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An Examination of Self-Care and Social Support Regarding Burnout Levels of Direct Care Staff and Social Workers

Tina Paskey
St. Catherine University

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An Examination of Self-Care and Social Support Regarding Burnout Levels
of Direct Care Staff and Social Workers

Tina Paskey

GRSW 682

University of Saint Thomas/ Saint Catherine University

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Abstract

Previous research has examined burnout in social workers and other helping professions, however, there is little research regarding burnout in “direct care” workers, or those who work directly with clients and tend to have less experience and education. This research examined the effect of demographic factors such as age, experience, gender, and degree level on burnout rates, as well as the effect of social support and self-care on burnout. Twenty-nine participants from two social service agencies in the Minneapolis-St Paul, Minnesota area completed an online survey. Results showed that none of the variables studied appeared to have an effect on burnout. The researcher attributes small sample size and convenience sampling to these results. Further research should examine the burnout rates of direct care workers, as well as workers in all professions, and should examine whether mezzo and macro factors contribute to burnout rates.

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Introduction

In recent years, burnout has been increasingly researched in regard to those working in human service professions. Christina Maslach, a leading researcher on the concept, defines burnout with three dimensions: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001). Emotional exhaustion is defined as “feelings of being emotionally overextended and exhausted by one's work,” while depersonalization refers to “an unfeeling and impersonal response toward recipients of one's service, care treatment, or instruction,” and reduced personal accomplishment refers to “the tendency to evaluate oneself negatively, particularly with regard to one's work with clients” (Maslach et al., 1996, p. 1.). Similarly, the International Classification of Diseases-10 equated burnout with the term “job-related neurasthenia,” which is defined as “either persistent or distressing complaints of increased fatigue... or of bodily weakness and exhaustion, [and] ... feelings of muscular aches and pains, dizziness, tension headaches, sleep disturbance....” (Schaufeli et al., 2001, p. 567). In this case, increased fatigue can equate to emotional exhaustion.

Maslach et al. (2001) surveyed over 25,000 North American employees and found that 20% met criteria for advanced burnout. While burnout can occur in any job, it tends to be higher in human service occupations, particularly teaching, social services, medicine, mental health workers, and law enforcement (Maslach et al., 2001). Social workers also have a high burnout risk. A study of 879 social workers found 17% to rate their burnout as “medium” and 24% to rate their burnout as “high” (Poulin & Walter,

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1993). A second study of 132 therapists in a variety of specialties found 33% to have “medium” scores for exhaustion and negative work environment, while 28% had high scores for exhaustion and negative work environment (Lee et al., 2010).

Employee burnout not only affects the employees, but it can be costly to agencies in the form of high rates of absenteeism, increased use of sick leave, and employee turnover, as well as less productive work and low quality of work performed. Additionally, it may contribute to low morale, psychosomatic complaints for the burnt-out employee, decreased interest in work, and ultimately, a decline in quality of client care (Maslach, Schaufeli & Leiter, 2001). Burned out workers in a study by Kalimo et al. (2003) stated that their burnout may have been due to lack of cooperation between workers and a negative organizational climate. These factors can clearly create a downward spiral, which may lead to low morale and a lack of enjoyment at work. Clearly, burnout should be a topic of interest for managers and employees in many human service professions, including but not limited to social work, teaching, and nursing. Finding interventions to decrease burnout in a small group of employees can affect all levels of an agency through increased morale, more effective client care, and increased profits and productivity of the agency.

Given the higher rates of burnout in helping professions, it is important to understand burnout within the social worker profession. Two of the three dimensions of burnout- emotional exhaustion and depersonalization-can directly affect the clients. If a social worker depersonalizes a client by being impersonal, this can be very invalidating for a client. If it continues, the client may leave therapy and/or discontinue services. If a social worker is emotionally exhausted and unable to focus on the task at hand, they are

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not able to be there emotionally for their clients. According to the NASW Code of Ethics (1996), one of the ethical principals of a social worker is Service, which states that “Social workers’ primary goal is to help people in need...” (p. 5). If a social worker is focused on their own problems and/or burned-out on the job, it becomes impossible to make the clients the first priority. Because burnout is a growing problem in the human services profession, including social work, it cannot be ignored.

Research has shown that increased self-care, adequate social support, as well as other mediating characteristics affect employee burnout levels and can even decrease burnout over time (Alarcon, Eschelman, Bowling, 2009; Baker, O’Brien & Salahuddin, 2007; Eastwood & Ecklund, 2008; Harrison & Westwood, 2009, Himle. & Jayaratne, 1991; Kalimo et al., 2003; Reid et al., 1999). Given these findings, the purpose of this research project is to examine how self-care and social support affect burnout levels of direct care staff and social workers.

Literature Review

This literature review will examine burnout with various professions and with both direct care staff and social workers. It will also examine various characteristics associated with burnout, and burnout as related to social support and self-care.

Burnout in Various Professions

Social work is one of many human service professions. Burnout has been found to be a phenomenon that spans many human service professions, including social work, medicine, law enforcement, and home-care services, among other professions.

Medicine/hospitals. Hospitals, particularly emergency rooms or psychiatric wards, tend to be perceived as very stressful environments by the staff that works in them

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and staff has a tendency for high burnout. For example, in a study of 103 hospital staff, 51% reported they experienced stress at work “frequently or very frequently.” The study also found ER nurses are 3.5 times more likely to use illegal drugs than nurses in other specialties, perhaps as a method of coping with high stress (Healy & Tyrrell, 2011). A qualitative study of nurses working in a psychiatric ward found sources of stress related to difficult and unrewarding relationships with clients, aggressive clients, and perception of a limited role with clients (Reid et al., 1999). In a study of staff in six psychiatric wards in Europe, hospital staff listed “violent and disruptive patients” as a major source of stress and 78% of staff in the study had experienced violence from patients at one point (Sorgaard et al., 2007). In a large scale study of over 250 nurses, it was found that “obsessive passion,” that is, throwing one’s self into their work and not being able to let go of work, can lead to burnout (Vallerand et al., 2010).

Law enforcement. Studies of law enforcement have found high levels of “cynicism and inefficacy,” (Maslach, Schaufeli & Leiter, 2001). In a study of workers in a psychiatric prison, only 25-34% stated they received high rewards from clients, while 36-64% stated there were high demands from clients. In comparison, 41-56% of social workers in public practice and 70-96% of homecare workers stated that they received high rewards from clients, with approximately comparable percentages of client demands. Thus less law enforcement workers find less high rewards from their clients (Borritz et al., 2006).

Home care/ family caregivers. Previous studies of home care workers and/or family caregivers have shown caring for others at home, either due to hospice or physical illness, can lead to burnout for various reasons. For example, a study of approximately

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200 caregivers showed on average, caregivers had moderate levels of emotional exhaustion and depersonalization, yet high levels of personal accomplishment (Ybema et al., 2002). Participants stated their emotional exhaustion stemmed from feeling they “gained too little” and that “emotional investment was low” (Ybema et al., 2002, p. 82). A second study of home care workers (69% of sample) and child protection workers (30% of sample) found 20% of all participants had high levels of emotional exhaustion, 23% of the sample had high levels of depersonalization, and 43% of the sample had low levels of personal accomplishment (Jenaro, Flores & Arias, 2007).

Social workers/therapists. Social workers tend to have variable burnout scores based on setting and type of client. Of social workers involved with clients with serious and persistent mental illness, a challenging client population, most had moderate scores on emotional exhaustion but low levels of depersonalization (Acker, 1999). Burnout levels also tend to remain steady over time. In a study of 879 social workers, two-thirds of participants’ burnout levels did not change over time while one-third of participants’ levels either increased or decreased (Poulin & Walter, 1993). In private practice, however, in a study of over 500 therapists (those with higher education and private practices) only 12% of participants met the qualifications for burnout (Craig & Sprang, 2010). As previously reported, those in private practice tend to have lower burnout rates than those in public practice due to more career experience and other factors (Schwartz, Tiamiyu, & Dwyer, 2007).

Characteristics of Professional Work Environment

Studies have found that social services, mental health, teaching, law enforcement, and medicine have high burnout rates due to the nature of the job (Maslach et al., 2001;

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Dennis & Leach, 2007; Healy & Tyrrell, 2011). This section will discuss what type of professional characteristics can affect burnout, such as setting, client population, private or public practice, and office environment. For the purpose of this study, “direct care workers” will be defined as those who work directly with clients and who do not have a qualification to perform therapy/counseling due to a lack of formal education/licensure. Social workers will be defined as anyone with a BSW or MSW degree, who may or may not be practicing therapy.

Setting. Studies have shown that residential workers tend to have higher burnout rates than non-residential workers. For example, a five year longitudinal study of human service employees found high client-related burnout and high work-related burnout in midwives, home care workers, and social workers in institutions for the mentally disabled, all of which are residential settings (Borritz et al., 2006). A study by Lernihan and Sweeney (2010) found residential workers scored higher on depersonalization scores and lower on sense of personal accomplishment than day program workers. Craig and Sprang (2010) also showed that inpatient therapists tend to have higher rates of burnout than outpatient or private practice therapists.

Client Population. Studies have shown that high stress jobs for social workers tend to be with “difficult consumers” such as those with serious and persistent mental illness, those who are suicidal, and/or those who have or are currently facing trauma/abuse. Acker (1999) explains that clients with severe mental illness often have difficulty maintaining the therapeutic relationship, show limited progress over time, and show minimal signs of change or improvement. He explains that “social workers... often expect evidence of insight, progress, and change” in clients, and the lack of improvement

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in the client “can reinforce a clinician’s own sense of failure,” which he states may lead to burnout (p. 113). A study of therapist burnout by Craig and Sprang (2010) showed that having a large number of clients with PTSD or trauma issues on a therapist caseload showed increased rates of burnout. Gray-Stanley and Muramatsu (2011) similarly found that the degree of the client’s disability was statistically significantly related to burnout scores: the more severe the disability, the higher the burnout score. Lawson and Myers (2011) found that counselors with larger percentages of traumatized clients or high risk clients tended to have higher burnout rates than those with lower numbers of these clients. A study of child maltreatment workers, a difficult occupation, showed that 75% had low personal accomplishment, and 100% of all workers had high scores on both emotional exhaustion and depersonalization. (Stevens & Higgins, 2002). In a study of those working with clients with severe and persistent mental illness, approximately 45% of participants reported high levels of emotional exhaustion, and staff listed difficult consumer behavior as one of the main causes for emotional exhaustion (Dietzel & Coursey, 1998).

Private Practice. Counselors in private practice, as opposed to public practice, have been found to have lower levels of burnout, regardless of age and years of practice (Schwartz, Tiamiyu, & Dwyer, 2007). Additionally, private practice therapists scored higher than public practice therapists on a wellness scale (Lawson & Myers, 2011).

Office Environment. A study of 232 social workers found perceived workload, supportive supervision, and perceived efficacy to be related to job satisfaction. If they felt they could affect positive change and have meaningful contribution in their work, these social workers tended to be more satisfied with their job, regardless of high workload

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(Cole, Panchanadeswaran, & Daining, 2004). Similarly, Acquavita et al. (2009) found social workers tended to have higher job satisfaction when they encountered more social support, higher perceived inclusion in the office place, and good supervisory support. A unique study by Travis and Mor Barak (2010) examined whether voicing problems at work or disengaging by ignoring problems related to staying or quitting a job. The researchers found that voicing opinions, whether positive or negative, was associated with inclusion in decision-making, while quitting one's job related to a lack of supervisory or organizational support. In a study of school social workers, job satisfaction was found to relate to low role discrepancy, perceiving being valued by colleagues/ co-workers, and having time to meet informally with others in the workplace to discuss their clients (Agresta, 2006). A study of public child welfare workers found that extraneous variables such as good pay, benefits, job security, opportunities to advance, and variety in routine were reasons people listed as why they stayed in their positions (Faller, Graberek & Ortega, 2010). A longitudinal study by Kalimo et al. (2003) found that workers who did not experience burnout over time tended to a sense of coherence of what occurs in the workplace day to day, to have job complexity, role clarity, feedback from others, and appreciation of work completed.

Personal Characteristics Associated with Burnout Levels

In addition to professional characteristics, there are many personal characteristics associated with burnout level, including attitude/outlook, identification with their profession, personality characteristics, demographic variables, professional experience, and level of education. These factors can be associated with either high or low levels of burnout.

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Attitude/ Outlook. There have also been studies examining vicarious resilience, compassion satisfaction, and the “Hope Theory” (Craig & Sprang, 2010; Hernandez, Gangsei & Engstrom, 2007; Schwartz, Tiamiyu, & Dwyer, 2007). All of these concepts appear to be associated with low therapist burnout and instead focus on positive therapist-client interactions.

Vicarious Resilience. Hernandez, Gangsei and Engstrom (2007) defined vicarious resilience as “transformations in the therapists’ inner experience resulting from empathetic engagement with the client’s trauma material” (p. 237). In a study of therapists working with clients who had experienced severe trauma, all 12 therapists gave examples of how they experienced vicarious resilience such as witnessing and reflecting individuals’ capacity to heal, reassessing the gravity of their own problems, further understanding the role of spirituality, seeing clients as sources of learning, maintaining hope, and developing increased tolerance for frustration. This study examined therapists who worked with “difficult” clients, and it shows that working with difficult clients does not always have to lead to burnout.

Compassion Satisfaction. Compassion satisfaction might be defined as “the pleasure one derives from being able to do his or her work effectively” (Craig & Sprang, 2010, p. 322). In a study of 532 therapists consisting of psychologists and clinical social workers, approximately 46% of those surveyed experienced high levels of compassion satisfaction. Only 5% of those surveyed met criteria for burnout (Eastwood & Ecklund, 2008). The authors suggested that evidence-based practices for clients may have resulted in increased compassion satisfaction.

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Hope Theory. Hope theory can be defined as a therapist's focus on client success and includes the concepts of goals, willpower, and waypower (Schwartz, Tiamiyu, & Dwyer, 2007). Their study of 676 social workers found those in private practice had higher hope scores and less burnout, as well as a positive correlation between client hope and social worker hope and a positive association between social worker age and hope. These findings agree with the previous findings of less burnout in private practice (Lawson & Myers, 2011). In addition, this study suggests that a positive attitude of the therapist (high hope scores) may lead to a more positive attitude of the client.

Identification with Profession. A study by Geng, Li, and Zhou (2011) showed that the more that a social worker identified with his/her occupation, the less emotionally exhausted they would be and thus the less they may burn-out. Similarly, those with greater occupational identity scores tended to find their occupations to be meaningful, valuable, and enjoyable. These studies suggest that when a social worker does not identify strongly with their profession, they may experience higher burnout, particularly depersonalization and emotional exhaustion.

Personality characteristic factors. Various personality characteristics have been found to either increase or decrease burnout levels. A meta-analysis by Alarcon, Eschelman & Bowling (2009) examined personality traits and burnout. Their findings suggest that self-esteem, internal locus of control, general self-efficacy, extraversion, conscientiousness, agreeableness, hardiness (defined as the extent to which a person can endure stressors without ill effects), and emotional stability are negatively associated with both emotional exhaustion and depersonalization. Similarly, Maslach, Schaufeli & Leiter (2001) found that low levels of hardiness may relate to high burnout scores, particularly

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in regards to emotional exhaustion. They also found that those with an external locus of control may have higher rates of burnout. They state that “low levels of hardiness, poor self-esteem, [and] an external locus of control... constitute the profile of a stress-prone individual” (p. 410). Various other studies have also shown self-esteem to be related to burnout levels (Poulin & Walter, 1993; Lee et al., 2010; Kalimo et al., 2003).

Demographic factors. Demographic factors also relate to burnout, particularly age and gender of the worker. Younger workers, particularly those with less experience in the field, tend to have higher burnout rates than those who are older and/or have more experience (Maslach, Schaufeli & Leiter, 2001; Poulin & Walter, 1993; Dietzel & Coursey, 1998; Craig & Sprang, 2010; Schwartz, Tiamiyu, & Dwyer, 2007). Dietzel and Coursey (1998) propose that this effect is due to the older staff gaining life and work experience, thus becoming more skilled and able to cope with stress. However, they also note that low burnout among older workers may be a “survivor effect,” a bias that occurs due to older, burned-out workers leaving, resulting in those that stay appearing to be less prone to burnout. Gender of the worker also appears to affect burnout, with females experiencing more burnout than males (Geng, Li & Zhou, 2011; Lawson & Myers, 2011).

Experience. Studies have shown that increased professional experience appears to decrease burnout levels (Dietzel & Coursey, 1998; Schwartz, Tiamiyu, & Dwyer, 2007; Acker, 1999; Craig & Sprang, 2010; Maslach, Schaufeli, & Leiter, 2001, Lee et al., 2010; Sommer, 2008). However, there are more recent studies that suggest professional experience has no relation to burnout. Healy and Tyrrell (2011), for example, found *more* experienced hospital staff to find the death of a patient more stressful. Only 20 percent of

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staff nurses found a patient death to be stressful, while 52 percent of clinical nurse managers found it to be stressful. In a study of direct care workers by Lernihan and Sweeney (2010), years of experience and amount of training did not have a significant relationship in regards to burnout measures. This could be due to the fact that Lernihan and Sweeney studied hospital staff and studied a high stress environment where burnout is very common to all staff.

Amount of education. Competency development, or feeling more “sure of oneself” in a profession, generally begins with increased education and/or increased career experience. Acker (1999) found that recent graduates with less education and less work experience were more likely to consider quitting their jobs. He cites reasons such as unsatisfactory pay, more direct client interaction, less downtime, unrealistic goals/expectations for clients, and disillusionment of the profession. Sommer (2008) similarly found that trauma counselors with less than two years of experience tended to show more trauma-related symptoms themselves than those with more experience. Dietzel & Coursey (1998) state that older, more experienced staff, in contrast, “...become more skilled and [are] able to cope effectively with stress and/or they may adjust expectations concerning work...” (p. 11). Many studies, in contrast, have shown that higher levels of education are associated with higher risk for burnout (Geng, Li & Zhou, 2011; Craig & Sprang, 2010; Dietzel & Coursey, 1998). This appears to be inconsistent with general expectations. Maslach et al. (2001) suggest this may be due to greater responsibilities, higher expectations, and thus higher stress.

Methods to Decrease Burnout: Self-care and Social Support

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There are many methods to decrease burnout. These methods can include self-care, increased support, increased education and experience, and high self-confidence and self-esteem, among other factors. For this study, I will examine how self-care and social support relate to burnout levels.

Self-care. The definition of self-care, in the simplest terms, is taking care of one's self, physically, mentally, emotionally, spiritually, and professionally. Studies have shown a lack of self-care is one factor directly related to burnout (Newell & MacNeil, 2010). Barnett et al. (2007) explain that there are various stressors and challenges of counseling that other careers may not carry, such as clients who place great emotional demands on the therapist, who do not improve or may relapse, and who are suicidal or aggressive, as well as paperwork and insurance demands, being on-call, and being professionally isolated.

Social workers and counselors are aware that self-care is helpful to them. A study by Lawson & Myers (2011) showed that wellness scores for counselors are positively correlated with compassion satisfaction scores and negatively correlated with burnout. A qualitative study of six therapists asked about why they use self-care practices They stated if they do not take care of themselves, they may be at risk of (emotionally) harming their clients. They stated that self-care is “renewing” and allows them “to be more present” in their relationships (Harrison & Westwood, 2009). A study comprised of 155 therapists regarding self-care found that many of the respondents used one or more forms of self-care. Seventy-five percent reported regular exercise, 50% used meditation/prayer, and 80% either used pleasure reading, vacations, hobbies, or artistic pursuits as self-care methods (Mahoney, 1997). Richards, Campenni, and Muse-Burke

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(2010) found self-care frequency and perceived self-care importance to be positively correlated, as well as both components being positively correlated with well-being and health.

Social support. Another method to decrease burnout is receiving support from others. A study by Himle & Jayaratne (1991) defined four types of support: emotional (friendship/rapport with co-workers), approval (from co-workers and management), instrumental (help with difficult tasks/issues), and informational (give information you need/desire). They found instrumental and informational support “buffered” burnout scores. Davis-Sacks, Jayaratne, and Chess (1985) found social support to be associated with lower stress levels, higher sense of personal accomplishment and higher self-esteem. Acker (1999) similarly found workplace support to be associated with higher job satisfaction and lower emotional exhaustion when working with clients with serious mental illness. Koeske and Koeske (1989) found spousal support and co-worker support to have a buffering effect on high workload and high burnout. Other studies found similar results (Eastwood & Ecklund, 2008; Gray-Stanley & Muramatsu, 2011; Baker, O’Brien & Salahuddin, 2007). A study examined 123 domestic violence shelter workers, which many would define as a high stress environment with potential for high burnout. Surprisingly, these workers reported low to moderate levels of emotional exhaustion, low levels of depersonalization, and high levels of personal accomplishment (Baker, O’Brien & Salahuddin, 2007). To be precise, only .8 % met criteria for “high burnout.” Participants were found to have high levels of social, instrumental, and emotional support, which have been found to decrease burnout (Himle & Jayaratne, 1991; Eastwood & Ecklund, 2008; Acker, 1991; Koeske & Koeske, 1989).

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In summary, there are many factors which affect burnout. Some of these factors can be controlled, while some cannot. Certain professions, including human service professions like social work, tend to have higher burnout. High demand environments also tend to have higher burnout scores in both direct care staff and social workers. There are also many characteristics, such as personality factors, demographic factors, and level of experience and/or education that impact burnout. Certain methods have been shown to decrease burnout, such as type of setting, increased age and experience, and the use of self-care and social support. There is currently insufficient research regarding direct care staff burnout levels. This study will examine whether self-care and social support decrease burnout levels of direct care staff and social workers.

Conceptual Framework

Some theories that apply to this research project include the transactional analysis theory and the ecological/systems theory. Transactional analysis theory “emphasizes the ritualistic transactions of interactions and behaviors that occur between individuals” (Szirony, 2008). It focuses on social interaction, emotional well-being, and responsibility and involves the concept of “life scripts” that people develop based upon early childhood experiences. Transactions can be defined as “communicative exchanges between people” (Szirony, 2008). One basic example of a transaction that uses a life script is the interaction between a grocery store cashier and a customer. Most people know what “script” to use with a cashier and how to act in that situation. Transactional analysis theory relates to this research project in that social workers may have certain scripts they use with clients. For example, there is a common script that most social workers would use when meeting a new client. It might go like this:

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Social worker:	Client
<i>Smile, act friendly and welcoming</i>	<i>Try to be polite, happy</i>
<i>Greet the client, introduce yourself</i>	<i>Introduce self, be friendly</i>
<i>Tell client what will be occurring in counseling</i>	<i>Listen to social worker, act interested</i>
<i>Ask client for information</i>	<i>Answer questions, stay somewhat guarded</i>

However, what might happen when a social worker is experiencing high burnout? Do they continue with the same script and cover up their problems? If they are unable to cover up their problems, how would that script look? If a social worker begins a transaction negatively, imagine how the client might react. Let's look at the scenario of meeting a new client again:

Social worker:	Client:
<i>Do not smile, appear agitated or tired</i>	<i>Becomes angry</i>
<i>Greet the client, and say "I'm the social worker."</i>	<i>Believes worker doesn't care</i>
<i>Start right in with counseling</i>	<i>Becomes confused, wants to leave</i>
<i>Don't ask if client has questions; don't seem interested</i>	<i>Looks into choosing a different counselor</i>

In summary, the way social workers act affects their clients. However, social worker burnout also affects other co-workers and may decrease agency morale and productivity. A social worker that does not enjoy his/her job may complain to a co-worker, who may agree with the social worker and decide they also dislike their job. If each of these people goes to another and the trend continues, eventually, there is very low

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morale and few people are satisfied with their job. Low job satisfaction can lead to decreased desire to help clients, thus clients may leave and the agency may lose money.

Social workers must practice self-care and use other strategies to decrease burnout so they can be helpful with their clients and also helpful and supportive to their colleagues. Whereas the transactional theory focuses on interactions between two or more people, the ecological theory more so focuses on interactions between a person or group and their environment.

The ecological theory looks at “the dynamic and reciprocal interaction between organisms and their multiple environments” (Hoffman et al., 2008). It looks at how people and other organisms adapt to their lives and how their adaptations help shape the contexts of their lives. The systems theory is very similar and one might say the ecological theory is a sub-section of the systems theory. The systems theory focuses on “human behavior as the outcome of reciprocal interactions between people and their environments, focusing on the interconnectedness of all life” (Hoffman et al., 2008). Burnout can often spread quickly throughout a agency, even if it just begins with one or two burned-out employees. Because others desire to be liked and part of the in-group, burnout levels can increase throughout a agency if a growing number of employees become burned-out.

How might a burned out social worker affect his/her co-workers? It might look like this:

Social worker complains to co-workers about their job → co-worker joins in and decides they dislike their job, increases their burn-out level → morale goes down → management notices morale is low, tries to encourage team-building → employees complain that management doesn't understand and continue to dislike job

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As you might notice in the above illustration, even if management tries to decrease burnout, the lower level workers may feel that management does not understand they are burned-out. If workers are in a “high stress” setting due to client factors or nature of the setting (for example, clients with severe or persistent mental illness or residential setting), there is potential for high burnout regardless of other mediating factors.

How might a burned-out social worker affect his/her clients? Here is an example:

Social worker is emotionally exhausted and depersonalizes the client → therapeutic relationship breaks down, client begins to dislike therapy → because of client's disinterest, client's depression problems increase → client's increased depression affects his family and his job → increased family problems and increased problems at work → client becomes very depressed and feels low social support → client quits job, cannot support family → client is overwhelmed, quits therapy

As social workers, we must remember our clients come first. One of the Social Work ethics, according to the NASW Code of Ethics, is the ethic of “Commitment to Clients.” This ethic states, “Social workers’ primary responsibility is to promote the well-being of clients. In general, clients’ interests are primary” (NASW, 1996, p. 7). Thus, we must take care of ourselves so we can appropriately help our clients and not damage them emotionally or otherwise. Though most social workers may be aware that burnout affects others besides themselves, they may not be aware how much one change can affect so many other people and groups.

Both the transactional theory and the ecological theory can explain how burned-out social workers, even if they quit their job, can affect the clients, their co-workers, and other parts of the system, whether they intend to or not.

Methods

Design

The study was a cross-sectional design utilizing a composite survey which included a demographic survey, the Professional Quality of Life scale: Version 5, Burnout Scale (ProQOL V; Stamm, 2009), a Self-Care Assessment, which was modified by the author (Saakvitne, Pearlman, and TSI staff, 1996), and the Medical Outcomes Study- Social Support Survey (Hays, 1994). Please see Appendix A for a sample of the survey.

Demographics Questionnaire. The Demographics Questionnaire consisted of six questions to provide demographic, educational, and limited career information of participants. The items included age, gender, degree, degree level, time in human services, and type of setting of job.

Pro-QOL V. The Professional Quality of Life scale (Pro-QOL V) is a 30 item survey that was designed to measure participants' responses on three scales: compassion satisfaction/compassion fatigue, burnout, and secondary traumatic stress. Items are statements regarding self-perceptions, beliefs regarding helping work, reactions to helping work, and experiences of trauma due to their helping work. Participants were asked to rate how frequently each item has been experienced in the last 30 days based on a 5 point Likert scale, with 1 being "never" and 5 being "very often."

Each scale was comprised of 10 questions from the survey. For the purpose of studying exclusively burnout, the researcher only used the questions from the burnout scale. Burnout was defined as feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. The scale was scored and measured as low,

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average, or high in regards to quality of life; the higher the quality of life, the lower the burnout. High scores on the burnout scale indicated high quality of life, or low burnout.

The Pro-QOL V has high reliability and validity. There is good construct validity with over 200 published papers on the scale and its efficacy. Of the 100 published research papers on compassion fatigue, secondary traumatic stress and vicarious traumatization, nearly half have utilized the Pro-QOL or one of its earlier versions. The Burnout Scale has an alpha scale reliability of .75. The inter-scale correlations with the Compassion Fatigue/ Compassion Satisfaction scale show 2% shared variance ($r = -.23$; $\text{co-}\sigma = 5\%$; $n = 1187$) with Secondary Traumatic Stress and 5% shared variance ($r = -.14$; $\text{co-}\sigma = 2\%$; $n = 1187$) with Burnout. The shared variance between Burnout and Secondary Trauma is 34% ($r = .58$; $\text{co-}\sigma = 34\%$; $n = 1187$). The scales both measure negative affect but are clearly different; the burnout scale does not address fear. (Stamm, 2009; Stamm, 2010).

Self-Care Assessment Survey. This assessment tool was originally developed by Saakvitne and Pearlman and consisted of approximately 75 items in five different scales: physical self-care, psychological self-care, emotional self-care, spiritual self-care, workplace self-care, and balance in life. Each scale consisted of 10-15 items, with the exception of the balance scale, which contains two items. Items were measured on a 5 point Likert scale, with 1 being “not at all” and 5 being “very often/almost always.” This author modified the scale by asking participants to rate how often they utilized any kind of self-care on each scale and asking for only one rating per scale, using a Likert format. For example, “how often is physical self-care used, such as exercise, healthy eating, etc?” This author modified the Self-care Assessment Survey to contain only five questions,

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once in each self-care category, and also deleted the “balance” scale. The author could not find any research or literature regarding the validity or reliability of this survey (Saakvitne, Pearlman, & Staff of TSI/CAAP, 1996).

Medical Outcomes Study- Social Support Survey (MOS-SSS). The Medical Outcomes Study-Social Support Survey was a 19 item survey originally developed to examine support systems of patients with chronic conditions, age 18 and older. It consists of four scales: Emotional/ Informational Support, Tangible Support, Affectionate Support, and Positive Social Interactions Support, plus one additional question regarding help with problems. Emotional/informational support was defined as having others to listen and give advice. Tangible support was defined as having others to physically assist you if you are unable. Affectionate support was defined as having others to show you love and affection. Positive Social Interactions was defined as having others to enjoy activities with and spend time with. Each scale had between 3 to 8 items. Items were rated on a 5 point Likert scale, with 1 being “none of the time” and 5 being “all of the time.” All support measures had alpha scale reliabilities greater than .91 and tended to remain stable over time. The author modified this scale to apply to those who are not physically ill or injured by deleting the Tangible Support scale and the additional item at the end of the survey (Hays, 1994).

Sample

The sample for this study was social workers and direct care staff in a metro area in Minnesota working in either a residential or non-residential setting with adult mental health. Facilities were selected through convenience sampling. Five agencies were contacted to complete this survey, but only two agencies agreed to participate. From the

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two agencies, thirty-three participants completed this survey. Four surveys were eliminated due to insufficient data. Of the final twenty-nine surveys, approximately 41% of participants identified themselves as social workers (n=12), while approximately 59% defined themselves as non- social workers, or “direct care workers” (n=17).

Protection of Participants

Several measures were taken to protect the confidentiality and integrity of participants. Managers of each agency were first called and given an explanation of the survey, and if they agreed to have workers participate, a link to the survey was provided and a member of the agency emailed this link to all employees. A consent letter was provided online before the employee began the survey. The consent letter detailed the rationale, benefits, risks, and voluntary nature of the study. Participants were told their responses would not be associated with them or their facility. Participants were also informed that their consent to participate or not participate would not affect their employment. Additionally, they were informed their answers would not be provided to management of the company, thus answers would not affect their employment. Surveys did not request identifying information of participants and there was no way for the researcher to know which participants were from a certain company. Participants were provided with contact information for the researcher and research advisor, as well as the St. Thomas IRB Board information, to ask questions or voice concerns. Please see Appendix B for a sample of the consent form.

Data Collection

Data was compiled using Qualtrix and then input through Minitab. A sample of 33 participants was obtained through two social service agencies. Four surveys were

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rejected due to insufficient data. Five agencies were contacted but three refused to participate. The researcher completed data entry and coding for each survey. Data from each survey was entered into an Excel spreadsheet and then entered into Minitab. Each survey received three summation scores as data was received: a burnout scale score, a social support scale score, and a self-care scale score. All data was stored on the researcher's computer and was password-protected.

Data Analysis

After compiling data, statistical analyses were conducted to determine the relationships between each variable. Independent variables were social support summation scores, self-care summation scores, gender, age, setting, human services experience, degree held, and position (social worker or not). The dependent variable was burnout summation scores. Statistics were measured using descriptive statistics and inferential statistics.

Descriptive statistics. The demographic variables such as gender, degree held, experience, age, and position (social worker or not) were taken from the questions in the demographic questionnaire at the beginning of the survey. Please refer to Appendix A in regards to the questions and possible answers. Frequency tests were run and results were depicted using a bar chart for gender, degree held, and position. Measures of central tendency were run for experience and age, and were depicted using a histogram.

The researcher also created scale scores, including the Pro-QOL burnout score, MOS-SSS social support summation scale, and the self-care scale score. Scale scores from the Pro-QOL and MOS-SSS used Likert scales from 1 to 5, with 1 being "never" or "none of the time" and 5 being "very often" or "all of the time." Scores on the Pro-QOL

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could range from 10 (high burnout) to 50 (low burnout). For the purpose of this study, scores from 10-21 were seen as high burnout, from 22-33 as medium burnout, and from 34-50 as low burnout. Scores on the MOS-SSS could range from 12 (low social support) to 60 (good social support). Scores on the self-care scale could range from 5 (low self-care) to 25 (very good self-care).

Inferential statistics. The researcher looked at whether the demographic variables such as age, years of experience, degree held, gender, or position (social work or direct care), affected burnout. Additionally, the research examined whether social support or self-care affected burnout. To examine how the demographic variables (independent variables) affected burnout (dependent variable), the researcher examined each demographic variable in relation to the burnout scale score. Relationships were measured by examining the individual variable and the burnout score.

For age, the research question was “Is there a relationship between age and burnout?” The hypothesis was that there is a relationship between age and burnout. The null hypothesis was that there is no relationship between age and burnout. Data was analyzed using correlation tests and findings were displayed using a scatterplot.

For years of experience, the research question was “Is there a relationship between experience and burnout?” The hypothesis was that there is a relationship between experience and burnout. The null hypothesis was that there is no relationship between age and burnout. Data was analyzed using a correlation test and findings were displayed using a scatterplot.

For degree held, the research question was “As degree level increases, does burnout decrease?” The hypothesis was that as degree level increased, burnout would

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decrease. The null hypothesis was that as degree level increased, burnout would not decrease. Data was analyzed using an Analysis of Variance (ANOVA).

For gender, the research question was “Which gender has higher burnout rates?” The hypothesis was that females would have higher burnout rates than males. The null hypothesis was females will not have higher burnout rates than males. Data was analyzed using a two-tailed t-test.

For position (social workers or direct care workers), the research question was, “Is there a difference in burnout levels between social workers and direct care workers?” The hypothesis was that there is a difference in burnout rates between the two groups. The null hypothesis was that there is no difference in burnout rates between the two groups. The researcher used a two-tail t-test to measure each group’s level of burnout.

The researcher also looked at whether social support and/or self-care affected burnout scores. Social support was defined using the MOS-SSS scale score. Self-care was defined using the self-care scale score. Burnout was defined with the Pro-QOL burnout scale score.

There were two research questions. The first research question was “Is there a relationship between social support and burnout?” The hypothesis was that there is a relationship between social support and burnout. The null hypothesis was that there is no relationship between social support and burnout. Data was analyzed using a correlation test and results were displayed in a scatterplot.

The second research question was “Is there a relationship between self-care and burnout?” The hypothesis was that there is a relationship between self-care and burnout.

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The null hypothesis was that there is no relationship between self-care and burnout. Data was analyzed using a correlation test and results were displayed in a scatterplot.

Strengths and Limitations

Strengths of this study included use of various settings, both residential and non-residential. Participants also widely varied in age, education, and experience. Another strength was the use two different agencies, which provided a broad range of employees and added some diversity to the sample. The Pro-QOL survey also had high validity and reliability in research. The survey also had roughly equal amounts of social workers and direct care workers, which made data easier to compare.

Limitations of this study included the use of convenience sampling. There was also a large majority of females, which may be representative of the human services population, but not representative of the population as a whole. The surveys that were used modified the scales introduced by the original researchers, which may affect the validity of the results. There was also limited generalizability due to a smaller sample size and the use of convenience sampling as opposed to random sampling. Some of the surveys, such as the Self-Care Assessment and the Social Support Scale, were not empirically tested for validity and reliability.

Findings

Descriptive Statistics

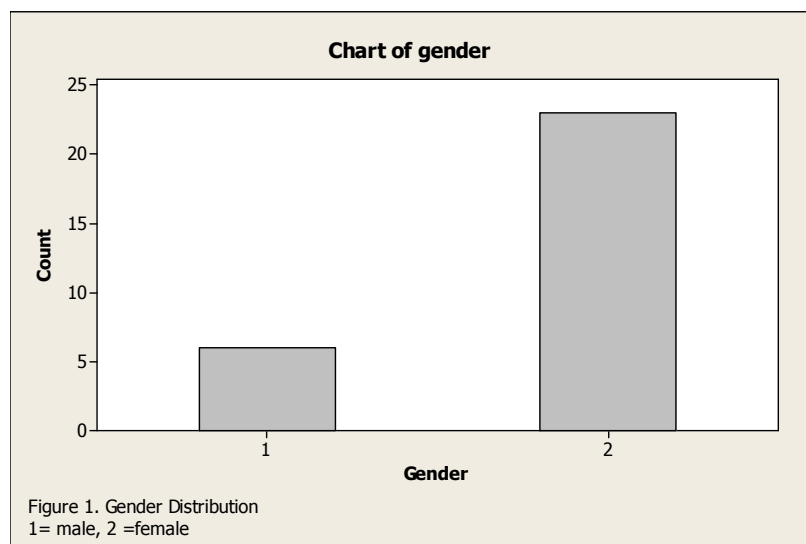
The researcher examined gender, degree held, and position and illustrated the findings through the use of frequency counts and bar graphs. The researcher examined experience level through measures of central tendency and a histogram.

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Regarding gender, as illustrated by Table 1, approximately 20% of participants were male (n=6), while approximately 80% of participants were female (n=23). As shown by Figure 1, the large majority of participants were female.

Table 1-Frequency Count: Gender Distribution

Gender	Count	Total Ct	Percent	Total %
Male	6	6	20.69	20.69
Female	23	29	79.31	100.00
N= 29				

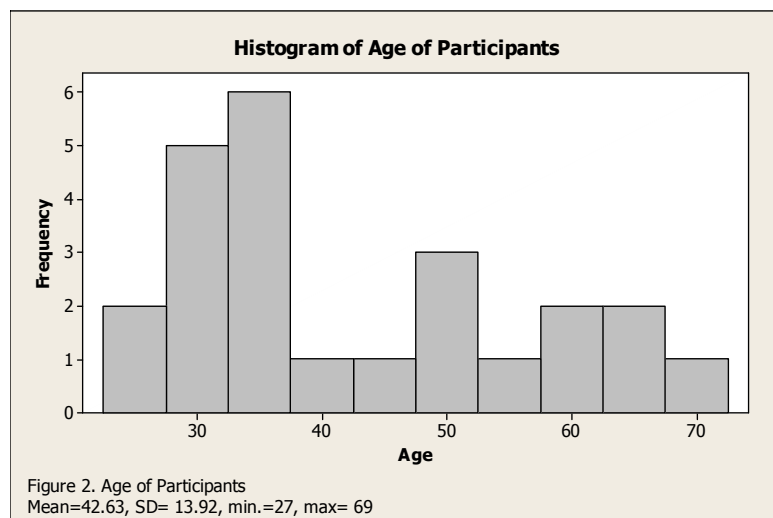


The researcher ran measures of central tendency for age, as illustrated by Table 2. The average age was approximately 42 years old, and age ranged from 27-69 years of age. Additionally, five participants did not give an answer regarding their age (n=24). As illustrated by Figure 2, it was most common for participants to be between 30-40 years of age.

Table 2: Measures of Central Tendency- Age

Variable	N	N*	Mean	SE Mean	StDev	Minimum	Q1	Median	Q3	Maximum
Age	24	5	42.63	2.84	13.92	27.00	30.25	37.00	55.50	69.00

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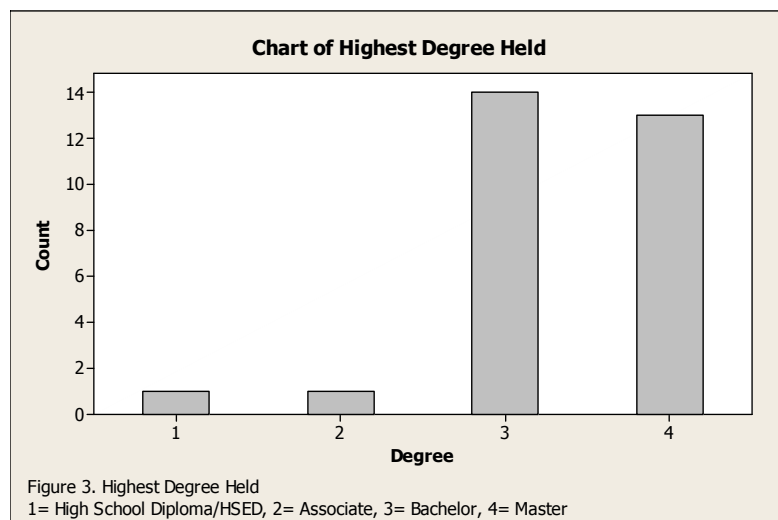


The researcher next examined what degree was held by participants. As illustrated by Table 3, most participants had either a Bachelor level or a Master level degree, with approximately 48% (n=14) possessing a Bachelor degree and approximately 44% (n=13) possessing a Master degree. Additionally, one participant held a high school degree and one held an Associate degree. Figure 3 also shows that most participants had a Bachelor or Master level degree.

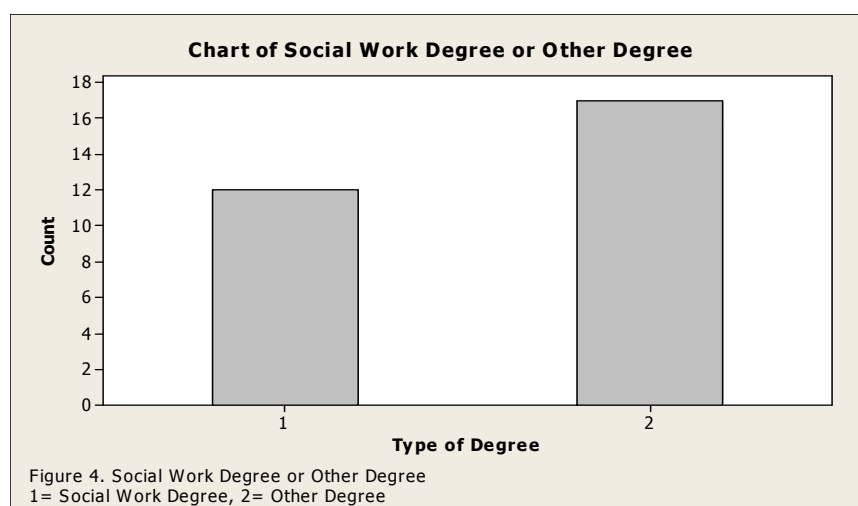
Table 3- Frequency Count: Highest degree held by participants

Type	Count	Total Ct	Percent	Total %
High School	1	1	3.45	3.45
Associate	1	2	3.45	6.90
Bachelor	14	16	48.28	55.17
Master	13	29	44.83	100.00
N=	29			

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Regarding the participant's position within the company, the researcher examined how many participants were social workers and how many held other positions. As shown by Figure 4, twelve participants held a social work degree and seventeen held a different degree.



The researcher ran measures of central tendency regarding human service experience, in years, of participants. As illustrated by Table 4, the average experience level was 12.81 years and the median level was 9.0 years. Experience level varied from 0 years (no experience) to 42 years. As illustrated by Figure 5, most participants (n=20) answered that they had between 5-10 years of experience.

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Table 4- Measures of Central Tendency: Human Service Experience (in years)

Variable	Mean	SE Mean	StDev	Minimum	Q1	Median	Q3	Maximum
Experience	12.81	2.04	10.98	0.00	5.50	9.00	16.00	42.00

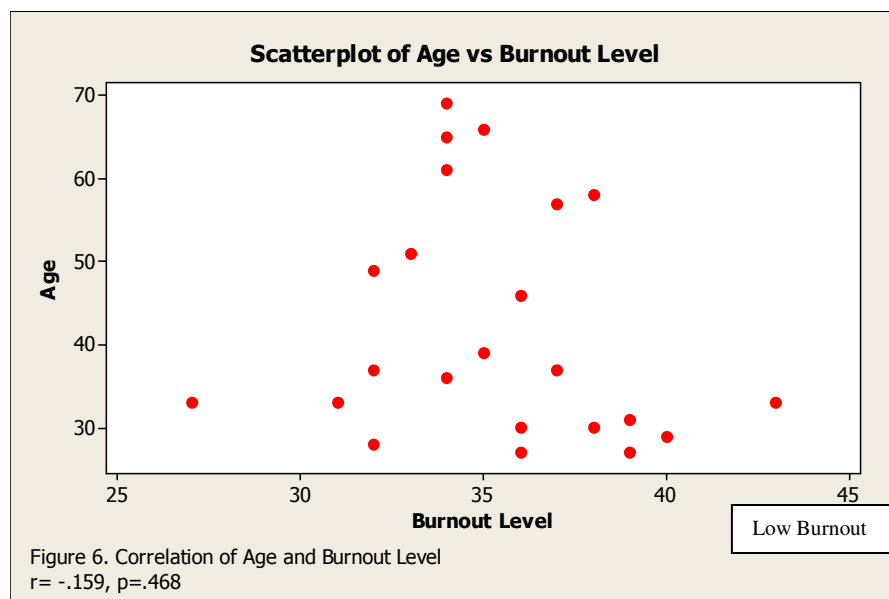
**Inferential Statistics**

As illustrated by Table 5 below, age and burnout had a weak negative relationship that was not statistically significant ($r=-.159$, $p=.468$). Therefore, this researcher fails to reject the null hypothesis, indicating there is no relationship between age and burnout level. As indicated in Figure 6, many points are scattered throughout the scatterplot, indicating that there is not a strong relationship.

Table 5- Correlations: age and burnout

Pearson correlation = -0.159
P-Value = 0.468

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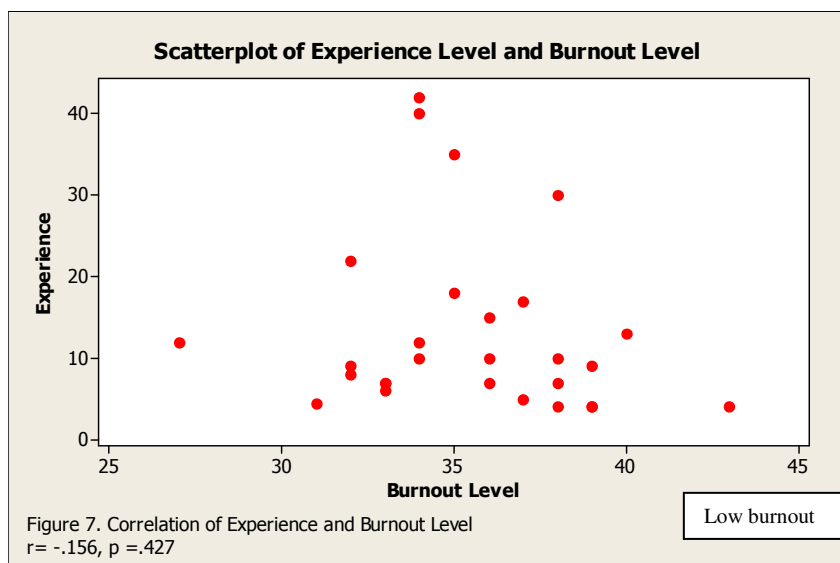


As illustrated by Table 6 below, amount of experience and low burnout level had a very weak positive relationship that was not statistically significant ($r = .156$, $p = .427$). Therefore, the researcher fails to reject the null hypothesis, indicating there is no relationship between amount of experience and burnout level. As indicated by Figure 7, the scores on the scatterplot vary greatly and do not appear to have any consistent pattern, showing that there is not a strong relationship between the two variables.

Table 6- Correlations: Amount of Experience and low burnout

Pearson correlation = -0.156
 P-Value = 0.427

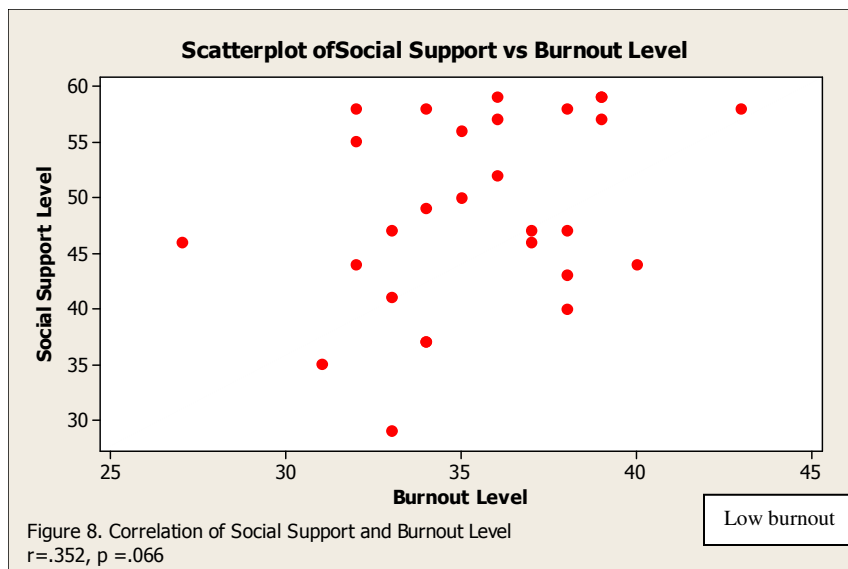
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As illustrated by Table 7 below, social support and burnout level had a weak positive correlation that was not statistically significant. ($r = .352$, $p = .066$). Thus, the researcher fails to reject the null hypothesis, indicating there is not a relationship between social support and low burnout levels. As illustrated by Figure 8, the points are variable and do not appear to form in a pattern.

Table 7- Correlations: Social Support and Low Burnout Level

Pearson correlation = 0.352
 P-Value = 0.066

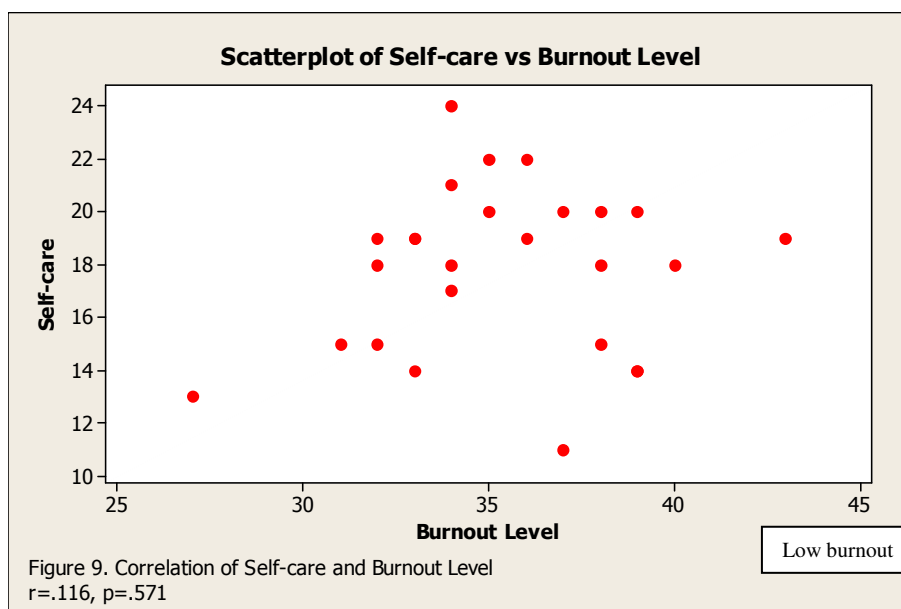


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As illustrated by Table 8 below, self-care and burnout had a weak positive correlation that was not statistically significant ($r=.116$, $p=.571$). The researcher fails to reject the null hypothesis, which indicates that there is no relationship between self-care and low burnout levels. As illustrated by Figure 9, the data points vary and do not form a specific pattern.

Table 8: Correlations: Self-care & low burnout level

Pearson correlation = 0.116
P-Value = 0.571



As illustrated in Table 9 below, the researcher completed a two-sample two test regarding gender of participant and burnout level. The average burnout score for males was 34.33, while the average burnout score for females was 35.77, a difference of 1.44, which indicates very similar scores among the two groups. Both groups had low burnout scores, as low burnout is defined as a score between 34 and 50, with males having slightly higher burnout scores. However, the p value was not statistically significant

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($p=.227$). Therefore the researcher fails to reject the null, indicating that there is no difference between males and females regarding their burnout levels.

Table 9: Two-Sample T-Test : Gender and Burnout

Two-sample T for burnout level & gender

gender	N	Mean	StDev	SE Mean
male	6	34.33	2.07	0.84
female	22	35.77	3.58	0.76

Difference = mu (1) - mu (2)

Estimate for difference: -1.44

95% CI for difference: (-3.88, 1.00)

T-Test of difference = 0 (vs not =): T-Value = -1.26 P-Value = 0.227 DF = 14

As illustrated by Table 10 below, regarding burnout levels among social workers and non- social workers, the findings were also not statistically significant ($p=.442$). The mean of each group was very similar, with an average burnout score for social workers of 36.08, and an average burnout score for non- social workers being 35.00, a difference of 1.08 points. Both groups had low burnout scores, as low burnout is defined as scores between 34 to 50. Therefore, the researcher fails to reject the null hypothesis, indicating that there is no difference in burnout levels among social workers and direct care workers.

Table 10: Two-Sample T-Test : Burnout of Social Workers vs. Non- Social Workers

Two-sample T for burnout and type of worker

	N	Mean	StDev	SE Mean
sw	12	36.08	4.21	1.2
non-sw	16	35.00	2.56	0.64

Difference = mu (QOL sw) - mu (QOL n-sw)

Estimate for difference: 1.08

95% CI for difference: (-1.83, 3.99)

T-Test of difference = 0 (vs not =): T-Value = 0.79 P-Value = 0.442 DF = 16

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Lastly, the researcher looked at the effect of degree held and burnout level. As illustrated by the ANOVA in Table 11 below, the findings are not statistically significant ($p=.485$). Therefore, the researcher fails to reject the null hypothesis, indicating there is no difference in burnout levels among the various levels of degree held. However, it should be noted that those with lower degrees tended to have slightly higher burnout scores, with those with a high school degree having a score on average of 33 points (medium burnout) and those with Bachelor's and Master's degrees having scores of 35 or above (low burnout).

Table 11: One-way ANOVA: Burnout vs Degree Held

Source	DF	SS	MS	F	P
degree	3	28.6	9.5	0.84	0.485
Error	24	272.3	11.3		
Total	27	301.0			

S = 3.369 R-Sq = 9.51% R-Sq(adj) = 0.00%

Level	N	Mean	StDev	Individual 95% CIs For Mean Based on Pooled StDev
HS	1	33.000	*	(-----*-----)
Assoc	1	31.000	*	(-----*-----)
Bachelor	14	35.571	3.524	(----*----)
Master	12	35.917	3.175	(----*----)

+-----+-----+-----+-----+
24.0 28.0 32.0 36.0

Pooled StDev = 3.369

Discussion

This research paper examined the effect of several demographic variables, as well as measures of social support and self-care, on the effect of burnout. The findings were not statistically significant on all variables measured. This was incongruent with what the previous research had suggested. The researcher believes this is largely due to the small

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sample size for the study and the use of a convenience sample which may not be an accurate reflection of the population studied.

Age. The researcher found that age did not appear to have an effect on burnout. This is contrary to what was concluded by several researchers, all of whom stated that younger workers tend to have higher burnout rates (Maslach, Schaufeli & Leiter, 2001; Poulin & Walter, 1993; Dietzel & Coursey, 1998; Craig & Sprang, 2010; Schwartz, Tiamiyu, & Dwyer, 2007). This difference could be attributed to the small sample size, as well as a large majority of participants being within the age range of 30-40, with few participants at either end of the younger or older spectrum.

Experience. This study also found that experience did not appear to have an effect on burnout. This matched some of the most recent research. For example, Healy and Tyrrell (2011), as well as Lernihan and Sweeney (2010), suggested that experience appears to have no effect on burnout. However, earlier research suggested that those with less experience tend to have higher burnout rates (Dietzel & Coursey, 1998; Schwartz, Tiamiyu & Dwyer, 2007; Acker, 1999; Craig & Sprang, 2010; Maslach, Schaufeli & Leiter, 2001; Lee et al, 2010; Sommer, 2008). It should be noted that the newer research of Healy and Tyrrell (2011) and Lernihan and Sweeney (2010) found different findings, which may suggest that findings regarding experience and burnout are changing and moving toward the belief that there is no correlation between the variables, possibly due to the inability to account for numerous extraneous job factors.

Gender. This study also found that gender did not appear to have an effect on burnout. This conflicted with previous findings, which suggested that females tend to have higher burnout rates (Geng, Li & Zhou, 2011; Lawson & Myers, 2011). This

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conflicted finding may be due to the large amount of female participants, which is to be expected in human service agencies. It should be noted that males had slightly higher burnout scores, though this was not shown to be statistically significant. Future research should attempt to equalize the amount of male and female participants.

Level of degree. This study found that level of degree did not appear to have an effect on burnout. Previous research had come to varying conclusions regarding level of degree and burnout. For example, many researchers had found that those with less education were more likely to experience burnout, while those with more education were more likely to be able to cope effectively and thus experience less burnout (Acker, 1999; Sommer, 2008; Dietzel & Coursey, 1998). However, other studies have concluded that higher education leads to higher responsibilities and thus higher stress and burnout rates (Geng, Li & Zhou, 2011; Craig & Sprang, 2010; Maslach et al, 2001). It is possible that the current study was unable to find a correlation between the variables due to a large amount of participants with Bachelor and Master degrees, but few participants with lesser degrees. It should be noted that those with lower degrees tended to have slightly higher burnout scores than those with a Bachelor's degree or above (33 points versus 35 points respectively).

Type of work. This study also found that there does not appear to be a difference in level of burnout between social workers and direct care workers. In this study, it appeared that both groups had low burnout rates of 35 points or above. There appears to be very little previous research regarding burnout rates of those with less education and less experience, typically direct care workers. However, research can be found regarding those with less education or less experience which does not mention burnout rates.

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Additional research is needed regarding burnout rates in other professions, particularly professions in which others work with clients with mental health issues (Dietzel & Coursey, 1998; Schwartz, Tiarniyu & Dwyer, 2007; Acker, 1999; Craig & Sprang, 2010; Maslach, Schaufeli & Leiter, 2001; Lee et al, 2010; Sommer, 2008; Geng, Li & Zhou, 2011; Healy & Tyrrell, 2011; Lernihan & Sweeney, 2010).

Social support. This study also found that there was no correlation between social support and burnout levels. This differed from previous findings, which stated social support has a large effect on lower burnout levels in the workplace (Himle & Jayaratne, 1991; Davis-Sacks, Jayaratne, & Chess, 1985; Acker, 1999; Koeske & Koeske, 1989; Eastwood & Ecklund, 2008; Gray-Stanley & Muramatsu, 2011; Baker, O'Brien & Salahuddin, 2007). It is possible that social support and team-building was not promoted in the two agencies studied or that other factors affected burnout rates.

Self-care. This study also showed that self-care appeared to have no effect on burnout rates. This differed from previous findings, which stated self-care decreased one's burnout level (Lawson & Myers, 2011; Harrison & Westwood, 2009; Mahoney, 1997; Richards, Campenni & Muse-Burke, 2010). Various studies have shown that therapists and social workers are aware that self-care is important and they make sure to use self-care practices to decrease or prevent burnout (Lawson & Myers, 2011; Harrison & Westwood, 2009; Richards, Campenni, Muse-Burke, 2010). As previously mentioned, burnout may have been affected by other factors not studied.

This researcher believes other factors than those researched may affect burnout also. These factors might include mezzo and macro factors, such as negative work environment, poor support or supervision from management, pressure for funding, the

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perception that “billable hours” are more important than quality work, lack of agency resources available, and so on.

Conclusion

In conclusion, the findings were inconclusive regarding the effects of age, experience, gender, level of degree, type of degree (social work or non), social support and self-care on burnout rates. Future research is needed in several areas regarding burnout and possible mediating factors. This study also showed that burnout continues to need to be examined in regards to how it affects social work practice.

Implications for Future research

Need for continued research. Further research is needed regarding burnout and the variables affecting it. This study was incongruent with various findings regarding the effects of numerous variables on burnout, possibly due to a small sample size and the use of convenience sampling. Future research should examine the effect of these factors on burnout with the use of a larger sample size and with various agencies to examine if results are similar to the current findings. Future research should also examine whether mezzo and macro factors additionally affect burnout.

Further research is also needed regarding “direct care” workers’ or line workers’ burnout rates. This researcher was unable to find a large amount of studies discussing the burnout rates of this group. Previous research had found that direct care workers and/or those with less education and experience tend to have higher burnout rates, but this study was unable to replicate the results.

Implications for Future Research

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Previous research has found that social support and self-care mitigate burnout rates, and that burnout can be affected by various demographic and personal characteristics of participants. This study was unable to replicate former research results. Thus, future research is needed to examine what social or personal factors affect burnout rates in an effort to reduce burnout rates of all workers in various positions. Additionally, research should focus on whether agencies that allow and encourage vacation time for their employees, as well as promote relaxation retreats and regular exercise, tend to have employees with lower burnout rates.

Additionally, this study did not examine burnout in other professions such as hospitals, law enforcement, home care workers, child protection workers, and others. Social work researchers should continue to examine burnout in other professions to find additional professional factors that contribute to burnout. This is particularly important in multi-disciplinary agencies or in agencies where the social worker is in a host setting.

Implications for Future Practice

For management. Though this study was unable to show the effects of social support and self-care on burnout, previous research is clear that both factors can decrease burnout. Therefore, social work and mental health management staff should examine how they can best support their staff in the areas of self-care and social support. Regarding social support, as Himle and Jayaratne (1991) mentioned, this might include attempting to provide the four common types of support within the work setting: emotional, approval, instrumental, and informational. Regarding self-care, management should check in with their employees regarding self-care practices and attempt to promote emotional, physical, and psychological wellness within the workplace.

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Additionally, all management should focus on burnout levels of their staff, as those with less education or experience may be more burned-out than those with more education (such as social workers

For staff. Social workers should focus on self-care practices frequently, as studies have shown that this reduces burnout. Social workers should also seek support in the workplace, whether through other colleagues or through management. A supervision group or consultation group may be beneficial to decrease burnout levels. Social workers should also seek support outside of work, in the form of supportive friends and family members and fellow social workers. It is the responsibility of all social workers to be appropriate models of those with low burnout and as social workers, we must learn how to achieve this goal through practices including but not limited to self-care, social support, and continuing education, and appropriate supervision or consultation. Social workers within multidisciplinary agencies or with agencies with staff with varied education or experience should discuss and promote self-care and encourage social support of all staff.

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Appendix A: Survey

1. **Gender:** male female transgender prefer not to answer
2. **Age** _____
3. **Do you have a degree in Social Work?** yes no
4. **What is the highest degree (any concentration) you hold?**
 High School Diploma/HSED Associate's Bachelor Master's Ph.D.
5. **Amount of time in human services, including previous human service work (in years)** _____
6. **Do you currently work in:**
 residential setting (clients reside at setting 24 hours per day)
 non-residential (clients do not reside at setting)

In the last 30 days, how often have you felt the following? Please place an “x” in the box you choose.

Pro-QOL burnout scale- Version 5	1=never	2=rarely	3=sometimes	4=often	5=very often
1. I am happy.					
2. I feel connected to others.					
3. I am not productive at work because I am losing sleep over traumatic experiences of clients.					
4. I feel trapped in my job					
5. I have beliefs that sustain me.					
6. I am the person I always					

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wanted to be.					
7. I feel worn out because of my work as a helper.					
8. I feel overwhelmed because my case load or workload seems endless.					
9. I feel “bogged down” by the system.					
10. I am a very caring person.					

In the last 30 days, how often has the following support been available to you if you need it? Please include support at work and support in other areas of your life. Please place an “x” in the box you choose.

Social Support Survey	None of the time	A little of the time	Some of the time	Most of the time	All the time
1. Someone you can count on to listen to you when you need to talk					
2. Someone to give you information to help you understand a situation or problem					
3. Someone to give you good advice in a crisis					
4. Someone to confide in or talk to about yourself or your problems					

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5. Someone to share your most private worries and fears with					
6. Someone who understands you					
7. Someone who shows you love and affection					
8. Someone to love and make you feel wanted					
9. Someone who hugs you					
10. Someone to have a good time with					
11. Someone to get together with for relaxation					
12. Someone to do something enjoyable with					

Self-Care Assessment

How often do you do the following? Please place a number in the blank.

Rate using the scale below:

1= not at all 2=rarely 3= sometimes 4= often 5= very often/ almost always

1. Physical Self-care _____

Examples: eat 3 meals a day, exercise, take time for fun/vacations, adequate sleep, get regular medical and dental checkups, eat healthy foods, engage in sexual activity

2. Psychological Self-care _____

Examples: self-reflection, write in a journal, say “no” to extra responsibilities, listen to your “inner voice”, have a therapist or close friend you share problems with

3. Emotional Self-care _____

Examples: Spend time family or friends, be kind to yourself, express your emotions openly (positive or negative) with self and others, seek out comforting activities and places

4. Spiritual Self-care _____

Examples: make time for prayer/ meditation, Spend time in nature, attend spiritual/religious services or gatherings, identify what is meaningful in your life, celebrate rituals, read inspirational books or listen to inspirational literature, read religious/ spiritual literature, be at peace with your body

5. Workplace/Professional Self-care _____

Examples: take time to eat lunch, chat with co-workers about non-work, set limits with clients and colleagues, attempt to balance your caseload, arrange your workspace so it is comfortable to you, get regular supervision/consultation, have a formal/informal peer support group

Appendix B: Consent Form**University of Saint Thomas****An Examination of Self-care and Social Support****Regarding Burnout Levels of Direct Care Staff and Social Workers****IRB Log # _____**

I am conducting a study about whether self-care and social support affects burnout levels of both direct care staff and social workers in various settings. I invite you to participate in this research. You were selected as a possible participant because of your position as either a direct care staff or social worker working in either a residential or non-residential setting working with adults with mental health issues.

This study is being conducted by: Tina Paskey, MSW student (researcher), with assistance from Dr. Lance Peterson, LICSW (researcher advisor). This study is being conducted in accordance with the University of Saint Thomas/ Saint Catherine University Social Work Department.

Background Information:

The purpose of this study is to examine whether direct care staff and social workers in the metro area have adequate self-care practices and adequate social support to prevent burnout in their careers and to ensure career satisfaction. This study will also investigate whether self-care and social support can mediate burnout and/or determine whether other factors such as age, education, or setting affect burnout.

Procedures:

If you agree to be in this study, I will ask you to do the following: Participants will be asked complete a short survey online, taking approximately 10-15 minutes at their place of employment. This survey will ask questions about your demographic information, setting, burnout level, self-care, and social support. Participants will be asked to complete the survey within one month of receiving the link. The survey link will be closed and unavailable after two months of receiving the link. No further information will be required from you after completing the survey.

Risks and Benefits of the Study:

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This study has one main risk, which is probing for sensitive information, including your level of burnout and level of support in your career. In an effort to minimize this risk, each survey will be taken anonymously online, without any identifying information about the participant. Responses will not affect the participant's position within his/her place of employment, and any participation in this study is entirely voluntary.

There are no direct benefits from participating in this study. No compensation will be provided.

Confidentiality:

The records of this study will be kept confidential. Any research published will not include identifying information of participants. Records created will include computer records, such as excel spreadsheets. Your name or company will not be identified in the survey or the results. Surveys will be unable to be tracked in regards to company or other identifying information. The information stored in the computer will be password-protected. Only the researcher and research advisor will have access to these records. After the completion of the project in May 2012, the information in the computer will be permanently deleted within six months.

Voluntary Nature of the Study:

Your participation in the study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your place of employment or with the University of St. Thomas/ St Catherine University. If you decide to participate, you are free to withdraw any time up to and until March 30, 2012. Should you decided to withdraw, any data collected about you will be used due to the anonymous nature of the responses. You are also free to skip or not answer any survey questions you desire.

Contact Information:

Should you have any questions or concerns about the survey or the study, you may contact me, Tina Paskey, at 651-245-0216 or my research advisor, Lance Peterson, at 651-962-5811. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with questions or concerns about this study.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. *By clicking "accept", I consent to participate in this study.* I understand I can withdraw from the research at any time before March 30, 2012. I am at least 18 years of age.

