

Stress, Burnout, and Experiential Avoidance in Clinical Psychology Doctoral
Students

by

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Bachelor of Arts
Psychology
University of Louisville
2017

Master of Science
Psychology
Florida Institute of Technology
2019

A Doctoral Research Project submitted to the
School of Psychology at
Florida Institute of Technology
In partial fulfillment of the requirements
for the degree of

Doctor of Psychology
In
Clinical Psychology

Melbourne, Florida
December 2020

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Abstract

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Research has shown that clinical psychology doctoral students experience stress and burnout, with attempts to moderate their experience utilizing various coping skills. The current study aimed to expand the literature on stress and burnout in clinical psychology doctoral students and the impact of experiential avoidance as a coping style. The current study surveyed clinical psychology doctoral students on their integration of experiential avoidance, as well as various coping styles, to mitigate stress and burnout. COVID-19 data and descriptive statistics were gathered as well. A correlational analysis and dependent sample t-test were conducted to understand the relationships between variables. The results from the study supported five out of the six hypotheses. The more experiential avoidance students engaged in, the higher their perceived stress and burnout scores. The higher levels of perceived stress, the higher levels of burnout. With respect to approach and avoidant coping styles, those with avoidant coping had higher levels of perceived stress, while those with approach coping showed no significant relationship with perceived stress. The results also suggested that self-care was

reported to have increased due to COVID-19. The study calls for clinical psychology doctoral students and clinical psychology doctoral programs to practice and implement coping strategies, such as psychological flexibility, rather than avoidant strategies which may result in increased stress and clinical and academic burnout. Future studies may benefit from taking into account for particular coping styles and which are efficacious, as well as a specific look at multicultural factors.

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Acknowledgements

I would first like to sincerely thank Dr. Patrick Aragon, who has not only guided me through this project, but been my closest mentor since my first day in this program. Your academic, clinical, professional and personal encouragement has meant the world to me the last four years. It feels difficult to reduce your impact on my development to two sentences. I will forever value your candid, constructive feedback and personable nature. I would also like to thank Dr. Victoria Follette, who encouraged me to conduct this project and provided invaluable expertise along the way. You have also been a listening ear for me through the program and a catalyst for my confidence and growth as a clinician and academic.

To my closest five friends, Shannon, Isabella, Victoria, Hayley and Audryn, who have become a family away from home, thank you. My sources of support, cathartic relief, and incredible memories to carry me through the tough times of this project. And to my sincerest “sister,” Olivia, my enthusiastic and supportive best friend since middle school—thank you.

I cherish the opportunity to express my appreciation for my stepmother, Dr. Sara Jones-Connor, who has provided endless academic support and love through this process. To my mother, Mary Gina, and father, Ed, thank you for your unconditional love, support, and confidence. To the three of you and my brother Nathan, thank you for providing a stable familial foundation that reassures and inspires me to excel each and every day.

And lastly, to my dear partner Justine, your never-ending love, encouragement, and sense of comfort, from near or afar, has been a driving force to my achievement. You are my safe base, always. Thank you for being with me through early mornings, late nights, and every step in between.

Stress, Burnout, and Experiential Avoidance in Clinical Psychology Doctoral Students

Chapter 1 Introduction

Professional training in clinical psychology is rigorous and requires academic instruction, as well as applied experiences. Doctoral level clinical psychology students are expected to develop skills to consume and produce research, as well as meet the demands of practicum hours and supervisor/supervisee roles. The completion of a dissertation and a breadth of coursework are also required. Bernard and Goodyear (2009) underscore that students are consistently evaluated for performance and expected to accept and implement constructive feedback. The stress of fulfilling the roles of both an academic student and a clinician are clearly challenging. While meeting rigorous educational demands, doctoral students must manage the stress and responsibility of caring for their patients' health as well. Research has demonstrated that stress can negatively impact quality of care for patients and promote professional burnout (Koinis et. al, 2015).

According to the National Institute of Mental Health (2019), all forms of stress carry physical and mental health risks. El-Ghoroury et al. (2012) note that 70% of psychology graduate students in a national survey answered "yes" when asked to self-report whether or not any personal or professional challenges/issues interfered with their optimal functioning after beginning graduate school. Further,

stress can increase the likelihood of occupational burnout (Rosenberg & Pace, 2006). Graduate students align with the aforementioned criteria, as they are often young and just beginning their training. Literature on how clinical psychology doctoral students manage stress and experience burnout is relatively sparse. While there is some literature on the coping mechanisms of clinical psychology doctoral students, research on experiential avoidance as a coping style is limited.

Experiential avoidance as a coping style during times of stress was found by one study to decrease students' self-reported abilities (Hamilton, 2018). The present study will aim to focus on clinical psychology students and their experience with stress, burnout, and experiential avoidance as a coping mechanism. Lastly, students' coping styles and experience with COVID-19 will also be briefly assessed.

Chapter 2 Prevalence

According to the American Psychological Association's Center for Workforce Studies, approximately 6,756 doctorate degrees in psychology were conferred in the 2018 school year (American Psychological Association, 2019). Doctoral degrees take approximately five to seven years to complete. As of 2019, there are approximately 434 psychology doctoral programs (Keilin, 2020). Programs include clinical, counseling, school, combined, industrial-organizational and applied psychology. Of the 434 programs, 268 of them are specific to clinical psychology (Keilin, 2020). Clinical psychology doctorates are earned as a Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.). Ph.D. programs require additional courses aimed at research, while Psy.D. program philosophies emphasize more practicum-based experience. Both programs require competencies in clinical care, assessment, multicultural issues, dissertation work and ethical/legal concerns. For purposes of this study, both Psy.D. and Ph.D. programs in clinical psychology will be addressed and looked at concurrently.

Chapter 3 Stress

Stress has been defined in the literature in a variety of ways. Hobfoll (1989) described stress as a perceived imbalance between the level of demand a threat poses and the coping resources available to meet the demand. Stress has also been defined as an appraisal process between an individual's subjective experience and their objective environment (Lazarus, 2006, p. 36). According to the National Institute of Mental Health (2019), stress is the body and brain's response to any form of a demand. The intensity of stress is dependent upon the situation, as well as available coping resources and strategies (Pakenham & Stafford-Brown, 2012).

Stress is not always a negative feeling and can depend on the individual's appraisal of what is being requested. For example, appraisal of stress as a challenge rather than a threat has adaptive implications, as it is more likely to create positive emotions (Lazarus & Folkman, 1984, p. 34). Interpretations of demands vary between individuals and are influenced by various factors, such as personality style and coping resources (Lazarus & Folkman, 1984, p. 31). According to these researchers' theory, the individual evaluates the threat and then evaluates their resources.

While stress is essential for response to demands, there is also potential for negative consequences on the body and brain (Conrad et al., 2009). Researching stress and the effects of it became prevalent after World War II due to the perceived impact on returning soldiers. Stress subsequently was noted to affect not only soldiers, but also those in the workplace, home and school (Lazarus, 2006, p. 29).

Research findings regarding the effects of stress are considerable as described below.

Impact of Stress

Physiological changes in the body occur in times of stress. According to Selye (1978), the fight or flight response is activated in the body when an individual becomes stressed. The fight or flight response can elicit physical reactions in the body, such as changes in breathing and heart rate, muscle tension, perspiration, blood pressure, as well as altered metabolism (Baker, 2003). This fight or flight response helps organisms to respond to threats and demands, and physiological energy is devoted accordingly throughout the body (von Dawans et al., 2012). Physiological changes that are repeatedly experienced can have long-term negative consequences.

Holmes and Rahe (1967) helped quantify that there is a relationship between life stress and the etiology of many illnesses and diseases. Researchers note that prolonged exposure to stress can decrease the body's ability to resist changes from the body's resting state (Persson & Zakrisson, 2015). According to The American Institute of Stress (2020), detrimental effects from chronic stress include irritability, high blood pressure, increased risk for stroke, depression, headaches, anxiety, type two diabetes and a depleted immune system. Researchers noted that prolonged exposure to stress can decrease the body's ability to resist changes from the body's resting state (Persson & Zakrisson, 2015). High, permanent levels of stress have been linked to attention and concentration

impairment, as well as feelings of fear, incompetence, uselessness, anger and guilt (Erschens et al., 2018).

Stress in Graduate Students

Research has suggested that stress is a significant factor in the lives of clinical psychology doctoral students (Cushway, 1992; El-Ghoroury, 2011; Stafford Brown & Pakenham, 2012). Rummell (2015) conducted an exploratory study of 119 psychology graduate students' workload, health, and program satisfaction. Psychological and somatic symptoms in this sample group were found to be higher than those in the general population. Rummell also found that as many as 60% of psychology graduate students identified graduate school as their primary life stressor.

Stress levels in clinical psychology trainees has also been evaluated. Cushway (1992) surveyed 287 clinical psychology trainees' level of stress and coping strategies. A general health questionnaire and self-report stress measure, as well as a health and daily living schedule questionnaire were administered. Clinical training was found to be a moderate to high stressor among three quarters of the trainees surveyed. Trainees who were in their second or third year reported higher stress levels than those in their first year. Psychological distress was found in an estimated 59% of clinical psychology trainees. A study by Quach (2015) found mild to moderate levels of stress levels in 131 Psy.D. students. The study utilized questionnaires to measure demographics, burnout, social support and stress to examine levels of stress and burnout among students studied. Stress scores were

found to average in the mild to moderate range. Higher levels of stress were also correlated with higher levels of burnout. Particularly the emotional exhaustion domain in which higher levels of stress were significantly correlated with higher levels of emotional exhaustion ($r = .49, p < .01$). The researcher found that those who received social support from family and friends had lower levels of emotional exhaustion with a significant negative correlation ($r = -.26, p = <.01$). Significant negative correlations between students' stress and forms of self-care such as psychological ($r = -.29, p < .01$), physical ($r = -.29, p <.01$), and spiritual ($r = -.28, p < .01$) were also found.

Stressors specific to psychology graduate students have also been researched. El-Gohoroury, et al. (2012) surveyed 387 psychology graduate students' stress, coping and barriers to wellness. Participants included psychology graduate students in counseling, industrial-organizational, general, social, school, educational, family, developmental, and clinical fields. Students in the sample included 54% working on a doctoral degree. The authors noted a limitation of their study in that it did not identify stressors particular to each respective field of training (i.e., clinical psychology versus counseling). Researchers found that specific sources of stress among participants included academic responsibilities or pressures (68.1%); anxiety (60.7%); poor work/school life balance (58.7%); and finances or debt (63.9%; El-Ghoroury, et al., 2012). With respect to finances, the predicted median debt of psychology doctoral students and new psychologists is \$110,000 (Lu, 2016). Finances are not only a burden for students; they also act as a

barrier to coping mechanisms (El-Gohoroury et al., 2012). Consequently, the opportunity to mitigate experienced stress at times is inhibited.

Coping with Stress

Coping strategies are imperative to adaptively managing stress. Lazarus and Folkman (1984) described the two-dominant means of coping with stress as problem-focused and emotion-focused.

Problem-Focused

Problem-focused coping is defined as an active effort to manage stress and alter the environment to eliminate sources of stress via behaviors (Schoenmakers et al., 2015). This form of coping can also be goal oriented and may include psychotherapy, professional consultation, and/or supervision. Problem-focused coping has been found in graduate psychology students. El-Gohoroury et al. (2012) found in their sample of 387 psychology graduate students that 48.3% of clinical psychology graduate students engaged in psychotherapy, 47.2% spent more time on school or in supervision, and 25.4% talked to a physician as a means of problem-focused coping. The study noted that another form of problem-focused coping can be upper year students helping younger year students navigate their programmatic and academic concerns. The researchers also stated another form of coping, emotion-focused, could be helpful such as validation and support.

Emotion-Focused

Emotion-focused coping encompasses efforts to diminish and/or regulate emotional outcomes of stressful events (Schoenmakers et al., 2015). Emotion-

focused coping by clinical psychology graduate students includes seeking social support from friends, family, and faculty (Clark et al., 2008). While some studies have shown benefits to particular means of social support, such as connecting with friends and family, others have not (Quach, 2015). In a study conducted by Clark et al. (2008), social support did not produce a significant moderating effect on stress with regard to burnout in clinical psychology graduate students. Participants included 284 doctoral students from 53 training programs. Students completed questionnaires regarding burnout, career choice satisfaction, global stress, role conflict, social support and psychological sense of community in their program. Researchers predicted that social support would buffer the impact of stress on burnout; however, there was no significant moderation.

Emotion-focused coping and problem-focused coping focus on the reduction, altering or avoidance of a stressful experience (e.g., behaviors, emotions), in order to manage one's internal experience with the discomfort of stress. A study by Cushway and Tyler (1994) indicated behavioral coping was prevalent among 101 British clinical psychologists and avoidant coping was associated with poorer mental health. Avoidance is also known to be reinforcing of the negative emotions and increases their intensity (Walser et al., 2012).

Stress and Coping Styles in Graduate Students

Various coping styles related to stress in clinical psychology graduate students have been researched. Meyers et al. (2012) examined the effects of perceived stress in clinical psychology graduate students and found that self-care

practices can be vital to managing stress in clinical training. Participants included 488 psychology graduate students in the United States. The following self-care practices were found to be advantageous: social support, mindful acceptance, cognitive reappraisal, suppression and emotional regulation. This study reported no significant stress differences between degree programs (i.e., Ph.D., Psy.D., M.S.) and suggested levels of stress may be similar across clinical psychology graduate students. However, the researchers only reported these self-care practices as they related to lower levels of perceived stress, not the levels of perceived stress.

Nelson et al. (2001) conducted a study on stress, coping and success among 53 graduate students in clinical psychology. Researchers administered measures of stress, psychological health, social support, and coping styles. Grade point average was utilized to measure the construct of success. Response options for coping strategies ranged from 4 to 16. Results showed that students as a whole typically utilized emotion-focused coping of positive reinterpretation and growth most frequently ($M = 12.96$). Drugs and alcohol were reported to be least utilized ($M = 4.62$), as was denial ($M = 4.71$). However, coping styles vary by graduate student. Findings are mixed and sparse regarding which coping styles and self-care activities are most efficacious.

Experiential Avoidance as a Coping Style

One method of coping is experiential avoidance. A study conducted by Hamilton (2018) addressed experiential avoidance as a coping style during times of stress and its relationship to attention. Participants included 79 psychology graduate

students. Experiential avoidance was found to decrease students' self-reported attention abilities during times of stress (Hamilton, 2018). Miller and Orsillo (2020) examined the impact of self-reported acceptance, values and sense of belonging among minority students in graduate school. Participants were 436 minority students in doctoral level programs. Of the 436 students, 84 were in the psychological and social sciences. Overall findings suggested that a stance of acceptance towards difficult internal experiences may enhance psychological well-being and success, despite the stressors of their program.

Acceptance of difficult internal experiences is a core principal of Acceptance and Commitment Therapy. Additional studies have been conducted to assess the efficacy of Acceptance and Commitment Therapy strategies on psychology graduate students. Pakenham (2014) and Stafford-Brown and Pakenham (2012) researched the impact of ACT- based strategies for clinical psychology trainees and stress. Groups participated in an experimental design utilizing ACT principles over multiple weeks. Both studies found that acceptance-based strategies, rather than avoidance, were beneficial for clinical psychology trainees. However, limitations include small sample sizes (e.g., 28 and 38 participants respectively) and these studies encompassed full Acceptance and Commitment Therapy strategies implemented for purposes of study rather than self-reported ability. A comprehensive sample examination of clinical psychology graduate students' utilization of experiential avoidance remains unexplored at this time.

Chapter 4 Experiential Avoidance

Experiential avoidance, also known as psychological inflexibility, is defined as an individual's attempt to reduce immediate psychological or physical discomfort (Wolgast, 2014). Hayes et al. (1996) define experiential avoidance as taking steps to alter and escape one's immediate negative experience (e.g., bodily sensations, thoughts, emotions, memories). Examples include isolation from family and friends, avoiding particular places or people and sleeping. For example, in moments of high stress, an individual may choose not to call their friend (i.e., social support), and instead watch television or engage in excessive work. While this may be comforting in the moment; over time, the relationship with the friend dwindles as does the social support for the individual. Some methods of avoidance can also be self-deprecating, such as self-harm, alcohol, or drugs.

Avoidance can have implications such as strengthening responses that are problematic and preventing adaptive exposure to negative emotions (Walser et al., 2012). Many forms of pathology derive from maladaptive forms of experiential avoidance (Hayes et al., 1996). The converse of experiential avoidance; psychological flexibility, is a healthier means of adapting. Psychological flexibility is defined as changing behaviors to enable the individual's values, experiencing what is to be experienced (e.g., anxiety), and remaining in the present moment consciously (Walser et al., 2012).

Chapter 5 Burnout

Burnout is defined as a persistent response to enduring emotional and interpersonal stressors with respect to an individual's occupation (Maslach et al., 2001). Maslach (1996) underscored that burnout occurs when these prolonged stressors exceed internal and external coping resources. Burnout is a syndrome that has been correlated with physical and mental health concerns (Maslach et al., 2001). Consequences of burnout include fatigue, somatization, social withdrawal, poor modulation of expressed emotions, and exhaustion (McCormack et al., 2018). The literature also noted gastrointestinal concerns, insomnia, and depression as symptoms of burnout (Lee et al., 2011).

Maslach particularly described burnout in the context of those “who do people work” (2003, p. 2). Maslach further explained burnout as a job stress that is notably prevalent among those who have an occupation that requires them to help others. Research and development of empirical measures were carried out by Christina Maslach, a social psychologist on those in-service occupations (Maslach et al., 2001).

The literature indicated that burnout is particularly pervasive among health care professionals (Abbott, 2020). Maslach and Jackson (1981) have stated that chronic stress from client-centered occupations can be emotionally draining. Immediate client concerns weigh heavily, especially in combination with stressful external and internal factors, with respect to the development of burnout (Baird & Jenkins, 2003). Many difficulties presented by patients carry intense negative

feelings and resolutions for providers to implement and can sometimes be ambiguous. Furthermore, burnout has been associated with healthcare professional patient dissatisfaction and poor work performance (Boamah et al., 2016; Reith, 2018; Maslach & Jackson, 1981).

The Three Dimensions of Burnout in Health Professionals

Burnout in health professionals is comprised of the following three dimensions: emotional exhaustion, depersonalization, and personal accomplishment. Maslach defines emotional exhaustion as when an individual experiences emotional overload and can no longer provide emotional resources to another individual (2003, p. 3). This is a result of demands placed on them by those they are caring for and overextension by the helper. Kroska et al. (2017) also defined emotional exhaustion as the individual's inhibited ability to care for their own psychological well-being in response to an inability to cope with occupational and emotional stressors. A core component of emotional exhaustion is that the individual feels empty inside (Seidler et al., 2014). Exacerbation of pain, irritability, lack of energy, mental and physical fatigue, and a depleted immune system are some symptoms of emotional exhaustion (Quach, 2015).

Depersonalization is defined as a detached and dehumanized response toward clients (Maslach, 2003, p.5). If experiencing burnout, health-professionals report feeling a sense of detachment from their clients and a loss of concern for patient health (Kroska et al., 2017). Negative emotions arise, as well as disinterest in the working relationship (Quach, 2015). Professionals experiencing

depersonalization become indifferent or negative toward their work, colleagues and patients (Maslach, 2003, p. 93).

Personal accomplishment is feeling a high sense of achievement and positive reinforcement in relation to patient-provider interactions (Kroska et al., 2017). Health professionals experiencing burnout may suffer from a reduced sense of personal accomplishment. Reduced personal accomplishment is when professionals begin to consistently evaluate their occupational worth negatively, experience apathy and poor self-esteem, as well as increased feelings of being insufficient and worthless (American Thoracic Society, 2016; Maslach et al., 2003, p. 7). When a sense of personal accomplishment is diminished, a provider may have increased feelings of hopelessness relative to their job (Quach, 2015).

Impact of Burnout on Psychotherapists

The implications of burnout prevalence have been studied across many professions. However, the unique nature of the profession of psychology means that variables leading to burnout differ from other health professions (Johnson et al., 2020). Psychology professionals experience extensive face-to-face care, knowledge of traumatic experiences and hardships, as well as the demands of confidentiality. The literature also underscored that professionals who are younger and earlier in their careers are more susceptible to burnout (Baird & Jenkins, 2003; Simionato & Simpson, 2018).

A meta-analysis of forty articles by Simionato and Simpson (2018) addressed burnout in psychotherapists. Over half of those in the samples were

reported to experience moderate to high burnout levels. Included in this review by Simionato and Simpson (2018) was a study of burnout among 562 licensed psychologists by Ackerley et al. (1988). These researchers found that 72% of participants fell within the high emotional exhaustion classification range, 59% fell into the moderate to high range for depersonalization, and less than 4% were moderate to high on the personal accomplishment scale. Factors associated with high levels of burnout included less work experience, younger age, and being overly involved in client issues.

Skorupa and Agresti (1993) stated that burnout and stress have been shown to impair a psychologist's ability to empathize with clients and can lead to increased apathy toward clients as well as depersonalization of clients. This is especially problematic because the therapeutic relationship has been a significant predictor in successful therapeutic outcomes (Horvath et al., 2011). Smith and Moss (2009) conducted a review of the literature regarding psychologists' impairment. The study noted the literature cites that psychologists could be at risk for burnout and impairment if they neglect to manage their professional distress. This study consequently called for emphasis in training programs on mediating the risk of burnout to best prepare budding professionals.

Burnout in Psychology Graduate Students

The literature on psychology graduate students, particularly clinical psychology doctoral students, is relatively sparse. Many of the published studies

include dissertations. Relevant literature includes international samples and looks at factors that contribute to burnout.

Kaeding et al. (2017) examined burnout with an international sample of clinical and counseling psychology postgraduate trainees. The study sample included 1,172 postgraduate university psychology programs, 78.3% of which were clinical. The study aimed to assess burnout in psychology trainees and the role of early maladaptive schemas in the development of burnout. Results yielded that 49.2% of participants scored in the high burnout range and 50.8% scored in the low-moderate burnout range. The researchers then conducted a median split into high and low burnout. Consequently, from this sample, 51.8% of participants scored in the high burnout range. Additional findings showed that higher burnout was associated with poorer physical health.

Not only are overall burnout scores high, experiences on the individual burnout domains have been found to be significant. A dissertation by Quach (2015) examined burnout in 131 clinical psychology graduate students, particularly Psy.D. students, in the Midwestern area. Psy.D. students in the sample were found to experience burnout. Specifically, the results revealed high levels of emotional exhaustion and depersonalization; however, high levels of personal accomplishment were still prevalent.

Both overall burnout levels and individual domains were studied in counseling trainees by Lushington and Luscri (2001) who conducted a cross-cultural comparison of burnout in counseling trainees. Participants included 306

trainees from Australia, Singapore and Hong Kong. Participants completed social support measures and the three Maslach inventory burnout scales. The study found that 13.4% of respondents had high level total scores for burnout. On a subscale level, results suggested that 10.7% had high emotional exhaustion scores, 7.8% had high depersonalization scores, and 9.8% had high reduced personal accomplishment. Results suggested that younger age and loneliness were significant predictors of emotional exhaustion and decreased sense of personal accomplishment. There was also a significant but weak finding that loneliness was a predictor of depersonalization.

Specific factors associated with burnout in student trainees have also been studied. Beaumont et al. (2016) researched associations between self-compassion, compassion fatigue, well-being and burnout in student counselors. The sample included 54 student counselors and student cognitive behavioral therapists. Factors associated with burnout in the sample were self-judgement and self-compassion. Participants with more self-compassion were found to have lower levels of burnout.

As student-therapists, burnout related to academic work is also relevant to clinical burnout. Surguladze (2018) researched academic and clinical burnout among mental health professionals in training along with the role of social support and demographic characteristics. The sample was comprised of 164 graduate students in psychology, social work and counseling programs earning either a Ph.D. or master's degree. The results yielded for clinical practice that 22.6% of students experienced high levels of emotional exhaustion, 5.5% experienced high

levels of depersonalization/cynicism, and 15.9% experienced low levels of personal accomplishment/efficiency. With respect to academic burnout, 64.6% experienced high levels of emotional exhaustion, 61% experienced depersonalization/cynicism, and 26.8% experienced low levels of personal accomplishment/professional efficacy. Overall, the study found that student clinicians in clinical training experienced both academic and clinical burnout.

Chapter 6 COVID-19

The COVID-19 pandemic began in the early phases of this project necessitating that clinical psychology doctoral students rapidly adapt to changes in their academic and practical learning. Clinicians moved from being the helper of distressed patients, to experiencing the stress themselves first-hand. While many of the unforeseen changes to clinical psychology doctoral students' training have been unprecedented, the experience of having a shared trauma with clients is not new. Bauwens and Tosone (2010) conducted a study of 201 Manhattan clinicians' experiences with collective trauma related to post-September 11th terrorist attacks. These clinicians reported enhanced self-care, changes in clinical modality and development of new skills. Positive outcomes also included increased compassion and connectedness with clients. However, negatives were reported as well, and included: (a) increased sense of vulnerability, (b) disappointment with professional organizations, and (c) feeling inadequate to deal with the magnitude of the event (i.e., the September 11th terrorist attacks). The COVID-19 pandemic is also a collective trauma; however, current research on the implications for clinicians is only just beginning to be conducted and reported to the public.

Due to COVID-19, students are expected to manage the risk of providing therapy, almost exclusively via telehealth to patients from their homes, with limited direct onsite supervisory support. Additionally, telehealth-related restrictions were suspended for licensed psychologists; however not for trainees, making it difficult

to maintain continuity of care in some cases. At the same time, students are still completing graduate school requirements such as online classes, meetings via online platforms, dissertation proposals and other unique program milestones.

On April 14th, 2020, the APA released guidance for students on coping with COVID-19 related stress during this unprecedented time. Advice included practicing self-care, finding ways to focus, seeking social support, helping others cope, finding ways to manage disappointment, limiting media consumption, and focusing on things one can control (APA, 2020). There is no existing literature on the impact of COVID-19 on clinical psychology graduate students due to the novelty of the virus and associated unprecedented and rapid changes. The current study will include the examination of students' ability to utilize the coping resources recommended by the APA.

Chapter 7 Study Purpose and Rationale

Burnout and stress are prevalent among clinical psychology doctoral students. The literature underscores the various stressors clinical psychology graduate students manage, some of which inhibit coping styles and contribute to burnout. Research on specific coping styles among this population has been examined; however, experiential avoidance as a coping style has been relatively neglected. The converse of experiential avoidance, psychological flexibility as a coping style, has been shown efficacious to managing negative internal experiences and enhancing well-being (Miller & Orsillo, 2020). The current study aimed to explore a relationship between burnout, stress, and experiential avoidance in clinical psychology doctoral students. General coping styles were also assessed. Demographic variables and novel questions regarding coping during COVID-19 were examined.

The current study expands on the most recent literature and tests specific hypotheses related to clinical psychology doctoral student stress, burnout and coping.

Chapter 8 Hypotheses

Hypothesis 1. Walser et al. (2012) stated that experiential avoidance can strengthen problematic responses and minimize adaptive exposure to negative emotions. It is hypothesized that in clinical psychology doctoral students there will be a positive correlation between perceived stress and experiential avoidance, such that those with higher levels of perceived stress will report higher levels of experiential avoidance.

Hypothesis 2. Burnout is defined as a persistent response to enduring emotional and interpersonal stressors with respect to an individual's occupation, typically those in human services (Maslach et al., 2001). It is hypothesized that in clinical psychology doctoral students there will be a positive correlation between burnout and levels of experiential avoidance. As such, those with higher levels of burnout will report higher levels of experiential avoidance, given experiential avoidance can strengthen problematic responses (Walser et al., 2012).

Hypothesis 3. Quach (2015) found higher levels of stress were also correlated with higher levels of burnout in a sample of Psy.D. students. It is hypothesized that in the overall sample of Ph.D. and Psy.D. clinical psychology doctoral students, there will be a positive correlation between perceived stress and levels of burnout, such that those with higher levels of perceived stress will report higher levels of burnout.

Hypothesis 4. Meyers et al. (2012) found that self-care practices can be vital to managing stress in clinical training. It is hypothesized that in clinical psychology doctoral students there will be a positive correlation between perceived stress and avoidant coping styles. As such, those with higher levels of perceived stress will report higher levels of avoidant coping as a consequence of avoidance strengthening negative responses (Walser et al., 2012).

Hypothesis 5. Meyers et al. (2012) found that self-care practices can be vital to managing stress in clinical training. It is hypothesized that in clinical psychology doctoral students there will be a negative correlation between perceived stress and approach coping styles. As such, those with higher levels of approach coping will report lower levels of stress as a result of not avoiding their discomfort.

Hypothesis 6. Clinicians in Manhattan experienced enhanced self-care after the collective trauma of the September 11th terrorist attacks (Bauwens & Tosone, 2010). It is hypothesized that in clinical psychology doctoral students will report an increase in practicing self-care methods due to the COVID-19 pandemic.

Chapter 9 Methods

Participants

Participants included Psy.D. and Ph.D. students working toward their Doctorate in Clinical Psychology degree. This included doctoral students on internship. Programs across the nation were requested to share the survey with psychology doctoral students via a Listserv. Consent was obtained and participants were presented with instructions to complete the survey. The online survey was accessible at any location where internet was available for use. The survey was also able to be taken on a cellphone, which does not necessarily require internet. Therefore, participants were not limited by location but were required to access to the internet or utilize their cellphone data.

Measures

Demographics

Standard demographics such as age, identified gender, ethnicity, and marital status were obtained. Specific demographics such as year in respective program, estimated hours spent for programmatic requirements, program model, socioeconomic status, financial aid assistance received and additional commitments (e.g., work, volunteering) were obtained. COVID-19 data was also gathered.

Stress

Students' perceived stress was measured using the Perceived Stress Scale (PSS; Cohen, 1994). The PSS is a psychological instrument used to measure how

unpredictable, uncontrollable and overloaded respondents find their life; thus, measuring the appraisal of whether one's life is stressful and to what degree. The PSS is a 10-item measure rated by respondents using a 5-point Likert scale. The PSS is found to be valid and reliable (.91).

Burnout

Burnout was measured using the Oldenburg Burnout Inventory (OLBI; Demerouti & Nachreiner, 1996; Demerouti, 1999). The OLBI is a 16-item questionnaire in which participants rate items on a 4-point Likert scale (1 = strongly agree, 4 = strongly disagree), with higher scores indicating a higher level of burnout symptoms. The OLBI assesses the emotional, cognitive and physical aspects of burnout and produces two dimensions: exhaustion and disengagement. The OLBI was found to have sound psychometric properties with internal consistency ranging from .74 to .87 and convergent validity that supported traits related to burnout (Halbesleben & Demerouti, 2005).

The OLBI was developed in efforts to assess a more-broad range of occupations relative to the Maslach Burnout Inventory. Instructions to the OLBI will be adapted to assess clinical psychology doctoral students' experience. The adaptation will read, "For the purpose of this study, consider your combined student responsibilities (i.e., going to classes, studying for exams, clinical duties, research commitment, assistantship responsibilities, etc.) as your 'work' and answer the following questions accordingly. Additionally, answer specific

questions which referred to ‘recipients’ or care in terms of your clinical interactions with clients” (Weaver, 2000, as cited in Quach 2015).

Experiential avoidance

Experiential avoidance will be measured using the Acceptance and Action Questionnaire, Second Edition (AAQ-II; Bond et al., 2011). The AAQ-II is a 7-item, self-report questionnaire. Research shows the AAQ-II to have good test-retest reliability ($r = .81$) and internal consistency (Cronbach’s $\alpha = .84$). Items are added, with a higher number being more associated with greater levels of experiential avoidance.

Coping

Coping strategies were measured using the Brief COPE (Carver, 1997). The Brief COPE is a 28-item inventory with two overarching styles, avoidant and approach. The inventory has fourteen, two-item subscales that include self-distraction, active coping, denial, substance use, use of emotional support, instrumental support, behavioral disengagement, venting, positive reframing, planning, humor, acceptance, religion, and self-blame. Respondents rate items on a 4-point scale (1= I haven’t been doing this at all, 4= I’ve been doing this a lot). The Brief COPE was validated from the original COPE inventory and scale reliabilities range from .50 to .60.

Procedure

The student investigator obtained approval for measures and procedures through the Institutional Review Board (IRB) at Florida Institute of Technology.

Chapter 11 Results

Sample Demographics

A total of 257 clinical psychology doctoral students, both Ph.D. and Psy.D., from various schools across the United States participated in the online survey for this study. Out of 257 participants, 86.8% were females ($n = 223$), 30% were males ($n = 11.7$), .4% identified as transgender ($n = 1$), and 1.2% identified as non-binary ($n = 3$). Age range of participants included 74.7% between 21 – 28 ($n = 192$), 22.6% between 29 - 35 ($n = 58$), and 2.7% over the age of 35 ($n = 7$). Identified ethnicity included 32.3% White ($n = 60$), 2.3% Black or African American ($n = 6$), .4% American Indian or Alaskan Native ($n = 1$), 3.1% Asian ($n = 8$), .4% Native Hawaiian or Pacific Islander ($n = 1$) and 3.1% identified as Other ($n = 8$). It should be noted that only 84 participants were able to identify their ethnicity due to an error in making the question available on the survey.

With respect to relationships, 38.5% of participants identified as Single ($n = 99$), 18.7% identified as Married ($n = 48$), 17.5% are Cohabiting ($n = 45$), and 25.3% are In a Relationship ($n = 65$). Participants' year in program varied as 9.73% were in their 1st year ($n = 25$), 18.72% were in their 2nd year ($n = 48$), 28.40% in their 3rd year ($n = 73$), 16.34% in their 4th year ($n = 42$), 12.06% in their 5th year ($n = 31$), 1.56% in their 6th year ($n = 4$) and 13.23% on internship ($n = 34$). With respect to debt, 62.3% of participants have debt from their doctoral degree ($n = 160$) and 13.23% did not ($n = 97$). Financial stressors were calculated as any participant who indicated above a 1 on the Likert scale (1 = Not at all) and were

reported by 95.72% ($n = 246$) of the sample. Described socioeconomic status was reported as Lower for 13.62% ($n = 35$), Middle – Lower for 32.30% ($n = 83$), Middle for 33.46% ($n = 86$), Upper – Middle for 17.51% ($n = 45$), and Upper for 3.11% ($n = 8$). Table 1 in Appendix B presents the demographics for the sample of this study.

Descriptive Statistics

The average Perceived Stress Score was 20.59 ($SD = 6.76$) which suggested that the sample experienced stress at a High level. The average Burnout score was 39.37 ($SD = 6.32$) which suggested that the sample experienced burnout at a Medium level. The average score for Experiential Avoidance was 20.61 ($SD = 7.66$) which suggested the sample experienced experiential avoidance below what is typically correlated with depression and anxiety. The average Avoidant Coping score was 23.25 ($SD = 5.09$) and average score for Approach Coping was 40.93 ($SD = 6.84$) which suggested approach coping is more frequently utilized by participants. Table 2 in Appendix B presents the descriptive statistics for this study.

Hypotheses

The correlations between variables (i.e., Perceived Stress, Burnout, Experiential Avoidance, Approach Coping, Avoidant Coping) and a dependent samples t-test of self-care during COVID-19 was analyzed using SPSS. There were 5 correlations that were significant. Table three in Appendix B presents the inferential statistics of this study.

Hypothesis 1. Hypothesis one examined if participants with higher scores of experiential avoidance would have higher perceived stress scores. A correlational analysis was performed to assess for a relationship between experiential avoidance and perceived stress scores. The total perceived stress score and experiential avoidance was found to have a significant relationship ($r = .64, p < .05$), which meant that as experiential avoidance increased, stress increased.

Hypothesis 2. Hypothesis two examined if participants with higher scores of experiential avoidance would have higher burnout scores. A correlational analysis was performed to assess for a relationship between experiential avoidance and burnout scores. The total burnout score and experiential avoidance had a significant relationship ($r = .40, p < .05$), which meant that as experiential avoidance increased, burnout increased.

Hypothesis 3. Hypothesis three examined if participants with higher scores of perceived stress would have higher burnout scores. A correlational analysis was performed to assess for a relationship between perceived stress and burnout scores. The total burnout score and perceived stress score had a significant relationship ($r = .53, p < .05$), which meant that as stress increased, burnout increased.

Hypothesis 4. Hypothesis four examined if participants with higher scores of avoidant coping would have higher perceived stress scores. A correlational analysis was performed to assess for a relationship between avoidant coping and perceived stress scores. The total perceived stress score and avoidant coping had a

significant relationship ($r = .52, p < .05$), which meant that as avoidant coping increased, stress increased.

Hypothesis 5. Hypothesis five examined if participants with higher scores of approach coping would have lower perceived stress scores. A correlational analysis was performed to assess for a relationship between approach coping and perceived stress scores. The total Perceived Stress score and Approach Coping was not a significant relationship ($r = -.04, p > .05$), which meant that approach coping was not a significantly beneficial in decreasing stress.

Hypothesis 6. Hypothesis six examined if a significant number of participants reported an increase in self-care due to the COVID-19 pandemic. A one-sample t-test was run to determine whether sample participants self-reported an increase in self-care due to the COVID-19 pandemic. An increase in self-care was defined as any report above a 4 (4 = self-care stayed the same) on a Likert-scale from 1 to 7 (1 = much less, 7 = much more). The mean score for sample participants was 4.27 with a mean difference of .268 (95% CI, .05 to .48), $t(256) = 2.46$, $p = .01$, indicating a small effect size (Cohen's $d = .23$). This means a significant portion of the sample reported an increase of self-care since the COVID-19 pandemic began.

Chapter 12 Discussion

The impact of stress and burnout on clinical psychology doctoral students is of notable interest, particularly given the role these variables on client care and academic functioning (Skorupa & Agresti, 1993; Surguladze, 2018). Experiential avoidance and avoidant coping styles are also of concern, as there is a significant relationship between these variables and stress and burnout. While much of the literature has focused on medical students and other health professionals, the findings are particularly important for clinical psychology doctoral students and programs to understand.

Hypothesis one was supported in that the more experiential avoidance students engaged in, the higher their perceived stress scores were. This is supported by Walser et al. (2012) that stated avoidance can have implications such as strengthening responses that are problematic and preventing adaptive exposure to negative emotions. In the case of clinical psychology graduate students, negative emotions, such as stress, are inevitable. Students may better manage their emotions by understanding that discomfort is expected in graduate school and engaging in the converse of experiential avoidance, psychological flexibility. In other words, students may be encouraged by programs and supervisors to manage the emotions by way of remaining in the present, experiencing what is to be experienced, and ensuring that their behaviors are align with their values (e.g., make time for friends or family, exercise, do their work to complete the doctoral degree) (Walser et al., 2012). This is also supported by Miller and Orsillo (2020) whose overall findings

suggested that a stance of acceptance towards difficult internal experiences may enhance psychological well-being and success, despite the stressors of their doctoral level program.

Similarly, hypothesis two was supported in that higher levels of experiential avoidance was positively correlated with higher levels of burnout. This study combined both academic and clinical responsibilities for participants to address with respect to burnout. The findings from this study supported Surguladze (2018) who found that student clinicians in mental health training experienced both academic and clinical burnout. Walser et al. (2012) is again supported in that avoidance can have implications such as strengthening responses that are problematic and preventing adaptive exposure to negative emotions. Students are encouraged to manage the emotions by way of remaining in the present, experiencing what is to be experienced, and ensuring that their behaviors align with their values. Programs should emphasize the implications that burnout can have on academic and clinical responsibilities and promote understanding and expectation of discomfort during graduate school.

Hypothesis three was supported in that the higher levels of perceived stress in clinical psychology doctoral students, the higher the levels of burnout. This finding is mirrored by Quach (2015) who again found higher levels of stress were also correlated with higher levels of burnout in a sample of Psy.D. students. Findings from this study expand this research with the inclusion of both Ph.D. and Psy.D. students from a national sample. Students should be encouraged to mitigate

their stress with adaptive coping in order to reduce burnout symptoms that can ultimately lead to a diminished therapeutic alliance with clients which is a significant predictor in therapeutic outcomes (Horvath et al., 2011).

Hypothesis four was supported in that those with higher avoidant coping scores had higher levels of perceived stress. This supports findings by Meyers et al. (2012) found that self-care practices can be vital to managing stress in clinical training. This also supports Walser et al. (2012) in that avoidance sometimes strengthens negative emotions. Training programs should educate their students on the role of avoidant coping and discourage students from engaging in avoidant coping styles (e.g., distraction, denial, substance use, behavioral disengagement, self-blame, venting).

Hypothesis five was not found to be significant in that those with higher approach coping scores did not have lower perceived stress scores. Approach coping in this study included active coping, use of emotional support, use of instrumental support, positive reframing, planning, humor, acceptance, and religion. These findings align with Nelson et al. (2001) in that it is unclear which coping styles and self-care activities are most efficacious for clinical psychology graduate students. However, it is clear that avoidance has negative implications for stress and burnout. Future research may include statistical analyses on specific coping styles and their relationship with students' stress and burnout scores.

Lastly, hypothesis six was supported in that the results suggested that self-care was reported to have increased due to COVID-19. This finding is similar to

clinicians' experience of enhanced self-care after the collective trauma of the September 11th terrorist attacks (Bauwens & Tosone, 2010). However, the COVID-19 pandemic may have increased self-care due to an increase of time that graduate students had available, given many practicum experiences were cut short and classes moved to remote learning.

Chapter 13 Limitations and Future Research

The first limitation related to the study is the timing and current state of national and global affairs. The study was dispersed during the middle of the COVID-19 pandemic in which many students were experiencing significant changes to their academic coursework and clinical experiences, such as practicums. Classes were transitioning to remote learning and/or hybrid teaching models, and many practicum sites, as well as clinical programs, were discontinuing student opportunities for safety concerns. An additional limitation is that there were many global movements, and particularly national protests, against racial inequality and inequity. Many students reported experiencing heightening levels of situational stress due to both the global pandemic and racial protesting. A second limitation is that the question of identified ethnicity embedded in the survey was only administered to 84 participants. Consequently, an accurate representation of ethnic participants could not be calculated. This would have been particularly beneficial due to the systemic and notable difficulties for persons of color with regard to both the pandemic and racial inequity pushback. Furthermore, while the study included 257 participants, sample size is still a limitation relative to the thousands of clinical psychology doctoral students across the nation. Additionally, geographical stressors may contribute to participants' scores. For example, students in a big city have to worry about transportation difficulties, while others in more suburban areas do not. Additionally, while year in program was accounted for, current program factors

were not (e.g., research autonomy, specific acute stressors within range of time survey was taken, versus being away from the school setting and/or on a vacation).

Future studies may include statistical analyses that take cultural considerations into account by way of incorporating ethnic and gender identity and the relationship with stress and burnout. Year in program and stress and burnout correlations may also be helpful to allow programs to better target students based on timing. Future studies may also account for particular coping styles and which are efficacious, specifically mindfulness and values-based behaviors as they pertain to experiential avoidance. Additionally, while the timing of the survey was inevitable, it would be interesting to compare respondent scores of stress and burnout in this study to those not in the midst of a global pandemic or heightened racial tensions. Thus, it is recommended the study be run again with the demographic question of race/ethnicity. Lastly, a larger sample size may allow for a viable comparison of stress and burnout scores between Ph.D. and Psy.D. students.

Chapter 14 Conclusions

There are approximately 268 clinical psychology programs in the United States that produce doctoral level psychologists each year (Keilin, 2020). Doctoral level clinical psychology students are expected to complete a breadth of coursework, a dissertation, demands of practicum hours and placements, as well as supervisor/supervisee roles. Both burnout and stress are sometimes a byproduct of these demands and can often inhibit the student clinician both academically and clinically, and also inhibit the therapeutic alliance with clients.

This study addressed levels of burnout, stress, experiential avoidance, and coping styles among 257 clinical psychology doctoral students, both Psy.D. and Ph.D., across the United States. High levels of experiential avoidance and other avoidant coping styles were found to have a relationship with higher levels of perceived stress and burnout among participants. Consequently, it is recommended that clinical psychology doctoral students and programs work to mitigate stress and burnout by way of encouraging adaptive coping skills and psychological flexibility along the journey of earning a doctorate degree.

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Appendix

Demographics

Are you a clinical psychology doctoral student?

- Yes
- No

Ph.D. or Psy.D.?

- Psy.D.
- Ph.D.

What is your age?

- 18 – 20
- 21 – 28
- 29-35
- 35+

What is your identified gender?

- Female
- Transgender
- Male
- Other (please specify) _____

What is your marital status?

- Single
- Married

- Cohabiting
- In a relationship
- Widowed

What year in your Psy.D. or Ph.D. program are you currently completing?

- 1st
- 2nd
- 3rd
- 4th
- 5th
- 6th
- Internship
- Other (please specify) _____

How many hours a week do you spend on programmatic requirements currently (i.e., coursework, practicum, meetings, supervision)?

-

How many hours a week did you spend on programmatic requirements (i.e., coursework, practicum, meetings, supervision) PRIOR to COVID-19?

-

Did hours spent on programmatic requirements increase, stay the same or decrease during COVID-19?

- Increased

- Stayed the same
- Decrease

Do you have student loan debt from your doctoral degree?

- Yes
- No

Are finances a stressor? (1 = not at all, 7 = Always)

- 1 = Not at all
- 2
- 3
- 4
- 5
- 6
- 7 = Always

How would you describe your socioeconomic status?

- Lower
- Middle-Lower
- Middle
- Upper-Middle
- Upper

Do you have additional commitments at this time in your program? (Check all that apply; this would be in addition to internship if currently in that year in your program)

- Work (Not including military)
- Volunteering
- Military
- Other

Have you been in psychotherapy yourself; either in the past and/or currently?

- Yes
- No

COVID-19 Questions

During COVID-19, were you able to practice self-care?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, how well were you able to find ways to focus?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, how well were you able to seek social support?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, how well were you able to help others cope?

- Much More
- Moderately More
- Slightly More
- About the same

- Slightly Less
- Moderately Less
- Much Less

During COVID-19, how well were you able to find ways to manage disappointment?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, did you limit your media consumption?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, how well were you able to focus on things you can control?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, were you able to seek appropriate supervisory support?

- Much More
- Moderately More
- Slightly More
- About the same
- Slightly Less
- Moderately Less
- Much Less

During COVID-19, were you forced to switch to telehealth for practicum/internship?

- Yes
- No
- N/A

Please check all that apply:

COVID-19:

- Increased my compassion for clients
- Increased my self-disclosure
- Increased internal pressure to self-disclose
- Increased my connectedness with clients

Perceived Stress Scale

Instructions: The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way.

0 = Never

1 = Almost Never

2 = Sometimes

3 = Fairly Often

4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?

2. In the last month, how often have you felt that you were unable to control the important things in your life?

3. In the last month, how often have you felt nervous and “stressed”?

4. In the last month, how often have you felt confident about your ability to handle your personal problems?
5. In the last month, how often have you felt that things were going your way?
6. In the last month, how often have you found that you could not cope with all the things that you had to do?
7. In the last month, how often have you been able to control irritations in your life?
8. In the last month, how often have you felt that you were on top of things?
9. In the last month, how often have you been angered because of things that were outside of your control?
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Acceptance and Action Questionnaire – II

Instructions: Below you will find a list of statements. Please rate how true each statement is for you by choosing the response that best represents how often you experience each situation.

0 = Never true

1 = Very seldom true

2 = Seldom true

3 = Sometimes true

4 = Frequently true

5 = Almost always true

6 = Always true

1. My painful experience and memories make it difficult for me to live a life that I would value.
2. I'm afraid of my feelings.
3. I worry about not being able to control my worries and feelings.
4. My painful memories prevent me from having a fulfilled life.
5. Emotions cause problems in my life.
6. It seems like most people are handling their lives better than I am.
7. Worries get in the way of my success.

Oldenburg Burnout Inventory

For the purpose of this study, consider your combined student responsibilities (i.e., going to classes, studying for exams, clinical duties, research commitment, assistantship responsibilities, etc.) as your 'work' and answer the following questions accordingly. Additionally, answer specific questions which referred to 'recipients' or care in terms of your clinical interactions with clients. 4-point Likert.

1 = strongly agree

2

3

4 = strongly disagree

1. I always find new and interesting aspects in my work.
2. There are days when I feel tired before I arrive at work.
3. It happens more and more often that I talk about my work in a negative way.
4. After work, I tend to need more time than in the past in order to relax and feel better.
5. I can tolerate the pressure of my work very well.
6. Lately, I tend to think less at work and do my job almost mechanically.
7. I find my work to be a positive challenge.
8. During my work, I often feel emotionally drained.
9. Over time, one can become disconnected from this type of work.
1. 10. After working, I have enough energy for my leisure activities.
2. 11. Sometimes I feel sickened by my work tasks.
3. 12. After my work, I usually feel worn out and weary.
4. 13. This is the only type of work that I can imagine myself doing.
5. 14. Usually, I can manage the amount of my work well.
6. 15. I feel more and more engaged in my work.
7. 16. When I work, I usually feel energized.

Brief COPE

1 = I haven't been doing this at all

2 = I have been doing this a little.

3 = I've been doing this a medium amount.

4 = I've been doing this a lot.

1. I've been turning to work
or other activities to take
my mind off things
2. I've been concentrating my
efforts on doing something
about the situation I'm in
3. I've been saying to myself
"this isn't real".
4. I've been using alcohol or
other drugs to myself feel
better.
5. I've been getting emotional
support from others.
6. I've been giving up trying to
deal with it.
7. I've been taking action to try
To make the situation better.
8. I've been refusing to believe
that it has happened.
9. I've been saying things to let
My unpleasant feeling escape.

10. I've been getting help and advice from other people.
11. I've been using alcohol or other drugs to help me get through it
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

20. I've been accepting the reality of the fact that it has happened.

21. I've been expressing my negative feelings.

22. I've been trying to find comfort in my religion or spiritual beliefs.

23. I've been trying to get advice or help from other people about what to do.

24. I've been learning to live with it.

25. I've been thinking hard about

26. I've been blaming myself for things that happened.

27. I've been praying or meditating.

28. I've been making fun of the situation.

Final Open-Ended Question

- What do you think would have been important or necessary in this survey?
- Do you have any additional thoughts after completing this survey?

List of Tables**Table 1: Demographics.**

Ph.D or Psy.D., Gender, Age, Identified Ethnicity, Relationship Status, Year in Program, Debt from Doctoral Degree, Finances as a Stress, Socioeconomic Status

Variable	<i>n</i>	%
Psy.D. or Ph.D.		
Psy.D.	172	66.67
Ph.D.	85	32.95
Neither	1	.39
Gender		
Female	223	86.8
Male	30	11.7
Transgender	1	.4
Non-binary	3	1.2
Age		
18 - 20	0	0
21 - 28	192	74.7
29 - 35	58	22.6
35+	7	2.7
Identified Ethnicity		
White	60	23.3
Black or African American	6	2.3
American Indian or Alaska Native	1	.4
Asian	8	3.1
Native Hawaiian or Pacific Islander	1	.4
Other	8	3.1
Total	84	
Relationship		
Single	99	38.5
Married	48	18.7
Cohabiting	45	17.5
In a relationship	65	25.3
Year in Program		
1st	25	9.73
2nd	48	18.72

3rd	73	28.40
4th	42	16.34
5th	31	12.06
6th	4	1.56
Internship	34	13.23
Debt from Doctoral Degree		
Yes	160	62.3
No	97	37.7
Finances As a Stressor		
Not at All	11	4.3
2	25	9.7
3	61	23.7
4	33	12.8
5	52	20.2
6	34	13.2
Always	41	16.0
Total for 2 and above	246	95.72
Socioeconomic Status		
Lower	35	13.6
Middle-Lower	83	32.3
Middle	86	33.5
Upper-Middle	45	17.5
Upper	8	3.1

Table 2: Average Stress, Burnout, Experiential Avoidance, Approach and Avoidant Coping Scores.

Variable	<i>M</i>	<i>SD</i>
Perceived Stress	20.59	6.76
Burnout	39.37	6.32
Experiential Avoidance	20.61	7.66
Avoidant Coping	23.25	5.09
Approach Coping	40.93	6.84
Self-care During COVID-19	4.27	1.75

Table 3: Correlations among variables.

Measure	Stress	Burnout	Experiential Avoidance
Stress	--	.53*	.64*
Burnout	.53*	--	.40*
Experiential Avoidance	.64*	.40*	--
Approach Coping	.04	--	--
Avoidant Coping	.52*	--	--

Note. * $p < .05$