

Report of the Council of University Directors of Clinical Psychology (CUDCP) Burnout Task Force: Workload, Burnout, and Emotional Health in Clinical Psychological Trainees

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Clinical psychology trainees have been struggling with significant burnout, anxiety, and depressive symptoms since well before the COVID-19 pandemic, but the problem has escalated in recent years. This study reports on a broad survey of trainees in clinical psychology doctoral programs across the United States and Canada ($N = 984$; $M = 27.5$ years, $SD = 3.39$). We found that trainees feel enormous time pressure despite working long hours (50–60 hr a week) and are suffering from high rates of burnout, especially emotional exhaustion. Most students do not feel they have adequate time for self-care and report that faculty in their programs talk about the importance of work–life balance but do not actually prioritize it. These problems are even more acute for trainees who identify as non-White. Self-care is often framed as an individual competency that trainees are responsible for learning and achieving on their own. However, the demands on trainees may make self-care almost impossible. These are institutional and field-specific problems that require systemic solutions. As a field, we must generate ways of reducing the burdens on all trainees, enhancing their well-being, and ensuring the future of our workforce.

Public Significance Statement

This study reports on a survey of clinical psychology graduate student trainees to examine workload, training program culture, burnout, and mental health. We need a healthy workforce to meet the demand for mental health services in the future. Documenting and addressing burnout in psychology trainees is an important step in this direction.

Keywords: burnout, emotional exhaustion, well-being, self-care, clinical psychology

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Graduate students across professions are at high risk of suffering from stress and burnout (Evans et al., 2018a, 2018b), with professional health care trainees being especially vulnerable (Bullock et al., 2017). Clinical psychology trainees in particular have been struggling with significant burnout, anxiety, and depressive symptoms since well before the COVID-19 pandemic (Rummell, 2015). Burnout is characterized by emotional exhaustion (EE), depersonalization (DP) or disengagement from and negative feelings about one's work and the people one works with, and reduced sense of personal accomplishment or effectiveness (Maslach et al., 2001). Many risk factors for burnout are inherent in health service psychology, including feeling responsible for others, dealing with problems and intense emotions, managing challenging or high-risk clients, and juggling multiple role demands (e.g., research, clinical work, teaching/mentoring; Rupert & Morgan, 2005). Thus, it is of little surprise that, even prepandemic, up to 50% of professional psychologists reported moderate to severe levels of burnout (Simionato & Simpson, 2018). However, trainees are even more vulnerable than later career professionals. Specific risk factors for burnout in clinical psychology include inexperience and younger age, having less confidence in one's abilities, low perceived control, a mismatch between perceived demands of the job and perceived available time and energy, and high levels of perfectionism (McCormack et al., 2018), all of which are likely to be present in trainees. Trainees also must cope with performance and evaluation anxiety and perceived (or actual) competition with peers (Pakenham & Stafford-Brown, 2012). Trainees with marginalized identities (e.g., Black, Indigenous people of color, LGBTQIA+, low socioeconomic status) may be at even greater risk, as they contend with all the usual challenges of graduate training and in addition often experience less sense of belonging, carry the uneven weight of representation, and

must cope with clueless comments, microaggressions, and, sadly, outright discrimination in their program or from their clients (Basma et al., 2021). These challenges for trainees with marginalized identities have only gotten worse with the COVID-19 pandemic (Aggarwal et al., 2023; Szkody et al., 2023). It is important to note that studies of burnout also find that *workload* and job demands contribute significantly to burnout above and beyond individual characteristics (e.g., Rupert & Morgan, 2005).

Studies indicate that burnout has serious consequences. In medicine, burnout prospectively predicts major medical errors, malpractice suits, and increased patient mortality (e.g., Parks-Savage et al., 2018; Shanafelt et al., 2010). In psychology, burnout is associated with compassion fatigue (Dehlin & Lundh, 2018). Burnout is also associated with an increased risk of alcohol abuse, depression, and suicidality, all of which can lead to impaired professional functioning (Barnett et al., 2007). Thus, professional ethics codes such as the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2017) and Canadian Psychological Association (CPA) Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 2017) have made awareness and management of personal distress and burnout an ethical obligation. For example, APA Standard 2.06 states that psychologists attend to personal problems and seek consultation or limit work-related duties if personal problems interfere with the competence (Bamonti et al., 2014).

These standards are similarly encompassed in the Canadian Code of Ethics for Psychologists under the principles of Responsible Caring and Integrity in Relationships (Maranzan et al., 2018). Moreover, APA's Committee on Accreditation (CoA) has identified self-reflection and self-care as foundational profession-wide competencies

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The authors' positionality statements follow: Mindful that our identities can influence our approach to the scientific endeavor, the authors wish to

provide the reader with information about our backgrounds. Of the nine authors, eight are cisgendered women, and one is nonbinary/gender fluid. One author identifies as bisexual. Five authors identify as White. One identifies as South Asian, one as Greek/Cambodian, one as Hispanic/multiracial, and one as Puerto Rican and White. Six were born in the United States, two were born in Canada (one currently resides on Treaty 6 territory), and one was born in India.

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that graduate programs in clinical psychology are expected to both train and evaluate. Implementing regulations (currently specified in IR-C-8-D; see <https://accreditation.apa.org/policies>) covers the category of professional values, attitudes, and behaviors, including the ability to engage in self-reflection regarding one's personal and professional functioning and the ability to engage in activities to maintain and improve performance, well-being, and professional effectiveness (Campoli & Cummings, 2019). Norcross and VandenBos (2018, p. 15) pointed out poetically that "self-care is not a narcissistic luxury to be fulfilled as time permits; it is a human requisite, a clinical necessity, and an ethical imperative."

There are situational and institutional factors that can protect psychologists and psychology trainees from burnout, including opportunities for professional development, supportive supervision, positive feedback, and perceived control over scheduling, workload, and location of work (Rupert et al., 2015). However, most of the research on preventing or mitigating burnout in health professionals, including in psychology trainees, focuses on the importance of *self-care skills* and cultivating *individual resilience* (e.g., Zahniser et al., 2017). Health care trainees are encouraged to cultivate self-awareness (Richards et al., 2010), to practice mindfulness (Spinelli et al., 2019), to employ skills from acceptance and commitment therapy (Pakenham, 2017), and to follow healthy lifestyles (Wise et al., 2012) including getting enough sleep, enjoying social support, and using emotion regulation strategies. Such practices can be quite helpful, and being "good" at self-care can mitigate the stress associated with graduate training (Colman et al., 2016; Myers et al., 2012). However, there is a fundamental irony in demanding that, in addition to everything else they are responsible for, trainees *also* be responsible for managing the problem of burnout. Framing self-care as an *individual* competency, while ignoring the *systemic* demands placed on trainees that make self-care difficult to sustain, is unrealistic and unfair. Thus, in 2021, the Council of University Directors of Clinical Psychology (CUDCP) formed a task force to examine the problem of burnout in trainees. The goal of the task force was to identify and address systemic barriers to self-care and work-life balance in clinical psychology trainees. The mission statement of the task force called for research into the workload demands on students and the relationship of workload to burnout and distress, as well as making recommendations for data-driven, systemic changes to graduate training that will decrease the demands on trainees, thus actually allowing for self-care.

This is an ambitious goal with numerous stakeholders who will need to be involved in the discussion and implementation of any such changes, including CUDCP member clinical training programs, the Association of Psychology Postdoctoral and Internship Centers, Directors of Internships, and possibly accrediting bodies such as the APA CoA, CPA, and the Psychological Clinical Science Accreditation System (PCSAS). Nevertheless, addressing burnout seems essential to the health and well-being of our young workforce, and solving these issues may help plug the "leaky pipeline" problem in which many trainees (especially women, minoritized individuals, and differently abled individuals) shy away from careers in clinical science and academic medicine that they perceive as impossibly demanding and incompatible with work-life balance (e.g., Ayala et al., 2017; Dimmick & Callahan, 2022; James-McCarthy et al., 2022; Lund, 2023).

This article reports on the results of the first goal: a survey of clinical psychology trainees to examine workload, training program

culture, burnout, and mental health. We examined five sets of questions: (1) How many hours do trainees report working and how much time pressure do they experience? (2) To what extent do trainees report being able to engage in self-care and what is their program culture regarding self-care? (3) What are the rates of reported trainee burnout and what types of burnout do they experience? (4) To what extent do trainees experience symptoms of depression, anxiety, and stress? (5) Which variables predict burnout, depression, anxiety, and stress? We also examined differences in these reports based on racial/ethnic minority status. The study was approved by the University of Pennsylvania's Institutional Review Board and received funding through a grant provided by CUDCP.

Method

Recruitment

Eligibility included (a) enrollment in a clinical psychology doctoral program in the United States or Canada and (b) being 18 years of age or older. Recruitment emails were sent to Directors of Clinical Training (DCTs) at all CUDCP member programs with a request to distribute to their clinical psychology graduate students. Participants were informed that the survey would take approximately 30 min to complete and that they would be entered into a lottery with a 1/10 chance of winning a \$20 Amazon gift card.

Eligible participants were instructed to follow a link embedded in the email and to provide electronic informed consent prior to initiating the survey. Within the survey, participants provided demographic information on gender identity, age, and year in the program and answered questions related to program and funding status, time spent on specific activities such as research and clinical work, health and wellness, and program culture and messaging.

Participants

A total of 1,227 trainees accessed the survey and completed the consent form. A total of 984 individuals completed at least the demographics and estimates of their hours worked. Participants were between the ages of 18 and 55 ($M = 27.5$ years, $SD = 3.39$) and were at all stages of training from the first year to the sixth year. Reflecting recent trends in clinical psychology (Fowler et al., 2018), the sample was mostly female ($N = 807$, 82.0%) and White ($N = 650$, 66.0%). However, there was some gender and racial diversity in the sample. See Table 1 for details.

Measures

Workload Estimates

We asked participants to estimate how much time they spent in an average week across a wide array of activities encompassing classwork, teaching, research, and clinical training. The list of activities was developed after consulting with a number of clinical psychology doctoral students. The goal was to prompt survey participants to consider all the different activities they engaged in. At the end, we asked participants to provide an overall estimation of the average number of hours worked per week.

Table 1
Sample Demographics

Demographic variable	<i>N</i> (%)
Gender	
Female	807 (82.0)
Male	117 (12.0)
Genderqueer	24 (2.4)
Nonbinary	22 (2.2)
Transman	2 (0.2)
Transwoman	1 (0.1)
Not specified	1 (0.1)
Race/ethnicity	
White	650 (66.0)
Hispanic	107 (10.9)
Black	53 (5.4)
East Asian	44 (4.5)
South Asian	29 (2.9)
Middle Eastern/North African	20 (2.0)
Southeast Asian	8 (0.8)
Multiple races endorsed	73 (7.3)
All possible race categories represented	
Training model	
Clinical scientist	270 (28.5)
Scientist–practitioner	616 (65.2)
Practitioner–scholar	32 (3.3)
Unsure or do not know	29 (3.0)
Degree type	
PhD	860 (90.8)
PsyD	87 (9.2)
Accreditation status	
APA accredited only	741 (78.0)
PCSAS accredited	169 (18.0)
CPA accredited	3 (0.3)
Accredited on contingency	21 (2.0)
Unaccredited	2 (0.2)
Unsure or do not know	14 (1.5)
Program size (no. of students in cohort)	
1–5	305 (32.2)
6–10	456 (48.2)
11–15	114 (12.0)
16–20	23 (2.4)
21–30	9 (1.0)
31–40	2 (0.2)
More than 50	38 (3.9)
Year in program	
Year 1	208 (21.1)
Year 2	219 (22.3)
Year 3	197 (20.0)
Year 4	164 (16.6)
Year 5	121 (12.3)
Year 6	75 (7.6)
On internship	
No	826 (84.0)
Yes	157 (15.9)
Funding	
Full tuition remission	702 (74.0)
Fellowship type	<i>N</i> (% of participants with a fellowship)
Teaching assistant	139 (28)
Research assistant	171 (34.4)

(table continues)

Table 1 (continued)

Demographic variable	<i>N</i> (%)
Clinical assistant	40 (8.0)
Other (e.g., National Science Foundation/ National Research Service Award - NSF/NRSA)	147 (29.6)
Hours required for fellowship	Mode = 20, <i>M</i> = 16, <i>SD</i> = 7, range = 0–30
Does fellowship cover living expenses?	
Yes	228 (46.0)
No	268 (54.0)
Has trainee taken out loans?	
Yes	313 (33.0)
No	632 (67.0)

Note. APA = American Psychological Association; PCSAS = Psychological Clinical Science Accreditation System; CPA = Canadian Psychological Association.

Chronic Time Pressure Inventory (*Denovan & Dagnall, 2019*)

The Chronic Time Pressure Inventory (CTPI) is a 13-item self-report measure of time shortage, pressure, and feeling rushed. Questions assessing time pressure are rated from 1 (*strongly disagree*) to 5 (*strongly agree*) and include the following: “There aren’t enough hours in the day.” “I think I won’t finish work that I set out to do.” “The days fly by without me ever getting anything done.” “I feel pressured to fit everything in.” The CTPI has demonstrated good reliability (Cronbach’s $\alpha = .80$ – $.85$) and convergent validity ($r = .59$ – $.60$) with other frequently utilized measures of time pressure in adults (*Denovan & Dagnall, 2019*). Scores range from 13 to 65 with higher scores indicating great time pressure. In our sample, the CTPI had good internal consistency at Cronbach’s $\alpha = .87$.

Self-Care Activities

We created a six-item self-report questionnaire to capture basic self-care activities including getting sufficient sleep and exercise, eating healthful meals, spending time with friends and loved ones, spending time relaxing, and spending time having fun and doing valued nonwork activities. Sample items include the following: “Over the past week, I’ve been able to get enough sleep at night to feel fully alert and well rested during the day.” “Over the past week, I’ve been able to get as much physical exercise as I would like.” “Over the past week, I’ve been able to spend enough time with friends and loved ones.” Each item was scored from 0 (*strongly disagree*) to 6 (*strongly agree*). Total scores range from 0 to 36 with higher scores indicating greater satisfaction with self-care activities and scores over 18 indicating overall agreement with self-care statements. The scale had acceptable internal consistency (Cronbach’s $\alpha = .82$).

Program Messaging

We created an eight-item self-report questionnaire to assess trainee perspectives on program values regarding self-care and work–life balance. Items cover whether trainees are taught about

self-care; encouraged and supported in engaging in it; the degree to which mentors, faculty, clinical supervisors, and other students model self-care; and whether the messaging about self-care is consistent with how it is actually prioritized. Each item was scored from -3 (*strongly disagree*) to 3 (*strongly agree*) with zero being neutral. Total scores range from -24 to 24 with more negative scores indicating poor messaging, support, or modeling of self-care and more positive scores indicating positive messaging, support, and modeling of self-care. The scale had acceptable internal consistency (Cronbach's $\alpha = .79$).

Graduate Program Climate Scale (Veilleux et al., 2012)

The Graduate Program Climate Scale (GPCS) is a 20-item self-report measure of perceptions of climate in professional psychology doctoral programs. The GPCS contains questions regarding perceptions of emotional safety, respectful relationships, and effective organizational systems, including the following: "The DCT really cares about the clinical students." "I feel wanted and needed in my program." "Students in my program are proud to be students here." Items are rated from 1 to 4 (*almost never*, *occasionally*, *frequently*, and *almost always*), and the mean of the total sum of items is calculated, with higher scores indicating a more positive program climate (Veilleux et al., 2012). Initial validation of the GPCS has demonstrated good internal consistency and construct validity ($\alpha = .96$; Veilleux et al., 2012). In our sample, it had excellent internal consistency at Cronbach's $\alpha = .95$.

Maslach Burnout Inventory (Maslach et al., 1997)

Maslach Burnout Inventory (MBI) is a 22-item self-report measure of academic burnout in university students. The MBI generates three separate subscale scores reflecting EE, DP, and personal accomplishment (PA). Sample questions include the following: "I feel emotionally exhausted because of my work," "I feel frustrated by my work," and "I have achieved many rewarding objectives in my work [reversed]," with item scores ranging from 0 (*never*) to 6 (*always*) on each dimension. Scores for EE range from 0 to 54, with higher scores suggesting more EE. Scores for DP range from 0 to 30, with higher scores suggesting more DP. Scores for PA range from 0 to 48, with *lower* scores indicating less sense of accomplishment (and hence greater burnout). The MBI has good internal consistency (Cronbach's $\alpha = .84-.88$) and has been used in hundreds of studies across multiple populations (e.g., Richardsen & Martinussen, 2004; Wickramasinghe et al., 2018). In our sample, each factor demonstrated adequate to good internal consistency (Cronbach's α for EE = .87; for DP = .71; and for PA = .74).

Burnout Clinical Subtype Questionnaire (Montero-Marín & García-Campayo, 2010)

Burnout Clinical Subtype Questionnaire-36 (BCSQ-36) is a 36-item self-report questionnaire that measures three subtypes of burnout: frenetic, underchallenged, and worn-out. Each subtype of burnout is comprised of three subscales containing four questions each, wherein ambition, overload, and involvement comprise the frenetic subtype; indifference, lack of development, and boredom comprise the underchallenged subtype; and lack of acknowledgment, neglect, and lack of control comprise the worn-out subtype

(Montero-Marín & García-Campayo, 2010). Scores on each item range from 0 (*totally disagree*) to 6 (*totally agree*). The BCSQ-36 has demonstrated good factorial validity and internal consistency (Cronbach's $\alpha = .84-.92$). In our sample, each subtype had good to excellent internal consistency (Cronbach's α for the frenetic subtype = .87, for the underchallenged subtype = .92, and for the worn-out subtype = .89).

Depression, Anxiety, and Stress Scale-21 (Lovibond & Lovibond, 1995)

Depression, Anxiety, and Stress Scale-21 (DASS-21) is a brief version of the DASS, a well-established, widely used self-report measure of clinically significant emotional states in adults over the past week (Lovibond & Lovibond, 1995). The DASS-21 contains three subscales: depression, anxiety, and tension/stress, each comprising seven questions. Scores ranging from 0 (*did not apply to me at all-applied*) to 3 (*me very much, or most of the time*) are summed to provide total subscale scores, where higher scores indicate more severe symptoms. The DASS-21 has demonstrated excellent internal consistency (Cronbach's $\alpha = .78-.89$) and good discriminative, concurrent, and convergent validity, as well as good correlations with other widely used measures of depression and anxiety (Coker et al., 2018). In our sample, the DASS had excellent internal consistency at Cronbach's $\alpha = .93$.

Participants were also prompted to complete a free-response question concerning any additional information or comments relevant to their workload and burnout. Participants were given the opportunity to decline to answer any question on the Qualtrics survey.

Results

See Table 2 for summary statistics on all outcome variables of interest. See Table 3 for all bivariate correlations.

The central findings of the survey are that clinical psychology trainees are working a lot of hours (50–60) and are experiencing considerable burnout. The distribution of hours worked is bimodal, with almost equal numbers reporting 50 and 60 hr a week. Students in the first 2 years (when the course load is heavy) report equal hours overall to students in the third and fourth years, when there are typically more clinical hours, $t(782) = 0.89$, *ns*. Students on internship report slightly fewer hours on average, $M = 52$, $SD = 14.8$, $t(976) = 3.35$, $p < .001$, but are still working well above 40 hr per week. The modal number of required hours reported by students with fellowships was 20 per week. First- and second-year students reported engaging in an equal number of hours taking classes, doing course readings and homework, and studying for exams (mode = 20 hr, $Mdn = 25$ hr). Students in the third year and above reported far less time on course work but equivalent time spent on clinical training (mode = 21 hr, $Mdn = 27$ hr). The reported workload is over 40 hr a week already and *does not include their own research*.

Despite these long hours, many trainees still feel like they cannot get everything done. Scores on the CTPI ($M = 51$, $SD = 8$) were significantly higher than the reported mean of the standardization sample, which was 43.1 ($SD = 8.1$, single sample $t = 22.61$, $p < .00001$; Denovan et al., 2024). Comparison of these two means yields a large Cohen's d effect size of 1.0.

Table 2
Distribution of Main Outcome Measures

Measure	Range of possible score	<i>N</i> <i>M (SD)</i> <i>Mdn</i> Mode	Percent in relevant range
Hours worked	NA	979 55 (13.6) 55 60	NA
Chronic Time Pressure Inventory	13–65 Neutral = 39 Population <i>M</i> = 43	950 50.5 (7.9) 51 50	90% of participants endorsed experiencing time pressure. 80% of participants scored above the population mean.
Adequacy of self-care activities	0–6 Neutral = 3 Disagree = 0–2	974 2 (1.3) 1.8 2.2	76% of participants disagreed with having adequate time for self-care.
Program messaging: overall	–24 to 24 Positive > 0 Neutral = 0 Negative < 0	918 –3.1 (8.4) –3.5 –6	63% of participants had an overall negative appraisal of program messaging about the importance of self-care.
Program messaging: Faculty <i>talk</i> about self-care importance.	–3 to 3 Neutral = 0 Disagree = –3 to –1	965 0.79 (1.6) 1 2	70% agree that faculty talk about the importance of self-care, with the modal response being <i>agree</i> .
Program messaging: Messaging about self-care consistent with the reality of how it is prioritized	–3 to 3 Neutral = 0 Disagree = –3 to –1	964 –1.7 (1.5) –2 –3	83% disagree that self-care is prioritized in reality, with the modal response being <i>strongly disagree</i> .
Graduate Program Climate Scale	1–4 (higher better) Almost never = 1 Occasionally = 2 Frequently = 3 Almost always = 4	856 2.5 (0.6) 2.5 2.74	20.0% < 2 58.0% > 2 but < 3
Maslach Burnout Inventory: Emotional exhaustion	0–54 (higher worse) Low degree ≤ 17 Moderate 18–29 Severe ≥ 30	933 33.5 (10.2) 34 37	7% low exhaustion 25% moderate exhaustion 67% severe exhaustion
Maslach Burnout Inventory: Depersonalization	0–30 (higher worse) Low degree ≤ 5 Moderate 6–11 Severe ≥ 12	928 8.5 (6.2) 7 4 or 6 (bimodal)	38% low depersonalization 32% moderate depersonalization 30% severe depersonalization
Maslach Burnout Inventory: Accomplishment	0–48 (higher better) High degree ≥ 40 Moderate 34–39 Low degree ≤ 33	926 27.6 (7.4) 28 32	5% high accomplishment 17% moderate accomplishment 78% low accomplishment
BCSQ: Frenetic	0–6 (higher more endorsement) 0–2 disagreement 3 neutral 4–6 agreement	882 3.99 (0.81) 3.92 3.75	90% of the sample in agreement
BCSQ: Bored	0–6 (higher more endorsement) 0–2 disagreement 3 neutral 4–6 agreement	880 1.57 (1.04) 1.5 2	9.4% of the sample in agreement
BCSQ: Worn-out	0–6 (higher more endorsement) 0–2 disagreement 3 neutral 4–6 agreement	878 2.28 (0.97) 2.25 2.17	21% of the sample in agreement
DASS depression	0–42 (higher worse) Normal 0–9 Mild 10–13 Moderate 14–20 Severe 21–27 Very severe ≥ 28	854 14 (11) 12 2	22% mild symptoms 16% moderate symptoms 12% severe symptoms 12% very severe symptoms
DASS anxiety	Normal 0–7 Mild 8–9 Moderate 10–14 Severe 15–19 Very severe ≥ 20	853 8.4 (8.6) 6 0	16% mild symptoms 8% moderate symptoms 10% severe symptoms 10% very severe symptoms

(table continues)

Table 2 (continued)

Measure	Range of possible score	N M (SD) Mdn Mode	Percent in relevant range
DASS stress	0–42 (higher worse)	854	12% mild stress
	Mild 15–19	17.2 (9.5)	24% moderate stress
	Moderate 20–25	16	15% severe stress
	Severe 26–33	16	5% very severe stress
	Very severe ≥ 34		

Note. NA = not applicable; BCSQ = Burnout Clinical Subtype Questionnaire; DASS = Depression, Anxiety, and Stress Scale.

Moreover, many trainees reported that they were unable to engage in sufficient self-care activities, including getting enough sleep or exercise, eating healthful meals, taking time to relax or spend time with family and friends, and enjoying fun activities outside of work. The mean score on the scale indicated overall dissatisfaction with the adequacy of opportunities for self-care.

With respect to program messaging, trainees generally agreed that their programs are teaching or *telling* them about the importance of self-care but strongly disagreed with the following statement: “In my program, the messaging about self-care, work–life balance, and wellness is consistent with the realities of how it is prioritized.” Overall scores on the program messaging measure were negative, suggesting that while some students feel supported, the majority of students do not see their programs as supporting self-care. With respect to program climate, scores suggested that, on average, trainees rated their program culture on the positive side, endorsing something between occasionally and frequently for positively framed items. However, the range of scores was wide, and almost 20.0% of trainees endorsed “almost never” to a number of positively framed items.

The majority of our participants reported a high degree of burnout. On the MBI, the average score on the EE subscale suggested a high degree of burnout. The average scores on the DP subscale suggested only moderate levels of DP and the lack of empathy. Indeed, the modal score on the DP subscale was a 4, suggesting that most clinical psychology trainees maintain their investment in their work. On the other hand, the average score on the PA subscale suggested a fairly low level of personal accomplishment, despite the long hours being worked. Interestingly, trainees in the first 2 years of training (when there is typically more course work but fewer demands for clinical work) scored somewhat lower on both EE and DP than students in years 3 and 4 of training, when clinical and research productivity demands presumably increase, $t(748) = 4.139, p < .001$ and $t(743) = 2.289, p < .001$, respectively. However, there was no significant difference in burnout between trainees who were or were not on internship (all $t < 1.6$, all *ns*). With respect to burnout subtype, the results of the BCSQ suggest that the vast majority of the trainees (90%) endorsed the frenetic subtype items, while far fewer endorsed feeling worn-out (21%) and very few endorsed feeling bored or disconnected (9%).

With respect to depression, half of trainees reported at least moderate symptoms of depression, with 24% reporting severe or very severe symptoms. With respect to anxiety, 28% reported at least moderate symptoms, with 20% reporting severe or very severe symptoms. With respect to stress, 44% reported at least moderate stress levels, with 20% reporting severe or very severe stress.

Racial/ethnic minority (non-White) status did make a difference in some measures, but not all. There was no significant difference in total hours worked, $t(977) = 1.28, ns$, nor were there significant differences in EE, DP, anxiety, or stress when examined by racial/ethnic minority status. However, trainees with non-White racial identities reported less satisfaction with program culture, $t(854) = 3.229, p < .001$; program messaging, $t(953) = 2.234, p = .01$; self-care, $t(972) = 2.37, p = .018$; more time pressure, $t(948) = 2.47, p = .014$; lower personal accomplishment, $t(924) = 3.796, p < .001$; and more depression, $t(852) = 2.78, p = .007$. See Supplemental Table 1 for descriptive statistics by race.

We ran six simultaneous linear regressions predicting each of the three facets of burnout (EE, DP, PA), depression, anxiety, and stress from hours worked, time pressure, program climate, program messaging, and self-care. See Table 4 for results. In sum, all of the variables predicted unique variance in EE in the expected direction. DP and PA were significantly predicted by all the variables except program messaging. Depression, anxiety, and stress were significantly predicted by time pressure, program culture, and self-care, but not by hours worked. Finally, we ran an analysis of covariance predicting EE from all the above variables but also covarying gender and race. All the predictors remained significant, while gender explained additional variance, $F(2, 821) = 3.472, p = .032$, with men being the least burned out, followed by women, followed by individuals who identified with some other gender identity or preferred not to specify their gender. Race was not a significant predictor of EE nor was the interaction between race and gender significant.

Discussion

The goals of this study were to document how many hours trainees are working and the relationships between workload, program culture and messaging, self-care, and burnout and emotional distress. Overwhelmingly, our sample reported working approximately 50–60 hr a week. Most trainees reported experiencing significant chronic time pressure, which was associated with high levels of not only burnout but also depression, anxiety, and stress. Our participants overall were dissatisfied with the adequacy of their ability to engage in meaningful self-care activities. Most trainees acknowledged that their programs or individual mentors talk about the importance of self-care but bemoaned how little self-care was prioritized in practice.

Our participants endorsed alarmingly high levels of burnout, particularly EE. Not surprisingly, most participants fell into the “frenetic” subtype of burnout—that is, their response to job

Table 3
Bivariate Correlations

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1. Hours	—													
2. Time press	.34**	—												
3. Self-care	-.39**	-.59**	—											
4. Messaging	-.25**	-.42**	.44**	—										
5. Culture	-.15**	-.34**	.33**	.66**	—									
6. MBI EE	.32**	.65**	-.53**	-.48**	-.42**	—								
7. MBI DP	.21**	.38**	-.29**	-.30**	-.36**	.54**	—							
8. MBI PA	-.10**	-.38**	.38**	.37**	.44**	-.40**	-.31**	—						
9. BSCQ frenetic	.24**	.29**	-.36**	-.14**	-.06	.28**	.13**	-.04	—					
10. BSCQ bored	.03	.28**	-.20**	-.31**	-.40**	.41**	.40**	-.44**	-.19**	—				
11. BSCQ worn-out	.11**	.41**	-.27**	-.41**	-.51**	.50**	.47**	-.50**	-.11**	.66**	—			
12. DASS dep.	.16**	.50**	-.41**	-.32**	-.42**	.57**	.46**	-.46**	.10**	.48**	.53**	—		
13. DASS anx.	.14**	.38**	-.34**	-.20**	-.22**	.39**	.28**	-.28**	.22**	.17**	.27**	.53**	—	
14. DASS stress	.24**	.56**	-.49**	-.31**	-.28**	.62**	.43**	-.39**	.33**	.27**	.37**	.65**	.65**	—

Note. Items in bold are statistically significant. Hours = total hours worked; Time press = Chronic Time Pressure Inventory; Self-Care = satisfaction with self-care activities; Messaging = program messaging about self-care and work-life balance; Culture = Graduate Program Climate Scale; MBI EE = Maslach Burnout Inventory, emotional exhaustion; MBI DP = Maslach Burnout Inventory, depersonalization; MBI PA = Maslach Burnout Inventory, personal accomplishment; BCSQ frenetic = Burnout Clinical Subtype Questionnaire, frenetic; BCSQ bored = Burnout Clinical Subtype Questionnaire, underchallenged; BCSQ worn-out = Burnout Clinical Subtype Questionnaire, worn-out; DASS dep = Depression, Anxiety, and Stress Scale, depression; DASS anx. = Depression, Anxiety and Stress Scale, anxiety; DASS stress = Depression, Anxiety and Stress Scale, stress.

** $p < .01$.

demands is to work harder and longer in an attempt to get everything done. Our sample also reported alarming levels of depressive symptoms, as well as moderate anxiety and stress. Overall, greater satisfaction with opportunities for self-care and a more supportive

program culture were associated with higher levels of well-being (less burnout, depression, and stress). On the other hand, hours worked and time pressure were associated with worse program culture, less self-care, and greater burnout and emotional distress. As

Table 4
Regression Results

Model	Dependent variable					
	Emotional exhaustion	Depersonalization	Personal achievement	Depression	Anxiety	Stress
Constant						
<i>B</i> (<i>SE</i>)	10.78 (2.98)	3.038 (2.29)	22.376 (2.563)	7.785 (3.663)	0.800 (3.273)	-0.73 (3.138)
β						
<i>t</i> , <i>p</i>	3.62, $p < .001$	1.326, $p = .19$, ns	8.732, $p < .001$	2.126, $p = .034$	0.244, $p = .81$, ns	-0.233, $p = .82$, ns
Hours						
<i>B</i> (<i>SE</i>)	0.044 (0.021)	0.032 (0.016)	0.04 (0.018)	-0.039 (0.025)	-0.014 (0.023)	0.005 (0.022)
β	.059	.069	.074	-.048	-.021	.402
<i>t</i> , <i>p</i>	2.145, $p = .032$	2.024, $p = .043$	2.26, $p = .024$	-1.531, $p = .13$, ns	-0.601, $p = .55$, ns	0.209, $p = .83$, ns
Time pressure						
<i>B</i> (<i>SE</i>)	7.31 (0.54)	2.69 (0.411)	-2.231 (0.46)	6.683 (0.657)	3.823 (0.592)	6.176 (0.564)
β	.438	.263	-.186	.377	.27	.402
<i>t</i> , <i>p</i>	13.65, $p < .001$	6.547, $p < .001$	-4.848, $p < .001$	10.166, $p < .001$	6.461, $p < .011$	10.955, $p < .001$
Messaging						
<i>B</i> (<i>SE</i>)	-0.132 (0.042)	0.006 (0.032)	0.015 (0.037)	0.141 (0.052)	0.059 (0.046)	0.017 (0.044)
β	-.108	.008	.018	.109	.058	.015
<i>t</i> , <i>p</i>	-3.097, $p = .002$	0.178, $p = .86$, ns	0.422, $p = .67$, ns	2.718, $p = .007$	1.283, $p = .20$, ns	0.383, $p = .702$, ns
Culture						
<i>B</i> (<i>SE</i>)	-2.385 (0.547)	-2.616 (0.419)	2.762 (0.47)	-5.759 (0.668)	-1.651 (0.597)	-1.104 (0.572)
β	-.144	-.258	.315	-.327	-.118	-.072
<i>t</i> , <i>p</i>	-4.359, $p < .001$	-6.242, $p < .001$	8.004, $p < .001$	-8.619, $p < .001$	-2.768, $p = .006$	-1.93, $p = .054$
Self-care						
<i>B</i> (<i>SE</i>)	-1.214 (0.263)	-.047 (0.201)	1.077 (0.227)	-1.162 (0.325)	-1.114 (0.29)	-1.718 (0.278)
β	-.151	-.01	.187	-.136	-.163	-.231
<i>t</i> , <i>p</i>	-4.615, $p < .001$	-0.236, $p = .81$, ns	4.755, $p < .001$	-3.58, $p < .001$	-3.841, $p < .001$	-6.176, $p < .001$

Note. Emotional exhaustion = Maslach Burnout Inventory, emotional exhaustion; Depersonalization = Maslach Burnout Inventory, depersonalization; Personal achievement = Maslach Burnout Inventory, personal accomplishment; Depression = Depression, Anxiety and Stress Scale, depression; Anxiety = Depression, Anxiety and Stress Scale, anxiety; Stress = Depression, Anxiety and Stress Scale, stress; *SE* = standard error; Hours = total hours worked; Time pressure = Chronic Time Pressure Inventory; Messaging = program messaging with respect to self-care and work-life balance; Culture = Graduate Program Climate Scale; Self-care = satisfaction with self-care activities.

expected, these burdens were even greater for non-White students, who reported struggling with even more time pressure and endorsed less engagement in self-care and fewer feelings of personal accomplishment as well as less satisfaction with program culture.

This is a crisis. Almost half (48%) of the sample reported at least moderate depressive symptoms, and two thirds of the sample (67%) reported a high degree of EE burnout. These numbers are even higher than those reported in a survey of more than 2,000 graduate students from 26 countries, which reported that 39% of students had moderate to severe depressive symptoms (Evans et al., 2018b), and a recent meta-analysis that identified 25% of doctoral students with clinically significant depressive symptoms (Satinsky et al., 2021). Similarly, prior research has shown that exhaustion and stress are relatively common among graduate students across disciplines, with up to one third of doctoral students in a prior survey endorsing high rates of EE (Hunter & Devine, 2016) compared with the two thirds in the current sample. EE is correlated with a desire to leave academia, contributing to the leaky pipeline problem (Hunter & Devine, 2016).

These problems are broad and systemic, and the solutions must be equally broad and systemic. This is a challenging problem no matter which way you look at it. There are enormous structural demands on our trainees that they (and their mentors) might feel compelled to meet to succeed in the field. The sheer number of hours required to complete coursework, teaching assistant and/or research fellowship work, clinical training, and students' own research and writing, never mind applying for grants or internship, may seem overwhelming. For example, many funding models are based on fellowships with work requirements of 20 hr per week.

Despite the challenges, we believe that there *are* things we could do, as a field, to reduce the burdens on our students and to put the brakes on the productivity arms race they are caught in. Berenbaum et al. (2021) proposed introducing more flexibility into our training model to allow trainees to choose which competencies to specialize in during the latter half of their training. They noted the importance of freeing doctoral programs from some administrative and regulatory constraints to allow more flexibility in developing specialized training models. We applaud that approach but also make some specific suggestions below that may help reduce trainee burnout without requiring us to reinvent our training model.

One example would be to cap the number of hours students can be required to work (as teaching assistants, Research Assistants, or clinical coordinators) at 10 or 15 hr per week. This may be unrealistic if the university's funding model requires 20 hr of work. Nevertheless, it is a solution that should be explored. Programs should also monitor the number of hours that their students are working and take corrective action when appropriate. Graduate institutions including internship and postdoctoral sites could consider allocating 2–4 hr for administration on a weekly basis.

When considering structural changes to reduce burnout and stress, we must also consider student funding. Finances are a well-documented stressor for graduate students with research suggesting that one third of graduate students have difficulty meeting basic monthly expenses (Denecke et al., 2016) and one fifth (22%) experience food insecurity due to financial limitations (Coffino et al., 2021). A recent Canadian survey of interns/residents highlighted the challenges most residents face in coping with financial insecurity during residency year, with 93% of interns/residents indicating that their salaries do not meet their basic needs (Schwartz & Pishdadian, 2022). Given the relationship between

financial insecurity and psychological distress among graduate students (Hyun et al., 2006) and the frequency with which students seek counseling for reasons related to financial stress (Furr et al., 2001), academic and internship programs must consider increasing financial support for graduate students. The Canadian Council of Professional Psychology Programs Training Directors' Finances Committee developed strategies aimed at raising intern/resident salaries, stating that financial compensation is not only an advocacy issue but also an ethical and equity issue (Hallam et al., 2023).

One significant change doctoral programs could work together with internship programs to bring about is decreasing the expectation for accumulated clinical hours prior to applying for an internship. An assessment of clinical competencies could replace the inclusion of clinical hours (Palitsky et al., 2022). It is more important to know *if* a student knows how to administer and interpret an IQ test well and to integrate it into a coherent case conceptualization than it is to know *how many times* they have administered an IQ test. Another change that doctoral programs *could collectively* make would be to cap the total number of clinical hours applicants are allowed to report on internship applications. The average number of hours on internship applications has been found to be around 1,000 ($M = 997.63$; Callahan et al., 2014). It is slightly lower for trainees applying from PCSAS-accredited programs ($M = 837$, $SD = 239$; Treat et al., 2024) but is still well above the minimum that most internship sites require (500). Capping the total that can be reported would disincentivize trainees from taking on extra hours that do not actually benefit their training in pursuit of being "competitive" for internship. Determining the appropriate cap would require that all programs with similar goals (e.g., clinical science, scientist–practitioner) agree on a cap that would ensure students are well-prepared, but not overburdened, and that internship sites would agree to interpret the resulting hours appropriately.

More dramatic changes have also been considered. Over the past few years, DCTs and faculty have started having discussions about whether or not internship is necessary for granting a PhD. Although data show that more hours are not necessarily better, students are actively accruing more and more clinical hours compared with their peers in the past. Not only is this adding pressure on students but also preventing students from entering the field of health care earlier. Although scholars have suggested the possibility of moving internship to the level of postdoc, such a change would require revisiting licensing requirements across states and standards of accreditation (Rodebaugh, 2023). Thus, moving the internship to postdoctoral training is not a quick fix. However, changing the way (or the number) of hours that are reported is something we as a field could implement in the next year or two.

Another way to approach the competency-based system is to determine whether all competencies are essential for students to obtain and also if there are multiple ways in which students can meet those requirements. This is particularly important for those students who know their area of specialization and/or career path early in their education and training. As an example, if a student is interested in furthering their career as a neuropsychologist, it could be argued that some competencies related to providing psychotherapy may be less relevant to their day-to-day functioning. Finding a way to match the education and training system to the interests and career paths of students could not only help reduce burnout but also get students to serve their clients sooner. Of course, figuring out how to measure

and report on competencies in a reliable and valid way across different programs and students is a significant problem to solve. However, it is surely a problem that clinical psychologists, with our knowledge of psychometrics and assessment, should be able to address.

Another avenue to pursue is to take steps to reduce the number of courses students must take. Meeting the demands of accreditation is difficult, and over the years, the APA, CoA, and CPA accreditation have added a number of, but not removed any existing, required competencies that must be trained and assessed. Many programs respond by simply adding more required courses. There is no evidence that we are aware of that adding more courses to graduate training leads to better clinical care for patients or more useful and productive research. Finding creative ways to combine required content into single integrative courses might reduce the burden and add back much needed degrees of freedom to our students. Mindful that systemic problems require systemic solutions, we may need to bring pressure to bear on CoA to allow more flexibility and relax increased demands for course work and breadth of training.

Another domain that contributes to student workload is research. While gaining competency in research is a critical goal of doctoral training, the pressure to publish prolifically continues to grow and creeps earlier and earlier into training (including prior to beginning doctoral training; [Alberts et al., 2014](#)). For example, one of the best predictors of receiving interview offers is number of publications, with the average student having over three peer-reviewed articles in press or in print ([Callahan et al., 2014](#)). Applicants to clinical science and scientist–practitioner internships may have even more. Trainees applying to internship from PCSAS-accredited programs in 2023 had even higher rates of productivity, with an average of 9.4 publications in total and an average of three *first-authored* publications ([Treat et al., 2024](#)). Such pressures can lead to more rushed publication, which may reduce the quality of research ([Alberts et al., 2014](#)), and for trainees result in less time for learning key research skills and becoming deeply familiar with the extant literature. This is particularly compounded because research time is often fit into student work schedules after the many hours per week of coursework, clinical, and assistantship activities that are required. Structurally, the continued increased pace of publishing is untenable and at an individual level, in the context of other competing demands, contributes to burnout. Systemic changes necessitate restructuring the incentivization of research activities. In addition, more flexibility in training as a function of each student's career goals would allow students to prioritize activities that support their personal goals rather than being beholden to burdensome expectations in domains outside their area of interest.

The research on burnout makes it clear that perceived control reduces the risk of burnout. To the extent possible, students should be empowered to control their own schedules. For example, the vast majority of training programs pivoted to telehealth models during the COVID-19 pandemic, but many then required a return to the clinic even when the trainees were meeting with patients remotely. Allowing continued telehealth and telesupervision, including flexibility of scheduling and place of work, within the bounds of legal and ethical practice, would help trainees feel more empowered, respected, and supported with no diminution of efficacy of clinical practice or training (e.g., [Thompson et al., 2023](#)). Finding the right balance of remote work and in-person collaboration and training should be a topic for future empirical investigations.

It was clear from our results that program culture matters. Students' perceptions of their program's emphasis on self-care positively correlate with engagement in these activities ([Campoli & Cummings, 2024](#); [Goncher et al., 2013](#); [Zahniser et al., 2017](#)). Students who feel respected and supported and who perceive that their program safeguards their well-being were less vulnerable to burnout. Small shifts in this regard may go a long way. For example, start supervision or lab meetings with a 1-min mindfulness meditation. Make time and space for 15-min yoga breaks in the clinic or reserve a small office with a couch for napping. Praise students for setting limits and boundaries and saying "no" to extra work or patients when they are already at maximum capacity. Make clear that emails sent after hours do not need to be responded to until the following business day. Faculty should also make every effort to *model* self-care and effective work–life balance. While this might be particularly challenging given the increased responsibilities of faculty, it could help promote positive shifts in the culture of academia and more broadly the field of mental health.

Of course, this study had significant limitations. We collected data cross-sectionally and have no way to verify the number of hours *actually* worked. A daily diary study conducted over multiple weeks might have provided a more reliable and valid measure of student workload, although it would also have (ironically) increased participant burden significantly. The study was also advertised as a study of "workload, burnout, stress and emotional health and well-being." Thus, we might well have attracted more burned-out trainees and students who valued their own well-being, leading to sampling bias and an overestimate of burnout in the population. We assessed financial precarity briefly, which prior research has shown to be a significant predictor of stress, depression, and anxiety in psychology trainees, but it was not the major focus of this project. We asked about gender identity, but not sexual orientation, and given the degree to which these trainees may experience extra burdens, we regret not including that question in our demographics. Participants were recruited only from CUDCP member programs, which limits the generalizability to non-CUDCP program trainees. Finally, data were collected between March 2022 and November 2022 when the COVID-19 pandemic was still active, which may have influenced our findings.

Despite these limitations, we feel that the results of this survey can help guide the development of evidence-based approaches to reducing burnout in psychology trainees. We recognize that solving the problem will take a coordinated and multifaceted approach with the cooperation and collaboration of numerous stakeholders including but not limited to students, faculty, DCTs, department heads, institutions, professional organizations, and accreditation bodies. However, it is a problem we must solve for the well-being of our trainees, who are the most vulnerable members of our profession, and for the future of our field.

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