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Increasing Conceptual Clarity of ACT Interventions for Burnout: A Novel Workshop for Women in Ministry

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Increasing Conceptual Clarity of ACT Interventions for Burnout: A Novel Workshop for

Women in Ministry

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Women in Ministry

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Abstract

The purpose of this study is threefold; to address a gap in the literature concerning mechanism of change of acceptance and commitment therapy (ACT) interventions for burnout, to create an evidence-based burnout intervention for women in ministry, and to propose a theory of burnout etiology and recovery. Participants in this novel 6-week online ACT-based workshop showed significant improvement in burnout, particularly those who endorsed higher pre-intervention burnout. Change in burnout scores was inconsistently mediated by changes in psychological flexibility across dimensions of personal burnout, work burnout, and client burnout as measured on the Copenhagen Burnout Inventory. Findings of this study in context of the burnout literature support the following theory of change for ACT interventions for burnout: ACT interventions increase the theory of mind capacity to differentiate self from others, fostering an interpersonal state of compassion and cognitive perspective taking rather than self-oriented empathy that is associated with burnout. Increase in prayer did not mediate reduction in symptoms, but a shift in prayer approach towards an apophatic style characterized by wordless connection and awareness of God mediated improvement in burnout scores. This finding was used to expand the proposed model of burnout etiology and recovery to include distinction of self in relation to divine and personal values amidst constructed and societal pressures. Apophatic prayer is theorized to improve burnout as the self shaped by experience with God is a more stable construct of self to bring to interaction with others, enabling a healthier empathy/compassion balance and self-other differentiation in interpersonal interactions.

Keywords: burnout, acceptance and commitment therapy (ACT), theory of mind, apophatic prayer, empathy, compassion, psychological flexibility

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Chapter 1

Up to 8 % of America's national spending on health care and 120,000 deaths a year are attributed to burnout (Goh et al., 2015). This exhaustion is associated with reduced productivity, lower quality of life, impaired physical health, loneliness, lowered self-esteem, marital conflict, job dissatisfaction, absenteeism, and significant loss of closeness and enjoyment in personal and professional relationships (Adams et al., 2017). Pressures of COVID-19 have increased this cost as half of all healthcare workers report being burned out, and allied health professions such as social workers are reporting the highest rates (Prasad et al., 2021).

Despite its increasing prevalence and cost, there exists no DSM-5 diagnosis and no universally accepted definition and diagnostic criteria for burnout.

Without consensus on a clear theoretical construct, burnout research has sought distinction from well-defined disorders. Burnout may be better defined through negation and is correlated with, albeit distinct from, compassion fatigue (Yu & Gui, 2022), depression (Koutsimani et al., 2019) and chronic fatigue syndrome (Coetzee et al., 2019). Interventions for burnout have focused on increasing positive, measurable psychological practices and constructs that have been found to be lacking, such as work-life balance (Rosdahl & Kingsolver, 2019), self-esteem (Richter et al., 2015), relaxation (Wild et al., 2014), organization-wide adjustments (Arronson et al., 2017), self-care practices (Henry, 2014), creative self-expression (Reed et al., 2020) and mindfulness (Sarazine et al., 2021).

Mindfulness is an ancient human practice that has recently permeated Western sciences and popular culture, prompting sects of the Western church to reclaim mystical and

contemplative aspects of faith lost during the Protestant Reformation (Timbers & Hollenberger, 2022). Other Christian persuasions have ignored or renounced the practice of mindfulness as a spiritual evil. Given evidence favoring mindfulness practice for spiritual health, fields of pastoral care and religious coping have repackaged mindfulness into forms palatable and familiar to Christians such as apophatic prayer (Timbers & Hollenberger, 2022). Central to apophatic prayer or *via negativa* is relinquishing speech and thought for spiritual experience of God, with the belief assimilated memories and knowledge of God may insulate from true experiencing (Williams, 2019). Andrea Hollingsworth (2015) proposed a cognitive scientific model for apophatic prayer involving four stages: resonance, rupture, reappraisal, and repair. Resonance is defined by an initial emotional warmth and connection to a constructed representation of the divine, followed by a rupture of that mental representation in realization that God cannot be objectified and fully known. Reappraisal involves a search for a new construct of self and God, a hunger to understand His mystery that unfolds into a process of repair described by a oneness in an unsayable, negative way.

There has been recent increase in mindfulness-based psychological interventions for burnout, primarily in the trending third-wave cognitive behavioral therapy acceptance and commitment therapy (ACT). However, a meta-analysis on ACT interventions for burnout concluded that the mixed results are due to a “lack of a clear conceptualization as to what treatment targets and benefits an ACT-intervention should hope to achieve” (Reeve et al., p. 19). It is well-established in the literature that psychological flexibility, defined by the ability to fully experience the present moment and live according to values, is the central goal of ACT interventions and the construct mediating change. However, ACT interventions have improved symptoms of burnout without corresponding changes in psychological flexibility (Barrett &

Stewart, 2020), bringing into question how ACT interventions are exerting their effect on burnout. In their meta-analysis, Towey-Swift et al. (2022) found inconsistent evidence for psychological flexibility mediating change for burnout, and proposed future research utilize process measures to clarify theory of change for ACT interventions for burnout. The present study addresses this need for conceptual clarity and more targeted treatment by moving away from outcome-focused research and deconstructing the constituent parts of ACT to test their impact on symptoms during the intervention process. It is hypothesized that seeking differences between individually administered ACT skills rather than the ability of the entire theoretical construct to create positive difference will improve clarity.

Theory

Maslach's seminal scale defining burnout as a tri-part psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment (Maslach & Jackson, 1981) is considered the "gold standard" for measuring burnout (Zhucheng et al., 2021). Of the currently available burnout measures, the Maslach Burnout Inventory has been the subject of the greatest number of psychometric studies but has the lowest quality of evidence (Shoman et al., 2021). Popular newer measures, the Oldenberg Burnout Inventory and Copenhagen Burnout Inventory (CBI), have forgone the personal efficacy dimension on the Maslach Burnout Inventory, viewing it as a consequence of burnout rather than a core dimension (Walters et al., 2018).

Mindfulness-based interventions for burnout are gaining traction (Puolakanaho et al. 2020) and support research finding a positive correlation between alexithymia and burnout symptoms (Augustin et al., 2020). A functional magnetic resonance imaging study found a correlation between increased activation of empathy-related brain structures and burnout in

physicians, and reduced activity in empathy-related brain areas with severe burnout symptomology, upholding the theory that increased empathy causes burnout and depersonalization sets in as a result of the burnout (Tei et al., 2014). This psychological model of burnout as an initial state of hyper-empathy leading to a state of reduced empathy and depersonalization is the model of burnout most congruous with neuroendocrinological research (Dahlman et al., 2021). Although medical research on burnout is inconclusive, largely due to difficulty studying an ill-defined concept, there is support for conceptualization of burnout as an initial state of increased hypothalamic-pituitary-adrenal axis and sympathetic nervous system activity that leads eventually to a state of autonomic hyporeactivity and parasympathetic dominance (Dahlman et al., 2021). Empathizing with another's feelings activates neural networks that are used for first-person experience of that pain, leading to a stress response and increased risk of burnout (Preckel et al., 2018).

Compassion is related to empathy, but distinct in that empathy is characterized by emotion sharing and compassion is defined by positive other-oriented feelings of love with motivation to help (Singer & Klimecki, 2014). Compassion is protective against burnout, improves well-being of providers, and increases positive patient outcomes in health care settings (Novak et al., 2022). Compassion fatigue is a construct related to burnout but the two have different underlying mechanisms with compassion fatigue being shorter-lived, circumstantial, and directly related to exhaustion from self-sacrifice and caring for others (Sweileh, 2020). In their path analysis, Yu & Gui (2022) determined burnout and compassion fatigue are independent constructs with distinct impacts on health; burnout is a chronic, slowly progressing disorder that affects attitudes towards others and ability to work, and compassion fatigue is defined by short-term irritability and fatigue from caring from others. The consequences of

compassion fatigue have been limited to mental health, whereas burnout is negatively correlated with both mental and physical health (Yu & Gui, 2022).

Literature on the relationship between empathy and burnout is inconclusive with findings that empathy is both correlated with and protective of burnout (Wilkensen et al., 2017). Mixed findings are best explained by the multidimensionality of empathy upon discovery that only one of three components of empathy is associated with burnout (Delgado et al., 2021). Delgado et al. (2021) found that two types of empathy are not correlated with burnout and are protective against burnout; empathic concern, defined by feelings of warmth/concern, and cognitive empathy, defined by intentional perspective-taking. They found the personal distress dimension of empathy, defined as a self-focused reaction of placing oneself in the sufferer's shoes, is significantly related to burnout. They concluded that personal distress in healthcare has "extremely negative consequences" for healthcare workers while other-oriented empathic responses of warmth/care and perspective taking are protective (Delgado et al., 2021, p. 7).

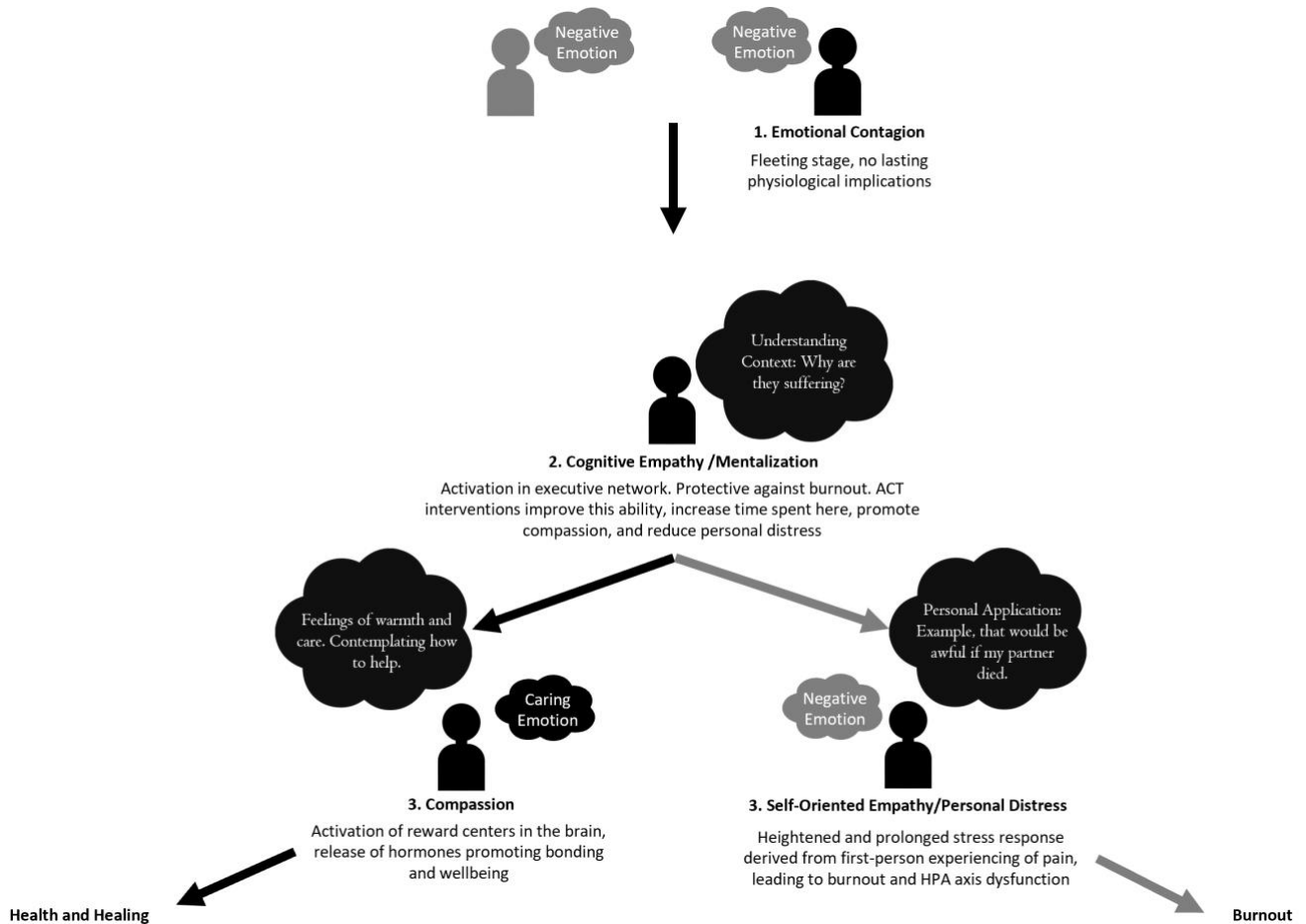
Theory of mind (TOM) is a construct related to cognitive empathy and is defined by the uniquely human capacity to think about one's own mental state and that of others (Beaudoin et al., 2020). TOM has traditionally been considered a standard developmental task, however, research is finding differences between adults' ability to infer mental states of others, depending on metacognitive ability and degree of reliance on one's own mental states to infer those of others (Conway et al., 2019). It has recently been discovered that TOM ability can be improved through teaching cognitive perspective taking with mindfulness exercises and practice inferring mental states of others (Trautwein, et al., 2020). Pertinent to this study, self-oriented empathy is inversely associated with a crucial task of theory of mind, being able to distinguish oneself from others (Banzhaf et al., 2018).

Model of Burnout

Combining these recent directions, the author proposes a model of burnout as a disorder of uncontrolled, self-oriented empathy caused by a lack of mindfulness and self-other distinction that leads to emotional exhaustion, depersonalization, and reduced personal efficacy due to the physiological consequences of chronic sympathetic arousal in response to personal distress:

Figure 1

Proposed Model of Burnout



Note. The above figure portrays the author’s proposed model of burnout etiology. The numbers in the figure correlate with numbers in the text below to more fully describe each step.

1. Emotional Contagion

Research on social emotion sharing has proposed that empathy and compassion both begin temporally with emotional contagion, a spontaneous and subconscious process of interpersonal behavioral, emotional, and attentional synchrony triggered by instinctual alignment with emotions we perceive during interactions (Herrando & Constantinides, 2021; Woodruff & Stevens, 2018). Physiological correlates of emotional contagion include the mirror neuron system and activation of emotion-specific networks that create interpersonal synchrony and emotion sharing (Herrando & Constantinides, 2021). This is a fleeting stage with no evidence of long-term physiological consequences as the emotions that are “caught” tend to have less valence than if generated by the person themselves and can be modified quickly depending on cognitive interpretation (Hatfield et al., 2014). Neural correlates involve networks near the visual dorsal stream with secondary motor and temporo-parietal association areas for processing visual, auditory, and somatosensory stimuli (Jeon & Lee, 2018). Emotional processing in the mirror neuron system is specifically correlated with activation in motor and emotion processing regions (Ramsey et al., 2021).

2. Cognitive Empathy/Mentalization

Following emotional contagion, empathy and compassion both involve a cognitive, top-down interpretation of one’s own affective response and interpretation of the other person’s situation (Woodruff & Stevens, 2018). This step is referred to as cognitive empathy and is considered synonymous with the process of mentalizing in theory of mind, the attribution of mental states to others. Theory of mind is considered the cognitive component of empathy and compassion (Stietz et al., 2019). Neurologically, activation of the right parietal temporal junction in theory of mind tasks is crucial for self-other distinction (Eddy, 2022). Cognitive empathy ability is improved through mindfulness and is negatively associated with burnout and affective

empathy (Perez-Fuentes et al., 2020). Research on neural correlates of perspective taking and empathy indicate that cognitive behavior therapy has the ability to enhance the metacognitive ability to assess another person's perspective (Shiota, 2017). Theory of mind and executive functioning share underlying neuroanatomical mechanisms (Wade et al., 2018).

3. Self-Oriented Empathy or Compassion

From a state of cognitive empathy, or perspective-taking, people can respond with either compassion or self-oriented empathy. Self-oriented empathy, or personal distress, has been uniquely associated with burnout (Delgado et al., 2021). In a state of self-oriented empathy, there is limited differentiation between self and other and first-hand experiencing of the other's pain as if it were one's own. In this state one is imagining themselves in the another's situation. This finding aligns with current neurological research indicating burnout is induced by frequent stress response leading to HPA axis dysfunction (Dahlman et al., 2021).

In contrast, compassion is defined as prosocial approach accompanied by feelings of warmth and care; it is defined by positive emotions and a desire to alleviate pain. Compassion has been found to be protective against burnout (Singer & Klimecki, 2014). Compassion is associated with brain areas that process warmth and positive emotions (Novak et al., 2022). Compassion activates neural networks involved in social connection, caring, and altruism and has beneficial effects on health by down regulating threat and stress reactions and releasing oxytocin (Seppala et al., 2017). Compassion training increases positive affect during interactions and afterwards and counters negative affective responses (Klimecki et al., 2014).

ACT interventions target cognitive empathy processes, particularly metacognitive processes such as self-as-context, mindfulness, acceptance, and cognitive defusion. When participants are focused on their own experiencing through metacognition, they are participating in the TOM task

of mentalizing and are maintaining self-other differentiation rather than slipping into a state of personal distress. Mentalizing and empathic sharing have been found to be distinctly different processes with heightened emotional sharing degrading mentalization performance (Kanske et al., 2016). Research has found that TOM can be taught through exercises similar to observing self (Trautwein, et al., 2020). The author proposes that ACT interventions reduce burnout by increasing cognitive empathy and participants' ability to stay in a state of mentalizing leading them to a place of compassion rather than a state of personal distress or self-oriented empathy.

Purpose of This Study

The author hypothesizes that ACT interventions alleviate burnout because they strengthen the TOM capacity to differentiate oneself from others, maintaining a state of compassion and perspective taking rather than slipping into self-oriented empathy that is associated with burnout.

The hypotheses for this study are as follows:

H1: The components of ACT that participants will rate as most effective for reducing burnout are those that focus on reducing hyper-empathy and promoting differentiation of self from others; cognitive defusion, self-as-context, acceptance, and mindfulness.

H2: The self-as-context lesson will be rated most highly as it relates most strongly to the TOM task of self-other differentiation and is focused on reducing uncontrolled, affective empathy responses.

H3: Participants who are the most burned out will experience the greatest improvement.

H4: Homework completion will be associated with reduction in burnout symptoms.

H5: Psychological flexibility will not mediate changes in burnout.

Chapter 2

Methods

Participants

Snowball sampling was used to gather volunteers for the workshop and fliers were distributed through churches, Christian organizations, Christian college newsletters and social media channels. Inclusion criteria was contingent on self-identifying as a “women in ministry” irrespective of the formality of ministry setting, frequency of engagement in ministry, or sexual identity. Participants were required to have access to Zoom and be currently involved in ministry. Inclusion criteria was purposefully broad to increase external validity. The flier directed volunteers to the study website where they could fill out the electronic sign-up survey.

During the workshop, 95 participants attended at least one session. Participants included in analysis were those who attended all six meetings and completed the pre and post surveys with a burnout and psychological flexibility measure ($N = 43$).

Table 1

Demographic Data of Participants

| Item | Category | <i>n</i> | % |
|-----------|---------------|----------|------|
| Age | 18–24 years | 3 | 7.0 |
| | 25–34 years | 16 | 37.2 |
| | 35–44 years | 5 | 11.6 |
| | 45–54 years | 9 | 20.9 |
| | 55–64 years | 8 | 18.6 |
| | 65–74 years | 2 | 4.7 |
| Ethnicity | White | 38 | 88.4 |
| | Black/African | 1 | 2.3 |
| | Hispanic | 1 | 2.3 |

| Item | Category | <i>n</i> | % |
|--------------------------|----------------------------|----------|------|
| Denomination | Asian | 1 | 2.3 |
| | Multiethnic | 2 | 4.7 |
| | Adventist | 1 | 2.3 |
| | Anabaptist | 1 | 2.3 |
| | Baptist | 4 | 9.3 |
| | Episcopal/Anglican | 1 | 2.3 |
| | Nondenominational | 22 | 51.2 |
| | Pentecostal | 1 | 2.3 |
| | Quaker | 1 | 2.3 |
| | Reformed/Presbyterian | 4 | 9.3 |
| | Wesleyan | 1 | 2.3 |
| | Other | 7 | 16.3 |
| Primary ministry role | Caregiver | 2 | 4.7 |
| | Community service | 1 | 2.3 |
| | Education | 5 | 11.6 |
| | Formal leadership role | 2 | 4.7 |
| | Lead or host group | 14 | 32.6 |
| | Missions/outreach | 6 | 14.0 |
| | Music/worship | 3 | 7.0 |
| | Pastor | 5 | 11.6 |
| | Support spouse in ministry | 1 | 2.3 |
| | Other | 4 | 9.3 |
| Time devoted to ministry | Full-time ministry | 31 | 72.1 |
| | Part-time ministry | 12 | 27.9 |
| Christian identity | Yes | 42 | 97.7 |
| | Not sure | 1 | 2.3 |

Note. The "other" category of ministry role was specified as mental health professional or allied health professional in training such a physician's assistant and speech language pathologist. $N = 43$.

Materials

The Copenhagen Burnout Inventory (CBI) was used to measure initial and final burnout scores. The CBI was developed by Kristensen et al. (2005) to address shortcomings of the Maslach Burnout Inventory, and it excludes the personal efficacy dimension in accordance with findings that reduced productivity is a result of burnout rather than a symptom. The CBI has the best validity of the current measures of burnout (Shoman, 2021), and conceptualizes burnout within three distinct domains: personal, work, and client. Cronbach alpha values for the three dimensions of the CBI are very high ($\alpha = .85-.87$).

The Acceptance and Action Questionnaire – Second Edition (AAQ-II) is a revised version of the original AAQ created by Steven Hayes and colleagues to measure psychological flexibility (Bond et al., 2011). Scores around 24–28 are considered clinically significant and indicate diagnosable pathology. The AAQ-II has better psychometric properties (mean α quotient is .84 [.78–.8]) than the original version. The 3- and 12-month test-retest reliability is .81 and .79, respectively, and the AAQ-II has been translated into over 30 languages (Bond et al., 2011). Concerns have been raised about the discriminant validity of the AAQ-II to assess for psychological inflexibility, with findings of significant construct overlap with depression, anxiety, and stress (Tyndall et al., 2019). However, given the lack of other available screeners to assess for psychological flexibility as an entire construct, the AAQ-II was used for this study. The

lack of discriminant validity of the AAQ-II in differentiating between stress, anxiety, depression, and psychological inflexibility will be considered in interpreting results.

Procedure

Research on the efficacy of telehealth for group mental health services is promising with studies finding no difference in outcomes between online and in-person mental health treatment, but further research is needed to establish videoconferencing as a best practices modality for groups (Weinberg, 2021). Due to the COVID-19 pandemic APA has permitted therapists to administer services virtually, with the requirement of HIPAA-approved platforms and informed consent clearly stating risks to privacy. To minimize privacy risks, the current study utilized Zoom for Healthcare, which is compliant with HIPAA's Security and Privacy rule. Participants were informed of risks and informed of technical controls that will be implemented to protect privacy such as encryption of data, and utilization of anti-virus and anti-malware software.

In the sign-up form participants were prompted to select their preferred workshop meeting time and were placed in their preferred groups. The groups met for 1 hour a week for 6 weeks. Workshops were on weekday evenings and weekend mornings in the author's time zone, not necessarily in the participants' time zone. Participants were allowed to switch between groups to accommodate scheduling conflicts. The workshop was provided once in the early spring with three meeting options, and once in the early summer with two meeting times. Attendance was taken objectively in the beginning of each session by the workshop technical assistant using an attendance sheet.

Each lesson corresponded with one component of ACT from the author's Christian perspective. Lessons were lecture-based and educational with research

presented from fields of neuroscience, psychology, and theology (see Table 2).

Experiential exercises were incorporated into most of the lessons. Participants were encouraged to participate in discussion time at the end of each lesson for 10–15 minutes.

Lessons were not limited to ACT concepts. The author took license to integrate ACT concepts with burnout symptomology and faith. For instance, the first lesson provided psychoeducation on the author's proposed model of burnout including differences between empathy and compassion, the importance of self-other differentiation in interpersonal interactions, and how this relates to the ACT concept of the observing self. The lesson on values was presented through a uniquely Christian lens with emphasis on personal callings and passion for demonstrating certain attributes of God to the world. However, all lessons and homework exercises corresponded strongly with the ACT theme of the lesson.

Makeup lessons were provided at the end of the workshop based on participant demand. If multiple participants requested a makeup lesson, the lecture was repeated for them. The purpose of the makeup lessons was to benefit participants and increase the number who attended all lessons. After participants finished the workshop or makeup lessons, they were given a final survey with the CBI, AAQ-II, prompts for ratings and feedback on the helpfulness of lessons, and space for takeaways and suggestions.

Statistical Analysis

IBM SPSS Statistics version 28.0.1.1 (14) was used for statistical analysis. To analyze the efficacy of the workshop in reducing burnout scores, paired samples *t*-tests were run using pre and post CBI scores from all participants who attended all six lessons and filled out both surveys ($N = 43$). Using Z-score method for outliers, none were excluded from analysis. Paired

samples *t*-tests were run for the three dimensions of the CBI in pre and post conditions. Effects were calculated according to Cohen's standardized conventions (i.e., *small* ≥ 0.20 , *medium* ≥ 0.50 , *large* ≥ 0.80).

To filter participants who joined the workshop for educational and preventative purposes and were not experiencing burnout, participants in the bottom quartile of initial burnout scores were excluded from analysis. A filter for the bottom quartile of scores for each dimension of the CBI (personal burnout, work burnout, client burnout) was applied so that each paired sample *t*-test was run filtering out the bottom quartile for that specific dimension, leaving sample sizes of 34, 33, and 35 participants respectively. This was the only test the filter for the bottom quartile was applied, the entire sample was used for the rest of statistical analysis.

Pearson correlation coefficient tests were run to determine strength and direction of relationship between amount of homework completed and final burnout scores in all three dimensions of the CBI. A paired samples *t*-test was run using pre and post AAQ-II scores to assess change in psychological flexibility. The difference between pre and post psychological flexibility scores was also calculated to visualize trends in psychological flexibility. Simple linear regression was used to determine if initial psychological flexibility scores significantly predicted initial burnout scores, and if final psychological flexibility scores significantly predicted final burnout scores. Simple linear regression was also used to determine the relationship between change in AAQ-II scores and change in CBI scores. Stepwise linear regression was used to determine components of psychological flexibility measured on the AAQ-II that were predictive of final burnout scores.

Scores around 24–28 on the AAQ-II are considered clinically significant, and the sample was coded and split in half based on whether their final psychological flexibility score was below

or above 24. To test whether someone was above or below the clinical cutoff for psychological flexibility impacted their final burnout scores, independent samples *t*-tests were run using variables of clinical/nonclinical final psychological flexibility score and final burnout scores in the three dimensions of the CBI.

The impact of demographic data on pre and post burnout scores and psychological flexibility scores was considered using one-way analysis of variance (ANOVA) and independent samples *t*-tests for variables of age and full-time or part-time ministry status. To test whether being in full-time or part-time ministry affected final burnout scores, independent samples *t*-tests were run grouping data by full-time or part-time ministry status with all three dimensions of the CBI. A one-way ANOVA was used to test whether there was a significant difference across age categories for the following variables: initial, final, and change in burnout scores; initial, final, and clinical cut-off of psychological flexibility scores; and change in prayer amount increase and approach. Tukey's HSD was used for post-hoc analysis.

Free-form answers to the final survey question inquiring whether the workshop increased amount of prayer were coded into "yes" and "no" responses. Additionally, given that a significant number of participants reported a prayer approach change towards a more mindful and apophatic approach, answers were also coded into yes and no responses for prayer approach change. Pearson correlation tests were run to determine whether an increase in prayer was associated with change in burnout scores on all three dimensions of the CBI. Pearson correlation tests were used to determine whether a change in prayer practice was associated with change in burnout scores on the three dimensions of the CBI.

An independent samples *t*-test was run to determine whether change in psychological flexibility and change in prayer approach were significantly related. A chi square test was used to

determine the independence of variables final psychological flexibility and prayer approach change. The data was filtered based on change in prayer approach, and Pearson correlation coefficient tests were run between change in flexibility and end burnout scores. VassarStats was used to implement the Fisher r to z transformation to determine if there was significant difference between the final correlation coefficients for each group between psychological flexibility and final burnout scores.

To determine whether certain lessons were subjectively more helpful than others, mean Likert scale ratings were calculated and compared. Qualitative coding was used to identify and systematically categorize themes and different lessons in participant's free-form, open-ended summaries of their final takeaways in the final survey. The number of votes each at-home exercise received as the most helpful was tallied. Throughout analysis all p -values were based on two-tailed statistical tests and a cut-off of $p < .05$.

Chapter 3

Results

Impact of Demographics on Outcomes

Full-time or part-time ministry status was not significantly related to initial personal burnout scores $t(41) = 1.05, p = .301$, work burnout scores $t(41) = .415, p = .679$, or client burnout scores $t(41) = -.216, p = .830$. Whether someone was involved in full-time or part-time ministry was not significantly related to change in personal burnout scores $t(41) = 1.19, p = .237$, work burnout scores $t(41) = -.373, p = .711$, or client burnout scores $t(41) = -.856, p = .397$.

ANOVA results indicated that there were no significant differences in age groups for beginning, end, and change in burnout scores respectively for dimensions of personal burnout, $F(5, 37) = .98, p = .445$; $F(5, 37) = .76, p = .586$; $F(5,37) = .78, p = .569$; work burnout, $F(5,37)$

= .31, $p = .907$; $F(5,37) = .37$, $p = .866$; $F(5, 37) = 1.39$, $p = .249$; and client burnout, $F(5, 37) = .80$, $p = .557$; $F(5,37) = .43$, $p = .838$; $F(5,37) = 1.50$, $p = .213$. ANOVA results indicated that there was no significant difference across age groups in final psychological flexibility scores, $F(5, 37) = 1.68$, $p = .164$ and whether someone was above or below the clinical cut-off for psychological flexibility at the end of the workshop, $F(5,37) = 2.14$, $p = .082$. ANOVA results also indicated there was no significant difference across age categories for variables of increase in prayer approach, $F(5,37) = .73$, $p = .607$, or change in prayer method, $F(5,37) = .37$, $p = .867$. ANOVA did indicate a significant difference across age groups in the variable of pre-intervention psychological flexibility, $F(5,37) = 104.85$, $p = .013$, with homogeneity of variances assumed, assessed by Levene's test for equality of variances ($p = .570$). Tukey Kramer's test was used due to unequal sample sizes, and results indicated no significant difference between any of the age groups and initial psychological flexibility score, although the mean difference between age groups 18–24 years and 25–34 years was approaching significance ($p = .083$), with those in the age range of 25–34 years reporting on average 9.75 more points on the AAQ-II indicating less psychological flexibility. Significance at the ANOVA level and not at the post hoc level is explained by Tukey's test being conservative in finding differences between group means as it attempts to control the overall alpha level.

Efficacy of Workshop to Reduce Burnout Scores

Paired samples t -tests found significant differences in scores for the personal burnout dimension of the CBI pre-intervention ($M = 57.75$ $SD = 15.33$) and post-intervention ($M = 49.61$ $SD = 12.98$), $t(42) = 3.56$, $p < .001$, with a medium effect size ($d = .547$). There was not a significant difference in pre and post intervention scores for work burnout ($p = .111$) and client burnout ($p = .151$). When the bottom quartile of initial burnout scores for the dimension of

personal burnout ($Q_1 = 50.00$) was filtered from analysis, paired samples t -test found a significant difference in pre intervention scores for personal burnout, $n = 34$; $M = 63.36$ $SD = 11.60$ and post intervention scores for personal burnout ($M = 52.21$ $SD = 11.66$), $t(33) = 4.92$, $p < .001$, with a large effect size ($d = .845$). When the bottom quartile of scores was filtered from analysis for work burnout ($Q_1 = 42.86$), paired samples t -test found a significant difference in pre intervention scores for work burnout, $n = 29$; $M = 57.55$ $SD = 9.77$ and post intervention scores for work burnout ($M = 50.25$ $SD = 13.15$), $t(28) = 3.83$, $p < .001$, with a medium effect size ($d = .712$). When the bottom quartile of scores was filtered from analysis for client burnout ($Q_1 = 25.00$), paired samples t -test found a significant difference in pre intervention scores for client burnout, $n = 35$; $M = 44.70$ $SD = 13.57$ and post intervention scores for client burnout ($M = 44.12$ $SD = 13.15$), $t(34) = 2.12$, $p = .041$, with a small effect size ($d = .359$).

Impact of Homework on Outcomes

There was a small and negative correlation between amount of homework completed and final personal burnout scores $r(43) = -.22$, final work burnout scores $r(43) = -.17$, and final client burnout scores $r(43) = -.14$, however the relationships were not significant ($p = .150$, $p = .257$, $p = .367$, respectively).

Psychological Flexibility Outcomes

No significant change in psychological flexibility was found using paired samples t -tests with pre and post psychological flexibility scores ($p = .49$). Using a difference calculation for pre and post psychological flexibility scores to visualize trends, 18 participants showed decreased psychological flexibility.

Simple linear regression was calculated to predict initial burnout scores based on initial psychological flexibility scores for all three dimensions of burnout.

Table 2

Linear Regression Results for Initial AAQ-II Predicting Initial CBI Personal Burnout

| Variable | <i>B</i> | <i>SE</i> | 95.00% CI | β | <i>t</i> | <i>p</i> |
|------------------------|----------|-----------|----------------|---------|----------|----------|
| (Constant) | 36.21 | 7.74 | [20.58, 51.85] | 0.00 | 4.68 | <.001 |
| BegTotalPsychFlexScore | 1.00 | .35 | [.30, 1.70] | .41 | 2.90 | .006 |

Note. Results: $F(1,41) = 8.39, p = .006, R^2 = .17, R^2$ adjusted = .15

Table 2 shows initial psychological flexibility scores explained 15% of the variance in initial personal burnout scores (R^2 adjusted = .15), $F(1,41) = 8.39, p = .006; R^2 = .17$. The regression coefficient ($B = 1.00$), 95% CI [.30, 1.70], indicated that an increase in initial psychological flexibility score on the AAQ-II by 1.00 point corresponded, on average, to an increase in personal burnout score on the CBI corresponded by 1.00 point. Initial psychological flexibility score was not significantly predictive of initial work burnout score ($p = .068$).

Table 3

Linear Regression Results for Initial AAQ-II Predicting Initial CBI Client Burnout

| Variable | <i>B</i> | <i>SE</i> | 95.00% CI | β | <i>t</i> | <i>p</i> |
|------------------------|----------|-----------|----------------|---------|----------|----------|
| (Constant) | 8.20 | 8.71 | [-9.40, 25.78] | 0.00 | .94 | .352 |
| BegTotalPsychFlexScore | 1.42 | .389 | [.63, 2.20] | .50 | 3.63 | <.001 |

Note. Results: $F(1,41) = 13.22, p < .001, R^2 = .24, R^2$ adjusted = .23

Table 3 shows initial psychological flexibility scores explained 23% of the variance in initial client burnout scores (R^2 adjusted = .23), $F(1,41) = 13.22, p < .001; R^2 = .24$. The regression coefficient ($B = 1.42$), 95% CI [.63, 2.20], indicated each 1-point increase in initial psychological flexibility score corresponded, on average, to increase in initial client burnout score on the CBI corresponded by 1.42 points.

Simple linear regression was also calculated to predict final burnout scores based on final psychological flexibility scores for all three dimensions of burnout.

Table 4

Linear Regression Results for Final AAQ-II Predicting Final CBI Personal Burnout

| Variable | <i>B</i> | <i>SE</i> | 95.00% CI | β | <i>t</i> | <i>p</i> |
|------------------------|----------|-----------|----------------|---------|----------|----------|
| (Constant) | 30.73 | 6.30 | [18.03, 43.44] | 0.00 | 4.89 | <.001 |
| EndTotalPsychFlexScore | .88 | .28 | [.31, 1.45] | .44 | 3.13 | .003 |

Note. Results: $F(1,41) = 9.81, p = .003, R^2 = .19, R^2$ adjusted = .17

Table 4 shows final psychological flexibility scores explained 17% of the variance in final personal burnout scores (R^2 adjusted = .17), $F(1,41) = 9.81, p = .003; R^2 = .19$. The regression coefficient ($B = .88$), 95% CI [.31, 1.45] indicated that a 1-point increase in final psychological flexibility score corresponded, on average, to an increase in final personal burnout score on the CBI by .88 points.

Table 5

Linear Regression Results for Final AAQ-II Predicting Final CBI Work Burnout

| Variable | <i>B</i> | <i>SE</i> | 95.00% CI | β | <i>t</i> | <i>p</i> |
|------------------------|----------|-----------|----------------|---------|----------|----------|
| (Constant) | 29.17 | 6.95 | [15.14, 43.20] | 0.00 | 4.20 | <.001 |
| EndTotalPsychFlexScore | .83 | .31 | [.20, 1.45] | .38 | 2.67 | .011 |

Note. Results: $F(1,41) = 7.11, p = .011, R^2 = .15, R^2$ adjusted = .13

Table 5 shows final psychological flexibility scores explained 13% of the variance in final work burnout scores (R^2 adjusted = .13), $F(1,41) = .7.11, p = .011; R^2 = .15$. The regression coefficient ($B = .88$) 95% CI [.21, 1.45] indicated 1 point increase in final psychological

flexibility score corresponded to an increase in final work burnout score on the CBI by .88 points.

Table 6

Linear Regression Results for Final AAQ-II Predicting Final CBI Client Burnout

| Variable | <i>B</i> | <i>SE</i> | 95.00% CI | β | <i>t</i> | <i>p</i> |
|------------------------|----------|-----------|----------------|---------|----------|----------|
| (Constant) | 5.65 | 7.43 | [-9.36, 20.65] | 0.00 | .76 | .451 |
| EndTotalPsychFlexScore | 1.43 | .33 | [.76, 2.10] | .56 | 4.33 | <.001 |

Note. Results: $F(1,41) = 18.70, p < .001, R^2 = .31, R^2$ adjusted = .30

Table 6 shows final psychological flexibility scores explained 30% of the variance in final client burnout scores (R^2 adjusted = .30), $F(1,41) = 18.70, p < .001; R^2 = .31$. The regression coefficient ($B = 1.43$) 95% CI [.75, 2.10] indicated that each 1-point increase in final psychological flexibility score corresponded to an average increase in final client burnout score on the CBI by 1.43 points. Simple linear regression found no significant relationship between change in psychological flexibility and change in burnout.

Whether someone was below the clinical cut-off for psychological flexibility on the AAQ-II ($n = 28, M = 46.88, SD = 12.40$) or above the clinical cut-off for psychological flexibility ($n = 15, M = 54.72, SD = 12.88$) did not significantly predict their final burnout scores in the dimension of personal burnout $t(41) = 1.95, p = .058$, and did not significantly predict their final burnout scores in the dimension of work burnout $t(41) = 1.58, p = .123$, but did significantly predict their final burnout scores in the dimension of client burnout $t(41) = 4.14, p < .001$ with a large effect size ($d = 1.3$).

Results of linear regression and independent samples *t*-tests indicated that of the dimensions of burnout, change in client burnout was the most significantly associated with

change in psychological flexibility. Stepwise linear regression shed light on the specific components of psychological flexibility that were predictive of client burnout scores pre and post intervention. A higher AAQ-II Likert rating on the statement “I’m afraid of my feelings” was significantly positively related to initial client burnout score $t(43) = .56, p < .001$. This changed in the post survey, with higher Likert ratings on the statements “Emotions cause problems in my life” and “Worries get in the way of my success” being significantly positively related to final client burnout scores $t(43) = .47, p = .002, t(43) = .469, p = .001$, respectively.

Impact of Prayer

Whether someone reported an increase in prayer amount was not significantly related to a change in personal burnout scores $t(40) = .329, p = .744$, work burnout scores $t(40) = .45, p = .656$, and client burnout scores $t(40) = -1.04, p = .306$. However, whether someone reported a change in prayer approach was significantly related to a change in personal burnout scores $t(40) = 2.24, p = .030$ and work burnout scores, $t(40) = 2.73, p = .010$, but was not significantly related to a change in client burnout scores $t(40) = 1.09, p = .281$. There were no significant correlations between an increase in prayer amount and change in burnout scores in all three dimensions, but there were significant positive correlations of medium strength between a change in prayer approach and change in personal burnout $r(43) = .334 (p = .03)$ and change in work burnout $r(43) = .396 (p = .01)$. There was no significant correlation between change in prayer approach and change in client burnout.

A chi square test of independence showed no significant association between change in prayer approach and psychological flexibility, $\chi^2 (1, N = 42) = 17.08, p = .518$. To further determine the relationship between psychological flexibility and change in prayer approach, Pearson correlation coefficients were calculated for psychological flexibility and final burnout

scores for those who had a change in prayer approach ($r = -.19, -.27, \text{ and } -.46$) and for those who did not have a change in prayer approach ($r = -.38, -.41, -.49$). These values were input into VassarStats to use the Fisher r – to - z transformation to determine the significance of the difference of between-group correlation coefficients, with p -values of .54, .63, and .90, indicating the relationship between flexibility and final burnout scores was not significantly different for those who changed their prayer approach and those who did not change their prayer approach. The results of chi-square and Fisher r -to- z transformation indicate that the variables change in prayer approach and psychological flexibility are independent predictors of burnout outcomes and are not significantly related.

Most Helpful Components of ACT

Average total Likert scale ratings on the subjective helpfulness of each lesson were not significantly different. At-home exercises on ACT concepts of observing self, mindfulness, cognitive defusion, and values received significantly more participant ratings as the most helpful exercises (11 votes, 10 votes, 11 votes, and 11 votes respectively) than exercises on acceptance and committed action (5 votes and 4 votes respectively). Qualitative coding on the free-form survey response about participant takeaways revealed that the lessons on observing self and values were significantly more impactful than the other lessons. Participants reported their primary takeaways were the importance of compassion vs. empathy (teaching that was integrated into the observing self lesson, $n = 18$) as well as learning about the observing self/nous ($n = 6$) for a total of 24 participants mentioning takeaways from the lesson on self as context. Participants also frequently mentioned the importance of living in line with one's values and that burnout is caused by living out of line with your values rather than just business ($n = 22$). A significant portion of participants also mentioned they were taking away the importance of accepting

emotions ($n = 14$). Distance from negative thoughts/feelings was also a prominent theme ($n = 13$) as was mindfulness ($n = 10$) and change towards a more apophatic, mindful prayer style ($n = 6$). Other themes included confidence in ability to prevent and treat burnout, confidence in sharing this information with others, excitement to pursue values, clarity in what activities to commit to, confidence in being able to serve without burning out, and freedom from being controlled by feelings and emotions.

Other Qualitative Data

Participants suggested that the homework exercises be mandatory, that the workshop be in person, that there be more time for discussion, and that lecture notes be provided.

Chapter 4

Discussion

Discussion of the Sample

Throughout the workshop, 95 volunteers attended at least one session. A total of 43 participants attended all lessons, filled out pre and post surveys, and were included in analysis. The sample was composed of a relatively equal distribution of participants below and above 44 years old, with the highest frequency of participants being 25–34 years old (see Table 1). Age did not significantly predict beginning or final burnout scores in dimensions of personal, work, or client burnout; outcomes of change in prayer approach or increase in prayer; or final psychological flexibility score and value above or below the clinical cut-off for psychological flexibility. Levene's equality of variance assumptions were met for age with all variables tested. At the ANOVA level, age did significantly predict initial psychological flexibility scores, but this result was not maintained at the post-hoc level using Tukey Kramer's test of honest significant difference. The age of participants did not significantly affect results.

Whether someone was in full-time ministry ($n = 31$), or part-time ministry ($n = 12$) did not impact any dependent variables studied. Every participant reported their ministry involved interpersonal communication and direct interaction with others. The sample was a blend of women in formal and informal ministry contexts involving direct interaction with others.

As seen in Table 1, all but one participant reported a Christian identity and most of the sample identified as ethnically White ($n = 38$). The sample was composed of primarily White, Christian women, and the lack of cultural diversity is a significant limitation to this study.

Discussion of the Hypotheses

Hypothesis One

The first hypothesis predicted the components of ACT that participants would rate as most effective in reducing burnout are those ACT components that focus on reducing hyper-empathy and promoting differentiation of self from others; cognitive defusion, self-as-context, acceptance, and mindfulness. This hypothesis was generated from the author's theory that ACT interventions alleviate burnout because they increase the TOM capacity to differentiate self from others. Due to limitations in sample size and ability to perform a randomized controlled study, efficacy of lessons was measured with subjective ratings using Likert scale and free-form responses. The hypothesis was partially supported by participants' free-form takeaway reflections. Participants mentioned the observing-self lesson most frequently in their takeaways, particularly the theme of compassion versus empathy and maintaining differentiation of self from other. However, the author was not correct in identifying which ACT lessons would be most helpful as the second most common theme in the free-form takeaways was the impact of clarifying values. On average, the total Likert scale ratings were the same for each lesson and were not sensitive enough to differentiate the relative impact of different ACT concepts.

However, there were differences in which at-home exercises received the most votes as the most helpful exercise, with exercises on committed action and acceptance receiving significantly fewer votes as the most helpful exercises.

Results of Likert scale and free-form response methods used to analyze the relative helpfulness of individual lessons were mostly in alignment. Likert scale and free response data agreed upon committed action as the least helpful concept, providing convergent validity to the interpretation that committed action was the only lesson significantly less helpful than other lessons. The original hypothesis, that both values and committed action would be less helpful, was not supported as values was the second most common theme mentioned in free-form takeaways.

In sum, results from qualitative analysis of free-form takeaways indicate the lesson on observing self was most impactful, followed by lessons on values, acceptance, cognitive defusion, mindfulness, and committed action. Total Likert-scale ratings of degree of helpfulness for each lesson were not significantly different. Participants indicated that home exercises based on concepts of acceptance and committed action were the least helpful. The hypothesis that committed action would be less helpful was supported, but the hypothesis that values would be less helpful was not supported.

Hypothesis Two

The second hypothesis predicted self-as-context would be the most helpful lesson as it most directly relates to the TOM task of self-other differentiation. This was supported by free-form response coding that showed self-as-context and components of that lesson (nous and empathy versus compassion) as the most frequently mentioned lesson in the takeaways.

Hypothesis two was not supported by Likert-scale ratings, which may reflect insensitivity of the Likert scale or a negligible difference between this lesson's subjective importance and others.

Hypothesis Three

The third hypothesis predicted those who were more burned out initially would evidence greater improvement. Because this research was advertised as a burnout treatment and prevention resource, it was expected that some participants joined with minimal symptoms of burnout. This was supported by data showing those in the upper three quartiles of initial burnout scores showed significantly greater improvement in burnout than those in the first quartile of burnout scores. This result aligns with research finding that those who are more burned out tend to experience the greatest benefit from burnout interventions (Szarko et al., 2022).

Hypothesis Four

The fourth hypothesis predicted those who completed more of the homework would evidence significantly greater reduction in burnout scores. This hypothesis was not supported by the data as there was no significant difference in final burnout scores for participants who completed more homework than others. However, a frequent suggestion in the final survey was to make homework exercises mandatory. Participants who completed the homework reported it was a helpful supplement to their learning. This result may be explained by personality and learning style differences between participants, as characteristic "optional homework doers" found it helpful to their learning, but characteristic "only required homework doers" escaped any significant drawback to not completing the optional homework. Other explanations may be limitations on self-reporting accuracy and sensitivity limitations of the Likert scale.

Hypothesis Five

The fifth hypothesis predicted that psychological flexibility would not mediate changes in burnout (Barret & Stewart, 2020). Final psychological flexibility scores were significantly predictive of final burnout scores in all three dimensions, with final psychological flexibility score predicting final client burnout to a moderate extent. Initial psychological flexibility was significantly and weakly predictive of initial personal and client burnout scores, but not work burnout scores. Whether someone was above or below the clinical cut-off for psychological flexibility was not correlated with final burnout scores in dimensions of personal and work burnout; however, it was significantly correlated with final burnout scores in the dimension of client burnout with a large effect size. Taken together, results indicated stronger association and predictive power of psychological flexibility with the dimension of client burnout on the CBI than other dimensions of burnout. Stepwise linear regression revealed that higher agreement with the statement “I’m afraid of my feelings” was significantly predictive of initial client burnout. Agreement with the statements “Emotions cause problems in my life” and “Worries get in the way of my success” were significantly associated with final client burnout scores, indicating themes of avoidance and cognitive fusion. These results could be used to argue that client burnout is more significantly related to psychological flexibility and specific difficulties with acceptance and cognitive fusion than other dimensions of burnout; however, psychometric concerns with the AAQ-II caution this interpretation (Tyndall et al., 2019). Change in psychological flexibility was not predictive of change in burnout and there was no significant change in psychological flexibility for the sample overall, indicating change in psychological flexibility did not mediate improvement in burnout. The inconsistent relationship between psychological flexibility and burnout in this study and in the literature (Towey-Swift et al., 2022) point to the need for more research on the AAQ-II and its psychometric properties.

Limitations

This research was limited by the need to prioritize volunteers' convenience to have a sufficiently large sample size, precluding randomized distribution and blind testing of hypothesis. This study was not double blind, and the author may have inadvertently placed more effort into lessons hypothesized to be most helpful. Another limitation was analysis of the most helpful components of ACT was limited to subjective ratings of participants. Additionally, the lacking diversity of the sample limits the application of the findings to ethnic minority groups. Participants were allowed to switch between groups, and the impact of not staying with the same group throughout the workshop was not controlled for. Additionally, other variables such as anxiety and depression were not controlled for. Another significant limitation was empathy and compassion training were integrated into the observing self lesson, and although this teaching is pertinent to burnout, it is not explicitly within the ACT framework. Data was collected during spring 2022 within the context of the COVID-19 pandemic, and the national socio-political climate of loosening mask restrictions and decrease in COVID cases may have impacted results.

Implications

The most significant finding of this workshop was that change in prayer approach towards a more mindful, apophatic style independently predicted final burnout scores in dimensions of work burnout and personal burnout. This has significant implications for future burnout research with Christian populations and to the best of the author's knowledge, is a novel finding not represented elsewhere in published literature. This workshop indicates there is something unique about apophatic prayer that reduces symptoms of burnout and additional research in this area is merited. The results of this study in combination with recent research on

burnout, empathy, compassion, and theory of mind, informed a Christian perspective on burnout to include not only differentiation of self and other, but also distinction of self and divine.

Theory of Apophatic Prayer and Burnout

One explanation for the benefit of apophatic prayer in treating burnout may be activation of similar neural structures involved in self-other differentiation that is crucial for avoiding burnout. Joshua Knabb (2016) has proposed that the Christian concept of the “Nous” meaning “eye of the soul” or “little radio”, the part of us that is receptive to God’s leading, is synonymous with the construct of the observing self in ACT, and that there is mutual benefit and overlap between spiritual and secular psychological practices of this cognitive capacity. It could be that practicing apophatic prayer strengthens brain areas involved in healthy self-other distinction and has a carry-over effect of reducing personal distress in interpersonal interactions that is correlated with burnout. Another explanation unrelated to social emotion sharing involves the unique healing benefits of mindfulness practice for nervous system regulation and physical and psychological health.

During the reappraisal step of apophatic prayer described by Hollingsworth (2015), there is a search for definition of divine and self, precipitated by releasing presupposed ideas of this relationship. This practice of deconstruction and reconstruction of knowledge of the divine, and self in relation to divine, promotes an understanding of self-identity rooted in experience of God rather than a self-identity that is socially constructed. A healthy understanding of the self in relation to God carries over into a healthy self-other differentiation in interpersonal interactions.

This workshop found values to be the second most important teaching to participants. It has been argued that compassion requires a healthy self-identity rooted in the “chosen self” rather than the “socially constructed self” to develop the mind in a desired way (Gilbert, 2020).

Values clarification may be impactful for burnout as it sheds pressures that originate from outside social and societal sources. This filtering process strengthens self-identity, carrying over into a better ability to be the “chosen self” to others, which for Christians often involves the virtue of compassion.

Burnout stems from an unhealthy self-other differentiation in interpersonal interactions that is maintained by an unhealthy empathy and compassion balance. From a Christian perspective, this can be ameliorated through apophatic prayer practices and meditative values clarification that increases an awareness of self in relation to divine, self as distinct from others, and personal calling in relation to constructed and societal pressures. From a Christian perspective, kindness and compassion for others flows from connection to God. Apophatic prayer is the gateway to praying without ceasing as it does not compete for cognitive resources in the same way as kataphatic prayer. By practicing apophatic prayer Christians can focus on the person in front of them while maintaining intentional connection with God, leading to a natural expression of God’s warmth and care for that person. Apophatic prayer promotes compassion and protects from cognitive lapsing into self-oriented empathy that is associated with burnout.

Future Directions

This research produced a significant theological implication, that apophatic prayer is uniquely able to reduce symptoms of burnout. This study was designed to clarify the relative impact of ACT concepts on burnout, and the finding that apophatic prayer mediated outcomes was surprising. Further research needs to be done to explore this correlation more thoroughly.

There is also a need for research explaining how values clarification relates to burnout, particularly from a Christian perspective.

This study indicated that ACT constructs of self-as-context and values were most helpful for participants. However, this was supported by subjective feedback and was not rigorously tested. Additionally, self-other differentiation in interpersonal interactions is a concept the author integrated with the idea of the observing self in the context of burnout prevention. Future research may need to limit the concept of the observing self to its manualized form to test its impact on burnout more definitively.

There is also a need for more research on the role of psychological flexibility in mediating burnout symptoms as this research aligned with current literature finding an inconsistent relationship.

Conclusions

In sum, this research found that online ACT interventions can significantly reduce burnout scores for women in ministry, particularly for those who have higher initial burnout scores. This research found an inconsistent relationship between psychological flexibility and burnout, in line with current research. Importantly, this research found apophatic prayer as a mediating variable of improvement in burnout symptoms, with important theological implications for prayer approach and burnout prevention and treatment. This research also supported the theory that burnout is caused by an unhealthy self-other differentiation leading to personal distress rather than compassion, and that metacognitive exercises can improve ability to maintain a state of cognitive empathy and compassion that is protective against burnout. This research is unique in its Christian perspective to treating burnout. There is a pressing need for our society and Christian communities to address burnout, and the author hopes this work will spur similar research.

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Appendix A

Acceptance and Action Questionnaire – Second Edition

My Flexibility Scores

The Acceptance and Action Questionnaire (AAQ-2)

This is perhaps the most commonly used measure of psychological flexibility that you can find. It has been cited over 2000 times in scientific publications, and we generally know what it's scores mean. My colleagues and I developed the original AAQ (Hayes et al., 2004) as well as the updated version presented below (Bond et al., 2011). You can use it weekly or biweekly to track how you are doing with applying psychological flexibility skills in your daily life.

Don't worry about trying to get to a "perfect" score. Use this number as a way to keep track of changes in your life over time. As you apply what you learned in *A Liberated Mind*, your psychological flexibility will improve.

AAQ-2

Below you will find a list of statements. Please rate how true each statement is for you by selecting a number next to it. Use the scale below to make your choice.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|--|------------|------------------|-------------|----------------|-----------------|--------------------|-------------|
| | never true | very seldom true | seldom true | sometimes true | frequently true | almost always true | always true |
| 1. My painful experiences and memories make it difficult for me to live a life that I would value. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. I'm afraid of my feelings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. I worry about not being able to control my worries and feelings. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My painful memories prevent me from having a fulfilling life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Emotions cause problems in my life. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. It seems like most people are handling their lives better than I am. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. Worries get in the way of my success. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Appendix B

The Copenhagen Burnout Inventory

Copenhagen Burnout Inventory (English version) used in the PUMA study

NB: The questions of the CBI are not being printed in the questionnaire in the same order as shown here. In fact, the questions are mixed with questions on other topics. This is recommended in order to avoid stereotyped response patterns.

Part one: Personal burnout

Definition: Personal burnout is a state of prolonged physical and psychological exhaustion.

Questions:

1. How often do you feel tired?
2. How often are you physically exhausted?
3. How often are you emotionally exhausted?
4. How often do you think: "I can't take it anymore"?
5. How often do you feel worn out?
6. How often do you feel weak and susceptible to illness?

Response categories: Always, Often, Sometimes, Seldom, Never/almost never.

Scoring: Always: 100. Often: 75. Sometimes: 50. Seldom: 25. Never/almost never: 0.
Total score on the scale is the average of the scores on the items.

If less than three questions have been answered, the respondent is classified as non-responder.

Part two: Work-related burnout

Definition: Work-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work.

Questions:

1. Is your work emotionally exhausting?
2. Do you feel burnt out because of your work?
3. Does your work frustrate you?

4. Do you feel worn out at the end of the working day?
5. Are you exhausted in the morning at the thought of another day at work?
6. Do you feel that every working hour is tiring for you?
7. Do you have enough energy for family and friends during leisure time?

Response categories:

Three first questions: To a very high degree, To a high degree, Somewhat, To a low degree, To a very low degree.

Last four questions: Always, Often, Sometimes, Seldom, Never/almost never. Reversed score for last question.

Scoring as for the first scale. If less than four questions have been answered, the respondent is classified as non-responder.

Part three: Client-related burnout

Definition: Client-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients*.

***Clients, patients, social service recipients, elderly citizens, or inmates.**

Questions:

1. Do you find it hard to work with clients?
2. Do you find it frustrating to work with clients?
3. Does it drain your energy to work with clients?
4. Do you feel that you give more than you get back when you work with clients?
5. Are you tired of working with clients?
6. Do you sometimes wonder how long you will be able to continue working with clients?

Response categories:

The four first questions: To a very high degree, To a high degree, Somewhat, To a low degree, To a very low degree.

The two last questions: Always, Often, Sometimes, Seldom, Never/almost never.

Scoring as for the first two scales. If less than three questions have been answered, the respondent is classified as non-responder.

Appendix C

Curriculum Overview

| | Lesson 1 | Lesson 2 | Lesson 3 | Lesson 4 | Lesson 5 | Lesson 6 |
|--------------------------------|--|---|---|--|--|--|
| ACT principle | Observing self | Mindfulness | Cognitive defusion | Values | Acceptance | Committed action |
| Relationship to burnout | Mentalizing fosters cognitive empathy and compassion | Default mode network, open-monitoring meditation | Shame, mental health, identity | Out of touch with passions, time off vs. changing activities | Mental health, relating to others suffering | Pursuing values reduces burnout |
| Related theological concept(s) | <i>Nous</i> , apophatic prayer, compassion vs. empathy | Distraction, Mary vs. Martha, church history of meditation practice | Sin, shame, identity, “pre-sin” thoughts | Universal Christian values vs. individual values, goals vs. values | The fall, sin, and pain; impact of avoidance on ministry | Primary suffering vs. secondary suffering |
| Homework theme | Observing self/apophatic prayer, using <i>Nous</i> | Mindfulness exercise: physical, psychological, and spiritual | Cognitive defusion practice, application to “pre-sin” and shameful thoughts | Identifying values (secular and explicitly Christian lists) | Self-examination of avoidance patterns | Choice point Analysis of commitments compared to values, identification of realistic changes |

Note. This is a general description of the content of lessons.