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Self-compassion among social workers

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J Jay Miller
University of Kentucky, Kentucky, USA

Jacquelyn Lee
University of North Carolina Wilmington, USA

Nada Shalash
University of Kentucky, Kentucky, USA

Zuzana Poklembova
University of Prešov, Prešov, Slovakia

Abstract

• *Summary:* In recent years, the practice of self-compassion has garnered increasing attention in the literature, yet little is known about self-compassion in the field of social work. The purpose of this cross-sectional exploratory study was to examine self-compassion among social workers (N = 1011) located in a state in the southeastern United States. Specifically, this study was guided by two distinct, yet interconnected research queries: (1) How self-compassionate are social workers and (2) what personal and professional factors contribute to self-compassion among social workers?

• *Findings:* Findings suggest social workers are fairly self-compassionate. Significant group differences in self-compassion exist by perceived health status (self-report), relationship status, social work licensing, and professional organization affiliation. Significant predictors of self-compassion included health status, educational level, and relationship status (in descending order of predictive power).

• *Applications:* Adept and ethical social work practice requires that practitioners engage in self-compassionate practices. This study offers pragmatic implications for social work practice, including training and apposite areas for research.

Corresponding author:
J Jay Miller, Self-Care Lab, College of Social Work, University of Kentucky, Kentucky, USA.
Email: jaymiller45@hotmail.com

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Over the past 15 years, the concept of self-compassion has garnered a great deal of attention in the literature. The intersection between Eastern traditions and Western approaches to health has spurred developments in understanding mental health and wellbeing, including a focus on self-compassion (Neff, 2003a). Similar to definitions of compassion that emphasize offering concern and kindness, self-compassion includes openness to and a nonjudgmental stance in response to one's own suffering, an inward expression of kindness, and acknowledgement such suffering as an inherent part of humanness (Neff, 2003a, 2003b). As such, Neff (2003a) suggests that conceptually self-compassion is comprised of three components: (1) mindfulness (versus over-identification with thought), (2) common humanity (versus isolation), and (3) kindness (versus self-criticism). Mindfulness is a means of relating to one's experience with openness, nonjudgment, and curiosity as opposed to instead being consumed by with the experience. Lessening the sense one is alone in moments of suffering, the notion of common humanity is characterized by the recognition that suffering is a natural part of the human experience. Finally, self-kindness is an expression of inward care and concern in contrast to harsh criticism. Self-compassion is a method of relating to oneself that can be particularly helpful when "considering personal inadequacies, mistakes, and failures, as well as when confronting painful life situations that are outside our control" (Germer & Neff, 2013, p. 856). These concepts are congruent with professional social work practice values.

Given the emergent nature of this line of inquiry, much of the literature examining self-compassion is theoretical (Neff, 2003b), focused on instrument validation (Neff, 2003a, 2016; Neff, Whittaker, & Karl, 2017; Raes, Pommier, Neff, & Van Gucht, 2011), or an examination of self-compassion in relation to variables such as emotional wellbeing, motivation, physical health, and interpersonal functioning (see Neff, 2012 for a review). Self-compassion has been noted to be helpful in times of stress (Neff, Hseih, & Dejitthirat, 2005) and is positively associated with variables such as happiness, optimism, positive affect, wisdom, personal initiative, curiosity and exploration, agreeableness, extroversion, and conscientiousness (Neff, Rude, & Kirkpatrick, 2007). Research suggests self-compassion is also connected to health-promoting behaviors (Sirois, Kitner, & Hirsch, 2015). Terry and Leary (2011) suggest self-compassion may aid in reducing emotional stress. Beyond promoting healthy behaviors, research suggests self-compassion reduces

problematic health behaviors such as smoking (Kelly, Zuroff, Foa, & Gilbert, 2010) and overeating (Adams & Leary, 2007).

In recent years, interest in examining the implications of incorporating self-compassion in the context of clinical treatment of psychological disorders or concerns is growing (Baer, 2010). For example, research supports the notion that self-compassion could potentially decrease posttraumatic stress symptoms severity and functional disability in veterans (Dahm et al., 2015). Authors suggest self-compassion can provide an opportunity for trauma survivors to address the patterns resulting from childhood trauma (Germer & Neff, 2015) as lack of compassion has been linked to criticism from early caregivers, dysfunctional family systems, and insecure attachment (Neff & McGeehee, 2010; Wei, Liao, Ku, & Shaffer, 2011). More broadly, the notion of considering one's relationship to suffering is central to the newest shift in behavioral therapies, which places particular emphasis on mindfulness (MacBeth & Gumley, 2012). Therapy models such as dialectical behavioral therapy (Linehan, 1993), acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999), mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), and compassion focused therapy (Gilbert, 2005, 2010) represent this trend is now at the forefront of clinical treatment.

Self-compassion and helping professionals

Beyond research elucidating positive treatment outcomes for those in community or clinical settings, a growing body of literature examines the role of self-compassion in the lives of helping professionals and trainees in health fields including medicine, nursing, social work, and psychology. Self-compassion appears to not only benefit practitioners and students physically and mentally, but the practice contributes to overall wellbeing and work-related variables as well. For example, Kemper, Mo, and Khayat (2015) found sleep disturbances correlated with less self-compassion in a sample of clinicians and trainees. Yet, resilience strongly correlated with self-compassion among other variables such as mindfulness, mental health, and decreased rates of stress. In another study, researchers using a sample of counseling and psychotherapy students revealed those who reported high rates of self-compassion reported less compassion fatigue and burnout (Beaumont, Durkin, Hollins Martin, & Carson, 2016).

Much of the research connects self-compassion and mindfulness, often by examining the outcomes associated with mindfulness-based interventions. The practice of mindfulness is typically central to interventions designed to increase self-compassion (Kabat-Zinn, 1994, p. 4). For example, mindfulness-based interventions have been shown to increase self-compassion among clinical psychology and counseling students (Moore, 2008; Rimes & Wingrove, 2011; Shapiro, Brown, & Biegel, 2007), and in one study, participants subsequently reported increased empathy with clients (Rimes & Wingrove, 2011). Shapiro, Brown, and Biegel (2007), whose study included counseling master's students, reported MBSR resulted in less rumination, anxiety, and perceived stress as well as an increase in

self-compassion. The connection between mindfulness and self-compassion is a valuable one, particularly given the notion that practitioners' lack of self-compassion can result in increased criticism of clients as well as poorer treatment outcomes (Henry, Schacht, & Strupp, 1990).

Self-compassion and social work

Though the inclusion of self-compassion in social work research is sparse, much of the literature exploring this concept occurs in social work education. In a study of 65 MSW students, Ying (2009) examined the relationship between self-compassion and students' perceived functioning (i.e. sense of coherence) as well as mental health (as measured by depressive symptoms). Sense of coherence is understood as having confidence in one's resources to meet internal and external demands to manage challenges deemed as worthy of addressing (Antonovksy, 1987). Ying found moderate levels of each among the study's sample, and as expected, self-compassion was generally correlated with both perceived competence and mental health. Analyses suggested over-identification predicted negative outcomes in reference to both sense of coherence and mental health. Among social work students, common humanity has also been shown to be predictive of satisfaction with coping with stress (Ying & Han, 2009).

Research questions

Given the aforementioned dearth of research, the purpose of this exploratory study was to examine self-compassion among social workers located in a state in the southeastern United States. The present study uniquely contributes to the literature through examining the following research questions that guide the present study:

1. *How self-compassionate are social workers?*
2. *What personal and professional factors contribute to self-compassion among social workers?*

Method

Sampling protocol

Researchers collected primary data utilizing an online survey platform (e.g. Survey Monkey™). All data were collected during Fall 2016/Winter 2017. To solicit participation in this study, researchers sent an email invitation to social service agencies known to employ social workers. Recipients were asked to forward the invitation to other potential participants. Thus, it was not possible to calculate a response rate. All participants self-selected into the study and identified as a social worker practicing in the southeastern state. All participants who completed the

survey were invited to enter a $500 cash card drawing. The incentive link was disconnected from the primary survey link, thus making the responses anonymous. The sampling approach and protocol utilized for this study was approved by a University Institutional Review Board (IRB).

Instrumentation

To collect primary data germane to answering the previously posed research queries, the researchers employed the Self-Compassion Scale (SCS, Neff, 2003a, 2003b). The SCS is a 26-item self-report measure designed to assess the frequency of compassionate responsiveness to the self. The SCS generates a summative self-compassion score, and scores for six subscales that represent both the three conceptual aspects of self-compassion and their opposing actions, respectively: Mindfulness versus Over-identification, Common Humanity versus Isolation, and Self-kindness versus Self-judgment (Neff, 2003a, 2003b). Items identify various responses toward the self in challenging moments (e.g. I'm disapproving and judgmental about my own flaws and inadequacies; I try to be loving towards myself when I'm feeling emotional pain). Each item is measured via a five-point Likert-type scale anchored at 1 "Almost Never" to 5 "Almost Always." In previous research, SCS has demonstrated acceptable psychotropic properties (e.g. Neff, 2003b; Neff, Pisitsungkagarn, & Hsieh, 2008; Van Dam, Sheppard, Forsyth, & Earleywine, 2011). This measure has been shown to have acceptable psychometric properties (Neff, 2003; Neff & Germer, 2013; Neff et al., 2007). For this study, Cronbach's alpha was .96 for the overall SCS. Cronbachs for the subscales are as follows: Mindfulness (.94), Over-identification (.97), Common Humanity (.90), Isolation (.89), Self-kindness (.92), and Self-judgment (.88). In addition, researchers collected general demographic and professional information from participants.

Findings

Participants

A total of 1011 social workers from one southeastern state participated in this study. The typical participant identified as female (88.3%), White/Caucasian (85.5%), and aged 40.16 (SD = 11.96) years. Professionally, the participants reported 12.84 (SD = 9.86) years of social work practice experience and reported working 40.56 (SD = 10.03) hours per week. Participants' demographic and general professional data are included in Table 1.

Overall self-compassion scores

For the overall sample, the self-compassion score was $M = 3.312$ ($SD = 0.695$). Subscale scores for each of the six sub-domains are included in Table 2.

Table 1. Participant demographic and professional descriptive data.

Social workers' characteristics	*N* (%)
Gender	
Male	108 (10.7)
Female	891 (88.3)
Gender-Expansive	5 (0.5)
Ethnicity	
White	862 (85.5)
Black	107 (10.6)
Other (American Indian, Asian, and Hispanic)	31 (3.9)
Marital status	
Married	621 (61.5)
Never Married	202 (20.0)
Divorced	88 (8.7)
Partnered	68 (6.7)
Other (widowed and separated)	30 (3.1)
Gross annual household income	
Less than $29,999	66 (6.6)
$30,000–$59,999	388 (38.8)
$60,000–$99,999	309 (30.9)
$100,000–$199,999	219 (21.9)
$200,000 or more	20 (2.0)
Education	
Bachelors	123 (12.2)
Masters	836 (82.8)
Doctorate	23 (2.3)
Others (High School and Associates)	24 (2.7)
Years of practice in profession	
M	12.84
SD	9.86
Average hours of work per week	
M	40.56
SD	10.03
Licensure status	
Currently licensed	831 (82.2)
Never licensed	168 (16.6)
Profit or non-profit work settings	
For-profit	299 (31.1)
Non-profit	656 (68.3)
Current member of professional organization(s)	
Yes	316 (31.3)
No	694 (68.7)
Supervise other social workers	
Yes	201 (19.9)
No	810 (80.1)

(continued)

Table 1. Continued.

Social workers' characteristics	*N* (%)
Perceived health status	
Excellent	130 (12.9)
Very good	439 (43.5)
Good	336 (33.3)
Other (fair and poor)	105 (10.4)

Table 2. Self-compassion scores.

	Self-Kindness Subscale	Self-Judgment Subscale	Common Humanity Subscale	Isolation Subscale	Mindfulness Subscale	Over-Identified Subscale	Total SC score
M	3.301	3.068	3.477	3.770	3.587	3.232	3.312
Median	3.200	3.000	3.500	3.250	3.500	3.250	3.269
SD	0.796	0.881	0.804	0.938	0.732	0.905	0.695
Skewness	−0.081	0.035	−0.269	−0.083	−0.215	−0.107	−0.048
Kurtosis	0.152	−0.213	0.120	−0.444	0.448	−0.372	0.045
Range	4.00	4.00	4.00	4.00	4.00	4.00	4.00
Min	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Max	5.00	5.00	5.00	5.00	5.00	5.00	5.00

SC: self-compassion.

Group differences

Relationships for personal demographic variables. Correlation, ANOVA analyses, or independent sample *t* tests were conducted to determine the possible effects of demographic variables, such as gender, race, age, education, marital status, and self-perceived health conditions (see Table 3). Results suggested that there was a significant main effect for health status (the social workers self-reported their own health conditions as "*Excellent*," "*Very Good*," "*Good*," "*Fair*," and "*Poor*"), $F\,(4,\ 950) = 18.66$, $p < .001$, partial $\eta^2 = .06$, such that the social workers who reported one level better health conditions had significantly higher SCS scores than those who reported one level less satisfactory health conditions (see Table 3 for the SCS mean scores and standard deviations). Significant differences were also found for marital status, $F\,(5,\ 949) = 6.33$, $p < .001$, partial $\eta^2 = .03$, where the married social workers ($M = 3.35$, $SD = 0.67$) reported greater self-compassion than those who were never married ($M = 3.12$, $SD = 0.67$), but lower self-compassion than those who were widowed ($M = 3.81$, $SD = 0.74$). In addition, age was found significantly related to the SCS scores ($r = .25$, $p < .001$).

Table 3. Self-compassion scores as a function of the social workers' education, marital status, and self-perceived health conditions.

Demographic	*n*	*M*	*SD*	Range
Married	589	3.35*	0.67	1.15–5.00
Partnered	58	3.22	0.76	1.00–4.92
Widowed	19	3.81*	0.74	2.15–4.96
Divorced	82	3.35	0.76	1.31–5.00
Separated	11	3.75	0.46	3.02–4.54
Never married	190	3.12*	0.67	1.15–5.00
Excellent health	128	3.61*	0.68	1.46–5.00
Very good health	414	3.40*	0.68	1.38–5.00
Good health	312	3.17*	0.66	1.15–5.00
Fair health	91	3.01*	0.69	1.00–4.58
Poor health	5	2.29*	0.43	1.85–2.96

Note. Item responses are indicated using a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). Means with "*" differ from other levels under the same variable at $p < .05$.

Relationships for professional variables. In terms of the social work license of the social workers, the mean for this sample was 3.31 (SD = 0.70). Considering that there were only 10 social workers who reported "*I had a social work license in the past*" compared to those who specified "*I currently have a social work license*" ($N = 794$) and "*I have never held a social work license*" ($N = 147$), 10 cases were removed from the mean-comparison analysis since theoretically, the possible difference in the self-compassion practice between those currently licensed and never licensed social workers was of more interest. Thus, an independent sample t test was conducted to determine if SCS scores differed according to their social work license status. Findings indicated that there was a significant effect for license status, $t = 2.87$, $df = 939$, $p < .01$, Cohen's $d = 0.19$, such that social workers who currently had a social work license ($M = 3.34$, $SD = 0.69$) had higher SCS scores than those who had never held a social work license ($M = 3.16$, $SD = 0.69$). Furthermore, independent sample t tests determined if there were differences in the self-compassion levels of the participants as a function of employment settings (for-profit versus non-profit), professional organization membership, and supervision duties. Significant differences were found associated only with professional organization membership and supervision duties (see Table 4). In terms of professional organization membership, results indicated that the social workers who were members of professional organization(s) ($M = 3.38$, $SD = 0.69$) reported greater self-compassion than those who were nonmembers of professional organizations ($M = 3.28$, $SD = 0.70$), $t = 2.14$, $df = 948$, $p < .05$, Cohen's $d = 0.14$. While regarding the function of supervision duties, the social workers who supervised other social workers ($M = 3.43$, $SD = 0.69$) reported greater self-compassion than those who had no supervision duties ($M = 3.28$, $SD = 0.69$), $t = 2.62$, $df = 949$, $p < .01$,

Table 4. Self-compassion scores as a function of the social workers' license status, professional organization membership, and supervision duties.

Professional characteristics	*n*	*M*	*SD*	Range
I currently have a social work license	794	3.34*	0.69	1.00–5.00
I had a social work license in the past	10	3.46	0.70	1.92–4.19
I have never held a social work license	147	3.16*	0.70	1.15–5.00
Current member of professional organization(s)	300	3.38*	0.69	1.46–4.96
Not current member of professional organization(s)	650	3.28*	0.70	1.00–5.00
I supervise other social workers	189	3.43**	0.69	1.00–5.00
I do not supervise other social workers	762	3.28**	0.69	1.15–5.00

Note. Item responses are indicated using a 5-point scale ranging from 1 (*almost never*) to 5 (*almost always*). Means with "*" differ from other levels under the same variable at $p < .05$, and means with "**" differ from other levels under the same variable at $p < .01$.

Cohen's $d = 0.17$. In addition, the social workers' years in practice was found significantly related to the SCS scores ($r = .26$, $p < .001$).

Significant predictors

To explore the effects key predictor variables may have on the self-compassion scores overall, a multiple regression analysis was conducted on the combined average (including six subscales) self-compassion scores. Total possible self-compassion scores could range from zero to five, with higher scores denoting stronger tendency to manifest certain self-compassion traits. Due to the exploratory natures of this study, researchers used the demographic and general information data as variables in this model. *Highest earned educational degree*, *relationship status*, *health status*, *professional organization affiliation*, *supervision duties*, and *current license status* were included as predictors of total self-compassion scores. This model was statistically significant for total self-compassion scores, $F(15, 948) = 8.086$, $p < .001$, $R^2 = .115$, adjusted $R^2 = .101$. Results revealed that only three variables significantly predicted total self-compassion: *health status*, *highest earned educational degree*, and *relationship* (in the descending order of the variables' predictive power). Controlling for all other variables in the model, as one's health status improved, it was estimated that the total self-compassion score would increase by 2.4 points; holding a "*Master*" or a "*Doctorate*" degree in social work tended to push up total self-compassion score both by 0.7 points compared to those who had "*high school diploma*," "*Associate's*," "*Bachelor's*," or "*first professional*" degrees. Finally, compared to the social workers experiencing other types of *relationship status* (i.e. "*married*," "*partnered*," and "*divorced*"), those who were "*widowed*" showed increased total self-compassion score by 0.8 points, and the total SCS would improve by 0.6 points for the "*separated*." However, for the social workers who were "*never married*," the total SCS was inclined to decrease by 0.7 points.

Discussion and implications

To address a significant gap in the literature, the present exploratory study examined two research questions: (1) *How self-compassionate are social workers?* and (2) *What personal and professional factors contribute to self-compassion among social workers?* On average and using five-point scale, social workers reported above a three for the three components of self-compassion (mindfulness, common humanity, and self-kindness), as well as their respective counterparts (over-identification, isolation, and self-judgment). Mean scores suggest, however, social workers perceive themselves as experiencing greater mindfulness than over-identification with thoughts, isolation versus recognition of common humanity, and more self-kindness than self-judgment. Health status, educational level, and relationship status (in descending order of predictive power) were significant predictors of self-compassion.

The present study provides implications for both social work practice but also importantly for future research. While preliminary, the study offers initial support for the notion that social workers may be fairly mindful and engaged in exercising kindness toward themselves, which could suggest formal social work education or experience in the field could be the agents cultivating these skills. Since practitioners only report moderate self-compassion, increased attention to this concept in both social work education and practice could be helpful in improving both the wellbeing of students and practitioners but also effectiveness in practice. Practitioners who are able to be kind toward themselves may consequently be more present, empathically engaged, and compassionate with clients. Yet, the increased isolation scores endorsed by workers may identify a particular aspect of self-compassion from which workers could benefit or suggest the potential toll social work practice can take on a worker. This finding may lead agencies to focus on building a sense of community for workers through debriefings, group self-care activities, or other experience that could serve to remind practitioners of their common humanity and stave off a sense of isolation. In fact, Ying (2009) proffers a worker's belief in human connectedness is necessary to sustain both the empathy and commitment necessary in social work practice.

Additionally, while appropriate for an effort of this type, the model tested in the current study was limited to demographic and general information variables. Future studies should look to expand these models to other variables that may impact self-compassion among social workers.

Study findings contribute to the broader conversation about self-care taking place in social work, both in social work education and in the field. Attention to this concept can support practitioners, supervisors, and administrators in considering how self-compassion could be operationalized in practice and the outcomes of this integration. While personal self-care emphasizes holistic health and well-being across physical, cognitive/emotional, social, leisure, and spiritual domains, professional self-care is focused on aspects of the self within professional roles (Lee & Miller, 2013). Self-compassion is a both way of relating to one's experience that

can promote both personal and professional self-care behaviors as well as a self-care practice itself.

Addressing primarily the cognitive and emotional aspects of personal self-care, self-compassion can support workers in engaging in practices to bolster six domains of professional self-care identified by Lee and Miller (2013), as well; these are (a) workload and time management, (b) attention to professional role, (c) attention to reactions to work, (d) professional social support and self-advocacy, (e) professional development, and (f) revitalization and generation of energy. If workers can mindfully notice the impact of personal or professional stressors, self-kindness may take shape as responsive or even preventative re-envisioning their work schedule, prioritizing well-timed breaks, or taking a vacation. In paying attention to one's professional role, a self-compassionate practitioner can notice moments of over-responsibility taking that can be painful or stressful and consequently take steps to acknowledge the client's role as the authority in his or her life. Attending to reactions to work that include emotional suffering makes space for a compassion, kind response to meet one's emotional needs (e.g. seeking therapy), seek out professional social support (e.g. participating in debriefings with colleagues), or advocate for needed changes (e.g. shift in how case that are particularly challenging are delegated). Further, self-compassion could lead a practitioner to engage in professional development. For example, a practitioner may continually notice emotional reactions in working with clients experiencing trauma and therefore seek out learning opportunities about secondary traumatic stress. A self-compassionate practitioner can notice when stress, pain, or suffering is impacting his or her work and determine rejuvenating practices (e.g. looking over thank you notes or drawings from clients). Similarly, students can focus on the development of self-compassion in these ways while participating in field education in addition to using self-compassion to manage the stress, feelings of inadequacy, and perceived failures that often accompany academics. According to the National Association of Social Workers (2008), professional self-care is considered an integral component of adept social work practice, and self-compassion can play a central role in the self-care process.

Given the paucity of research focused on the self-compassion of social workers, future research is needed to build on the present exploratory study and extant literature. Certainly, continued research examining professional characteristics would provide greater clarity as to why membership in a professional organizations, supervisory status, and experience in the field predicts self-compassion. For example, are organizations focusing on specific content for continuing education that is particularly helpful or is simply the networking aspect of membership encouraging of self-compassion? Further, understanding how are practitioners with more experience cultivating self-compassion could provide useful information for the continuing education. Clarity about the factors that prevent or inhibit self-compassion—as well as those personal, professional, and organizational factors that promote it—would allow for the development of meaningful interventions to

encourage self-compassion, which Zessin (2015) argues is an important aspect of an individual's wellbeing.

In addition, future research is needed to examine the relationships between self-compassion and other emergent concepts related to workforce wellbeing (e.g., professional self-care) as well as more heavily studied phenomenon such as occupational stress, burnout, turnover, and resilience. The integration and evaluation of interventions such as mindful self-compassion (MSC; Neff & Germer, 2013) may also be helpful for practitioners. MSC is an eight-week curriculum designed to increase participants' self-compassion through focused two-hour weekly meetings exploring self-compassion through topics such as developing a compassionate inner voice, dealing with difficult emotions, and dealing with challenging relationships. MSC includes a retreat held between the fourth and fifth sessions that includes various meditations, restorative yoga, and mindful eating. Boellinghaus, Jones, and Hutton (2014) further underscore the need for a focus on emotional safety in the implementation of self-compassion interventions designed for helping professionals.

Limitations

As with all research, study findings should be considered in the context of study limitations. While these findings do shine light on an understudied area of social work, findings from the current study should be considered within the context of several limitations. First, all participants self-selected into this study and identified as social workers currently practicing in one southeastern state. All data were self-reported by participants. Respondents were overwhelmingly Female and White/Caucasian. Including more diverse perspectives, including practice area, may have impacted the findings. The cross-sectional nature of this study does not allow for inferences related to causality and self-compassion. As well, the predictive models tested for this study only included demographic/professional variables. Future research should look to address these limitations. And, given these limitations, broad generalizations associated with these results should be considered carefully and critically.

Conclusion

Practitioners who can compassionately relate to perceived mistakes, inadequacies, and internal criticism—as well as the stress, pain, or suffering that can arise in the context of or as a result of work—are likely more capable of being present with clients, mentally and emotionally available to use practice skills effectively, and cognizant of when and how to rejuvenate their own energy for the work they do. Social workers are regularly exposed to the difficult and often traumatic life experiences of those whom they serve and actively work to address systems that promote inequity and injustice. As such, recognition of the potential for suffering inherent to social work practice remains an ethical concern for the profession to

address proactively both in service of sustaining a healthy workforce and ensuring competence in practice.

Ethics

This study was approved by the IRB at the University of Kentucky (0947-X4B).

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