COMPASSION FATIGUE AMONG SERVICE PROVIDERS IN A COMMUNITY HEALTH AGENCY

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A Project

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Division of Social Work
Abstract

of

COMPASSION FATIGUE AMONG SERVICE PROVIDERS IN A COMMUNITY HEALTH AGENCY

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This study set forth to examine the rates of compassion fatigue among community health providers. The study included 30 providers from one agency in Alameda County. Data for this project was collected utilizing one scale, The Professional Quality of Life Scale (PRoQOL) Compassion Satisfaction and Fatigue Version 5. An additional 12 questions were also asked to gather sociodemographic information from the participants. The findings from this study indicated that participants possess a low level of compassion fatigue, low to average burnout, low secondary traumatic stress, and high compassion satisfaction. Recommendations for this project include agency promotion of self-care, consistent supportive supervision, and the creation of supportive groups within the provider’s environment.

_______________________
Maura O’Keefe, MSW, Ph.D

_______________________
Date
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Chapter 1

PROBLEM STATEMENT AND OVERVIEW

Introduction

I have worked as an advocate for survivors and victims of violence for approximately fifteen years. I have had the privilege to serve those individuals who have suffered intimate partner violence through listening, accompanying clients to various appointments, and helping clients and their children seek safety. I will never forget one particular client with whom I worked extensively through my work at a non-profit domestic violence agency. The client would periodically call our crisis hotline for housing assistance, advice, and support. One Saturday, she appeared at the building where I was the only staff member working the day shift. Her face was battered, black and blue, swollen eyes and lip, and cuts all over her face and body. I had never seen a human being so beaten up and battered in my life, nor have I experienced anyone this battered to this date. The woman was able to get into a safe place away from her abuser, and thanked me for all of the help. She left the office with a smile on her face as shelter staff accompanied her to our shelter. For the following months, I experienced horrifying dreams of her being beaten and again and again coming to me for help. I would dream that I was unable to help her, and that she died as a result of being unable to get help.

The aforementioned story illustrates my personal experience with secondary trauma. Secondary trauma affects those who work with victims of trauma. As quoted by Stebnicki, “In a traditional Native American teaching, it is said that each time you heal
someone you give away a piece of yourself until, at some point, you will require healing” (Bush, 2009,p.26).

This research project will discuss those individuals who have worked with victims of trauma in one community health care agency. It will describe and discuss compassion fatigue, vicarious trauma, burnout and secondary trauma and the contributing factors to the abovementioned terms. It will also discuss what providers are in need of to maintain good and healthy self-care.

Background of the Problem

According to Figley (1995), helping professionals who work with clients who have experienced trauma can become traumatized themselves as a result of doing the work. As providers engage in empathy with their clients, they are at risk for developing compassion fatigue and secondary trauma. This is as a result of sitting with and listening to their clients, who have been affected by trauma (Figley, 1995). The types of cases and situations that providers often assist and listen to include domestic violence, sexual assault, childhood violence, homelessness, and issues related to substance abuse.

There have been many studies completed during the last decade on assisting professionals who have experienced compassion fatigue, vicarious trauma, secondary trauma, and job burnout. The studies generally include those who work as medical professionals, social workers, and first responders to traumatic disasters. Much of the literature includes providers who work with victims of domestic violence and sexual assault. Those individuals assisting and working in the helping profession are at risk for having experiences with vicarious trauma, job burnout, compassion satisfaction, and
secondary trauma. The literature states that those providers who work with clients affected by trauma are at risk for experiencing compassion fatigue. The helping professional may have trouble sleeping, dream about clients, call in sick more often, have trouble maintaining current caseloads, experience depression as well as an inability to effectively serve clients. It is important for us to explore and understand both the negative and positive consequences and outcomes that providers experience working with a client who has been affected by trauma.

Burnout and secondary trauma are both elements of compassion fatigue. The term burnout is associated with and defined as negative feelings towards one’s job. Burnout can occur at any job an individual possesses. Symptoms can include one having feelings of being overwhelmed by work, not feeling effective at the job, not agreeing with management’s protocols or not having support from management, and not having enough time to work effectively with individuals. The feelings of burnout are generally brought on gradually as one is at their job. One who has experienced burnout may feel that they have worked really hard at their job, and yet still have feelings of not making any difference in the work they do (Collins & Long, 2003).

Secondary traumatic stress is the additional component of compassion fatigue. According to Figley (1995), secondary trauma can and may occur to those in the helping profession who work directly with trauma victims on a regular basis. Secondary trauma occurs when a provider is exposed repeatedly to clients who have experienced traumatic and stressful events. Secondary traumatic stress generally is triggered by one event, and can include feeling afraid, difficulty sleeping, and constant thinking about the
information a consumer has presented you with. Secondary traumatic stress can make it difficult for a provider to separate personal from professional life, and is triggered by bearing witness to the consumer’s trauma (Zimering, Munroe, & Bird-Guliver, 2003).

Vicarious trauma describes a providers experience with hearing the repeated traumatic stories as told by clients. Many individuals who work in the medical field as ER providers, first responders, and disaster response workers may experience vicarious trauma. Community health care providers are exposed to hearing second hand traumatic information and are therefore at risk to secondary traumatic exposure. The literature points out that those who are newer to the helping field may have higher rates of vicarious traumatization (Cunningham, 2003).

Compassion fatigue is often discussed with the words “the costs of caring” (Figley, 2002). Compassion fatigue was used to describe those helpers who assisted in the aftermath of September 11th. The term is often used interchangeably with vicarious trauma, and describes the stressors placed upon the helping professional to assist those in need. Compassion fatigue is created when the helper fails to take care of self, becomes wrapped up in helping others, and forgets about the importance of self (Hrehocik, 2009). Compassion fatigue, burnout, vicarious trauma, and secondary traumatization all occur from provider lacking in support and not focusing on self-care.

The literature on compassion fatigue states that providers need to find a balance between empathy and avoiding “emotional over involvement” with their consumers (Bush, 2009). As community health care providers, a great amount of emotional energy and dedication is provided to each consumer, and it is important for the provider to have
self-care routines in place. As a provider, it is important to watch for all of the signs of secondary trauma, vicarious trauma, and/or compassion fatigue and practice self-awareness and good, consistent self-care (Frandsen, 2010).

We, as providers in the community, now have a much more in depth professional understanding of the term burnout referring to general job dissatisfaction. Secondary trauma and vicarious trauma have replaced what was once thought of as burnout, and encompasses a helping professional’s psychological response to working with someone affected by trauma. The literature shows us that those individuals working with people affected by trauma, worry about their personal safety, and the safety of their loved ones (Cunningham, 2003). The literature shows us that those helpers who are hearing firsthand experiences of others affected by trauma may experience secondary trauma, a reaction similar to PTSD (Zimering, Munroe, & Bird-Gulliver, 2003). Community health care providers work with the population affected by trauma each day. A provider who experiences compassion fatigue may experience trouble sleeping, calling in sick, depression, dreams, and chronic reoccurring thoughts about their clients (Pearlman & Saakvitne, 1995). Another important note to make is that an individual provider’s experience with his/her own personal trauma history can interfere with his/her ability to deliver quality services (Salston & Figley, 2003). The below mentioned thesis project will discuss the importance of understanding and researching compassion fatigue, vicarious trauma, secondary trauma, and understanding the importance of engaging in self care activities.
Statement of the Research Problem

Those in the helping profession who work as community health care providers may be at risk for experiencing compassion fatigue, secondary trauma, and vicarious trauma. Community health care workers’ exposure and experiences of hearing stories of violence from individuals who have suffered trauma can have a negative effect and cause an individual to experience compassion fatigue and secondary trauma. Further research is needed to provide those in the helping field with support and information on the importance of self-care activities. Although there has been considerable research conducted over the last ten years on compassion fatigue, secondary trauma, and vicarious trauma to illustrate some of the effects, many providers, supervisors, and managers are unaware of all of the factors and symptoms associated with compassion fatigue, vicarious trauma, and secondary trauma, as well as self-care activities that can be implemented to reduce the rates.

Purpose of the Study

The purpose of this study is to examine the extent of the problem of compassion fatigue in a community health care agency. Specifically this study will compare the rates of those individuals who have worked less than five years with those who have worked more than five years with victims of trauma to determine whether length of time working with trauma victims increases the risk for compassion fatigue, vicarious trauma and job burnout. In addition, the study compares those community health care providers’ educational levels to determine if educational level is associated with compassion fatigue,
vicarious trauma and job burnout. It is hoped that this research project will provide useful information to community health care providers for purposes of recognizing what compassion fatigue, secondary trauma, and vicarious trauma are in order to possibly receive help before their symptoms become too much to handle.

**Theoretical Framework**

Social workers need to surround themselves with, “Knowledge and theories to give meaning to the interaction of social systems and the lives of people” (Boyle, Hull, Mather, Smith, & Farley, 2009, p.159). Theory is important to provide one a good understanding of the consumer’s environment. The researcher utilized two theoretical frameworks for purposes of this research project. This research project uses cognitive behavioral theory and ecosystems theory to guide this study.

Cognitive behavioral theory describes the “influence of cognitive factors such as learning and the importance of the individual’s perception and interpretation of external events” (Boyle, Hull, Mather, Smith, & Farley, 2009, p.92). Cognitive behavioral theory emphasizes the individual’s thought process and how one organizes his/her own thoughts. This particular model aims to “initiate positive change throughout one’s systems by way of the cognitive system” (Boyle, Hull, Mather, Smith, & Farley, 2009, p.94). Cognitive behavioral theory is client-centered and encourages clients to challenge their false or distorted beliefs. For example, a client who has been a victim of domestic violence will often times feel that the violence is his/her fault. Cognitive behavioral theory challenges individuals’ belief of thinking the violence is their fault. This can allow the helper entrance to the underlying beliefs the client has, in this case, domestic violence.
As a provider working with trauma victims, the provider would take in the information, process it, and develop the plan to work with the client in the most beneficial way. This theory and framework assists clients in examining their behavior and thought process in order to begin growth and personal change. The concept of taking in information, processing it, and having a plan for self-care is valuable for providers working with those affected by trauma. If a provider has the false belief that he or she did not do enough to assist a victim of trauma who was killed by their partner, cognitive behavioral theory can challenge the self-doubt and negative feelings. Through cognitive behavioral theory, the provider would be able to shift his/her thinking to focus on the reality of all the positive ways they assisted the client.

Ecosystems theory focuses on the individual person and his or her environment. This theory combines systems theory and the ecological perspective. This theory allows providers to look at the behavior of clients, and in turn themselves though a system’s perspective (Boyle, Hull, Mather, Smith, & Farley, 2009, p.172). This theory blends our consumer’s relationship with their family, themselves, their community, and work. If an individual experiences trauma, and is unable to get the assistance needed to work through the event, they are at risk for taking out their negativity on their family, their communities, and even the provider who is their support and helper.

Ecosystem theory posits that micro, macro, and mezzo systems are all connected, and work together. A micro system is defined as an individuals’ family, self, and those that are most intimate and close to the specific individual. Macro system includes societies values and concerns. Mezzo system provides an explanation for how a client
interacts within their social network. Mezzo system is most easily defined for purposes of this project as the agencies that interact and communicate with one another (Schriver, 2004).

Providers who work with trauma victims are often times working with the communities and larger systems to better serve the clients. There are many factors that can influence a provider’s experience. These can include hospitals, jail, CPS, and school. It is important for providers to examine their own experiences and relationships with others in order prevent compassion fatigue. The individual provider must collaborate often times with the community resources, while building a personal relationship with members of other community resources. The provider must also work within their own personal system that includes family, workplace community, friends, and general community. This is especially important for developing and maintaining healthy support systems and building self-care as part of their routine to prevent compassion fatigue, vicarious trauma, and burnout.

**Definition of Terms**

The following definitions are included to provide clarity to the reader for the following research study:

*Burnout*: Burnout is not limited to working with those individuals who have experienced trauma. Burnout is simply a “...conflict between an individual’s values and the organizations goals and demands, too many responsibilities, no control over the quality of services provided, and the existence of inequity or lack of respect at the workplace”
(Salston & Figley, 2003, p39). Burnout is a component of compassion fatigue, and for purposes of this research project may look like physical and emotional fatigue.

Community Health Care Provider: For purposes of this study a community health care provider is defined as either a para professional or a professional who works with clients in a community health care setting. The individual may be administration, nurse, doctor, physician assistant, social worker, psychiatrist, psychologist, and/or case manager.

Compassion Fatigue: Both burnout and secondary trauma are elements of compassion fatigue. This is a negative secondary outcome. Compassion fatigue is often associated with the same symptoms as burnout. However, compassion fatigue refers to providers who work with individuals affected by trauma. Those providers who experience compassion fatigue will experience a decrease in empathy over time for their consumers’ experiences.

Compassion Satisfaction: This is defined as the pleasure individuals get from their work, and being able to do their job well. A provider may feel positive towards their co-workers, management, feel their work makes a positive difference, and that they are effective helpers.

Countertransference: This is defined for purposes of this study as a therapeutic reaction between the consumer and the provider. The provider is emotionally activated, (positive or negative), through the therapeutic alliance. The feelings the provider has are believed to, “originate at the unconscious level and be connected to past conflicts in the life of the helper” (Boyle, Hull, Mather, Smith, & Farley, 2009, pg. 234). Countertransference is
normal but it is important to process issues that arise through good supervision and support.

Secondary Traumatic Stress: This is defined as “indirect exposure to trauma through a firsthand account or narrative of the traumatic event. (Zimering, Munroe, Bird-Gulliver, 2003, p .380) The provider hearing traumatic events may experience and have a similar reaction to that of post-traumatic stress disorder. Secondary traumatic stress is defined by Figley as essentially the consequences that result from assisting another human with their traumatic event and wanting to help that individual (Collins & Long 2003).

Post Traumatic Stress Disorder (PTSD): This is defined in the DSM IV and includes the individual developing specific characteristics after a traumatic event. Individuals who suffer from PTSD will have a higher baseline level of arousal, startled response, and one’s “bodies are always on alert for danger” (Herman,1997,p.36). PTSD is characterized by specific symptoms following a traumatic event according to the DSM IV. PTSD can be acute, chronic, or with the delay in onset in respect to duration of time. The individual who experiences the trauma first hand must have significant fear in responding to the event, and must meet specific criteria as specified in the DSM IV (American Psychiatric Association [DSM-IV-TR], 2000).

Vicarious Trauma: Vicarious trauma and burnout are similar. Both result in physical symptoms. However, vicarious trauma only results from providers work with victims affected by trauma whereas, an individual experiencing job burnout can have the same experiences and symptoms at any job. A provider who experience vicarious trauma will
have his or her emotional and spiritual sense of self negatively affected by hearing the stories of those affected by the trauma (Trippany, Kress, and Wilcoxon, 2004).

**Assumptions**

The research assumed that some providers have experienced compassion fatigue as a result of the work they do with victims of trauma. The researcher of this thesis project has assumed that compassion fatigue, burnout, secondary trauma, and vicarious trauma need to be addressed and is an important research topic. The researcher assumed that the survey instrument and information is reliable, and that participants answered the survey questions honestly. It is also assumed that the sample did not have an agency bias, and that those who wished to participate did so.

**Justification**

The following research project will benefit the profession of social work by bringing more awareness to individual providers and the profession on one being aware of secondary and vicarious trauma, learning self-care routines, and methods specific to that individual. In addition, as outlined by the NASW Code of Ethics, this study was completed with adhering to integrity, an ethical study, and a responsibility to the agency and individuals who participated. This study is important to the NASW for the commitment to both clients and consumers, to discover alternative ways for individuals to care for themselves, and in-tern, provide services to consumers. It is critical for those working with victims of trauma to have a firm grasp on the warning signs of compassion fatigue, secondary trauma, burnout, and vicarious trauma. Providing quality client
services can become difficult for the provider who doesn’t take care of him or herself and promote health to self equal to that of their clients.

**Limitations**

A major limitation of this study is the small sample size, the fact that the study was conducted at only one agency, with only those individuals who wished to participate in the sample size. Thus, findings are not generalizable and are not meant to represent all providers. This was a convenience sample and those who chose to participate in the study may be somehow different than those who did not participate in the study.

**Summary**

Compassion fatigue, vicarious trauma, secondary trauma, and burnout have been written and studied over the last decade. This is an important topic to research because although studied, many individuals who serve as providers in our communities know little about the topic, or how to prevent compassion fatigue. The following research study will discuss more in-depth the problem of compassion fatigue and how providers can incorporate self-care into their daily lives.
Chapter 2

LITERATURE REVIEW

“It makes intuitive sense that engaging with another person in an empathetic relationship characterized by the identification with and understanding of their emotional experience, similarly impacts upon the emotional experience of the therapist, both at a conscience, and subconscious level” (Devilly, Wright, & Varker, 2009, p.373).

Introduction

After reviewing the literature on burnout, compassion fatigue, vicarious trauma, and secondary trauma, it became abundantly evident that the majority of providers who work with trauma survivors will experience some form of burnout, vicarious trauma, compassion fatigue, or secondary trauma in their careers. The effects of these on individual providers can vary from nightmares and/or avoidance of work, to more severe symptoms including PTSD like symptoms, or the provider becoming ill as a result of hearing clients’ stories of trauma. The terms burnout, vicarious trauma, compassion fatigue, and secondary traumatic stress, while having differences in their definitions, essentially equate to the same outcome for providers who work with victims affected by trauma. Essentially, those who care and have worked with those trauma victims may suffer negative consequences from their work (Figley, 2002). The literature discusses the need for providers to be educated about the terms, along with learning how to provide self-care for themselves early on in their careers. It is especially important for those working with victims of trauma to continue to do the good work they do, while maintaining healthy mental health. Community health care workers comprise social
workers, psychologists, case managers, psychiatrists, nurses, and doctors. These workers are exposed to various client situations, including many clients affected by trauma.

The literature review will examine what trauma cases may look like for community mental health providers as well as some data on domestic violence and sexual assault. It will provide working definitions and explanations of burnout, compassion fatigue, countertransference, vicarious trauma and secondary trauma, as defined by previous studies. The review will then discuss the research already compiled on the effects of trauma on service providers and how it presents symptomatically. The literature review will then discuss what the research states about self-care, coupled with suggestions to guide self-care. According Collins and Long (2003), the longer one works with populations affected by trauma, the more at risk those individuals are for developing secondary traumatic stress. Studies have indicated roughly 38 percent of social workers experience moderate or high levels of secondary traumatic stress (Dalton, 2001).

**Typical Trauma Cases for Community Health Care Providers**

Typical cases community providers in a health care agency assist clients with include domestic violence, sexual assault, homelessness, child abuse, elder abuse, substance use and abuse, employment, legal and medical issues, including lack of accessible healthcare, and violence in the community. The majority of the literature on compassion fatigue, secondary trauma, and vicarious trauma has described providers who have worked with sexual assault and domestic violence survivors. Information on domestic violence and sexual assault is provided.
Domestic violence is a rampant and widespread health problem and is difficult to quantify, as it is an underreported crime (Break the Cycle, 2006). It is estimated nationally by the National Coalition of Domestic Violence that one in four (and fast growing to 1 in 3) or approximately 1.3 million women are victims each year of intimate partner violence. Females ages 16-24 are at greatest risk for becoming victims of intimate partner violence. The costs of intimate partner violence top over 5.8 billion dollars each year as a result of emergency room visits and lost time from work. Domestic violence victims can and do often times have problems of homelessness, legal issues, substance abuse, child and elder abuse involved, medical issues, and issues of mass violence within their communities (Bureau of Justice Statistics, 2009). The abovementioned statistics provide a high likelihood for community providers to work with victims of domestic violence.

Sexual assault is also largely an underreported crime in the U.S. Sixty percent of sexual assaults will never be reported in the United States (National Coalition of Domestic Violence, 2010). Forty-four percent of victims are under the age of eighteen years old, with eighty percent of victims under the age of thirty. As discussed above, an individual’s intimate partner commits many of the sexual assaults. Someone the victim knew commits approximately two thirds of sexual assaults (RAINN, 2010). Theses statistics provide a startling reality for those in the helping profession. Statistically, it is very likely that a community health care provider will work with clients who have been victims of sexual assaults. Community health care workers are on the front lines working
with victims to provide education, advocacy, and support so that victims can break free of the denial.

Roughly 275 million children worldwide are exposed to violence in the home according to the UN Secretary-General’s study on violence against children (UNICEF). According to the Bureau of Justice (2007), between 2001-2005, 35.2% of households where non-fatal domestic violence occurs had children under 12 in the home. Children, who are subjected to chronic violence as a result of living in a household where domestic violence is present, experience more fear, heightened anxiety, become more reactionary, and can disassociate under stress as a learned coping mechanism for survival (Perry, 2000).

Providers who work with trauma victims, often times provide supportive listening and are exposed to a firsthand account of the violence. Providers also serve as their clients’ advocates, provide family therapy, accompany clients to appointments including legal and medical, provide resources, and are privy to the enormity of the violence that befalls these individuals and families. The provider often times hears a victim’s story the first time it is told, and often have access to police, court reports, and medical files. You said this before. As a result, the following provides definitions and information as to the effects of hearing trauma has on the providers.

**Effects of Burnout**

Burnout, vicarious trauma, secondary trauma, compassion fatigue, and counter transference are labels that warrant clear definitions. As early as the mid 1970’s, the definition of burnout was used in reference to health care workers who had experienced
low morale, absenteeism from their job due to calling in sick more often, job stress, and positions that had a high job turnover (Collins & Long, 2003). The definition of burnout broadened in the 1980’s to include physical, emotional and behavioral, work-related symptoms, and interpersonal symptoms. Behavioral symptoms of burnout interestingly can include substance abuse and emotional symptoms can include guilt, depression, and anxiety (Kahill, 1988). Figley described the process of burnout as gradual and one that intensifies over time (Figley, 1995). In other words, one does not quickly experience “burnout” on the job. It happens over a long period of time.

Traditionally, we think about burnout in terms of being tired of our administration, their policies and often times bored of the work. Burnout is now identified as an element of compassion fatigue. It was initially believed that helping professionals who worked with those experiencing trauma were similar to workers having the experiences of burnout or countertransference (Trippany, Kress, Wilcoxon, 2004). Burnout is associated with the negative feelings of not getting one’s job completed, high workload, or feeling unsatisfied with one’s work, and lack of support from either administration or the consumers that one works with. Symptoms of burnout can include an unwillingness to discuss work, a reluctance to check one’s messages, return appointments, and a resistance to look at the causes and remedies as to why one is experiencing burnout (Emerson, Shirley, Markos, & Patricia, 1996 ). Burnout can also include daydreaming, procrastination, not returning phone calls or missing appointments, and a loss of overall enthusiasm for the work that was once there previously (Kahill, 1988).
The literature states that younger workers are less likely to stay on the job where they assist those victims of trauma (Acker, 1999). One explanation to this is that those new to the field may feel that the organization they are employed by does not share the values they have, nor do they share the same expectations in common (Acker, 1999). The literature on compassion fatigue continuously described the importance of good leadership, organized, regular, and consistent staff meetings and supervision, taking time out for self away from work, and paying attention to one’s body for cues. Tehrani’s study of 319 providers who work with survivors of trauma discovered a high percentage of support coming from friends and colleagues, and concluded that it was an individual’s most valuable source of support (Tehrani, 2007).

One study by Collins & Long (2003), looking at the psychological effects of trauma on mental healthcare workers, found that burnout could occur at any job an individual possesses, was associated with and is defined by the researchers as negative feelings towards one’s job. The feelings of burnout were generally brought on gradually over time. Those who had experienced burnout believed that they had worked hard at their job, yet still felt they were not making any difference in the work they did. It was important for the profession of social work to address burnout because of the negative impact on work environments, client continuity and the delivery of services (Hansung & Lee, 2009).

Lewandowski’s research on workplace burnout involved 141 subjects who were service professionals. The study investigated the correlation between the service professional’s level of burnout and agency factors that contributed to the burnout. A
Likert scale instrument was utilized for the study. Findings revealed that workplace burnout appears to originate with the provider’s agency. The study also found that one’s personal situation and circumstances contributes to their ability to cope (Lewandowski, 2003).

**Compassion Fatigue**

Compassion fatigue can affect all of the helping professions who work with individuals who experience some form of suffering. Those helping professionals who sit with others through the midst of their suffering often times find themselves exhausted from being present for others, and can experience physical and emotional depletion. Therapists who experience compassion fatigue have both their personal and professional lives impacted negatively (Berzoff & Kita, 2010). Compassion fatigue can be described best as a “unique kind of burnout” (Neale, 2009, p1). People who have developed compassion fatigue can show symptoms of being chronically tired, distancing self from their work, and may have depression and anxiety disorders as a result of suffering from compassion fatigue (Neale, 2009).

Figley, as cited by Anderson, defines compassion fatigue as “the natural results of empathetic engagement with clients and exposure to their traumatic material and the stress of helping or wanting to help a traumatized or suffering person” (Anderson, 2004, p.254). Caregivers who are able to inherently show sympathy to others are at the greatest risk of compassion fatigue (Bush, 2009).

Compassion fatigue has been found to be associated with the amount of time exposed to client suffering (Berzoff & Kita, 2010). Those who experience compassion
fatigue are giving more energy and compassion than they receive; Compassion fatigue manifests itself as “physical, emotional and spiritual exhaustion” (MacLaughlin-Frandsen, 2010, p. 3). According to Berzoff & Kita (2010), providers’ experiences with compassion fatigue can cause them to feel a sense of guilt, powerlessness, rage, emotional depletion, mood changes, nightmares, hypervigilence, changes in self-esteem, and somatic symptoms. Compassion fatigue reduces the ability and interest to bear witness to the suffering of others (Figley, 2002) and is a form of caregiver “burnout” (Figley, 1995).

Compassion fatigue was described by Berzoff & Kita (2010, p.349) as one’s own “emotional stress having to continually support others.” It is also important to differentiate between “compassion” and “compassion fatigue”. Having compassion for an individual does not mean that the individual will suffer from compassion fatigue. Compassion and empathy are important attributes for a provider to work with individuals affected by trauma. Empathy is an important “helper” tool and one that is vital to be of assistance to others. Compassion helps the helper to have a greater understanding and to empathize with our client’s situations (Berzoff & Kita, 2010).

Devilly, Wright, and Varker (2009) conducted a study that included 152 participants who worked as mental health professionals. The study asked questions that measured the participants’ burnout, secondary traumatic stress, and vicarious trauma. The study asked questions about the provider’s exposure to hearing about their client’s trauma. The study’s results stated that the mental health providers were not affected by their hearing their client’s trauma and therefore did not have significant secondary
trauma, vicarious trauma, or burnout. The results of the study discussed stressors that correlated with significant secondary traumatic stress, burnout, and vicarious trauma was other “work related stressors” (Devilly, Wright, & Varker, 2009, p.373).

Adams, Boscarino, and Figley (2006) completed a study in which 236 social workers participated. The research focused on the contributing factors of compassion fatigue among the social workers that had worked with trauma victims. Less than 20% of the social workers that participated had a caseload with clients who experienced trauma. The results discovered that demographic information had no influence on the rates of compassion fatigue. The results also state that negative life events elevated the level of compassion fatigue and that having adequate information on working with victims of trauma lowered the rates of compassion fatigue (Adams, Boscarino, & Figley, 2006).

Research on vicarious trauma and compassion fatigue states that an individual’s social support plays a critical role in the provider’s wellbeing and ability to effectively assist clients (Mathiewu, 2007). Providers should watch out for warning signs, practice prevention skills, and implement self-care into their daily lives. The literature illustrates that when individuals find their workplace to be supportive, they experience lower levels of vicarious trauma and compassion fatigue (Anderson, 2004). According to Frandsen, avoiding burnout and compassion fatigue requires one to set boundaries, have awareness of work and personal life, watch one’s warning signs, and practice self-care (Frandsen, 2010).
**Countertransference**

Countertransference has been defined in multiple ways since the times of Freud who defined countertransference as integral to psychodynamic theory (Berzoff & Kita, 2010). Countertransference can best be defined as a psychodynamic concept that relates to the helpers past experiences in life. Figley (1995) describes countertransference as seeing yourself in the client, an emotional reaction of the provider to the client. Those particular and individualized experiences that the provider has experienced, both unconscious and conscious, determine the response that the provider will have with an individual client (Marriage & Marriage, 2005). Berzoff and Kita note that compassion fatigue can interfere with the practitioner’s ability to engage in countertransference. At times, countertransference is noted to be a tool of communication, and a tool to utilize reflection (Berzoff & Kita, 2010). Countertransference can take on multiple difficult forms, which may or may not include exhaustion or fatigue. Countertransference is essential to the engagement process with clients (Berzoff, Kita, 2010). It is important for providers to understand and be aware of countertransference and how to better serve their client in their therapeutic role (Marriage and Marriage, 2005). “Countertransference is not something to be gotten rid of, or to be ashamed about, but is an unavoidable communication between therapist and client…essential to the treatment process” (Berzoff & Kita, 2010, p. 342).
Vicarious Trauma

Vicarious trauma is a term that is close to and is often times used in the same vein as compassion fatigue (Bush, 2009). Vicarious trauma appears to be synonymous with compassion fatigue. Vicarious trauma can cause a change in one’s cognitive schema. Some studies show that a provider’s personal trauma history predisposes them to vicarious trauma (Devilly, Wright, & Varker, 2009). In other words, if the provider has a history of sexual trauma, domestic violence, or other trauma, they themselves may be at a higher risk for developing vicarious trauma. Figley (1995) stated that vicarious traumatization can be present and common only in trauma work, and affects only those individuals who work with trauma victims and survivors.

Vicarious trauma is caused by the empathic engagement with one’s clients. Vicarious trauma impacts one’s worldview, and can shift an individual’s particular worldview (Trippany, Kress, & Wilcoxon, 2004). Anderson (2004) describes this “shift” in the worldview as providers stepping into their role as helpers working with individuals who have been affected by trauma with the belief that people are inherently good. After a period of time, the provider’s worldview shifts in terms of losing hope and becoming more cynical.

Secondary Traumatic Stress and PTSD

Post traumatic stress disorder or PTSD is a diagnosis with specific criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders. PTSD was first recognized in 1980, and has been the subject of multiple studies and articles. The DSM IV provides diagnostic criteria to diagnose PTDS by a qualified professional. The DSM
states that “an individual must have been exposed to a traumatic event and either experienced or witnessed an event that caused serious injury, or that had the threat of injury to self or others, and the individual must have a response that involves fear, helplessness, or horror” (American Psychiatric Association, 2000, p.467). Post traumatic stress disorder is characterized by three main groups of symptoms: (1) re-experiencing an aspect of the trauma through recurrent and intrusive dreams, thoughts, intense psychological distress, and/or intense psychological distress to internal or external cues that symbolize the event, (2) avoidance of anything related to the trauma through avoidance of anything related to the trauma which could include thoughts, emotions, people, places, memories, detachment from others, and a restricted range of affect, and (3) persistent symptoms of increased arousal which includes symptoms such as hypervigilance, heightened irritability or anger, sleep difficulties, and startled responses (American Psychiatric Association, 2000, p.468). Those who have been victims of trauma including domestic violence and sexual assault may be diagnosed as having PTSD (Figley, 1995). Figley stated that having the knowledge of another’s trauma could also be traumatizing to the listener.

Figley defines secondary traumatic stress as, “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress resulting from helping or wanting to help a traumatized or suffering person“ (Figley, 1995, p. 7). These reactions that a provider feels as one of inevitability. These stressors that one may develop can be increased due to an individual’s work and length of time with trauma victims (Herman, 1992).
The concept of secondary trauma, or secondary traumatic stress, has historically been understudied. Certain studies have correlated higher rates of secondary trauma with an individual’s trauma history, while others have not noted a connection between personal trauma history and higher rates of secondary trauma (Zimering, Munroe, & Bird, 2003). Secondary trauma serves as a component, along with burnout, of compassion fatigue. Secondary traumatic stress can be exacerbated in the provider if they themselves have a trauma history (Salston and Figley, 2003). Figley described secondary traumatic stress as a syndrome nearly identical to PTSD. Those who suffer from secondary traumatic stress may experience shifts in their core beliefs. The shifts within the individual include suspicion of others, a sense of vulnerability that is heightened, helplessness, and the loss of personal control and freedom (Collins & Long, 2003). This is also echoed and discussed by Herman (1992) who describes the witness guilt that providers can experience. There can also be the feelings of the helper who did not experience the trauma, but has the knowledge of knowing another individual has suffered. This can also be thought of as “survivor’s guilt.” Sommer (2009) stated that as a result of conducted research on providers who work with trauma victims, as one’s income and education increased, the individual providers experienced decreased levels of secondary traumatic symptoms.

In general, the research shows that those who assist trauma victims, whether they are social workers, doctors, or other medical or helping professionals, can experience compassion fatigue. One theory holds that it is difficult for those who help and hear the
horrors of client’s trauma, to hold in the information confidentially, and to not be able to discuss their cases at home and with loved ones (Landau, 2010).

**Impact of Self-Care on Mental Health Providers**

“…a culture that values staff and promotes their care should be cultivated in working environments where staff know that they are supported and feel comfortable …” Collins & Long, 2003, p. 423

The literature on those working with victims affected by trauma echoes time and time again the importance for the helper to take care of himself or herself. Nelson (2003) discussed how difficult it is for the provider to cope with the trauma he or she hears on a day-to-day basis. Smith (2009) outlines five important activities to engage in to avoid suffering from compassion fatigue. These five items include: understanding one’s own life; being aware of negativity and focus on the positive; stop engagement with those in our personal life who are negative, and engage in five activities a day which promote positively (Smith, 2009).

In addition to the above, the research on self-care includes the importance of supportive managerial support and good supervision. Providers who have experienced compassion fatigue or vicarious trauma may have their worldview impacted, their sense of identity, and their success with clients clouded (Anderson, 2004). It is important for the individual provider to have access to support from management, as well as from co-workers to prevent compassion fatigue (Mathiewu, 2007). Wasco and Campbell (2002) discussed the importance of self-care routines including how individuals can implement a self-care regimen into their daily routine.
Self-care as prevention is essential for preventing secondary trauma and can be provided in our educational system as well as at our worksites. Zimberg, Munroe, and Bird-Guliver (2003) discuss four domains that are essential in the prevention of secondary trauma. These include balancing caseloads, accessible supervision, organizational strategies, personal strategies including boundaries and self-care activities, and general coping strategies. Figley (1995) notes that it is important in managing compassion fatigue to desensitize the therapist to traumatic stressors (Figley, 2002). This can be accomplished through the amount of exposure a provider is exposed to, while having the self-care routines implemented. Pearlman and Saakvitne (1995) described strategies, training, and support for trauma workers as an important resource to assist providers (Pearlman & Saakvitne, 1995).

Several articles discuss prevention of the aforementioned accomplished through workshops and resources to assist with avoiding any secondary trauma or vicarious traumatization. Every piece of literature discussed the importance of good, reliable, and consistent supervision available to the providers (Ben-Porat & Itzhaky 2009). The research also seems to point to good supervision and agency support equaling the provider experiencing lower levels of vicarious trauma (Anderson, 2004). Marriage and Marriage (2005) emphasize the importance of continuing to maintain and develop a professional network, support, and paying attention to self and needs. They also discussed the importance of “…managing stress by self monitoring their emotional responses” (Marriage & Marriage, 2005, 117). According to Frandsen (2010) and specific work conducted with nurses who experience compassion fatigue, secondary and vicarious
trauma, prevention includes setting boundaries, daily breaks, learning ways to manage stress, taking time each day for to do a self-care activity such as journaling, and exercise, (Frandsen, 2010).

Another perspective for coping with one’s reaction to working with those who have experienced trauma is to recognize from a therapeutic and organizational viewpoint that vicarious trauma is an “occupational hazard of the work” (McSwain, Robinson, and Panteluk, 2004, p.14). This statement normalizes providers’ experiences and brings awareness to those who may not have been educated on the effects of trauma.

Summary

A significant number of studies have been conducted over the last decade that focused on learning about the causes of compassion fatigue, burnout, and secondary trauma. The research is clear that there is an indication of negative consequences for providers who work with those individuals who have been affected by trauma (Cunningham, 2003). The research has also included the prevention and reduction strategies for compassion fatigue. The research also indicates that those individuals who work with victims of trauma can grow and learn from working with clients affected by trauma (Tehrani, 2007).

It is important to understand and make a distinction between burnout, compassion fatigue, countertransference, and secondary trauma. Burnout can be summarized as “emotional exhaustion” that can be exhibited in the form of calling in sick, low productivity, and feeling depleted (Kim & Lee, 2009, p.366). Secondary trauma can be summarized as the reaction of provider hearing firsthand information about a client’s
trauma (White, 2003), while countertransference can be negative or positive and is a part of our client and provider’s interaction. Compassion fatigue is best described as being comprised of both burnout and secondary traumatic stress. The literature provided information on the issue of compassion fatigue, burnout, and secondary trauma. The literature review has discovered that younger workers are more likely to leave the job earlier when working with trauma victims. The literature also found that the majority of a provider’s support comes from their friends and family, good supervision, and self-care. The literature also provided information that stated burnout and compassion fatigue can often times be correlated to their personal life and other work related stressors, and not necessarily their direct work with clients.
Chapter 3

METHODOLOGY

Introduction

This chapter discusses the research methods used for this research study including the research design, research questions, and hypotheses. In addition, the data procedures, data analysis, and the protections of human subjects are discussed. The focus of this study is to examine the problem of compassion fatigue among community health care workers, and determine if years of working in the field had any influence on level of compassion fatigue. The study also examines if one’s educational achievement is associated with the level of compassion fatigue. The underlying principle in this study is the importance of providers to understand the value of self-care.

Research Design

This exploratory study uses a quantitative research design. The researcher chose a quantitative research design in order to have a larger sample of individuals to survey, and to gather generalized information about the experiences of vicarious and secondary trauma of community health care workers. “Descriptive studies in the quantitative tradition are large-scale efforts that attempt to characterize a population group in a definitive way” (Royse, 2008, p.29).

Research Question

This study is aimed at answering the following three questions: 1) What percentage of community health care providers have clinical levels of compassion fatigue? 2) Does the length of time working with victims of trauma have an effect on level of compassion
fatigue among providers? 3) Is the education level of community health care providers associated with compassion fatigue scores?

**Hypothesis**

Two hypothesis are proffered: Hypothesis 1: Those individuals who have worked less than five years as a community health provider working with trauma victims will experience higher levels of compassion fatigue than those who have worked more than five years. Hypothesis two: Community health provider who have a Bachelor’s degree or less will experience higher levels of trauma than those with a master’s degree or higher.

**Sample Participants**

The sample includes thirty individuals who currently work as community health care providers in one agency. The providers need to have worked for a minimum of six months as a provider in a health care agency in order to participate study. The participants were over the age of eighteen. This agency was used because the researcher had access to the agency as a result of personal contact with administration.

**Variables and Instrumentation**

All subjects participating in the study were asked to complete a questionnaire that included 12 demographic questions and thirty questions regarding compassion fatigue. The demographic questions included such items as age, gender, educational level, and marital status. The researcher also included a thirty-question survey, the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (PRoQOL) (Hudnall Stamm, 2009). Permission is granted to utilize this survey as long as credit is given, no changes are made, and the author provided permission to make copies of the PRoQOL.
The thirty questions are designed to measure compassion satisfaction, burnout, and compassion fatigue within the last thirty days of working with client’s affected by trauma. It is anticipated that the information gathered from participants will assist in the agencies awareness of the needs around staff self-care.

These variables were measured using a 1-5 rating Likert scale. The number 1 answer equals never, answering 2 on the scale equals rarely, number 3 equals sometimes, 4 equals often, and 5 are very often. The ProQOL requested participants to answer the questions in reference to their current work situation and the feelings that they have had within the last thirty days. Questions included on the ProQOL asked if the individual felt trapped by their work, if they felt worn out by their work as a helper, and if they avoid certain activities or situations because they are reminded of frightening experiences or people (Hudnall Stamm, 2009).

The analysis for this study included the use of dependent and independent variables. The dependent variable is compassion fatigue. The variable comprises three sub scores: burnout, compassion satisfaction, and secondary traumatic stress. The independent variables are the number of years the provider has worked and their educational level.

The following discusses how each of the variables in the study were measured: Compassion Fatigue was measured by using the three subscales; compassion satisfaction, burnout, and secondary trauma scale. (the subscales are defined below)

*Compassion Satisfaction:* Compassion satisfaction was measured by the PRoQOL survey and calculated by adding up the scores from 10 responses. As stated above these
questions were answered using a Likert scale, 1-5, and measured one’s level of compassion.

_Burnout:_ Burnout was measured by utilizing the ProQOL survey and calculated by adding up the scores from 10 responses. As noted previously, these questions were answered using a Likert scale, 1-5, and measured one’s burnout.

_Several Trauma Scale:_ Secondary trauma was measured by utilizing the PRoQOL survey and calculated by adding up the scores from 10 responses. These questions were also answered using a Likert scale, and measured one’s level of secondary trauma. It is important to note that each of these scales utilized and calculated ten different questions for each measurement.

The analysis for this study included the use of dependent and independent variables. The dependent variable is compassion fatigue. This variable comprises three sub scores: burnout, compassion satisfaction, and secondary traumatic stress. The independent variables are the number of years the provider has worked and their educational level.

**Data Collection Methods**

The researcher collected the data while providing a confidential survey and consent form to participants who voluntarily wanted to participate. The researcher presented the survey and research study at various staff meetings, and simply left the survey for those individuals who wished to participate in the study. To maintain the fairness and credibility of the study, every member who participated in the study was provided the same consent form and survey. The researcher developed and constructed a
twelve-question survey instrument. The instrument asked very basic information to gather socio demographic information, client caseload, and general self-care information from the participants.

Permission was previously granted from LifeLong Medical Care for me to discuss my survey at client staff meetings, and to pass out the survey and consent form at their worksite. Those individuals who participated in the research were asked to complete and return the consent form to participate in a sealed envelope. The participants returned the consent in a separate sealed envelope, and the survey in a separate sealed envelope. The researcher at their worksite provided a locked box and that is where those who participated in the research returned the forms. The researcher was the only individual who had access to the locked box to retrieve the survey and consent forms.

Data Analysis

Once the data was collected it was entered and analyzed into SPSS. The statistical analyses used included descriptive statistics to describe the sample. The PRoQOL scores were computed according to the author’s instructions. To test hypothesis one, an independent t-test was utilized to analyze the data to determine if one’s time working with trauma victims. This was coded less than 5 years and more than five years affected their rates of compassion fatigue. To test hypothesis two, an independent t-test was also utilized to determine if their educational level determined their rates of compassion fatigue. Other hypothesis has to worded similarly if those with less than a BA had higher compassion fatigue scores than those who had greater than a BA educational level.
Protection of Human Subjects

The participants maintained the right to refuse to take the survey, to decline to answer specific questions, or to discontinue participation in the research at any time. (See Appendix A for interview questions). Approval from the California State University’s Division of Social Work Human Subjects Review Committee was granted prior to the collection of data. The Human Subject Review Board determined that risk to the subject was minimal. In addition, two resources to the community were provided should the research subject require someone to speak with. The researcher provided an informed consent form for the participants to review and sign before they fill out the survey. The consent form explained the voluntary participation and confidentiality. Moreover, both consent forms and surveys would be secured in a locked cabinet, accessible to the researcher only. The data entered into SPSS did not contain any identifying information as it was deleted. There was not any conflict of interest, and no inducements were offered to the participants for their participation. The researcher ensured the participant’s right to privacy. There were two referrals provided to the participants should they experience any discomfort. Participants were aware that they could withdraw or refuse to answer any question any time if they wish to do so.
Introduction

This quantitative study explored the rates of compassion fatigue among community health care providers. This chapter presents the data findings and is divided into three sections. The first section presents some general demographic information of the participants. The second section will discuss participants’ scores on compassion fatigue (PRoQOL scores), and section three discusses the results of hypothesis testing.

Section 1 - Demographics

There were 30 subjects in this study. Of those surveyed, 41.4% (n=12) were male, and 58.6% (n=17) were female. (See Table 1).

Table 1 Gender of the Subjects

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>41.4%</td>
<td>12</td>
</tr>
<tr>
<td>Female</td>
<td>58.6%</td>
<td>17</td>
</tr>
</tbody>
</table>

Answered Questions 29 Skipped Questions 1

The age group of the respondents are as follows: those ages 18-29 represent 28.6% (n=8), those ages 30-39 are 32.1% (n=9), those ages 40-49 are 17.9 % (n=5), ages 50-59 (n=5), and those ages 60 or older represent 3.6% (n=1) for the age group (see Table 4). The age group of 30-39 year olds possesses the highest percentage of providers. The
number of years the surveyed individuals have worked in the field with those affected by trauma is reported as 6 months to 1 year 10.3% (n=3), 2-4 years is 13.8% (n=4), 5-7 years is 27.6% (n=8), and 7-10 years is 17.2% (N=5), and 10 years or more working in the field with trauma victims equals 31.00 % (n=9). (See table 5) The majority of participants have worked ten years or more with trauma victims.

The subjects’ educational background ranged from High School Diplomas, to those that possessed a Ph.D. Of these subjects 16.4% (n=5) had high school diplomas, 56.7% (n=17) had Bachelors degrees, 20% (n=6) had Master’s degrees, and 6.7 % (n= 2) possessed a Ph.D. (see table 2). The majority of those surveyed possess a Bachelor’s degree. Table 5 represents participants who engage in self-care activities. 86% of the participants engage in some form of self-care.

Table 2 Subjects Educational Background

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School Diploma</td>
<td>16.7%</td>
<td>5</td>
</tr>
<tr>
<td>Bachelors Degree</td>
<td>56.7%</td>
<td>17</td>
</tr>
<tr>
<td>Masters Degree</td>
<td>20.0%</td>
<td>6</td>
</tr>
<tr>
<td>PHD</td>
<td>6.7%</td>
<td>2</td>
</tr>
<tr>
<td>Answered Questions</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>
Table 3 *Subjects Age Group*

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-29</td>
<td>28.6%</td>
<td>8</td>
</tr>
<tr>
<td>30-39</td>
<td>32.1%</td>
<td>9</td>
</tr>
<tr>
<td>40-49</td>
<td>17.9%</td>
<td>5</td>
</tr>
<tr>
<td>50-59</td>
<td>17.9%</td>
<td>5</td>
</tr>
<tr>
<td>60+</td>
<td>3.6%</td>
<td>1</td>
</tr>
</tbody>
</table>

Answered Question 28
Skipped Question 2

Table 4 *Amount of years working with those affected by trauma*

<table>
<thead>
<tr>
<th>Number of Years</th>
<th>Response Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months-one year</td>
<td>10.3%</td>
</tr>
<tr>
<td>2-4</td>
<td>13.8%</td>
</tr>
<tr>
<td>5-7</td>
<td>27.6%</td>
</tr>
<tr>
<td>7-10</td>
<td>17.2%</td>
</tr>
<tr>
<td>10 years +</td>
<td>31%</td>
</tr>
</tbody>
</table>

Answered Question 30
Skipped Question 0
Self Care

Table 5 Do subjects engage in self-care activity?

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>N=</th>
</tr>
</thead>
<tbody>
<tr>
<td>True</td>
<td>86.7%</td>
<td>26</td>
</tr>
<tr>
<td>False</td>
<td>13.3%</td>
<td>4</td>
</tr>
<tr>
<td>Answered Question</td>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>

Section 2- Professional Quality of Life: Compassion Satisfaction and Fatigue

The ProQOL manual scores are discussed below for each of the three variables, compassion satisfaction, burnout, and secondary traumatic stress. The ProQOL manual states that each of the three variables has a mean score of 50, and a standard deviation of 10. The range for each of the variables is slightly different and is listed below for each variable.

Compassion Satisfaction Scores

The PRoQOL manual states that compassion satisfaction scores of 22 or less indicate low compassion satisfaction; scores from 23 to 41 indicate medium or average compassion satisfaction, while scores 42 or above indicate high compassion satisfaction. The mean for participants in this study was 42.3, which indicates the average score for compassion satisfaction was in the average or medium range. The standard deviation for compassion satisfaction was 21.2. Table 6 displays the participants’ compassion
satisfaction scores as mean scores and percentages. Fourteen (14) individuals scored in within the mean for compassion satisfaction, or 47%, while 16 individuals score equaled high compassion satisfaction, or 53%.

Table 6 PRoQOL Compassion Satisfaction Scores

<table>
<thead>
<tr>
<th>PRoQOL scores</th>
<th>Low Compassion Satisfaction (22 or less)</th>
<th>Average Compassion Satisfaction (Scores 23-41)</th>
<th>High Compassion Satisfaction (Scores 42 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Scores</td>
<td>n = 0</td>
<td>n = 14</td>
<td>n = 16</td>
</tr>
<tr>
<td>Sample Scores in Percentage</td>
<td>0 %</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Burnout Scores

Table 7, shown below, discussed the results of burnout in this study. The PRoQOL manual states that the higher an individual scores on the burnout scale, the higher they are at risk for burnout. The mean for burnout according to the participant’s answers is 20.1. The standard deviation is 3.71. The research for this study indicates that 63% (n=19) of participants have low burnout. Average burnout is 37% (n=16). There was zero percent for high burnout.
Table 7 PRoQOL Burnout Scores

<table>
<thead>
<tr>
<th>PRoQOL scores</th>
<th>Low Burnout (Scores 22 or less)</th>
<th>Average Burnout (Scores 23-41)</th>
<th>High Burnout (Scores 42 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Scores</td>
<td>n = 19</td>
<td>n = 11</td>
<td>n = 0</td>
</tr>
<tr>
<td>Sample Scores in Percentage</td>
<td>63%</td>
<td>37%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Secondary Traumatic Stress

The PRoQOL states as with the other scores, that the higher an individual scores on the secondary traumatic stress scale, the higher their secondary traumatic stress. The mean for study participants was 21.2 with a standard deviation of 5.3. Thus, 60% of participants have low secondary traumatic stress (n=18) and 40% (n=12) of the participants have average secondary traumatic stress. There was zero percent for high secondary traumatic stress.

Table 8 PRoQOL Secondary Traumatic Stress Scores

<table>
<thead>
<tr>
<th>PRoQOL scores</th>
<th>Low Secondary Traumatic Stress (Scores 22 or less)</th>
<th>Average Secondary Traumatic Stress (Scores 23-41)</th>
<th>High Secondary Traumatic Stress (Scores 42 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Scores</td>
<td>n = 18</td>
<td>n = 12</td>
<td>n = 0</td>
</tr>
<tr>
<td>Sample Scores in Percentage</td>
<td>60%</td>
<td>40%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Table 9 presents results of bivariate correlations conducted on all three of the outcome variables: compassion satisfaction, burnout, and secondary traumatic stress. Not surprisingly burnout and compassion satisfaction were found to be significantly associated with each other, but the relationship was an inverse one. The correlation between burnout and compassion satisfaction is statistically significant (r= -.427, p=0.033). Thus, low burnout was related to high compassion satisfaction. In addition, a significant relationship between burnout and secondary traumatic stress was found (r= .496 and p=.022).

Table 9 Correlations Between the Three Outcome Variables

<table>
<thead>
<tr>
<th></th>
<th>BO</th>
<th>CS</th>
<th>STS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout Pearson</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Correlation</td>
<td>1</td>
<td>-.427*</td>
<td>.496*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.033</td>
<td></td>
<td>.022</td>
</tr>
<tr>
<td>Compassion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfaction Pearson Correlation</td>
<td>-.427*</td>
<td>1</td>
<td>-.105</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.033</td>
<td></td>
<td>.627</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress Pearson Correlation</td>
<td>.496*</td>
<td>-.105</td>
<td>1</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.022</td>
<td>.627</td>
<td></td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed)
Section 3 Hypothesis Testing

To test the hypothesis that providers who have worked under five years with trauma victims would have more compassion fatigue than those providers who have worked over five years with trauma victims, t-tests were conducted. The grouping variables were recoded 1 = less than five years and 2 = more than five years, and the outcome variables were compassion satisfaction, burnout, and secondary traumatic stress. No statistical differences were found on any of the three outcome measures and length of time working.

Table 10 Mean scores on Compassion Satisfaction, Burnout and Secondary Trauma By Years of Experience

<table>
<thead>
<tr>
<th>Direct Experience</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>16</td>
<td>41.3332</td>
</tr>
<tr>
<td>5-10 years</td>
<td>13</td>
<td>40.8750</td>
</tr>
<tr>
<td>BO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>16</td>
<td>21.5000</td>
</tr>
<tr>
<td>5-10 years</td>
<td>13</td>
<td>20.000</td>
</tr>
<tr>
<td>STS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 years</td>
<td>16</td>
<td>22.2500</td>
</tr>
<tr>
<td>5-10 years</td>
<td>13</td>
<td>23.8885</td>
</tr>
</tbody>
</table>
Table 11 Correlations

<table>
<thead>
<tr>
<th>Kendall’s tau_b</th>
<th>CS</th>
<th>BO</th>
<th>STS</th>
<th>ExpField</th>
<th>ExpDirect</th>
<th>Educatio</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS Correlations</td>
<td>1.000</td>
<td>-.305</td>
<td>-.008</td>
<td>.137</td>
<td>.055</td>
<td>-.066</td>
</tr>
<tr>
<td>Coefficient</td>
<td>.29</td>
<td>.25</td>
<td>.24</td>
<td>.28</td>
<td>.28</td>
<td>.29</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.051</td>
<td>.960</td>
<td>.364</td>
<td>.713</td>
<td>.672</td>
<td>.916</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>24</td>
<td>28</td>
<td>28</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>BO Correlations</td>
<td>-.305</td>
<td>1.000</td>
<td>.270</td>
<td>-.051</td>
<td>.000</td>
<td>-.018</td>
</tr>
<tr>
<td>Coefficient</td>
<td>.051</td>
<td>.25</td>
<td>.21</td>
<td>.25</td>
<td>1.000</td>
<td>.916</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.29</td>
<td>25</td>
<td>21</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>STS Correlations</td>
<td>-.008</td>
<td>.270</td>
<td>1.000</td>
<td>.042</td>
<td>.132</td>
<td>-.143</td>
</tr>
<tr>
<td>Coefficient</td>
<td>.960</td>
<td>.108</td>
<td>.25</td>
<td>.789</td>
<td>.402</td>
<td>.389</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.24</td>
<td>.21</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>25</td>
</tr>
<tr>
<td>N</td>
<td>24</td>
<td>21</td>
<td>24</td>
<td>25</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>ExpField Correlations</td>
<td>.137</td>
<td>-.051</td>
<td>.042</td>
<td>1.000</td>
<td>.829**</td>
<td>.202</td>
</tr>
<tr>
<td>Coefficient</td>
<td>.364</td>
<td>.751</td>
<td>.789</td>
<td>.29</td>
<td>.000</td>
<td>.206</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>25</td>
<td>25</td>
<td>25</td>
<td>28</td>
<td>28</td>
<td>29</td>
</tr>
<tr>
<td>N</td>
<td>28</td>
<td>28</td>
<td>28</td>
<td>29</td>
<td>29</td>
<td>29</td>
</tr>
</tbody>
</table>

To test hypothesis two, that those who possess a Bachelors degree or less will experience higher rates of compassion fatigue then those who have a master’s degree or higher, an independent t-test was run with the grouping variable coded 1= BA degree and less and 2 = master’s degree or higher and the dependent variable as compassion satisfaction, burnout and secondary trauma. No significant differences were found. Table 12 presents the mean scores for each of the outcome variables by education level.
Table 12 *Group Statistics for Education*

<table>
<thead>
<tr>
<th>Education</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS 1.00</td>
<td>21</td>
<td>41.9524</td>
<td>2.72903</td>
<td>0.59552</td>
</tr>
<tr>
<td>2.00</td>
<td>8</td>
<td>41.1250</td>
<td>4.91172</td>
<td>1.73656</td>
</tr>
<tr>
<td>BO 1.00</td>
<td>18</td>
<td>21.5000</td>
<td>3.38248</td>
<td>0.79726</td>
</tr>
<tr>
<td>2.00</td>
<td>7</td>
<td>20.5714</td>
<td>4.27618</td>
<td>1.61624</td>
</tr>
<tr>
<td>STS 1.00</td>
<td>18</td>
<td>22.5556</td>
<td>5.52238</td>
<td>1.30164</td>
</tr>
<tr>
<td>2.00</td>
<td>7</td>
<td>20.7143</td>
<td>4.23140</td>
<td>1.59932</td>
</tr>
</tbody>
</table>

*Note-1.00 represents group one, High School and Bachelors Degree and 2.00 represents group two, Masters and PhD.*

**Summary**

This chapter presented findings of the study. The Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 survey (ProQOL) was used to measure compassion fatigue using three variables: compassion satisfaction, burnout, and secondary traumatic stress.

Of those who participated, 47% have average compassion satisfaction, while 53% have high compassion satisfaction rates. Of the 30 participants in this study, 60% have low secondary traumatic stress and 40% have average secondary traumatic stress. In addition, 63% of the participants have low burnout, while 37% have average burnout scores.

The hypothesis that service providers who had a BA degree or less would have higher compassion fatigue that those who earned a MA degree or more was not supported. In fact, the two groups had an almost identical mean score for all three components of compassion satisfaction.
The hypothesis that service providers who have worked under five years with trauma victims would have greater compassion fatigue than those providers who have worked over five years with trauma victims was also not supported. Again, the means for each of the outcome variables by the number of direct experience years were similar. The data did show that there is an inverse relationship between burnout and compassion satisfaction. If burnout is low, one can expect compassion satisfaction would be high. Conversely if burnout were high, compassion satisfaction would be low. The following chapter will further discuss the significance of the data.
Chapter 5
CONCLUSION AND RECOMMENDATIONS

Introduction

Although there have been several studies conducted over the last decade on compassion fatigue, burnout, and secondary trauma, many providers remain unaware of how to prevent them from occurring. Many individuals in the helping field also remain uneducated on what the aforementioned terms mean or symptoms associated with compassion fatigue. The purpose of this research study was to determine the rates of compassion fatigue in community health care workers through studying one particular agency. The study attempted to answer three questions; what percentage of community health care workers suffer from compassion fatigue, does the length of time working with trauma victims have an affect on one’s compassion fatigue, and is one’s educational level associated with of compassion fatigue. This final chapter will discuss the significant findings of the research, and propose recommendations for further study.

Summary

This study included 30 community health care providers from one community based agency in Alameda County. Utilizing the Professional Quality of Life Scale (PRoQOL), and asking specific demographical information the researcher was able to analyze quantitative and descriptive data. The research concluded that 60% of participants have low secondary traumatic stress and 40% of the participants have average secondary stress. The participant’s rate of compassion satisfaction concluded that
53% have high compassion satisfaction, while 47% have average compassion satisfaction. For burnout, 63% of the participants experienced low burnout, while 37% have average burnout. According to these findings, half of individuals have average compassion satisfaction, which puts them at risk for low compassion satisfaction. This could indicate that the participants need to examine their self-care and ensure that self-care is a part of their daily lives. This could assist in the prevention of low compassion satisfaction with their jobs. None of the individuals who participated in the study experienced high rates of secondary traumatic stress or burnout. This was a surprising conclusion as the researcher expected significance in high burnout and secondary traumatic stress. This perhaps means that the providers are having a positive experience at their work environment, feeling supported, and able to engage in empathy with their clients. This may also suggest that those who participated in the research have support in their personal lives.

The study explored whether the number of years working with victims of trauma affected their level compassion fatigue. The data did not discover any significant differences in compassion fatigue between those providers that had worked five years or less and those that had worked five years or more. This finding contradicted some of the research which stated that those who worked less than five years with trauma victims would have higher rates of compassion satisfaction (Acker, 1999). It is difficult to explain the disparity in findings. The vast majority in the present sample had worked longer than five years with over 30% reporting they had worked more than 10 years. Only three participants had worked until a year. It is possible that those who are new to
the field and experience compassion satisfaction leave the job early on in their careers thus skewing results.

The research found that one’s educational level also did not have a significant effect on compassion fatigue. The researcher posited those who had less education would have higher compassion fatigue. This finding is also incongruent with prior studies indicating that those who with less education would have higher levels of compassion fatigue compared to those with more education. Again, this lack of significance is difficult to explain. It is possible that the participants’ agency may have self-care measures into place, causing the participants to have low compassion fatigue. Based upon the relatively low scores on burnout and secondary traumatic stress, it is likely that the agency from which the sample was obtained already promotes and implements good self-care activities or promote a supportive work environment for its providers. It is also possible that the participants were having a positive day, and therefore felt and answered accordingly on the survey. The research did not investigate participants’ personal support system or personal history, which could influence the level of compassion fatigue.

**Implications for Social Work Research and Practice**

Research indicates that working with those who have experienced trauma often has negative effects on the provider which include burnout, secondary trauma, vicarious trauma, and compassion fatigue (Figley 2002). This study attempted to discover the rates of compassion fatigue among community health care providers. The study and topic of compassion fatigue have implications for social work practice and education on micro,
macro, and mezzo levels. If a provider scored high or at risk for compassion fatigue, not only the clients but also the providers’ s family and those closest to them could be affected negatively on a micro level. The above could also be true for macro and mezzo systems and influenced negatively. For example, if a provider is experiencing compassion fatigue and needs to work with another social service agency, the negative feelings the provider is experiencing could be shared with the other agency through attitudes and behaviors. This study found that that 60% of community health care providers who participated in the project have low compassion fatigue, and 40% have average compassion fatigue. The participants who have average compassion fatigue could be at risk for having low compassion fatigue, and may be at risk for developing burnout or secondary traumatic stress. It would be prudent for the agency to examine site self-care practices to prevent any compassion fatigue.

The NASW’s Code of Ethics states their core values as service, social justice, dignity, self worth of the person, and importance of human relationships, integrity, and competence (NASW, 2008). The study highlights how important these values are since service providers cannot abide by these values unless they also have self care. Study participants have an overall high compassion satisfaction rate, and low job burnout and secondary trauma. The outcome of the research speaks to how each individual interacts with and promotes the NASW’s core values. If a particular community health care service provider is experiencing high compassion satisfaction and low compassion fatigue, it is likely that the delivery of services will be more effective and competent.

Based on the data from this study, future studies could involve multiple agencies
and a larger sample size. The majority of research for this project included quantitaive studies. Perhaps a qualitative study would be better suited and provide more specific information. The questions on the survey could be modified, expanded, and more specific. In addition to asking the participants if they engage in self-care activities and the amount of times per week, the researcher could ask what the activities are and the amount of time daily or weekly the participant spends in self-care activities. Questions could also include, “How do you feel emotionally on average when you start your work day?”, “How do you feel emotionally at the end of your work day?”, and “Who are the individuals that you identify in your support system?” As an addition to the question included in this survey, “does your agency support self-care”, a more direct question could be asked such as, “Give specific examples of how your agency supports self-care, and “In your education and trainings was self-care discussed and were you able to practically develop self-care from the information provided.” Further studies with broader sample sizes, qualitative studies, and an emphasis on the provider’s support system could provide more specific information and more awareness to upper administration at agencies.

The limitations of this research project include small sample size conducted at one agency. The results of this study cannot be generalized to other agencies nor was the study meant to represent all community health service providers. It is important to note that those who participated in the study could be different than those who did not participate. For example, the most stressed service providers may have chosen not to participate in the study.
Conclusion

Although the hypotheses of this study were not supported, the data gathered can still be beneficial. Compassion fatigue can negatively impact an individual and those negative feelings can spill over to the clients that are being served. Addressing compassion fatigue, compassion satisfaction, burnout, and secondary and vicarious trauma are important to the prevention of compassion fatigue in the workplace. The study concluded 40% of individuals have average secondary traumatic stress. While the ProQOL instrument states that average does not necessarily mean to ring the alarm for concern, the average score for almost half of those who participated should warrant further examination. Increasing self-care activities and reducing compassion fatigue are invaluable to those providers who work in the community with clients, particularly with clients affected by trauma. Another study on compassion fatigue could certainly be modified and expanded to a larger sample size to gain a more detailed understanding of all the factors associated with compassion fatigue.

Recommendations

As an agency that is a provider of direct service to vulnerable populations and those affected by trauma, a recommendation that the literature stated was to have consistent and good supervision. An agency that has not already, could easily implement a standardized checklist for weekly supervision with topics to cover that included self-care. Consistent supervision means that every week at a specific time the supervisor will meet and be available for a specific employee for x amount of time. It may also be effective to implement group supervision that meets one to two times per month in
addition to individual supervision.

For any agency, continuing education that included the topic of self-care is invaluable. It is important that an agency employees recognize that their leaders promote and value self-care. The data from this study found concluded that 13.3% of participants did not engage in any type of self-care. Perhaps through emails the agency could provide ideas for self-care to plant seeds in their employees, or provide information on the warning signs of compassion fatigue, burnout, and vicarious trauma. As a provider, suggestions are provided continuously to clients for improving life’s situations. Clients are told to exercise, eat better, to learn how to say no, and to try to find time for self each day (Mathiew, 2007). This same advice should be utilized by individual providers each day. Providers working together in an agency can create walking clubs, book review clubs, weight management groups at work, healthy eating clubs, support groups, and wellness activities such as yoga and massage. The list is endless and with support from upper management, compassion fatigue, secondary trauma, and burnout can be greatly reduced.
APPENDICES
TO: Harmonne Isenbarger Ellis  
FROM: Committee for the Protection of Human Subjects 

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION 

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “Vicarious trauma among service providers in a community health agency.”

__X__ approved as ___EXEMPT ___ NO RISK __ MINIMAL RISK.

Your human subjects approval number is: 10-11-076. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Jude Antonyappan, Maria Dinis, David Demetral, Susan Eggman, Serge Lee, Kisun Nam, Maura O’Keefe, Sue Taylor, Santos Torres

Cc: Dr. Maura O’Keefe
APPENDIX B

Consent Form

You are being asked to participate in a research study conducted by Harmonee Isenbarger-Ellis, a second year graduate student in the Division of Social Work at California State University, Sacramento. The purpose of this study is to examine the rates, patterns, and trends of vicarious trauma among service providers in a community health agency. You were selected to participate in this study because you are a provider at a community health agency.

You will be asked to complete a 10-15 minute short survey. The survey will ask you to answer questions regarding self-care activities, demographical information, and job satisfaction. Upon completion, please return the survey and informed consent in the folder provided, and slip into the locked box as directed.

Your participation is completely voluntary. You are free to skip any questions or discontinue your participation in this study at any time, without any negative consequences.

Your participation in this study is confidential. No identifying information will be requested. The Informed Consent and the completed survey will be separated and kept in different locations to prevent your name from being linked to the survey. Survey data will be secured and locked in a location only accessible by the researcher. Once data is processed, all surveys will be destroyed.

You will not benefit directly from the study. However, it is hoped that the information you provide will increase knowledge and understanding of secondary and vicarious trauma on community health providers. Unfortunately, you will not receive any compensation for participating in this research study. Your participation is greatly appreciated.

If you have any questions about this research study, you may contact Harmonee Isenbarger-Ellis at Harmoneeie@hotmail.com. You may also contact my thesis advisor, Maura O’Keefe, Ph.D., LCSW, at 916-278-7067 or email okeefem@csus.edu. If you experience any discomfort during or after taking the survey, please contact Alameda Behavioral Community Services at 510-567-8100, and/or Pathways Counseling Center at 510-357-5515.

You will be provided with a copy of this consent form to keep.

Your signature below indicates that you have read this page and agree to participate in the research.

_________________________________________________________  ____________________
Signature of Participant                                      Date
APPENDIX C

Survey

Thank you once again for agreeing to take part in this survey on Compassion Satisfaction/Fatigue for those who are in the helping field. Please answer the below questions to the best of your ability. There are three pages to the survey which should take no more than 15 minutes to answer.

Please circle/write your answers on the page.

1)  My gender is: Male
    Female

2)  My age group is: ______

       _____ 18-29
       _____ 30-39
       _____ 40-49
       _____ 50-59
       _____ 60 or older

3)  I am:

       _____ Single
       _____ Married
       _____ Divorced
       _____ Long term committed relationship

4)  My educational background is: (Please circle highest achievement)

       _____ High School Diploma
       _____ Bachelors Degree
       _____ Masters Degree
       _____ PhD

5)  I live in the community I serve?

       _____ Yes
       _____ No
6) I work as a:

_____Social Worker   _____Medical Provider
_____Nurse            _____Administration
_____Doctor           _____Admin Support
_____Other

7) I have ________ (amount of years) working in the field helping others who have been affected by trauma. Trauma can include homelessness, poverty, illegal substances, working with clients who are the victims of crimes, experiences with law enforcement, domestic violence, sexual assault, child and elder abuse.

8) My approximate percentage of trauma victims/survivors on my caseload is: (Please estimate percentage to the best of your ability from 0-100 percent)

________percentage

9) I have ________ years working with individuals affected by trauma.

_____6 months- 1 year  _____8 years-12 years
_____1 year- 3 years  _____12 years-15 years
_____3 years- 5 years  _____15 years-20 years
_____5 years-8 years  _____20 plus years

10) I engage in self-care activities.

_____True
_____False

12) If you selected True, to “I engage in self-care activities”, how do you rate your engagement in self-care. Self-care can include exercise, prayer, taking time for self, massage, and support from others. (please circle)

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always/Excellent</td>
<td>Good</td>
<td>Somewhat</td>
<td>Very Little</td>
<td>Not at all</td>
</tr>
</tbody>
</table>

13) My work environment encourages me to engage in self-care activities? (please circle)

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Sometimes</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>
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. Please mark next to each question 1 thru 5 to reflect the scale below.

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.
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.
REFERENCES

10.117711468017310392418


doi:10.1080/08975353.2010.529003


doi:10.1007/s10615-010-0271-8


http://breakthecycle.org/statistics.htm


http://www.ojp.usdoj.gov/bjs


Frandsen, Betty MacLaughlin. (May 2010) Burnout or Compassion Fatigue?, Long-Term Living For the Continuing Care Professional, 59, 1-6. doi: 19403358


