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The Relationship of Self-Care to Burnout Among Social Workers in Health Care Settings

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Abstract

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MS, Virginia Commonwealth University, 2002

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Dissertation Submitted in Partial Fulfillment

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Abstract

Self-care is critical in minimizing the symptoms of burnout among human services professionals, but specific information on the role of self-care among social workers in healthcare settings is limited. This correlational study was designed provide a fuller understanding of this relationship. Orem's theory of self-care and the theory of reasoned action and planned behavior served as the theoretical foundations of this study. The sample included 185 members of the National Association of Social Workers, who volunteered to participate in this study. Participants completed online versions of the Maslach Burnout Inventory and Self-Care Assessment Work Sheet. Correlation and analysis of variance (ANOVA) were performed to test research hypotheses concerning associations between self-care and aspects of burnout among social workers in healthcare settings. The results showed that higher levels of self-care were significantly correlated with lower scores on measures of emotional exhaustion and depersonalization and higher scores on measures of personal accomplishment. No significant differences were found by practice setting in mean ratings of specified self-care activities. More years of social work practice were associated with lower burnout. Implications for positive social change include highlighting the need for self-care to prevent burnout, promoting health and wellbeing among social workers, and saving organizations the costs associated with employee burnout. Future research on self-care and burnout will be beneficial to the profession to expand current literature and highlight trends between social work practice and client populations served.

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Dedication

To my two beautiful daughters, Dona and Lauren, who understood my multiple roles and obligations at tender ages. May you fully embrace the importance of education and excel in all your endeavors.

To every social worker in the United States of America, the work we do is unique and life changing. Let us strive to take care of ourselves to continue our roles as positive change agents in society.

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To God be the glory, great things He has done. I thank God for enabling me to successfully complete my dissertation. This educational journey has been one of learning, personal and spiritual growth, endurance, commitment, patience, and opportunities.

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Chapter 1: Introduction to the Study

Background

Maslach and Jackson (1981) defined *burnout* as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do work with people of some kind" (p. 99). Leatz and Solar (1993) also defined *burnout* as "a physical, emotional, and mental exhaustion caused by long term involvement in situations that are emotionally demanding and very stressful, combined with high personal expectations for one's performance" (p. 116). Maslach and Jackson (1986) explained that *burnout syndrome* is characterized by negative attitudes about clients, decreased feeling of personal accomplishment, and negative self-evaluation. Emotional exhaustion, depersonalization, and personal accomplishment are the main burnout domains highlighted. Cooper, Dewe, and O'Driscoll (2003) indicated that burnout results from mental stress and strain encountered by workers in helping professions that include social workers. In helping professions such as nursing, social work, teaching, and ministry, there has been research on the concept of burnout and its effects on professionals.

Maslach (2003) noted that the basic aspects of burnout are prevalent in research conducted on burnout in many countries, particularly Israel, and Canada, and the countries of Europe. Burnout is considered a type of occupational stressor that affects individuals who do "people work" and report lacking a sense of control over the care they are providing. The main feature of burnout is a change in the helping professional's disposition toward others from optimistic and caring to pessimistic and uncaring.

As Maslach (2003) explained,

> Many different job settings that are burnout-prone have one thing in common—overload. Whether it be emotional or physical, the burden that exceeds the person's ability to handle it is the epitome of what we mean by stress. Too much information is pouring in, too many demands are being made, and it is all occurring too fast for the person to keep up with it. For the professional helper the overload translates into too many people and too little time to serve their needs adequately—a situation ripe for burnout. (p. 62)

Furthermore, emotional exhaustion is characterized by people feeling drained, used up, and lacking energy to continue the work of helping others. Sufferers report that their emotional resources are depleted and sources of replenishment lacking. Maslach (2003) explained that depersonalization is the development of a detached, callous, dehumanized response toward individuals being helped, with the helping professional developing a poor opinion of others, expecting the worst, and disliking the individuals being helped. The helping professional has a negative attitude and reaction, cares less about others, and demonstrates the following behaviors: (a) derogating others by putting them down; (b) refusing to be civil and professional; (c) ignoring requests; and (d) failing to provide needed and appropriate help, care, or service. These negative behaviors can lead to feelings of reduced personal accomplishment; the helping professional may experience a sense of inadequacy in relating with individuals being helped, feelings of failure, decreased self-esteem, and feelings of depression. This aspect of burnout is highlighted as causing some professionals to change professions and abandon occupations that will cause them to interact with individuals who are stressed (Maslach, 2003).

Maslach (2003) provided an example of a male psychologist who had been employed at a mental health center for three years and was labeled as having "a full-blown bout with burnout" (p. 7). He was initially eager, open-minded, avid, and caring in providing client services. He reported changing into an "extremely cynical, not-giving-a-damn individual" (p. 7). In addition, the employee described other concerns, including developing ulcers, consuming alcohol to sleep, taking tranquilizers, taking maximum sick leave, and viewing the employment setting as a mental health factory. Maslach and Leiter (1997) explained that the impact of burnout can be deadly and costly to the individual and is felt by everyone around that person at work and away from work. Maslach and Leiter wrote, "It can be detrimental to your health, your ability to cope, and your personal lifestyle" (p. 18).

Moreover, Maslach and Leiter (1997) indicated that the physical symptoms of burnout are headaches, stomach problems, hypertension, muscle tightness, and chronic, long-lasting feelings of tiredness. Mental health stressors that include feeling anxious and depressed and having sleep problems are also symptoms of burnout. Individuals suffering from burnout tend to retreat from their work psychologically and physiologically, spending limited time and effort on working, performing only those tasks that must be done, and missing work frequently. "High-quality work requires time and effort, commitment and creativity, but the burned-out individual is no longer willing to give these freely. The drop in quality and quantity of work produced is the occupational bottom line of burnout" (Maslach & Leiter, 1997, p. 19).

Self-care, which can be defined simply as an individual caring for himself or herself (U.S. Army for Health Promotion and Preventive Medicine, 1995), has also been

defined as “the range of health-related decision making and care undertaken by individuals on their own behalf” (Dean, 1989, p. 117). Self-care practices enhance wellbeing (Richards, Campenni, & Muse-Burke, 2010). Self-care includes physical, psychological, spiritual, personal, and professional support. Self-reflection, taking a break, and eating healthy foods are examples of self-care. Self-care as a subject is gaining popularity within helping professionals, and research has been conducted demonstrating the importance of self-care in helping professions (Alkema, Linton, & Davies, 2008; Baker, 2002; Carroll, Gilroy, & Murra, 1999; Mahoney, 1997; Dale, 2008; Norcross, 2000).

Norcross and Guy (2007) indicated that the ethical code for every mental health profession highlights the need for self-care. Barnett, Johnston, and Hillard (2006) and Carroll, Gillroy, and Murra (1999) addressed the importance of self-care as an ethical necessity and moral imperative rather than a personal issue for a psychotherapist. However, multiple reasons are provided for psychotherapists not conducting self-care activities (Norcross & Guy, 2007), with an emphasis on the needs of others surpassing theirs and the busy and demanding nature of the mental health profession. Pope and Vasquez (2005) reported that a psychotherapist’s goal must be to succeed in helping others by prioritizing his or her own self-care.

Social work is a profession for individuals who are committed to helping people address challenges in their lives. Social workers assist people with developing, coping, and problem-solving skills to address personal, family, relationship, and occupational concerns (Bureau of Labor, 2010; Dale, 2008). Social workers offer interventions that affect clients directly or indirectly and also serve in psychotherapeutic and counseling

roles. Thus, social workers are highly vulnerable to feelings of burnout. Kurland and Salmon (1992) addressed social workers' increased vulnerability to stress because of their sensitivity to the needs of others. In addressing the importance of self-care among social workers, Lewandowski (2003) described the negative consequences of failing to address personal needs, including feelings of depression and anxiety, stress-related ill health, feelings of anger with patients and colleagues, increased consumption of alcohol, and drug use.

Lewandowski (2003) explained that social workers experience frustration with feelings of isolation, powerlessness, decreased energy in working with clients and completing organizational requirements pertaining to high caseload assignments, lack of agency support, and time limitations with clients because of increased documentation. This study examined the relationship between self-care activities of social workers in medical, public health, and mental health settings and their reported feelings of burnout.

Problem Statement

Limited research is available on social workers in medical, public health, and mental health settings and self-care activities conducted in relation to their feelings of burnout. This creates a gap in the literature in the field of social work on the topic of specific self-care activities conducted to prevent and alleviate symptoms of burnout. This study was different from other studies previously completed, in that it provided information on specific self-care activities conducted by social workers as well as provided correlational data on the effects of self-care activities performed and reported feelings of burnout. Social workers from medical, mental, and public health settings were surveyed, adding demographic information and information pertaining to burnout and

self-care to the current literature. Using the National Association of Social Workers' (NASW) database to recruit social workers enabled information to be obtained on social workers with a wide variety of practice experiences, degrees, age, ethnicities, and other demographic information.

Figley (2002) and DeAngelis (2002) stressed the importance of self-care for social workers in burnout prevention. Chenoweth, King, and Lloyd (2002) alluded to the differences in the availability of research on burnout and self-care between the social work profession and other mental health and helping professions. The National Association of Social Workers (NASW; 2009) highlighted the importance of self-care practices conducted by social workers to the ongoing existence and continued growth of the social work profession. Despite challenges faced by social workers in the field of social work, the NASW explained that social workers who engage in self-care activities will remain in the profession.

Research Questions and Hypotheses

This study addressed the following research questions:

Research Question 1

What is the relationship between reported feelings of burnout among social workers who are employed in medical, public health, and mental health settings and their frequency of engagement in self-care practices?

Null hypothesis (H_{01}). There is no statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory (MBI), among social workers in medical, public health, and mental health settings and their

frequency of engagement in self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a1}). There is a statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory (MBI), among social workers in medical, public health, and mental health settings and their frequency of engagement in self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

Research Question 2

Is there a relationship between employment or practice setting (medical, public health, or mental health) and social workers' experience of burnout?

Null hypothesis (H_{02}). There is no statistically significant effect of employment or practice setting (medical, public health, or mental health) on social workers' experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a2}). There is a statistically significant effect of employment or practice setting (medical, public health, or mental health) on social workers' experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

Research Question 3

Are there differences in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation?

Null hypothesis (H_{03}). There are no statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities:

exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a3}). There are statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

Research Question 4

What is the relationship among social workers' practice setting (medical, public health, or mental health), years of practice, and reported feelings of burnout?

Null hypothesis (H_{04}). There is no statistically significant relationship among social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a4}). There is a statistically significant relationship between social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

Purpose of the Study

The purpose of this correlational study was to further understand how specific self-care activities and practice setting influence the experience of burnout in the population of social workers in medical, public health, and mental health settings. The sample was drawn from a list of members of the National Association of Social Workers.

Theoretical Base

The two main theories that guided this study were Orem's theory of self-care (Orem, 1991) and the theory of reasoned action and planned behavior (Ajzen, 1991). Orem (1991) posited that self-care involves activities solely initiated and performed by individuals for the maintenance of their well-being. Effective self-care performance maintains human functioning and contributes to human development. Self-care behaviors are learned and not only address necessities, but also create equilibrium among daily activities and stressors, rest, and relaxation. In addition, conducting self-care activities assists with the promotion and preservation of human life, functioning, and well-being. The nursing profession has applied Orem's theory of self-care. However, important concepts of self-care theory can be related to social workers in the profession as well as in this study. By applying Orem's theory of self-care to this study, I have sought to solidify and explain the importance of self-care among social workers.

The theory of reasoned action (TRA) by Ajzen (1991) was expanded to include planned behavior (TPB) and provides a set of explanations for the relationship between attitudes and behaviors (the theory of reasoned action and planned behavior). Behavior is posited to be the result of intentions, which in turn are based on attitudes and subjective norms. According to Fishbein and Ajzen (1975), subjective norms are individuals' thoughts of others' opinions about a specific behavior. The theories of reasoned action and planned behavior are the most widely researched theories related to understanding behavior changes (Fishbein, 1995). These theories can be applied to intentions and behavioral factors related to the performance of self-care activities by social workers in

medical, public health, and mental health settings. Both theories are described in detail in Chapter 2.

Nature of the Study

This correlational study improved understanding of factors that affect reported feelings of burnout and performance of self-care activities among social workers in medical, public health, and mental health settings. Burnout and self-care-related variables were examined in this study by using the Maslach Burnout Inventory Health Services Survey (MBI-HSS) and the Self-Care Assessment Worksheet (SCAW). Social workers employed in medical, public health, and mental health settings who were members of the National Association of Social Workers (NASW) were recruited for this study. Online survey methods were used via mindspring.com to collect data using the MBI-HSS, SCAW, and a demographics form.

Operational Definitions

Burnout: Burnout is defined as the "physical, emotional, and mental exhaustion caused by long term involvement in situations that are emotionally demanding and very stressful, combined with high personal expectations for one's performance" (Leatz & Solar, 1993, p. 116). Cooper, Dewe, and O'Driscoll (2003) emphasized the psychological strain encountered by human service professionals. Characteristics of burnout are negative self evaluation and attitudes about patients and decreased feeling of personal accomplishment (Maslach & Jackson, 1986).

Self-care: Dean (1989) defined self-care as an individual making health-related decisions and taking action about his or her health. Faunce (1990) explained that self-care involves individuals caring for themselves by engaging in physical, mental, and spiritual

behaviors. Behaviors and actions performed are highlighted as enhancing functioning of the holistic self, which includes an individual's mind, body, and spirit.

Assumptions, Limitations, Scope, and Delimitations

It was assumed that both the MBI (Maslach & Leiter, 1996) and SCAW (Saakvitne & Pearlman, 1996) accurately measure feelings of burnout and self-care activities (e.g., exercising, taking a vacation, and spending time with family), respectively. It was also assumed that the voluntary participation of study participants created no bias swaying the results of the study in any direction. Although obvious, the assumption that study participants truthfully answered the questionnaires is worth noting.

Limitations of this study pertain to the correlational nature of the study, as well as the self-report nature of the MBI and the SCAW. This study focused on the correlation between reported feelings of burnout and self-care practices by social workers in medical, public health, and mental health settings. Given that the study was one of correlation, causation was not used (Creswell, 2009).

Social workers who were members of the National Association of Social Workers (NASW) and who worked in medical, public health, and mental health settings were the only participants in the study. The results of this study cannot be generalized to other populations, as this study primarily focused on social workers in medical, public health, and mental health settings.

Significance of the Study

This study on the effects of self-care on social workers in medical, public health, and mental health settings contributed to the literature on social workers, self-care, and burnout. This study provided specific details on the types of self-care activities that are

most protective against burnout as reported by social workers in the various settings. The findings of this study indicated the need for tailored self-care interventions for social workers in the various settings. This information will be beneficial to both social workers and organizations in addressing the issue of burnout. Early detection of burnout-related symptoms is essential in helping professions to prevent full onset of burnout-related symptoms that is detrimental to the professional providing effective services to clients. This study may enable social workers to identify burnout-related symptoms and promote the importance of self-care to prevent burnout. Proactive measures can then be implemented to prevent burnout that benefit the organization, professionals, and clients served.

Summary

Reasons for burnout among social workers include lack of improvements in patients' conditions and reported helplessness by patients, low pay, high number of assigned cases, and lack of support from supervisors (Kostouros & McLean, 2006). Burnout has been addressed as a problem in numerous helping professions including nursing, medicine, ministry, social work, counseling, teaching, and emergency services. Burnout negatively affects helping professionals in all aspects of their lives with reported physical, mental, and psychosocial symptoms and concerns (Maslach & Leiter, 1997). Furthermore, Osborn (2004) noted the physiological and psychological challenges encountered by helping professionals due to occupational stress. A wide range of studies have been conducted on burnout and its effect on helping professionals, and causes of burnout have been explored.

This study is important in the field of social work because it will add to the literature on the relationship between reported feelings of burnout and performing self-care activities. The benefits for social workers in understanding this correlation are significant, in that they may become able to identify self-care strategies to prevent symptoms of burnout, improve their quality of life, and provide quality services to clients served. Kostouros and McLean (2006) clearly stated that no helping professional will complete his or career without conducting self-care activities. The results of this study will serve as a guide to social workers in medical, public health, and mental health settings as to the self-care activities conducted by study participants and their effects on reported feelings of burnout. As previously indicated, Orem's theory of self-care and the theory of reasoned and planned behavior were used to understand the effects of self-care and reported feelings of burnout. This quantitative research study has social change implications that address health promotion and saving lives, health related cost savings to organizations, and possible policy changes that will benefit clients, organizations, and social workers in the specified settings.

Transition Statement

Chapter 1 presented an introduction of the examination of a possible relationship between reported feelings of burnout and self-care activities conducted among social workers in medical, public health, and mental health settings. The research questions, hypothesis, purpose of the study, and theoretical constructs used in understanding social workers conducting self-care activities and their reported feelings of burnout are outlined in this chapter. Operational definitions of concepts, assumptions and limitations, significance, and social change implications are also addressed.

Chapter 2 will present a detailed literature review on the concepts of burnout and self-care in the field of social work and other helping professions. The literature review solidifies the importance of this study in the field of social work. In addition to literature on burnout and self-care and their relationship based on previous research studies, specific examples of self-care activities (e.g., mindfulness-based stress reduction, supervisory support, and meditation) that can be performed by social workers are addressed, along with their reported benefits. The theoretical constructs of this study are addressed in detail with background and applicable previous research studies. Chapter 2 concludes with addressing the methodology for this study. Chapter 3 expands on the methodological aspects of this study. The research design, sample characteristics, methodologies, and survey instruments are addressed. Chapter 4 provides information on the results of the study that highlights the data collection process, description of study participants and analyses of the data. Chapter 5 focuses on the interpretation of the study's findings as related to research questions and previous studies. It includes recommendations for actions and further study and implications for social change.

Chapter 2: Literature Review

Chapter Organization

This chapter presents an overview of professional literature and research on burnout and self-care in the helping professions. The effects of self-care on reported feelings of burnout among social workers are emphasized. This chapter begins with an introduction of the topics of burnout and self-care and their relevance to helping professions, followed by an outline of the research search strategy and an in-depth discussion of burnout and self-care concepts in other helping professions, including nursing, medicine, counseling, and education. Studies on the related topics of vicarious traumatization and compassion fatigue are reviewed, and detailed information is provided on the theoretical frameworks used to understand the various aspects of burnout and self-care. This chapter concludes with a summary of the key concepts.

Search Strategy

The concept of burnout has been researched extensively in studies on helping professions over the past decades. However, few studies are available on social workers' reported feelings of burnout and self-care activities. The literature search on this topic was extended to studies beyond the past 5 years to capture as much information as possible. Databases searched included EBSCO, PsycInfo, SocIndex, Psychology: Sage Collection, Health and Social Instruments, Academic Search Complete, and Expanded Academic Search Premier. Searches were conducted using a combination of key words, including *social workers* and *burnout, burnout, burnout* and *medical professionals, burnout* and *helping professions, self-care* and *helping professionals, medical social worker* and *self-care, social workers* and *self-care strategies, self-care strategies* and

medical professions, self-care among *therapists, self-care* and *psychologists,* and *self-care* and *mental health and public health social workers.*

A search for the term *burnout* yielded 2,150 articles, and 242 articles were found with the keywords *social workers* and *self-care.* Hundreds of articles were found pertaining to burnout in the medical profession, with an emphasis on nursing, medical doctors, and specialized therapists (occupational, physical, and respiratory). Within this topic, the literature included works concerning vicarious traumatization because this concept is often referred to in addressing burnout and self-care. Eleven articles were found with the terms *social workers* and *burnout*, and when specific social work roles like *public health social worker* were combined with *self-care* in searches, no results were found.

A combination of approximately 120 sources of references that included peer reviewed and general articles as well as books were included in the literature review pertaining to burnout among helping professionals. Over 50 articles were selected for inclusion in this literature review that pertained to self-care among social workers and other helping professionals. The remaining 45 articles mainly covered other aspects of research pertaining to this topic. The selection of articles for inclusion in the literature review was based on the following criteria: ideally less than five years old but based on topics less than 8-10 years old, mainly from peer-reviewed journals, covering the topics of burnout or self-care related information in depth, providing full-text information, and written by reputable authors regarding the topic.

Burnout

Burnout is a term for a work-related syndrome that is often used to refer to occupational stress and discomfort. Burnout continues to be a significant problem for various organizations and professions (Ayers, 2006), as the need for helping professionals continues to rise for programs and services supported by federal and local funding. These programs and services (e.g., behavioral health services for adults and children) help individuals, families, and groups with their identified needs (Ritchie, Kirche, & Rubens, 2006). Specifically, human-services workers in bureaucratic organizations face burnout as a result of increased work stress, feelings of worker isolation, and an environment in which worker skills are minimized (Arches, 1991).

The concept of burnout has been comprehensively researched by numerous authors in various fields and practice settings. Freudenberger (1974) coined the term *burnout* and described it as "a feeling of exhaustion, fatigue, being unable to shake a lingering cold, suffering from frequent headaches and gastrointestinal disturbances, sleeplessness, and shortness of breath" (p. 160). This definition addresses the physiological symptoms of burnout, while Maslach (1986) defined *burnout* with an emphasis on emotional exhaustion, depersonalization, and reduced personal accomplishment. Addressing human service professions, Bakker and Heuven (2006) defined *burnout* as a "specific kind of occupational stress reaction among human service professions, resulting from demanding and emotionally charged interactions with recipients" (p. 425). Deutsch (1984) and Barnett et al. (2005) alluded to therapists reporting alcohol problems. A therapist experiencing the negative symptoms of burnout can lose commitment and focus in being a therapist. Additional physical and

psychological symptoms of burnout were reported by Farber (1982) and Raquepaw and Miller (1989), including ongoing feelings of fatigue, ulcers, insomnia, hypertension, headaches, lasting colds, gastrointestinal problems, and relationship problems that include interpersonal conflicts with friends, family, and loved ones. Cherniss (1980) indicated that professionals in the early stages of their careers are affected by burnout and often lose their sense of idealism about the profession, report decreased trust in others and their capabilities, and express decreased sympathy for clients.

The negative effects of burnout on organizations were noted by Halbeslaben (2006) as decreased work performance, organizational commitment, creativity, and innovation. Increased turnover and high burnout-related health-care costs have been reported as major concerns with burnout in organizations. Professionals with symptoms of burnout are prone to cause more harm to clients, creating increased negative symptoms for clients than they had when they sought therapeutic intervention (Maslach & Leiter, 1997). Although not all employees report symptoms of burnout, Van Dierendonck, Garssen, and Visser (2005) reported that employees who demonstrate the strongest levels of motivation and involvement in their work are vulnerable to burnout. Understanding the effects of burnout and the importance and benefits of self-care is essential to organizations having healthy and productive workforces that successfully address the needs of clients.

Ewalt (1991) indicated that important characteristics for human-services organizations are personnel quality and effectiveness. In helping professions, employee engagement is key to addressing clients' needs. Addressing problems associated with employee dissatisfaction and stress in the workplace enhances employee engagement

(Freeney & Tiernan, 2006). Maslach (2001) cited job turnover, absenteeism, and intention to leave current employment as negative consequences of burnout that affect employee performance. Additional negative health consequences include feelings of depression, anxiety, decreased self-esteem, and substance abuse. The negative effects and consequences of burnout indicate the importance of helping professionals taking active steps to address their personal needs and their need for self-care to prevent burnout-related symptoms. As Norcross (2000) noted, therapists must recognize the hazards of psychological practice and conduct self-care practices to maintain their professional and personal well-being.

Carroll et al. (1999) outlined four main domains of self-care that are addressed in detail later in this chapter: intrapersonal work, interpersonal support, professional development and support, and physical and recreational activities. In addition, Coster and Schwebel (1997) indicated that multiple self-care activities including being aware of one's actions; tracking activities; receiving assistance from friends, supervisors, and other colleagues; and balancing life events all address feelings of burnout. Self-care activities and specific examples provided can be categorized based on activity performed. Kostouros and McLean (2006) explained that self-care is invaluable to helping professionals, because the professional's ability to help others depends on that professional's ability to deal effectively with personal issues in his or her own life. Doing so leads to maximum therapeutic benefits for the client population served.

Social Work Practice Overview

Bureau of Labor (2010) reports have indicated that social workers assist people with developing coping and problem-solving skills to address concerns related to

personal, family, relationship, and occupational issues. In addition, social workers work with vulnerable populations to address various physical and mental illnesses; provide psychosocial support services to individuals, families, groups, and communities; and offer monitoring, evaluation, and consultation services. The social work profession is unique in its multidisciplinary approach to addressing complex social problems. Rose (2003) noted that social work is considered to be one of the most rewarding jobs. Social workers have indicated gaining much satisfaction from their work with clients; they are highly committed to their work and strongly believe that they are able to stimulate change among their patients (Eborall & Garmeson, 2001; Huxley et al., 2005).

Whitaker, Weismiller, and Clark (2006) and the National Association of Social Workers (NASW, 2009) added that the social work profession offers members a unique combination of difficult situations to address, which can be overwhelming but gratifying. Furthermore, Whitaker et al. identified some stressors in the field of social work, including long working hours, deadlines and time pressures, enormous case loads that are challenging professionally, inadequate and limited resources, low pay, safety issues and concerns, and ongoing crises and emergencies. Graham and Shier (2010) also reported low morale, burnout, and high turnover as negative aspects of the social-work profession.

Self-Care in Helping Professions

There are multiple definitions of self-care that focus on activities individuals perform to promote rest, relaxation, and well being. Dean (1989) defined *self-care* as "the range of health-related decision making and care undertaken by individuals on their own behalf" (p. 117). The U.S. Army Center for Health Promotion and Preventive Medicine (1995) defined *self-care* as involving an individual caring for himself or herself. Further,

the World Health Organization (1983) defined *self-care* as actions conducted by persons and groups intending on accomplishing health promotion and restoration, disease prevention, and minimizing sickness. Orem (1991) described self-care as ongoing activities that adults begin conducting for the purpose of maintaining their lives, healthiness, and welfare. Finally, McGowan (n.d.) noted that self-care activities can be performed without receiving specialized support and that the activities conducted are based on practical expertise from skilled and nonskilled experiences.

The topic of self-care is often addressed among helping professionals, but the meaning and implications are not always clarified. Richards et al. (2010) indicated that self-care practices enhance well-being and noted that the various categories of self-care include physical, psychological, spiritual, personal, and professional support. Filaroski (2001) noted that counselors must have support to continue caring for others. As a pastor in Florida (Filaroski, 2001) stated, "People in the helping professions need to engage in self-care, or their wells go dry" (p. A1). Dale (2008) stressed the importance of self-care by questioning the amount of help social workers can provide clients if their individual self-care has not been a priority and they are experiencing feelings of being stressed, ill, or fatigued.

Hooyman and Kramer (2006) emphasized that self-care is individually based and is developed based on an individual's "needs, beliefs, interests, lifestyle, and spirituality" (p. 355). They reported that social workers frequently encounter challenges pertaining to the institution and often face organizational and institutional barriers and demands, noting that these professionals need to engage in self-awareness and self-care strategies to be of service to their clients and help themselves. Social workers working with disadvantaged

individuals are in critical need of self-care practices (NASW, 2009). Figley (2002) reported that psychotherapists who work with chronically ill patients tend to disregard their self-care needs when focusing on the needs of patients. Carroll et al. (1999) stated that "therapist self-care must be viewed not only as an ethical principle, but as a moral imperative" (p. 134). Richards et al. (2010) further stressed the ethical importance of self-care in the mental-health profession by stating, "Because mental health professionals are susceptible to impairment and burnout that may negatively affect clinical work, it is ethically imperative that they engage in self-care" (p. 1). This study adds to existing knowledge on the relationship between burnout and self-care by providing specific information from social workers on self-care activities used to alleviate symptoms of burnout. This information highlights the importance of social workers performing self-care activities to prevent symptoms of burnout and ensure that their patients receive quality services from them. Profitt (2008) explained that ethical practice requires helping professionals to monitor "their physical, psychic, and spiritual state to ensure the provision of competent and adequate services to clients" (p. 149). Finally, Brenn (2011) reviewed the various codes of ethics of mental-health professionals and related them to the importance of practicing self-care as part of preventing harm to patients.

Carroll et al. (1999) reported that self-care is the integration of the psychological, mental, and spiritual aspects of life that serve the three functions of (a) reducing burnout, (b) promoting positive display of self-caring that creates well-being for both clients and therapists, and (c) protecting clients from therapist ethical violations in which therapists do not practice according to their code of ethics, which serves as a guide for practice with clients. Helping professionals assessing themselves to determine their mental state to

continually provide services to clients was addressed by Profitt (2008), who expressed that ethical practice requires helping professionals to monitor "their physical, psychic, and spiritual state, to ensure the provision of competent and adequate services to clients" (p. 149). Furthermore, Mahoney (1997) indicated that individual self-care includes maintaining health through healthy eating, working out, and addressing personal cleanliness. Examples of self-care activities outlined by Mahoney and Kelly et al. (2010) include participating in recreational activities, taking vacations, pursuing hobbies, engaging in personal psychotherapy or meditation, practicing self-reflection, and engaging in other health-promoting activities. McCormack (2003) explained that self-care behaviors are chosen by people to sustain positive living, prevention strategies related to being injured and ill, and health promotion. These self-care activities enable individuals to add to their understanding of conducting several life's tasks pertaining to continued existence and reaching their full potential.

Moreover, Coster and Schwebel (1997) stressed the importance of self-care in the professional functioning of a helping professional over time amid both personal and professional stressors. Norcross and Brown (2000) encouraged therapists to conduct self-care activities regardless of their theoretical orientations. According to Baker (2002), critical components of self-care include having self-awareness and regulation and maintaining balance. Self-awareness enables therapists to recognize things they require and challenges to promote them in their personal and professional lives. Self-regulation involves managing conscious and less cognizant physiological and feeling-oriented actions, anxious feelings, and thoughts. Maintaining balance pertains to keeping a positive relationship among oneself, other people, and the world at large. Faunce (1990)

reported that therapists experiencing a state of wellness tend to have high self-esteem, personal power, and a sense of self as a unique individual.

Collins (2005) summarized the importance of self-care in the field of social work by stating that establishing and maintaining regular self-care habits will create and reserve needed energy to address intense and challenging issues. Engaging in self-care activities enables social workers to be effective in their various roles as spouses, friends, and colleagues (Collins, 2005). Collins also indicated that social workers are responsible to be physically and mentally capable through self-care of addressing the needs of patients. Furthermore, embracing spiritual practices and values can create inspiration, reverence, awe, meaning, and purpose in a divine power (Baldacchino, Donia, & Draper, 2001; Case, 2001; Ramsey, 2001). Spiritual practices have been noted as creating a sense of harmony with the universe and providing focus in times of emotional stress (Ramsey, 2001). Collins stated, "Inattention to self-care results in emotional depletion and a lack of energy to problem solve in a purposeful manner" (p. 264).

Harris (2002) explained that spiritual self-care teaches individuals how to progress when "reason and resources" (p. 266) have failed. Hooyman and Kramer (2006) described several categories of self-care, including physical, psychological, emotional, spiritual, and workplace or professional and explained that professionals with multiple caregiving roles, for example, being a mother, a volunteer, and a social worker, may find significant benefits in the effects of therapeutic massages and other healing interventions. In addition, Collins (2005) expressed full support for spirituality being an aspect of self-care and offered six strategies for spiritual self-care that help in embracing strength and love from within, are practical, decrease stress and anxiety, and provide practitioners with

solutions to stress and burnout that are feasible and attainable. The six strategies include keeping the Sabbath, finding holy silence, expressing gratitude, expressing spiritual essence, developing a sense of compassion, and embracing a principle of stewardship. Collins noted that standard Christian living involves love of self and love of others.

In addressing the effect of self-care, Barnett et al. (2005) explained that performing self-care activities prevents, disrupts, reverses, and minimizes therapists' burnout-related symptoms and other impairments. The negative effects of stress are prevented through self-care (Brucato & Neimeyer, 2009; DeAngelis, 2002). This study provided information and highlighted specific self-care activities utilized by social workers. This added to the current literature on burnout and self-care, particularly among social workers in medical, public health, and mental health settings. Therapists' lack of self-care will render them unable to address the needs of clients, relatives, and others in need (Baker, 2003). Further, Profitt (2008) reported that self-care enables professionals to maintain positive energy, enhances empathy for patients, and helps professionals embrace the transformation process of patients. In addition, Saakvitne and Pearlman (1996) recommended that the stressors in the field of social work should be used as motivation for social workers to initiate self-care activities. However, as responsibilities and stressors increase for social workers, many tend not to initiate self-care activities but continue to work to benefit others.

The NASW (2009) stressed that self-care practices conducted by social workers are important to the ongoing existence and continued expansion in the field of social work. Social work professionals are directed to seek appropriate interventions if mental-health concerns and personal problems are identified because they can affect the well-

being and interest of clients. The NASW (2009) stressed that social-work professionals engaging in self-care practices will remain in the profession despite challenges.

> NASW supports the practice of professional self-care for social workers as a means of maintaining their competence, strengthening the profession, and preserving the integrity of their work with clients. Education, self-awareness, and commitment are considered key to promoting the practice of professional self-care. (NASW, 2009, p. 270)

Depression, suicide, substance abuse, sexual misconduct, burnout, and relational problems can be significant issues for professionals that provide limited and ineffective individual self-care to address workplace related stress (Brady, Guy, & Norcross, 1994). As Baruch (2004) noted, challenges and issues encountered by professionals in therapy-related professions include depressive feelings, minimal anxious states, relationship problems, and emotional exhaustion. Therapists are encouraged to practice self-care activities that they encourage their clients to perform. Setting priorities, using assistance from others, and creating time for cure are all preventative measures to combat burnout (Baruch, 2004). According to Pope and Vasquez (2005), although multiple self-care strategies can be used, helping professionals must select and use self-care activities that best meet their needs, recommending that multiple self-care strategies be explored to identify, select, and perform appropriate self-care strategies.

Baruch (2004) noted several important questions therapists must ask themselves, including "(1) Am I personally doing what I'm helping others to do? (2) How am I attending to signals from all aspects of my being and life? (3) Is vertical growth important to me personally?" (p. 85). He further reported that therapists, who engage in

helping others without significant stressors and no burnout-related symptoms, engage in these behavioral steps, seek help, reduce client load, and focus on relaxation, such as taking vacations and engaging in stress-reducing activities (Baruch, 2008). Finally, Norcross (2000) identified 10 self-care strategies that he asserted are practitioner tested and research informed. They included recognizing the hazards of psychotherapy practice, emphasizing strategies to increase self-care practices rather than techniques or methods, starting with self-awareness and self-liberation, using multiple self-care strategies with diverse theoretical orientations and using stimulus control and counter conditioning, fostering supportive relationships, focusing on doing and avoiding personal self-blame, working with a diverse population group, and appreciating rewards. According to Norcross, therapists' useful and beneficial use of self-care strategies involves behavioral, experiential, psychodynamic, and systematic traditions.

Burnout Further Defined and Explained

Burnout was previously defined earlier in this chapter. However, additional definitions are provided in this section to present comprehensive information on the definition of burnout and the various viewpoints of authors. Although worded differently, all definitions of burnout address occupational stress that leads to physical, mental, and emotional consequences. Killian (2007) explained that burnout is a slow process that occurs over time because of increasing work-related stressors and, because of burnout, the individual expresses a no-win situation. Moreover, Schaufeli, Maslach, and Marek (1993) added that burnout has the possibility of triggering mental and emotional pain that is a slow and intricate process. There is no specified beginning but a steady change in level of operating together with degrees in symptoms. Jenkins and Baird (2002) defined

burnout as "a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and inadequate support" (p. 424). Wright (2003) reported that burnout results when workers from human service fields are dedicated to their work and have impractical goals, which causes them to experience decreased motivation and limited interest pertaining to clients and themselves.

Katz, Wiley, Capuano, Baker, and Shapiro (2005) explained that the term *burnout* describes disturbances that are based on occupational and individual stressors, occupational unrest and uncertainties, as well as mental and physiological fatigue. Furthermore, burnout creates relational challenges, physiological symptoms, habitual actions, limited output and negative feelings. Prolonged exposure to stress can result in burnout, which leads to a decrease in the value of services extended to patients (Maslach, 2003). In addition, Hannigan, Edwards, and Burnard (2004) stated that stress has many consequences, including job burnout, increased staff turnover, absenteeism, low morale, and reduced efficiency and performance. According to Hudson (2005), burnout causes people previously dedicated to their employment to be less motivated with less attention to activities."Sufferers face physical, emotional, and mental exhaustion, a sense reduced personal achievement and a lack of concern for customers and clients" (Hudson, 2005, p. 2). Moreover, Maslach and Leiter (1997) stated that frustration and anger are emotional hallmarks of burnout, together with fear and anxiety. General signs of burnout include low morale, absenteeism, tardiness, decrease in average length of stay on a job, high turnover, increased accidents on the job, and poor performance (Pines, 1993). In the field of mental health, burnout involves emotional exhaustion among workers that causes mental and physical problems and other illnesses (Freudenberger, 1974; Maslach, 1986;

Sturgess & Polsen, 1983). Individuals with high levels of commitment to their work are considered candidates for burnout (Faber, 1983).

Symptoms and Effects of Burnout

Burnout has physical, cognitive, emotional, and behavioral symptoms. Lambie (2006) outlined that physical symptoms of burnout include low energy, chronic fatigue, and weakness. Cognitive symptoms of burnout include stereotyping of patients and their various situations, depersonalization, cynicism, negative attitudes towards clients, work, and the individual self. Emotional symptoms of burnout include feelings of helplessness, hopelessness, and entrapment. Behavioral symptoms of burnout include absenteeism, changing jobs, and leaving the profession (Lambie, 2006). In addition, Bowie (2008) identified three categories of burnout: physical, behavioral, and psychological or emotional. Physical signs of burnout include low energy, decreased overall health, sleep disturbances, and psychosomatic illness. Behavioral signs of burnout include increased chemical abuse (coffee, alcohol, and tobacco), isolation from service users, increased nonproductive work, decreasing occupational and individual relations, and limited decision making abilities. Bowie (2008) added that psychological signs of burnout include irrational thinking, withdrawal, increased critical and cynical outlook, loss of sense of humor, and rigidity in thinking. Interpersonal or clinical and spiritual dimensions of life are two additional dimensions of burnout. Interpersonal or clinical dimensions include inability to concentrate with clients, withdrawal from clients and coworkers, and dehumanizing or intellectualizing clients. Spiritual dimensions include the absence of assurance the purposefulness of life, feeling estrangement and alienation;

hopelessness; and changes in core values, beliefs, and connections with others (Grosch & Olsen, 1994; Kahill, 1988).

Espeland (2006) explained that problems relating with others can be attributed to emotional exhaustion, making communication with family members, friends, and coworkers challenging. Symptoms include hostility; outbursts; paranoia; and withdrawing and losing compassion and empathy for friends, family members, and coworkers. Fauber (1990) indicated that individuals respond to burnout in the following three ways. First, they respond to frustration by working harder and valuing their professional successes. They frequently disregard their individual needs and necessities; increase their workload in an effort to accomplish occupational plans. Second, individuals quit or give up when faced with significant challenges. Professional obstacles, according to Fauber (1990), are overwhelming to such individuals; thus, they terminate their involvement with the task prior to using alternative plans. Third, burnout causes some individuals to have low productivity. Individuals encounter the following burnout symptoms: limited deciding capabilities, increased work absences, declining work focus, and relational problems with coworkers and individuals being served (Maslach, 1978; Shapiro, Brown, & Biegel, 2007; Soderfelt et al., 1995).

Burnout Among Mental-Health Professionals and Nursing

Burnout has been researched among nurses and mental health professionals that include therapists, social workers, psychologists, and counselors due to the demanding nature of their jobs and increased exposure to clients. Therapists play an intimate role in the lives of patients and are particularly at risk for burnout (Valente & Marotta, 2005). The literature on burnout among therapists indicated a significant lack of systematic

study on self-care among therapists; lack of applying psychological principles, methods, and research for therapists; and therapists reporting feelings of shame related to being impaired in their work (Baruch, 2008). Burnout-related organizational factors include huge amount of cases, in adequate resources, extensive work hours, servicing challenging populations in difficult life circumstances, for example alternative child placements (Dane, 2000) and chronic health conditions (Stoesen, 2008; Sormanti, 1994). Bride (2007) noted that therapists listening to clients' traumas in the therapist-client relationship can lead to burnout-related symptoms, secondary stress, and vicarious traumatization. Furthermore, Maslach and Goldberg (1998) noted that counselors' qualities of selflessness in prioritizing clients' needs, extensive work days, and assisting without limitations, make them highly susceptible to symptoms of burnout. Pope and Vasquez (2005) explained that burnout causes therapists to "begin trivializing, ridiculing, or become overly self critical about work and see their role as a therapist a charade" (p. 14).

As Leyba (2009) explained, in the long run burnout can negatively impact social workers' emotional state and lead to a decline in outcomes. In addressing school social workers, Leyba (2009) stated, "To remain effective, efficient, and healthy school social workers must be able to combat overload and work toward balance in their roles" (p. 219). In addition, Stoesen (2008) reported that burnout often affects social workers and causes physiological and mental problems that enable workers to leave the field. Social workers most often affected by stress and burnout are those offering one on one services, particularly in settings related to healthcare and psychological needs. Lambie (2002) addressed the effects of burnout among counselors and explained that burnout can affect

their client relationship and rapport building capabilities, work requirements, and prevent them from addressing their self-care needs.

In addressing counselor wellness, Cummings, Massey, and Jones (2007) reported that it is imperative for counselors to increase their awareness of their vulnerability to distress due to the nature of their work. However, leading counseling theorists, such as Rogers, have reported difficulty in managing both client and self-care (Cummings et al., 2007). To prevent an early departure from the field, counselors need to utilize self-care strategies. In the field of nursing, Espeland (2006) reported that nurses described burnout as being overworked, frustrated, and emotionally derailed and having less productivity at work and home. According to Davies (2008), nurses have a unique position in providing care for patients, placing them in the middle of the patient/health-care relationship and causing them to spend more time with patients than professionals in any other discipline.

This section has addressed the current lack of detailed information on the self-care practices of mental health providers that includes social workers. Organizational factors that contribute to burnout among mental health professionals and other factors that affect the professional-client relationship were addressed. In the next section below, detailed information currently available is outlined. The lack of specific information utilized by social workers and other mental health professionals is highlighted and the need for more specific information is clear. The importance of self-care is outlined with multiple examples and benefits of different types of self-care activities that can be used by mental health providers to care for themselves and in turn provide quality services to the clients they serve.

Research on Self-Care Interventions and Strategies

Yager and Tovar-Blank (2007) noted that counselors must work mindfully and practice self-care to sustain individual wellbeing for their entire professional lives and to enable them to feel capable to address the needs of their clients. The research literature suggested several self-care strategies, including mindfulness-based stress-reduction programs (MBSRP), meditation, staff supervision, psychosocial work environment, self-reflectiveness, exercise, and amusement activities.

Guy, Poelstra, and Stark (1989) reported information on therapists who used self-care interventions to manage distress and avoid impairment, indicating that 70% of clinicians who reported distress responded to a corrective plan. Multiple self-care interventions were used, including reducing caseload, participating in family or marital therapy, taking leave, participating in self-help groups, using pharmacotherapy, and being hospitalized. Carroll et al. (1999) clustered self-care activities into four domains: intrapersonal work, interpersonal work, professional development and support, and physical or recreational activities. Examples of intrapersonal work include increasing self-awareness through individual psychotherapy, engaging in spiritual or consciousness raising activities, following personal morals and sustaining an equitable lifestyle. Interpersonal support involves sustaining positive relationships (spousal/intimate, friendship/collegial). Professional development and support are work-related activities, including attending continuing-education conferences, having a manageable caseload at work, and setting realistic goals at work. Physical and recreational activities are leisure activities not related to work: reading, exercising, and participating in hobbies.

Described below are self-care interventions used by professionals in helping professions and reported as beneficial in alleviating symptoms of burnout. These interventions are relevant to this study because information is provided concerning self-care strategies and interventions used by social workers and other helping professionals. Because the questions of this research study pertain to the types of self-care activities performed according to the social-work practice setting, these interventions exemplify research-based evidence in terms of usefulness and effectiveness.

Mindfulness-Based Stress-Reduction Programs (MBSRP)

Kabat-Zinn (2003) defined *mindfulness* as "paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (p. 145). Henry (2003) elaborated by explaining that achieving understanding and sensitivity involves practicing aspects of mindfulness that include being aware and present in the environment, being nonjudgmental, patient, and kind. MBSRP are effective in reducing and preventing stressors as well as enhancing the wellbeing in several health groups (Mackenzie, Poulin, & Seidman-Carlson, 2006). Furthermore, Baer (2003) and Grossman, Niemman, Schmidt, and Walach (2004) provided reviews and meta-analyses in support of mindfulness-based stress-reduction programs having major preventative effects among clinical populations including individuals diagnosed with terminal illnesses and behavioral health problems.

Mackenzie et al. (2006) conducted a small study among nurses and nurses' aides that involved developing and evaluating a short month long mindfulness intervention. Participants who received the mindfulness intervention reported noteworthy benefits with burnout symptoms, feeling relaxed, and satisfied with life. It is further stated that

mindfulness philosophy and nursing practice theory are well connected. Mindfulness training is indicated as potentially being beneficial for nurses to address occupational stress with limited time. Individuals in nursing careers should utilize this intervention for addressing the stressors related to the field as to promote positive wellbeing.

The effectiveness of mindfulness-based stress-reduction (MBSR) to be used as a strategy for therapist self-care was investigated by Shapiro et al. (2007). They explained that, through mindfulness practice, one can decrease individually based mental challenges that lead to unhealthy mood states. According to Shapiro et al., MBSR has been shown to decrease mental challenges and enhance positive health practices among professionals who encountered mental challenges overall and in health-care professions specifically. Receiving self-care training and conducting self-care activities are noted as actions therapists can take to prevent occupationally related psychological problems. Lynn (2010) also alluded to the importance of mindfulness and added that it can create opportunities for profound knowledge. Further, Birnbaum (2005) experimented using developing students their capabilities to develop self observation and awareness skills to be used in therapist and client interactions. Relaxation and both mindfulness and guided meditations were used. In a survey of mental-health professionals, Richards, Campenni, and Muse-Burke (2010) found that, mindfulness is a major intermediary between self-care and wellbeing.

Meditation

Kabat-Zinn (2005) referred to meditation as a cognitive exercise that enhances one's experience by quieting the mind and teaching recognition and control of intrusive thoughts. Meditation teaches individuals to respond to situations rather than being

reactive to them (Valente & Marotta, 2005). According to Oman, Hedburg, and Thoresen (2006), regular meditation has positive benefits that include "increased mental clarity, improved concentration, and the ability to withstand and repel the stresses of everyday life, and provide physical benefits" (p. 714). Baruch (2004) also alluded to the benefits of meditation, including providing social support networks and relationships; developing and clarifying personal values and ethics; enhancing self-awareness, self-monitoring, and altruism. In a phenomenological study, Valente and Marotta (2005) explored the effect of regularly practicing yoga in the personal and professional lives of psychotherapists. Themes identified included: individual knowledge and acceptance and equilibrium.

The benefits of meditation are essential to nurses and other health-care professionals throughout their careers as they deal with emergencies and their personal health. Meditative practices are therapeutic modalities that can be used as interventions for anxiety, stress, and compulsive behaviors. As Davis (2008) stated, "Mindful meditation can be that source of strength and rejuvenation to help prevent the insidious effects of stress and burnout" (p. 33). Those using meditative practice are encouraged to conduct meditation regularly for affirmative outcomes. Nurses are encouraged to use meditative programs that fit their lifestyle in terms of time and finances and to incorporate mindfulness into their practice with patients.

Clinical Supervision

Edwards, Burnard, Coyle, Fothergill, and Hannigan (2000) reported that using clinical nursing supervision proves to be an effective ways of supporting individuals in the field of nursing to address burnout and occupational stressors. Addressing health-care

professionals in general, Severinsson (1990) stated that supervision is helpful in assisting professionals during times of stress and increase their tolerance with clients. Counselors who work in a supportive environment and have positive interactions with other colleagues who encourage them to engage in self-care activities and promote manageable caseloads of clients experiencing trauma are less likely to encounter burnout (Cummings et al., 2007). Proper supervision is essential to provide counselors with the necessary checks and balances and to detect vulnerability to distress prior to a counselor's behaviors becoming unethical or developing into significant impairment (Cummings et al., 2007).

Psychosocial Work Environment

According to the World Health Organization (2014), decreasing occupational stressors to promote safety and better workplace environment is important. A psychosocial work environment (PWE) entails the human surroundings and environment in which nurses live, work, and have mutual relationships with colleagues and clients (Theorell, 2008). Nurses desire to offer valuable caring services to their patients to enhance positive outcomes, but they cannot do so successfully and the full potential of their care cannot be reached if the environment is uncomfortable and unhealthy (Tschudin, 1999). Bégat and Severinsson (2006) stated,

> A satisfactory PWE empowers nurses by offering them freedom to act and an opportunity to influence. It contributes to the well-being of the people working in the organization as well as to the application of nursing codes and values, both of which are achieved by improved cooperation. (p. 610-611)

Support

Collins (2008) noted that support is an important strategy employees use to cope with stress. Payne (1980) defined *support* as "the degree to which the environment makes available resources relevant to the demand made upon the system" (p. 284). Thompson, Murphy, and Stradling (1994) added that individuals use support by being in supportive relationships with others. Formal and informal are two categories of support in the field of social work. Formal support includes line management, supervision, and the appraisal system. Information support includes support received from both inside and outside the work setting, for example, family and friends. According to Carver, Scheier, and Weintraub (1989), individuals seek support for two reasons: for advice, assistance, or information, known as *problem-focused coping*, and for emotion-focused reasons. Furthermore, Lepore, Ragan, and Jones (2000) noted the benefits of talking about stressors include providing structure for resolving stressful experiences.

Employee Assistance Programs

Employee assistance programs (EAPs) are considered essential and common institutional resources in many establishments to promote health and emotional well-being, improve performance, and reduce absenteeism (Cooper et al., 2003; Stazewski, 2005; Ruiz, 2006). Coles (2003) attributed the increasing growth rates of EAPs to the issue of workplace stress. Although considered a tertiary intervention in stress management (Murphy, 1995), EAPs are effective in assisting employees address stressors, decrease work-related accidents, and minimize health-care costs (Ramanathan, 1992). Intervention strategies used by EAP personnel include individual and group counseling.

Self-Reflectiveness

According to Sanders (2009), *reflection* is a "metacognitive process that occurs before, during, and after a situation with the purpose of developing greater understanding of both the self and the situation so that future encounters with the situation are informed from previous encounters" (p. 685). Urdang (2010) explained that development of the professional self and foundation for maturation requires self-reflectiveness. Learning opportunities for students in the field of social work to develop self-reflectiveness include understanding psychodynamic theories, stressing self-awareness, using process recording to provide students directions with understanding their inner reactions and assisting the evolving process of the client-worker relationship. Utilizing other strategies that enable students to observe teaching and reflective opportunities are also beneficial (Urdang, 2010). Self-reflectiveness is a self-care strategy that "builds clinical competence, prevents boundary violations and burnout, and offers protection against client violence" (Urdang, 2010, p. 523).

Creative or Reflective Writing

Writing is an excellent approach for dealing with challenging incidents and situations and expressing feelings (Gladding, 2007; La Torre, 2005), achieving insight, changing, and healing (Schneider & Stone, 1998). Warren, Morgan, Morris, and Morris (2010) promoted creative writing for wellness, counselor self-care, and expressive writing about traumatic experiences as beneficial for both physical and mental health. In the field of medicine, particularly the medical education process, Wald and Reis (2010) reported that reflective writing "fosters the development of reflective capacity, extends empathy with deepened understanding of patients' experience if illness, and promotes

practitioner well-being" (p. 746). Reflection's objective is the enhancement of an individual's ability and understanding that creates continued growth, adaptation, and modesty (Epstein, 1999). Reflective writing is effective for individual based teaching in medical school (Charon, 2006; Shapiro, Kasman, & Schafer, 2006).

Self-Care Planning

According to Jones (2005), clinical staff members routinely develop care plans for their patients and encourage staff members to develop plans for themselves that provides effective equilibrium between individual and clients needs. Hospice workers are examples of using individualized self-care planning to relieve stress. Jones emphasized the importance of maintaining balance in output and input energies in professional and personal lives. Four aspects of self-care planning include physical, emotional or cognitive, relational, and spiritual. The physical aspect addresses where stress is manifested throughout the human body. "The most common areas are the neck and shoulders, followed by headaches and sleep difficulties, then gastrointestinal symptoms and exacerbation of existing medical conditions" (Jones, 2005, p. 126). Such physical exercise as walking, swimming, yoga, and strenuous aerobic workouts has been reported as commonly used by hospice workers to alleviate physical stress (Jones, 2005).

Crying easily is the most common red flag requiring intervention in the emotional or cognitive aspect of the self-care plan (Jones, 2005). Additional, crying should be encouraged as it is reported as needed and helpful. Hospice workers are encouraged to allow themselves to cry. Finding additional ways of expressing oneself, such as writing or engaging in other creative tasks, may be useful. Hospice workers commonly conduct

amusement activities including dancing, horseback riding, gardening, sailing, traveling, fishing, and socializing for stress relief (Jones, 2005).

Concerns in the relational aspect of self-care planning include creating distance in intimate relationships, irritability towards other people, and being overly involved or overly dependent in close relationships. According to hospice workers, supportive interactions with relatives and friends are beneficial to help with stress (Jones, 2005). Addressing the spiritual aspect of self-care planning for hospice workers, Jones (2005) stated "consists of some belief in something beyond the self, some way of making meaning of the world and life" (p. 128). Jones concluded that it is critical that hospice workers create and utilize individualized self-care plans. Doing so highlights proactiveness in using their abilities, reaching personal contentment, and minimizing work related stressors.

Guided Imagery

Stephens (1993) reported that imagery is a excellent source of healing. Imagery is described as using imagination to summon experiences using the various human senses. Toth et al. (2007) reported on the benefits of using imagery to decrease anxiousness and decrease health rate in medical patients. Orem (2001) explained that behaviors that constitute self-care have two orientations: internal and external. Internal orientation includes controlling the way an individual thinks, feels, and is oriented using action sequencing. Internally oriented self-care includes deliberate actions. External orientation is explained as purposeful actions conducted by an individual that has interactions with other people or other environments. Guided imagery is an internally oriented self-care

strategy that enables an individual to engage his or her imaginations and simultaneously listen to a story (Schmidt, 2008).

Reiki

According to Gallob (2003), one middle-aged retired counselor used reiki for stress reduction. *Reiki* is an energy-based healing modality with ancient roots. It involves a precise technique of healing energy through touch. It is considered beneficial positive health outcomes related to physiological and psychological health, and a strong connectedness and awareness of the spirit realm.

Self-Care Recommendations

Encouraging counselors to engage in self-care activities and avoid symptoms of burnout, Filaroski (2001) provided the following recommendations for self-care: talk about it; eat well; get plenty of rest and exercise; avoid excessive drinking and risky activities; engage in positive, relaxing, and soothing activities; and spend time with family. Furthermore, Meichenbaum (n.d.) described coping strategies to combat vicarious traumatization and promote self-care. Such strategies include being realistic in setting expectations for both the therapist and client, understanding that therapists make mistakes, using goals and subgoals achieved as accomplishments, using individual spirituality, and taking pride in one's work as a helping professional. As Michenbaum stated, "Remind yourself that you cannot take responsibility for the client's healing, but rather you should act as a midwife on the client's journey toward healing" (p. 15). In addition, Baruch (2008) emphasized the unrealistic nature of therapists reporting feelings of shame because of the challenges encountered in working with patients. Baruch reported that some successful therapists have functioned well for years after working with

distressed clients. Five important aspects of such therapists and their self-care methods are "balance, diversity, robust selves, empathy to self, and pro-activity" (Baruch, 2008, p. 87).

The lack of information on self-care activities performed by social workers in medical, public-health, and mental-health settings and their feelings of burnout is a significant gap in the literature. Social workers occupy positions in medical, public-health, and mental-health settings, and it is essential for information to be available on the effects of self-care in relationship to their work settings. Identifying the frequency with which self-care activities are conducted and the activities' effects on burnout will help determine the benefits and effects of self-care among social workers in the specified settings.

In the field of social work, there is currently no established self-care measure with psychometric details available. Saakvitne and Pearlman (1996) developed a checklist, the Self-Care Assessment Worksheet (SCAW), of self-care activities performed by social workers; the frequency of activities performed can be ranked on the checklist. No psychometric details are available on this instrument, so reliability for this study was established through test-retest procedures. Alkema, Linton, and Davies (2008) reported that the SCAW measures individual engagement in multiple activities in six domains. The six domains include; physical, psychological, emotional, spiritual, professional workplace, and balance. The information presented in this section emphasizes the importance of self-care among helping professionals. Although a plethora of self-care activities are available, knowing how helpful specific self-care activities are for social workers in particular is invaluable. Other social workers working in the specified settings

of social workers in the study will possibly be more apt to experiment with such activities. The following section presents information on burnout as it relates to helping professions. Current and previous research on the topic of burnout are summarized with the effects of burnout highlighted.

Burnout-Related Research in Helping Professions

Siebert (2005) indicated that burnout is often discussed and studied in helping professions and previous research on social work burnout had used qualitative methods with small samples. The only instrument used to measure feelings of burnout with a threshold score of 21 or higher is the Maslach Burnout Inventory (MBI). In a study that examined occupational and personal factors associated with burnout, Siebert used a cross-sectional mailed survey design to administer the MBI to 751 social workers providing services to patients. Siebert's findings indicated a 39% burnout rate at the time the study was being conducted and a 75% burnout rate projected throughout the social workers' life spans. Siebert concluded that researchers, practitioners, managers, and educators should actively seek to understand and address the influences of burnout among social workers.

Furthermore, Cohen and Gagin (2005) explored different levels of burnout among social workers who attended two types of skill-development groups. The skill-development groups varied based on social workers' experiences in hospital settings. Cohen and Gagin reported that limited studies were available on skill-development programs that focused on educating professionals concerning new interventions skills or for enhancing existing skills. The 25 study participants were from the Rambam Medical Center north of Israel. Participants completed demographic information, including their

level of seniority, and the MBI. They completed the questionnaires prior to starting the group programs and one month after completing them. The study results indicated that feelings of personal accomplishment rose by 12.39% and depersonalization decreased by 29.75%. Cohen and Gagin reported that the findings were in accordance with previous research on the benefits of employee training interventions.

Evans et al. (2006) examined burnout, job satisfaction, and stress among 610 mental-health social workers in England and Wales. A postal survey that included the MBI, the Karasek Job Content Questionnaire, and a job satisfaction measure was used. The study results indicated high levels of stress, emotional exhaustion, and decreased job satisfaction. Evans et al. concluded that employers must value the services provided by mental-health social workers.

In addition, Lee, Cho, Kissinger, and Ogle (2010) used cluster analysis and the Counselor Burnout Inventory to identify the burnout types of professional counselors. Convenience sampling procedures were used and 170 research packets were initially distributed at a state conference in the U.S. Only 132 packets were used in the analysis due to incomplete data on the others. Counselors have diverse backgrounds and years of experiences ranged from 1-33. Women comprised most of the sample population (83.3%), and Caucasian was the dominant ethnicity (94.7%). The results revealed counselors fell into three groups: well-adjusted, persevering, and disconnected. Lee et al. concluded by stressing the importance of designing strategies devoted to preventing and alleviating counselor burnout.

Priebe, Fakhoury, Hoffmann, and Powell (2005) assessed morale, group characteristics, work contentment, and burnout in mental health professionals and nurses

in community mental health settings in Europe. Group comparisons were conducted to determine whether personal characteristics, work setting, and professional group predicted morale and to identify challenges and stressors participants considered important to their work. Participants included 189 professionals, with at least 35 participants from each group. The following scales were administered: a job satisfaction scale, a team identity scale, and the MBI. The study results revealed that the burnout scores for social workers in London exceeded the threshold and that employment in London envisioned high burnout and lower work contentment and group characteristics. Psychiatry envisioned increased group characteristics, and educational background and employment setting predicted burnout and employment contentment. Responses to open-ended questions pertaining to challenges and stressors revealed that participants enjoyed direct practice with patients and disliked bureaucracy. Priebe et al. concluded that burnout is a problem for some professions but not for all. This study stressed that social workers in London reported low morale, so further research was needed to understand the perceptions of mental-health professionals concerning their work.

Mackenzie et al. (2006) noted the shortage of nurses in the United States and indicated a possible worsening of the situation. Growing concerns for nurses and the effects of burnout as they care for patients and work in health-care institutions were addressed by Aiken, Clarke, Solane, Sochalski, and Silber (2002). Factors related to the shortage of nurses, according to Aiken et al., include unrealistic workload in perioperative settings and nurses being on call. These factors were linked to the possibility of increased absenteeism and high rates of burnout. The job dissatisfaction rate for nurses was noted as being 4 times higher than for the average U.S. worker. To

cope with stress and burnout, nurses often call in sick, and the increased turnover rates compromises patient safety (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007). Furthermore, Espeland (2006) indicated that nurses often feel overwhelmed and overworked due to competing demands for their time. For nurses, the following are signs of burnout: constantly feeling frustrated, feeling emotionally drained, feeling less productive, feeling cynical, and having changes in performance from doing a great job to just getting by. Aiken et al. specifically stated that burnout is a global phenomenon in the field of nursing and it affects nurses worldwide in every area of practice. In addition, Graham (1999) indicated that burnout is prevalent among nurses in academia and management because of pressure to conduct research, publish, perform community service, conduct didactic presentations, and be active in clinical practice.

Shanafelt (2011) addressed the important roles of medical personnel in health care systems. Caregivers providing excellent services are dependent upon them being engaging, qualified, concerned, as well as the group work well together to the benefits of patients. Shanafelt, Sloan, and Habermann (2003) reported that increasing evidence suggested that medical staff that include both doctors and nursing personnel are encountering significantly high burnout displeasure and other occupational stressors. Thus, the providers of care were sick themselves. Contributing factors and causes to the problem included increasing productivity requirements, decreasing reimbursements, bureaucracy and regulation, less time with patients, limited time allocated to continued training, excessive work hours making it difficult to balance work and personal life, and frequent night calls.

Furthermore, in the United Kingdom, Edwards et al. (2000) noted that community mental-health nurses (CMHNs) experienced substantial occupational stress and burnout. Seven of the 17 papers addressed issues related to stress and burnout for all community mental health teams (CMHT). The results indicated that personnel that work on the CMHTs experienced high occupational stress and burnout. Stressors related to CMHNs included inappropriate referrals, increasing workloads and administration, time management, unclear roles and uncertainty, limited guidance, National Health Service reforms, and lack of funding and resources.

Hyman et al. (2011) reported on the increasing nature of burnout among physicians and nurses. They evaluated burnout risk factors among medical personnel in one perioperative unit. The aim of the study was to quantify work related burnout, identify risk factors, and identify essential factors to improve work satisfaction and coping with other occupational stressors. Eligible participants ($N = 250$) included nurses, surgeons, anesthesiologists, scrub technicians, and other non-degreed clinical staff. The web survey comprised a form for demographic information, modified MBI-HSS, and the Social Support and Personal Coping Survey. Hyman et al. (2011) conducted the surveys from February to July 2007, and 145 surveys were completed. Physicians constituted 46.2% of the respondents (22.8% residents) while 43.4% were in the field of nursing, and 10.3% were other personnel. Age and sex were adjusted and residents' scores were higher than other staff. Particularly in these areas; global burnout score, emotional exhaustion, and depersonalization. Compared with nonphysicians, residents' scores were higher than the established $p < 0.05$ level in all cases. Residents also had higher health and workload values than physicians. Hyman et al. (2011) concluded that physicians

(particularly residents) had the largest global burnout scores, indicating increased risk of burnout. They report that "improving overall health, increasing personal support, and improving work satisfaction may decrease burnout among perioperative team members" (Hyman et al., 2011, p. 194).

Burnout in the medical profession is an international phenomenon, and a host of studies have been conducted addressing the prevalence of burnout among medical professionals. Camps et al. (2009) evaluated the incidence of burnout and the weight of sociodemographic variables, background, and consequences involved in the process among medical oncologists affiliated with the Spanish Society of Medical Oncology. A scale of demographic variables and three scales of the medical professional burnout questionnaire were mailed to eligible participants ($N = 795$). In response, 200 were received, and statistical analyses were conducted using the completed questionnaires. Camps et al. reported that participants demonstrated increased burnout levels in exhaustion and loss of expectations. Time pressure and social deterioration were the background elements that explained burnout syndrome the most. The authors concluded by highlighting the importance of creating burnout prevention strategies in the field of medical oncology.

Physician burnout and related causes were addressed by Devalk and Oostrom (2007). Causes included personality characteristics of being committed and a perfectionist; a demanding workload, with the physician having limited control resulting in long working days; lack of self-care; and limited time for personal lives and home environment. Consequences of personal and professional burnout included decreased job satisfaction and empathy for patients, increased medical errors, substance abuse, and

depressive feelings. Solutions to physician burnout included stress and self-management, early recognition, changing working conditions and policies, and using support programs (De Valk & Oostrom, 2007).

Compassion Fatigue and Vicarious Traumatization Related to Burnout

Compassion fatigue or secondary traumatic stress is a form of caregiver burnout (Figley, 2002). Joinson (1992) first used the term *compassion fatigue* in referring to nurses working at emergency rooms and feeling worn down by the daily emergencies. Figley (1995) focused the definition of *compassion fatigue* on adverse reactions encountered by helpers in assisting trauma survivors. Furthermore, Panos (2007) defined *compassion fatigue* as "a set of symptoms experienced by caregivers who become so overwhelmed by the exposure to the feelings and experiences of their clients that they themselves experience feelings of fear, pain, and suffering" (p. 1). Killian (2007) added to the definition of *compassion fatigue* by stating that it is ongoing exposure to the distress of others, without the ability to create positive change or relieve the distress. Reported feelings and behaviors included having less empathy and decreased engagement with clients and over diagnosing and minimizing severity.

According to Macchi, O'Conner, and Garrett (2008), the difference between compassion fatigue and burnout is that the first has rapid onset of symptoms and is more pervasive than burnout. Symptoms of compassion fatigue are as follows: feelings of helplessness, shock, confusion, and isolation. In addition, individuals report feeling disconnected from the real causes of feelings. Stamm (1999) stated that *compassion fatigue* and *secondary traumatic stress* are frequently utilized in place of each other with *vicarious traumatization* (VT). However, VT is indicative of a lasting stress response.

Figley (1995) reported, to limit compassion fatigue, psychotherapists with chronic illnesses need to develop methods for enhancing satisfaction and learning to separate from their work emotionally and physically to feel renewed.

Vicarious traumatization (VT) is the negative effects of caring for others with an emphasis on the helping professional re-experiencing the reported trauma of the client. VT is different from burnout in that VT may exacerbate burnout symptoms (Pearlman & Saakvitne, 1995). According to Hatfield, Cacioppo, and Rapson (1994), VT occurs when psychotherapists catch the emotions of the clients they serve. Mahoney (2003) reported that, in VT, clients' voices and stories become part of the daily lives and dreams of therapists and cause changes in therapists. Furthermore, Meichenbaum (n.d.) reported VT sufferers feel overwhelmed, drained, overloaded, and burned out and experience guilty feelings from being present, feeling ashamed, and self-doubt. Therapists' behaviors related to VT include difficulty maintaining professional boundaries with clients, numbness, staying busy, and avoidance of clients with traumatic experiences. Cognitively, therapists with VT question their competence, lose hope, become pessimistic and cynical, and become preoccupied with clients' stories and experiences outside the workplace. Meichenbaum concluded by outlining the following work related factors of VT: work dissatisfaction, increase work absences, decreased confidence, and increased work turnover. The American Counseling Association Task Force on Counselor Wellness (n.d.) indicated that mental-health workers are prone to impairment due to VT, compassion fatigue, and burnout-related symptoms. *Impairment* is defined as negative consequences in professional functioning that threaten or can potentially harm clients.

Kessler, Sonnega, Bromet, and Nelson (1997) discussed the inevitability of individuals encountering traumatic experiences and indicated health-care professionals as one class of individuals who may experience multiple traumas as they provide care to others. Furthermore, Thomas and Wilson (2004) reported that approximately 7 percent of helping professionals working with trauma populations exhibit behaviors and react like post traumatic stress disorder (PTSD) suffers. PTSD is differentiated from secondary traumatic stress (STS) in that STS being someone experiencing the trauma indirectly or having knowledge of the traumatic event. The American Psychological Association (APA; 2012) identified three categories for PTSD that includes; re-experiencing the traumatic event, increased arousal, and avoidance or thought numbing related to the traumatic event. As Naturale (2007) explained, social workers are among the helping professions called to respond to disasters. Services provided by social workers during such interventions are crisis counseling, trauma treatment, and assessment. Figley (2002) and Bride (2007) noted the limited recognition of the damaging effects on mental-health workers who respond to disasters. Disaster sites are can involve challenging mental state, frightening sights and stomach turning odors, vast devastation of land and belongings and chaos (Meyers & Wee, 2005; Young, Ford, Ruzek, Friedman, & Guzman, 1998). The workload pressures at disaster sites include long working hours, limited breaks, and individual stressors relating to hunger and fatigue, adding to development of STS.

Sprang, Clark, and Whitt-Woosley (2007) conducted a study that explored compassion fatigue, compassion satisfaction, and burnout variables that may influence responses to vicarious exposure to traumatic stress among mental-health professionals in a rural southern state. Licensed or certified behavioral-health providers were recruited (*N*

= 6,720) and received mailed surveys at their residences. The response rate was 19.5% (n = 1,121). Respondents completed the Professional Quality of Life Scale and indicated if they possessed advanced trauma training and answered questions regarding individual and career related distinctiveness. According to Sprang et al., the study results indicated that having higher levels of compassion fatigue was associated with being female while having higher levels of compassion satisfaction was associated with having specialized training in trauma work. When compared to other rural and urban classifications, workers in the more rural classifications reported increased symptoms of burnout.

Trippany, Kress, and Wilcoxon (2004) generalized the concept of counselors working with traumatized patients by arguing that counselors from a variety of backgrounds work with trauma survivors. The American Psychiatric Association (2000), defined *trauma* as exposure to or confrontation with an incident that involves actual or threatened harm to physical well-being. In clinical practices, James and Gilliland (2001) reported that clients often encountered childhood/adulthood sexual, physical, and emotional abuse. In addition to domestic and school-related violence and natural disasters, sexual victimization is reported as one of the most frequently occurring traumas experienced by trauma survivors. Trippany et al. concluded that counselors' must be aware of their responses to VT and use self-care strategies to minimize negative impact, possible ethics violations, and interpersonal challenges. Supervisors and administrators should take active preventative roles in working with counseling professionals who may be treating clients who are trauma survivors. Examples of support that can be provided to counselors include promoting mental-health care by offering counseling services and support, welcoming collegial supportive interactions, diversifying workloads, providing

information on the effects of VT and trauma experienced by others on the helping professional. Professional development and transitioning from being social-work students to professionals were addressed by Larkin (2010). Limited information is available on the process of social-work students becoming professionals and the importance of educating students about issues related to the field in preparation for clinical practice.

Sabo (2006) addressed the issue of compassion fatigue in the field of nursing and noted that it is a natural consequence for nurses caring for individuals with pain and trauma. According to Sabo (2006), empathy used in the field of nursing is a doubled-edged sword that facilitates caring, and the act of caring causes nurses to be vulnerable to compassion fatigue. Van Hook and Rothenberg (2009) described the significant problems concerning high turnover rates in child-welfare settings. The child-welfare system is described as a network of organizations providing services to children and their relatives, where the children experienced abuse and/or neglect to prevent children being placed in foster care. Services include monitoring out-of-home placements, assessing services, and facilitating adoptions. Concerns in relation to the cost of training include those staff retention problems, which negative affects the worth of service rendered to children in the child-welfare system. The importance of staff retention in working with children is particularly evident for issues pertaining to children needing to form trusting relationships with staff because of challenges they may have encountered and their overall vulnerabilities.

Van Hook and Rothenberg (2009) examined levels of compassion satisfaction, burnout, and compassion fatigue or vicarious trauma among child-welfare staff in central Florida. In addition, they explored how staff coped with stress and made

recommendations for organizations to reduce stress among workers. Anonymous surveys were conducted using the Professional Quality of Life Survey and questions pertaining to stress management and recommendations for organizations. Demographic information obtained addressed age, gender, length of employment at the current agency and in the field of child welfare, professional identity or occupation, and current position. Of the 182 eligible participants for the study, 175 completed surveys. The results of the study indicated that respondents were generally female and younger in age. Social workers represented 31.5% of the study population, and many of the respondents were considered relatively new to the field of child welfare (18.5% with less than one year in the field, 34.5% with 2 years experience, and 45.8% with 3 years). Direct-line staff and supervisors indicated working with more challenging situations and cases recommended that the organization establish realistic caseloads and increased administrative supportive. There was a positive correlation between compassion satisfaction, compassion fatigue, and burnout. Stamm (2005) defined *compassion satisfaction* as "being able to do one's work well" (p. 5).

Badger, Royse, and Craig (2008) addressed the exposure of hospital social workers to indirect trauma. The fast-paced nature of hospital environments was discussed in terms of the limited time for social workers to process their reactions (Pockett, 2003) and meeting their personal needs (Dane & Chachkes, 2001). Hospital environments are fast paced, with social workers having increased number of patients with acute health problems and limited time to provide clients needed services. Symptoms experienced by helping professionals because of indirect trauma exposure were identified as relieving experiences in an almost real sense, trouble sleeping,

avoiding others and being distant, and being irritable (Bride, 2004; Dane & Chachkes, 2001; McCann & Pearlman, 1990).

Furthermore, Badger et al. (2008) explored predictive factors that produced STS in hospital social workers. Work challenges, empathetic understanding, general assistance from others, and being able to emotionally separate were factors examine. A cross-sectional study was conducted with 212 participants working at five different locations of trauma centers. Services provided at all facilities were for children and adults, and direct services ranged from psychiatric to medical. Several measures were used in the study, including the Interpersonal Reactivity Index to measure empathy, Maintenance of Emotional Separation Scale to measure emotional separation, the Work-Related Strain Inventory (WRSI) to measure occupational stress, and the Multidimensional Scale of Perceived Social Support measuring general assistance received.

The hospital social workers in the study by Badger et al. (2008) were all women with masters' degrees and averaged 15.8 years of practice. The results indicated that being able to emotionally separate and work problems predicted the onset of STS. In addition, for better outcomes against STS, social workers were urged to separate job related emotions concerning clients and personal emotions concerning their relatives. (Badger et al., 2008). Furthermore, hospice-care workers participated in a survey that examined the relations among self-care, compassion fatigue, burnout, and compassion fatigue. Thirty-seven home-care professionals participated in the study from two hospice agencies in the Midwest using a demographic sheet, the Professionals Quality of Life Assessment (Stamm, 2002), and the SCAW (Saakvitne & Pearlman, 1996). The study results indicated a relationship between self-care strategies and decreased levels of

burnout and compassion fatigue (Alkema et al., 2008). Moreover, Meadors, Lamson, Swanson, White, and Sira (2009) conducted a twofold research study exploring overlapping and differential information related to secondary traumatization, including post traumatic stress disorder, secondary traumatic stress, compassion fatigue, and burnout. Also examined was the effect of secondary traumatization and some personal and professional elements on how pediatric health-care providers experience PTSD, STS, compassion fatigue, and burnout.

Meadors et al. (2009) reported that study participants (N = 167) were individuals located nationwide and employed by various pediatric facilities. Facilities included a pediatric intensive care unit (PICU), neonatal intensive care unit (NICU), and a pediatric unit (PEDS). Participants could have been employed by one of the previously stated units within the previous year. The participant pool was largely female 89% (n = 143) with a small number of men (n = 24). The study participants' ethnic groups were White 89% (n = 143), African American (n = 5), and Hispanic (n = 3). Regarding employment, approximately 51% of participants reported that they had been employed at a PEDS unit, 45% at a PICU, and 40% at a NICU. Participants completed online surveys sent to several listservs for health-care workers who had worked at the various facilities in the last year. The study results indicated a significant overlap between STS, PTSD, burnout, compassion satisfaction, and compassion fatigue for PICU, NICU, and PEDS workers. Participants also reported a variety of pediatric losses and traumatized patients. The results for the second study indicated that STS, burnout, compassion satisfaction, and PTSD all contributed to compassion fatigue. STS was noted as providing the strongest predictive factor for compassion fatigue. Burnout and related concepts that include

vicarious traumatization, compassion fatigue, and STS were addressed in this section. Research information on the topic of burnout highlights the need for helping professionals for fully participate in self-care activities to alleviate the negative aspects of burnout. This chapter now transitions to addressing the theoretical aspects of burnout and self-care. This study's use of the selected theories is addressed in detail.

Theoretical Framework

Levin, Katz, and Holst (1976) noted an ongoing debate about the availability and lack of theoretical framework for addressing self-care. Organizing theory into classical categories of health-maintenance, risk-reducing, illness, sick role, rehabilitation, and chronic-care behaviors provides a descriptive listing from which gaps and incongruencies in theory relevant to self-care were identified. The two theories used in this study to understand the behavioral intentions of social workers in conducting self-care activities and the effect of self-care on feelings of burnout among social workers in medical, public-health, and mental-health settings are the theory of reasoned action and planned behavior (Ajzen & Fishbein, 1980) and Orem's (2001) theory of self-care. The theory of self-care (Orem 2001) focuses on self-care activities being performed by the individual to maintain well-being.

Theory of Self-Care

Orem (1991) noted that self-care involves activities solely initiated and performed by individuals for the maintenance of their well-being. The two orientations of self-care practices presented by Orem (2001) are internal and external. Self-care practices that are internally oriented include "action sequences to control oneself (thoughts, feelings, and orientation) and thereby regulate internal factors or one's external orientations" (Orem,

2001, p. 269). Deliberate self-care activities conducted for the maintenance of well-being are internal orientations. Externally oriented self-care "is deliberate action performed by an individual that involves interactions with others or the environment" (Orem, 2001, p. 268). Easton (1993) noted that in the field of nursing, the subject of self-care is very well established. Orem (1991) indicated eight self-care requisites, which are necessities and tools utilized to complete self-care acts. The self-care requites include maintaining air, water, food, bowel movements, balancing activity and rest, being alone or interacting with others, preserving human life, performance, and welfare, and promoting optimal human functioning. Orem (1991) noted that, when self-care is effectively performed, it helps in maintaining the structure of human functioning and contributes to human development. Orem (2001) further explained that individuals form behaviors to be used. Self-care is learned through family and cultural systems. Easton (1993) alluded to self-care being learned and added that self-care theory assumes that individuals have a need to care for themselves.

Simmons (2009) stressed the importance of engaging clients concerning care that they receive. They should be encouraged to be responsible for their self-care in order to minimize diseases and healthcare costs. Orem (1995) reported that individuals can naturally care for themselves and nurses should support clients in doing so. Although the theory of self-care is primarily a nursing theory, it is highly applicable to this study in that it highlights the importance and benefits of self-care for individuals to address health concerns, decrease health-care-related costs, and enhance the quality of life for social workers. Isenberg (2006) indicated that the theory of self-care (Orem, 1991) provides a nursing guide in multiple practice settings and engages clients throughout their life spans.

The varying needs for nursing care include individuals who require nursing care and lack the capability to care for themselves because of a related illness or injury, individuals who need partial nursing care during the process of recovering from an illness or injury, and individuals who are self-care sufficient but need continued support and education. Social workers and other health-care providers may fall anywhere on this continuum according to their reported symptoms of burnout and other related illnesses. According to Timmerman (1999), in the field of health promotion, self-care involves developing the needed skills to plan, execute, evaluate, and revise if necessary an individual's plan for lifestyle change.

Dorsey and Murdaugh (2003) defined *self-care management* as "engaging in specific therapeutic behaviors and implementing social actions to access resources to improve health status and quality of life in chronic illness" (p. 47). This literature review included the challenges of burnout-related symptoms among helping professions and the importance of self-care to maintain well-being and assist clients in achieving better outcomes. Self-care management is vital in helping human service professions focusing on actually engaging in the therapeutic behaviors or self-care activities. Orem (1991) alluded to the limited nature of self-care abilities for some individuals because of health conditions out of their control and lack of knowledge. Furthermore, the theory of self-care, according to Orem (1991), indicates that, except for the aforementioned limitations, individual's actions and behaviors are based on choices made. Cavanagh (1991) alluded to individual choice in engaging in self-care actions although individuals can functionally conduct self-care activities. As Lauder (2001) stated, "Self-care theory, like the medical model, proposes that to care for one's self is a rational act, and that humans as rational

beings are inherently predisposed to engage in self-care" (p. 548). Self-neglect is explained in the context of self-care activities not being performed by individuals without limitations as needed. Furthermore, Lauder (2001) indicated that self-neglect includes the following behaviors: an individual's failure to care for their health needs, unhealthy diet, poor personal hygiene, and household squalor. Signs and symptoms of self-neglect are reported as mental and physical-health problems and interpersonal relationship problems. In addition, Lauder (2001) asserted that it is useful to utilize self-care theory has to understand the notion of self-neglect.

Theory of Reasoned Action and Planned Behavior

Ajzen and Fishbein (1980) stated that the theory of reasoned action (TRA) is a specific theory that outlines cognitive and attitude determinants of behaviors. This theory was developed to predict and understand the causes of behavior, providing an understanding of attitudes towards performing behaviors. As Petosa and Jackson (1991) stated, "an overview of research based on the TRA indicates that correlations between behavioral intentions and behaviors are usually between .6 and .9" (p. 466). Using the TRA, Frankish, Lovato, and Poureslami (2008) explained that questions must be highly specific because this theory is often used for elicitation research to determine appropriate variables to target during introduction of a program or intervention. The two beliefs that comprise an attitude are the extent, in which the individual believes that a specific behavior will lead to a consequence, and the person's value of the consequence.

Fishbein and Ajzen (1975) originally explained that attitude in performing behaviors is based on individual views about the specific behavior. Social norms are measured by individuals' perceptions of others' thoughts and the individuals' desires to

conform to the thoughts of others. Subjective norms are described as a person's thoughts about other people's opinions about a behavior. According to Ajzen and Fishbein, TRA is applicable only to behaviors in which no internal or external impediments may prevent an individual from performing a behavior once the intention to perform that behavior has been established. However, Ajzen (1988) reported that the assumption of total volitional control (no internal or external impediments) is difficult to establish in daily activities, making TRA restrictive. The perceived behavioral control variable was added to TPB because it influences intentions and behaviors. The greater the perceived behavioral control, defined as perception of the level of difficulty for performing an activity, the greater the perceived behavioral control and likelihood that a behavior will be attempted.

The theory of planned behavior (TPB) is considered closely related to TRA (Jemmott, Jemmott, & Hacker, 1992) and an extension of it (Conner & Sparks, 1996; Fishbein & Ajzen, 1975; Hankins, French, & Horne, 2000). TPB was developed to provide a model of how behaviors are produced outside of volitional control. Both theories have been described as focusing primarily on determinants of behavior (Bartholomew, Parcel, Kok, & Gottlieb, 2006), although they do not provide specific methods for behavior change. Ajzen (1988) argued that TPB proposes behavior is not determined by intentions alone but also by the individual's level of control over the behavior.

Both TRA and TPB can help health educators understand the specific variables that need to be changed (Hardeman et al., 2002; Witte, 1995). TBP can be applied to situations in which individuals are aware of both negative and positive consequences of behavior (Brug, Hospers, & Kok, 1997; Brug, Van Asseman, Kok, Lenderink, & Glanz,

1994). It has been used to study exercise and health behaviors (Frankish et al., 2008). Furthermore, Leone, Perugini, and Ercolani (1999) noted that multiple approaches have been used to predict and understand certain behaviors and an individual's attitude is a key factor. TRA and TPB are "simple, parsimonious, easy to operationalize, and applicable to a wide range of behavioral domains" (p. 162).

Health educators tend to be more concerned with attitudes towards behaviors and, as Ajzen and Fishbein (1988) stated, "The individual's positive or negative evaluation of performing the particular behavior is of interest" (p. 117). Kerner (2005) reported using TBP as a framework for assessing attitude towards activity, expectations of others, perceived control, and intention to engage in activities among middle school students. Furthermore, Blanchard et al. (2003) added to the research on TPB by examining ethnicity and TPB with regards to exercise. The conclusion was that exercise was related to intentions and attitudes. In addition, Bartholomew et al. (2006) noted that TPB is most often used on an individual level but that other levels, including the ecological level, are appropriate.

Marcoux and Shope (1997) used the TPB to predict and explain alcohol use among 3946 fifth through eighth grade students in southern Michigan. Emphasis was placed on the , number of times alcohol was consumed and misused. Their research assessed the plausibility and robustness of TPB. This longitudinal study included students from 179 classes in 16 buildings and 6 school districts. The participants were largely White (51% male) ranging from 9-16 years of age (11.9 average). In results of the study by Marcoux and Shope (1997), Ajzen's (1991) TPB was supported and outlined as useful for the prediction and explanation of alcohol use among adolescents (Marcoux &

Shope, 1997). All components reached the significance level of 0.05; intention to use alcohol explained up to 26% of variance in use, frequency of use explained 38% of variance, and misuse explained 30% of variance. The variance of 76% noted in the intention to use alcohol was explained by attitudes, subjective norms, and perceived behavioral control. Marcoux and Shope explained that the findings of the study showed that external factors, including peer pressure, friends' experiences with alcohol, availability of alcoholic beverages, and normative beliefs of parents, are all more important in predicting intention to use alcohol than internal factors such as attitudes.

Moreover, Casper (2007) explained that TPB provides a model for behavior modification and prediction: "Assessing people's attitudes, norms, and perceived control, all of which underpin their intention to perform a given behavior can reveal information that may be applied to create communication strategies to alter these elements and thereby intention and behavior" (p. 1324). TPB is considered applicable in educational settings in which adults are being taught to use a new technique or intervention. Casper compared the effects of a continuing-education class designed using the principles of the TPB and another class using a standard format, both of which addressed the intentions and behaviors of mental-health practitioners to apply a new assessment tool. Communication strategies guided by TPB were used in one class. The attitudes, norms, perceived control, and intentions of the study's participants (mental-health practitioners) were assessed before and after the class. Three months after completing the classes, practitioners' use of the assessment tool was assessed via self-reports.

Casper (2007) explained that the study was conducted by the Behavioral Healthcare Education division of the psychiatry department at Drexel University College

of Medicine. The classes were conducted in the fall of 2006 in Philadelphia and Pittsburgh, where registrants worked. The study participants ($N = 98$) were assigned to the two formats described. Forty-six were assigned to the TPB format while 48 attended class with the standard format. The study results indicated that the continuing-education class using TPB principles resulted in stronger intentions to implement the assessment tool than the standard format class did. In the 3-month follow-up, significantly more participants in the TPB class had implemented the assessment tool than those in the standard format class (72% and 42%, respectively). Casper concluded that TPB is applicable in continuing-education settings as a method of modifying practice among mental-health practitioners. TPB provided a framework and practical means of going beyond information dissemination to translating new discoveries into improved practice.

TBP and TRA are the most widely researched behavior-change theories and have factors in common factors (Armitage & Conner, 2001; Fishbein, 1995). Perkins et al. (2007) reviewed the application of theory-driven approaches to understanding and changing clinician behaviors. Multiple databases that included PsycINFO, MEDLINE and other documents on health behavior, public health were used that describe TRA and TPB theory-driven approaches to modifying and understanding health-professionals' behaviors. Nineteen articles detailing 20 studies described the use of TRA and TPB and clinician's behaviors. Only two articles applied TRA and TPB to mental-health clinicians. Perkins et al. concluded that constructs pertaining to TRA and TPB can predict intentions and behavior among different groups of clinicians for different behaviors and guidelines.

Ajzen and Manstead (2007) explained that human behavior is being highly researched in the health domain because of its potential contribution to addressing medical conditions that affect individuals daily. Social workers may fully understand the benefits of performing self-care activities but fail to do so because of lacking motivation, having no one to support self-care activities, having limited time or funds, and or being unable to quantify the value of conducting self-care activities. In addition, social workers may have intentions to conduct self-care activities, but environmental factors prevent them from conducting the specified activities. Examples of such environmental concerns include bad weather, violence in the neighborhood, and lack of community resources. Using the TRA and TPB, the behavioral intentions, value of self-care, and influence of other sources (friends, family, and organizations) can be better understood. Thus, the TRA and TPB, together with Orem's (1991) theory of self-care, are important and useful theories in better understanding social workers' thoughts, attitudes, and perceptions toward conducting self-care activities.

Critique of Methodologies Used

The effects of self-care and feelings of burnout among social workers in medical, public-health, and mental-health settings were examined in this study. Through the MBI (Maslach & Leiter, 1996), the SCAW (Saakvitne & Pearlman, 1996), and a demographics form, burnout levels and self-care activities performed by social workers were assessed to determine any relationship between self-care and burnout variables. The MBI-HSS was selected for use because it is the most widely used instrument for assessing burnout (Maslach et al., 1996). The SCAW (Saakvitne & Pearlman, 1996) was selected for use to enable social workers to identify self-care activities being performed in various

categories that include physical, psychological, emotional, and spiritual self-care activities. The demographics survey was used to collect data on the study participants beyond that being addressed by the other two instruments. The demographics questionnaire utilized the census format of questioning to ensure that questions are asked appropriately and all possible categories are provided and explored.

The MBI (Maslach & Jackson, 1996) is the most widely used inventory for measuring burnout among helping professionals in a wide variety of settings. It has three subscales, the Emotional Exhaustion subscale, the Depersonalization subscale, and the Personal Accomplishment subscale. According to Maslach and Jackson (1996), the Emotional Exhaustion subscale contains nine questions that address feelings of being emotionally exhausted because of one's employment. The Depersonalization subscale has five questions that address limited feelings towards clients and being impersonal. The Personal Accomplishment subscale includes eight questions that address feelings of personal accomplishment and competence in one area of employment. Detailed psychometrics are available on the MBI. Priebe et al. (2005) and Cohen and Gagin (2005) used the MBI and other scales in their studies. These instruments and their use in this study will be discussed further in chapter 3.

Summary

There is a lack of research literature concerning the effects of self-care on social workers in medical, public-health, and mental-health settings. The importance of self-care, reasons for burnout, and strategies to prevent burnout have been discussed. Social workers can function well as individuals and uphold their ethical standards when engaging in self-care activities to prevent burnout and other occupational stressors.

Saakvitne and Pearlman (1996) stated, “We are serious, playful, careful, spontaneous, sexual, intellectual, intense, self-indulgent, and much much more. We are complex and we are human. Our self-care must reflect our diversity and complexity” (p. 61). In addition, Norcross and Guy (2000) urged psychotherapists to use various self-care strategies that are take a wide variety of activities and actions in efforts to replenish themselves.

Transition Statement

Chapter 2 includes detailed information on concept of burnout, addressed self-care, and provided examples of self-care activities used in previous research studies with helping professionals. Detailed information was provided on the theories used to understanding reported feelings of burnout and self-care activities conducted by social workers in this study.

Chapter 3 will address research design and rationale, sample characteristics, methodologies, and the survey instruments to be used in this proposed study. The survey instruments to be used include the Maslach Burnout Inventory (MBI), the Self-Care Assessment Worksheet (SCAW), and a demographics form. Chapter 3 concludes with plans for data analysis.

Chapter 3: Methodology

Introduction

This chapter includes discussion of burnout and self-care variables examined in this study and provides a description of the design to address the research questions. Information is presented on the target population and sampling procedures for the recruitment of study participants. The data analysis plan, possible threats to validity, and ethical concerns are also discussed. The chapter concludes with a summary of the methodological aspects of this study.

Research Design and Rationale

This correlational study identified potential relationships between an independent variable, self-care, and a dependent variable, burnout, among the social worker population. This design was selected because predictions can be made about the relationship between self-care activities conducted and reported feelings of burnout. Lanier (2002) explained that one of the strengths of correlations is that predictions can be made based at least two variables. Frankfort-Nachmias and Nachmias (2008) explained that the correlational design is the most predominantly used in social sciences and is often identified with survey research. The patterns of the relationships between variables are described in terms of the strength and direction of the association between variables. Lanier (2002) reported that one disadvantage of this design is the lack of measurement of causation; "correlation is not causation" (Lanier, 2002, p. 1).

This design is the best method to address the research questions, as correlation allows for analysis of the relationships among self-care and burnout variables obtained from social workers. Self-care variables were operationalized through reporting of self-

care activities such as practicing yoga, engaging in meditation, taking vacations, and spending time with family and friends. Burnout variables measured by the MBI include emotional exhaustion, depersonalization, and decreased personal accomplishment.

An online survey via mindspring.com was used to obtain quantifiable information from social workers. Couper (2000) noted that the Internet survey is increasingly being used for research. Study participants were randomly chosen from the NASW's database of members. The MBI-HSS (Maslach et al., 1996) and SCAW (Saakvitne & Pearlman, 1996) were administered to participants to collect their reported experiences related to burnout and self-care activities. The MBI-HSS was selected for use because it is the most widely used instrument to assess the main components of burnout (Maslach et al., 1996). The SCAW (Saakvitne & Pearlman, 1996) was selected for use because it provides a description of respondents' use of self-care activities (Alkema et al., 2008).

Sampling Procedure

Participants

The social worker participants recruited through a convenience sampling procedure for this study were members of the NASW in medical, public-health, and mental-health settings. As members of the NASW, participants possess a variety of degrees in the field of social work. The required number of participants to achieve a power of .80 and a medium effect size ($f^2 = .30$) is 159 (Faul, Erdfelder, Lang, & Buchner, 2007). This convenience sample of social workers was selected because these individuals were accessible, could provide informed consent based on age appropriateness, and had been identified as practicing in the specified fields. Selected

study participants had the experience of working with a variety of clients and had the reading comprehension skills necessary to complete the survey instruments.

Procedures

The NASW is the largest social work membership organization worldwide (NASW, 2011) with approximately 145,000 members. The purpose of this organization is to "enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies" (NASW, 2011, p. 1). Participants in this study were recruited via Infocus Marketing, Inc, an approved vendor that sells registered members' mailing lists. Members on the NASW mailing list initially received an initial contact letter outlining a brief plan of the study, and a survey link to the study site was provided where participants could consent to participate. Only those who indicated their consent by checking the box via the specified link were able to participate in the study. By providing their consent prior to completing the survey, participants were made aware that this study was confidential and that no personal identifiers such as name, phone number, e-mail address, and residential address would be reported in the final dissertation in order to maintain anonymity. They were also made aware that the survey results would be used only for the stated research purposes and that their participation was of no potential financial interest to me. The participants were notified that they could withdraw from participating in the study at any stage without adverse consequences.

This study was hosted by Mind Garden, Inc., which also provides copyright licenses for the MBI. Mind Garden was selected because this organization allows study participants to complete the MBI online and scores the information collected; fidelity of

the instruments in terms of question wording and options provided for answers was thus maintained by the owners of the instrument. For an additional cost, Mind Garden agreed to host both the demographics form and the SCAW. Thus, data from all survey instruments were collected via one link. Participants were given 15 days after receiving their initial letter to complete the surveys online via the specified link.

Because of the lack of psychometric information on the SCAW, test-rest reliability was determined. Doing so made it possible to establish the consistency of test scores between the initial and second test administrations. Determining the test-retest reliability provided basic information on the reliability of the SCAW with this population. Due to the small sample size, all participants who provided their email addresses to complete the SCAW a second time were contacted again to complete the SCAW. The total time for the data collection process was approximately 8 weeks.

Instrumentation and Materials

Two main survey instruments and a demographics questionnaire were used in this study to obtain information from social workers who worked in medical, public-health, and mental-health settings.

Maslach Burnout Inventory—Human Services Survey

Maslach et al. (1996) indicated that the MBI-HSS is the leading measure on burnout. It includes three subscales addressing emotional exhaustion (EE), depersonalization (D), and personal accomplishment (PA). The MBI-HSS includes 22 items that describe feelings of burnout and enable respondents to rate the frequency of their burnout-related feelings. Items are responded to using a 7-point Likert scale ranging

from 0 (*never*) to 6 (*daily*). The approximate completion time for the MBI-HSS is 10 minutes (Maslach et al., 1996).

In addressing the varying degrees of burnout, Maslach et al. (1996) explained that high burnout is indicated by high scores on the EE and D subscales and a low score on the PA subscale. Low burnout is indicated by low scores on EE and D subscales and a high score on the PA subscale. Furthermore, scores for emotional exhaustion ranging from 0-16 indicate a low level of burnout, and scores above 27 indicate a high level of burnout. Depersonalization scores from 0-6 indicate low levels of burnout, and scores above 13 indicate a high level of burnout. However, personal accomplishment scores between 0 and 31 indicate a high level of burnout, and scores above 39 indicate a low level of burnout (Maslach et al., 1996).When using the MBI-HSS, it is recommended that the actual numerical scores (raw scores) be used for statistical analyses instead of using categories that include low, moderate, and high. Doing so provides specific information to participants regarding their scores in the areas of emotional exhaustion, depersonalization, and personal accomplishment. It also enables comparisons to be made of participants to the overall norm (Maslach & Jackson, 1996).

Burnout was classified based on participants' responses (total raw scores) to questions in each subscale (emotional exhaustion, depersonalization, and personal accomplishment). Using the norms previously stated for categories of burnout that include high, moderate, and low, participants were categorized based on their total raw scores in each subscale. For example, a participant with scores above 27 on the emotional exhaustion scale (high score), above 13 on the depersonalization scale (high score), and above 15 on the personal accomplishment scale (low score) is viewed as being in the high

category with burnout-related feelings. Maslach et al. (1996) explained that high burnout is indicated by high scores on the EE and D subscales and a low score on the PA subscale.

Reliability and Validity of the Maslach Burnout Inventory—Health Services Survey

Maslach et al. (1996) found high reliability and validity of the MBI-HSS with coefficients of reliability as follows: emotional exhaustion, .90; depersonalization, .79; and personal accomplishment, .71. Test-retest reliability coefficients for the subscales were .82 for emotional exhaustion, .60 for depersonalization, and .80 for personal accomplishment; all coefficients were statistically significant, $p < .001$.. The MBI-HSS, according to Ackerley, Burnell, Holder, and Kurdek (1988), has good and well-researched psychometric properties that reflect a variety of burnout levels experienced by a diverse group of mental health professions that include psychologists, psychiatrists, counselors, and psychotherapists.

The MBI manual notes that confirmatory factor analyses have been conducted on all subscales. The factor structure was replicated with a large sample of psychologists (Ackerley et al., 1988). The MBI-HSS is an appropriate measure for this study to measure burnout reliably and validity through subcategories that include emotional exhaustion, depersonalization, and reduced personal accomplishment.

Self-Care Assessment Worksheet (SCAW)

Saakvitne and Pearlman (1996) developed the SCAW to measure frequency of self-care activities in six categories: physical, psychological, emotional, spiritual, professional workplace, and balance. This instrument was originally developed to assist individuals struggling with issues related to vicarious traumatization. The emphasis is on

identifying self-care strategies being used. This self-report questionnaire asks respondents to rate self-care activities with scores ranging from 1 to 5 based on frequency (1 = *never occurs* and 5 = *frequently occurs*). No psychometric properties have been established for the SCAW (Alkema et al., 2008). This study included a test-retest component to help establish reliability. Sample items on the SCAW include frequency of writing in a journal (psychological), taking vacations (physical), and having a peer support group (workplace or professional). The SCAW can be completed in 5 minutes.

Despite the lack of psychometric properties for the SCAW, this measure was appropriate for this study because it allows participants to rate the frequency with which self-care activities are performed and the resulting information can be used to examine correlations with reported feelings of burnout. In this study, the self-care scores were formed based on each subscale (categories of self-care: physical, psychological, emotional, spiritual, workplace, and balance). The number of items in each subscale varies due to assessment of a range of self-care activities performed by participants. Respondents were asked to rate activities listed based on frequency on a scale 1-5 (1 = *never occurs* and 5 = *frequently occurs*). High scores in each subscale indicate increased frequency of self-care activities in each of the six domains.

Demographics Form

The demographic questionnaire (Appendix C) was used to collect the following information from participants using a census format to ensure that participants could accurately report their demographic information: gender, age range, years of social work practice, type of social work setting (medical, public-health, or mental-health), type of social work licensure, degree, marital status, and time in service at current work setting.

This questionnaire was brief and was used to collect information on possible covariates. To ensure participants' privacy, no personal contact information was collected. This questionnaire could be completed in less than 5 minutes.

Data Collection

This study design included oversampling strategies. Bartlett et al. (2001) stated that oversampling by as much as an additional half of the required sample size should be practiced, as this will likely yield increased responses that ensure adequate power. Infocus Marketing, the NASW vendor selling social workers' mailing lists, was asked to randomly select 5,000 names and addresses of social workers from medical, public health, and mental health settings from its database. This is the minimum purchase amount when using this service. The list of 5,000 names obtained was separated into three sections, with two sections having 1,500 names and addresses each and the third section having 2,000 names and addresses. The purpose of sectioning the names and addresses was to facilitate random sampling of each section to increase response rates and prevent duplication in sampling.

After receiving IRB approval and the list of names and addresses of social workers from Infocus Marketing, I performed a random selection of names and addresses numbering 500 from the first list of 1,500 names. The random number selection was done using an online random number generator. Those randomly selected were sent initial contact letters (see Appendix A). After 7 days, reminder letters (Appendix *D*) were sent. Due to the limited response rate, the second and third sections of 1,500 and 2,000 names and addresses each were randomly sampled using an online number generator to select

additional 500 names each. In total, 1,500 social workers were contacted to participate in this study.

To determine test-retest reliability for only the SCAW, social workers were asked to provide their email addresses on the consent form if they were interested in completing the SCAW. A total of 64 participants provided their email addresses and completed the SCAW a second time. Mind Garden Inc. representatives transformed survey data to raw and scaled scores and provided a .csv file to me.

Data Analysis

The data obtained from the completed surveys were analyzed using SPSS version 21.0. Data were screened to identify missing information. Both descriptive and inferential statistics were used in the data-analysis process. Hypothesis testing for this research study was based on the .05 level of significance.

RQ1

Null hypothesis (H_{01}). There is no statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory (MBI), among social workers in medical, public health, and mental health settings and their frequency of engagement in self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a1}). There is a statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory (MBI), among social workers in medical, public health, and mental health settings and their frequency of engagement in self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

To test this hypothesis, the Pearson *r* correlation was calculated to assess whether a correlation exists between social workers' feelings of burnout and self-care activities.

RQ 2

Null hypothesis (H_{02}). There is no statistically significant effect of employment or practice setting (medical, public health, or mental health) on social workers' experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a2}). There is a statistically significant effect of employment or practice setting (medical, public health, or mental health) on social workers' experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

The second hypothesis was examined by conducting a one-way analysis of variance (ANOVA) on the employment settings of social workers (medical, public health, and mental health) and reported feelings of burnout using the three scales (emotional exhaustion, depersonalization, and personal accomplishment).

RQ 3

Null hypothesis (H_{03}). There are no statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a3}). There are statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

This hypothesis was investigated using one-way ANOVA to determine statistically significant differences among the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation.

RQ 4

Null hypothesis (H_{04}). There is no statistically significant relationship among social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a4}). There is a statistically significant relationship between social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

To test these hypotheses, Pearson *r* correlation coefficients were calculated.

Ethical Considerations

Participants received statements of full disclosure of the nature and purpose of this study, clearly stating the voluntary nature and the minimal risk of participation. Participants were required to provide informed consent prior to participating in the study (see *Appendix B*). If responding to survey questions became emotionally distressing to participants, they had the opportunity to withdraw from the study, decline to answer questions, and utilize the national substance abuse and mental health hotline number and web address to locate a mental health provider in their state. My contact information was clearly stated in all research materials so participants could ask questions, express

concerns, and gain clarification if needed. Other research staff were identified in the documentation in addition to Walden University's research personnel.

Confidentiality was addressed by ensuring that all data collected were coded and individual names could not be linked to survey information provided, except for the individuals that agreed to complete the test-retest reliability data collection of the Self-Care Assessment Worksheet (SCAW). All efforts were made to withhold all identifying information in the final dissertation. All research information collected, including consent forms and questionnaires, were kept securely on a website and accessible only by the me. In addition, information stored on the research computer and external flash drive are under lock and key held by myself. The information on the computer remains password protected and at the culmination of the study, research data will be kept for at least 5 years. The results of this study will be made available to the NASW for publication in order that study participants have access to the results of this study.

Summary

This chapter included a detailed description of the research design and approach as well as the setting and sample descriptions, ethical considerations, instrumentation, data-collection, and data analysis procedures. The research explored the relationship between reported feelings of burnout and self-care activities among social workers in medical, public-health, and mental-health settings. Infocus Marketing, the approved vendor for selling the mailing lists of all NASW members, provided a random selection of social workers in medical, public-health, and mental-health settings. The survey instruments used in this study were the MBI, the SCAW, and a demographics form. Mind Garden, Inc., agreed to host all survey instruments. After participants completed

the surveys, Mind Garden Inc scored the surveys and sent the data to me. Results of data analysis are presented in Chapter 4. Chapter 5 includes the interpretation of findings and discussion of the implications of the study for positive ssocial change. Also included are recommendations for action and further research on burnout and self-care.

Chapter 4: Results

Introduction

The purpose of this study was to further understand the relationship between experiences of burnout among social workers in medical, public health, and mental health settings and the relationship of self-care to burnout experiences. In this chapter, I present the results of this current study by providing information on the data collection process, a description of the study participants, and analyses of data.

Characteristics of Sample

Table 1 provides detailed information on the sample characteristics ($N = 185$). A majority of the study participants were Caucasian (84.4%), female (82.7%), married (67.9%), holders of a master's degree in social work (91.4%), and licensed at the master's clinical level (57.4%). The average study participant was 51 years old, had practiced social work for 20 years, and had been at the current work setting for 10 years. The majority of social workers in the study identified their work setting as mental health (48%), followed by medical (30.8%) and public health (21.1%) settings. Approximately 42.2% of the participants reported 5 or fewer years of experience in their current place of employment.

Table 1

Sample Characteristics (n = 185)

Characteristic	*n*	(%)
Gender		
Female	153	(82.7%)
Male	32	(17.3%)
Relationship		
Single	33	(17.8%)
Married	114	(61.9%)
Divorced	17	(9.2%)
Separated	0	(0.0%)
Widowed	1	(0.5%)
Committed Relationship	20	(10.8%)
Social Work Degree		
Bachelor's	9	(4.9%)
Master's	169	(91.4%)
Doctoral	7	(3.8%)
Social Work License Type		
Bachelor's Level	9	(4.9%)
Master's	48	(25.9%)
Graduate Level	2	(1.1%)
Master's Clinical Level	108	(57.4%)

table continues

Characteristic	*n*	(%)
Social Work License Type		
Master's	18	(9.6%)
Advanced Level	0	(0.0%)
Ethnicity (Check all that apply)		
African American	13	(7.0%)
Caucasian	157	(84.4%)
Native American	1	(0.5%)
American Indian/Alaskan	1	(0.5%)
Asian Indian	0	(0.0%)
Hispanic Latino	10	(5.4%)
Chinese	2	(1.1%)
Japanese	1	(0.5%)
Korean	0	(0.0%)
Guamanian or Chamorro	0	(0.0%)
Filipino	1	(0.5%)
Vietnamese	0	(0.0%)
Other Asian	0	(0.0%)
Other Pacific Islander	0	(0.0%)
Native Hawaiian	2	(1.1%)
Samoan	0	(0.0%)
Other	0	(0.0%)

table continues

Characteristic	*n*	(%)
Practice Setting		
Mental Health	89	(48.1%)
Medical	57	(30.8%)
Public Health	39	(21.1%)
Age		
34 and under	34	(18.4%)
35-50	45	(24.3%)
51-65	86	(46.5%)
66 and over	20	(10.8%)
Years of Practice		
0-10	52	(28.1%)
11-20	48	(25.9%)
21-30	39	(21.1%)
31 and Over	46	(24.9%)
Years at Current Place of Employment		
0-5	78	(42.2%)
6-10	39	(21.1%)
11-15	24	(13.0%)
16 and more	44	(23.8%)

Note. The ethnicity category totals more than the total number of participants in this study due to participants being able to select more than one ethnic background.

Test-Retest Reliability

To assess the reliability of the SCAW, correlations between scores on the initial and follow-up administration of the SCAW were analyzed. Sixty-four social work participants took the SCAW twice. Results suggested strong and positive correlations between initial and follow-up administrations of the SCAW. The results were as follows for all self-care domains: physical, $r = .83$; psychological, $r = .78$, emotional, $r = .79$; spiritual, $r = .91$; work or professional, $r = .79$; and balance, $r = .65$. Overall results suggested that the SCAW is a reliable instrument.

The quality of the data received for this study was good, with no missing information and participants were given the option of reporting other self-care strategies they used. Mindgarden implemented the skip logic technology, which made responding to all questions mandatory in order to proceed to the next page of the questionnaires (Maslach Burnout Inventory: Human Services Survey [MBI-HSS] and Self-Care Assessment Worksheet [SCAW]) and to complete the survey process. Doing so was helpful in obtaining completed surveys with no missing information. No outliers were noted in the data set, as participants rated their feelings of burnout and engagement in self-care activities based on scales provided. In order to participate in completing the SCAW a second time to assess the reliability of the SCAW, participants were asked to provide their email addresses on the consent form. Participants diligently entered their email addresses, with all addresses being accurate except one that was returned to me as an incorrect email address. Prior to data analysis, the data received from Mindgarden Inc, were reviewed for outliers and possible missing information. Also, all survey questions were reviewed to ensure accuracy of scores based on the scales provided.

Data Analysis

Descriptive statistics are provided below in Tables 2, 3, and 4. Table 2 outlines the means and standard deviations of burnout scores reported by social work participants based on practice setting (medical, public health, and mental health settings). Table 3 provides information on the means and standard deviations of self-care scores based on practice setting. Table 4 categorizes participants' self-care scores by domain (physical, psychological, emotional, spiritual, workplace/professional, and balance). The higher the self-care score for each domain, the more self-care activities study participants completed in that domain of self-care activities. The total scores were formulated based on participants' responses to questions in each domain on the following scale: 5 = *frequently*, 4 = *occasionally*, 3 = *rarely*, 2 = *never*, 1 = *it never occurred to me*.

Table 2

Burnout and Practice Settings: Means and Standard Deviations (*n = 185)*

	Medical		Public Health		Mental Health			
	M	*(SD)*	*M*	*(SD)*	*M*	*(SD)*	*F*	*p*
Emotional Exhaustion	2.11	(1.33)	2.31	(1.19)	2.12	(1.40)	.333	.717
Depersonalization	0.98	(1.04)	0.93	(0.83)	0.89	(0.86)	.153	.858
Personal Accomplishment	5.00	(0.86)	4.91	(0.76)	5.06	(0.77)	.513	.600

Table 3

Self-Care and Practice Settings: Means and Standard Deviations (*n = 185)*

	Medical			Public Health			Mental Health		
	M	*(SD)*	*N*	*M*	*(SD)*	*N*	*M*	*(SD)*	*N*
Physical Self-Care	59.39	(6.27)	57	59.15	(6.83)	39	60.25	(6.81)	89
Psychological Self-Care	48.16	(5.17)	57	47.95	(5.65)	39	48.65	(5.36)	89
Emotional Self-Care	41.37	(4.68)	57	42.10	(4.57)	39	41.25	(4.78)	89
Spiritual Self-Care	67.32	(8.24)	57	65.62	(9.01)	39	66.47	(8.15)	89
Workplace or Professional Self-Care	43.58	(6.38)	57	46.03	(5.13)	39	44.55	(6.28)	89

Note. Total self-care domain (physical, psychological, emotional, spiritual, workplace/professional) scores used.

Table 4

Self-Care Domain Scores by Practice Setting

Self-Care Domain	Score Categories	Medical	Public Health	Mental Health	Total
Physical	41-45	1	1	3	5
	46-50	2	5	4	11
	51-55	16	4	13	33
	56-60	13	10	19	42
	61-65	16	13	29	58
	66-70	7	5	17	29
	71-75	2	1	4	7
	Total (*n*)	57	39	89	185
Psychological	36-40	5	4	8	17
	41-45	11	10	17	38
	46-50	18	9	24	51
	51-55	21	13	33	67
	56-60	2	3	7	12
	Total (*n*)	57	39	89	185
Emotional	25-29	1	0	1	2
	30-34	2	4	6	12
	35-39	17	5	22	44
	40-44	23	20	36	79
	45-49	13	8	22	43
	50-54	1	2	2	5
	Total (*n*)	57	39	89	185
Spiritual	41-45	1	0	1	2
	46-50	0	4	4	8
	51-55	3	3	5	11
	56-60	7	5	12	24
	61-65	12	5	14	31
	66-70	9	8	17	34
	71-75	16	8	28	52
	76-80	9	6	8	23
	Total (*n*)	57	39	89	185

Self-Care Domain	Score Categories	Medical	Public Health	Mental Health	Total
Workplace/Professional	25-29	2	0	2	4
	30-34	3	0	3	6
	35-39	6	3	10	19
	40-44	16	14	26	56
	45-49	23	9	24	56
	50-55	7	13	24	44
	Total (*n*)	57	39	89	185
Balance	0-2	0	0	0	0
	3-4	0	0	0	0
	5-6	2	2	5	9
	7-8	21	11	33	65
	9-10	34	26	51	111
	Total (*n*)	57	39	89	185

Research Question 1

What is the relationship between reported feelings of burnout among social workers who are employed in medical, public health, and mental health settings and their frequency of engagement in self-care practices?

Null hypothesis (H_{01}). There is no statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory (MBI), among social workers in medical, public health, and mental health settings and their frequency of engagement in self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a1}). There is a statistically significant relationship between reported feelings of burnout, as measured by the Maslach Burnout Inventory

(MBI), among social workers in medical, public health, and mental health settings and their self-care practices, as measured by the Self-Care Assessment Worksheet (SCAW).

Based on Pearson correlation analysis, Table 2 shows significant but negative correlations between frequency of engagement in self-care and emotional exhaustion and depersonalization and positive correlations between frequency of engagement in self-care and personal accomplishment. Thus, the null hypothesis was rejected in favor of the alternative hypothesis.

Table 5

Pearson Correlation (R) of Self-Care and Burnout

Self-Care	Emotional Exhaustion	Deperson-alization	Personal Accomplishment
Physical	-.402	-.258	.292
Psychological	-.375	-.297	.361
Emotional	-.396	-.322	.414
Spiritual	-.368	-.309	.382
Workplace	-.557	-.389	.405
Balance	-.423	-.320	.321

Note. $n = 185$. All correlations significant at $p < .001$.

Research Question 2

Is there a relationship between employment or practice setting (medical, public health, or mental health) and social workers' experience of burnout?

Null hypothesis (H_{02}). There is no statistically significant effect of employment or practice setting (medical, public health, or mental health) on social worker's experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a2}). There is a statistically significant effect of employment or practice setting: medical, public health, or mental health on social worker's experience of burnout, as measured by the Maslach Burnout Inventory (MBI).

To test these hypotheses, one-way analysis of variance (ANOVA) was conducted to test the significance of differences in mean levels of each burnout scale between social workers in medical, public health, and mental health settings. ANOVA assumptions checked include, the dependent variable being continuous, the independent variable consisting of two of more categorical independent groups, no significant outliers, independence of observations, normality, and homogeneity of variances. No significant differences were found between social workers in medical, public health, and mental health settings and their reported feelings of burnout. Emotional exhaustion [$F(2, 182) = .333$, $p = .717$], depersonalization [$F(2, 182) = .153$, $p = .858$], and personal accomplishment [$F(2, 182) = .513$, $p = .600$]. Table 3 reports the results of the ANOVA. The null hypothesis was retained due to no significant differences found between social workers in medical, public health, and mental health settings and their reported feelings of burnout.

Table 6

Analysis of Variance on Burnout and Practice Setting (n = 184)

Source		Sum of Squares	*df*	Mean Square	*F*	η	*p*
Emotional Exhaustion	Between Groups	1.198	2	.599	.333	.510	.717
	Within Groups	327.595	182	1.800			
	Total	328.793	184				
Derpersonali-zation	Between Groups	.255	2	.128	.153	.263	.858
	Within Groups	151.965	182	.835			
	Total	152.221	184				
Personal Accomplish-ment	Between Groups	.648	2	.324	.513	.393	.600
	Within Groups	114.866	182	.631			
	Total	115.514	184				

Research Question 3

Are there differences in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation?

Null hypothesis (H_{03}). There are no statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

Alternative hypothesis (H_{a3}). There are statistically significant differences by practice setting in the frequency of social workers conducting the following self-care activities: exercise, meditation, journal writing, and obtaining supervision or consultation as measured by the Self-Care Assessment Worksheet (SCAW).

A one-way between subjects analysis of variance (ANOVA) was employed to test the significance of differences by practice setting (independent variable) in mean ratings of exercise, meditation, journal writing, and supervision and consultation activities (dependent variables). Table 7 shows the results of the analysis. For each of the four types of activities; exercise [F(2, 182) = .149, p = .869], meditation [F(2, 182) = 0.77, p = .926], journal writing [F(2, 182) = 1.034, p = .358], and supervision and consultation [F(2, 182) = .613, p = .543] the overall F statistic was not significant; thus, the alternative hypothesis was not supported.

Table 7

Analysis of Variance for Utilization of Self-Care Strategies (n = 184)

Source		Sum of Squares	*df*	Mean Square	*F*	η	*p*
Exercise	Between Groups	.226	2	.113	.149	.098	.861
	Within Groups	137.374	182	.755			
	Total	137.600	184				
Journal	Between Groups	1.661	2	.830	1.034	.084	.358
	Within Groups	146.199	182	.803			
	Total	147.859	184				
Meditate	Between Groups	.180	2	.090	.077	.008	.926
	Within Groups	213.085	182	1.171			
	Total	213.265	184				
Supervision/ Consultation	Between Groups	1.171	2	.586	.613	.172	.543
	Within Groups	173.964	182	.956			
	Total	175.135	184				

Research Question 4

What is the relationship among social workers' practice setting (medical, public health, or mental health), years of practice, and reported feelings of burnout?

Null hypothesis (H_{04}). There is no statistically significant relationship among social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

Alternative hypothesis (H_{a4}). There is a statistically significant relationship between social workers' practice setting (medical, public health, or mental health), years of practice as measured by a demographic questionnaire, and reported feelings of burnout as measured by the Maslach Burnout Inventory (MBI).

To answer this question, the correlation between years of social work practice and burnout were computed (Table 8). Social workers with more experience reported significantly lower levels of emotional exhaustion (r = -.208, n= 185, p=.01) and depersonalization (r = -.182, n= 185, *p=.05)*. The correlation between years of social work practice and personal accomplishment (r = .086, n= 185, *p=.05)* were not statistically significant. Thus, the alternative hypothesis was partially supported.

Table 8

Pearson Correlation (r) of Experience and Burnout (n = 185)

	Years of Experience
Emotional Exhaustion	-.208 **
Depersonalization	-.182 *
Personal Accomplishment	.086

* $p < .05$, ** $p < .01$.

Summary

The results of this study indicated that there is a statistically significant relationship between reported feelings of burnout and frequency of self-care activities

conducted by social workers. No statistically significant differences were noted among mean ratings of exercise, meditation, journal writing, supervision/consultation by practice setting, and there also was no statistically significant effect of employment setting on reported feelings of burnout. Social workers with more experience reported significantly lower levels of Emotional Exhaustion and Depersonalization. The correlation between years of social work practice and personal accomplishment was not statistically significant.

Chapter 5 will provide a summary of the study and offer conclusions based on the findings of the research. Study limitations, recommendations for future research related to the topic of social workers, burnout, and self-care, and implications for positive social change will be outlined.

Chapter 5: Discussion

Introduction

Chapter 5 begins with an overview of the reasons for conducting the study and explains how the study was conducted. This chapter focuses on the interpretation of the study's findings as related to the research questions and previous studies. It includes recommendations for action and further study and implications for social change.

The aim of the study was to expand understanding of how practice setting and specific self-care activities influence the experience of burnout among social workers in medical, public health, and mental health environments. This correlational study identified relationships between self-care and burnout in the targeted social worker population using the 22-item Maslach Burnout Inventory Human Services Survey (MBI-HSS; Maslach et al., 1996) and the Self-Care Assessment Worksheet (SCAW; Saakvitne & Pearlman, 1996).

Previous research on burnout has shown that individuals in professions that provide services to others are highly susceptible to burnout (Maslach & Jackson, 1981). Ben-Zur and Michael (2007) showed that social workers, psychologists, and nurses were most vulnerable to burnout due to their intensive encounters with people. Burnout has been attributed to an unhealthy relationship between the individual and the work environment (Norcross & Guy, 2007). The work environment is more than just the physical structure; it includes workload, employee autonomy and job control, personal values, job recognition and compensation, and interpersonal relationships (Hiscott, 1998). Entering a job with high motivation and commitment and then experiencing significant disappointment or a lack of positive results can lead to burnout (Pines, 1993), as can a

combination of high workload and low coping resources (Winstanley & Whittington, 2002).

Interpretation of Findings

Members of the National Association of Social Workers (NASW) who worked in medical, public health, and mental health settings comprised the sample. A significant negative correlation was found between self-care activities conducted by social workers and emotional exhaustion and depersonalization. These results are consistent with previous research on the importance of self-care in addressing burnout-related issues and concerns (Norcross & Guy, 2007). Chacksfield (2002) found that lack of self-care caused burnout and vicarious traumatization, and Norcross (2000) recommended that therapists engage in self-care practices to best maintain their personal and professional well being. It is noteworthy that, in the present study, a positive correlation was found between self-care activities and feelings of personal accomplishment.

Alkema, Linton, and Davies (2008) investigated the relationship between self-care, compassion fatigue, burnout, and compassion satisfaction among 37 hospice care professionals (HCPs). The results indicated that compassion fatigue was negatively correlated to all aspects of self-care, meaning that as reports of compassion fatigue increased, the number of self-care activities that HCPs reported decreased. Significant negative correlations also resulted between burnout and all aspects of self-care. As reported feelings of burnout increased, self- care activities in all domains decreased. A relationship between self-care strategies and lower levels of burnout, compassion fatigue, and higher levels of compassion satisfaction was highlighted by Alkema, Linton, and Davies.

The second research question examined the relationship between employment setting (medical, public health, or mental health) and the experience of burnout. Results indicated that reported feelings of burnout among social workers were prevalent in all settings with no significant differences. This study supports Ben-Zur and Michael's (2007) statement that social workers are vulnerable to burnout due to their intensive encounters with people. The social workers in this study, from medical, public health, and mental health settings, all interacted with people and reported similar feelings of burnout. In highlighting the prevalence of burnout among social workers, Lloyd, Chenoweth, and King (2002) stated that being a social worker is associated with high stress, lower job satisfaction, and higher levels of emotional exhaustion as measured by the MBI.

The third research question involved understanding possible differences in frequency of engaging in exercise, meditation, journal writing, and obtaining supervision by practice setting type. These activities were specifically selected because previous research outlined in Chapter 1 provided support for such activities and they are considered self-care in nature and beneficial. No differences were found. A holistic approach is recommended to manage work stress and engagement in self-care activities that address social, emotional, spiritual, physical, cognitive, and vocational needs (Jones, 2005; O'Halloran & Linton, 2000).

Payne (2001) identified problem solving and support seeking as effective self-care strategies used by hospice nurses. However, Alkema, Linton, and Davies (2008) explained that little empirical research is available to assist hospice care professionals in selecting effective and proven self-care strategies. The same is true in the field of social

work, as there is a gap in the literature on this topic of self-care and burnout prevention. The benefits of meditation, which include increased mental clarity, improved concentration, physical benefits, and the ability to manage life's stressors, were highlighted by Oman, Hedberg, and Thoresen (2006). In the field of nursing, supervision is reported as an effective way of supporting nurses to address feelings of burnout and other occupational stressors (Edwards, Burnard, Coyle, Fothergill, & Hannigan, (2001). Supervision is a major form of support for social workers as they seek assistance with cases and further develop their skills (Collins & Murray, 1996; Mizrahi & Abramson, 1985; Rushton, 1987). The American Psychological Association Advisory Committee on Colleague Assistance (ACCA; 2013) provided the following self-care tips: get adequate sleep, exercise regularly, maintain a healthy diet, nurture meaningful relationships, and allow for leisure time.

The fourth research question concerned the relationship between years of practice and reported feelings of burnout. Correlation analysis revealed that social workers with more experience reported significantly lower levels of emotional exhaustion and depersonalization. Interestingly, no significant correlation was found between years of social work practice and feelings of personal accomplishment. This finding was unexpected because previous studies had shown a connection between burnout and personal accomplishment. For example, Lloyd, King, and Chenoweth (2002) showed that social workers experienced a high degree of role ambiguity and role conflict. The authors stated, "it is not surprising to find a high degree of burnout on the dimension that measures feelings of personal accomplishment" (p. 262).

This study provided psychometric information on the SCAW. Based on the test-retest reliability results, the SCAW appears to be a reliable instrument for assessing the frequency of practice on self-care activities. The balance domain on the SCAW received the lowest correlation (r =.65) when test-retest reliability was assessed. This domain asks two questions pertaining to striving for balance within one's work-life and workday and striving for balance among work, family, relationships, play, and rest. In the assessment of reliability, it is possible that study participants encountered changes in the balance domain when they took the SCAW a second time. Stress-related issues and symptoms of burnout might have caused study participants to indicate lower scores on the balance domain. One week after participants completed the initial SCAW, they were invited to complete the second round of the SCAW again. Although the timing between administrations was limited, life events and unpredictable circumstances could have affected participants' ratings of balance scores.

The results of this study support Orem's (1991) theory of self-care in that social work participants who reported engaging in self-care activities indicated lower levels of burnout. In essence, as self-care activities increased, reported feelings of burnout decreased. Orem explained that self-care involves activities that are solely initiated and performed by individuals for the maintenance of their well-being. Despite the high potential for burnout in the social work profession as outlined in the literature review, social work participants who reported engaging in self-care activities reported lower levels of burnout. Orem also highlighted that self-care is a rational act and individuals can choose to engage in self-care activities unless there are limitations due to health conditions out of their control or lack of knowledge. The results of this study indicated no

differences in the type of self-care activities conducted by social workers based on practice setting. As Orem reported, individuals make a choice to engage in self-care behaviors. This study provides social workers in medical, public health, and mental health settings with information and knowledge on the topics of burnout and self-care and the importance of engaging in self-care activities to combat burnout-related symptoms.

The theory of reasoned action and planned behavior by Ajzen and Fishbein (1980) was used in this study to better understand the behavioral intentions of social work participants in the engagement of self-care activities and their reported feelings of burnout. Social workers from all three settings reported engaging in self-care activities. However, social work participants who engaged in self-care activities more frequently reported lower feelings of burnout. Specifically, participants with higher scores on the SCAW domains had significantly lower scores on measures of emotional exhaustion and depersonalization and high scores on personal accomplishment. Fishbein and Ajzen (1975) outlined that attitude in performing behaviors is based on individual views about the specific behaviors. Ajzen (1988) defined perceived behavioral control as an individual's perception of the level of difficulty for performing an activity. The greater the perceived behavioral control, the increased likelihood that the activity will be attempted. The results of this study did not indicate that social work participants are opposed to engaging in self-care activities or perceive that engagement in self-care activities is out of their control. When completing the SCAW, participants provided other self-care activities they conducted that were on the SCAW, including aromatherapy, communicating with spouse on important issues, having retreat days, and getting together with old friends. Social work participants with more experience reported lower levels of

emotional exhaustion and depersonalization, but personal accomplishment and years of social work practice were not statistically significant. Further study is needed in this area to better understand social workers' views of personal accomplishment in relation to years of practice and practice setting.

Limitations of the Study

One limitation of this study was its correlational research design. While tentative predictions can be made using correlational data, definitive conclusions regarding causation cannot be offered. Both survey instruments used in this study, the MBI-HSS (Maslach et al., 1996) and the SCAW (Saakvitne & Pearlman, 1996), are self-report measures that are subject to response bias and rely on participants completing the surveys truthfully. It is possible that some participants overestimated or minimized their reports of burnout or practice of self-care activities. In addition, the online nature of the study instruments may have biased the sample toward participants with ready access to a computer and the Internet.

This study was also limited by its small sample size ($N = 185$). In order to make more definitive conclusions regarding self-care activities among social workers in medical, public health, and mental health settings and reported feelings of burnout, larger sample sizes are needed. Given the small sample size and the convenience sampling strategy used by selecting social workers who were members of the NASW and who worked in medical, public health, and mental health settings, the generalizability of this study may be restricted to this population. Lack of diversity in some demographic variables, including gender, race and ethnicity, relationship status, degree status, and social work license type, may also limit generalizability. With smaller sample sizes, it is

more difficult to establish statistical significance, as statistical tests generally require a larger sample size to ensure a representative sample of the population. The a priori sample size calculation conducted prior to the start of the study based on Faul, Erdfelder, Lang, and Buchner (2007) indicated that a sample of size of 159 participants is needed to confer 80% power. Based on the sample size of 185 participants, this study conferred approximately 86% power. The response rate for this study was 12.3% (185 respondents/1,500 participants contacted). In this study, a larger sample size might have revealed a significant relationship between social workers' feelings of burnout and personal accomplishment.

Recommendations

This study highlights the importance of engaging in self-care activities in order to decrease symptoms of burnout. More studies of self-care among social workers should be conducted to add to the current literature and to educate social workers on the significance of engaging in self-care activities for burnout reduction and other possible benefits. Social workers should develop and set realistic and practical goals to engage in self-care activities as often as possible. Social work students must also be educated on topics related to burnout and self-care and be highly encouraged to develop self-care strategies early on so they can continue these practices throughout their career.

Organizations should create and support policies and procedures that promote self-care practices among social workers so that social workers feel supported, empowered, and motivated to engage in these activities. Examples of activities that organizations can support include encouraging social work employees to go walking at nearby trails or areas that are considered safe and conducive to walking, encouraging

social work employees to engage in stretching and yoga activities at work, creating space for meditation or aromatherapy, and promoting staff supervision and support. Recently, my employer instituted a health promotion program that focused on self-care activities for staff. Staff were highly encouraged to participate in exercise-related self-care activities 3 days a week for an hour during the workday. The organization worked with the local gymnasium to provide exercise classes that would accommodate the limited time, and staff were encouraged to use area walking trails to go walking. In an effort to enhance participation, senior management officials expressed support for the program and ensured that supervisors and department heads were enabling staff to engage in approved activities.

In this study, some participants reported lack of support by organizational leaders for social workers to engage in self-care activities at work and indicated that patient care requirements made it virtually impossible for self-care activities to be completed during the work day. High levels of burnout among workers in the workplace is indicative of workers lacking the resources to deal with the demands of the job, leading to impaired job performance. Workers may not be willing to expend effort, leading to suboptimal functioning at work (Taris, 2006). Corrigan (1990) added that burned-out workers may be less able to be empathetic, collaborative, and attentive. These are all characteristics that have been associated with high consumer satisfaction. Organizations can conduct surveys, particularly among social workers, to elicit valuable information on their thoughts, needs, ideals, and recommendations with regard to self-care and burnout-related feelings. By surveying social workers, organizational leadership can obtain information on supportive programs and strategies that can be implemented within the

workplace that can be beneficial for social workers. Beyond surveying workers, organizations can promote self-care within the work environment by providing space for meditation outside of social workers' offices, providing a CD player in the break room for use during breaks, enforcing break/lunch policy to support social workers in taking their lunch breaks, and supporting supervision, consultation, and peer support among social workers to process challenging cases. If possible, organizations can enable social workers to have flexible schedules in which they can work longer days and take a day off every other week. Organizational leadership can also provide monthly luncheons or self-care events for social workers. Various forms of professional development can be discussed in addition to ethics. Additionally, a yoga instructor can be invited to teach the staff poses that can minimize feelings of stress and increase a sense of well being. If they are fully supported in engaging in self-care activities, social workers may feel supported and valued by the organization.

In the area of organizational support for self-care programs and activities among social workers, organizational leadership and social workers should be enabled to provide important information on current organizational culture and programs and interventions implemented in support of self-care. Social workers should be enabled to share recommendations on self-care activities and programs that will be beneficial to them. These recommendations will be helpful for organizations to explore and possibly implement, if feasible, for the benefit of social workers. Volk, Guarino, Grandin, and Clervil (2008) explained that building an organizational culture of self-care requires an initial reflection on current happenings within the organization. Thereafter, the goal for the organization becomes building self-care practices into daily routines and rituals in

order to develop good habits within the organization. The need for burnout prevention and interventions for mental health providers has been highlighted by Pines and Maslach (1978) for decades. However, the authors reported that few burnout programs have been implemented and evaluated. Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) reported that research conducted on the evaluation of burnout prevention programs is limited. The same is true for self-care programs and interventions specific to the field of social work.

Salyers, Hudson, Morse, Rollings, Monroe-DeVita, Wilson, and Freeland (2011) conducted a study on mental health staff that combined cognitive-behavioral coping skills with other strategies that included mindfulness, meditation, identifying personal meaning, time was given to participants to develop personal strategies for coping with individual stressors, and developing gratitude in a one-day training session. The results of this study showed a decrease in emotional exhaustion and depersonalization and an increase in positive perceptions of consumers six weeks later. The interventions used in the study by Salyers et al. (2011) are all self-care activities that social workers can conduct to decrease burnout related symptoms. Another study conducted by vanDierndonck, Schaufeli, and Buunk (1998) sought to reduce burnout by reducing feelings of inequity in workers by improving worker congruence. Cognitive behavioral interventions (cognitive structuring and relaxation training) were used for staff and supervisors were also trained in communication and social skills. The results of the study indicated reduced burnout, absenteeism, and feelings of being deprived for over a year among the intervention group in a quasi-experimental study. Morse, Salyers, Rollins, Monroe-DeVita, and Pfahler (2012) suggested that research on reducing staff burnout should examine the effects on

consumers, hoping that burnout reduction programs will improve the quality, quantity, and outcomes of services to individuals with mental health.

Organizational factors that have been identified as contributing to the burnout process for social workers include role ambiguity, role conflict, challenge of the job and job autonomy. Changes to organizational structures have rendered social workers unable to use their skills due to conflicting role expectations of them. Social workers are expected to address the plight of clients with reduced autonomy and reduced resources creating a high degree of burnout on the personal accomplishment scale (Lloyd, King, & Chenoweth, 2002). Social workers unique contribution to multidisciplinary teams is not always clearly understood or valued as their knowledgebase is largely derived from allied fields (Dillon, 1990; Rabin & Zelner, 1992; Reid et al., 1999). Changes to health and social care in relation to organizations and delivery of services have been highlighted. In order to respond to these changes, Lloyd, King, and Chenoweth (2002) outlined that it is necessary for individual professions to develop effectiveness in their own areas of practice to further develop their personal identity. Organizational leaders can work with social workers to develop position descriptions, roles, expectations, and requirements in order to foster a clearer understanding of their roles and minimize role ambiguity.

The lack of clarity by other professionals and the general public on social workers roles and functions creates stress for social workers (Collings & Murray, 1996; Gibson, et al, 1989; Jones et al., 1991; Smith & Nursten, 1998). Dillon (1990) added that others misinterpret social workers as just being nice or doing common sense things that anyone can do. Confusion related to social work roles and tasks within the field and the inability to demonstrate effectiveness was highlighted by Ruston (1987) and this has been

attributed to the challenges faced by social workers regarding legitimacy and social work identity (Jones & Novak, 1993). In a qualitative study, mental health social workers reported feelings of frustration because their roles and range of skills were misunderstood and inadequately valued by other health service staff (Reid et al., 1999). Kudushin and Kulys (1995) alluded to social workers reporting conflicting role expectations compared to other members of the team. Social workers reported a lack of understanding of their roles and lack of appreciation for their work with clients. Problems with role conflict increases reported burnout related feelings and job dissatisfaction among social workers (Um & Harrison, 1998). Social workers should be encouraged to educate other professionals with whom they work, and in some instances multidisciplinary teams, on their roles, functions, and scope of practice to differentiate themselves from other helping professionals, such as psychologists, counselors, psychiatrists, and therapists. Doing so will address issues related to social work role clarity and possibly minimize feelings of frustration and burnout among social workers.

Further Study

Based on the results of this study, it is evident that social workers that engage in self-care activities do benefit from decreased burnout related feelings. Replicating this study and adding social workers from other practice settings to include child and welfare services, addiction services, and private practice will add to the current gap in the literature on the topic of self-care and social workers. Also, including social workers from other practice settings will enable similarities and differences to be examined based on practice settings, reported feelings of burnout, and frequency of self-care activities conducted. Future research should continue to advance our understanding of burnout among social workers,

especially factors that affect their reported feeling of personal accomplishment. This will add to the current literature that implies that it is not surprising to find a high degree of burnout among social workers on measures of feelings of personal accomplishment (Lloyd, King, Chenoweth, 2002). Majority (46%) of the participants in this study were between ages 51 – 56. This raises the question of whether or not the results of this study are due to having mature and experienced study participants? In order to have a representative sample of the social work population, additional research is needed among social workers with diverse sample characteristics. This will enable comparisons to be made with existing research, thus adding to the literature and providing recommendations for the field of social work. Additional information will also be obtained regarding social workers reported feelings of burnout and their engagement in self-care activities using a more representative sample.

Additional research is needed on the quality of care provided to patients by social workers that report feelings of burnout. Results of this study will gain organizational and professional attention, particularly if a negative impact is implied. Hence, self-care interventions may swiftly be implemented on behalf of social workers to ensure that quality services are provided to clients. The SCAW is useful and effective in assessing the various types of self-care activities conducted by social workers as well as the frequency. Additional research with a larger sample size to validate the psychometric properties of this instrument will be key to potentially use this instrument across helping professions such as psychologists, psychiatrists, and nurses to assess self-care activities conducted. Although social workers are able to identify and rate the frequency of their self-care activities using the SCAW, a qualitative study should be conducted among

social workers with varied educational backgrounds and licensure, practice settings, age, gender, and years of practice. Open ended questions should be asked regarding types of self-care activities conducted, rationale, and effectiveness. The information obtained from the proposed qualitative study should be compiled and widely available to all social workers as a research based self-care practice resource guide.

Implications for Social Change

This study has implications for positive social change that would benefit the social work profession, social workers, organizations, and the various client populations being served. Given the limited information available on the self-care patterns of social workers in relation to reported feelings of burnout, this study adds to scientific understanding of correlates of burnout. The current literature describes social workers as being intensely involved with clients and thus being prone to feelings of burnout. However, social workers are encouraged to engage in self-care activities to prevent the development of burnout related symptoms. This study provides detailed information on the topic of self-care and burnout among social workers that serves educational and preventative purposes for social work readers.

The results of this study highlight the benefits of engaging in self-care activities to prevent burnout and to provide quality care to patients. Higher levels of self-care were significantly associated with lower levels of burnout. Specifically, social work participants with higher levels on the SCAW scales had significantly lower scores on measures on emotional exhaustion and depersonalization, and high scores on personal accomplishment. No significant mean differences were found between practice settings and reported feelings of burnout. This highlights the wide spread nature of burnout in the

field of social work and the importance for all social workers regardless of practice setting to frequently engage in self-care activities to prevent burnout related symptoms. Social workers with increased years of practice experience reported lower levels of emotional exhaustion and depersonalization. However, the correlation between years of social work practice and personal accomplishment was not statistically significant. This result cautions social workers with increased years of practice experience to be mindful of not experiencing increasing feelings of personal accomplishment. Being a veteran in the field, social workers can become accustomed to providing services to clients and find it challenging to identify personal accomplishments. However, frequently engaging in a variety of self-care activities like supervision and consultation can provide additional insight and a change in perceptions of client's progress and overall personal accomplishment of veteran social workers. Social workers with twenty or more years of practice experience and social workers that have been employed in the same setting for over five years completing the same tasks may find it challenging to identify personal accomplishment.

Newly hired social workers in medical, public health, and mental health settings should be educated on the self-care strategies utilized by their fellow colleagues. Specific information should be provided to them on the impact of conducting self-care activities on feelings of burnout, other social workers self-care activities that they conduct and benefits. Doing so can encourage and empower social workers entering the various practice settings to adopt frequent engagement in self-care activities to prevent symptoms of burnout. Social workers who may be feeling the effects of burnout and are not actively engaged in conducting self-care activities may benefit from the results of this study by

raising their awareness on the topics of burnout and self-care. Also, they may be motivated to attempt engaging in self-care activities due to the statistically significant relationship established between self-care and reported feelings of burnout.

The results of this study can be used to educate organizational leadership on the topic of burnout and the importance of social workers engaging in self-care activities. Leadership should be provided the results of this study to high the findings and emphasized the relationship between increasing self-care activities and decreasing reported feelings of burnout. The focus will also be to encourage leadership to create a self-care friendly environment using some of the aforementioned recommendations that will empower social workers to utilize resources available to them. The results of this study that indicated that practice setting was not statistically significant with specific self-care activities that included; exercising, meditation, journal writing, and supervision and consultation. The key to sharing this result would be to highlight that the specific type of activity conducted based on practice setting is not as critical as the staff engaging in self-care activities in general to reduce reported feelings of burnout. Leadership will be encouraged to foster an environment of peer support among seasoned and new social workers to the field. The results of this study pertaining to social years with increased years of practice reporting decreased emotional exhaustion and decreased depersonalizations will be highlighted. The lack statistical significance indicated by seasoned social workers will also be addressed in order for leadership to ensure that all social workers feel valued and support the assertion that they are making a difference in the lives of clients they serve.

There are significant costs to organizations due to absenteeism, staff turnover, paid time off, and sick leave when staff experience burnout. To reduce these costs, organizational leadership should implement programs and policies to enable staff to alleviate burnout-related symptoms and concerns. Morse, Salyers, Rollins, De-Vita, and Pfahler (2012) found that burnout reduction programs improved the quality, quantity, and outcomes of services to individuals with mental health concerns. Although these programs may be costly to organizations to implement, they should be viewed as an investment for social workers and the various populations served. Social workers will benefit from self-care programs to combat possible burnout related symptoms.

Conclusion

As providers of mental health services, it is vital that social workers care for themselves in order to provide excellent care to individuals, families, and other groups that they serve. The importance of engaging in self-care activities to alleviate symptoms of burnout should continually be emphasized to social workers, students, and organizations. Doing so will sustain awareness on self-care related topics. The potential benefits to organizations for supporting self-care activities among social workers are many, including quality care for clients, decreased employee absenteeism, decreased costs related to absenteeism, and reduced employee turnover.

Social workers are encouraged to utilize their advocacy skills on their own behalf, within their organizations if necessary, to promote a self-care friendly environment and to receive support from their leadership. Some social workers suffer in silence from burnout; they are encouraged to seek help to develop coping strategies, establish strong supportive networks, and engage in self-care activities such as walking, yoga, journaling,

meditation, taking a vacation, and seeking supervision and consultation. As a social worker myself, conducing this research highlighted the following three points; (1) the importance of developing a realistic self-care plan and engaging in self-care activities outlined in order to alleviate symptoms of burnout, (2) prioritizing engagement in self-care activities daily, (3) exploring and engaging in other self-care activities regularly to keep one's self-care plan interesting, fun and evolving.

Social workers should view frequently engaging in self-care activities as the guard against burnout related symptoms that can negatively affect a social worker personally and professionally. Due to issues with timing and availability, it is important that self-care plans include activities that that can be conducted within a short amount of time and require limited space. For example, taking a ten-minute brisk walk, brief meditation and deep breathing exercises in between seeing clients, and stretching in one's office space every morning before the start of the workday. Social workers should endeavor to always engage in self-care activities to maintain their passion as change agents and commitment to helping others as human service professionals.

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Appendix A: Initial Letter

Social Worker Self-Care Study—Initial Contact Letter

From: Jennifer Weekes, MSW, LICSW
PhD Candidate – Walden University

Date: April 16th 2013

Greetings Social Worker,
My name is Jennifer Weekes and I am a Licensed Independent Clinical Social Worker in the District of Columbia and the state of Georgia (LCSW). I am also a PhD candidate in the Public Health program at Walden University. I am currently in the dissertation process and have been approved by the Walden University IRB (**Approval Number: 04-02-13-0084264**) to conduct my study on: **The Effects of Self-Care on Burnout among Social Workers in Medical, Public Health, and Mental Health Settings**. My dissertation chair is Dr. Ji Shen and he can be reached via email. I decided to utilize social workers that are members of the National Association of Social Workers (NASW) because the NASW is the largest organization of social workers in the United States of America. Also, I am hoping to obtain information from social workers on current feelings of burnout and self-care practices being conducted.

I would truly appreciate your participation in this study. This study entails completing three surveys that include; a demographics form, the Maslach's Burnout Inventory – Health Services Survey, and the Self-Care Assessment Worksheet. Completing all three surveys will take no more than 20 minutes. Please note below the link to review the consent form and access the surveys. Responses provided on the surveys are anonymous, confidential, and password protected. Kindly note that participation in this study is fully voluntary and you may choose to terminate your participation at any time.

Survey Link: http://www.mindgarden.com/survey/11952

Please know that your participation in this study will enable important data to be collected and analyzed on the topic of social workers and self-care. This study will not only add to the social work literature, but it will also be used to encourage fellow social workers on the importance and effects of self-care. Organizations can utilize the results of this study to promote self-care and advance the health and wellbeing of social workers as we strive to help others. If you have any questions or concerns, please do not hesitate to contact me. I will be pleased to provide you the results of the study in a summary upon completion, after your participation.

Sincerely,
Jennifer Weekes
Jennifer Weekes, MSW, LICSW
PhD Candidate – Walden University

Appendix B: Social Workers and Self-Care in Medical, Public Health, and Mental Health Settings Consent Form

We invite you to participate in this research study on the effects of self-care on social workers in medical, public health, and mental health settings because you are a member of the National Association of Social Workers (NASW). Please read this form completely and ask questions if any before you agree to participate in this study. I, Jennifer Weekes am conducting this study under the supervision of Dr. Ji Shen and Dr. Gary Burkholder. I am a PhD candidate with Walden University.

Background Information: This study aims to examine the effects of self-care on social workers in medical, public health, and mental health settings.

Procedures: To state your agreement to participate in this study, please click the button labeled "I Agree to Voluntarily Participate" after reading this consent form. After agreeing to participate please complete the three questionnaires that follow. The first questionnaire is a demographic questionnaire that asks basic questions about you and your current status. The second questionnaire is the Maslach's Burnout Inventory that asks questions about your feelings of burnout in your current work settings. The third and final questionnaire is the Self-Care Assessment Worksheet that allows you to rate if you conduct the self-care activities stated. Completing all three questionnaires should take no longer than 20 minutes.

Please note that there is an opportunity to complete the Self-Care Assessment Worksheet a second time after your initial completion, in order to gather additional reliability information. If you agree to complete the Self-Care Assessment worksheet a second time, there is a space at the bottom of this form for you to provide your email address. By providing your email address, an online survey link will be sent to you via email requesting your second completion of the Self-Care Assessment Worksheet. Completing the Self-Care Assessment Worksheet a second time will take no longer than 10 minutes. Note that you do not have to complete the Self-Care Assessment Worksheet a second time if you choose not to do so.

Voluntary Participation of this Study: Your participation in this study is completely voluntary and you can withdraw from this study at any time while completing the surveys. Information reported on the surveys will not be provided to the NASW or your current employer. Everyone will respect your decision of whether or not you chose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at anytime.

Risks and Benefits of Participating in this Study: This study poses no physical risks and there are no foreseen risks to participation. The benefits to participation are to assist the researcher in understanding the effects of self-care among social workers in medical,

public health, and mental health settings. Also, this research will add to the social work literature on this topic. There is no financial or other compensation for participating in this study. Due to the types of questions asked in this study, emotional upset is possible. If you experience emotion upset, please contact the Substance Abuse and Mental Health Services Administration (SAMHSA) – Center for Mental Health Services (CMHS) for a national listing of mental health providers. The number to call for SAMHSA is: 240-276-1310. Mental Health Treatment Facility Locator can be done online via SAMHSA's webpage at: http://findtreatment.samhsa.gov/MHTreatmentLocator/faces/faq.jspx Please note that you are under no obligation to complete parts of the surveys that make you feel uncomfortable.

Payment: There is no payment or financial compensation for your participation in this study.

Privacy: All information obtained from this study will be kept private and confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Research information will be password protected and only this researcher will have access. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions: You may ask any questions you have now. Or if you have questions later, you may contact the researcher via email. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Walden University's approval number for this study is **04-02-13-0084264** and it expires on **April 1, 2014**.

Please print or save a copy this consent form for your records. After the study is completed and dissertation has been completed, please email me for a copy of the results of the study.

Statement of Consent: I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By checking the box below, "I consent", I understand that I am agreeing to the terms described above.

Appendix C: Demographic Questionnaire

Please complete this questionnaire by selecting the responses that best addresses your current status. Information reported on this survey will remain confidential and any reports published will not contain identifying information.

Gender: ____Female _____Male

Relationship Status: _____Single_____Married _____Divorced

_____Separated _____Widowed _____Committed Relationship

Age Range (Please specify): ____

Degree (Please select highest social work degree held – Check only one):
_____Bachelor's _____Master's _____Doctoral

Type of Social Work Licensure (Please selected highest social work licensure held – check only one): _____ Bachelor's Level _____Master's

_____Graduate Level _____Master's Clinical Level _____Master's

_____Advance Level

Ethnicity – Please check all that apply: _____African American____Caucasian/White

_____Native American _____American Indian or Alaskan Native _____Asian Indian

_____Hispanic/Latino _____Chinese ____ Japanese _____Korean

_____Guamanian or Chamorro ____ Filipino ____Vietnamese ___Other Asian

____Other Pacific Islander ____Native Hawaiian ____Samoan Other_____

Practice Setting – Please select the setting that best applies to your current place of employment

Medical Setting_____ (These settings include hospitals, medical centers or clinics (inpatient or outpatient) and nursing and personal care facilities that provide medical services to patients).

Public Health Setting_____ (These settings include working at individual and family services agencies and local governments**).**

Mental Health Setting_____ (These settings include facilities that may be inpatient or outpatient and focus on mental health and psychiatric care).

Years of Employment at Current Employment Setting – Please specify: _____

Total Years of Social Work Practice – Please Specify _____

Thank you for completing this survey. Please proceed to completing the next two surveys.

Appendix D: Social Worker Self-Care Study—Reminder Letter

From: Jennifer Weekes, MSW, LICSW
PhD Candidate – Walden University
Date: April 24th 2013
Dear Social Worker,
This is a reminder to participate in the research study entitled: **The Effects of Self-Care on Burnout among Social Workers in Medical, Public Health, and Mental Health Settings**. A week ago, an initial letter was mailed to you outlining details about the study and requesting your voluntary participation, by visiting the following survey link listed below.

Survey link:
HTTP://WWW.MINDGARDEN.COM/SURVEY/11952

The benefits to participation are to assist this researcher in understanding the effects of self-care on reported feelings of burnout among social workers in medical, public health, and mental health settings. Also, this research will add to the social work literature on this topic.

You are being guaranteed that your survey responses will be kept private and confidential. This researcher will not use your personal information for any purposes outside this research project. Also, this researcher will not include your name or anything else that could identify you in the study reports.

If you have not had a chance to participate in this study by completing the online surveys, please let me urge you visit the survey link stated. Completing all three surveys will take no more than 20 minutes. Please remember that there is also the opportunity to complete the Self-Care Assessment Worksheet (SCAW) a second time to obtain reliability information. Only the first 50 voluntary respondents that indicate "yes" on the demographics questionnaire and provide their email addresses will be contacted via email with another survey link to complete the SCAW a second time. If you have already participated in the study by completing the surveys, thank you very much. Please do not hesitate to contact this researcher via email with any questions or concerns regarding this study.

Again, the survey link:
HTTP://WWW.MINDGARDEN.COM/SURVEY/11952

Thank you,

Jennifer Weekes

Jennifer Weekes MSW, LICSW
PhD Candidate – Walden University

Appendix E: Maslach Burnout Inventory: Human Services Survey—Approval

Subject : **Response from Mind Garden - Jennifer Weekes - re: Confidentiality**

Date : Wed, Feb 27, 2013 06:17 PM CST

From : **Mind Garden**

To : Jennifer Weekes

Hello Jennifer Weekes,

Based on your purchase of the MBI manul (Order 17260 in July 8, 2011), you have our permission to make ONE copy of the MBI instrument (from the manual) for presenting in your proposal to your IRB.

Best regards,
Mind Garden, Inc.

Appendix F: Self-Care Assessment Worksheet (SCAW)—Approval

Subject : **Re: Request to use the Self-Care Assessment Worksheet (SCAW) for Dissertation Purposes**

Date : Fri, Mar 08, 2013 04:12 PM CST

From : **Jennifer Weekes**

To : Permissions

Mrs.
Thank you very much. I am most grateful.

With Sincere Thanks,
Jennifer Weekes.

Original E-mail
From : Permissions [
Date : 03/08/2013 03:27 PM
To : Jennifer Weekes Subject : RE: Request to use the Self-Care Assessment Worksheet (SCAW) for
Dissertation Purposes
Dear Jennifer Weekes:
Thank you for your request to use the Self-Care Assessment Worksheet from TRANSFORMING THE PAIN: A WORKBOOK ON VICARIOUS TRAUMATIZATION by Karen W.Saakvitne and Laurie Ann Pearlman in your dissertation, The Effects of Self-Care on Burnout Among Social Workers in Medical, Public Health, and Mental Health Settings.

This letter will grant you one time, nonexclusive rights to use the material in your dissertation, and in all copies to meet university requirements including University Microfilms edition and 500 copies of the Self-Assessment Care Worksheets for Social Work study participants subject to the following conditions:
1. Such material must either be reproduced exactly as it appears in our publication
2. Full acknowledgment of the title, author, copyright and publisher is given as follows:
>From TRANSFORMING THE PAIN: A WORKBOOK ON VICARIOUS TRAUMATIZATION by Karen W. Saakvitne and Laurie Ann Pearlman. Copyright (c) 1996 by the Traumatic Stress Institute/Center for Adult & Adolescent Psychotherapy LLC. Used by permission of W.W. Norton & Company, Inc.
3. You must reapply for permission if your dissertation is later published.

_____
From: Jennifer Weekes
Sent: Wednesday, February 27, 2013 11:21 AM
To: Permissions
Subject: Request to use the Self-Care Assessment Worksheet (SCAW) for Dissertation Purposes
Greetings Sir/Ma'am,
My name is Jennifer D. Weekes and I am PhD student with Walden University. I am currently in the dissertation phase and my topic is: The Effects of Self-Care on Burnout Among Social Workers in Medical, Public Health, and Mental Health Settings. In order to capture Social

Workers reported engagement in self-care activities, I would greatly appreciate your approval for me to use your published Self-Care Assessment Worksheet (SCAW). Please note that my target sample size for this study is 159 participants. I also plan on conducting test-retest reliability using the Self-Care Assessment Worksheet by administering the SCAW twice to participants that provide consent.

Please assist me with my dissertation process by providing me the approval of using 500 Self-Assessment Care Worksheets for Social Work study participants. In the event that I need to utilize additional Worksheets, I will contact you again. Kindly note that you can provide me your approval at my email address or by replying to this email.

Please also provide me approval that I can submit a copy of the SCAW with my IRB application and as an appendix on my completed dissertation. Thank you very much in advance. I look forward to your feedback. If you need to reach me, please do not hesitate to email me or call me directly.

The source for the Self-Care Assessment Worksheet is: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996).

Sincerely,
Jennifer Weekes

Curriculum Vitae

JENNIFER D. WEEKES

EDUCATION

2014	PhD, Public Health Walden University	2013	MPH, Public Health New Mexico State University
2002	MSW, Social Work Virginia Commonwealth University	2001	BSW, Social Work Virginia Commonwealth University

PROFESSIONAL LICENSES

2007	Licensed Independent Clinical Social Worker District of Columbia	Licensed Clinical Social Worker Georgia

EMPLOYMENT EXPERIENCE

08/13 – Present	Chief, Social Work Services
12/12 – 08/13	Licensed Clinical Social Worker
12/11 – 12/12	Licensed Clinical Social Worker
1/10 – 12/11	Family Advocacy Social Worker
1/08-1/10	Licensed Clinical Social Worker
7/06 – 12/07	Social Worker
3/03 – 7/06	Clinical Support Specialist
7/02 – 1/03	Qualified Social Worker

PROFESSIONAL MEMBERSHIPS: National Association of Social Workers (NASW) and American Public Health Association (APHA)