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THE IMPORTANCE OF SELF-CARE AMONG HOSPICE SOCIAL WORKERS

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THE IMPORTANCE OF SELF-CARE AMONG HOSPICE SOCIAL WORKERS

A Project

Presented to the

Faculty of

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San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

by

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ABSTRACT

Social workers, in general, face daily challenges, but social workers in the field of hospice face unique daily stressors. The purpose of this study was to investigate what self-care methods hospice social workers use to combat burnout and compassion fatigue. One hundred hospice social workers were surveyed. Researchers used two scales to measure participants' current self-care methods and their current quality of life. Researchers used a two-tailed Pearson test to analyze relationships between self-care and burnout as well as self-care and compassion satisfaction. Researchers also utilized various SPSS tests to analyze the relationship between demographics and self-care methods. Participants reported using all categories of self-care methods equally with no significant difference. The most significant results are that compassion satisfaction was positively correlated to all self-care categories and burnout is negatively correlated to all the self-care areas. These results indicated that there is a relationship between the frequency of self-care methods and low rates of burnout and compassion fatigue.

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CHAPTER ONE

INTRODUCTION

Problem Formulation

Social work is a profession in the human service field with the mission of improving the overall well-being of all people, but specifically those who are vulnerable, oppressed and in poverty (National Association of Social Workers, 2017). Social workers first develop relationships with clients and assist the clients by advocating, providing direct services, or providing therapy ("Why Choose the Social Work Profession," n.d.). As reported by a nationwide study of 10,000 social workers within the U.S. challenges faced by social workers on a daily basis has increased (Whitaker, Weismiller, & Clark, 2006). Daily stressors include increased documentation, increased caseload size, and increased waiting lists of resources for clients (Whitaker et al., 2006). While stressors have increased, supportive measures for social workers have decreased such as opportunities for supervision/consultation, employment opportunities, and resources for clients (Whitaker et al., 2006). A subsect of social workers, hospice social workers, face these challenges and more.

According to the Centers for Disease Control and Prevention [CDC] (2019), in 2015, there were 1.4 million patients of all ages using hospice care programs in the United States. This program consists of improving the quality of life for patients that have a life expectancy of six months or less ("Social Workers in Hospice and Palliative Care Occupational Profile," 2010). Hospice care

workers work in interdisciplinary teams to guide patients on this transcendental journey. This team consists of doctors, nurses, aides, volunteers, and social workers. Daily stressors for hospice care workers include working in a field in which death is viewed as a medical failure, numerous regulations, insurance eligibility issues, short staffing, mandatory overtime, and communication issues between workers and administration, (Keidel, 2002; Sardiwalla, Vandenberg, & Esterhuyse, 2007).

As part of the interdisciplinary team, hospice social workers guide patients and their families through the end-of-life services, advocate for the families' needs, provide references to resources, and provide counseling services to patients and their families. Hospice social workers manage stressful events such as patients' deaths, grieving families, observing pain in patients, and deal with intense emotional states daily (Alkema, Linton, & Davies, 2008). Managing these stressors over time leads to feelings of burnout or compassion fatigue. Burnout is a response to the stress experienced in a work environment (Stamm, 2010). Compassion fatigue is a response to being exposed to the suffering of others for a long period (Figley, 1999). As per Alkema et al. (2008), the terms, burnout, and compassion fatigue have been used interchangeably in past studies.

When a hospice worker is stressed out, there are negative effects on an individual, work team, and patient basis. On an individual basis, effects include poor judgment, professional boundary violations, and evading highly emotional situations (Kearney, Weininger, Vachon, Harrison, & Mount, 2009). On a work

team basis, the effects include high job turnover, low morale, and staff conflicts (Kearney et al., 2009). These reactions are not conducive to maintaining engagement with emotionally vulnerable patients, affect the high quality of care that is expected of hospice, and create an unstable work environment (Keidel, 2002). Since burnout and compassion fatigue have adverse effects on the hospice care system, it is logical that both need different protective measures in the form of self-care methods.

Purpose of the Study

The purpose of this study is to raise awareness of self-care methods that hospice social workers use to minimize burnout and compassion fatigue. The hospice social work profession is increasing, and it is vital to research burnout related to this field since there will be an increased need for hospice social workers within the next ten years. By 2050, there will be 88 million people that will be 65 years and over which will test the U.S. healthcare system (He, Goodkind, & Kowal, 2016). Moreover, hospice social workers provide unique services to clients in comparison to other social work professions. There is an increasing risk for burnout and compassion fatigue in this field due to a high-stress and high-loss environment (Quinn-Lee, Olson-McBride, & Unterberger, 2014).

Hospice social workers work with the needs of families and patients who are near the end of their lives. Hospice workers work to maintain or improve the quality of life of patients. Working in a stressful and high-loss environment can

take a toll on hospice social workers and can impact the relationships with clients and the ability to complete daily tasks while on the job. Once hospice social workers and hospice agencies become aware of the impact the hospice environment can have on employees, there will be clear strategies on how to combat burnout and compassion fatigue.

The research method will incorporate a quantitative design. The research will consist of self-administered surveys to determine hospice social worker self-care methods. Quantitative design was chosen due to the limited time frame. This type of research design will give an opportunity to collect data from a large group of people in a short amount of time.

Significance of the Project for Social Work

The findings of this study will contribute to social work practice on both micro and macro levels. On a micro level, protective measures that are discussed can be implemented individually by future social workers. These individually applied measures will help maintain healthy engagement between social workers and patients and help prevent ongoing compassion fatigue. On a macro level, these protective measures can be integrated into the work environment by employment agencies and help prevent future employee turnover, low morale, and staff conflicts, caused by burnout. Ideally, protective measures for both burnout and compassion fatigue will be implemented individually and organizationally, thus providing high-quality care to future hospice patients and their families. Also, the protective measures or self-care

methods that are successful in hospice could be applied to other professional fields as well.

One of the guiding principles of the National Association of Social Work [NASW] (2017) is to be competent when servicing vulnerable populations. Competence in social work not only relates to understanding the challenges that vulnerable populations face but also understanding the challenges of the medium that provides the much-needed services, the social workers. A stressed-out social worker cannot provide high-quality care to an emotionally vulnerable hospice patient and their family. Ultimately, this leads to the problem formulation of this paper to be: What self-care methods do hospice social workers use to combat burnout and compassion fatigue?

CHAPTER TWO

LITERATURE REVIEW

Introduction

This chapter consists of an overview of the literature related to daily stressors and self-care in the field of social work. The subsections will include hospice social work stressors, burn out and compassion fatigue, an overview of self-care, and address the limitations of past studies. The final subsection will examine systems theory within the framework of self-care for social workers.

Hospice Social Work Stressors

Hospice is a unique human service field. Unlike the Western model of medical care in which the end goal is to heal, hospice is focused on providing comfort and care to patients and their family while the patient's lives out the natural course of their medical condition (Ditullio & MacDonald, 1999; Keidel, 2002). Hospice social workers hold a distinctive role within the hospice care team by being the primary guide for patients and their families through the hospice care system. Hospice social workers provide spiritual, psychological, and emotional support to patients and their families (Ditullio & MacDonald, 1999). Hospice social workers' duties include therapy or counseling, education on coping skills and nonpharmacological symptom management strategies, facilitate end of life planning, mediate conflicts, advocate on behalf of the family, and

connect the family with community resources (“Social Workers in Hospice and Palliative Care Occupational Profile,” 2010).

Hospice social workers experience daily stress from working with clients. Hospice social workers report having high caseloads. Hospice social workers have an average of 24.2 patients whereas hospice nurses average 13.3 patients per caseload (National Association of Social Workers, 2010). Any interventions or resources provided by hospice social workers have a sense of urgency, are crisis driven and hospice social workers have anxiety over patient care since the patient's condition is deteriorating (Pelon, 2017; Quinn-Lee et al., 2014). Additional challenges include having reduced time to emotionally process their own feelings, seeing emotional and physical pain, hearing traumatic stories, dealing with their own personal feelings of grief, and being physically and emotionally exhausted (Alkema et al., 2008; Ditullio & MacDonald, 1999; Quinn-Lee et al., 2014). According to Quinn-Lee et al. (2014), hospice social workers also face death anxiety. This was reported to be experienced by hospice social workers starting their career, when working with a patient similar in age or life stage, or when a patient’s pain wasn’t properly controlled (Quinn-Lee et al., 2014).

Hospice social workers face organizational stressors from their agency of employment. Hospice social workers are not properly compensated for their work duties. Hospice social workers earn the lowest salaries in the field of health care. According to Whitaker, Weismiller, and Clark (2006), health care social workers

in hospitals earn the highest, followed by health clinics, and then hospice. Hospice care workers have minimal opportunities to continue their education. As reported by Whitaker et al. (2006), one in five hospice social workers stated that there are continuing education programs available at their agency of employment. Hospice social workers are also the most likely to be dissatisfied with the support and guidance provided by their supervisors than their counterparts in the healthcare sector (Whitaker et al., 2006). In a study of 547 hospice workers that included hospice social workers, 60% of participants reported moderate to high stress (Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013). With the aforementioned stressors, it is no surprise to find that hospice social workers are less likely to remain in their current position than their colleagues in the healthcare field (Whitaker et al., 2006).

Burnout and Compassion Fatigue

Compassion fatigue and burnout are terms that are used interchangeably to refer to stress in past studies, but each has different origins and each has distinctive symptoms (Alkema et al., 2008). The stress response of burnout originates from occupational challenges such as hospice social workers having overwhelming caseloads, organizational dysfunction, lack of recognition of work, limited resources for clients, etc. (Alkema et al., 2008; Ditullio & MacDonald, 1999). Burnout was first described as being displayed through behavior or physical symptoms consisting of being extremely tired, depressed, or cynical (Freudenberger, 1974). For the purpose of this study, burnout will be defined as

a response to occupational stress and its symptoms include exhaustion, cynicism, detachment from work, feeling ineffective, and feeling unaccomplished (Maslach, Schaufeli, & Leiter, 2001). The major consequence of burnout is high rate of employee turnover in addition to lack of staff cohesion, and miscommunication within the organization (Kearney et al., 2009; Kim & Lee, 2009).

Compassion fatigue, however, is developed as hospice social workers experience the loss of patients, anxiety when a patient's pain is not controlled and deals with the grief of patients' families (Quinn-Lee et al., 2014). Compassion fatigue is displayed as a loss of empathy for others, apathy towards work, and personal health issues (Pelon, 2017). Compassion fatigue for this study is defined as the worker's reduced ability or interest to be empathic to the client's needs (Figley, 2002). Compassion fatigue is perceived as the natural behavior that results from experiencing a traumatic event or the suffering of a person (Figley, 2002). Compassion fatigue impedes interpersonal relationships with clients and affects the quality of patient care (Alkema et al., 2008; Keidel, 2002). Both responses to burnout and compassion fatigue stress affect both the providers and recipients of hospice care.

Self-Care

Self-care is engaging in activities to promote overall well-being (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2016). Self-care has five main categories: physical, spiritual, psychological, emotional, and professional

(Saakvitne & Pearlman, 1996). Physical self-care is looking after one's physical body and physical self-care activities consist of going for a walk or having a healthy diet. Spiritual self-care is reflecting in the belief that there is a greater force than oneself and can consist of attending a religious service or meditating. Psychological self-care consists of participating in self-reflection and activities include journaling or attending therapy. Emotional self-care fosters supportive relationships and consists of spending time with loved ones (Bloomquist et al., 2016). Professional self-care consists of activities that promote professional well-being and education and activities consists of attending training and setting client boundaries (Bloomquist et al., 2016). Engaging in the above mentioned areas of self-care is thought of to counter work related stress while the worker balances clients' needs and their own professional needs (Lee & Miller, 2013; Quinn-Lee et al., 2014).

Limitations of Self-Care in Social Work

From early in a social worker's educational journey, social workers are left on their own to figure out what self-care methods could work. A study of MSW programs and employers, show social workers are not taught how to effectively engage in self-care practice (Bloomquist et al., 2016). Understandably, the next option for new social workers in their career is to individually research what self-care methods can be implemented to remain healthy and effective. However there is little empirical evidence on the focus of self-care within the field of social work (Lee & Miller, 2013). Once in the field of hospice social work, a social

worker has minimal resources specific to find applicable self-care methods in the field. As reported by Alkema et al. (2008), little empirical research exists on assisting hospice care providers to choose successful and tested self-care methods. With the discussed stressors and lack of research on self-care in social work, it is no surprise that social workers are the most likely to leave the field of practice within four years of acquiring their master's degree (Whitaker et al., 2006). According to the U.S. Bureau of Labor Statistics (2020), the social work profession will grow 13% from 2019-2029 and this is higher rate than the average for all professions. With the projected field growth in mind, the intention behind this study is to help fill the gap in research for hospice social workers in regard to effective self-care methods.

Theories Guiding Conceptualization

Two theories are used to conceptualize the ideas in this study. The theories are the person in environment theory and the systems theory. These approaches help frame the process of hospice social workers in their work environment within an agency. The person in environment theory assesses the goodness of fit with the environment and the person's setting (Hepworth, Rooney, Rooney, & Strom-Gottfried, 2017). Moreover, the person in environment theory is looking at the context of the person's environment. For instance, hospice social workers are in a high-stress environment within their employment. The person in environment theory helps conceptualize that hospice social workers are working in a stressful environment because the clients' common

outcome is death. The person in environment theory also creates an understanding of working in a debilitating climate for hospice social workers. While working in a draining environment, the individual is also impacted by the possibility of high burnout and compassion fatigue.

Furthermore, systems theory is another way of looking at individuals within their environment (Zastrow, 2016). Systems theory has numerous concepts including systems, homeostasis, input, output, positive feedback, interface, differentiation, entropy, negative entropy, relationship, role, feedback, and equifinality (Zastrow, 2016). All the entities of systems theory shines light onto hospice social work. For instance, homeostasis is the balance and maintaining status quo (Zastrow, 2016). If hospice social workers are unable to maintain the balance, therefore, the agency or social worker will not be able to function effectively. In addition, systems theory helps assess the impact of the hospice social worker's systems. The theory also creates a better understanding of the different influences' hospice social workers face.

Summary

The study will explore the obstacles of working as a hospice social worker and identify self-care strategies to combat burnout and compassion fatigue associated with the social work profession. Hospice social workers experience daily stressors working with hospice clients and from organizational stressors from their employment. Hospice social workers are constantly dealing with a high stress and high loss work environment. Self-care needs are vital to help to battle

work related stressors, similar to burnout and compassion fatigue. Moreover, the stressors are impacting not only the providers, but also those receiving hospice care. Therefore, the self-care needs of hospice social workers are important due to lack of literature on the subject. Further research on self-care among hospice social workers will help overcome the barriers that impact the workers and the hospice clients receiving care. The person in environment theory and the systems theory will assist in identifying ways to combat compassion fatigue and burnout while utilizing self-care techniques.

CHAPTER THREE

METHODS

The focus of this study is to provide additional insight into self-care methods that hospice social workers currently use to combat burnout and compassion fatigue. This chapter contains the details of how this study was conducted. The sections of this chapter consist of study design, sampling, data collection and instruments, and procedures.

Study Design

Hospice social workers work in a high stress and loss environments such as medical facilities and homes (Quinn-Lee et al., 2014). Little research exists in terms of self-care pertaining to the social work field and the field of hospice (Alkema et al., 2008; Lee & Miller, 2013). Our goal is to supplement current knowledge by examining self-care methods currently implemented by hospice social workers. This was achieved through an exploratory study design. The exploratory study design consisted of a quantitative approach with a focus on hospice social workers as participants. The research method incorporated an electronically self-administrated questionnaire.

The practical methodological strengths of this study design provided participants with examples of self-care methods on the questionnaire. This allowed for a clear understanding of self-care methods that participants could be using. Since self-care methods can vary from person to person, a blank response

area was listed under each self-care method as well. This permits participants to include any self-care methods that are specific to that individual. Questionnaires were sent to participant electronically to facilitate the process of acquiring data.

The limitations of this design includes having a small participant population. This study has a small participant population since the study is taking place during an international COVID-19 pandemic and access to various populations is currently limited due to state regulation on social distancing. This is a cross-sectional study so the results of this study cannot show trends of self-care methods over time. Finally, the sampling method consisted of a non-probability sampling which results in a sample that does not fully represent the population of interest.

Sampling

This study implemented a non-probability sampling method as it is key to acquire hospice social workers as participants. Researchers acquired participants including but not limited to posting on online platforms such as Reddit forums and Facebook groups and reaching out to their personal network to contact hospice social workers. Participants were acquired through purposive snowball sampling in which participants sent the survey link to other potential participants for the study. It is required that participants have hospice social work experience. There are 100 participants in this research study. Due to the limitation of time and the current COVID-19 pandemic, researchers believed acquiring participants would be challenging.

Data Collection and Instruments

This study collected data on the current self-care methods that hospice social workers use. The researchers utilized quantitative data with nominal, categorical levels of measurement. The independent variable consists of self-care methods. Burnout and compassion fatigue are the dependent variables. The independent variables of self-care were measured using the Self-Care Assessment Worksheet (Saakvitine & Pearlman, 1996). The dependent variables of burnout and compassion fatigue were measured using the Professional Quality of Life Scale, [ProQol 5] (Stamm, 2009-2012).

Participants first filled out a demographic survey consisting of questions regarding age, number of years in the field, gender identification, ethnicity, marital status, income, spirituality, employment status, and geographical location in addition to two standardized instruments. The first instrument was the Self-Care Assessment Worksheet [SCAW] (Saakvitine & Pearlman, 1996). This self-assessment contains six categories of self-care that consist of physical, psychological, emotional, spiritual and professional. Participants answered questions using a Likert scale where “1 - it never occurred to me” to “5- do frequently” (Saakvitine & Pearlman,1996). Examples of questions include, “do you take time off when needed?” and “do you get enough sleep?” (Saakvitine & Pearlman, 1996). A strength of this instrument is its internal consistency. According to a study, conducted by La Mott and Martin (2019) the internal consistency for total self-care scale was 0.95 which makes this instrument

reliable. However, this instrument is not a good measurement of overall wellness (Alkema et al, 2008).

The secondary instrument utilized to acquire the quantitative data is the Professional Quality of Life Scale, ProQol 5, (Stamm, 2009-2012). This instrument inquires the participants' experience with burnout and compassion fatigue. This consists of 30 statements with three subscales consisting of burnout, compassion satisfaction, and secondary traumatic stress (Stamm, 2010). Participants were asked to reflect on their experiences within the last 30 days. Participants can score the statements using a Likert scale that ranges from "1 - never" to "5- very often" (Stamm, 2009-2012). Some examples of the statements include "I am the person I always wanted to be" and "I like my work as a helper" (Stamm, 2009-2012). The alpha reliability scale for secondary traumatic stress is 0.81, for compassion satisfaction is 0.88, and burnout is 0.75 which is considered to be good reliability.

This instrument has good construct validity as it has been utilized with over "200 published papers" and over "100,000 papers online" (Stamm, 2010). The alpha reliability, the construct validity, and how well known this instrument are all strengths of this instrument. Since the SCAW only identifies the self-care methods used by participants and the frequency of those self-care methods, the inclusion of the ProQOL5 assisted the researchers in determining the participants' current level of burnout and compassion fatigue (Saakvitine & Pearlman, 1996; Stamm, 2009-2012).

Procedures

The researchers conducted the research by posting on Reddit forums and Facebook support groups and word of mouth. Identified participants were asked to recruit other participants who work in the same role as hospice social workers. An email address was created as the primary source of communication between the participants and the researchers should participants have any questions or concerns. The initial posts for participants described the study's purpose and goals and provided a statement for recruiting participants. Within the initial posts a link was provided for participants to access a consent form and a Qualtrics link to access the questionnaire, including the demographic survey.

Protection of Human Subjects

Due to the current COVID-19 shelter in place regulations, this study has was created to be conducted through electronic measures. No in person surveys will be administered in order to observe current social distancing measures. Individuals outside of the study will not be able to identify participants. Participants' identities were kept confidential. Data was collected and stored on a password protected cloud drive that will be only shared and accessed by both researchers. Participants signed an informed consent form before participating in the research. Participants were not forced to complete the survey and were permitted to discontinue participation, if desired. There was no identifying information in the results of this study. Moreover, the researchers deleted the online posts after the data collection was completed. The email address, emails,

and all data collected on the cloud drive will be deleted after three years of completing the study.

Data Analysis

This study utilized a quantitative design with a multivariate analysis. The independent variable is self-care methods, and the dependent variables are compassion fatigue and burnout. SPSS software was utilized to analyze this study. Self-care methods were measured from the results using the Self-Care Assessment Worksheet (Saakvitine & Pearlman, 1996). The level of measurement was nominal, categorical. Emotional Self-Care, Spiritual Self-Care, Psychological Self-Care, Physical Self-Care, Workplace or Professional Self-Care, and Balance are the categories.

Moreover, compassion fatigue and burnout results were measured utilizing the Professional Quality of Life Scale (ProQol 5) (Stamm, 2009-2012). The level of measurement was interval on a Likert scale of 1-never, 2-rarely, 3-sometimes, 4-often, 5-very often. The level of compassion fatigue and burnout a participant has was added up and a score of 22 or less was low, between 23-40 was moderate, and 42 or more was high. The one-way ANOVA between two groups was the statistical analysis utilized in this study. The one-way ANOVA between two groups was used to analyze the participant scores of compassion fatigue and burnout. Descriptive statistics on the participants was also collected and analyzed using frequency analysis. The descriptive statistics were age,

gender, number of years working in the field, income, race/ethnicity, and marital status.

Summary

This study reviewed the various self-care methods utilized among hospice social workers and explored whether such methods help combat burnout and compassion fatigue. The quantitative methods allowed a more considerable sum of participants to partake in the study in a short amount of time.

CHAPTER FOUR

RESULTS

Introduction

This chapter will discuss the overall data from this study. A total of 100 online participants contributed their responses to this study from the period of January 2021-May of 2021. Researchers will first review the descriptive statistics of this study. Secondly, the researchers will review the data, and finally, the researchers will discuss the results of the study.

Demographics

There were 100 participants in this study, and there was a total of 11 demographic questions asked. Of the total participants, 89.0% identified as female, 8.0% as male, and 1.0% as nonbinary. The ages of the participants ranged from younger than 24 to older than 55 years of age. From the sample, 4.0% were younger than 25, 35.0% were between the ages of 25-34, 18.0% were between the ages of 35-44, 31.0% were between the ages of 45-54 years, 11.0% were 55 years old and older. From an ethnic origin perspective, 74.0% of participants identified as white/Caucasian, 11.0% percent identified as Hispanic/Latino, 8.0% identified as black/African American, 4.0% identified as multiracial/biracial, and 1.0% identified as Native Hawaiian/Pacific Islander. Of the participants, 54.0% are married, or in a domestic partnership, 29.0% are single, 11.0% are divorced, 3.0% are widowed, and 1.0% are separated.

In terms of educational background, 93.0% percent stated that they have a master's degree, and 6.0% have a bachelor's degree. Ninety-two percent of participants had a major related to social work, while 5.0% majored in criminal justice, finance, health informatics, and exercise science. In terms of employment status, 88.0% stated that they were employed 40 or more hours per week, 9.0% were employed less than 40 hours a week, and 1.0% stated they were students. Sixty-six percent of participants stated that they were licensed, while 33.0% were unlicensed. The approximate average annual income varied.

Forty-four percent were at the $80,000 and over income level, 34.0% were at the $55,000-$79,999, 16.0% were at the $30,000-$54,999, and finally, 3.0% were at the $29,999 or less level. In terms of hospice field experience, 46.0% stated that they have 0-2 years of experience, 28.0% stated that they have 3-5 years, 3.0% have 6-9 years, 2.0% have 10-12 years, and 20.0% stated that they have 13 or more years of experience. Since hospice social work involves patient death and family grief, the researchers asked participants if religion or spirituality was a part of their daily lives. Forty-three percent of participants stated it was, 36.0% stated that it sometimes was, and 20.0% stated that it was not a part of their lives. Please note that there are some missing responses as some participants chose not to answer all the demographic questions. Please see the demographics results in Table 1.

Table 1: Demographic Results

Variable		Frequency (N)	Percentage (%)
Gender			
	Females	89	89.0%
	Males	8	8.0%
	Non-binary	1	1.0%
	Prefer not to answer	1	1.0%
	Missing	1	1.0%
Age			
	Younger then 25	4	4.0%
	25-34	35	35.0%
	35-44	18	18.0%
	45-64	31	31.0%
	55+	11	11.0%
	Missing	1	1.0%
Ethnicity			
	White/Caucasian	74	74%
	Hispanic/Latino	11	11.0%
	Black/African American	8	8.0%
	Multiracial/biracial	4	4.0%
	Native Hawaiian or Other Pacific Islander	1	1.0%
	Prefer not to answer	1	1.0%
	Missing	1	1.0%
Marital Status			
	Married or in partnership	54	54.0%
	Single (never married)	29	29.0%
	Divorced	11	11.0%
	Widowed	3	3.0%
	Separated	1	1.0%
	Missing	2	2.0%
Education Level			
	Master's Degree	93	93.0%
	Bachelor's Degree	6	6.0%
	Missing	1	1.0%
Major of Study			
	Major related to social work	92	92.0%
	Other	5	5.0%
	Missing	3	3.0%
Employment Status			
	Employed full-time	88	88.0%
	Employed part-time	9	9.0%
	Student	1	1.0%
	Missing	2	2.0%
License Status			
	Yes	66	66.0%
	No	33	33.0%
	Missing	1	1.0%
Average Annual Income			
	$29,999 or less	3	3.0%
	$30,000-$54,999	16	16.0%
	$55,000-$79,999	34	34.0%
	$80,000 and over	44	44.0%
	Missing	3	3.0%
Hospice Field Experience			
	0-2 Years	46	46.0%
	3-5 Years	28	28.0%
	6-9 Years	3	3.0%
	10-12 Years	2	2.0%
	13+ Years	20	20.0%
	Missing	1	1.0%
Religiosity/Spirituality			
	Yes	43	43.0%
	Sometimes	36	36.0%
	No	20	20.0%
	Missing	1	1.0%

Study Results

Through the instrument of the Professional Quality of Life Scale, ProQol 5, researchers asked participants to rank the negative or positive feelings that the participants experienced with their work within the last 30 days (Stamm, 2009-2012). The participants ranked the statements with a scale from (1) never to (5) very often (Stamm, 2009-2012). The sum of specific questions determined if the participants had low, moderate, or high levels within each category of compassion fatigue, burnout, and secondary traumatic stress (Stamm, 2009-2012). If a participant scored 22 or less, they had a low level (Stamm, 2009-2012). If they had a score between 23-41, they had a moderate level, and 42 or higher signified they had a high level (Stamm, 2009-2012). The mean of Compassion Satisfaction was 41.59, making it the highest-ranked category. The standard deviation was 5.68. The minimum was 25.00 and the maximum was 50.00. Compassion questions included if the participants get satisfaction from helping others or they feel invigorated after helping someone (Stamm, 2009-2012).

The second-ranked category was secondary traumatic stress, and the mean of this category was 23.50, giving participants a moderate level of STS. The standard deviation was 6.51. The minimum was 10.00 and the maximum was 46.00. The final category is burnout, and the mean was 22.86, which would place participants at a moderate level within this category. The standard deviation was 5.83. The minimum was 11.00 and the maximum was 39.00.

Please refer to Figure 1, Figure 2, and Figure 3 which display the analyzed variables of this sample.

Figure 1. Frequencies of Participants' Compassion Satisfaction Scores

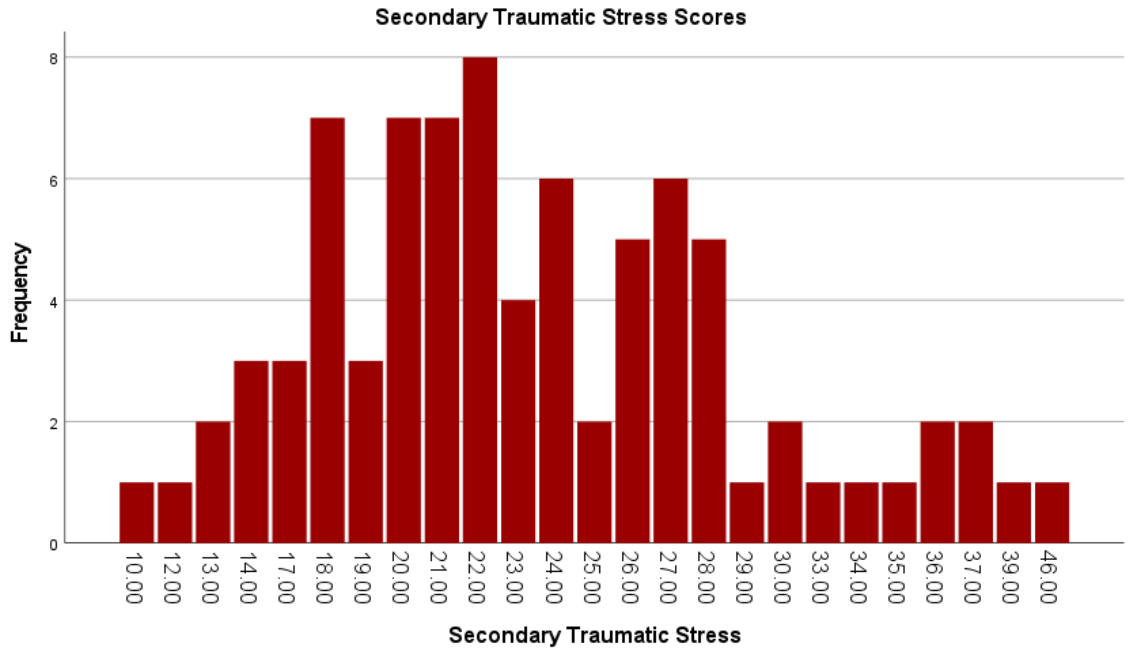

Figure 2. Frequencies of Participants' Secondary Traumatic Stress

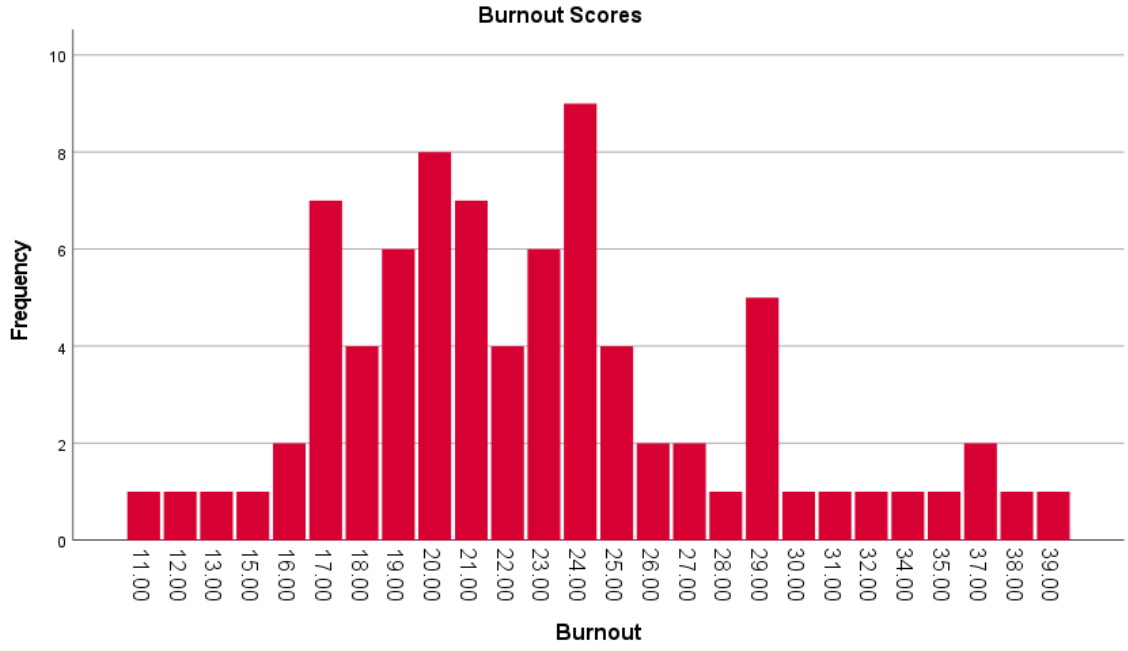

Figure 3. Frequencies of Participants' Burnout Scores

Implemented Self-Care Methods to Combat Burnout and Compassion Fatigue

Participants were also asked to designate which activities they use to maintain self-care using a scale of (1) it never occurred to me to (5) frequently using the Self-Care Assessment Worksheet [SCAW] instrument (Saakvitine & Pearlman, 1996). The SCAW self-care categories, consisted of physical self-care, psychological self-care, emotional self-care, spiritual self-care, professional self-care, and balance (Saakvitine & Pearlman, 1996). The variables analyzed consisted of physical self-care, psychological self-care, emotional self-care, spiritual self-care, and professional self-care. Each self-care category had a varied amount of questions, so the data analysis was based on weighted averages.

The highest mean score was 3.95 in the category of emotional self-care. Examples of activities listed under this category include spending time with people you like and complimenting yourself. Emotional self-care was followed by 3.94 in the spiritual self-care category (Saakvitine & Pearlman, 1996). Examples of spiritual activities include spending time in nature or being conscious of nonmaterial aspects of life (Saakvitine & Pearlman, 1996). Physical self-care mean was 3.91 placing this category in third. Examples of physical self-care include getting medical care when necessary and exercising (Saakvitine & Pearlman, 1996). Please see Figure 4, Figure 5, and Figure 6.

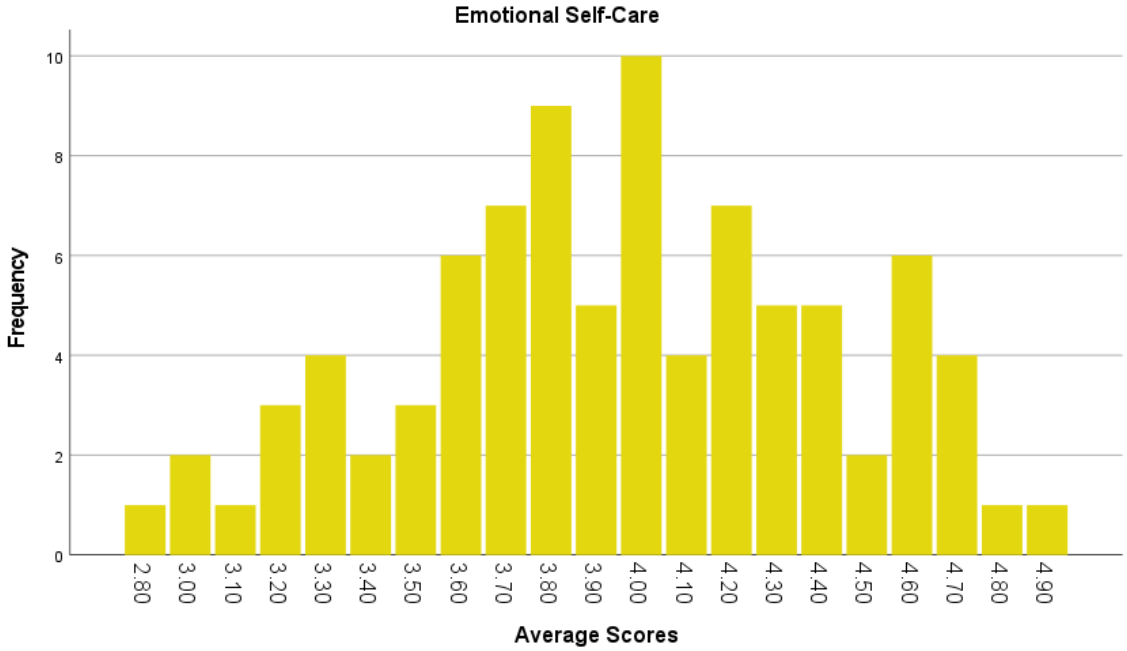

Figure 4. Frequencies of Participants' Average Emotional Self-Care Scores

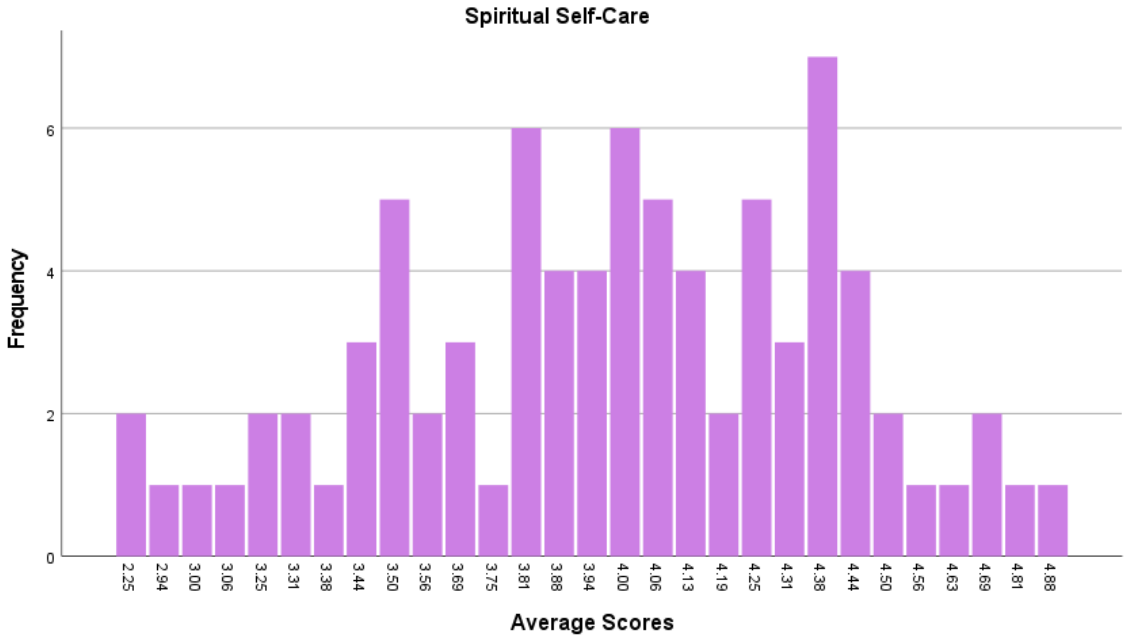

Figure 5. Frequencies of Participants' Average Spiritual Self-Care Scores

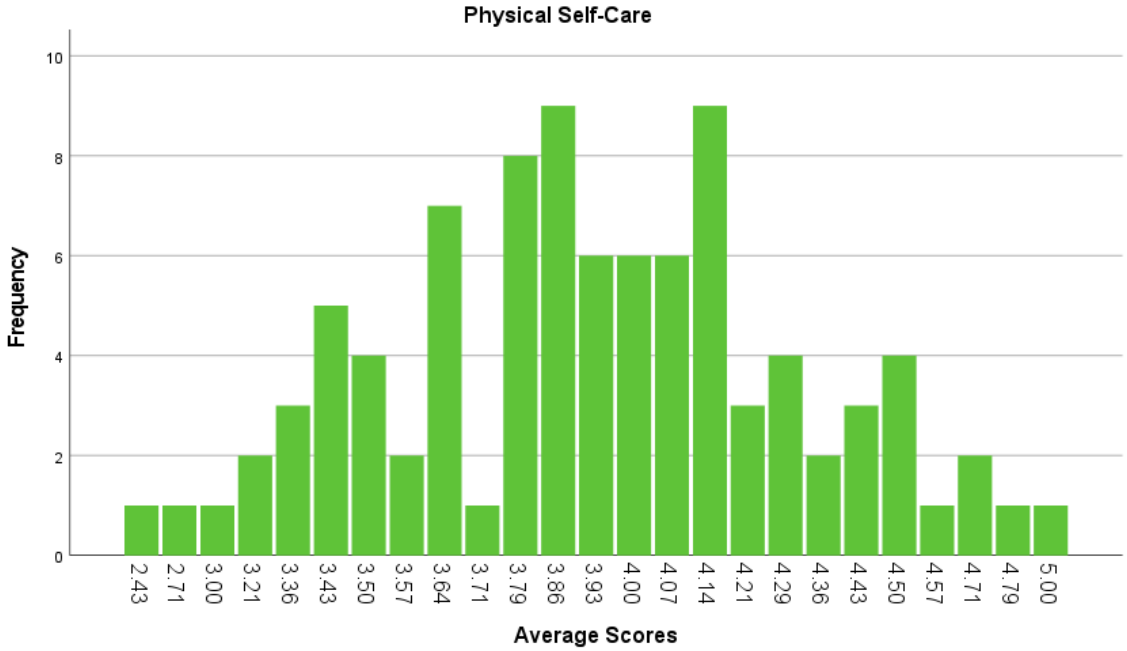

Figure 6. Frequencies of Participants' Average Physical Self-Care Scores

Psychological self-care followed with a mean of 3.78 in fourth place. Examples of psychological activities include making time for self-reflection and having personal therapy (Saakvitine & Pearlman, 1996). Lastly, professional self-care was ranked fifth with a mean of 3.70. Examples of professional care activities include taking breaks and setting boundaries with clients and coworkers (Saakvitine & Pearlman, 1996). Although emotional self-care was the highest-ranked category, it is ranked the highest by a minimal lead. Please see Figure 7 and Figure 8.

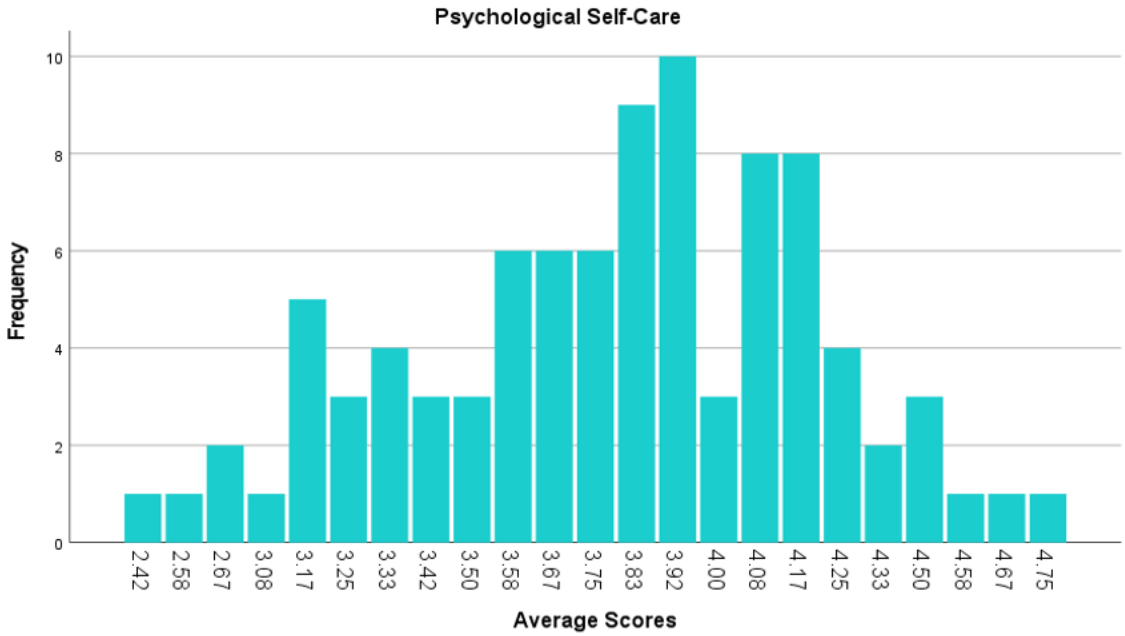

Figure 7. Frequencies of Participants' Average Psychological Self-Care Scores

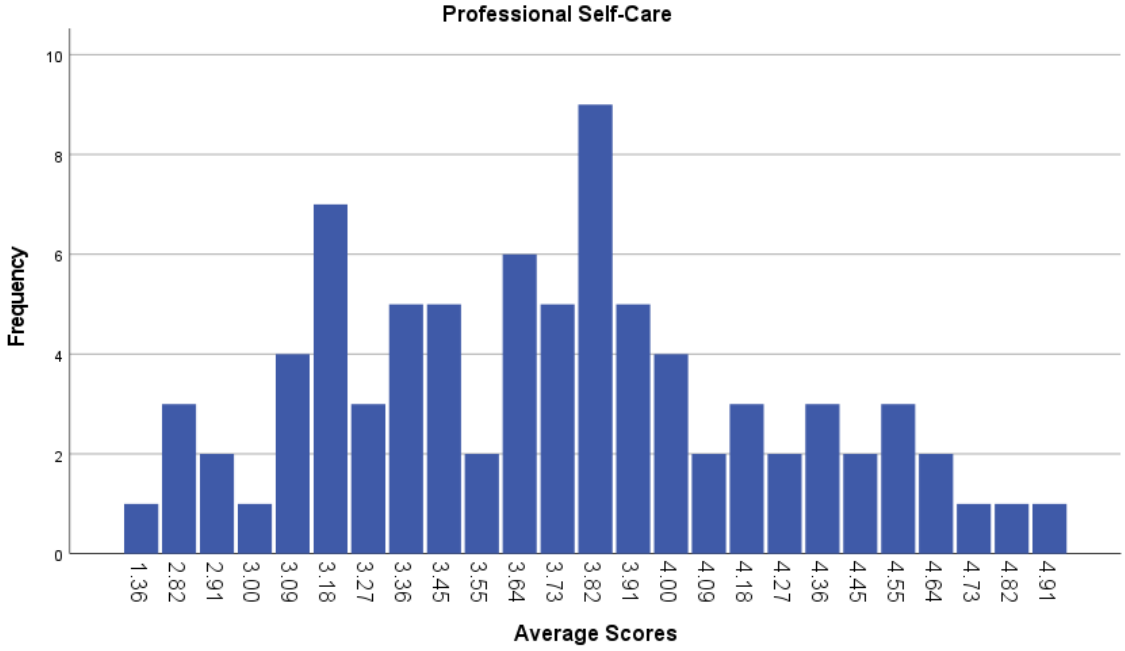

Figure 8. Frequencies of Participants' Average Professional Self-Care Scores

The most significant difference between the top-ranked self-care care category, emotional self-care, and the lowest self-care category, professional self-care, held a difference of only 0.25. Additionally, the variables of compassion satisfaction, burnout, and secondary trauma were also analyzed in this study.

Relationship Between Self-Care and Compassion Fatigue

The researchers used two tailed no significance Pearson tests in SPSS to analyze possible correlations among the self-care and compassion fatigue variables. Compassion satisfaction was positively correlated to all self-care categories except physical care. Compassion satisfaction to psychological self-care was r(80)=.369,p=.001. Compassion satisfaction to emotion was reported as r(79)=.508, p=.000.Compassion satisfaction to spiritual was reported as r(78)=.402, p=.000. Compassion satisfaction to professional self-care was reported as r(78)=.249, p=.028. Compassion fatigue was negatively correlated with burnout as it resulted in r(80)=-.642, p=.000.Compassion fatigue was negatively correlated with Secondary Traumatic Stress as it resulted in r(82)=-.411, p=.000. This meaning the that the more compassion fatigue participants reported the less burnout and secondary trauma they reported.

Self-Care Methods Used to Combat Burnout and Compassion Fatigue

Participants were asked to designate which activities they use to maintain self-care using a scale of (1) it never occurred to me to (5) frequently using the Self-Care Assessment Worksheet [SCAW] instrument (Saakvitine & Pearlman,

1996). The SCAW self-care categories, consisted of physical self-care, psychological self-care, emotional self-care, spiritual self-care, professional self-care, and balance (Saakvitine & Pearlman, 1996). The variables analyzed consisted of physical self-care, psychological self-care, emotional self-care, spiritual self-care, and professional self-care. Each self-care category had a varied number of questions, so the data analysis was based on weighted averages. The highest mean score was 3.95 in the category of emotional self-care. Examples of activities listed under this category include spending time with people you like and complimenting yourself. Emotional self-care was followed by 3.94 in the spiritual self-care category (Saakvitine & Pearlman, 1996). Examples of spiritual activities include spending time in nature or being conscious of nonmaterial aspects of life (Saakvitine & Pearlman, 1996). Physical self-care mean was 3.91 placing this category in third. Examples of physical self-care include getting medical care when necessary and exercising (Saakvitine & Pearlman, 1996). Psychological self-care followed with a mean of 3.78 in fourth place. Examples of psychological activities include making time for self-reflection and having personal therapy (Saakvitine & Pearlman, 1996). Lastly, professional self-care was ranked fifth with a mean of 3.70. Examples of professional care activities include taking breaks and setting boundaries with clients and coworkers (Saakvitine & Pearlman, 1996). Although emotional self-care was the highest-ranked category, it is ranked the highest by a minimal lead. The most significant difference between the top-ranked self-care care category, emotional self-care,

and the lowest self-care category, professional self-care, held a difference of only 0.25.

Relationship Between Self-Care and Burnout

Our second test analyzed if there is a relationship between self-care and burnout. The most significant result is that burnout is negatively correlated to all the self-care areas. Burnout to physical self-care resulted as r(74)=-.589, p=.000. For psychological self-care, burnout was r(78)= -.419, p=.000. For emotional self-care, burnout to r(77) = -.454, p=.000. Burnout to spiritual self-care resulted as r(76)=-.549, p=.000 and burnout to professional self-care was r(76)=-.408, p=.000. Burnout was positively correlated to secondary traumatic stress, r(80)=.609, p=000 meaning that as burnout increased so does secondary traumatic stress.

Relationship Between Work-Life Balance, Compassion Fatigue, and Burnout

Next researchers analyzed the correlation between work-life balance, compassion fatigue, and burnout. Burnout and Secondary Traumatic stress were negatively correlated with work life balance. Burnout to work life balance was r(79)=-.383, p=.000 and secondary traumatic stress was r(81)=-.338, p=.002. This means that the more participants report having work life balance, the less burnout and secondary traumatic stress had. On the other hand, Compassion satisfaction to work life balance was r(81)=.214, p=.055. Therefore, there is not a significant relationship between work-life balance and compassion fatigue.

Higher Income and Impact on Physical Care

Researchers conducted a Kendall two tail no significance nonparametric test to analyze the relationship between average income and physical self-care. Physical care to average annual income was r(90)=.195, p=.020. This is a positive correlation in which participants that report higher income, report more physical activity.

Employment Status and Impact on Self-Care

Next researchers applied a t-test between employment status and self-care to further analyze the relationship between the two groups. However, there is no significant relationship between employment status and self-care. The research indicates that people who are not working full-time are possibly burnt out equally as individuals who are working less than full-time.

Religiosity/Spirituality and Self-Care

The next test conducted was a spearman's rho test to assess the correlation between spirituality and self-care. Interestingly, the findings identified that the more spiritual and psychological self-care a hospice social worker engages, the more burnout the hospice social worker experiences. The findings for spiritual self-care and burnout are Rho (91) =-.213, p=0.43. The findings for psychological self-care and burnout are Rho (91) =-.213, $p<0.05$.

Number of Years in Working in the Field and Self-Care

Moreover, the researchers administered a Kendall two tail no significance nonparametric test to investigate the relationship between number of years working in the hospice social work field and self-care methods. The research amongst self-care methods and number of years in the field were not significant. Therefore, there is no significant relationship indicated between the two.

Ethnicity and Self-Care

Additionally, the researchers conducted a one-way ANOVA test between self-care and ethnicity. The research findings did not indicate a relationship between self-care and ethnicity. The research suggests that self-care is practiced regardless of a person's ethnicity.

Gender and Self-Care

Lastly, researchers applied a t-test with gender and self-care to analyze the relationship between the two. Spiritual self-care to gender was $t=2.007$, $p=0.048$. The research indicated that there was a significant relationship between self-care and gender. For instance, research suggests that individuals who identify themselves as women are more likely to practice self-care methods than individuals who identified as male. All participants identified as either male or female.

Conclusion

This chapter reported the demographic information of the surveyed participants and the significant findings for the surveyed participants from the data collection process.

CHAPTER FIVE

DISCUSSION

Introduction

This chapter will discuss the overall data collected from hospice social workers and its implications on the field of social work. This chapter will also describe how this study's finding relate to the existing literature. Finally, this chapter will discuss the limitations of the study and how the findings can improve social work policies and practices in the future.

Hospice social workers hold a distinctive role on the in the health care system. These professional helpers guide patients and their families through a transitional life journey as their life expectancy diminishes. Hospice social workers face organizational challenges such as low salaries, working in an urgent and high stress environment, and minimal opportunities for continued education (Pelon, 2017; Quinn-Lee et al., 2014; Whitaker et. Al., 2006). Hospice social workers also face daily challenges such high caseloads, facing death anxiety, and processing their own person feelings of grief (National Association of Social Workers, 2010; Alkema et, al., 2008; Quinn-Lee et al., 2014;). With the above stressors, hospice social workers can develop compassion fatigue and burnout. Burnout and compassion fatigue affect the clinician and client relationship, quality of care, and the long-term duration of social workers in the growing field of hospice.

Engaging in self-care activities is often described as a resolution to reduce the work stressors for professional helpers (Lee & Miller, 2013; Quinn-Lee et al.,2014). However, there is little empirical evidence of self-care studies focused on the general field of social work or in the field of hospice (Alkema et al., 2008; Lee & Miller, 2013; Miller et. Al, 2017). With self-care widely perceived as a personal responsibility, hospice social workers have to figure out how to take care of themselves while facing various stressors. Without professional or personal support, it is logical for hospice social workers to be the least likely to stay in their current position compared to their colleagues in the health care field (Whitaker et al., 2006). This study sought to explore what self-care methods hospice social workers use to combat compassion fatigue and burnout to remain in this field.

The first major result of this study found that participants average results indicated that they use all five self-categories with no significant difference among physical, psychological, emotional, spiritual, and professional self-care. Hospice social workers incorporate various kinds of self-care activities to help reduce stress due to their professional responsibilities (facing death anxiety daily, high caseload, short staffed, etc.) or personal responsibilities (caring for a sick family member, taking their child to school, attending family events, etc.). Self-care is not tied to one specific category and participating in varied activities is an approach widely used by participants. This result aligns with the few past studies

that hospice workers (including social workers) take a whole person approach in terms of self-care (Ditullio & MacDonald, 1999; Pelon, 2017).

The second major result indicated that compassion satisfaction was positively correlated to all self-care categories except physical self-care. This shows that compassion satisfaction also increased as participants engaged in self-care activities. It is logical that if participants regularly engage in meditation, attend a religious ceremony, take a vacation, etc., they will be more satisfied or at peace with their current personal and professional state. This differed from the results reported by Alkema et al. (2008) in which compassion satisfaction was significantly correlated with emotional, spiritual, and work-life balance self-care categories only. This shift could have been affected by the period in which this study took place, spring 2021. This study took place during the COVID-19 pandemic, which may have prompted participants to incorporate various self-care methods as the time to engage in those methods due to the government's stay at home order.

The third major result indicated that burnout is negatively correlated to all self-care categories. Meaning that as participants engaged in self-care categories, burnout decreased. While participants actively engage in self-care methods, compassion satisfaction increases while burnout decreases. Due to these results, compassion satisfaction can be viewed as a protective factor for general social workers and hospice social workers. This is also in agreement with past studies (Lee & Miller, 2013; Pelon, 2017; Whitebird, et al., 2013). On

another note, 43.0% of participants considered religion and spirituality as a part of their daily lives, and 36.0% percent considered it as sometimes part of their lives. Religion or spirituality can be viewed as an advantage in this field of work in terms of personal inner strength in a field where patients will pass away. This helps build rapport and helps social workers assist patients in making peace with their end-of-life journey. The very same advantage of religion and spirituality can be viewed as a burden for hospice social workers as results indicated that participants engaged in more spiritual practice and psychological self-care, the more burnout participants experienced.

Limitations

There are limitations to this study; for instance, the population of this study was majorly individuals who had identified as female, and there was a small sample size. The small sample size may not be representative of all hospice social workers. A larger sample size and a mixture of individuals with different gender identities could potentially provide more significant information about the self-care methods of hospice social workers. Another limitation to this study is the large number of questions asked in the study; some participants left answers blank and stopped the survey mid-way through. Providing a simpler and time-effective way for members to participate in surveys could potentially increase participation in surveys along with providing an incentive for a selected winner after completing the entire survey. An incentive to provide a selected winner from participating would surely increase survey completion rate. Lastly, responses

from participants were limited to online platforms due to the COVID-19 Pandemic. In-depth in-person interviews could provide additional insight regarding self-care methods Hospice social workers utilize to combat compassion fatigue and burnout.

Implications for Social Work Practice and Policy

Engaging in self-care is often perceived as an individual's responsibility. Nonetheless, Lee and Miller (2013) explain that personal and professional self-care are linked. The relationship between professional and self-care is contingent on the other (Lee & Miller, 2013). Meaning the scale in which a social worker participates in self-care in the personal realm will affect the other aspect of self-care in the professional realm and vice versa (Lee & Miller, 2013). An example by Lee & Miller (2013) is a social worker's ability to participate in deep and meaningful personal relationships outside of work, promoting the social worker's ability to create healthy boundaries with clients within the work environment. This intrinsic relationship offers a different perspective on how to address self-care measures for current and future social workers. The recommendations from the few studies on self-care for social workers in the medical field state that it is time to re-envision self-care as both a personal and professional responsibility (Bell, Kulkarni, & Dalton, 2003; Miller & Lee, 2013; Miller et al., 2017). This starts by changing the organizational culture of agencies to see personal and professional care as essential for medical social workers within healthcare systems (Bell Kulkarni, & Dalton, 2003; Miller & Lee, 2013; Miller et al., 2017). Further research

is needed to better understand self-care methods hospice social workers use to take care of themselves in a growing field. These future studies will guide agencies of employment on what agency-wide self-care methods to incorporate to help promote career longevity, which will ultimately benefit the quality of care received by terminally ill patients and their families.

Conclusion

This study sought to bring awareness to the essential need for self-care support in the personal and professional realm for social workers in general, but specifically hospice social workers, given the expected growth in this field. The results of this study indicated that use hospice social workers use a variety of self-care methods. Results also stated that compassion satisfaction increased as social workers practiced emotional, psychological, spiritual, emotional, and professional self-care methods while burnout and secondary traumatic stress decreased. Social workers implement the whole person perspective when working with clients. It is time to take the same approach to the vulnerable population of hospice social workers. The holistic process starts by continuing research on this population. Ideally, acquiring more detailed research on this population through in-depth interviews will ignite a change in viewing self-care as a personal and professional responsibility and give agencies of employment ideas of self-care methods that can be incorporated agency wide. Supportive measures can consist of ongoing professional education, peer support, permitting hospice social workers an additional personal leave day, etc. Thus,

providing clients with well-balanced professional helpers in one of the most vulnerable stages of life, death. Clients' future needs are far too great to continue to believe that self-care is solely a hospice social worker’s responsibility.

APPENDIX A

SELF-CARE ASSESSMENT

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care

____ Eat regularly (e.g. breakfast, lunch and dinner)
____ Eat healthy
____ Exercise
____ Get regular medical care for prevention
____ Get medical care when needed
____ Take time off when needed
____ Get massages
____ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
____ Take time to be sexual—with yourself, with a partner
____ Get enough sleep
____ Wear clothes you like
____ Take vacations
____ Take day trips or mini-vacations
____ Make time away from telephones
____ Other:

Psychological Self-Care

____ Make time for self-reflection
____ Have your own personal psychotherapy
____ Write in a journal
____ Read literature that is unrelated to work
____ Do something at which you are not expert or in charge
____ Decrease stress in your life

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

____ Let others know different aspects of you
____ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
____ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
____ Practice receiving from others
____ Be curious
____ Say "no" to extra responsibilities sometimes
____ Other:

Emotional Self-Care

____ Spend time with others whose company you enjoy
____ Stay in contact with important people in your life
____ Give yourself affirmations, praise yourself
____ Love yourself
____ Re-read favorite books, re-view favorite movies
____ Identify comforting activities, objects, people, relationships, places and seek them out
____ Allow yourself to cry
____ Find things that make you laugh
____ Express your outrage in social action, letters and donations, marches, protests
____ Play with children
____ Other:

Spiritual Self-Care

____ Make time for reflection
____ Spend time with nature
____ Find a spiritual connection or community
____ Be open to inspiration
____ Cherish your optimism and hope
____ Be aware of nonmaterial aspects of life
____ Try at times not to be in charge or the expert
____ Be open to not knowing

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

____ Identify what in meaningful to you and notice its place in your life
____ Meditate
____ Pray
____ Sing
____ Spend time with children
____ Have experiences of awe
____ Contribute to causes in which you believe
____ Read inspirational literature (talks, music, etc.)
____ Other:

Workplace or Professional Self-Care

____ Take a break during the workday (e.g. lunch)
____ Take time to chat with co-workers
____ Make quiet time to complete tasks
____ Identify projects or tasks that are exciting and rewarding
____ Set limits with your clients and colleagues
____ Balance your caseload so that no one day or part of a day is "too much"
____ Arrange your work space so it is comfortable and comforting
____ Get regular supervision or consultation
____ Negotiate for your needs (benefits, pay raise)
____ Have a peer support group
____ Develop a non-trauma area of professional interest
____ Other:

Balance

____ Strive for balance within your work-life and workday
____ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

APPENDIX B

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL 5)

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never **2=Rarely** **3=Sometimes** **4=Often** **5=Very Often**

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 23, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job. (Alpha scale reliability 0.88)

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

If your score is below 23, this probably reflects positive feelings about your ability to be effective in your work. If you score above 41, you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern. (Alpha scale reliability 0.75)

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

If your score is above 41, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional. (Alpha scale reliability 0.81)

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: ____

The sum of my Compassion Satisfaction questions is	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

Total: ____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: ____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

APPENDIX C

INFORMED CONSENT AND INSTITUTIONAL REVIEW BOARD APPROVAL EMAIL

CSUSB

WE DEFINE THE Future

School of Social Work

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
5500 University Parkway, San Bernardino, CA 92407
909.537.5501 | fax: 909.537.7029
http://socialwork.csusb.edu

INFORMED CONSENT

The study in which you are asked to participate is designed to examine the self-care methods that hospice social workers use. The study is being conducted by Divina Perez and Lillianna Gomez, both graduate students, under the supervision of Dr. Carolyn McAllister, Director of the School of Social work at California State, University, San Bernardino (CSUSB). The study has been approved by the Institutional Review Board at CSUSB.

PURPOSE: The purpose of the study is to examine the self-care methods that hospice social workers use.

DESCRIPTION: Participants will be asked questions about their demographics, the various types of self-care methods they use, and questions pertaining to their professional work experience.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY: Your response will remain confidential and data will be reported in group form only.

DURATION: It will take 10-15 minutes to complete the survey.

RISKS: Although not anticipated, there may be some discomfort in answering some questions. You are not required to answer all of the questions. You can skip questions, or you can end your participation.

BENEFITS: There will not be any direct benefits to the participants. However, the findings from the study will contribute to the knowledge in this area of research.

CONTACT: If you have any questions about this study, please feel free to contact Dr. McAllister at (909) 537-5501.

RESULTS: Results of the study can be obtained from the Pfau Library Scholar Works database (https://scholarworks.lib.csusb.edu/) at California State University, San Bernardino after July 2022.

I understand that I must be 18 years of age or older to participate in your study, have read and understand the consent document, and agree to participate in your study.

_____ _____

Please place an X mark here Date

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

January 29, 2021

CSUSB INSTITUTIONAL REVIEW BOARD
Administrative/Exempt Review Determination
Status: Determined Exempt
IRB-FY2021-111

Carolyn McAllister Divina Perez, Lillianna Gomez
CSBS - Social Work
California State University, San Bernardino
5500 University Parkway
San Bernardino, California 92407

Dear Carolyn McAllister Divina Perez, Lillianna Gomez:

Your application to use human subjects, titled "The Importance of Self-Care Among Hospice Social Workers" has been reviewed and determined exempt by the Chair of the Institutional Review Board (IRB) of CSU, San Bernardino. An exempt determination means your study had met the federal requirements for exempt status under 45 CFR 46.104. The CSUSB IRB has not evaluated your proposal for scientific merit, except to weigh the risk and benefits of the study to ensure the protection of human participants. Important Note: This approval notice does not replace any departmental or additional campus approvals which may be required including access to CSUSB campus facilities and affiliate campuses due to the COVID-19 pandemic. Visit the Office of Academic Research website for more information at https://www.csusb.edu/academic-research.

You are required to notify the IRB of the following as mandated by the Office of Human Research Protections (OHRP) federal regulations 45 CFR 46 and CSUSB IRB policy. The forms (modification, renewal, unanticipated/adverse event, study closure) are located in the Cayuse IRB System with instructions provided on the IRB Applications, Forms, and Submission webpage. Failure to notify the IRB of the following requirements may result in disciplinary action. The Cayuse IRB system will notify you when your protocol is due for renewal. Ensure you file your protocol renewal and continuing review form through the Cayuse IRB system to keep your protocol current and active unless you have completed your study.

- Ensure your CITI Human Subjects Training is kept up-to-date and current throughout the study.
- Submit a protocol modification (change) if any changes (no matter how minor) are proposed in your study for review and approval by the IRB before being implemented in your study.
- Notify the IRB within 5 days of any unanticipated or adverse events are experienced by subjects during your research.
- Submit a study closure through the Cayuse IRB submission system once your study has ended.

If you have any questions regarding the IRB decision, please contact Michael Gillespie, the Research Compliance Officer. Mr. Michael Gillespie can be reached by phone at (909) 537-7588, by fax at (909) 537-7028, or by email at mgillesp@csusb.edu. Please include your application approval number IRB-FY2021-111 in all correspondence. Any complaints you receive from participants and/or others related to your research may be directed to Mr. Gillespie.

Best of luck with your research.

Sincerely,

Nicole Dabbs

Nicole Dabbs, Ph.D., IRB Chair
CSUSB Institutional Review Board

ND/MG

APPENDIX D

DEMOGRAPHIC SURVEY

DEMOGRAPHICS SURVEY

1. What is your age?
   - ☐ Younger than 25
   - ☐ 25-34
   - ☐ 35-44
   - ☐ 45-54
   - ☐ 55+

2. What is your gender?
   - ☐ _____
   - ☐ Prefer not to answer

3. Please specify the ethnic origin you identify with the most.
   - ☐ American Indian or Alaska Native
   - ☐ Hispanic/Latino
   - ☐ Asian
   - ☐ Black/African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White/Caucasian
   - ☐ Biracial/Multiracial
   - ☐ Other
   - ☐ Prefer not to answer

4. What is your marital status?
   - ☐ Single (never married)
   - ☐ Married, or in a domestic partnership
   - ☐ Widowed
   - ☐ Separated
   - ☐ Divorced

5. What is your approximate average annual household income?
   - ☐ $29,999 or less
   - ☐ $30,000-$54,999
   - ☐ $55,000-$79,999
   - ☐ $80,000 and over

6. What is your level of education?
   - ☐ H.S. Diploma/GED
   - ☐ Some College
   - ☐ Associate Degree
   - ☐ Bachelor's Degree
   - ☐ Master's Degree
   - ☐ PhD
   - ☐ Other
7. What was (or is) your major?
   - ☐ _____
8. Are you (or were you) licensed in your position?
   - ☐ Yes
   - ☐ No
9. What is your employment status?
   - ☐ Employed full-time (40+ hours a week)
   - ☐ Employed part-time (less than 40 hours a week)
   - ☐ Student
   - ☐ Retired
   - ☐ Other
10. How long have you worked (or did you work) in the field of Hospice Social Work?
    - ☐ 0-2 Years
    - ☐ 3-5 Years
    - ☐ 6-9 Years
    - ☐ 10-12 Years
    - ☐ 13+
11. Is religion or spirituality part of your daily life?
    - ☐ Yes
    - ☐ Sometimes
    - ☐ No

Created by Lillianna Gomez and Divina Perez

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ASSIGNED RESPONSIBILITIES

Research partners Divina Perez and Lillianna Gomez contributed equally to the development of this research study. Divina and Lillianna were mindful of the strengths and skills each partner contributed to this research project. Both partners worked collaboratively weekly through Zoom to discuss challenges and creative solutions for all chapters of this research study. Both researchers equally developed and revised the study to prepare for submission. Both researchers put forth equitable efforts toward the completion of this project.