reduced sense of personal accomplishment affects productivity, motivation, and leads to an increase in clinical errors (Yang & Hayes, 2020). Emotional exhaustion effected mental health providers' energy levels and attention toward their patients (Yang & Hayes, 2020).

Secondary Traumatic Stress

Hearing an individual recall their firsthand trauma experience is a common occurrence for mental health providers, but exposes them to secondary traumatic stress. Secondary traumatic stress has been shown to be directly related to mental health provider burnout in a number of studies (Shoji et al., 2016; Thompson et al., 2014). Repeated exposure to secondary trauma can lead to symptoms similar to posttraumatic stress disorder such as re-exposure, avoidance, and hyperarousal in response to someone else's trauma (Stamm, 2009). This could be a potential issue of concern for mental health providers during the COVID-19 pandemic. As mental health providers will not only be exposed to secondary trauma of their patients' COVID-19 experience, but could also experience a similar trauma in their own lives. However, research on this is not extensive at this time (Holmes et al, 2021). Compassion fatigue, a limited capacity to empathize, and feelings of being overwhelmed by another's trauma can also occur after repeated exposure to individuals' trauma (Holmes et al, 2021).

Isolation

Effects of Isolation

Isolation can be described as the experience of being separated from others, either physically or emotionally (Rokach & Boulazreg, 2022). Neff (2003) defines isolation as "a sense of loneliness in one's own failure and suffering (p.16)". *Social isolation* encompasses a lack of social interactions with others or in the broader community (Leigh-Hunt et al., 2017). *Emotional*

isolation is when an individual is unwilling or unable to share their emotions with others (Rokach & Boulazreg, 2022). Research has indicated mental health providers are at risk to experience both social and emotional isolation and the accompanying negative effects (Gündoğan, 2017; Rokach & Boulazreg, 2022, Simionato et al, 2018). It should be noted that although isolation differs from loneliness, a number of studies use loneliness as a marker for isolation, and research has shown isolation and loneliness are linked (Hawkley & Capitnaio, 2015)

Negative Effects of Isolation

As discussed earlier, in response to COVID-19 many governments implemented strategies to slow the spread which also created more isolation in individual lives. This makes it vital to identify potential consequences of isolation on individuals' functioning. Research has identified a number of mental health concerns related to isolation. These include increased risk of developing anxiety and depression, more psychological distress, and decreased well-being (Espinosa & Rudenstine, 2020; Liao & Weng, 2018; Santini et al., 2015). It has also been found that individuals with less psychological flexibility and more experiential avoidance are at a greater risk to experience mental health concerns related to isolation (Smith et al., 2020). Isolation also affects individual's physical health by increasing the risk for sensory loss, auto-immune disorders, cardiovascular issues, and obesity (Banerjee & Rai., 2020). These effects are especially concerning for mental health providers, since isolation and loneliness are a leading complaint among independent mental health providers (Gündoğan, 2017). Additionally, feelings of emotional exhaustion—a symptom of burnout—are more prevalent in mental health providers working in private practice compared to other environments such as medical clinics (Rokach & Boulazreg, 2022). This may be a result of the confidentiality that is legally required when

practicing mental health treatment, causing mental health providers to feel isolated professionally and personally in difficult experiences with patients (Rokach & Boulazreg, 2022). This means mental health providers may potentially be more at risk to experience isolation due to the solitary nature of their work (Rokach & Boulazreg, 2022).

Teletherapy

While teletherapy is not a new concept to the field of psychotherapy, its use rapidly increased with the onset of COVID-19 as mental health providers switched from in-person to remote therapy due to social distancing measures (MacMullin et al., 2020; McBeath et al, 2020). Mental health providers had limited opportunities for training or support during the transition from in-person to remote therapy (Bell et al., 2021; Sampaio., 2021). Certain distinct challenges have been noted regarding the change to teletherapy such as ethical concerns, increased clinical demands, decreased ability to assess a client's interpersonal cues or risk, and increased feelings of fatigue and isolation (Inchausti et al., 2020; McBeath et al., 2020). This abrupt change for mental health providers has not been extensively researched at this time, leaving questions regarding the impact of teletherapy on the wellbeing of mental health providers (MacMullin et al., 2020).

Self-Compassion

Defining Self-Compassion

The concept and research of self-compassion first appeared in western psychology in 2003 with the development of the Self-Compassion Scale by Kristin Neff. Neff (2003), defined self-compassion as:

> being open to and moved by one's own suffering, experiencing feelings of caring and kindness towards oneself, taking an understanding, non-judgmental attitude toward one's

> inadequacies and failures, and recognizing that one's common experience is part of the common human experience (p.244).

Measuring self-compassion is related to three positive components: (a) self-kindness in the face of failure, (b) a perception of common humanity, and (c) mindfulness, a balanced state of awareness of one's emotions and experiences (Neff, 2003). Low levels of self-compassion are related to three negative components: (a) self-judgement in the face of failure, (b) a perception of isolation from humanity, (c) over-identification with negative thoughts and emotions of one's experience (Neff, 2003).

Effects of Self-Compassion

Research has identified a number of positive effects related to self-compassion. One study found that self-compassion was related to a number of aspects measuring well-being, and helps protect against negative emotions related to dealing with failure, not meeting expectations, or feelings of inadequacy (Zessin et al., 2015). Practicing self-compassion assists individuals to accept themselves for who they are, including their imperfections (Stuntzner, 2017; Zessin et al., 2015). By integrating and accepting negative experiences, self-compassion helps individuals avoid rumination on negative emotions or experiences and create a more balanced evaluation of their experience (Neff et al., 2018; Zessin et al., 2105). Additionally, self-compassion has been shown to have a positive relationship with a number of beneficial aspects of psychological function such as happiness, optimism, self-concept, empathy, and motivation (Neff et al., 2018). Further, self-compassion has a negative relationship with depression, anxiety, isolation, and burnout (Hashem & Zeinoun, 2020; McCade et al., 2021; Neff, 2003). Evidence suggests high levels of self-compassion could act as a protective factor against the negative effects of burnout in mental health providers (McCade et al., 2021; Richardson et al, 2018).

Purpose of the Study

The purpose of this study was to investigate the relationship between burnout, isolation, secondary traumatic stress, and self-compassion in mental health providers. Examining the interaction between these concepts will contribute new knowledge to the profession of psychology by exploring how isolation, secondary traumatic stress, and burnout are related. Determining whether self-compassion can combat the effects of isolation and secondary traumatic stress will provide evidence on how to help treat the negative effects of burnout in mental health providers. The study used a one-time online survey to measure burnout, isolation, secondary traumatic stress, and self-compassion.

Hypothesis

H1: Isolation and secondary traumatic stress will be correlated with burnout and inversely correlated with self-compassion.

H2: Isolation will be predictive of burnout. Self-compassion subscales will add additional predictive variance.

H3: Isolation will be predictive of secondary traumatic stress. Self-compassion subscales will add additional predictive variance.

Chapter 2

Methods

Participants

The study consisted of adult participants who are mental health providers currently practicing. A total of 20 mental health providers started the survey; 16 completed the survey in its entirety, but the remaining four completed the demographic items and no further items. Participants are members of the Oregon Psychological Association who were recruited through an

email and completed the demographic questionnaire and self-report measures online using Survey Monkey. The study was approved by the University Institutional Review Board (GFU #2203009) prior to data collection.

On average, participants were 54 years old (*SD* = 16.77), with 21 years of work experience (*SD* = 14.33). The typical participant was White (95%), female (80%), obtained a doctorate level of education (95%), working in a private practice setting (85%), practiced remotely in some capacity (70%) and currently practiced teletherapy (90%).

Materials

The measures included an informed consent and demographic questionnaire. The demographic questionnaire included the participant's age, gender, ethnicity, area of practice, number of years in practice, whether they have previous teletherapy experience, whether they currently practice teletherapy, confidence in practicing teletherapy, where they received support in transitioning to teletherapy, and whether they work remotely. It also included questions about type of practice (e.g., private, group, hospital etc.…), and level of education.

Measures

Self-Compassion Scale

The self-report self-compassion measure is the Self-Compassion Scale (SCS; Neff, 2003; Neff et al., 2019). The SCS (Neff, 2003; Neff et al., 2019) was completed by participants to measure their self-compassion. It consists of 26 questions on a 5-point Likert scale ranging from 0 as *almost never*, to 5 as *almost always*. Total self-compassion score was calculated by reverse scoring negative subscale items Self-Judgement (1, 8, 11, 16, 21), Isolation (4, 13, 18, 25), and Over-Identification (2, 6, 20, 24). Then summing the responses for reverse scored negative subscale items and positive subscale items Mindfulness (9, 14, 17, 22), Common Humanity (3, 7,

10, 15), and Self-Kindness (5, 12, 19, 23, 26), then take the mean of each subscale to calculate the total mean average of the six subscales. Higher scores on negative self-compassion subscales mean less self-compassion and more self-compassion after reverse scoring (Neff, 2003; Neff et al., 2019). Researchers found the SCS to be a reliable measure of self-compassion (α = 0.92), self-judgement (α = 0.73), self-kindness (α = 0.84), common humanity (α = 0.81), isolation (α = .83), mindfulness (α = .67), and over-identification (α = .70) (Neff, 2003; Neff et al., 2019). In the present study alphas were self-compassion (α = 0.95), self-judgement (α = 0.74), self-kindness (α = 0.94), common humanity (α = 0.86), isolation (α = .80), mindfulness (α = .88), and over-identification (α = .78) respectively.

Professional Quality of Life Scale Version 5

Professional Quality of Life Scale Version 5 (ProQOL-5; Stamm, 2009) was used as a self-report measure for burnout. The ProQOL-5 scale (Stamm, 2009) was completed by participants to measure the pleasure they derived from being able to do their work well (Compassion Satisfaction), their feelings of hopelessness and difficulties in dealing with work or in doing their job effectively (Burnout), and work-related secondary exposure to trauma (Secondary Traumatic Stress). The ProQOL-5 scale consists of 30 questions on a 5-point Likert scale ranging from 0 as *never*, to 5 as *very often*. Items 1, 4, 15, 17, and 29 were reverse scored. Then items for each subscale were averaged and z-scores were converted to t-scores with a raw mean score of 50 and a standard deviation of 10. Items 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 were summed for the Burnout subscale. While items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 were summed for the Secondary Traumatic Stress subscale (Stamm, 2009). Additionally, items 3, 6, 12, 16, 18, 20, 22, 24, 27, 30 were summed for Compassion Satisfaction subscale (Stamm, 2009). The ProQOL-5 was found to be a reliable measure of compassion satisfaction (α = 0.88),

burnout (α = 0.75), and secondary traumatic stress (α = .81) (Stamm, 2009). In the present study alphas were compassion satisfaction (α = 0.92), burnout (α = 0.81), and secondary traumatic stress (α = .84) respectively.

The UCLA Loneliness Scale (Version 3)

The UCLA Loneliness Scale (Version 3) was utilized as the self-report measure for isolation. It demonstrated high validity and reliability scores for measuring experiences of loneliness and social isolation (r =.73, α = 0.89 to 0.94) (Russel, 1996). It is also correlated with a significant positive relationship (r = 0.74, p < .01) to a seven-item professional isolation scale (Golden et al., 2008). It consists of 20 questions on a 4-point Likert scale ranging for 1 as *never*, to 4 as *often* (Russel, 1996). Items that are asterisked are reversed scored. Items are then summed sample, alpha was α = 0.97 and was positively correlated with the isolation subscale on the SCS (r = 0.77, p = < .001).

Procedures

Participants were recruited through listserv emails sent out through the Oregon Board of Psychology. Participants were contacted by an email that provided information about the study and asked whether they would like to participate or not. Participants were asked to sign an informed consent and the survey was administered electronically using Survey Monkey.

Measurement Structure

Participants spent around 20-30 minutes online to complete the measures and demographic questionnaire. First, participants completed the informed consent and demographic questionnaire. Next, participants completed the SCS, ProQOL-5, and UCLA Loneliness Scale (Version 3). Data was collected once during the study.

Data Analysis

Scores on the SCS, ProQOL-5, and UCLA Loneliness Scale (Version 3) were computed with SPSS to obtain mean and standard deviation for the scales and subscales.

Hypothesis 1: Correlations between scores on the UCLA Loneliness Scale (Version 3) total, the Secondary Traumatic Stress subscale of the ProQOL-5, the Burnout subscale of the ProQOL-5, the Compassion Satisfaction subscale of the ProQOL-5, and the SCS subscales were conducted.

Hypothesis 2: A stepwise linear regression was conducted to evaluate the relationship between isolation as measured by the UCLA Loneliness Scale (Version 3) and Isolation subscale on the SCS and burnout as measured by the Burnout subscale on the ProQOL-5. SCS subscales were also evaluated to assess whether they would add additional predictive variance.

Hypothesis 3: A multiple regression was conducted to evaluate the relationship between secondary traumatic stress as measured by the Secondary Traumatic Stress subscale of the ProQOL-5 and isolation as measured by the UCLA Loneliness scale (Version 3) and Isolation subscale on the SCS. SCS subscales were also evaluated to add additional predictive variance.

Chapter 3

Results

Scores on the SCS, ProQOL-5, and UCLA Loneliness Scale (Version 3) were analyzed with SPSS to obtain alpha, mean, sum, standard deviation, for the scales and subscales. Descriptive data are provided in Table 1.

This study examined the role of isolation and self-compassion, as factors that contribute to professional burnout and secondary traumatic stress among practicing mental health providers.

Prior to evaluating the hypotheses, internal consistency was calculated for each scale in the study. Cronbach's alpha was calculated for SCS and each of the six subscales, the ProQOL-5

three scales, and UCLA Loneliness. Internal consistency for SCS ranged from .95 (SCS Self-Compassion) to .74 (SCS Self-Judgement). Internal consistency for ProQOL-5 ranged from .92 (ProQOL-5 Compassion Satisfaction) to .81 (ProQOL-5 Burnout). Internal consistency was .97 for UCLA Loneliness (Version 3). See Table 1 for each individual Cronbach's alpha calculated. Despite limited response to the survey, there was enough responses to extrapolate on findings. Demographic variables were not evaluated for potential variance when measures were analyzed. This will further be explored as well as implications in Chapter 4.

Table 1

Descriptive data for scores on predictor and criterion variables

Predictors	α	*M*	*SD*	*N*
SCS Self-Compassion	.95	101.56	18.29	16
SCS Mindfulness	.88	16.00	3.69	16
SCS Self-Kindness	.94	18.13	5.15	16
SCS Common Humanity	.86	16.31	4.10	16
SCS Isolation	.80	15.50	3.61	16
SCS Self-Judgement	.74	19.00	2.96	16
SCS Over-Identification	.78	16.63	6.38	16
ProQOL-5 CS	.92	41.81	6.34	16
UCLA Loneliness	.97	35.29	13.33	16
Criteria				
ProQOL-5 Burnout	.81	24.88	5.68	16
ProQOL-5 STS	.84	19.44	5.97	16

Note. SCS = Self-Compassion Scale; ProQOL-5 = Professional Quality of Life (Version 5); CS = Compassion Satisfaction; STS = Secondary Traumatic Stress.

Hypothesis 1 Results

Hypothesis 1 of this study predicted isolation and secondary traumatic stress will be correlated with burnout and inversely correlated with self-compassion. Pearson's correlations among study measures were computed to test this prediction. Data are provided in Table 2. This prediction was supported as the correlation between isolation and burnout (r = .713 p = .002) and the correlation between loneliness and burnout (r = .859, p = < .001) were both was statistically supported. While on the positive subscales of the SCS; SCS Self-Kindness (r = -.846, p < .001) and Common Humanity (r = -.684, p = .003) were inversely correlated with burnout. SCS Self-Judgement (r = .530, p = .035) and SCS Over-Identification (r = .507, p = .045) were correlated with isolation. While SCS Self-Kindness (r = -.685, p = .003) and SCS Common Humanity (r = -.673, p = .004) were inversely correlated with isolation. Additionally, there was statistically significant effect size correlation between secondary traumatic stress and burnout (r = .565, p = .023). Furthermore, there was a significant correlation between the negative subscale on SCS, SCS Self-Judgement, and burnout (r = .630, p = .009). However, there was not a statistically significant relationship between secondary traumatic stress and any of the self-compassion variables.

Table 2

Pearson Correlations Among Study Measures

Scale	Burnout	STS	Compassion Satisfaction	UCLA Loneliness[2]
Burnout				
STS	.565*			
Compassion Satisfaction	-.701**	-.192		
UCLA Loneliness[2]	.859**	.643**	-.591*	
SCS Isolation	.713**	.282	-.644**	.772**
SCS Self-Judgement	.630**	-.279	.518*	.530*

Scale	Burnout	STS	Compassion Satisfaction	UCLA Loneliness[2]
SCS Over-Identification	.459	.453	-.349	.507*
SCS Mindfulness	-.462	.089	.645**	-.370
SCS Self-Kindness	-.846**	-.293	.681**	-.685**
SCS Common Humanity	-.684**	-.189	.366	-.673**

Note. $N = 16$; SCS = Self-Compassion Scale; STS = ProQOL-5 Secondary Traumatic Stress. SCS Self-Judgement, SCS Over-Identification, and SCS Isolation are reverse scored. High Scores signify loneliness.

*$p < .05$.

**$p < .01$.

Hypothesis 2 Results

Hypothesis 2 of this study proposed participants' isolation and self-compassion scores would be predictive of burnout. A stepwise linear regression was conducted. Model 1 evaluated the predictive power of a linear combination of scores on isolation as measured by the UCLA Loneliness scale and scores on the Isolation subscale on the SCS in predicting burnout as indicated by scores on the Burnout subscale on the ProQOL-5. Model 2 sought to account for any incremental predictive variance of the SCS subscales in in predicting burnout.

As seen in Table 3, Model 1 revealed that there is a relationship between isolation as measured by the UCLA Loneliness Scale (Version 3) ($\beta = 0.77$, $t = 3.46$, $p = .004$) and burnout; SCS Isolation did not contribute to this relationship. When other Self Compassion and Professional Quality of Life scales were added, SCS Mindfulness ($\beta = 0.49$, $t = 2.28$, $p = .057$) and ProQOL-5 Compassion Satisfaction ($\beta = -0.51$, $t = -2.08$, $p = .076$) each approach accounting for significant incremental variance in the ProQOL-5 Burnout, but none of these predictors was significant at $p < .05$.

Table 3

Results of Linear Regression for Predictive Variables of ProQOL-5 Burnout Linear Regression

Model 1	*R*	R^2	δ R^2	β	*t*	Sig.
	863	.744	744 ($F_{2,13}$ = 18.89, $p < .001$)			
UCLA Loneliness				0.77	3.46	.004
SCS Isolation				-0.12	-.551	.591
Model 2	*R*	R^2	δ R^2	β	*t*	Sig.
	.966	.934	.190 ($F_{8,7}$ = 3.36, $p = .069$)			
UCLA Loneliness				0.34	1.58	.158
SCS Isolation				0.36	1.33	.226
SCS Mindfulness				0.49	2.28	.057
SCS Over-Identification				0.04	0.23	826
ProQOL-5 Compassion Satisfaction				-0.51	-2.08	.076
SCS Common Humanity				-0.45	-1.57	.160
SCS Self-Kindness				-0.33	-1.44	.192
SCS Self-Judgement				-0.31	-1.57	.160

Note. SCS = Self-Compassion Scale; ProQOL-5 = Professional Quality of Life (Version 5); UCLA Loneliness = UCLA Loneliness (Version 3)

Hypothesis 3 Results

Hypothesis 3 of this study speculated isolation will be predictive of secondary traumatic stress in participants. A multiple regression was conducted. Model 1 evaluated the relationship between isolation as measured by the UCLA Loneliness scale and Isolation subscale on the SCS and secondary traumatic stress as measured by the Secondary Traumatic Stress subscale of the ProQOL-5. For Model 2, a second multiple regression sought to identify any predicative

variance of the SCS subscales in the relationship between secondary traumatic stress and isolation.

As seen in Table 4 there is a relationship between isolation and secondary traumatic stress ($F_{2,13} = 7.24$, $p = .008$). In Model 2 when accounting for additional predictive variance, no other variables added additional predictive variance.

Table 4

Results of Multiple Regression for Predictive Variable for ProQOL-5 Secondary Traumatic Stress Multiple Regression

Model 1	*R*	R^2	δ R^2	β	*t*	Sig.
	.726	.527	.527 ($F_{8,7}$ = 7.24, p = .008)			
UCLA Loneliness				1.05	3.51	.004
SCS Isolation				0.53	1.77	.101
Model 2	*R*	R^2	δ R^2	β	*t*	Sig.
	.827	.684	.158 ($F_{2,13}$ = 1.90, p =.207)			
UCLA Loneliness				1.32	2.39	.048
SCS Isolation				0.76	1.28	.243
SCS Mindfulness				0.25	0.52	.618
SCS Over-Identification				-0.22	-0.64	.618
ProQOL-5 Compassion Satisfaction				-0.02	-0.03	.975
SCS Common Humanity				0.04	0.06	.952
SCS Self-Kindness				0.08	0.16	.879
SCS Self-Judgement				-0.28	-0.64	.540

Note. SCS = Self-Compassion Scale; ProQOL-5 = Professional Quality of Life (Version 5); UCLA Loneliness = UCLA Loneliness (Version 3).

Chapter 4

Discussion

This study examined the degree to which isolation, secondary traumatic stress, and self-compassion could predict burnout in mental health providers. Research on burnout has shown a number of adverse effects, both physical and mental, on individuals who experience burnout (Hammond et al., 2018; Yang & Hayes, 2020). This is relevant for mental health providers due to the expectation these providers will experience some level of burnout during their careers (Simionato & Simpson, 2018). Both the effects and the prevalence of burnout among mental health providers have been widely studied (Yang & Hayes, 2020; Hammond et al., 2018; Simionato & Simpson, 2018). Results show mental health providers who experience burnout are at a greater risk for developing depression, anxiety, and post-traumatic stress disorder, as well have worse clinical outcomes and increased professional issues (Hammond et al., 2018; Yang et al., 2020).

Examining the relationship between burnout, secondary traumatic stress, loneliness/isolation, and self-compassion has not yet been explored and was addressed with this study. This can help provide information on how mental health providers experience burnout and what factors are related to it. Additionally, this analysis could show whether self-compassion protects from the negative effects of burnout, isolation, and secondary traumatic stress, thereby providing evidence on how to help treat the negative effects of burnout in mental health providers.

The results displayed in Table 2 showed correlations among these items, clarifying the relationship between these in mental health providers. Further, examination of the subscales on the SCS provided more detail on the interactions and factors that may put mental health

providers at more risk for experiencing burnout. As such, the self-judgement (r = .630, p = .009), self-kindness (r = -.846, p = <.001), and common humanity (r = -.684, p = .003) subscales on the SCS are strongly correlated with burnout. With this relationship in mind, interventions or actions that target self-judgement, promote self-kindness, and common humanity could be beneficial measures to take in addressing burnout in mental health providers. Further, examination into potential relationships indicates a lack of relationship between factors of self-compassion and secondary traumatic stress. Taking into account this information, mental health providers experiencing both secondary traumatic stress and burnout may not benefit from interventions and actions to promote self-compassion compared to a mental health provider only experiencing burnout. This helps better understand the relationships of self-compassion to burnout and secondary traumatic stress. It could be an avenue for further research on the prevalence of secondary traumatic stress and ways to address this issue in mental health providers.

This study sought to examine the relationship between isolation and burnout. Not only was there a relationship between isolation and burnout (r = .859, p = <.001; r = .713, p = .002), results showed a predictive relationship between loneliness and burnout (β = 0.77, t = 2.051, p = .004). The relationship between these two variables is important to note as the solitary nature of mental health providers' work may place individuals in this profession at a greater risk to experience isolation (Rokach & Boulazreg, 2022). Additionally, due to the significant relationship between isolation and loneliness measures in this study (r = 0.77, p = < .001). This allowed us to make the conclusion that both measure similar things, with the loneliness scale being more predictive of the two. As for a large degree in the sample they are the same thing, so isolation may be a key element to address even though loneliness was a somewhat for powerful

predictor. Thus, it may be important for mental health providers to build community within the profession through initiatives such as peer-to-peer supervision, consultation, or self-care activities involving others or done in groups to help with the issues loneliness presents. Additionally, SCS Mindfulness ($\beta = 0.49$, $t = 2.28$, $p = .057$) and ProQOL-5 Compassion Satisfaction ($\beta = -0.51$, $t = -2.08$, $p = .076$) approached predictive variance when accounted for in this study. This should be noted when providing strategies to help address isolation and burnout in mental health providers.

This study also examined whether loneliness and isolation were predictive of secondary traumatic stress in participants. There is a relationship between loneliness and secondary traumatic stress ($\beta = 1.05$, $t = 3.51$, $p = .004$). Even when accounting for other variables the relationship between isolation and secondary traumatic stress remained significant ($\beta = 1.32$, $t = 2.39$, $p = .048$). This highlights how loneliness not only has a relationship with burnout but secondary traumatic stress as well. This is cause for concern due to the number of negative side effects both mentally and physically associated with loneliness (Banerjee & Rai, 2020; Espinosa & Rudenstine, 2020; Liao & Weng, 2018; Santini et al., 2015). Additionally, recent research shows an increase in worldwide loneliness related to the COVID-19 pandemic (Ernst et al., 2022). Because the data for this study was collected in 2021, COVID-19 may have exacerbated loneliness related to isolation and secondary traumatic stress in mental health providers which could affect the data collected from participants and the results of the study. When considering this study's results, they should be interpreted in this context due to the worldwide heightened levels of loneliness during this time period.

Surprisingly, self-compassion scores did not contribute any unique variance to predicting isolation, burnout, and secondary traumatic stress in this sample. This was a surprising finding as

previous studies suggest high levels of self-compassion could act as a protective factor against the negative effects of burnout in mental health providers (McCade et al., 2021; Richardson et al, 2018). With secondary traumatic stress being related to burnout, it was interesting to see no relation between secondary traumatic stress and any of the SCS subscales (Shoji et al., 2016; Thompson et al., 2014). However, many of these relationships may have been confirmed with a larger sample.

Limitations

There were several limitations that arose during this study. First, the small sample size of 16 makes it difficult to draw generalizable conclusions based on the data gathered from participants. Smaller sample sizes in studies make them more susceptible to error, including Type 2 errors which are false negatives due to inadequate power, as well as Type 1 errors which create false positives due to biased samples. Due to the small sample size of the study, results should be interpreted with caution as the data collected may be more prone to the errors listed above.

Another limitation is that data were collected during the COVID-19 pandemic. As increased demands faced by mental health providers during the time of data collection may have caused them to be less available to complete a research survey. This could help explain the small sample size of participants which created issues in displaying statistical significance in the data collected.

Perhaps the most serious limitation is that many mental health providers did not choose to participate. Thus, representativeness is seriously compromised. It is possible that the most seriously distressed mental health providers declined to participate due to high levels of distress and results may thus underestimate the severity of distress in the target sample.

Future Research

The lack of a diverse sample population including both geographically and demographically in mental health providers limits the generalizability of these findings across different populations. The average participant in this study had worked in this profession for 21 years (*SD* = 14.33), was White (95%), female (80%), and worked individually in a private practice setting (85%). Future research should have a more representative sampling across the demographics listed above. Also, it should examine how demographic variables could impact the factors examined in this study, as demographic variables were not evaluated for potential variance when measures were analyzed. Geographically, this sample was collected from mental health providers in Oregon. A broader geographic sample will help obtain a more representative sample across mental health providers who practice in rural, urban, or suburban areas. Additionally, data collected outside the COVID-19 pandemic may increase provider willingness to participate in the study as well, as account for the potential impacts COVID-19 had on both the sample size of participants in this study and the data collected from the participants. As discussed above, research on secondary traumatic stress in mental health providers is limited at this time especially in relation to the effects on COVID-19, and research on this topic could help with addressing this issue within this profession.

Summary

The current study examined the relationship between loneliness and isolation, self-compassion, with burnout and secondary traumatic stress in mental health providers. There was a relationship between these factors outside of self-compassion factors and both burnout and secondary traumatic stress. Loneliness was associated with secondary traumatic stress and burnout scores in mental health providers. The current study showed the impact loneliness and likely isolation can create in mental health in relation to burnout and secondary traumatic stress.

Overall, the results of this study have important implications for individuals, organizations, and populations treated by and containing mental health providers. Thus, present findings suggest, interventions and actions within the population of mental health providers focused on decreasing loneliness and isolation may be beneficial for preventing and treating burnout and secondary traumatic stress in mental health than interventions and actions focused solely on self-compassion.

References

Atkinson, D. M., Rodman, J. L., Thuras, P. D., Shiroma, P. R., & Lim, K. O. (2017). Examining burnout, depression, and self-compassion in veterans affairs mental health staff. *Journal of Alternative and Complementary Medicine*, *23*(7), 551–557. https://doi.org/10.1089/acm.2017.0087

Banerjee, D., & Rai, M. (2020). Social isolation in Covid-19: The impact of loneliness. *International Journal of Social Psychiatry*, *66*(6), 525–527. https://doi.org/10.1177/0020764020922269

Bell, C. A., Crabtree, S. A., Hall, E. L., & Sandage, S. J. (2021). Research in counselling and psychotherapy Post-COVID-19. *Counselling and Psychotherapy Research*, *21*(1), 3–7. https://doi.org/10.1002/capr.12334

Ernst, M., Niederer, D., Werner, A. M., Czaja, S. J., Mikton, C., Ong, A. D., Rosen, T., Brähler, E., & Beutel, M. E. (2022). Loneliness before and during the COVID-19 pandemic: Asystematic review with meta-analysis. *The American Psychologist*, *77*(5), 660–677.https://doi.org/10.1037/amp0001005

Espinosa, A., & Rudenstine, S. (2020). The contribution of financial well-being, social support, and trait emotional intelligence on psychological distress. *British Journal of Clinical Psychology, 59*(2), 224–240. https://doi.org/10.1111/bjc.12242.

Golden, T. D., Veiga, J. F., & Dino, R. N. (2008). The impact of professional isolation on teleworker job performance and turnover intentions. *Journal of Applied Psychology*, *93*(6), 1412–1421. https://doi.org/10.1037/a0012722

Gündoğan, H. (2017). Meaning-making process of psychotherapists on feelings of incompetence through the framework of the professional self-development: Sources, consequences, and

defense mechanisms [Doctoral dissertation, Middle East Technical University, Ankara, Turkey]. https://open.metu.edu.tr/handle/ 123456789/26931

Hammond, C. A., & Drummond, S. (2018). A thematic inquiry into the burnout experience of Australian solo-practicing clinical psychologists. *Frontiers in Psychology*, *8*, 1996–1996. https://doi.org/10.3389/fpsyg.2017.01996

Hashem, Z., & Zeinoun, P. (2020). Self-compassion explains less burnout among healthcare professionals. *Mindfulness*, *11*(11), 2542–2551. https://doi.org/10.1007/s12671-020-01469-5

Hawkley, L. C., & Capitanio, J. P. (2015). Perceived social isolation, evolutionary fitness and health outcomes: a lifespan approach. *Philosophical Transactions. Biological Sciences*, *370*(1669), 20140114. https://doi.org/10.1098/rstb.2014.0114

Holmes, M. R., Rentrope, C. R., Korsch-Williams, A., & King, J. A. (2021). Impact of COVID-19 pandemic on posttraumatic stress, grief, burnout, and secondary trauma of social workers in the United States. *Clinical Social Work Journal*, *49*(4), 495–504. https://doi.org/10.1007/s10615-021-00795-y

Inchausti, F., MacBeth, A., Hasson-Ohayon, I., & Dimaggio, G. (2020). Psychological intervention and COVID-19: What we know so far and what we can do. *Journal of Contemporary Psychotherapy*, *50*(4), 243–250. https://doi.org/10.1007/s10879-020-09460-w

Kaeding, A., Sougleris, C., Reid, C., Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of Clinical Psychology*, *73*(12), 1782–1796. https://doi.org/10.1002/jclp.22485

Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., & Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health, 152*, 157–171. https://doi.org/10.1016/j.puhe.2017.07.035

Liao, K. Y.-H., & Weng, C.-Y. (2018). Gratefulness and subjective well-being: Social connectedness and presence of meaning as mediators. *Journal of Counseling Psychology, 65*(3), 383–393. https://doi.org/10.1037/cou0000271

MacMullin, K., Jerry, P., & Cook, K. (2020). Psychotherapist experiences with telepsychotherapy: Pre COVID-19 lessons for a post COVID-19 world. *Journal of Psychotherapy Integration*, *30*(2), 248–264. https://doi.org/10.1037/int0000213

Maslach, & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*(2), 99–113. https://doi.org/10.1002/job.4030020205

McBeath, A. G., Plock, S., & Bager-Charleson, S. (2020). The challenges and experiences of psychotherapists working remotely during the coronavirus pandemic. *Counselling and Psychotherapy Research*, *20*(3), 394–405. https://doi.org/10.1002/capr.12326

McBride, H. L., Joseph, A. J., Schmitt, P. G., & Holtz, B. M. (2020). Clinical recommendations for psychotherapists working during the coronavirus (COVID-19) pandemic through the lens of AEDP (Accelerated Experiential Dynamic Psychotherapy). *Counselling Psychology Quarterly*, *ahead-of-print 34*, 411–431. https://doi.org/10.1080/09515070.2020.1771283

McCade, D., Frewen, A., & Fassnacht, D. B. (2021). Burnout and depression in Australian psychologists: The moderating role of self-compassion. *Australian Psychologist*, *56*(2), 111–122. https://doi.org/10.1080/00050067.2021.1890979

McCormack, H. M., MacIntyre, T. E., O'Shea, D., Herring, M. P., & Campbell, M. J. (2018). The prevalence and cause(s) of burnout among applied psychologists: A Systematic review. *Frontiers in Psychology*, *9*, 1897–1897. https://doi.org/10.3389/fpsyg.2018.01897

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, *39*(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, *2*(3), 223–250. https://doi.org/10.1080/15298860309027

Neff, K. D., Long, P., Knox, M. C., Davidson, O., Kuchar, A., Costigan, A., Williamson, Z., Rohleder, N., Tóth-Király, I., & Breines, J. G. (2018). The forest and the trees: Examining the association of self-compassion and its positive and negative components with psychological functioning. *Self and Identity*, *17*(6), 627–645. https://doi.org/10.1080/15298868.2018.1436587

Neff, K. D. (2019). Setting the Record Straight About the Self-Compassion Scale. *Mindfulness*, *10*(1), 200–202. https://doi.org/10.1007/s12671-018-1061-6

Neff, K. D, Tóth-Király, I., Yarnell, L. M., Arimitsu, K., Castilho, P., Ghorbani, N., Guo, X.H., Hirsch, J. K., Hupfeld, J., Hutz, C. S., Kotsou, I., Lee, W. K., Montero-Marin, J., Sirois, F. M., de Souza, L. K., Svendsen, J. L., Wilkinson, R. B., & Mantzios, M. (2019). Examining the factor structure of the self-compassion scale in 20 diverse samples: Support for use of a total score and six subscale scores. *Psychological Assessment*, *31*(1), 27–45. https://doi.org/10.1037/pas0000629

Prime, H., Wade, M., & Browne, D. T. (2020). Risk and resilience in family well-being during the COVID-19 pandemic. *The American Psychologist*, *75*(5), 631–643. https://doi.org/10.1037/amp0000660

Richardson, C. M. E., Trusty, W. T., & George, K. A. (2018). Trainee wellness: Self-critical perfectionism, self-compassion, depression, and burnout among doctoral trainees in psychology. *Counselling Psychology Quarterly*, *33*(2), 187–198. https://doi.org/10.1080/09515070.2018.1509839

Rokach, & Boulazreg, S. (2022). The COVID-19 era: How therapists can diminish burnout symptoms through self-care. *Current Psychology*, *41*(8), 5660–5677. https://doi.org/10.1007/s12144-020-01149-6

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. *Journal of Personality Assessment*, *66*(1), 20–40. https://doi.org/10.1207/s15327752jpa6601_2

Sampaio, M., Haro, M., Navarro, V. M., De Sousa, B., Melo, W. V., & Hoffman, H. G. (2021). Therapists make the switch to telepsychology to safely continue treating their patients during the COVID-19 pandemic. Virtual reality telepsychology may be next. *Frontiers in Virtual Reality*, *1*. https://doi.org/10.3389/frvir.2020.576421

Sander, L. & Bauman, O. (2020). Five psychological reasons to reduce the number of Zoommeetings. Retrieved from https://www.inverse. com/science/zoom-meeting-psychology. Accessed 10 May 2020.

Santini, Z. I., Koyanagi, A., Tyrovolas, S., Mason, C., & Haro, J. M. (2015). The association between social relationships and depression: A systematic review. *Journal of Affective Disorders, 175*, 53–65. https://doi.org/10.1016/j. jad.2014.12.049.

Shoji, C., R., Smoktunowicz, E., Rogala, A., Benight, C. C., & Luszczynska, A. (2016). Associations between job burnout and self-efficacy: A meta-analysis. *Anxiety, Stress, and Coping*, *29*(4), 367–386. https://doi.org/10.1080/10615806.2015.1058369

Simionato, G., Simpson, S., & Reid, C. (2019). Burnout as an ethical issue in psychotherapy. *Psychotherapy* , *56*(4), 470–482. https://doi.org/10.1037/pst0000261

Simionato, G. K., & Simpson, S. (2018). Personal risk factors associated with burnout among psychotherapists: A systematic review of the literature. *Journal of Clinical Psychology*, *74*(9), 1431–1456. https://doi.org/10.1002/jclp.22615

Smith, B. M., Twohy, A. J., & Smith, G. S. (2020). Psychological inflexibility and intolerance of uncertainty moderate the relationship between social isolation and mental health outcomes during COVID-19. *Journal of Contextual Behavioral Science*, *18*, 162–174. https://doi.org/10.1016/j.jcbs.2020.09.005

Stamm, B. H. (2009). *The ProQOL test manual*, (2nd ed.) Sidran Press and the ProQOL.org.

Stuntzner. (2017). Compassion and self-compassion: Conceptualization of and application to adjustment to disability. *Journal of Applied Rehabilitation Counseling*, *48*(2), 15–25. https://doi.org/10.1891/0047-2220.48.2.15

Thompson, I. A., Amatea, E. S., & Thompson, E. S. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, *36*(1), 58–77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Yang, Y., & Hayes, J. A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, *57*(3), 426–436. https://doi.org/10.1037/pst0000317

Zessin, D. O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology: Health and Well-Being*, *7*(3), 340–364. https://doi.org/10.1111/aphw.12051

Appendix A

Consent Form

I authorize Michael Underriner of the Graduate School of Clinical Psychology, George Fox University and/or any designated research assistants to gather information from me on the topic of burnout, isolation, secondary trauma, and self-compassion in mental health providers. I understand that the general purposes of the research are to understand if there is a relationship between self-compassion, burnout, isolation, and secondary trauma. I will be asked to complete questionnaires that will take approximately 20- 30 minutes. I am aware that I may choose not to answer any questions that make me uncomfortable. I understand that my participation is voluntary and that I may refuse to participate or discontinue my participation at any time without penalty or loss of benefits to which I am otherwise entitled. I understand that if, after my participation, I experience any discomfort or have questions about the research or my rights as a participant, I can contact Michael Underriner (nunderriner18@georgefox.edu) or Marie-Christine Goodworth, Ph.D. faculty supervisor (mgoodworth@georgefox.edu) Confidentiality of research results will be maintained by the researcher. My individual results will not be released without my written consent. The potential benefits/risks of the research study are being able to understand how self-compassion can protect against burnout, isolation, and secondary trauma. There should be no perceived risks to you for participating. I have read the information above and agree to be a participant in the study on the impact of peer support training on well-being.

_____ _____

Signature of Participant Date

I am over the age of 18. YES NO

I have read the information above and agree to be a participant in the study. YES NO

Appendix B

Demographics

1.Do you currently engage in providing mental health therapy?
a.Yes
b.No

2.What is your highest degree?
a. Masters Degree (e.g., MA, MS, MSW)
b. Doctoral Degree (e.g., EdD, PsyD, Ph.D)
c. Other (please specify)_____

3.Are you over 18?
a.Yes
b.No

4.Age: _____

5.Gender:
a.Male
b.Female
c.Gender Queer
d.Transgender Male/Transwoman/FTM
e.Transgender Female/Transwoman/MTF
f.Other (please specify _____)
g.Prefer not to say

6.Ethnicity:
a.White
b.African American
c.Latino or Hispanic
d.Asian
e.American Indian or Alaska Native.Native Hawaiian or Pacific Islander
g.Middle Eastern/Arabic
h.Unknown
i.Prefer not to say
j.Other (Please specify) _____

7.What area of psychology do you specialize in?
a. General Practice
b. Family and Marriage
c. Child & Adolescent
d. Assessment

e. Substance Use
f. Primary Care
g. Other (Please specify) _____

8. What setting do you practice in?
a. Individual Practice
b. Group Practice
c. School Setting (Elementary, Middle, High School, College)
c. Medical Setting (Hospital, VA)
d. Primary-Care Clinic
e. Other (Please specify)

9. How long have you been practicing? (Please approximate number of years) ____

10. To what extent did you have teletherapy experience prior to the past year?
a. None
b. A small amount
c. A moderate amount
d. A large amount
e. A very extensive amount

11. If yes, how confident are you in conducting teletherapy?
a. Very Confident
b. Moderately Confident
c. Minimally Confident
d. Not at all Confident

12. How much do you currently practice teletherapy?
a. Not at all
b. From 1 to 20% of client contacts
c. From 21 to 40% of client contacts
d. From 41 to 60% of client contacts
e. From 61 to 80% of client contacts
f. From 81 to 100% of client contacts

13. To what extent do you currently practice remotely?
a. Not at all
b. From 1 to 20% of client contacts
c. From 21 to 40% of client contacts
d. From 41 to 60% of client contacts
e. From 61 to 80% of client contacts
f. From 81 to 100% of client contacts

15. Where did you go to receive support in your transition to teletherapy? Please specify:
_____

Appendix C

Measures

The Self-Compassion Scale (SCS)

Instructions: Please read each statement carefully before answering. Indicate how often you feel or behave in the stated manner on a scale from 1 ‘Almost Never’ to 5 ‘Almost Always.’ Please answer according to what really reflects your experience rather than what you think your experience should be.

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, 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.

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the

following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been affected by the traumatic stress of those I *[help]*.
10. I feel trapped by my job as a *[helper]*.
11. Because of my *[helping]*, I have felt "on edge" about various things.
12. I like my work as a *[helper]*.
13. I feel depressed because of the traumatic experiences of the people I *[help].*
14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a *[helper].*
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.

21. I feel overwhelmed because my case [work] load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

The UCLA Loneliness Scale (Version 3)

Scale:
INSTRUCTIONS: Indicate how often each of the statements below is descriptive of you.

Statement	Never	Rarely	Sometimes	Often
*1. How often do you feel that you are "in tune" with the people around you?	1	2	3	4
2. How often do you feel that you lack companionship?	1	2	3	4
3. How often do you feel that there is no one you can turn to?	1	2	3	4
4 How often do you feel alone?	1	2	3	4
*5. How often do you feel part of a group of friends?	1	2	3	4
*6. How often do you feel that you have a lot in common with the people around you?	1	2	3	4
7. How often do you feel that you are no longer close to anyone?	1	2	3	4
8. How often do you feel that your interests and ideas are not shared by those around you?	1	2	3	4
*9. How often do you feel outgoing and friendly?	1	2	3	4
*10. How often do you feel close to people?	1	2	3	4
11. How often do you feel left out?	1	2	3	4
12. How often do you feel that your relationships with others are not meaningful?	1	2	3	4
13. How often do you feel that no one really knows you we11?	1	2	3	4
14. How often do you feel isolated from others?	1	2	3	4
*15. How often do you fee1 you can find companionship when you want it?	1	2	3	4
*16. How often do you feel that there are people who really understand you?	1	2	3	4
17, How often do you feel shy?	1	2	3	4
18. How often do you feel that people are around you but not with you?	1	2	3	4
*19. How often do you feel that there are people you can talk to?	1	2	3	4
*20. How often do you feel that there are people you can turn to?	1	2	3	4

Scoring:
The items with an asterisk are reverse scored. Keep scoring on a continuous basis.