Exploring Compassion Fatigue, Burnout, Compassion Satisfaction and Mindfulness in Direct Service Providers

A graduate project submitted in partial fulfillment of the requirements
For the degree of Master of Social Work

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in collaboration with Christie Barboza

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# Table Contents

Signature Page.................................................................ii

Abstract.................................................................iv

Section 1 Introduction..................................................1

Section 2 Literature Review...........................................3

Section 3 Research Question...........................................9

Section 4 Methodology..................................................10

Section 5 Data Analysis................................................13

Section 6 Results........................................................14

Section 7 Discussion....................................................17

Section 8 Limitations...................................................20

Section 9 Recommendations..........................................21

Section 10 Conclusion..................................................23

References...............................................................24

Appendix A: Addendum................................................30

Appendix B: Tables......................................................32
Abstract

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By
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Master of Social Work

Los Angeles Family Housing (LAFH) provides housing, wraparound services, basic need and homeless services since 1983, and has reached 3,518 children, parents and single adults through its multi-tiered supportive housing system. The administration has indicated that direct service staff experience high stress and want recommendations for supporting employees and staff in their positions. The purpose of this quantitative study is to explore the relationship between compassion fatigue, burnout, compassion satisfaction, and mindfulness among LAFH direct service providers.

Key Words: Burnout, Compassion Satisfaction, Compassion Fatigue, Mindfulness, Secondary Traumatic Stress, Social Service Providers, Social Work
SECTION 1

INTRODUCTION

In 1983 Los Angeles Family Housing (LAFH) began as a non-profit agency that provides housing, wraparound services, basic need and homeless services and has reached 3,518 children, parents and single adults through its multi-tiered supportive housing system. The agency’s vision is to be a regional leader providing solutions to end homelessness through a continuum of housing enriched with supportive services (LAFH 2012). LAFH has indicated a pattern of over exhausted sick days and medical leaves, low morale, and a general feeling of stress and being overworked by direct service staff (J. Biggs, personal communication, November 2, 2015). Upper management is concerned that this can ultimately lead to a high turnover rate. It is known that some of the demands faced by healthcare professionals include dense caseloads, limited control over the work environment, long hours, work transitions (Irving, Dobkin & Park, 2009), exposure to traumatic content, and the burden of dealing with ethical dilemmas (Ben-Porat & Itzhaky, 2015). Research suggests that many service providers are at risk for compassion fatigue and burnout (Ray, Wong, White, & Heaslip, 2013) and compassion fatigue is almost impossible to recognize without a heightened awareness (Joinson, 1992). Professional burnout is a condition that affects all workforces, but it is especially predominant within health care professions. Similar to burnout, compassion fatigue is associated with negative outcomes for staff including behaviors such as prominent turnover rates, physical illness, substantial sick time use, low productivity, and lower morale in the workplace (Ray et al., 2013). While burnout occurs slowly over time, compassion fatigue may occur rapidly when staff are exposed to client trauma. Many empathic providers do not develop compassion
fatigue, instead experiencing positive results from their work with clients after secondary exposure to trauma. Mindfulness can function as a protective factor for helping professions.

The purpose of this quantitative study is to explore the relationship between compassion satisfaction, compassion fatigue, and mindfulness among direct service providers at Los Angeles Family Housing (LAFH). The administration has indicated that direct service staff (N=84) experience high stress and want recommendations for supporting employees and staff in their positions.
SECTION 2
LITERATURE REVIEW

*Compassion Fatigue*

Compassion fatigue is the exhaustion and negative emotional, physiological, biological, and cognitive effects resulting from the increasing effects of vicarious secondary exposure to trauma (De Figueirendo, Yetwin, Sherer, Radzik, & Iverson, 2014). Compassion fatigue occurs gradually among helping professionals when working with traumatized individuals and is referred to in a variety of ways such as vicarious traumatization, secondary traumatic stress (Ray et al., 2013), or burnout (Decker, Brown, Ong, & Stiney-Ziskind, 2015). Compassion fatigue is associated with negative outcomes for staff (White, 2006) including behaviors such as prominent turnover rates, physical illness, substantial sick time use, low productivity, and lower morale in the workplace (Austin, Goble, Leier, & Byrne, 2009; White, 2006). Gough (2007) explains how compassion fatigue symptoms come about with no warning and consist of emotional and physical fatigue, withdrawal and excessive stress (as cited in Decker et al., 2015). Compassion fatigue is developed by carrying or “bearing the suffering of others” (Figley, 2002, p. 1434). Ray et al. (2013), further describe compassion fatigue as repercussions that come from the involvement between helping professionals and individuals exposed to traumatic stress. Most findings on compassion fatigue emphasize not only the negative health effects that it can generate among helping professionals, but anyone around them such as the individuals they work with and exterior relationships (Ray et al., 2013).
Burnout

Professional burnout is a condition that affects all workforces, but it is especially prominent within health care professions (Baker, O’Brien, & Salahuddin, 2007). Burnout was first recognized as a psychological problem in the 1970’s (Galek, Flannelly, Greene, & Kudler, 2011). The term was developed by Herbert Freudenberger, a clinical psychologist that specializes in stress responses displayed by individuals working in free clinics and halfway houses (Jackson, Randall, & Schwab, 1986). Freudenberger defined burnout “as [a] state of fatigue or frustration brought about by devotion to a cause, way of life or relationship that failed to produce the expected reward” (Hamama, 2012, p.1335). It was later defined as a “psychological syndrome in response to chronic interpersonal stressors on the job” (Schaufeli, Maslach, & Leiter, 2001, p.399). Burnout can result in loss of motivation due to continuing psychological stress on the job (Galek et al. 2011), exhaustion and fatigue, feelings of vulnerability, negative outlook, insomnia, substance abuse, interpersonal conflict, and in more severe cases, suicide. On an organizational level, some of the effects can include increased absences; staff turnover, more sick days, low morale, and early retirement (Baker et al., 2007). Burnout can result from the urge to help others but as Galik et al. (2011) detailed, established organizational factors are thought to contribute to burnout, such as managerial style, limited promotion opportunities, lack of an optimistic environment, lack of self-sufficiency, and lack of appreciation and recognition. Most burnout studies have been based on Maslach and Jackson’s (1986) hypothesis of burnout having three components: emotional exhaustion, depersonalization, and diminished personal accomplishment. Whereas compassion fatigue emphasizes emotional and physical burdens brought on by secondary traumatic stress (Sprang, Clark,
& Whitt-Woosley 2007), burnout emphasizes feelings of ineffectiveness and lack of personal satisfaction at work (Hamama, 2012).

**Compassion Satisfaction**

Empathic providers experience positive results from their work with clients after secondary exposure to trauma (De Figueirendo, Yetwin, Sherer, Radzik, & Iverson 2014). Compassion satisfaction is defined as “the positive effect on providers” sense of fulfillment and pleasure resulting from effective clinical practice, particularly with traumatized populations (De Figueirendo et al., 2014, p. 287) and “the enjoyment obtained from the work that one does” (Decker et al., p. 31). Bride, Radey, and Figley (2007) state that the relationship between compassion fatigue and compassion satisfaction is unclear, but there is enough evidence to support that there is a balance between the two experiences. As compassion fatigue increases it may diminish the clinician’s ability to experience compassion satisfaction (Figley, 2001). Some of the ways that providers can enhance compassion satisfaction are by having access to social support, availability to process traumatic events, ability to cope, psycho-education, trainings on trauma, evidence-based treatment, and use of leisure time and self-care (De Figueirendo et al., 2014).

**Importance of Mindfulness**

Mindfulness first emerged from Zen Buddhism and its importance lies as a constructive and productive tool that can lead to results of value when working with individuals (Grepmair, Mitterlehner, Loew, Bachler, Rother, & Nickel, 2007). Kabat-Zinn (2003) defined mindfulness as “the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment” (p. 145). Additionally, Huss and Baer (2007) describe it as the control and awareness of oneself and “observe these phenomena without evaluating their truth,
importance, or value and without trying to escape, avoid, or change them” (p. 17). Decker et al. (2015), suggest that mindfulness can function as a protective factor for helping professionals. Mindfulness has been shown in research as an intervention to be pivotal in diminishing burnout, enhancing the well-being and mental health of helping professionals, and potentially improving therapeutic relationships (Irving, Dobkin, & Park 2009; Shanafelt et al. 2012; Shapiro, Astin, Bishop, & Cordova, 2005).

Measuring Common Practices of Mindfulness

As stated in Garland (2013), mindfulness-based interventions are becoming well regarded for their therapeutic ability, as demonstrated by recent publications in mainstream media. A number of controlled studies have confirmed the efficacy of Mindfulness Based Stress Reduction (MSBR) with a range of clinical populations and health care professionals for conditions such as chronic pain (La Cour & Petersen, 2015), psychiatric disorders such as generalized anxiety (Irving et al., 2009), and illnesses such as cancer (Carlson, Ursuliak, Goodey, Angen, & Speca, 2001). Moreover, despite the promising findings, research on MBSR has been limited by a number of theoretical and operational problems. While there is strong support for the helpful effects of MBSR there has not been thorough symptom-focused outcome measures (Irving et al., 2009). The mindful attention awareness scale (MAAS) is a self-report instrument that measures individual differences in the occurrence of mindful states over time. The MAAS is “focused on the presence or absence of attention to and awareness of what is occurring in the present rather than on attributes such as acceptance, trust, empathy, gratitude, or the various others that have been associated with mindfulness” (Brown & Ryan 2003, p. 824). The MAAS has been examined in a series of studies and indicated strong psychometric properties with other measures of psychological
well-being; it also has the capacity to predict depressive and anxious symptomatology (MacKillop & Anderson, 2007).

Mindfulness among Social Service Providers

The modern practice of mindfulness is essential to providing physical and mental benefits to the well-being of helping professionals. Individuals working in social services may be unaware of the extent of the fallouts that can be encountered when working with vulnerable populations (Garland, 2013). Hearing and fostering others about their traumatic experiences in mental health, death, loss, grief, or abuse, can consequently produce stress and compassion fatigue among social workers (McGarrigle & Walsh, 2011). Furthermore, workers have to tackle environmental factors like high caseloads, low pay, insufficient resources, and lack of leadership in the work setting (Farrell & Geist-Martin 2005; Stalker, Mandell, Frensch, Harvey, & Wright, 2007). The systems in place within the workplace are complex while creating a multitude of difficult tasks and potential dissatisfaction for workers (McGarrigle & Walsh, 2011) resulting in social workers having to bear with many layers of stress. Turner (2009), comments on mindfulness as a useful tool that can enhance the lives of social workers and reduce their distress. Moreover, it is a valuable method for clinicians to use due to the focus on creating well-founded therapeutic relationships by being present, nonjudgmental, acclimated with oneself and others (Turner, 2009). Mindfulness training has demonstrated favorable outcomes and there continues to be an increased desire for the practice of mindfulness in social work practice in order to strengthen self-care and well-being of individuals (McGarrigle & Walsh, 2011). However, few studies have explored natural mindfulness in individuals and the potential relationship with compassion satisfaction, fatigue, and burnout (see Decker et al., 2015). Therefore, the purpose of this study is to explore the relationship between compassion fatigue,
burnout, compassion satisfaction, and mindfulness in a sample of direct social service providers.
SECTION 3

RESEARCH QUESTION

For the purpose of this research, the researchers posit that staff reporting higher compassion fatigue and/or burnout will report lower compassion satisfaction and/or mindfulness. The researchers expect to see a linear relationship; higher compassion fatigue and burnout will be related to lower compassion satisfaction and mindfulness.
SECTION 4

METHODOLOGY

Design

A one-shot case study (XO) design was used for this study where adult staff members at LAFH completed a one-time survey. Because it is a type of pre-experimental design, one group is studied at a single point in time and there is no control or comparison group. Due to limitations that exist in a pre-experimental design, such as the absence of a control group or randomization, this design does not allow for causality (Rubin & Babbie, 2014). However, strengths are that it is reasonably low cost, provides minimal threat to subjects, and is useful as a pilot study. This research explored the extent of the relationship between compassion fatigue and compassion satisfaction. The California State University, Northridge MSW IRB Subcommittee approved this study on December 7, 2015.

Site of the Study

LAFH aids families out of homelessness and poverty into temporary, transitional, and permanent housing and serves clients of all ages through best practices of basic needs, wraparound services, and homeless services throughout the greater Los Angeles area. Over ninety percent of revenue funds direct services and housing. In total LAFH owns and operates 22 properties, including three shelters and 19 permanent affordable apartment buildings. The agency maintains a ninety two percent success rate in placing families in permanent independent housing (LAFH, 2012).
Sample

The study population includes Masters in Social Work (MSW), Bachelor's degree (BA/BS) and Associate's Degree (AA), entry-level staff, and peer advocate employees of Los Angeles Family Housing (LAFH). The sample (N=84) are composed of both men and women 18 years or older. The sample (N=84) is primary educated (40% obtained a postgraduate degree), single (60%), young (86% are under 49 years old; of those 38% are between the ages of 18-29), and female (based on observation; no formal statistics were collected). Exclusion criteria include all non-direct service staff at LAFH.

Measures

Two standardized instruments were used to measure compassion satisfaction, burnout, compassion fatigue, and mindfulness.

The Professional Quality of Life Scale (ProQOL). The ProQOL (Stamm, 2010) is a 30-item self-report instrument that measures pleasure derived from being able to do work well, feelings of hopelessness and difficulties in dealing with work or in doing a job effectively, and work-related, secondary exposure to extremely stressful events. The ProQol has three domains that consist of burnout (reliability in the current study $\alpha=.76$), compassion satisfaction (reliability in the current study $\alpha=.89$), and compassion fatigue (reliability in the current study $\alpha=.80$). An example question for burnout is “I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].” A sample compassion satisfaction item is “I like my work as a [helper],” and for compassion fatigue includes “I jump or am startled by unexpected sounds.” All questions are measured on a 5-point Likert scale where 1 = never and 5 = very often. There have been various modifications of the ProQOL and the updated ProQOL 5 (2010) version was
used in the current study. The ProQOL has been used with numerous populations such as oncology nurses (Potter, Deshields, Divanbeigi, Berger, 2010) in addition to healthcare providers and children and family workers (Stamm, 2009).

**Mindful Attention Awareness Scale (MAAS).** The MAAS is a 15-item self-report instrument measuring awareness across cognitive, emotional, physical, and general domains of daily life (Brown & Ryan, 2003). Questions include “I find it difficult to stay focused on what’s happening in the present” and “I rush through activities without being really attentive to them” and are rated on a 7-point Likert-type scale where 1 = almost always and 6 = almost never. Therefore, higher scores indicate higher levels of dispositional mindfulness. The MAAS has been widely used with a variety of populations and issues including cancer patients (Carlson & Brown, 2005), adult attachment (Cordon & Finny, 2008), doctor–patient communication skills (van Es, Schrijver, Oberink & Visser, 2012), and has demonstrated reliability (α=. 92) in the current study.

Demographic questions included discrete categorical and continuous variables such as age, marital status, education, job description, years of experience, and employment status (full time/part time).
SECTION 5

DATA ANALYSIS

Data were analyzed using SPSS version 22. Descriptive statistics for individual variables are reported (see Table 1). The relationship between all continuous variables (compassion fatigue, compassion satisfaction, burnout, mindfulness, and years of experience) was explored using Pearson product moment correlation (see Table 2). Independent samples t-tests and analysis of variance (ANOVA) were used to compare differences between groups (i.e. staff focused on individuals, families and both) on compassion satisfaction, compassion fatigue, burnout, and mindfulness.
SECTION 6

RESULTS

The demographic sample (N=84) is comprised predominantly of full time (86.9%) staff with a postgraduate degree (39.3%) between 30-49 years of age (48.8%) who work with families, individuals or both (see Table 1).

Table 2. (see below) explores the relationship between burnout, compassion satisfaction, compassion fatigue, and mindfulness by work group and years of experience, independent samples t-test and one-way ANOVA statistics were performed using SPSS.

Compassion Fatigue

A one-way between groups analysis of variance was conducted to explore the impact of compassion fatigue, as measured by the Professional Quality of Life Scale, on the types of services provided. Participants were divided into three groups according to the groups they provide services to (Group 1: individuals; Group 2: families; Group 3: both). There was no significant difference in compassion fatigue and direct service staff working with different groups: $F(2.74)=.07, p=.92$.

An independent-samples t-test was conducted to compare the compassion fatigue scores for direct service staff that work full time versus those that are part time employees. There was a significant difference in scores for part time employees ($M=18.36, SD=7.07$) and for full time employees ($M=23.05, SD=5.49; t(76) = -2.52, p=.01$, two-tailed), with full time employees reporting higher compassion fatigue than part time employees. The magnitude of the difference in the means (mean difference= -4.69, 95% CI: -8.40 to -.98) was moderate (eta squared .07).
**Burnout**

A one-way between groups analysis of variance was conducted to explore the impact of burnout, as measured by the Professional Quality of Life Scale, on the types of services provided. Participants were divided into three groups according to the groups they provide services to (Group 1: individuals; Group 2: families; Group 3: both). There was no significant difference in burnout among direct service staff working with different groups: $F(2.76) = 1.08, p = .34$.

An independent-samples t-test was conducted to compare the burnout scores for direct service staff that work part time (1-39 hours per week) and full time (40 or more per week). There was no significant difference in burnout scores of part time employees ($M=19.81, SD=6.14$) and for full time employees ($M=22.88, SD=5.96$; $t(78) = -1.57, p = .11$, two-tailed), although the mean burnout score for full time employees was higher than the mean burnout score for part time employees.

**Compassion Satisfaction**

A one-way between-groups analysis of variance was conducted to explore the impact of Compassion Satisfaction, as measured by the Professional Quality of Life Scale, on types of services provided. Participants were divided into three groups according to the groups they provide services to (Group 1: individuals; Group 2: families; Group 3: both). There was statistically significant difference at the $p < .05$ level in compassion satisfaction scores for the three work groups: $F(2.78) = 4.8, p = .01$. The effect size, calculated using eta squared, was .11. Post-hoc comparisons using the Tukey HSD test indicated that the mean score for individuals ($M = 42.24, SD = 5.76$) was significantly
different from families \( (M = 37.83, SD= 5.87) \). There was significant difference in families and both (individuals + families) \( (M=42.56, SD=6.55) \).

An independent-samples t-test was conducted to compare the compassion satisfaction scores for direct service staff that work part time (1-39 hours per week) and full time (40 or more hours per week). There was no significant difference in compassion satisfaction scores part time employees \( (M=39.90, SD=6.47) \) and for full time employees \( (M=41.11, SD=6.24; t (80) = -.59, p = .56, \text{ two-tailed}) \).

**Mindfulness**

A one-way between groups analysis of variance was conducted to explore the impact of mindfulness, as measured by the MAAS, on types of services provided. Participants were divided into three groups according to the groups they provide services to (Group 1: individuals; Group 2: families; Group 3: both). There was no significant difference in mindfulness among direct service staff working with different groups: \( F(2.78)= .54, p=.58. \)

An independent-samples t-test was conducted to compare the mindfulness scores for direct service staff that work part time (1-39 hours per week) and full time (40 or more hours per week). There was a significant difference in scores for part time employees \( (M=2.16, SD=.75) \) and for full time employees \( (M=2.63, SD=.75; t (80) = -1.92, p=.05, \text{ two-tailed}) \), with full time employees reporting higher mindfulness scores than part time employees. The magnitude of the difference in the means (mean difference= -4.6, 95% CI; -.95 to .01) was small (eta squared .04).
Examining the results from this quantitative study provides an understanding into how compassion satisfaction, compassion fatigue, and burnout are related to mental health professionals’ mindfulness. Findings resulted in no significant difference in mindfulness among direct service staff working with individuals, families, or a combination of individuals and families, although full time employees reported higher mindfulness. A contributing factor as to why part time employees report less mindfulness could be due to how full time employees hold a difference in work status such as obtaining benefits or having opportunities for growth. Conway and Briner (2002) found that part-timers are looked upon differently through their work performance, benefit coverage, autonomy, and advancement within the workplace. Thus, if part time employees perceive themselves as being treated differently than full time employees there will be a decrease in desire for mindfulness. An additional factor could be that part time employees aim for different career orientations which results in working reduced hours in order to accommodate to their out of work commitments (Conway & Briner, 2002).

This study determined that working part time or full time had no significant difference in experiencing burnout and a slight difference in experiencing compassion satisfaction. However, the results of this study showed that there was statistically significant difference between full time and part time employees in their level of compassion fatigue. This study contributes to existing research, which demonstrates that compassion fatigue results in those experiencing long hours of work with few resources (Figley, 2001). Full time direct service providers at LAFH are reporting higher levels of
compassion fatigue, which may be why they are reporting more use of sick time from employees and an overall consensus of low morale. Based on our results, full time staff at LAFH are not experiencing burnout. However the direct service providers at LAFH feel effective in their work and might be experiencing secondary traumatic stress based on the clientele that they serve.

Direct service providers encounter complex situations when working with individuals struggling with housing and navigating social services, the services that they are providing are delivered with meaning and purpose. Although the work can be challenging, previous research reveals that direct service providers consistently fail to meet the criteria for burnout rather than compassion fatigue because of their feelings of personal accomplishments related to their work in helping others (Baker, O’Brien, & Salahuddin, 2007). The results in the current study are congruent with Baker et al.’s (2007) findings.

The results of this study indicated that there was statistical significance in the impact of compassion satisfaction, as measured by the Professional Quality of Life Scale, among direct service providers that work with individuals in comparison to direct service providers that work with families. There is currently limited research available that explores work being done with urban families as it relates to compassion satisfaction for direct service providers. Concurrently, there is also limited research on direct service providers that work with families or group settings in contrast to working with individuals. Based on the findings it appears that working in a family setting could be a lot more rigorous than working on an individual level, perhaps because of the multitude of stressors a family can bring to the table. There are different factors that play into the
family setting that may result as to why direct service providers are not experiencing compassion satisfaction. When working with a family, one may have a multitude of goals that might not seem measurable, while working on an individual level one might be able to develop a more realistic treatment plan. Working in a family setting can involve other entities such as the legal system (e.g. a possible restraining order in place from one party against another) or disagreement between parents, which can create conflict in a therapeutic setting. Furthermore, one must always meet the client where they are, and the family might not be collectively ready to make a change. When working with a family the treating provider must always define their role and realize that the role can change at any moment based on the family’s needs. Therefore, high compassion fatigue and lower compassion satisfaction for direct service providers working with families makes for a challenging work environment. Limited research exists on the unique challenges working with families compared to individuals and future research should explore this preliminary finding further.

The study also determined that the majority of direct service providers employed at LAFH are at the beginning stages of developing their career in social services. It was reported by upper management at LAFH that if the concerns are not addressed soon it will lead to possible turnover. This in turn can lead to direct service providers leaving the agency once they have developed work experience, reached state licensing requirements or attained possible career goals. Previous studies in the U.S reveal younger, less experienced social workers reported lower personal accomplishments, low autonomy and low perceived potential for personal growth and self-fulfillment than experienced workers (Hamama, 2012).
SECTION 8

LIMITATIONS

The study conducted possesses several limitations. Weaknesses related to the design include an inability to control for threats to internal validity. Administering a pretest-posttest design could have provided the study with more internal validity. However, standardized measures of compassion satisfaction, compassion fatigue, burnout, and mindfulness were used and data collected anonymously from a relatively large sample. While a chance for social desirability bias exists, the anonymous nature of the data collection likely precludes this potential limitation.

The present study did not implement a mindfulness intervention and thus cannot determine whether mindfulness increases compassion satisfaction and decreases burnout and/or compassion fatigue. However, given the findings that full time staff report greater mindfulness, future research should consider implementing and testing the results of a mindfulness intervention. Additionally, having conducted the study at a single agency leads to findings that are not generalizable and are not meant to exemplify all direct service providers that are currently working with homeless individuals and families.
SECTION 9
RECOMMENDATIONS

Research shows that working with individuals seeking social services often has adverse effects on the providers. The findings of this study suggest that agencies must focus on specific areas when working to reduce the levels of compassion fatigue and burnout amongst direct service providers. Studies demonstrate that high levels of psychological demands (Baker, O’Brien & Salahuddin, 2007), low levels of participation in decision making (Papathanasiou, 2015) and low levels of social support from colleagues (Hamama 2012) lead to higher levels of burnout and compassion fatigue. More recently it has been found that health care providers engaged in wellness-promotion practices, including mindfulness were more likely to report higher scores in well-being (Weiner, Swain, Wolf, & Gottlieb, 2001). Although it is noted in literature that self-care strategies need to be implemented within practice, many academic and work related trainings do not explicitly include these strategies; it is characteristically presented as an individual responsibility (Irving, Dobkin & Park, 2009). Mindfulness can serve as a protective factor for the practicing provider; this study demonstrated that full time staff at LAFH had higher mindfulness. LAFH could implement weekly supervision that will cover topics that includes self-care, trainings on continuing education and providing a mentor for staff that could ultimately lead to growth within the agency. In addition, providing staff with an individualized checklist of the different topics that would be discussed during supervision in an effort to assure that all staff is utilizing supervision to its full potential might be useful. This may help staff cope with the everyday work stressors that can be contributing to compassion fatigue. Given that our study
demonstrated that current direct service providers at LAFH are within the first 5 years of their career, they are in a pivotal state where they can take in mentorship and supervision to build their skill set, ultimately working towards the prevention of the stressors that can lead to compassion fatigue and burnout. In a meta-analysis studying the relationship between age or years of experience it was determined that supervisory support can be instrumental in buffering the effects of burnout, newer employees might be more inclined to respond to supervisory interventions than older employees (Brewer & Shapard, 2004).
SECTION 10

CONCLUSION

The findings highlight how direct service providers are at risk for experiencing compassion fatigue and burnout in the workplace. In this study it was found how different variables are of influence to the occurrence of compassion fatigue, burnout, compassion satisfaction and mindfulness. Variables such as employment status (full time vs. part time) and which groups staff provide services to (individuals, families, or both) differed in the sample of LAFH staff. In acquiring a strong understanding of both risk and protective factors for stress related conditions, there can be suitable interventions developed for direct service providers.

Direct service providers working with individuals and families who provide multi-tiered supportive services to the homeless population can generate negative outcomes for staff. A combination of the emotional demands and daily challenges in the workplace, such as recognizing their values through their work, can create an impact on the well-being of direct service providers. Future research is needed to help support direct service providers working with challenging groups. Therefore, it is necessary to invest in ways that institutions can help their workers prevent or alleviate experiencing burnout and compassion fatigue to ultimately enhance the quality of services that are delivered to clients.
References


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Appendix A: Addendum

Exploring Compassion Fatigue, Burnout, Compassion Satisfaction and Mindfulness in Direct Service Providers

Exploring Compassion Fatigue, Burnout, Compassion Satisfaction and Mindfulness in Direct Service Providers is a joint graduate project between Karla Reyes and Christie Barboza. This document will explain the division of responsibilities between the two parties. Any additional information can be included in a separate document attached to this Addendum page.

Karla Reyes is responsible for all the following tasks/document sections:
Completion and review of literature review sections: Compassion fatigue, Compassion satisfaction, Importance of Mindfulness and Mindfulness among Social Service Providers.
Karla provided definitions, common knowledge, and most current research on Compassion fatigue, Compassion satisfaction. Literature and evidence that states that Mindfulness is beneficial and the importance of mindfulness among professionals that provide direct practice in the field of social work. All this information was supported with journal articles obtained from Oviatt Library.

Christie Barboza is responsible for all the following tasks/document sections:
Completion and review of literature sections: Burnout, mindfulness and measuring common practices of mindfulness.
Christie provided definitions, common knowledge and most current research on burnout and mindfulness. Literature and evidence is provided which states that measuring common practices of mindfulness and how mindfulness-based interventions are beneficial among professionals that provide direct practice in the field of social work. All this information was supported with journal articles obtained from Oviatt Library.

Both parties shared responsibilities for the following tasks/document sections:

Abstract- Researchers collaboratively developed a synopsis of the research project. Briefly described the services that LA Family Housing provides and stated the purpose of our quantitative study which is to explore the relationship between compassion fatigue, burnout, compassion satisfaction and mindfulness.

Introduction- Collaboratively developed identifying information about the agency that will be used to conduct the study at and indicated the agency's current concerns. Provided brief definitions of compassion fatigue, burnout, compassion satisfaction, and mindfulness. Lastly, discussed the purpose of the study which is to explore the relationship between compassion fatigue, burnout, compassion satisfaction, and mindfulness.

Research Question- Researchers collectively determined the core of the research project. For the purpose of this research, the researchers posit that staff reporting higher compassion fatigue and/or burnout will report lower compassion satisfaction and/or mindfulness.

Methodology- Researchers provided information of the study design. The design use is a one shot case study. Researchers provided information of the current sample, (N=84), and
their current composition. Researches utilized two standardized instruments; The Professional Quality of Life Scale and Mindful Attention Awareness Scale.

**Conducted Surveys at Agency Site** - Researchers both attended an agency meeting where they administered the survey. Survey consisted of The Professional Quality of Life Scale (ProQol) and Mindful Attention Awareness Scale (MAAS) and demographic questions. The researchers provided the participants 20 minutes to complete the survey, provided pencils and raffled a $20 gift card at the end. Lastly, informed participants that data would be analyzed and results would be presented at a staff meeting in May 2016.

**Data Analysis** - Researchers analyzed the data using SPSS version 22. Descriptive statistics for individual variables were reported. Independent sample T-tests and analysis of variance were used to compare differences between groups.

**Results** - Researchers collaboratively provided a snapshot of what the results table demonstrated of the demographic sample and the relationship of our variables. Further, results were provided of the relationship between burnout, compassion fatigue, compassion satisfaction and mindfulness through one-way ANOVA and sample t-test using SPSS.

**Discussion** - Researchers collaboratively examined the results of the study and analyzed findings. Discussed findings and supported evidence with previous research. Informed the reader where future research is needed.

**Limitations** - Collaboratively determined the study limitations, determined that there were weaknesses related to design and generalizability.

**Recommendations** - In collaboration researchers recommended that utilizing supervision to its full potential by discussing topics of self-care, trainings, continuation of education and providing a mentor could be useful by supporting staff and help cope with the everyday work stressors.

**Conclusion** - Researchers collaboratively provided a closing of the research project and determined the need of future research in order to help support direct service providers working with challenging groups.
### Table 1. Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Attributes</th>
<th>F(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education Level</strong></td>
<td>Some High School</td>
<td>1 (1.2 %)</td>
</tr>
<tr>
<td>(N=84)</td>
<td>H.S Graduate</td>
<td>6 (7.1%)</td>
</tr>
<tr>
<td></td>
<td>Some College</td>
<td>10 (11.9%)</td>
</tr>
<tr>
<td></td>
<td>Trade School</td>
<td>1 (1.2%)</td>
</tr>
<tr>
<td></td>
<td>College Graduate</td>
<td>23 (27.4%)</td>
</tr>
<tr>
<td></td>
<td>Some Post Graduate</td>
<td>10 (11.9%)</td>
</tr>
<tr>
<td></td>
<td>Post Graduate Degree</td>
<td>33 (39.3%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>18-29</td>
<td>32 (38.1%)</td>
</tr>
<tr>
<td>(N=84)</td>
<td>30-49</td>
<td>41 (48.8%)</td>
</tr>
<tr>
<td></td>
<td>50 -64</td>
<td>10 (11.9%)</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>1 (1.2%)</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Single</td>
<td>51 (60.7%)</td>
</tr>
<tr>
<td>(N=84)</td>
<td>Married</td>
<td>26 (31%)</td>
</tr>
<tr>
<td></td>
<td>Domestic Partnership</td>
<td>1 (1.2%)</td>
</tr>
<tr>
<td></td>
<td>Separated</td>
<td>4 (4.8)</td>
</tr>
<tr>
<td></td>
<td>Never Married</td>
<td>2 (2.4%)</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Divorced</td>
<td>0</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td>Part Time</td>
<td>11 (13.1%)</td>
</tr>
<tr>
<td>(N=84)</td>
<td>Full Time</td>
<td>73 (86.9%)</td>
</tr>
<tr>
<td><strong>Years of Experience</strong></td>
<td>1-5 years</td>
<td>47 (57.4%)</td>
</tr>
<tr>
<td>(N=82)</td>
<td>6-10 years</td>
<td>17 (20.7 %)</td>
</tr>
<tr>
<td></td>
<td>11 and above</td>
<td>18 (21.8 %)</td>
</tr>
<tr>
<td><strong>Work Group</strong></td>
<td>Individuals</td>
<td>41 (49.4 %)</td>
</tr>
<tr>
<td>(N=83)</td>
<td>Families</td>
<td>26 (31.3 %)</td>
</tr>
<tr>
<td></td>
<td>Both</td>
<td>16 (18.1 %)</td>
</tr>
</tbody>
</table>
Table 2. Relationship of Continuous Variables

<table>
<thead>
<tr>
<th>Scale</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compass Fatigue</td>
<td>-.201</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Burnout</td>
<td></td>
<td>.589**</td>
<td>.702**</td>
<td>-</td>
</tr>
<tr>
<td>Compass Satisfaction</td>
<td>1</td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>.355**</td>
<td>.690**</td>
<td>.659**</td>
<td>-</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed)**