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A Study of the Relationship Between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals

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ABSTRACT. Hospice care professionals (HCPs) experience a large number of stressors in their work settings. The purpose of this study was to investigate the relationship between self-care, compassion fatigue, burnout, and compassion satisfaction among HCPs. Thirty-seven HCPs were surveyed regarding their levels of compassion satisfaction, compassion fatigue, and burnout. Respondents also reported the types of self-care activities in which they took part. Results indicated a relationship between self-care strategies and lower levels of burnout and compassion fatigue, and higher levels of compassion satisfaction.

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Several suggestions are offered for continued research and practice in the hospice care field.

KEYWORDS. Burnout, compassion fatigue, compassion satisfaction, hospice professionals, self-care

Stress among hospice care professionals (HCPs), including social workers, has long been a topic in the literature (Dean, 1998; Hulbert & Morrison, 2006; Keidel, 2002; Masuda, 1995; Payne, 2001; Vachon, 2000; Vachon, Lyall, & Freeman, 1978; Yanick, 1984). For example, Payne identified several job specific stressors among hospice nurses including patient death, lack of support, inadequate preparation, and conflict with co-workers. Many authors have proposed that high levels of job stress can lead to burnout and compassion fatigue among HCPs (Glass & Hastings, 1992; Keidel; Lafer, 1991; Masuda; Vachon). The purpose of this study was to explore the relationship between self-care, burnout, compassion fatigue, and compassion satisfaction in HCP workers.

LITERATURE REVIEW

Stress is an inherent part in the helping professions (Jenaro, Flores, & Arias, 2007; O'Halloran & Linton, 2000). Stress can be defined as a dynamic interaction between person and environment where certain environmental tasks or situations are perceived as taxing, exceeding the person's skills and abilities, or jeopardizing his or her well-being (Lazarus & Folkman, 1984). HCPs are continually exposed to stressful events in their day-to-day work and are at risk for the negative effects of stress. Stressful events often experienced by HCPs include frequent encounters with: (a) death and dying, (b) grieving families, (c) personal grief, (d) traumatic stories, (e) observing extreme physical pain in patients, (f) strong emotional states such as anger and depression, and (g) emotional and physical exhaustion (DiTullio & MacDonald, 1999; Keidel, 2002; Payne, 2001). This has led to research in the area of self-care strategies and protective factors for stress management among HCPs (Dean, 1998; Hawkins, Howard & Oyeboode, 2007; Jones, 2005; Payne; Vachon et al., 1978).

Over time, high levels of stress can lead to burnout (O'Halloran & Linton, 2000; Payne, 2001). Burnout, a much researched topic in the helping professions, has been defined as "a syndrome composed of emotional exhaustion, depersonalization, and reduction of personal accomplishments" (Jenaro et al., 2007, p. 80). Burnout may also lead to negative self-concept, negative attitudes about work, and a loss of caring about work-related issues (Keidel, 2002). Several reasons for the onset of burnout in the workplace are proposed in the literature. These include such factors as (a) low salaries, (b) demanding schedules, (c) varying work shifts, (d) low social recognition, (e) lack of financial resources, (f) role ambiguity, and (g) difficult client behaviors (Jenaro et al.), all of which may be experienced by HCPs in the course of their work. Research on burnout rates among HCPs is not conclusive with some studies indicating higher rates and others indicating lower rates when compared with other medical professionals (Payne).

Compassion fatigue, a construct similar to burnout, is a topic that has emerged in the literature in recent years (Bride & Figley, 2007; Figley, 1995; Kanter, 2007; Keidel, 2002; Rourke, 2007). Radley and Figley (2007) define compassion as a "deep sense or quality of knowing or an awareness [among helping professionals] of the suffering of another coupled with the wish to relieve it" (p. 207). Compassion fatigue, a possible effect of long-term demonstrations of compassion, is defined as "a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain" (Pfifferling & Gilley, 2000). Compassion fatigue is thought to be a result of long exposure to the suffering of others, listening to descriptions of traumatic events experienced by others, little to no emotional support in the workplace, and poor self-care (Radley & Figley). Symptoms of compassion fatigue include difficulty sleeping, increased startle response, avoidance of places or things that are reminders of the event(s), obtrusive thoughts and images about the event(s), and depressed and/or anxious mood (Figley, 1995; Radley & Figley).

The ability to demonstrate compassion is a central component of HCPs day-to-day work (DiTullio & MacDonald, 1999). HCPs often serve patients and their families during extremely stressful times and, as a result, continually listen to stressful, traumatic, and upsetting patient situations. Because of this, HCPs may be at higher risk than others in the helping professions for developing compassion fatigue. It has been suggested that compassion fatigue in HCPs can lead to

reduced quality of care for patients (Keidel, 2002). Therefore, in order to maintain high standards of service in hospice care environments it is essential that compassion fatigue be addressed in the workplace by both HCPs and their employers.

It is important to distinguish compassion fatigue from burnout as there is some overlap between these constructs. As described above, burnout relates to feelings of hopelessness, work-related problems, high workload, lack of professional support in the workplace, and feeling as if work efforts do not make a difference in the lives of those being served (Stamm, 2007). Stamm stated that burnout usually has a slow onset and is the result of long-term work-related issues.

Stamm (2007) described compassion fatigue, however, as the result of specific secondary exposure to traumatic events (also known as vicarious trauma). For example, HCPs may experience compassion fatigue after listening to family members describe a loved one's traumatic suffering and death. Symptoms of compassion fatigue may have a rapid onset and can be related to one particular event or long-term exposure to many traumatic stories. While workers in any professional field may experience burnout, compassion fatigue is specific to those professionals in the helping professions who listen to clients' stories of traumatic events. Furthermore, burnout is a general construct describing a reaction to work-related stress; compassion fatigue is the direct result of specific experiences in the helping professions. Put simply, compassion fatigue is a professional hazard for those who choose to help others.

Long-term displays of compassion, however, do not always lead to negative emotional states such as burnout and compassion fatigue; a sense of compassion satisfaction can also result. Stamm (2005) defined compassion satisfaction as "the pleasure [derived] from being able to do your work well" (p. 4). Generally, compassion satisfaction is thought to be related to seeing clients and patients change for the better and recognizing the positive impact the HCP has on those with whom they work (Radley & Figley, 2007). Factors that enhance compassion satisfaction include having a positive affect, being optimistic, having and utilizing several social resources, maintaining good health, and leading a balanced life (Radley & Figley). Generally, these and other similar activities are referred to as self-care strategies (DiTullio & MacDonald, 1999; Jenaro et al., 2007; Jones, 2005; Keidel, 2002; O'Halloran & Linton, 2000). Just as hospice employers should pay attention to issues of compassion fatigue in the

workplace, these employers should also address issues around compassion satisfaction. Increasing compassion satisfaction for HCPs may enhance the quality of their work and the care that they provide to their patients.

Promoting self-care may be one way to enhance compassion satisfaction and decrease burnout and compassion fatigue in HCPs and several authors have developed suggestions for self-care strategies. Keidel's (2000) suggestions for self-care included adapting job environments rather than accepting them as is, developing an enjoyable and supportive social network, striving for personal and professional balance, getting enough sleep, and healthy eating. Likewise, Jones (2005) and O'Halloran and Linton (2000) suggested taking a holistic approach to managing work stress and engaging in self-care activities that address social, emotional, spiritual, physical, cognitive, and vocational needs. Finally, Payne (2001) identified several effective self-care strategies employed by hospice nurses such as planful problem solving and support seeking. As detailed above, because of the stress inherent in their work, it is suggested that HCPs develop and maintain effective self-care plans that address many aspects of their personal and professional life. However, little empirical research exists to assist HCPs in choosing effective and proven self-care strategies.

The purpose of this study was to explore the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among HCPs. The use of these variables to measure emotional wellness of workers in the helping professions has been well established in the literature (Hawkins et al., 2007; Jenaro et. al., 2007; Radley & Figley, 2007; Stamm, 2005; Vachon, 2000). As noted above, it has also been suggested that levels of compassion fatigue, burnout, and compassion satisfaction may also affect the degree to which persons in the helping professions can effectively complete their job duties (O'Halloran & Linton, 2000). Research on these variables in the hospice care field is not yet conclusive and further investigation is needed. The researchers in this study, therefore, elected to assess and explore these variables as they pertain to HCPs. It was hoped that the information gleaned from this assessment would further our knowledge about self-care, compassion fatigue, compassion satisfaction, and burnout among HCPs and provide direction for future research on specific and proven self-care strategies.

It was hypothesized that those HCPs who engaged in several self-care activities would experience higher levels of compassion

satisfaction and lower levels of compassion fatigue and burnout. The researchers were particularly interested in identifying specific areas of self-care strategies that influenced compassion fatigue, burnout, and compassion satisfaction. In addition, the researchers were interested in exploring the relationship between several demographic variables (e.g., length of tenure in the field, age, gender) and compassion fatigue, compassion satisfaction, burnout, and self-care. The study was correlational in nature with the overall goal of exploring work-related self-care issues in the hospice care field and making suggestions regarding ways in which HCPs can address problematic work-related stress and enhance work-related satisfaction.

METHOD

Participants

Participants in the study were among a convenience sample of HCPs working in home hospice settings. In total, 37 HCPs from two hospice agencies in the Midwest participated in the study. To collect data, the researchers visited interdisciplinary team meetings at each of the hospice care agencies and invited those in attendance to participate in the study. A total of 50 HCPs were present at the interdisciplinary team meetings and given the opportunity to participate.

Participants in the study disclosed extremely sensitive information about their personal and professional attributes. Therefore, confidentiality of participating agencies and employees was of the utmost importance to the researchers. To protect the confidentiality of the participating agencies, and to be in compliance with the Human Subjects Institutional Review Board's protocol, further identifying information about the agencies where participants in the study worked cannot be provided.

Data Collection Instruments

Three data collection instruments were used in the study. These were a basic demographic information sheet, the Professional Quality of Life Assessment (Stamm, 2002), and the Self-Care Assessment Worksheet (Saakvitne & Pearlman, 1996). These are described below.

Demographic Information Sheet. A basic demographic information sheet was developed by the researchers to gather data relevant to the study. The information sheet included items on age, gender, and racial and ethnic background. Participants were also asked to provide information about their job title, educational background, number of months at their current job, and number of months in the profession. Finally, participants were asked to rate their overall job satisfaction on a scale from 1 (*highly unsatisfied*) to 10 (*highly satisfied*).

Professional Quality of Life Assessment (ProQOL-RIII). The ProQOL-RIII measures aspects related to care giving professionals' quality of life (Stamm, 2002). The instrument consists of three subscales: Compassion satisfaction, burnout, and compassion fatigue. Possible scores on each subscale and the meaning ascribed to each subscale score are presented in Table 1. The subscales scores are derived from self-report indicators. Scores are appropriately used as comparability information, but not for diagnostic or confirmatory information. Alpha reliabilities for the subscales are 0.87 for compassion satisfaction, 0.72 for burnout, and 0.80 for compassion fatigue. Stamm (2005) reported that the construct validity upon which the test is based has been "well-established in over 200 [peer reviewed articles]" (p. 8).

The compassion satisfaction score refers to the pleasure one derives from helping others and being able to do their work well. The average score is 37. About 25% of people score higher than 41 (see Table 1). Higher scores on this scale represent a greater satisfaction in one's ability to be an effective caregiver. A high score is an indication that the respondent derives a great deal of satisfaction from doing his or her job.

The burnout score is an indicator of feelings of hopelessness, difficulties in dealing with work, and poor work performance. The

TABLE 1. Cut Points Ranges for Professional Quality of Life Assessments Scales

Subscales	Low	Average	High
Compassion Satisfaction	0–32	24–41	42–50
Burnout	0–19	20–28	29–50
Compassion Fatigue	0–8	9–17	18–50

average score is 23. About 25% of people score above 28 (see Table 1). Higher scores may be an indicator that the respondent is at greater risk of burnout.

The compassion fatigue score is a measure of work-related exposure to extremely stressful events. It is intended to measure secondary exposures to traumatic events. The average score is 13. About 25% of people score above 17 (see Table 1). Higher scores indicate a greater likelihood that the respondent may experience compassion fatigue symptoms.

Self-Care Assessment Worksheet (SCAW). The SCAW is a self-care indicator that measures the degree to which individuals engage in a variety of self-care activities and strategies (Saakvitne & Pearlman, 1996). The instrument measures six areas of self-care: physical, psychological, emotional, spiritual, professional workplace, and balance. Each of the subscales presents a different number of items assessing an array of self-care strategies engaged in by the respondent. Respondents are asked to rate each activity on a scale from 1 to 5 in terms of frequency (1 = *never occurs*, 5 = *frequently occurs*). Sample items from the SCAW include (a) eat regularly (physical), (b) make time for self-reflection (psychological), (c) allow yourself to cry (emotional), (d) be open to inspiration (spiritual), (e) take time to chat with coworkers (workplace), and (f) strive for balance among work, family, relationships, play, and rest (balance). A copy of the SCAW is available in multiple outlets on the World Wide Web.

Possible scores on each subscale of the SCAW depend on the number of items within that subscale. Information on the number of items in each subscale, and the possible range of scores for the subscales is provided in Table 2. Higher total scores for each subscale indicate

TABLE 2. Number of Items in Each Area of the Self-Care Assessment Worksheet

Self-Care Area	Number of Items	Minimum Score Possible	Maximum Score Possible
Physical Care	15	15	75
Psychological Care	13	13	65
Emotional Care	11	11	55
Spiritual Care	17	17	85
Workplace Self-Care	12	12	60
Balance	2	2	10

more engagement in self-care activities and lower scores indicate low engagement in self-care. The SCAW is not meant to be an indicator of wellness but rather a description of the ways in which the respondent is, and is not, engaging in self-care. Psychometric properties have not been established for the SCAW.

Data Analysis

Data analysis was descriptive and correlational in nature. Results for the two data collection instruments were tabulated and correlated to determine whether any significant relationships existed within and between subscales on the ProQOL-RIII and the SCAW. All demographic data gathered in the study was also considered in the analysis and correlations between these variables and the ProQol-RIII and the SCAW were tabulated. All data was analyzed using SPSS 13.0.

Given the number of correlations being tabulated, the researchers considered using a Bonferroni adjustment during analysis. Typically used for significance testing, a Bonferroni adjustment is used when there are multiple outcome measures and there is concern about the possibility that the analysis might be construed as unplanned and ad hoc in nature. This is not the case in this study. More importantly, if you apply a Bonferroni correction with a small data set like this one, you are implicitly stating that it is important only to control the probability of a Type I error (rejecting the null hypothesis when the null hypothesis is true), and not limiting the probability of a Type II error (accepting the null hypothesis when the null hypothesis is false). Certainly the resulting loss of power for the statistical analysis used in this situation is of considerable concern. However, in this case the correction would be far too conservative (Rothman, 1990).

RESULTS

Participants

Thirty-seven HCPs working in home hospice settings participated in the study. Two participants were male and 35 were female. Regarding racial and ethnic background, 28 participants identified as Caucasian, 2 as African-American, 1 as Asian-American, 1 as Middle Eastern, and 1 as “multiple” (2 participants did not respond to this question). Average age for participants was 46.35 years (range

29–64). Because of confidentiality issues, it is not known if the 13 HCPs present at the data collection meetings differed significantly from those who did participate. According to data from the U.S. Department of Health and Human Services (2003), the health care provider populations are dominated by Caucasian workers in nearly every job category and minority groups are significantly underrepresented. Therefore, the sample utilized in this study may be consistent with national employment trends in the field.

Participants were employed in one of eight types of positions in their work environment (see Table 3). These were registered nurse ($N=17$), home health aide ($N=5$), social worker ($N=4$), volunteer coordinator ($N=1$), bereavement professional ($N=3$), chaplain ($N=2$), administrative assistant ($N=1$), medical director ($N=2$), and “other” ($N=2$). At the time of data collection, the average length of employment in participants’ current job was 53 months and the average number of months in the hospice care field was 72.91. Regarding highest degree obtained, 6 participants reported a high school diploma, 10 an associates degree, 8 a bachelor’s degree, 10 a master’s degree, 2 a doctoral degree, and 1 a 3-year degree. All but three participants indicated some type of helping profession as their major area of study (e.g., nursing, counseling, social work).

Professional Quality of Life Assessment (ProQOL-RIII)

Mean scores for the ProQOL-RIII are presented in Table 4. Mean compassion satisfaction and compassion fatigue scores were at the

TABLE 3. Hospice Job Responsibility of Participants

Current Position	Frequency	%	Holistic Responsibility	Regular Contact with Patients
Register Nurse	17	45.9	Yes	Extensive
Home Health Aide	5	13.5		
Social Worker	4	10.8		
Volunteer Coordinator	2	2.7		
Bereavement Professional	3	8.1	No	
Chaplain	2	5.4		
Administrative Assistant	1	2.7	No	Rarely
Medical Director	2	5.4		
Other	2	5.4		
Total	37	100		

TABLE 4. Average Professional Quality of Life Assessment Scores

Subscores	<i>N</i> ^a	Mean	<i>SD</i>	Min. Score	Max. Score
Compassion Satisfaction	35	40.5	6.6	26	50
Burnout	35	23.8	6.6	11	41
Compassion Fatigue	36	17.5	7.2	6	35

Note. ^aOnly those who completed all items in a scale were included.

high end of each subscale's average range. The mean burnout score for this group was also in the average range.

Self-Care Assessment Worksheet (SCAW)

Mean scores for each of the subscales in the SCAW are presented in Table 5. Low scores on each subscale indicated participation in a low number of self-care activities while high scores indicated more participation in self-care activities. Because there are not an equal number of items on each subscale of this instrument (see Table 2), direct comparison of scores between the scales is not possible.

Correlations

Correlational results for the ProQOL-RIII, the SCAW, and participant demographics are presented in Table 6. As expected a strong negative correlation was observed between compassion satisfaction and burnout ($r = -.612$). A negative correlation was also observed between compassion satisfaction and compassion fatigue

TABLE 5. Average Self-Care Assessment Worksheet Scores

Self-Care Area	<i>N</i>	Mean	<i>SD</i>	Min. Score	Max. Score
Physical Care	37	55.1	6.2	42	67
Psychological Care	37	45.3	7.2	19	57
Emotional Care	37	39.8	5.9	25	50
Spiritual Care	37	64.6	8.5	46	77
Workplace Self-Care	37	40.8	6.4	28	55
Balance	37	8.5	1.6	4	10

TABLE 6. Correlation Between Scales and Subscales

Factor	CS	BO	CF	Age	TM	PhyC	PsyC	EC	SC	WP	Bal
CS—Compassion Satisfaction	1	-0.612*	-0.300*	-0.203	0.112	0.138	0.205	0.375*	0.294*	0.274	0.320*
BO—Burnout		1	0.761*	0.306*	-0.138	-0.311*	-0.332*	-0.497*	-0.496*	-0.546*	-0.496*
CF—Compassion Fatigue			1	0.047	-0.226	-0.213	-0.415*	-0.438*	-0.415*	-0.515*	-0.482*
Age—Participant's Age				1	0.370*	0.272	0.223	0.239	0.357*	0.093	0.165
TM—Total Month in Profession					1	0.333*	0.321*	0.455*	0.393*	0.407*	0.389*
PhyC—Physical Care						1	0.591*	0.698*	0.719*	0.535*	0.662*
PsyC—Psychological Care							1	0.574*	0.640*	0.529*	0.444*
EC—Emotional Care								1	0.735*	0.632*	0.662*
SC—Spiritual Care									1	0.601*	0.646*
WP—Workplace Self-Care										1	0.519*
Bal—Balance											1

Note. * Correlation is significant at the 0.05 level (1-tailed).

($r = -.300$). Data analysis also revealed a strong positive correlation between compassion fatigue and burnout ($r = .761$). With the exception of compassion fatigue and physical care, burnout and compassion fatigue were negatively correlated to all aspects of self-care ($p \leq .05$). Compassion satisfaction was significantly correlated ($p \leq .05$) with emotional care ($r = .375$), spiritual care ($r = .294$), and having balance between work and personal life ($r = .320$).

With regard to personal characteristics, participant age was significantly positively correlated ($p \leq .05$) with burnout but not compassion fatigue or compassion satisfaction. Total months in the profession was significantly positively correlated ($p \leq .05$) with all aspects of self-care. No significant relationships were observed between any other demographic variables and burnout, compassion fatigue, compassion satisfaction, or self-care.

Lastly, data analysis revealed an overall pattern of self-care among study participants. Significant positive correlations were observed between all self-care variables. This result is illustrated in Table 6.

DISCUSSION

The purpose of this study was to explore the relationship between self-care, compassion fatigue, burnout, and compassion satisfaction among HCPs. It was hypothesized that those HCPs who engaged in several self-care activities would experience higher levels of compassion satisfaction and lower levels of compassion fatigue and burnout. Several findings of interest emerged during data analysis concerning these variables.

First, significant ($p \leq .05$) negative correlations were observed between compassion satisfaction and burnout ($r = -.612$), and compassion satisfaction and compassion fatigue ($r = -.300$). It is interesting to note that the strength of these relationships differs somewhat, supporting the suggestion that compassion fatigue and burnout may in fact be different constructs. Data analysis also revealed a strong positive correlation between compassion fatigue and burnout ($r = .761$), again suggesting that these are related, but different constructs. These results were expected and appear consistent with the literature in this area.

Second, with the exception of physical self-care, compassion fatigue was significantly negatively correlated to all aspects of self-care. This indicates that as compassion fatigue increased, the number of self-care activities that HCPs reported decreased. A similar pattern of significant negative correlations emerged in the relationship between burnout and all aspects of self-care. These results may suggest that taking part in a variety of self-care strategies, not just one or two, can assist HCPs in managing symptoms of compassion fatigue and burnout. This is consistent with Jones (2005) and O'Halloran and Linton's (2000) suggestion that helping professionals should take part in holistic self-care activities. Because these results are correlational in nature, one cannot predict a causal relationship between self-care and compassion fatigue and burnout. However, if these results hold true, future research should explore ways in which hospice care employers can assist, and perhaps require, their workers to take part in holistically focused self-care activities. Related to this, it is also suggested that future research focus specifically on the types of self-care activities that can assist HCPs in managing compassion fatigue and burnout and enhancing compassion satisfaction.

It was also interesting to note that compassion satisfaction was significantly positively correlated with the emotional, spiritual, and balance subscales of the SCAW but not the physical, psychological, and workplace subscales. This could suggest that while engaging in a variety of self-care strategies may prevent burnout and compassion fatigue, only emotional and spiritual self-care, and personal-professional balance are predictive of higher levels of compassion satisfaction. Again, while these results are correlational in nature, they may suggest an overlap between some, but not all activities that decrease work-related stress and increase work-related satisfaction.

This result has ramifications for the manner in which HCPs take care of themselves relative to job stress and satisfaction. First, taking part in self-care strategies that are effective in promoting compassion satisfaction may not directly equate to low levels of burnout and fatigue. Second, HCPs who are not experiencing burnout or compassion fatigue, but wish to increase their compassion satisfaction, may find it most effective to focus their self-care efforts in the emotional, spiritual, and personal-professional balance areas of life. It is therefore suggested that HCP professionals and their

employers match the types of self-care strategies they engage in with their desired outcome; either to reduce burnout and fatigue, increase satisfaction, or both.

Additionally, it was interesting to note significant positive correlations between all areas of self-care measured by the SCAW. This result suggests that HCPs who take care of themselves in one area are more likely to take care of themselves in several other areas. In other words, persons who engage in healthy behaviors in one area of life may also tend to engage in beneficial self-care activities in all areas of life. This suggests that self-care may be more of a holistic tendency rather than area specific as the Self Care Assessment Worksheet (SCAW) suggests.

Finally, several results of interest pertaining to the relationship between participant age and number of months in the profession, and self-care, compassion satisfaction, compassion fatigue, and burnout were observed. The results suggested that HCPs with more months of service in the profession seem to be taking care of themselves in all areas of self-care to a greater extent than those with less experience. There is also a somewhat obvious relationship between the age of the participants and their experience in the profession ($r = .370$). One explanation for this result might be that those who take care of themselves in the various areas of self-care are less likely to leave the profession early because of burnout or compassion fatigue. Older participants were more likely to indicate experiencing symptoms of burnout ($r = .306$), but there was not a corresponding association between more months of experience and burnout ($r = -.138$). This may indicate that those who start the profession later in life are equally susceptible to burnout if they don't take care of themselves in the various self-care areas. Further research, therefore, should investigate the effects of self-care on tenure in the hospice care field with the goal of retaining skilled professionals in the workforce. Research in the area of self-care strategies will again be important relative to this result.

While these results are informative, the present study is not without limitations and results should be interpreted with caution. First, the study is limited by its small sample size. In order to make more definitive conclusions regarding self-care, compassion satisfaction, compassion fatigue, and burnout, larger sample sizes are needed. The results of this study could be further informed by gathering

qualitative data from participants pertaining to their specific experience with self-care, compassion satisfaction, compassion fatigue, and burnout. Given the small sample size used in this study, though, the generalizability of findings in this study may be of limited utility. In order to offer more definitive conclusions, future research should employ larger samples sizes and mixed methods of data collection in order to triangulate the constructs of interest.

The results of this study are also limited because of the correlational research design employed. While tentative predictions can be made with correlational data, definitive conclusions regarding causation cannot be offered. As the dictum goes, correlation does not imply causation. Future research in this area should utilize mixed methods including in-depth qualitative methods and confirmatory, cause and effect research designs.

Additionally, the study is limited by a lack of diversity in the sample. While HCPs of all racial and ethnic backgrounds were eligible for participation, the majority of participants were Caucasian (28 of 37 participants). Therefore, extension of these results to non-Caucasian HCPs should be made with caution. A similar limitation in study pertains to the lack of gender diversity in the sample. Because the majority of the participants were women, these results may not be generalizable to male HCPs. Furthermore, study results may be limited by geographic variables. All participants in the study were from the Midwest which may limit application of these findings to other regions of the country. Finally, data was gathered from only two hospice care agencies. It is possible, therefore, that the data was biased by variables idiosyncratic to those agencies.

In spite of these limitations, the results of this study can be useful in improving the overall emotional health and work functioning of HCPs. Based on these preliminary findings, it is highly recommended that hospice care employees and their employers begin to engage in and promote activities that encourage emotional health and satisfaction in the workplace. This may include offering employer structured activities that promote self-care, increasing the amount of paid time off so that HCPs may engage in more self-care activities, starting worker support groups to manage work-related stress, increasing funds for professional development, creating outlets for patients and families to demonstrate their appreciation for the services they receive; and providing specific training on compassion fatigue, compassion, satisfaction, burnout, self-care, and related constructs. These

and other activities may create work environments where compassion satisfaction can flourish and compassion fatigue and burnout can be diminished. Ultimately, this will lead to improved care of all patients and consumers in hospice care settings.

Social workers are in a unique position to assist other HCPs in improving their overall emotional health and work functioning. Because social workers have specific training in mental health, advocacy, and group and systems issues they are uniquely positioned to propel self-care efforts in their work settings. Therefore, it is recommended that social workers in hospice settings advocate for improved work conditions to address emotional health in workers. It is also recommended that social workers be involved in the development and delivery of self-care programs in their agency. Finally, social workers can offer key services to monitor levels of emotional health in HCPs and recommend courses of action for those professionals in need of assistance. Of course, social workers offering such services must also pay attention to their own self-care. A high level of emotional health for social workers is imperative before they can assist their colleagues in improving work-related satisfaction.

In closing, the results of this study indicate a tentative relationship between self-care, compassion fatigue, burnout, and compassion satisfaction. Future research should build on the results of this study and further investigate ways in which HCPs can effectively engage in self-care strategies. If HCP's emotional health and patient care is to be improved in hospice care settings, continued research will be important in this area.

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