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On Job Resiliency Training, Tailored for Hospital Nurses: A Feasibility Study

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ABSTRACT

Introduction: Burnout is a primary threat to professional wellness and performance. It reflects work-related emotional stress and is commonly manifested among professional caregivers. This study explores whether self-compassion training can alleviate hospital nurses' work-related emotional stress and burnout.

Methods: In the present study, we conducted a weekly, 7-session, self-compassion training program among 15 hospital nurses, primarily working in critical care units, between January 22, 2020, and March 4, 2020. A group of nine other nurses, comprising a waiting list for the following training workshop, served as a control group. Beyond feasibility assessment, we also measured outcome effects according to previous research based on self-determination theory that proposed the specific way in which self-compassion contributes to reducing burnout among professional caregivers. This study used an interventional delta (after-before) experimental design, alongside a control group with similar interval delta measurement.

Results: Findings indicated high feasibility of the training program, with a trend noted toward improvement in self-compassion among the experimental group nurses ($p = 0.06$) - which was not observed among the control-group nurses. Despite the interventional success in self-compassion growth, burnout scores increased during the training program (exhaustion: $\Delta = 1.85$, $p = 0.007$; depersonalization: $\Delta = 1.83$, $p = 0.05$; lack of achievement: $\Delta = 1.33$ $p = 0.10$).

Conclusion: The training program's institutional framework, complemented by its preliminary results in self-compassion optimization, suggest future directions for conducting preemptive resilience training among hospital nurses. Burnout remains a complex combination of stressor-related phenomena that (at least from these preliminary results) suggest that complete amelioration is multifaceted beyond the domain of self-compassion growth.

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INTRODUCTION

Burnout is considered a primary threat to professional well-being and performance [1]. Burnout consists of three main components: (a) emotional exhaustion, (b) depersonalization, and (c) lack of personal efficacy. Emotional exhaustion is an overall sense of fatigue and being emotionally drained by work. Depersonalization is the hostile or apathetic response to tasks and people with whom workers interact. Finally, a reduced sense of personal accomplishment denotes the decline in feelings of competence and reward in one's career [2, 3]. Burnout reflects individuals' prolonged psychological response to unsustainable stress at work and not their pre-dispositions for psychopathology [4].

Burnout is a pressing issue among caregivers in the health care system [5], especially among caregivers working in critical care settings [6]. Caregivers are most vulnerable to burnout due to exposure to multiple stressors such as life-endangering situations and traumatic experiences. Therefore, the risk of burnout among caregivers should be addressed proactively and identified as an institutional priority [6].

Self-compassion (SC) training has recently been demonstrated as a promising tool in reducing the risk of burnout among professional caregivers [7]. SC entails three main components that overlap and interact [8, 9]: self-kindness, feelings of common humanity, and mindfulness. Self-kindness refers to the inclination of self-compassionate people to embrace and soothe themselves when experiencing personal hardships. Common humanity reflects the understanding that all people fail, err, and experience pain. Thus, a self-compassionate person regards failure and struggles as a shared human condition. Mindfulness refers to awareness of the present moment, experiencing it in a clear and balanced manner. It reflects a broad perspective-taking of one's own experience beyond transient pain [10]. The vast interest in cultivating SC in general led Neff and Germer [11] to develop a program designed to promote SC called Mindful Self-Compassion (MSC). This leading SC cultivation protocol is applicable to different clinical contexts [12]. We presumed that the MSC would be relevant in reducing burnout among nurses working mainly in acute care settings.

Drawing on recent research, we hypothesized that the MSC

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would influence burnout among nurses by maintaining their intrinsic motivation [13-14]. Intrinsic motivation is crucial in self-determination theory (SDT), a macro theory of human motivation [15]. Intrinsic motivation refers to acting according to personal values and interests while experiencing a sense of choice, initiation, and endorsement of one's behavior. It is sustained, according to SDT, by ongoing satisfaction of three essential psychological needs: autonomy, competence, and relatedness. Autonomy reflects a sense of self-causality and choice while experiencing a sufficient degree that daily activity reflects personal values. Competence reflects individuals' personal feelings of effectiveness in interactions with their environment. Finally, relatedness refers to a sense of engagement with others and belonging. Studies have underscored the importance of satisfying these needs within the work environment as an active buffering component against burnout [16, 17]. Notably, SC has been considered a viable means of meeting these needs. Therefore, we presumed that SC training would facilitate the fulfillment of these three psychological needs that underlie intrinsic motivation which, in turn, would decrease burnout.

We differentiated between two SC factors: the positive (SC+), which consists of common humanity, self-kindness, and mindfulness; and the negative (SC-), which involves isolation, self-criticism, and over-identification. Between the two, the SC+ is more controlled for interpersonal variability and more reflective of SC from a state perspective. Thus, it is more suitable as an outcome measure for the MSC [18, 19]. We hypothesized that the MSC intervention would enhance SC+ and, subsequently, would reduce burnout. Furthermore, we hypothesized that the intervention would enhance the satisfaction of psychological needs that underlie intrinsic motivation.

METHODS

Ethical Considerations

Ethical permission was granted by the hospital's Helsinki's Ethics Committee (0437-19-HMO). All participants signed an informed consent form upon enrollment.

Participant Recruitment

On December 29, 2019 the hospital's nursing administration distributed an email invitation to the hospital's general nursing staff which introduced the originally planned 8-session experience (which was reduced to 7 sessions due to COVID pandemic-related cancelation of the final session); see **Appendix A**.

Intervention

The training was structured according to MSC protocol [12], including eight weekly, 90-minute meetings. The initial meeting took place on January 22nd, 2020. The final session, initially scheduled for March 11th, 2020, was canceled with a two week notice due to the growing interference of the COVID-19 pandemic. Throughout the sessions, we incorporated from the MSC toolkit the primary contents and exercises essential for contemplating and experiencing SC. We also applied the understanding presented above regarding SC's role in reducing burnout by facilitating intrinsic motivation as a caregiver. This was done both within the theoretical input and the experiential practice (see **Appendix B**). The first author led the training based on his clinical experience with the medical staff in several of the hospital's pediatric intensive care units as a consulting staff psychologist. An outline of all session themes, contents, and practices appears in **Table 1**. Every session was comprised of the following five components: (1) theoretical input, (2) experiential practice, (3) group inquiry, (4) transfer to caregiving context, and (5) overview of the following session. Throughout the training, there was much discussion regarding participants' experiences and thoughts stemming from the workshop contents. Difficult emotions that arose were discussed from a self-kindness perspective within a warm and friendly group atmosphere.

Table 1: Week Session, summary of contents and list of experiential practice

Week	Session theme	Summary of contents	Experiential practice
1	Introduction to SC	An overview of SC, its working components, and its relevance to caregiving	"How would I treat a friend"
2	(Mindfulness) within SC	A general overview of mindfulness, and its role within SC in particular	"Affectionate breathing"
3	SC and caregiving	Application of SC across various aspects of caregiving and introducing the concept of intrinsic motivation	"Affectionate breathing"
4	Upholding intrinsic motivation as a caregiver	Determining and sharing between participants their inner core values as caregivers throughout their initial training and ongoing clinical experience	"Intrinsic motivation enhancement" *
5	Upholding intrinsic motivation as a caregiver-continuation	determining and sharing between participants their inner core values as caregivers throughout their initial training and ongoing clinical experience	"Intrinsic motivation enhancement" *
6	Vulnerability and inspiration in caregiving	Participants shared and reflected on their mixed feelings of vulnerability and inspiration as caregivers	Inspirational reading (selected by the first author)
7	Summary of the intervention	Participants shared their thoughts and feelings regarding their intervention experience	**

**This experimental practice was specifically developed for the current program (see Appendix 2). All other practices are according to the MSC protocol [12].*

***This experimental practice was originally planned to include all participants but was changed due to the cancellation of the final session (due to the pandemic outbreak).*

Procedure

Participants completed a battery of self-report scales on an individual basis at the start of the first meeting of the intervention (Time 1), and seven weeks later during the final session (Time 2) when they also completed feasibility measures. The control group participants completed identical outcome measures according to the exact timetable as the intervention group.

Measures

Self-compassion Scale (SCS) [8]

The 26-item SCS measures six aspects of SC: self-kindness

(e.g., "I try to be understanding and patient toward aspects of my personality I don't like"), self-judgment (e.g., "I'm disapproving and judgmental about my own flaws and inadequacies"), common humanity (e.g., "I try to see my failings as part of the human condition"), isolation (e.g., "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"), mindfulness (e.g., "When something painful happens I try to take a balanced view of the situation"), and over-identification (e.g., "When I'm feeling down I tend to obsess and fixate on everything that's wrong"). Responses range on a 5-point scale from "almost never" to "almost always," and all reversed outcomes are recoded [8]. The internal consistency of the SCS in Time 1 was 0.89 and in Time 2 0.91. As detailed above, we computed an overall SCS positive and negative average for each participant.

Psychological Needs Scale (PNS) [20]

The 21 item PNS measures the satisfaction level of the three needs: autonomy (e.g., "I feel like I can pretty much be myself in my daily situations"), competence (e.g., "Most days I feel a sense of accomplishment from what I do"), and relatedness in life (e.g., "I consider the people I regularly interact with to be my friends"). The scale reliability in the current study was 0.64 at Time 1 and 0.72 at Time 2 - somewhat lower than what we expected, presumably due to the small sample size [21].

Maslach Burnout Inventory (MBI) [2]

The MBI measures three aspects of burnout: (a) emotional exhaustion (e.g., "I feel like I'm at the end of my rope"), (b) depersonalization, (e.g., "I worry that my work is hardening me emotionally"), and (c) reduced feelings of personal accomplishment (e.g., "I have accomplished many worthwhile things in this job"). The scale consists of 22 items on a 6-point Likert scale, and positive items are reversed-scored so that higher scores reflect higher burnout. Cronbach's alpha coefficient was 0.96 at Time 1 and Time 2, respectively.

Feasibility Assessment

We assessed the program's feasibility according to six standardized dimensions [22]:

a. The Demand dimension was based on the noticeable mental distress among ICU staff members at the intervention site, as described by them to the first author.
b. Acceptability was based upon individual participant satisfaction, perceived helpfulness of various session components, the perceived benefit resulting from participation in the program, and willingness to recommend it to peers.
c. Implementation assessed whether the program was delivered as planned. We evaluated implementation by the number of canceled sessions and participants' satisfaction with the program organization (e.g., time allocated to different topics, site adequacy, distributed materials, etc.).
d. Practicality evaluated the perceived monetary costs of the intervention.
e. Modification reflected tailoring the MSC program to critical care nurses' particular needs and circumstances while implementing additional scientific materials.
f. Integration reflected the extent to which participants perceived self-compassion as beneficial in their everyday life and intended to pursue its cultivation in the future (see **Table 2**).

Table 2: Dimensions of feasibility (after 22)

Dimension	**Area of focus**
Demand	To what extent the program judged is suitable, satisfying, or attractive?
Acceptability	To what extent the program is likely to be used?
Implementation	To what extent can the program be delivered to intended participants in some defined context?
Practicality	To what extent can the program be carried out with intended participants using existing means, resources, and circumstances?
Modification	To what extent does the program perform when changes are made for a new format or with a different population?
Integration	To what extent can the program be integrated within an existing system?

Analysis

We selected a non-parametric approach to examine the mean difference between the two study groups (T2 – T1) due to our small sample. Specifically, we utilized a two-tailed Wilcoxon signed-rank test to assess the differences between the intervention and control groups.

RESULTS

Table 3 below details the demographics and characteristics of the research groups at the start of the intervention. Participants were randomly assigned to either the training group or the waiting-list group. The latter group was planned to participate in the next training program.

The two groups did not differ in terms of age or years of clinical experience, $t(16) = 1.67$, $p = 0.11$; $t(16) = 1.69$, $p = 0.11$. Initially, we planned to have 15 participants in each group. This

Table 3: Hospital unit, age and clinical experience (CE) of participants

	Intervention group			**Control group**		
	Frequency (N)	Age (average)	CE (average)	Frequency (N)	Age (average)	CE (average)
Hospital unit						
Intensive care	8	41.00 (7.83)	16.57 (7.32)	6	37.00 (6.24)	11.80 (7.85)
Oncology	4	43.50 (10.60)	20.00 (14.14)	3	37.00 (16.97)	13.16 (16.26)
Midwifery	3	58.50 (4.95)	36.00 (5.65)	_	_	_
Overall	15	44.64 (9.92)	20.73 (10.91)	9	37.00 (8.60)	12.29 (9.26)

Note. Standard deviations (SD) in parentheses

Table 4: Time 1 / pre-intervention (T1)) and Time 2 / post-intervention (T2) Mean (top) and Median (bottom); SDs in parentheses

	Intervention group (N = 11)			Control group (N = 7)		
	T1	T2	T2 – T1	T1	T2	T2 – T1
SC+	2.93 (0.75) 3.00	3.16 (0.66) 3.31	0.23† 0.31	3.51 (0.54) 3.46	3.14 (0.51) 3.05	–0.37† –0.41
SC-	2.80 (0.68) 2.85	2.70 (0.85) 2.62	–0.10 0.23	2.94 (0.45) 3.08	3.02 (0.37) 3.15	0.07 0.07
Self-needs	4.47 (0.43) 4.43	5.25 (0.60) 5.24	0.78* 0.81	4.90 (0.54) 4.95	5.38 (0.53) 5.48	0.48 0.53
Burnout	3.09 (0.48) 2.27	4.75 (0.41) 5.14	1.66* 2.87	3.09 (1.37) 2.48	3.14 (1.34) 2.64	0.05 0.16

Note. SC+ (overall factor of the SCS positive components), SC- (overall factor of the SCS negative components).
†The SC+ difference in the intervention group approached significance ($p = 0.06$) in contrast to that of the control group, which worsened concurrently during the time of the intervention.
*Significance at $p < 0.05$ level as determined using a two-tailed Wilcoxon signed-rank test—notice: unexpectedly, burnout increased over the course of the intervention.

sample size was based on a meta-analysis demonstrating a medium-to-large effect size (Hedge's g = 0.76) of mindfulness-based interventions among self-compassion in health care professionals [21; 1-β = 0.80, α = 0.05, one-tailed).

Of the 15 participants enrolled in the training group (all women) eleven fully completed the course (two oncology nurses, one midwife, and one critical care nurse could not commit to attending the majority of the pre-scheduled meetings). In the control group, seven women nurses completed questionnaires simultaneously at the intervention commencement and conclusion (two nurses from oncology were unable to do so).

Table 4 displays descriptive statistics for the SC scores, the satisfaction of the three self-needs, and burnout scores at T1 (pre-intervention) and T2 (post-intervention) for the two groups. It also shows the mean difference from pre- to post-workshop among the intervention and control groups. The results indicate that the SC+ increase in the intervention group was higher compared to the pre- to post-change of the control group (Δ = 0.23 and Δ = -0.37, respectively). SC- decrease was similar in the two groups (Δ = –0.10 and Δ = 0.07, in the intervention and control group, respectively). Satisfaction of the self-needs also increased more in the intervention (Δ = 0.78) than in the control group, (Δ = 0.47).

T2 – T1 differences for SC+ indicated that the delta in the intervention group was near significant ($p = 0.06$); while in the control group SC+ in fact worsened during the time that the intervention was carried out, see Table 4.

Regarding MBI measurements, the T2 – T1 measurements noted an increase in burnout which was greater in the intervention group (Δ = 1.66) than in the control group (Δ = 0.05). We also examined separately in the intervention group the T2 – T1 changes in the three component factors of burnout (exhaustion, depersonalization, and lack of achievement). All three burnout factors paradoxically increased following the intervention (Δ = 1.85, t(10) = 3.40, $p = 0.007$; Δ = 1.83, t(10) = 2.21, $p = 0.05$; and Δ = 1.33, t(10) = 1.80, $p = 0.10$; for exhaustion, depersonalization, and lack of achievement, respectively).

Feasibility dimension outcomes were as follows: recurring inquiries with various nurses throughout the hospital confirmed that they perceived a great deal of stress during work hours and yearned for a proactive way in dealing with it (Demand). As can be seen in **Table 5,** the mean ratings of overall satisfaction with the program and the ratings of personal and professional benefits were high. Participants rated the various components of the program as helpful; and all participants highly recommended the workshop (Acceptability). Satisfaction with the general conditions, including the handout materials, ranged between 3.54 and 4.00. Unfortunately, we canceled the final session, and the planned curriculum was shortened (Implementation). Eleven out of fifteen participants completed the program while attending at least five out of the seven sessions. The monetary costs were minimal given that the entire project was carried out by the first author (a rehabilitative psychologist) during his work hours (Practicality). The Modification included ongoing tailoring of the MSC to hospital nurses' psychological self-needs and the implementation of an intrinsic motivation enhancement practice (**see Appendix B**). Finally, participants indicated that SC was relevant to their everyday life and planned to continue its cultivation in the future.

Table 5: Participant program evaluation score

Feasibility Dimension	Evaluation domains and items	Mean (SD)	Min-max
Acceptability	*Overall satisfaction (1=very dissatisfied; 5=very satisfied)*		
	How satisfied were you with the program?	4.72 (.46)	4 – 5
	How satisfied were you with the trainer?	4.72 (.46)	4 – 5
	Helpfulness of session components (1=not helpful; 5=very helpful)		
	How helpful was the theoretical input?	4.18 (.40)	4 – 5
	How helpful were the experiential practices?	4.09 (.30)	4 – 5
	How helpful was the inquiry among colleagues	4.81 (.40)	4 – 5
	Benefit (1=no benefit; 5=great benefit)		
	How do you rate your professional benefit of the program?	4.18 (.40)	4 – 5
	How do you rate your personal benefit of the program?	4.36 (.50)	4 – 5
	Recommendation (1=no; 5=yes)		
	Would you recommend the program	4.72 (.46)	4 – 5
Implementation	*Satisfaction with general conditions (1=very dissatisfied; 5=very satisfied)*		
	How satisfied were you with the program organization	4.00 (.44)	3 – 5
	How satisfied were you with time requirements	3.72 (.46)	3 – 5
	How satisfied were you with the premises	3.54 (.52)	3 – 5
Integration	*Relevance (1=not at all; 5=very much)*		
	How relevant is SC to your everyday life?	4.45 (.52)	4 – 5
	Do you plan to continue cultivating it in the future?	4.36 (.50)	4 – 5

DISCUSSION

The present study implemented and assessed the feasibility of an evidence-based resiliency training program focused on SC cultivation, offered to hospital nurses as part of their occupational framework. The intervention followed the MSC protocol, as well as additional research and clinical experience. We administered multiple self-report measures to assess preliminary effectiveness and feasibility. The feasibility results indicate a positive participant experience and attest to the value of the intervention framework. The preliminary effectiveness results partially support the intervention's efficacy in enhancing SC's positive aspects and the satisfaction of self-needs. However, they also suggest that the intervention increased participants' perceived burnout regarding their caregiving experience. In the following, we discuss each of the effectiveness findings and suggest directions for future research.

Our finding regarding the increase of positive aspects of SC (SC+) is expected, given that, presumably, SC+ is more sensitive to contextual factors and, therefore, we expected it to be more responsive to the intervention. This finding indicates the attainment of the primary intervention goal. In contrast, there was no increase from pre- to post-treatment in the intervention group regarding SC's negative component (SC-). However, this null effect was also expected considering that the negative component of the SCS is more reflective of individual psychopathology and, therefore, less responsive to contextual intervention [18, 19]. Importantly, had the recently introduced state self-compassion measurements been available at the time, it would have served as a more accurate outcome tool for SC training evaluation [23].

The increase in SC+ in the current study was underscored by the significant increase in the satisfaction of psychological self-needs in the intervention group, which is considered a contextual responsive phenomenon as well [15]. This may suggest, in accordance with our hypothesis, that the SC training facilitated participants' contextual self-needs' satisfaction. Notably, self-needs' satisfaction is considered a central buffering component in reducing burnout and a leading measure of personal and professional well-being [16, 24].

Our results, however, indicated that cultivating SC increased burnout. Our original hypothesis was that nurturing SC would reduce burnout rather than increase it. We would like to present two explanations for this unexpected finding. First, the workshop may have highlighted the notion of burnout among the participants and accentuated the importance of intrinsic motivation in work settings. These insights may have caused increased conscious feelings of burnout in the short-term. Thus, the effect of SC on burnout may have been observable in a long-term follow-up and not in immediate post-workshop observations.

Second, as part of SC's cultivation and enhancement intervention, participants were encouraged to acknowledge contexts in which caregiving abilities to heal others, soothe their pains, or, at times, allow them peaceful death are limited. It was emphasized throughout the training that, for the most part, these limitations are due to the tragic aspects of caregiving as opposed to personnel errors or insufficient clinical ability.

Thus, the increase in burnout that was found in our study may reflect a reckoning with the limitations of caregiving abilities which appeared to be an ongoing struggle for some of the participants. Indeed, some research has indicated negative associations between expectations of achieving professional success through one's efforts (such as curing patients) and burnout [25]. Thus, our results show that the relationship between MSC intervention and burnout is more complex than initially assumed. The increase in self-needs' satisfaction and the positive participant experience in the intervention group support this understanding. These findings suggest that the MSC effectively influenced critical components of our theory. Future research should comprise larger samples with longer-term follow-up and include additional assessments of professional well-being beyond burnout and self-needs' satisfaction, including implicit and behavioral considerations that could shed light on the contradictory nature of the results in the current study.

LIMITATIONS

Our research effectiveness outcomes are limited due to the small number of participants in the intervention and control group. The COVID-19 pandemic outbreak interfered with our initial plan to conduct follow-up analysis and additional workshops to increase our sample. Our sample is somewhat heterogeneous and subject to selection bias considering that participants were required to take the initiative in signing up for the workshop. In addition, our findings are based on self-report measures designed for larger samples and are therefore exposed to various statistical and self-serving biases. Future research should attempt to use more objective measures across larger samples.

CONCLUSION

This feasibility study indicates that hospital nurses and caregivers, in general, have much to benefit from what psychological science has to offer in the form of resilience training. Notably, however, despite increasing self-compassion, the training did not evoke any immediate benefit to participants' sense of burnout. It did demonstrate a potential framework for hospital organizations to leverage available resources to enhance resilience training for caregivers—which should be embraced as an institutional priority.

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Appendix A: Email invitation to the workshop

Hi,

My name is Zach Gerber, and I am a staff psychologist in the pediatric departments and pediatric clinics at Hadassah University Medical Center. For the past five years, I have been researching how caregivers' self-compassion contributes to the quality of their clinical work.

Research indicates that self-compassion contributes on two levels:

1. It enables learning from mistakes and preserves a sense of meaning regarding one's clinical work and thus predicts a reduction in burnout symptoms among various medical staff overtime

2. It reduces the trauma associated with encountering loss and tragedies that characterize clinical work in a hospital.

Self-compassion reflects a person's caring for himself when experiencing difficulties and is based on the understanding that we all experience difficulties that are an integral part of life. Furthermore, this is based on the understanding that people in a difficult medical condition bring those who care for them to experience the limit of their caregiving abilities, despite the caregivers' care and dedication in carrying out their work. Therefore, cultivating self-compassion is vital for those who care for others with complex medical conditions daily.

I invite you to participate in a workshop of 8 weekly sessions to cultivate the components of self-compassion. The workshop will start on 01.01.2020 and is intended for 15 participants. The meetings will take place on Wednesdays between 13:15 to 14:45 during working hours in coordination with the nursing management. Participants in the workshop are expected to attend all the meetings held in the library on the second floor in the pediatrics building and fill in some short questionnaires at the beginning and end of the workshop that I will use to evaluate its effectiveness. The following is a list of the planned sessions:

Session Number	**Session Content**
Session 1	We will focus on the basics of self-compassion and their relevance to the practice of caregiving.
Session 2	We will learn about and practice the foundations of mindfulness
Session 3+4	We will focus on applications of self-compassion in various aspects of caregiving.
Session 5+6	We will cultivate participant's sources of intrinsic motivation in their clinical work
Session 7	We will focus on coping with the difficulties typical of workplace relationships
Session 8	We will focus on the positive and meaningful aspects of clinical caregiving and conclude the workshop

Appendix B: The mediating role of intrinsic motivation in SC-burnout relationship

The following paragraph is a short theoretical description of the mediating role of intrinsic motivation on the relationship between SC and burnout. This understanding was provided to the participants, along with experiential practice induced by the questions that appear below.

The emotional strain inflicted on the caregiver by the subjects of his concern requires an ongoing and dynamic belief of the former that his efforts, though limited in their capacity to alleviate suffering, are nonetheless worthy and worthwhile [12]. Indeed, it has been demonstrated that one's self-compassionate nutriment of autonomy can be situationally enhanced [26]. Drawing on contemporary thought and clinical experience in addressing perceived burnout among caregivers, we developed an experiential technique to foster autonomous motivation among caregivers via an auxiliary facilitated self-kindness perspective. Its perceived functionality is in extracting the respondent caregivers' original sense of choice and personal creed, as it remains present in their caregiving's ongoing practice. The technique builds on the contemporary Jungian "initial dream" concept in which all that is lived can be traced back to a preliminary dream or vision of the future experience [27]. Participants are introduced to this conceptual context, and are requested to elaborate regarding the following:

1. What was it that guided your decision to study and become a caregiver?
2. What remains in the present of that original quest?