Self-care and Professional Quality of Life: Predictive Factors Among MSW Practitioners

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Abstract: *This study explored the effects of self-care practices and perceptions on positive and negative indicators of professional quality of life, including burnout, secondary traumatic stress, and compassion satisfaction among MSW practitioners. Results reveal that while social workers value and believe self-care is effective in alleviating job-related stress, they engage in self-care on a limited basis. Findings indicate that MSW programs and employers do not teach social workers how to effectively engage in self-care practice. Various domains of self-care practice contribute differently to indicators of professional quality of life. This study sheds light on the under-studied relationship between social worker self-care and professional quality of life, provides insight into the type of activities practiced and not practiced by MSW practitioners, and identifies gaps between perceived value and effective teaching of self-care. Implications exist for social work educators and employers and the potential to support a healthier, sustainable workforce.*

Keywords: *Self-care practice, self-care perceptions, professional quality of life*

Social workers represent a significant segment of human service professionals in the public and private sectors. There are nearly 600,000 social workers in the United States, and this number is expected to grow by 19 percent by the year 2022, which is faster than the average growth rate of 11 percent for all occupations (U. S. Bureau of Labor Statistics, 2013). Social workers practice in a variety of settings including child welfare and family practice, schools, mental health and addictions, and health care (U. S. Bureau of Labor Statistics, 2013). Social workers often juggle high volumes of paperwork, complex caseloads, and challenging client situations (Kim & Stoner, 2008). Additionally, social workers routinely engage with individuals, families, and groups who have experienced significant trauma and recent crises; exposure to such clients and the suffering they experience may become emotionally demanding on social workers (Newell & MacNeil, 2010). Compassion fatigue, secondary traumatic stress, and burnout are potential consequences of these emotional demands and can lead to feelings of exhaustion and incompetence, turnover intention, and actual turnover from one's organization (Bride, 2007; Figley, 1995; Killian, 2008; McCann & Pearlman, 1990; McGarrigle & Walsh, 2011; Newell & MacNeil, 2010).

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Self-care and Professional Quality of Life

The practice of self-care refers to the purposeful actions people and organizations take that contribute to wellness and stress reduction (Alkema, Linton, & Davies, 2008; Barker, 2010; Killian, 2008; Kraus, 2005). Self-care has been heralded in the field of social work as a means to protect against the many stressors of the profession. According to the National Association of Social Workers (NASW, 2008), social workers have an ethical responsibility to address impairment or personal challenges that could interfere with professional decision-making and services to clients, but is self-care predictive of professional quality of life? Greater understanding is needed about self-care practices and perceptions of self-care as well as the relationship of self-care to the consequences of working with vulnerable and traumatized populations. The current study explored social worker self-care as a means to support a healthy and effective workforce. This study intends to enhance the social work knowledge base in the areas of self-care and professional quality of life.

Literature Review

Professional Quality of Life

The effect of trauma on professionals who work in direct contact with clients has been investigated over the past several decades across multiple disciplines including nursing, social work, psychology, mental health, and case management (Ray, Wong, White, & Heaslip, 2013; Stamm, 2010; Thielman, & Cacciatore, 2014; Thompson, Amatea, & Thompson, 2014). Understanding the factors that influence professional quality of life is important to helping professionals, including clinical social workers, and to their clients (Thomas, 2013). The current body of literature indicates that the experiences of compassion satisfaction and compassion fatigue influence one's overall professional quality of life (Ray et al., 2013; Stamm, 2010). Professional quality of life refers to "the quality one feels in relation to their work as a helper" and is influenced by both positive and negative aspects of the work (Stamm, 2010, p. 8). Compassion satisfaction is a positive indicator of professional quality of life and refers to the pleasure derived from being able to do one's work effectively (Stamm, 2010). Compassion fatigue involves negative responses to caring for those who have experienced trauma, including feelings of fear associated with trauma work (Stamm, 2010). Compassion fatigue is comprised of two parts–secondary traumatic stress (STS) and burnout (Stamm, 2010). Together, compassion satisfaction and the two components of compassion fatigue—secondary traumatic stress and burnout—generate a professional quality of life for helping professionals.

Secondary traumatic stress (STS) is a clinical extension of compassion fatigue (Alkema et al., 2008; Bride, 2007; Figley, 1995; Killian, 2008; Stamm, 2010). Figley (1995) argues that STS is experienced not only by people working with those who have experienced trauma, but also the families and extended support systems of victims. Consequences of STS include sleep disturbance, intrusive thoughts (Killian, 2008; Stamm, 2010), forgetfulness, an inability to separate work and private lives, and an avoidance of trauma reminders (Stamm, 2010). Experiencing STS has the potential to compromise a practitioner's well-being and service delivery. A significant number of social workers have

been found to have symptoms of STS—most often intrusive thoughts, psychological stress, and avoidance of reminders of particular clients (Bride, 2007).

Burnout is an additional component of compassion fatigue. Maslach and Jackson (1986) recognize burnout as a syndrome of "emotional exhaustion, depersonalization, and reduced personal accomplishment" common among human service workers (p. 1). Burnout is typically the result of highly stressful work environments (Grosch & Olsen, 1994; Maslach & Jackson, 1986) and can also result from lack of esteem (McCann & Pearlman, 1990). Burnout has been found to be positively correlated with amount of time on the job (Galek, Flannelly, Greene, & Kudler, 2011); it can impact job performance (Maslach & Jackson, 1986) and interrupt cognitive schema including frame of reference and rationalization (McCann & Pearlman, 1990).

Self-care. Self-care practice requires individuals and organizations to purposefully engage in behaviors that contribute to wellness and reduced stress. Five primary domains of self-care practice are recognized in the literature. These domains include physical, psychological, emotional, spiritual, and professional self-care (Saakvitne & Pearlman, 1996). Physical self-care can be thought of as actions taken to promote one's physical well-being. Common physical self-care activities include exercise, adequate sleep, and a healthy diet. Psychological self-care refers to actions taken to endorse self-awareness and healthy decision-making. Engaging in therapy, journaling, and reading are examples of psychological self-care activities. Emotional self-care refers to actions taken to encourage emotional well-being. Emotional self-care activities include spending time with loved ones, laughing, and self-praise. Spiritual self-care involves nurturing connections and finding meaning in life. Attending religious or spiritual events, praying, and meditation are common spiritual self-care activities. Professional self-care can be thought of as actions to promote professional health and competence. Common professional self-care activities include participating in relevant trainings, setting appropriate boundaries with clients, seeking adequate supervision or support, and advocating for one's own needs within the workplace. Research suggests that specialized trauma training can improve compassion satisfaction and decrease compassion fatigue and burnout among mental health professionals (Sprang, James, & Whitt-Woosley, 2007). Knowledge and training may provide some protection against the harmful effects of trauma exposure (Sprang et al., 2007).

Self-care perceptions. Perceptions of self-care involve the attitudes and beliefs one holds about self-care and can be influenced by a variety of environmental and personal factors. A paucity of research exists with regard to social workers' perceptions of self-care and the perceptions of self-care among helping professionals in general. However, in a study to determine the relationship between perceptions of self-care and quality of life among clinical psychology doctoral students, Goncher, Sherman, Barnett, and Haskins (2013) found that perceived self-care emphasis was a significant predictor of both quality of life and self-care practice. Self-care perceptions are influential among students in a related helping field, clinical psychology. Therefore, it is possible, if not likely, that the attitudes and beliefs social workers hold about self-care may influence quality of life and self-care practice.

Environmental considerations of helping others. Research has found that higher rates of burnout occur for social workers who have lengthy engagement with clients because the social worker can begin to feel helpless while assisting the client (McCann & Pearlman, 1990). Bober and Regehr (2006) and Brady, Guy, Poelstra, and Brokaw (1999) found that therapists who spend more time working with victimized clients have higher levels of post-traumatic symptoms and distress. Thus, it appears that more time in direct contact with clients is related to higher levels of job-related stress. Studies using the Traumatic Stress Institute Belief Scale have shown a statistically significant association between years of experience in the field and dysfunctional views of intimacy with others (Bober & Regehr, 2006). In essence, the longer someone is in the field, the more intimacy issues are encountered. Conversely, a longer length of time in the field has been associated with less vicarious trauma (Pearlman & Mac Ian, 1995). Age (being younger), having children, and socioeconomic status have been found to be predictive of helping professionals' intent to turnover from their current position (Barak, Nissly, & Levinal, 2001).

Despite recognition of the stress and demands faced by human service professionals, including social workers, a historical lack of systematic research regarding the self-care of these workers exists (Newell & MacNeil, 2010; Norcross, 2000). Some scholars posit that increased use of self-care strategies may decrease strain outcomes, or the negative consequences of engaging in human service work (Alkema et al., 2008; Bober & Regehr, 2006; Deery-Schmitt & Todd, 1995; Kraus, 2005; Kulkarni, Bell, Hartman, & Herman-Smith, 2013; Newell & MacNeil, 2010; Richards, Campenni, & Muse-Burke, 2010; Skovholt, Grier, & Hanson, 2001). Additionally, researchers theorize that increased engagement in self-care practice leads to greater compassion satisfaction and professional resiliency (Fink-Samnick, 2009; Killian, 2008). However, emotional and psychological risks associated with providing direct social work services to vulnerable populations and the use of professional self-care in response to these risks have been largely overlooked in social work practice, training, and education (Newell & MacNeil, 2010). The purpose of this research study was to expand knowledge regarding the association among social workers' self-care practices and perceptions and professional quality of life. Exploring ways in which social workers perceive and practice self-care has the potential to improve employment retention, augment training, and enhance job satisfaction and overall professional quality of life among social work professionals. The researchers hypothesized that more frequent engagement in self-care practice and more positive perceptions of self-care would be predictive of lower levels of STS and burnout and greater compassion satisfaction among MSW practitioners.

Methods

Study Participants

This study focused on practitioners with an MSW, as MSW-level practitioners are likely to deliver clinical interventions and are thus at risk for experiencing trauma and strain outcomes. Inclusion criteria for the study included holding an MSW degree from a program accredited by the Council on Social Work Education (CSWE) and being employed either

part-time or full-time as a social worker at the time of data collection. The study used a convenience sample of alumni from CSWE-accredited MSW programs (n=786). The CSWE website provided a list of 217 colleges and universities with an accredited MSW program (CSWE, 2011). The researchers identified and contacted program directors and/or other MSW administrative staff with a personalized email about the study. Programs that did not respond to the initial email were contacted with a second email. Three programs were not able to be contacted. Of the 214 programs contacted, 32 programs expressed interest in the study and agreed to forward the study information (e.g., recruitment email with a link to the online survey) to a list of their program alums (15% response rate). Two follow-up emails were sent to the 32 participating schools in an effort to ensure the survey had been forwarded to alumni. This study was approved by the Indiana University Institutional Review Board.

Measures

Professional quality of life. Professional quality of life was measured using the Professional Quality of Life Scale, version 5 (ProQual-5), developed by Stamm (2005). This instrument is the most commonly used measure of both positive and negative consequences of working with people who have experienced exceptionally stressful events (Stamm, 2005). Since its development in 1995, it has been revised multiple times. Version 5 is the most current version of the instrument (Stamm, 2015). The ProQOL-5 is a 30-item scale with three subscales to measure compassion satisfaction, burnout, and STS. Each subscale includes 10 items. Respondents were asked to rate how frequently they have experienced each item on 5-point Likert scale (1=never to 5=very often). The compassion satisfaction scale measured the pleasure one derives from doing one's work well (α=0.90, Stamm, 2005). Example items from the compassion satisfaction subscale include: "I get satisfaction from being able to help people" and "I feel invigorated after working with those I help." The burnout scale measured feelings associated with hopelessness and difficulty in dealing with work or doing one's work effectively (α=0.92, Stamm, 2005). Example items from the burnout subscale include: "I am happy" and "I feel connected to others." Lastly, the STS scale measured work-related secondary exposure to people who have experienced trauma (α=0.93, Stamm, 2005). Example items from the STS subscale include: "I am preoccupied with more than one person I help" and "I jump or am startled by unexpected sounds." A summary score for each subscale was used for analysis with higher scores indicating greater compassion satisfaction, burnout, and STS, respectively.

Self-care practice. Self-care practice was measured using a scale developed by the researchers based upon the work of multiple contributors to the field of self-care. The self-care practice items included in this study were largely influenced by the works of Bell, Kulkarni, and Dalton (2003), Bober, Regehr, and Zhou (2005), and Saakvitne and Pearlman (1996). The measure included five domains of self-care practice—physical, professional, emotional, psychological, and spiritual. Domains included between eight and 12 self-care activities associated with well-being in that particular area of life (see Table 2 for items in each domain). In an effort to measure which activities social workers practice and how often they engage in each activity, respondents were asked to indicate frequency of engagement in 45 different self-care activities during the past 30 days. Responses were

rated on a 6-point Likert scale (0=never to 6=very frequently). A summary score was used to indicate each self-care practice domain as well as overall self-care practice. Higher scores indicated a greater frequency of engagement. Internal consistency reliability of the self-care practice scale was tested overall (α=0.90) and for each sub-scale (physical subscale α=0.73; professional subscale α=0.79; emotional subscale α=0.69; psychological subscale α=0.76; spiritual subscale α=0.76).

Self-care perceptions. Self-care perceptions refer to one's appreciation, value, and/or awareness of self-care. An 11-item scale to measure self-care perceptions was developed based upon existing literature (Bell et al., 2003; Bober et al., 2005; Saakvitne & Pearlman, 1996). Respondents were asked to indicate their agreement with each item on a 5-point Likert scale (1=strongly disagree to 5=strongly agree). Four items were reverse-coded. A summary score was created with higher scores indicating more positive self-care perceptions (α=0.76).

Background variables. The study instrument also included questions to ascertain respondents' demographic and additional background information. A total of 16 items inquired about current practice status, education level, licensure status, area of social work practice, salary, position status (full or part-time, clinical or administrative), amount of time spent in direct practice with clients, race, ethnicity, age, years of post-MSW experience, years in current position, practice location (urban or rural setting and state where practicing), and gender.

Data Analysis

Descriptive statistics were used to examine the current level of self-care practice and perceptions and capture respondents' characteristics. In an effort to predict compassion satisfaction, burnout, and STS, multiple linear regression analyses were used. Summary scores of each of the five self-care practice subscales as well as the summary score for self-care perceptions and background variables were used as independent variables to predict each indicator of professional quality of life. Years of post-MSW experience, percentage of time in direct contact with clients, and annual salary were selected as independent variables in the analyses based upon their relationship to professional quality of life as identified in previous research. Before the hypotheses were tested, several assumptions for regression were examined. Multicollinearity did not prove to be a challenge in any of the regressions.

Findings

Participant Characteristics

The sample of MSW practitioners (n=786) hailed from 42 states and the District of Columbia. The majority of respondents were female (88%) and Caucasian (85%). On average, respondents were about 42 years of age (M=41.52, SD =12.59), had practiced over nine years after earning their MSW (M=9.54, SD=9.44), and had been in their current position for about five years (M=4.95, SD=5.79). The majority of respondents were licensed (68.9%), clinical (58.9%) practitioners. Most respondents spent more than half of

their work week in direct contact with clients (63.5%). Nearly half of respondents earned between $30,000 and $50,000 annually. Further sample characteristics can be found in Table 1.

Table 1. *Study Sample Background Characteristics (n=786)*

	Frequency (%)
Gender	
Female	693 (88.2%)
Male	86 (10.9%)
Other	2 (0.3%)
Race	
Caucasian	665 (85.0%)
Black or African American	58 (7.4%)
Other	39 (4.0%)
Multi-racial	20 (2.6%)
Ethnicity	
Not Hispanic or Latino	709 (93.0%)
Position	
Clinical	461 (58.9%)
Administrative	147 (18.7%)
Other	175 (22.3%)
Licensed	
Yes	541 (68.9%)
Income	
Less than $30,000	73 (10.6%)
$30,001-$40,000	181 (23.4%)
$40,001-$50,000	198 (25.4%)
$50,001-$60,000	139 (17.8%)
$60,001-$70,000	85 (10.9%)
$70,001-$80,000	48 (6.1%)
Direct Contact with Clients	
0-25%	142 (18.1%)
26-50%	144 (18.4%)
51-75%	270 (34.4%)
75-100%	228 (29.1%)
Practice Setting	
Urban	554 (71.3%)
Area of Practice	
Health	136 (18.7%)
Public Welfare	79 (10.1%)
Mental Health	277 (35.3%)
Child Welfare	114 (21.5%)
Other*	104 (14.5%)

Self-care Practice Domains

As seen in Table 2, on average, respondents reported engaging in physical self-care most frequently (M=3.6), followed by professional (M=3.5), emotional (M=3.4), and psychological self-care (M=3.3). Respondents reported engaging in spiritual self-care activities less frequently than all other domains (M=2.9). Overall, respondents were not routinely or frequently engaging in self-care practice (M=3.3, SD=0.61). None of the 45 listed self-care practices were rated at less than 1 (Never), indicating that each activity was used by at least some respondents. Each respondent indicated engagement in at least one of the 45 listed self-care practice activities. Only 12 of the 45 activities were rated at a 4 or above (Often–Frequently). The self-care activities rated at a 4 or above included practicing healthy eating, sleeping regularly (physical), taking breaks throughout the work day, discussing cases with colleagues, chatting with co-workers, making quiet time to complete tasks, and setting limits with clients (professional), laughing, spending time with those one enjoys (emotional), and practicing being mindful, reading non-work related literature, and taking time for reflection (psychological). Five of these 12 items are professional self-care activities.

The least frequently practiced self-care activities, with a rating at a 2 or lower (Rarely–Never), included writing in a journal (psychological), practicing yoga (spiritual), participating in stress

management training, and negotiating one's own needs (professional). There were no items from the physical or emotional domains rated at a 2 or lower.

Table 2. *Self-Care Activities by Domain*

Physical Self-Care Activity	**N**	**M**	**SD**
Healthy eating habits	781	4.55	1.26
Sleep regularly	777	4.54	1.38
Engage in activity/hobbies	777	3.80	1.44
Exercise	779	3.78	1.44
Medical care when needed	777	3.77	1.62
Preventative medical care	776	3.57	1.61
Take time to be sexual with self or partner	765	3.33	1.41
Take time off from work	778	2.87	1.46
Take a vacation	772	2.56	1.45
Physical Self-Care Dimension-OVERALL	*782*	*3.64*	*0.74*
Professional Self-Care Activity	**N**	**M**	**SD**
Take time to chat with co-workers	781	4.71	1.37
Set limits with clients	771	4.58	1.31
Take breaks during the work day	781	4.31	1.56
Discuss cases with colleagues	781	4.21	1.40
Make quiet time to complete tasks	781	4.03	1.43
Arrange your work space so it is comforting	780	3.69	1.65
Get regular supervision	780	3.07	1.39
Diversify your caseload	769	3.03	1.68
Participate in professional education/training	778	2.88	1.56
Participate in a peer support group	780	2.09	1.37
Negotiate your needs	773	1.99	1.19
Participate in stress management training	777	1.54	0.92
Professional Self-Care-OVERALL	*782*	*3.46*	*0.76*
Emotional Self-Care Activity	**N**	**M**	**SD**
Laugh	778	5.24	1.04
Spend time with those you enjoy	780	4.89	1.20
Play with children	777	3.73	1.72
Give yourself praise	767	3.25	1.41
Allow yourself to cry	777	2.82	1.15
Take social action	773	2.79	1.32
Re-watch favorite movie(s)	775	2.68	1.34
Re-read favorite book(s)	778	2.09	1.38
Emotional Self-Care Dimension-OVERALL	*781*	*3.44*	*0.75*
Psychological Self-Care Activity	**N**	**M**	**SD**
Practice being mindful	778	4.21	1.47
Read non-work related literature	779	4.11	1.61
Take time for reflection	778	4.05	1.42
Set goals for yourself	777	3.86	1.37
Say "no" to extra activities	777	3.16	1.12
Develop a plan for caring for yourself	773	2.83	1.47
Participate in your own therapy	777	2.10	1.38
Write in a journal	778	1.81	1.25
Psychological Self-Care Dimension-OVERALL	*781*	*3.28*	*0.86*

Table 2. *Self-Care Activities by Domain*

Spiritual Self-Care Activity	N	M	SD
Pray	781	3.82	1.96
Visualize yourself having a positive day	778	3.48	1.71
Sing	778	3.36	1.74
Spend time with nature	780	3.2	1.36
Read inspirational literature	778	3.03	1.72
Spend time in a spiritual community	782	2.52	1.54
Meditate	781	2.37	1.57
Practice yoga	778	1.72	1.15
Spiritual Self-Care Dimension-OVERALL	*782*	*2.94*	*0.98*

Note: Respondents selected responses from 1 (N: Never), 2 (R: Rarely—Once a Month), 3 (S: Sometimes—A few times a month), 4 (O: Often—Weekly), 5 (V: Very Often—A Few Times a Week), and 6 (F: Frequently—Almost Daily to Daily)

Self-care Perceptions

Using the general definition of self-care provided in the instrument, on average, respondents reported moderately positive perceptions of self-care. Of the 11 perception items, respondents most strongly agreed with the statement "I value self-care" (M=4.5) followed by "Self-care is effective in alleviating job-related stress" (M=4.38) (see Table 3). These findings indicate that social workers value self-care and believe it is effective in combating strain outcomes. When asked about their MSW program (M=3.8) and employer (M=3.3) valuing self-care, responses were more moderate as were responses related to respondents' MSW program (M=3.2) and employer (M=2.4) effectively teaching them how to engage in self-care practice. Respondents indicated a moderate level of disagreement with the four items related to self-care practice barriers. Overall, respondents indicated their MSW program and employer value self-care much less than the individual worker, that MSW programs and employers do not effectively teach workers how to engage in self-care practice, and when compared to MSW programs, employers were less likely to value and effectively teach self-care.

Table 3. *Self-Care Perceptions*

Perceptions	N	M	SD
I value self-care.	779	4.47	0.64
Self-care is effective in alleviating job-related stress.	781	4.38	0.69
The MSW program from which I graduated values self-care.	780	3.79	1.01
My current employer values self-care.	773	3.34	1.28
My MSW program taught me how to effectively engage in self-care.	780	3.22	1.08
It is easy to engage in self-care practice.	780	3.06	1.15
My workload prevents me from engaging in self-care.	779	2.83	1.23
My family obligations prevent me from engaging in self-care.	780	2.45	1.18
My current employer effectively teaches me how to engage in self-care.	774	2.44	1.25
My community obligations prevent me from engaging in self-care.	780	2.03	.95
My social life prevents me from engaging in self-care.	778	1.95	.87

Variable Correlations

The researchers were interested in the relationships among study variables. Self-care perception was found to have a significant positive correlation with multiple self-care practice domains including psychological ($r=0.14$, $p<.01$), spiritual ($r=0.15$, $p<.01$), emotional ($r=0.18$, $p<.01$), and professional ($r=0.28$, $p<.01$). Multiple dimensions of self-care practice were found to be significantly correlated, ranging from $r=-.08$, $p<.05$ to $r=0.55$, $p<.01$. Among the background variables used in the analyses, there were significant positive correlations between years of post-MSW experience and multiple domains of self-care practice including physical ($r=0.16$, $p<.01$), psychological ($r=0.18$, $p<.01$), spiritual ($r=0.14$, $p<.01$), and emotional ($r=0.07$, $p<.05$).

Predicting Professional Quality of Life

The primary goal of this study was to explore the effect of self-care practice and perceptions on indicators of professional quality of life among MSW practitioners. Multiple regression analyses was conducted to identify predictors of each indicator of professional quality of life.

Secondary traumatic stress. The results of the STS regression revealed that the predictor variables explained 19.3% of the variance ($R^2=0.19$, $F_{(9, 746)}=19.83$, $p<.001$). Respondents reported less STS when they held more positive perceptions of self-care and had more years of post-MSW experience (see Table 4). Psychological self-care was the only significant self-care practice domain; however, respondents who practiced more psychological self-care reported higher levels of STS ($b=.11$, $p<.05$).

Burnout. The results of the burnout regression indicated the six predictor variables explained 38.6% of the variance ($R^2=0.39$, $F_{(9, 746)}=52.06$, $p<.01$). As seen in Table 5, respondents reported less burnout when they held more positive perceptions of self-care, engaged in more professional, emotional, and spiritual self-care practice, and had more years of post-MSW experience. However, respondents who practiced more psychological self-care ($b=.09$, $p<.05$) reported higher levels of burnout.

Compassion satisfaction. In the compassion satisfaction regression, self-care practice, perceptions, and the background variables explained 24.5% of the variance ($R^2=0.25$, $F_{(9, 746}=26.92$, $p<.001$). As seen in Table 6, respondents reported more compassion satisfaction when they held more positive perceptions of self-care, practiced more professional and emotional self-care, and had more years of post-MSW experience.

Table 4. *Predictors of Professional Quality of Life*

Secondary Traumatic Stress	**B**	**SE**	**β**	**t**	**p**
Constant	33.78	1.51		22.31	<.001
Self-care Perceptions	-.32	.03	-.37	-9.49	<.001***
Physical Self-care	.01	.02	.01	.30	.761
Professional Self-care	-.05	.03	-.09	-1.93	.054
Emotional Self-care	-.07	.04	-.07	-1.73	.085
Spiritual Self-care	.03	.03	.05	1.17	.244
Psychological Self-care	.08	.03	.11	2.37	.018*
Annual Income	.00	.12	.00	-.00	.998
Direct Time with Clients	.06	.18	.01	.33	.745
Years Post-MSW	-.11	.02	-.19	-5.08	<.001***
Burnout	**B**	**SE**	**β**	**t**	**P**
Constant	44.50	1.29		34.57	<.001
Self-care Perceptions	-.37	.03	-.44	-12.90	<.001***
Physical Self-care	.02	.02	.03	1.03	.302
Professional Self-care	-.60	.02	-.11	-2.82	.005**
Emotional Self-care	-.16	.03	-.19	-5.11	<.001***
Spiritual Self-care	-.07	.02	-.10	-2.85	.004**
Psychological Self-care	.06	.03	.09	2.19	.029*
Annual Income	-.10	.10	-.03	-.99	.321
Direct Time with Clients	-.03	.15	-.01	-.18	.860
Years Post-MSW	-.08	.02	-.15	-4.50	<.001***
Compassion Satisfaction	**B**	**SE**	**β**	**t**	**P**
Constant	23.21	1.57		12.47	<.001
Self-care Perceptions	.23	.04	.24	6.54	<.001***
Physical Self-care	-.02	.02	-.03	-.78	.438
Professional Self-care	.08	.03	.12	2.74	.006**
Emotional Self-care	.17	.04	.18	4.45	<.001***
Spiritual Self-care	.01	.03	.02	.49	.623
Psychological Self-care	.03	.04	.04	.85	.399
Annual Income	.32	.12	.05	1.52	.130
Direct Time with Clients	.28	.18	.05	1.52	.130
Years Post-MSW	.06	.02	.09	2.51	.012*

*p < .05; **p<.01; ***p<.001

Discussion

This study provided interesting insights into the self-care practices and perceptions of social work practitioners. Physical self-care was the most frequently practiced domain with average scores indicating between monthly and weekly use. This was closely followed by use of professional and emotional self-care. The most practiced activities overall included laughing, spending time with friends and family, and taking time to chat with co-workers. These activities were practiced often to very often by respondents. In their study of residential youth workers, Eastwood and Ecklund (2008) found healthy eating and spending time with friends and family to be among the most endorsed self-care practices (Eastwood & Ecklund, 2008). Similarly, Turner et al. (2005) found that psychology interns most often used relationships, humor, eating well, and self-awareness as self-care activities.

Van Hook and Rothenberg (2009) also found that exercise, social time, and hobbies to be the most used self-care activities among child welfare workers. The use of multiple self-care strategies among social workers in this sample follows Norcross' (2000) recommendation for workers to use a variety of self-care approaches to increase professional quality of life

Rated at a 2 or lower (Rarely–Never), journaling, practicing yoga, participating in stress management training, and negotiating one's own needs were found to be the least practiced self-care activities among the respondents in this study. As noted, there were no items from the physical or emotional domains rated at a 2 or lower. Perhaps activities in these two domains of self-care practice are more easily accomplished or available to social workers. Participating in yoga and stress management training could potentially pose a cost to participants or agencies and perhaps deter social workers from engaging in these activities. It is somewhat concerning that negotiating one's own needs within the workplace was practiced with such low frequency (M=1.92). While social workers are trained to advocate for their clients in practice, it does not appear that they are doing so for themselves in professional settings.

Of the five self-care domains explored in this study, three proved to be significant predictors of professional quality of life: professional, emotional, and spiritual. More professional, emotional, and spiritual self-care practice are predictive of less burnout. More professional and emotional self-care are predictive of greater compassion satisfaction. As discussed by Nissly, Barak, and Levin (2005), burnout has been found to be predictive of turnover. Findings from this study suggest that professional self-care, such as chatting with co-workers, setting limits with clients, and taking breaks throughout the work day, may buffer against burnout. This finding has implications for employers; endorsing and teaching professional self-care could support worker sustainability. With regard to professional social worker self-care, Dombo and Gray (2013) advocate a comprehensive model that incorporates interventions at the macro, mezzo, and micro-levels of an organization. Content regarding professional self-care practice could also be built into social work education curricula, especially in the areas of practice skills and field, as a means to promote career longevity for new practitioners. Newell and Nelson-Gardell (2014) strongly advocate for the incorporation of professional self-care into social work curricula and encourage the use of professional self-care techniques as a means for supporting a healthy workforce. Van Hook and Rothenberg (2009) feel it is important top incorporate ways to identify work-related stress within the social work educational curriculum and also build supports into the organization context.

Emotional self-care activities can play a valuable role in professional quality of life. Figley (2002) advocates the use of socially supportive relationships, a form of emotional self-care, as a way to manage or treat compassion-related stress that results from working with vulnerable and traumatized populations. Killian (2008) found that clinicians cited spending time with friends and family as a self-care strategy and that social support was an important factor in predicting levels of burnout and compassion satisfaction. In the current study, emotional self-care proved to be significant in predicting less burnout and greater compassion satisfaction. These findings suggest that employers and educators may have the opportunity to support healthier, more satisfied social workers by attending to the

emotional self-care needs of employees and students, including assessing and enhancing the social support networks of human service professionals (Figley, 2002). Although respondents reported engaging in spiritual self-care less frequently than the other domains, spiritual self-care was predictive of less burnout. Hong (2012) found that workplace spirituality was associated with less intent to turnover among community mental health workers. Collins (2005) also advocated the use of spiritual self-care practice as a means for social workers to address professional fatigue, over-commitment, and the trauma associated with human service work. Dombo and Gray (2013) assert that a model of self-care that engages spiritual practices can prevent burnout, support social workers in developing adaptive coping strategies, and actually "offer the support needed to be present in clinical practice" (p. 94). In general, very little is known about the realm of spiritual self-care among human service professionals, especially social workers. Further exploration of this domain of self-care practice is needed.

Self-care perceptions and psychological self-care proved to be particularly interesting predictors of professional quality of life in this study. In existing literature, self-care perceptions have been found to be a predictor of improving quality of life (Goncher et al., 2013) and reducing burnout among workers in a residential youth center (Eastwood & Ecklund, 2008). Respondents in the current study largely agreed that they value self-care and believe it is effective in alleviating stress. However, overall findings suggest that social workers are not frequently practicing self-care. Perhaps this is related to respondents' perceptions of the ease of engagement in self-care practice or perceived barriers to self-care practice. Though respondents took a neutral position regarding ease of engaging in self-care, they largely disagreed that family, workload, community obligations, and social life prevented them from engaging in self-care practice. Therefore, something else must be contributing to social workers' lack of frequent engagement in self-care activities. In future research, it will be necessary to explore additional potential barriers to practicing self-care as well as other contextual and environmental factors that could affect the way social workers perceive self-care. The use of qualitative methods could be helpful in shedding light on these topics of interest.

Additionally, while respondents perceived their MSW programs to value self-care, they were less likely to agree that their program effectively taught them how to engage in self-care practice. This finding demonstrates a potential gap between the value of self-care by MSW programs and actual teaching of self-care practice to social work students. While there is no existing literature to directly address this gap, Newell and Nelson-Gardell (2014) acknowledge that students routinely go into the field unaware of the potential for strain outcomes. Newell and Nelson-Gardell highlight an ethical responsibility of social work educators to equip students with information and skills to acknowledge and address consequences of human service work.

While responses to employers' value of self-care were neutral, respondents disagreed that their employers effectively taught them how to engage in self-care practice. Provided this study's findings related to the role of professional self-care in predicting less burnout and greater compassion satisfaction, it appears employers have a real opportunity to address self-care in the workplace as a means to promote a healthier workforce. In an effort to learn more about how to best support social worker self-care, further investigation into

social work educational programs' and employing agencies' value and teaching of self-care practice is needed.

As noted, more psychological self-care was found to have a negative impact on professional quality of life, as indicated by higher levels of burnout and STS. The researchers theorized about possible explanations for these findings. Commonly reported psychological self-care activities included taking time for reflection, journaling, saying "no" to extra activities, developing a plan for caring for yourself, and practicing being mindful (listening to your thoughts, belief, acknowledging your behaviors, suspending judgments, etc.). Brown and Ryan (2003) suggest that self-awareness is simply "knowledge about the self" (p. 823). Psychological self-care techniques, such as participating in one's own therapy, support the development of awareness of one's boundaries and limitations (Richards, Campenni, & Muse-Burke, 2010). It is suspected that social workers who engage in these types of activities may be highly self-aware and particularly in-tune with negative indicators of professional quality of life—perhaps more so than those who do not practice psychological self-care or practice it limitedly. Further research is needed to explore the relationships between psychological self-care practice and negative indicators of professional quality of life.

Additional interesting findings from this study include the role of post-MSW experience in predicting indicators of professional quality of life. While some may have predicted that more years of practice experience would result in greater instances of negative indicators of professional quality of life, this was not the case in this study. Years of post-MSW experience actually seemed to buffer against negative indicators of professional quality of life. This finding may suggest that as practitioners gain more experience, they also learn how to cope with and/or address strain outcomes from their work. In their study of professional quality of life in child welfare workers (14% held an MSW degree), Van Hook and Rothenberg (2009) found younger workers (age 18-29 years) reported higher burnout scores than older workers (age 30 years and older). It is possible that these older workers also had more years of post-MSW experience. Alkema et al. (2008) found increased time of service to be connected to increased self-care: the longer hospice professionals worked, the more compassion satisfaction and self-care strategies they developed. These authors also found that chronological age was not a significant factor in self-care. Additional research is needed to determine where and how experienced practitioners learn to address work-related stress and build capacity for compassion satisfaction. Coupled with the findings from this study, research seems to indicate that experience, not biological age, is related to self-care practice and overall professional quality of life. This makes the emerging self-care practice of students, who are at an increased risk for burnout, even more critical to professional longevity (Harr & Moore, 2011). Interestingly, direct service time with clients was not a significant predictor of any indicators of professional quality of life. This finding suggests that contextual factors outside of direct practice with clients, may influence practitioners' experiences of strain outcomes.

Findings from this study suggest that overall, social workers are not frequently or routinely engaging in self-care practice. While the self-care perception measure used in this study included some items regarding potential barriers to practice, future research is

needed to understand how and why social workers do not engage in self-care practice. Conversely, further research is also needed to better understand how and why social workers do engage in some self-care activities, including those that may seem routine or easily accessible, such as chatting with co-workers and spending time with loved ones. In general, there exists a need for future research into social worker self-care practice and perceptions. This study focused on the direct impact of perception on professional quality of life. Self-care perception is significantly correlated with multiple domains of self-care practice. Future studies are necessary to shed light on how perception relates to practice, which in turn may affect professional quality of life. Investigating the relationship between psychological self-care practice and negative indicators of professional quality of life may lead to new learning related to how best to support and maintain the social work workforce.

Limitations

This study has notable limitations. Respondents were from a self-selected sample of MSW-level social workers in the United States. The sample of 786 MSW social workers was not nationally representative; however, participants of this study came from 42 states and D. C., and their backgrounds mirrored previous random samples in terms of gender (NASW, 2003) and average annual income (U. S. Bureau of Labor Statistics, 2013). Respondents in this study had an average of approximately nine years of post-MSW experience. In the NASW (2003) sample, respondents had, on average, 16 years of experience as a social worker. The use of alumni lists as a means of identifying study participants might have influenced the sample to include more recent graduates. In this study a vast majority of the participants (85%) was Caucasian as compared to 58% of MSW students in the CSWE (2011) survey. Overall, the sample is not representative of the general population of social work practitioners. Thus, the results are not generalizable.

An additional limitation relates to the use of a new survey instrument. Although the internal consistency reliability for all subscales of professional quality of life measures were .90 or greater and the instrument has been used in numerous studies, some of the self-care scales developed by the researchers for this study demonstrated only an acceptable degree of internal consistency reliability, which has implications for measurement. Further testing of these scales in future studies as well as scale adaptations based upon new learning may improve the scales' psychometric properties.

The study was cross-sectional in nature. While a cross-sectional design allows for a snap-shot measure of the phenomena under study, this type of design is not able to capture participants' changes in their perceptions and practice of self-care or professional quality of life over time (Rubin & Babbie, 2011). Also, this study may not have accounted for the full scope of other variables that affect professional quality of life. Stamm (2010) notes that professional quality of life is dynamic because it is associated with both environmental and personal characteristics. In future studies it will be valuable to explore additional contextual factors that may affect professional quality of life as well as self-care practice and perceptions. Despite these limitations, this study does offer valuable insights regarding social worker self-care practice, perceptions, and indicators of professional quality of life.

Conclusion

Professional quality of life is a complex concept that is comprised of both positive and negative experiences of human service work. Study respondents valued self-care but engaged in self-care practice activities on a limited basis. This study explored the predictive ability of self-care practice domains, perceptions of self-care, and background characteristics on multiple indicators of professional quality of life and found that the perceptions practitioners have of self-care are significant in predicting levels of burnout, STS, and compassion satisfaction. Also, domains of self-care practice contribute differently to indicators of professional quality of life. Professional, emotional, and spiritual self-care predicted lower levels of burnout, and professional and emotional self-care practices were both predictive of greater compassion satisfaction. Findings from this study have important implications across levels of practice. Social work practitioners, agencies, and educators should no longer just pay lip service to the value of self-care, but instead embrace self-care as a legitimate tool to support professional quality of life.

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