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The Impact of Compassion Fatigue and Burnout Among Residential Care Workers on Client Care: Implications for Social Work Practice

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The Impact of Compassion Fatigue and Burnout Among Residential Care Workers
on Client Care: Implications for Social Work Practice

by

Amanda J. Hanson, B.S.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
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St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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This Clinical Research Paper is a graduation requirement for the MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The purpose of this study was to explore what factors contribute to burnout and compassion fatigue in a residential treatment setting, what factors may help to minimize risk for the development of compassion fatigue in a residential treatment setting, and how these two issues affect client care. This study utilized a mixed-methods design by sending out an online survey to two residential treatment centers serving youth with emotional and behavioral difficulties ($n = 88$). Descriptive statistics were used to identify participants compassion fatigue and burnout levels as well as better understand what symptoms of these two phenomena were most affecting participants as well as what factors they most contribute to the development of burnout and compassion fatigue. An open coding process was used on qualitative questions to better understand how burnout and compassion fatigue effect client care standards and what participants felt was needed to help mitigate burnout and compassion fatigue in their agencies. Five major themes emerged: *quality of work; organizational needs; worker-client relationship; self-care; and, organizational support and incentives*. These findings aligned with previous research, however they were able to add new information and depth to the already limited research out there on burnout and compassion fatigue in a residential treatment setting.

KEY WORDS: Burnout, Compassion Fatigue, Residential care, Residential care workers

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The Impact of Compassion Fatigue and Burnout Among Residential Care Workers on Client Care: Implications for Social Work Practice

Introduction

Residential care workers employed within residential treatment settings for youth may feel challenged in their work in these organizations for several reasons. First, residential treatment is often a last resort out-of-home placement option for adolescents who are suffering from severe emotional and behavioral problems, meaning that these children have been unsuccessful at all other previous less restrictive placements (American Association of Children's Residential Centers [AACRC], 2014). Secondly, on average, youth who enter residential treatment facilities have experienced two or more significant trauma incidents prior to entering treatment that may include experiencing parental loss; being abused physically, sexually or verbally; being raped or sexually assaulted; being neglected or homeless, and/or witnessing violence within the family (Harr, Horn-Johnson, Williams, Jones, & Riley, 2013). Moreover, past trauma coupled with multiple placement histories are two variables that contribute to challenging behaviors from youth, which can be physically, emotionally, and mentally draining for residential care workers (Calheiros & Patricio, 2014). Lastly, residential care workers often get overwhelmed with excessive responsibilities and feel that they are not given enough resources by administration to fulfill their job duties (del Valle, Lopez & Bravo, 2007). Furthermore, they often feel unsupported by co-workers and management, struggle with role ambiguity, and do not feel that they are offered enough training to do their job effectively (del Valle et al., 2007). All of these factors contribute to excessive turn-over rates, which becomes a vicious circle for care workers, youth, and organizations as a whole and perpetuates problems within the system further (del Valle et al., 2007).

Children's residential care workers—also called *mental health workers*, *direct care workers*, or *youth counselors*—are often the ones who have the most frequent contact with children in care, making their role extremely important to recovery. Most residential care workers begin employment with limited education beyond that of a high school diploma (Hodas, 2005). Although some do have higher degrees, many have little to no experience working with emotionally disturbed youth, and often receive minimal training before working directly with the youth (Hodas, 2005).

Residential care workers take on many roles in their job: they are a member of the treatment team, a role model, a counselor, and often times mimic the role of a parent to many youth. This makes role definition challenging for youth care workers as they have exhibit flexibility by providing each youth with a unique relationship that provides nurturance and acceptance, but also need to provide youth with very clear limits and boundaries (Pazaratz, 2000). Furthermore, they are expected to teach new skills through crisis situations, and effectively de-escalate and problem-solve situations without damaging their relationship or further traumatizing the youth (Pazaratz, 2000). Although many residential care workers work in this setting because they have a desire to help others who are suffering, building a therapeutic alliance and working with these adolescents daily can prove to be a very difficult task.

Challenging behavior and trauma exposure can take a toll on residential care workers as it can be exceptionally difficult for workers to separate themselves from their clients suffering, which comes at a cost to their own personal health and well-being. Although most care workers have a strong desire to help youth grow and change, the behavioral challenges of the youth as well as the emotional, psychological, and physical demands of the job can be wearing. It is imperative that these workers are better-prepared to work in this setting because the therapeutic

alliance and relationship they build with the youth in care is one of the biggest catalysts of change throughout the treatment process (Hodas, 2005). Furthermore, their beliefs, values, and attitudes all affect the quality of client care they provide for the youth in these settings.

Working long-term in residential care settings can come at a cost to the direct care workers personal health and well-being. The emotional and behavioral problems that these youth present can prove to be very physically, emotionally, and mentally draining for the workers in charge of their care. Two direct effects of working in this type of setting are burnout and compassion fatigue. *Burnout* is defined as a prolonged response to chronic emotional and interpersonal stressors on the job (Maslach et al., 2001). *Compassion fatigue*, is defined as a state of exhaustion and compilation of emotional, physiological, biological, and cognitive effects that is the result of working directly with, and empathetically engaging others who have experienced significant trauma (de Figueiredo, et al., 2014; Ray, Wong, White, & Heaslip, 2013). To date, research specific to burnout and compassion fatigue in social service professions remains mostly within the health care field, namely nurses, emergency responders, mental health professionals, and workers who provide services to clients with developmental disabilities, but there is very little research done on lower-level residential youth care workers (Ashill & Rod, 2011; Rose, Mills, Silva, & Thompson, 2013; Vassos & Nankervis, 2012). The purpose of this study is to explore what factors contribute to burnout and compassion fatigue in a residential treatment setting, what factors may help to minimize risk for the development of compassion fatigue in a residential treatment setting, and how these two issues affect client care.

Literature Review

Overview of Residential Treatment Services for Youth

A variety of rehabilitative services are offered within residential treatment centers. By definition, *residential treatment centers* are intensive, live-in facilities that offer a variety of rehabilitative services and therapy to people who are struggling with drug and/or alcohol addiction, mental health issues, and/or other related difficulties (Minnesota Department of Human Services [MDHS], 2014). Residential treatment centers that specialize in children's mental health typically provide 24-hour-a-day programming in which services are offered under the clinical supervision of a mental health professional in a community setting (MDHS, 2014). Furthermore, residential treatment centers—which aim to be one stop shop for struggling youth and their families—accept youth with varying diagnoses and degrees of psychopathology, and offer a variety of mental health services such as individual, group, and family therapy (Lakin, Leon, & Miller, 2008).

The main goal of placing youth in a residential setting is to provide intensive treatment services in order to promote long-lasting change. This is meant to prevent future placement in settings that are more intensive, costly, or restrictive than necessary and/or are inappropriate to meet the child's needs. These facilities promote wellness to the youth and their families by providing services to aid in: improvement of family living and social interaction skills; learning necessary skills to return to the community; and improve relationships within the family system by enhancing parent or caregivers abilities to care for their children with severe emotional disturbance in the home (MDHS, 2014).

The goal upon admittance to a residential program is that every youth, along with their treatment team, build a unique treatment plan that focuses on long and short-term treatment goals

based off of their individual treatment needs. Throughout this process, each youth works with a team of both clinical and non-clinical staff. The clinical staff are usually comprised of the child's individual/family therapist, social worker, psychiatrist, and mental health case worker. The non-clinical workers are the care workers who work directly with the youth in the *milieu* (the youth's everyday treatment experience and environment). The residential care workers within the milieu support the youth in their treatment by teaching self-knowledge, social skills, self-control, problem-solving, communication, and life skills (Pazaratz, 2000). Furthermore, to ensure successful outcomes and promote success outside of placement, all youth entering residential care must have a targeted discharge date with specified recipient outcomes (MDHS, 2014).

Overview of Burnout

Burnout is often an ambiguous term with many differing definitions depending on the theoretical framework one uses to view it (Maslach et al., 2001). For the purposes of this study, *burnout* is defined as a prolonged response to chronic emotional and interpersonal stressors on the job, comprised of three dimensions: exhaustion, depersonalization, and inefficacy (Maslach et al., 2001). Burnout has been a widely accepted term since the 1970's when researchers began exploring the phenomenon further so they could better define and describe it (Maslach et al., 2001). Original research on burnout was done by Herbert Freudenberger and Christina Maslach between 1975 and 1976 (Maslach et al., 2001). Freudenberger, was a psychiatrist working in an alternative health care setting, who had become interested in the phenomena due to his personal experience of the effects of emotional depletion and loss of commitment in the workplace (Maslach et al., 2001). Maslach, was a social psychologist who studied emotions, her original research focused on emotional job stress and personal coping strategies (Maslach et al., 2001).

Burnout research originated in human service and care giving professions, where the relationship between the provider and the recipient was a core component of the job (Maslach et al., 2001). The goal of the research was to heighten people's awareness of burnout, and enhance people's ability to recognize that it was not an uncommon response when working in an occupation in which you provide aid and service to people in need (Maslach et al., 2001). These interpersonal dynamics were an important aspect of emerging literature as researchers began to further explore this relationship, to distinguish specific characteristics of burnout across service professions.

Researchers have studied burnout across all different human service professions such as nursing, psychiatry, disability support workers, mental health case workers, and non-clinical health services workers (Ashill & Rod, 2010; Cieslak, et al., 2013; Li, Early, Mahrer, Klaristenfeld, & Gold, 2014; Meyer, Li, Klaristenfeld, & Gold, 2012; Ray et al., 2013; Rose et al., 2012). Five common elements emerged from research as the core symptoms of burnout: (1) a predominance of dysphoric symptom's such as mental and emotional exhaustion, fatigue, and depression; (2) there is an emphasis on mental and behavioral symptoms rather than physical ones; (3) symptoms are work-related; (4) symptoms are evident in those who have never previously suffered from psychopathology before; (5) poor work performance and decreased effectiveness arise due to negative attitudes and behaviors (Maslach et al., 2001).

There are three main dimensions of burnout that present themselves consistently throughout the literature: exhaustion, depersonalization, and reduced professional efficacy (Maslach et al., 2001). *Exhaustion* is defined as a depletion of emotional resources and is often referred to as the core dimension of burnout (Maslach et al., 2001). According to Maslach and colleagues, exhaustion is not something that is simply experienced, it also causes people to

distance themselves emotionally and cognitively from their work (2001). Clients with emotional and behavioral disorders have many needs, and meeting these individually can be very challenging for human service workers, so exhaustion is often experienced as a way to cope with the emotional overload (Maslach et al., 2001).

Cynicism, also referred to as *depersonalization*, is evident when employees begin to distance themselves from their work and display uncaring or cynical attitudes towards clients or customers (Ashill & Rod, 2011; Maslach et al., 2001). *Cynicism* decreases effectiveness, productivity, and commitment in one's work, which contributes to higher rates of absenteeism and turnover in staff, and negatively affects their ability to perform their job duties (Ashill & Rod, 2011). It is problematic for workers in the human services field because it hinders their ability to form caring and supportive relationships with their clients, which are the foundation of therapeutic work (Maslach et al, 2001). Moreover, when workers put too much distance between themselves and their clients, it adversely affects their ability to connect with their clients and meet client needs.

Inefficacy, also referred to as *inadequacy*, or feelings of reduced personal accomplishment, is the last dimension of burnout (Maslach et al., 2001). Inefficacy is often a function of exhaustion and depersonalization because they both are causal factors in one feeling ineffective in their work (Maslach et al., 2001). Furthermore, as stated by Maslach and colleagues (2001), "it is difficult to gain a sense of accomplishment when feeling exhausted or when helping people toward whom one is indifferent." Because human service workers often enter the field with a wish to help others in need, and through this they gain a sense of accomplishment, lacking efficacy could cause them to feel as though there is no reason to continue working in a helping profession.

Overview of Burnout in Residential Treatment

Because residential care workers are often overloaded with an abundance of responsibilities in their daily work life, their susceptibility to develop job burnout increases. For example, residential care workers are not only expected build relationships with youth, manage crisis situations, and assist them in achieving their treatment goals, but they also need to take part in treatment planning, and are responsible for managing group living, working directly with families, and expected to be skilled in documentation and communication (Pazaratz, 2000). Furthermore, unclear work demands, too much responsibility, and role ambiguity can also become extremely overwhelming (Cheng, Chen, Chen, Burr, & Hasselhorn, 2013; Maslach et al., 2001).

The problematic effects of burnout can be costly to the employees, the youth in care, and the organization as a whole. For example, employees experiencing burnout tend to withdraw from their work, causing higher rates of absenteeism and greater intentions to leave the job (Maslach et al., 2001). Furthermore, employees are also less productive, effective, and satisfied in their work, which can negatively impact co-workers and youth by creating unnecessary conflicts with them and spreading pessimism across the workplace (Maslach et al., 2001). Burnout is also associated with mental dysfunction and can increase the likelihood of anxiety, depression, and drops in self-esteem, which all have an impact on workers personal and professional lives (Maslach et al., 2001).

Overview of Compassion Fatigue

Compassion fatigue was not a widely recognized term until the mid-1980's when researchers began studying the distinct components PTSD and noticed that traumatization did not only happen to those who were directly exposed to the trauma incident (Figley, 1995). For the

purposes of this study *compassion fatigue* is defined as a state of exhaustion and compilation of emotional, physiological, biological, and cognitive effects that is the result of working directly with, and empathetically engaging others who have experienced significant trauma (de Figueiredo et al., 2014; Ray, Wong, White, & Heaslip, 2013). Charles Figley (1995) often refers to *compassion fatigue* as “the cost of caring,” and says it is often a product of taking on the burden of others pain and suffering.

Compassion fatigue has become a much more recognized term in recent literature and is many times used interchangeably with other terms such as: *secondary traumatic stress* and *vicarious traumatization*. In his book *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in those who treat the Traumatized*, he notes the distinct differences in definitions of these terms:

“ (1) simultaneous trauma takes place when all members of the system are directly affected at the same time , such as by a natural disaster; (2) *vicarious trauma* happens when a single member is affected out of contact with the other members (e.g., in war, coal mine accidents, hostage situations, distant disasters); (3) intra-familial trauma or abuse takes place when a member causes emotional injury to another member; and (4) chiasmal or *secondary trauma* strikes when the traumatic stress appears to “infect” the entire system after first appearing in only one member. This last phenomenon most closely parallels what we are now calling *STS* [secondary traumatic stress] and *STSD* [secondary traumatic stress disorder].” (Figley, 1995, Conceptual Clarity section, para 8, p. 448).

The act of being compassionate often comes at a cost to human service workers as it can be difficult to stop one from bearing the suffering of others, especially when in direct contact

with clients during moments of crisis (Figley, 2002). High levels of compassion fatigue can reduce care workers capacity and interest to others suffering, to the point where workers will actively avoid clients and/or feel numb to clients traumatic experiences (Figley, 2002). People experiencing this can also re-experience the trauma in their clients causing nightmares, sleeplessness, and anxiety (Figley, 2002). Furthermore, working with traumatized clients can evoke past traumatic experiences of their own, creating fear, guilt, and avoidance of clients all together (Figley, 2002). Learning to recognize and manage symptoms of compassion fatigue may be an important variable to increase overall health and wellness for care workers as well as enable them to continue to provide superior support and service to their clients.

Overview of Compassion Fatigue in Residential Treatment

There has been little research done on the prevalence of compassion fatigue in residential treatment settings; however research shows that working with highly traumatized clients does increase the risk of developing symptoms (de Figueiredo et al., 2014). It should be assumed that many care workers begin their careers in human service work because they have a high degree of empathetic concern and wish to help alleviate pain and suffering in others. This often requires them to take on and relive some of their client's pain, which increases their risk for compassion fatigue (Figley, 1995). Research also shows that the wish to help others who have experienced trauma often stems from one's own experience(s) with trauma in the past, and re-experiencing client's trauma can evoke trauma responses in oneself (Figley, 2002). Furthermore, as the traumatic experiences compile it increases susceptibility to become fatigued (Figley, 1995). Finally, working with and re-experiencing children's traumatic experiences can be especially painful because many view children as powerless, innocent, and undeserving of any kind of suffering (Figley, 1995).

Compassion fatigue, has many adverse effects on every part of the organization including the youth care workers, clients in care, and the quality of the services that are being provided. The crisis situations that arise in residential care are prevalent and often stem from youth's trauma history. Re-experiencing these traumatic experiences with the youth can cause workers to become fearful and avoidant of clients (Figley, 2002). It can also cause them to lose compassion and become numb to the youth's experiences (Figley, 2002). Furthermore, this numbness can create a barrier in the growth of the worker-youth relationship and cause workers to be less able to distinguish trauma responses from oppositional, defiant behaviors (Figley, 2002). Care workers who have lost compassion may retreat to undesirable methods of behavior management like, being less caring/nurturing, being more short-tempered and avoidant, and/or more quickly resorting to the use of physical or punitive methods of punishment. Because the care workers responses to children in crisis are so important to their recovery, it is imperative that they learn how to understand and recognize their compassion fatigue symptoms.

Risk Factors for Burnout and Compassion Fatigue

There are an abundance of organizational, client-related, and personal factors that can increase the risk for residential care workers to develop compassion fatigue and burnout. Oftentimes, it is a compilation of one or many of these factors that cause staff distress. The goal should be to increased awareness within residential care facilities in order to mitigate the negative effects that these two phenomena have on the clients, care workers, and organization as a whole.

Organizational factors. It is not always client-related issues that contribute to burnout and compassion fatigue, sometimes its work-related stressors related to organizational job demands (Alarcon, 2011; de Figueiredo et al, 2014; Vassos & Nankervis, 2012). There have

been numerous studies done showing the impact of organizational factors in predicting and burnout in employees (Alarcon, 2011; de Figueiredo et al, 2014; Vassos & Nankervis, 2012). . For example, de Figueiredo and colleagues (2014) did a mixed-method, cross-sectional study on perceptions of compassion fatigue and satisfaction among two ambulatory divisions within a large, urban pediatric tertiary care unit institution that provided clinical services to infants, children, and adolescents with significant exposure to psychological and physical trauma. They found that other issues such as large caseloads, meeting deadlines, maintaining productivity, addressing billing requirements, receiving mixed messages from administrators, meeting clinical, programmatic, and administrative demands, and navigating policies were all primary contributors to burnout (de Figueiredo et al., 2014, p. 8).

Maslach identified the six areas of work life as factors that can contribute to job burnout and satisfaction. The degree to which a person matches or mismatches with their organization on these six factors can increase or decrease their risk for job burnout (Maslach et al., 2001). The six areas of work life are labeled and defined as follows: workload (excessive overload, too many demands placed on a worker); control (insufficient control over resources needed to accomplish work; insufficient authority to pursue work demands); reward (recognition for work contributions i.e. financial, social, intrinsic); community (lost sense of positive connection with others in the workplace); fairness (inequity of workload or pay, lack of openness and respect with regard to decision-making); and values (incongruence of priorities, values, and ethics between employee and organization) (Maslach et al., 2001; Ray et al., 2013). A study done by Ray and colleagues (2011) looked at six primary areas of work life and hypothesized that a higher person-job congruence in these area's would decrease compassion fatigue and burnout, and increase compassion satisfaction in frontline mental health workers ($n = 430$). In this

quantitative study, a survey was sent to frontline mental health professionals (including registered nurses, registered practical nurses, social workers, psychologists, case managers, and other mental health workers) in Ontario. Results confirmed the hypothesis that increased overall congruence in the six areas of work life predicted lower rates of burnout overall in frontline mental health professionals (Ray et al., 2013). Similarly, they confirmed that compassion fatigue was negatively associated with positive matches in the six areas of work life (Ray et al., 2013). Furthermore, higher levels of compassion satisfaction, lower levels of compassion fatigue, and increased person-job match in the six areas all predicted lower levels of burnout (Ray et al., 2013, p. 263).

Excessive workload, role ambiguity, and role conflict have also been found to be significant predictors of burnout in many different human service professions (Alarcon, 2011; Vassos & Nankervis, 2012; Ray et al., 2013). According to Alarcon (2011), job demands (i.e. role ambiguity, role conflict, and workload) were significant predictors of all three dimensions of burnout, with the strongest correlation being to that of exhaustion. Moreover, this study found that high rates of exhaustion and cynicism decreased job satisfaction, organizational commitment, and increased turn-over intentions in employees (Alarcon, 2011). He also noted that autonomy and control were negatively correlated with emotional exhaustion, showing that giving workers more flexibility in how they meet their job demands could increase satisfaction in one's job, which promotes productivity and effectiveness (Alarcon, 2011).

Another qualitative study conducted by Vassos and Nankervis (2012) investigated the importance of individual, interpersonal, organizational, and demographic variables as predictors of burnout among disability support workers ($n = 108$). They found that role conflict or ambiguity were significant predictors of emotional exhaustion in employees. Furthermore, they

suggested that having clearer job descriptions and clearer distinctions between all professionals working within the organization could help give employees more autonomy within the workplace, which in turn could lower burnout rates (Vassos & Nankervis, 2012).

Lack of training or knowledge about the characteristics of the client population one works with and helpful interventions and responses with clients in crisis situations as well as less experience in the field have also been found to be significant predictors for people feeling symptoms of burnout or experiencing compassion fatigue in their work (McLindon & Harms, 2011). For example, McLindon and Harms (2011), conducted a study where they examined mental health workers who do assessments and provide treatment to women disclosing sexual assault experiences ($n = 15$) and found professional experience to be a crucial factor in participants current thinking and understanding of sexual assault and the victims of sexual assault. Findings from this qualitative study also revealed that lack of training was a major issue (McLindon & Harms, 2011). For example, 11 out of 12 respondents indicated that they had little to no professional training on victims of sexual assault or how to respond appropriately to their experiences (McLindon & Harms, 2011). These organizational issues impacted workers confidence levels in working with clients and made many feel as if they were ill-equipped to respond to sexual assault disclosures or deal with the personal impact of the disclosures (McLindon & Harms, 2011). Although this study mainly focused on mental health workers who worked with women, residential care workers may be similarly, if not more at-risk because they face diverse populations of clients daily with a variety of mental health difficulties and unique trauma experiences. Because each client is dealing with a variety of issues at once, it can be even more difficult for residential care workers to know effective ways to respond each client

individually as they disclose traumatic experiences or present challenging behaviors as a response to their trauma.

Client-related factors. Recent literature has also found a link between challenging behavior, traumatic experiences, and violence in the workplace on burnout and compassion fatigue rates (Cheng, Chen, Chen, Burr, & Hasselhorn, 2013; McLindon & Harms, 2011; Ray et al., 2013; Rose, Mills, Silva, & Thompson, 2013; Vassos & Nankervis, 2012). Residential care workers experience crisis situations with clients several times daily, which often lead to clients to display challenging and violent behavior. Vassos and Nankervis (2012) did a quantitative study on predictors of job burnout in disability support workers ($n = 108$), and concluded that challenging behaviors of clients was a major predictor of all three dimensions of burnout (exhaustion, cynicism, and depersonalization). They found that challenging and aggressive behavior on the part of the client increases fear in staff, leading to exhaustion, depersonalization, and burnout.

Likewise, another study done by Rose, Mills, Silva & Thompson (2013) on client characteristics, organizational variables, and burnout in care staff of clients with intellectual disabilities ($n = 78$) found that fear of assault by clients was a significant predictor of emotional exhaustion (Rose et al., 2013). These two studies suggest that changing the way staff perceive challenging behavior, through the use of training and staff support, may mediate the overwhelming feelings of stress produced by challenging and aggressive behavior of clients (Rose et al; 2013, Vassos & Nankervis, 2012). Furthermore, organizations should better prepare and enhance their workers knowledge by providing on-going training opportunities, utilizing evidence-based support strategies, and engaging in positive behavior support planning (Rose et al., 2013; Vassos & Nankervis, 2012).

Another risk factor for burnout and compassion fatigue is the fact that most youth enter residential treatment with significant trauma histories and other complex mental health and environmental difficulties. Working with high need clients and complex trauma can be extremely emotionally, physically, and psychologically demanding for workers. In a mixed-methods, cross-sectional study done by de Figueiredo and colleagues (2014) on perceptions of compassion fatigue and satisfaction among two ambulatory divisions within a large, urban pediatric tertiary care unit institution providing clinical services to infants, children, and adolescents with significant exposure to psychological and physical trauma ($n = 44$) found several factors that increase the risk of compassion fatigue and burnout in providers such as: working with clients with complex trauma histories, managing clients with multiple stressors (e.g., homelessness, developmental disabilities, lack of resources, unemployment, familial conflict, complex medical illnesses); working with intergenerational and caregiver trauma; working with younger and infant clients; and working with older youth with inadequate transition services to adulthood. Participants stated that working with clients with such high needs presents many difficulties for them, namely having to work longer hours and work outside of their designated roles (de Figueiredo et al., 2014). This study is relevant to residential care workers as they too work with clients with significant trauma histories, and are often trying to provide immediate support to clients who are dealing with complex mental health problems, stressors, and adversities.

Adams and colleagues (2006) found similar results in a study on compassion fatigue and psychological stress done on social workers living in New York City who worked with clients following the September 11, 2001 World Trade Center attack ($n = 236$) (Adams, Boscarino, & Figley, 2006). One interesting finding of this study was that they were able to show that

exposure to traumatized clients alone does not lead to compassion fatigue or burnout (Adams, et al., 2006). They also found that compassion fatigue and burnout are usually the result of a mixture of several factors in the workplace and personal environment, such as negative life events, personal trauma, lack of social support, and low job mastery (Adams et al., 2006). Although, this study was done on social workers working with clients with a different kind of traumatic experience, the trauma responses and PTSD symptoms presented by clients are often similar to youth in residential care. Furthermore, the unique horrific stories and experiences of the clients have a major impact on human service workers regardless of the type of trauma that was experienced.

Personal factors. There are many personal factors that play an important role in the susceptibility for compassion fatigue and burnout in the workplace such as personality type, age, culture, personal history, work experience, and self-care strategies (Cieslak et al., 2014; Lakin et al., 2008). Age, gender, work experience, and cultural background have also shown up in research as risk factors for burnout and compassion fatigue (Cheng, et al., 2013; Knight, 2013; Meyer et al., 2014; Ray et al., 2013). Professionals with less education, less work experience, and those who work more frequently with survivors of trauma, like those in a residential treatment setting are at a much greater risk of compassion fatigue (Knight, 2013). A thesis study done on compassion fatigue, burnout, and compassion satisfaction among residential child care workers ($n = 56$) yielded interesting results on these factors (Sepulveda, 2003). The majority (64.3%) of the participants had less than 3 years' experience in the field and was directly correlated with high turn-over rates (Sepulveda, 2003). Furthermore, this study showed that 28.6% of the residential care workers scored in the moderate to high risk range for compassion fatigue (Sepulveda, 2003). It should be noted that more experience in the field can positively

influence workers approaches to their work and make them better able to process stress (de Figueiredo, et al., 2014). Furthermore, workers with less tenure need more supportive relationships and should be paired up with more senior colleagues who can provide mentorship to them (Ray et al., 2013).

Personality characteristics such as resiliency, empathy, and compassion can also be helpful characteristics in human service workers to decrease the risk of burnout and compassion fatigue. Cieslak and colleagues (2013) did a systematic review, which included 45 studies, on the relationship between job burnout and secondary traumatic stress among workers with indirect exposure to trauma and found that certain cultural or individual resilience factors such as hardiness and self-efficacy can also serve as a protective factor for staff in preventing burnout and compassion fatigue (Cieslak et al., 2014). They attributed these differences to several factors such as, differences in shaping of emotional experiences and emotional processing, and differences in organizational characteristics, health inequalities, or policies regarding work conditions (Cieslak et al., 2014, p. 83). The question still remains: can resiliency be built through experience, training, and support or is it characteristic that one either has or does not have? If it is possible to build resiliency in residential care workers, than this could help organizations to either find ways to search for staff with higher resiliency or learn how to build it within existing staff because this could help them to mitigate the effects of compassion fatigue and burnout within their agencies.

Another study done by Lakin and colleagues (2008) on predictors of burnout in residential treatment care workers ($n = 375$) suggested that workers with greater levels of empathetic concern were able to better communicate with the youth they worked with, which lowered burnout rates (Lakin et al., 2008). Conversely, they found that employees with high

levels of neuroticism had stronger reactions to daily stressors, were more self-critical, and experienced much more fatigue each day than workers who were less neurotic (Lakin, et al., 2008). Both of these findings suggested that finding staff with personality traits that are better suited for the type of work they are doing can lower stress and burnout rates within the organization (Lakin et al., 2008).

Having experienced trauma in one's own life can also be a risk factor for burnout and compassion fatigue. It is not an uncommon phenomenon to have workers who have themselves experienced trauma in human services professions (Figley, 1995). For example, a quantitative study ($n = 430$) on compassion satisfaction, compassion fatigue, and burnout done by Ray and colleagues (2013), on frontline mental health professionals (including registered nurses, registered practical nurses, social workers, psychologists, case managers, and other mental health workers) in Ontario found that 27.8% of the participants had a history of trauma. Furthermore, they also found that compassion fatigue scores were higher for those who have experienced trauma, possibly because they more deeply identify with their clients traumatic experiences (Ray et al., 2013). Similarly, a thesis done on compassion fatigue, burnout, and compassion satisfaction in residential care workers ($n = 56$) found that 89.3% of the care workers in the study had experienced some level of trauma in their personal lives (Sepulveda, 2003).

Likewise, in a mixed-methods, cross-sectional study done by de Figueiredo and colleagues (2014) on perceptions of compassion fatigue and satisfaction among two ambulatory divisions within a large, urban pediatric tertiary care unit institution providing clinical services to infants, children, and adolescents with significant exposure to psychological and physical trauma ($n = 44$) found that participants own histories played an important role in the development of compassion fatigue (de Figueiredo et al., 2014). The participants highlighted several factors that

influence this development including: dealing with multiple stressors from both their work and personal life, lack of work-life balance, and pressure to achieve (de Figueiredo et al., 2014).

These results suggest that professionals with histories of trauma may need additional support and supervision to be a protective factor to combat compassion fatigue and burnout symptoms (Ray et al., 2013).

Mitigating Compassion Fatigue and Burnout

Due to the high cost and burden that compassion fatigue and burnout have on organizations and their workers, many researchers have done studies aiming at finding useful intervention strategies to mitigate the deleterious effects of their symptoms (Figley, 2002; Knight, 2013; Lakin et al., 2008; Li et al., 2014; Meyer et al., 2014; Riches, Harman, Keen, Pennell, Harley, & Walker, 2011). The literature has shown several factors that put workers at risk of developing compassion fatigue and burnout and like the risk factors, preventative factors should also be looked at as human service workers and their organizations have a responsibility to attempt to minimize the presence of these two issues for the sake of the clients that they are serving.

Organizational Interventions. Supervision and consultation has been found to be an important supportive factor for staff to help mitigate and alleviate symptoms of compassion fatigue and burnout. It is a supervisor's responsibility to encourage supervisees to talk openly about their thoughts, feelings, and actions regarding clients, especially the ones that they would most like to keep secret (Knight, 2013). Unfortunately, most supervision consists of talk related to the "technical" aspects of supervisees work with clients such as client issues, theories, and research yet fails to focus on their affective reactions to their work. Organizations should

encourage their supervisors to explore supervisee's emotional reactions to their work and validate their feelings so they can learn to better manage them (Knight, 2013).

Figley (2002) noted the significance of supervision in his case study on compassion fatigue. Professionals need to be encouraged to speak openly about their own struggles with compassion stress and fatigue because letting it linger in silence only perpetuates the problem (Figley, 2002). Furthermore, planned, regular, and formal supervision has many benefits to employees such as: it is a way to support staff members in their work role, it improves attitudes, beliefs, and perceptions of the supervisee, clients, and the organization, it proves to the supervisee that their job is valued and important, it provides an opportunity for feedback and critical thinking, and it gives supervisees the support and training necessary to feel confident in their skills and abilities as practitioners (Figley, 2002; Knight, 2013; Lakin et al., 2008; Vassos & Nankervis, 2012).

A supportive work environment has also been found to play a critical role in helping employees to combat and relieve symptoms of burnout and compassion fatigue. A study conducted by Li and colleagues (2014), on group cohesion as a factor in predicting job satisfaction, compassion fatigue, compassion satisfaction, and burnout in resident nurses with less than one year experience in a hospital in Los Angeles ($n = 251$) found that higher levels of PTSD symptoms increases the likelihood of burnout in nurses (Li et al., 2014). However, group cohesion and positive affiliation with the workplace was a protective factor in combating burnout and the negative effects of stress exposure in nurses who are experiencing PTSD symptoms from their work life (Li et al., 2014). Similarly, Vassos and Nankervis (2012) did a quantitative study on predictors of job burnout in disability support workers ($n = 108$) and found that

providing regular supervision and support services for workers lowered burnout by showing them that the organization finds their job meaningful and important.

Enhanced training for employees can help them better manage the impact of the daily stressors from their work (de Figueiredo et al., 2014; Ray et al., 2013; Riches et al., 2011; Rose et al., 2013). However, there is very few studies done on specific evidence-based training programs, i.e. self-care and coping strategies, mentorship programs, etc., that help to combat burnout and compassion fatigue in the human service setting. Understanding what training employees need within their organization could help to eliminate burnout and compassion fatigue altogether. One example of this is a study done by Riches and colleagues (2011) on transforming staff through active support by modeling a three-stage training model that promoted active support and mentorship as part of an enhanced training program for staff working with adults with profound developmental and intellectual abilities ($n = 63$). This program yielded many significant and positive results for the residential homes that were a part of the training such as improved communication between staff, better, more thorough, programming plans, clearer systems were put in place for staff meetings and goals, they had more well-defined staff roles, and they were able to induct regular staff training programs (Riches et al., 2011). This study also yielded positive results for the clients in care such as increased flexibility in daily routines, more individualized programming for clients, more improved teaching programs, enhanced monitoring of progress and successes, and some clients even showed decreased depression scores (Riches et al., 2011).

High levels of burnout and compassion fatigue in residential care workers can have some negative impacts not only on the care workers themselves, but the organization as a whole and the youth in care. The literature available shows the variety of organizational, personal, and

client-related factors that contribute to high risk levels of burnout and compassion fatigue in human service workers. There is very little research that shows how varying levels of compassion fatigue and burnout in residential care workers affects client care as well as what things the workers need to help them combat these two issues when they arise. Because residential care workers play a significant role in youth's lives it is important to try to better understand how to minimize the risk of them developing compassion fatigue and burnout. This study seeks to better understand how these two factors affect the quality of care that care workers are able to give to clients, what factors most contribute to compassion fatigue and burnout, and what interventions may be helpful to them to help them mitigate the deleterious effects that compassion fatigue and burnout have on clients.

Conceptual Framework

Ecological Systems Theory

The theoretical framework that influenced this study is ecological systems theory, which was presented by Urie Bronfenbrenner. Ecological systems theory was formed on the basis that every person's development is shaped by their relationship with different systems within their environment (Bronfenbrenner, 1977). There are four separate systems the micro-, mezzo-, exo-, and macro-system, which are all working and evolving at once, effecting each other, and influencing human development (Bronfenbrenner, 1977). A conflict within one of the systems can have a ripple effect into other systems, which can cause distress to one's development.

There are several different system interactions taking place within a residential treatment setting. The system of residential treatment shapes how residential care workers view the youth in care and their role within the organization. These system interactions all influence the development of compassion fatigue and burnout, which effect client care on a daily basis.

Micro-system. Bronfenbrenner (1977) defines the *micro-system* as, "the complex of relations between the developing person and environment in an immediate setting [i.e. home, school, workplace] containing that person." One major micro-system affecting residential care workers is role definition. While at work, care workers are placed in several roles (e.g., a professional, a counselor, a role model, a parent), and expected to be able to quickly adapt and jump into any role that is necessary in the moment.

Role ambiguity can be confusing and become overwhelming for care workers, especially those with very little experience in the human services field and/or working with youth with emotional and behavioral problems. Because residential care workers are in the work setting, it may be difficult for them to let their organization know that they are experiencing symptoms of

burnout and compassion fatigue because of embarrassment or fear of losing their job. Furthermore, when residential care workers are feeling pressured and experiencing these symptoms they are much more ineffective in their work. For example, a care worker who is burnt out is more likely to use ineffective intervention techniques with residents in crisis (e.g., yelling, creating power struggles), which strains their relationship with youth and potentially further traumatizes them. Organizations could address burnout and compassion fatigue within their organization by expecting supervisors to schedule regular supervision with their employees. Supervisors might encourage open communication with care workers and help to support them when they are feeling burnt out, which increases their communication skills not only with co-workers and external clientele, but with the youth in care.

Mezzo-systems. Bronfenbrenner (1977) defines a *mezzo-system* as interrelations among major settings (e.g., micro-systems), which contain a person at a particular point in his or her life. All people who have a job are balancing different micro-systems. For residential care workers, the psychologically and emotionally exhausting nature of their work often causes their personal and professional lives to blend. For example, a residential care worker who has too much responsibility at work, and is experiencing burnout, can easily struggle to understand their personal limitations and boundaries, leading them to take their work home with them. This can cause strain to their relationships with their own family and friends, who are typically the providing guidance and support to them during times of stress. Furthermore, a worker experiencing compassion fatigue may become easily triggered by things in both their home and work environment, which could cause them become avoidant of certain people or situations. If burnout and compassion fatigue are addressed organizationally in the form of training or supervision, this could provide residential care workers with tools to enable them to find a better

balance between their home and work life. For example, a mandatory workshop on mindfulness skills could help workers find clarity and appreciation in moments with their family and/or with achievements at work.

Exo-systems. *Exo-systems* are extensions of mezzo-systems that embrace other formal and informal social systems that do not necessarily directly contain the developing person, but impact the settings in which they are a part of, dictating what can and cannot go on in these settings (Bronfenbrenner, 1977). Examples of these can be found in the work; the neighborhood; the mass media; the agencies of government; the distribution of goods and services; and any other informal social networks (Bronfenbrenner, 1977).

Two examples of exo-systems that impact residential care workers daily in their work are client care standards set forth by the Department of Human Services, and insurance companies need for more and more documentation and proof of services provided in treatment. For example, because insurance companies are often trying to save money, and want to ensure they are paying for something worthwhile, residential care workers need to ensure that they are documenting the services offered to the clients several times daily as well as documenting progress of clients daily. Although this documentation is important, it is also very time consuming and take away from quality time that could be spent with the youth in care building relationships or teaching them new skills.

Oftentimes, care workers enter the field because they want to relate to others and help them with their problems, but the actuality of the job is becoming less and less about interacting and more about documenting, which can increase burnout in workers because they are unable to find time to connect with their clients. Care workers who are experiencing compassion fatigue, may struggle to document certain situations because it causes them to re-experience the trauma.

Furthermore, the lack of time they have to get their work done makes it more difficult for them to take the time to process their feelings and experiences with supervisors and co-workers, which perpetuates their symptoms.

Macro-systems. Macro-systems are the largest system within this theoretical framework and differ from the other systems because they do not refer to specific contexts that affect the life of a person, but a general culture or subculture that sets a pattern for how certain activities occur within the systems (Bronfenbrenner, 1977). Bronfenbrenner (1977) defines *macro-systems* as “institutional patterns of the culture or subculture such as the economic, social, educational, legal, and political systems, of which micro-, meso-, and exo-systems are the concrete manifestations.”

Residential care workers need to understand how the macro-system that influenced their attitudes, beliefs, and values, influences the way they view and work with the youth in care. Similarly, it is also important for them to try to understand the child’s cultural belief and value systems, in order to find better ways to work with and support them in their treatment goals.

Residential care workers are expected to be able to leave their feelings and belief systems at the door so that they can remain non-judgmental and unbiased when working with clients, however this is not an easy task. A major macro-level issue that increases burnout is the American value system regarding work ethic. Workers in our culture are expected to work hard without complaining or showing signs of weakness. Similarly, many organizations have a mindset that everyone is “replaceable.” This can prevent residential care workers from seeking the help and support they need when they are overwhelmed with their job duties. Furthermore, this mindset can decrease morale in care workers, leaving them feeling unvalued, which decreases their drive and motivation to work hard for the organization.

An example of a macro-level issue that influences compassion fatigue is when care workers and youth have clashes in value systems. These differing ideologies create more power struggles and put strains worker/youth relationships. The youth in care come from varying backgrounds and grow up in vastly different cultures, let alone generations, than residential care workers, so there needs to be more formal training and open dialogue to help workers maintain awareness of this so it does not affect the way they are treating the youth. An example of this within the residential treatment setting would be how a youth's culture has affected the things that they enjoy doing. Many workers expect kids to enjoy the same activities and music that they do and end up accidentally shaming youth rather than embracing their individuality.

Burnout and compassion fatigue are both problematic because they are difficult for residential care workers to recognize, and even more difficult to talk about if they do recognize the onset of symptoms. It is important that residential care workers have an awareness of their own attitudes, values, and belief systems, as well as how their environment and culture affect their work with clients. When organizations and the staff within the organizations understand how these systems have influenced and continue to influence them, it can help to mitigate the negative effects that they have on client care.

Personal and Professional Lens

My personal journey has influenced by decision to choose this study topic because of my history of dealing with mental illness within my family as a child. I had several support systems in my life that got me through some very difficult times, so I fully understand the impact that understanding and caring adults can have on a child in pain. I also understand how the environment you are in, and the adults in your life, can be either detrimental or beneficial to your functioning. These experiences influenced my decision to get my Bachelor's degree in

Psychology because I really wanted to understand the underlying components of mental illness and use my experiences to inform my work with those who are struggling themselves with symptoms.

My professional journey is what really led me to this topic area because I have worked in residential treatment for six years and seen firsthand the impact that adults have on children's lives. I have experienced both burnout and compassion fatigue several times over the years, and learned the hard way the negative impact it had on my clients. Bronfenbrenner (1977) poses that systems impact each person's individual development, and the youth I have worked with have impacted my professional development immensely. In my early career work as a youth counselor, I was taught to reflect and use critical thinking to better understand myself and my personal limits. My supervisors and other support systems also helped me gain awareness of my symptoms and learn how to effectively cope so not to negatively affect clients. Hearing firsthand that I was harming clients because of my personal issues was an eye-opener for me and I hope to help other care workers to be proactive so they can avoid what I experienced.

The topic of this paper was shaped by the youth counselors I currently supervise as I can empathize with and see how their lack of experience and knowledge of youth development and emotional and behavioral disorders makes their job much more challenging and increases their susceptibility to burnout and compassion fatigue. I also see the negative impact it has on the youth in our care and how at times the care workers are actually further traumatizing the youth that we care for because they are unaware and completely absorbed by their symptoms. My hope is that this study will help organizations become more aware of the problems burnout and compassion fatigue can present if unattended.

Methods

The purpose of this study was to explore the levels of burnout and compassion fatigue in residential care workers, and to develop a better understanding of how these two phenomena affect client care. Since positive client care outcomes are the goal for most agencies, it is important to better understand the impact of compassion fatigue and burnout from the perspective of the residential care workers whose primary role is to work directly with the youth in care.

Research Design

The research design for this study is both quantitative and qualitative in nature. The purpose for the mixed-method design was to be able to better address the research question components. The quantitative portion consisted of abbreviated portions of both the *Bergen Burnout Inventory* (BBI) and the *Professional Quality of Life Scale* (ProQOL), which were used to better understand the symptoms of compassion fatigue and burnout that the participants are experiencing (Hudnall Stamm, 2009; Salmela-Aro, Rantanen, Hyvonen, Tilleman, & Feldt, 2010). The qualitative portion of this study consisted of questions that aimed to explore what factors most contribute to burn out and compassion fatigue among residential care workers and how these two issues affect the quality of client care.

Recruitment of Sample

Participants for this study were recruited from two residential treatment sites that primarily serve youth ages six to 20. One site is in a rural area in northern Minnesota and is a 52- bed residential program for boys ages 13 to 19 with harmful sexual issues and significant mental illness. The second, a residential treatment site in central Illinois, consisted of a 79-bed

residential unit, divided into smaller programs, a 9-bed group home, and an 8-bed transitional living home.

To obtain consent I emailed each site's Executive Director, and sent them a consent form (See Appendix A) and cover letter (See Appendix B) that explains the purpose of the study, procedures, risks/benefits, compensation, and confidentiality measures. Each site's Executive Director then put me in contact with their primary training coordinators to help facilitate survey allocation. Prior to collecting data, an expedited Institutional Review Board application was sent through the University of St. Thomas. Once permission was obtained by both the site director and the IRB, convenience sampling was done through an online survey (See appendix C) that was distributed by each site's training coordinator via Qualtrics by email, along with the consent form (See Appendix A), to all employees within the residential treatment facility.

Inclusion criteria for this study included: (1) employment within a residential treatment facility; and (2) employees who provided direct treatment services to youth (i.e. youth counselors, case managers, therapists, unit coordinators, clinical supervisors, clinical directors, etc.). Exclusion criteria included: (1) other non-clinical positions within the organization (i.e. administrative staff, human resources, admissions, etc.). The goal for this study was to have a sample population of 60- 80 participants. To encourage participation, those who agreed to complete the online survey were entered into a drawing for two- \$25 dollar Amazon gift cards.

The study was sent out via email two separate times, three weeks apart to encourage participation a second time for those who didn't have time when the first email was sent. The majority of respondents completed the survey either on the day it was sent or one day prior or after it was sent. A total of 96 participants started this survey, with 88 making it past the two

inclusion criteria. This survey had a mean rate of 82% completion and took participants an average of 22 minutes to complete.

Confidentiality and Protection of Human Subjects

Overall risks for participating in this study were minimal. Participants were notified via the consent form (See Appendix A) of any risks or benefits for their participation in this study. Qualtrics is the system that was used to conduct the study, and it assured anonymity of the respondents. The link to the survey was sent to residential care employees within each agency via email. Qualtrics did not capture the IP address of the respondents so there was no way to identify them. All participants were provided with a consent form (See Appendix A), which stated that their information would be kept private and any and all data collected would be presented together, which eliminated the possibility of anyone being able to match any answers to participants.

The survey consisted of both open and closed ended questions, and participants could choose to forego answering any questions if they felt stressed or uncomfortable. The consent form also contained phone numbers to a Crisis Connection hotline as well as other online and periodical resources if they felt they needed further support. Because the survey was sent via email, participants could also choose to forego clicking the link and not participate in the survey at all. All data collected is being stored in a file on a secured personal password protected computer. All documents and files containing data for this survey will be destroyed on or before June 1st, 2018.

Data Collection

Data was collected using an online mixed-methods survey (See Appendix C) that consisted of both quantitative and qualitative questions. The quantitative portion included two

sets of demographic questions to help categorize the data. The first were questions pertaining to the participant's educational level, amount of experience, and the participant's role within their organization. The second set of questions were client-related and aimed to find out the primary gender participants served as well as the primary age range of clients served.

The next set of questions in the quantitative portion were related to burnout and compassion fatigue. The first set were developed from a modified version of the *Bergen Burnout Inventory*, these questions were used to better understand the symptoms of burnout the participants were experiencing (Salmela-Aro, et al., 2010). The *Bergen Burnout Inventory* consisted of nine statements, such as "I am overwhelmed with my current work environment," to which participants could answer on a scale of 1 (Completely Disagree) to 5 (Completely Agree) (Salmela-Aro, et al., 2010). This was followed by three yes/no questions to assess if they felt they have been impacted by burnout in the past, are currently experiencing burnout, and if they felt that they were at risk of developing it in the future. These were followed by one rank/order question aimed at understanding of what participants felt were the leading contributors to burnout.

The second set of quantitative questions were similar in nature, but were designed to better understand the symptoms of compassion fatigue the participants were experiencing. A modified version of the *Professional Quality of Life Scale* was used (Hudnall Stamm, 2009). The *Professional Quality of Life Scale* originally consisted of 30 statements, but 12 were taken out due to them pertaining more to compassion satisfaction as compassion fatigue was the variable that was most relevant to this study. The abbreviated version consisted of 18 statements, to which participants could answer on a scale of 1 (Never) and 5 (Very Often). An example of a statement is "I am preoccupied with more than one person I help." This was

followed by one rank/order question aimed at understanding of what participants felt were the leading contributors to compassion fatigue.

The qualitative questions in this study consisted of questions used to obtain residential care workers perspectives on what contributes most to staff developing burnout and compassion fatigue as well as how burnout and compassion fatigue effect client care. There were two open-ended questions at the end the survey that allowed participants to freely express opinions on client care outcomes and contributors to burnout and compassion fatigue. Questions include: (1) Do symptoms of burnout affect your ability to provide adequate care to the clients in your organization? Why or why not? Please describe. (2) Do symptoms of compassion fatigue affect your ability to provide adequate care to the clients in your organization? Why or why not? Please describe. (3) Do symptoms of burnout affect others ability to provide adequate care to the clients in your organization? Why or why not? Please describe. (4) What do you think would help you to combat burnout and compassion fatigue? Why? Please describe.

Data Analysis

Quantitative and qualitative data for this study were collected via an online survey. Quantitative data are data that use numbers, counts and measures of things (Monette, Sullivan, & DeJong, 2011). This data was calculated using descriptive statistics (a description of characteristics present within the sample) and inferential statistics (procedures that allow researchers to make generalizations from the sample data to the populations from which the samples were drawn) (Monette et al., 2011). Descriptive statistics were used to analyze the demographic data, better understand the prevalence of burnout and compassion fatigue symptoms, and categorize participant's opinions of the leading contributors.

Qualitative data or “data in the form of words, pictures, descriptions, or narratives” will be obtained through a list of open-ended questions (Monette et al., 2011). The open-ended questions allowed for unrestricted answers to the questions, and allow for more possible concepts to emerge (Monette et al., 2011). Open coding was used to analyze the data regarding compassion fatigue and burnout’s effect on client care. In the open coding process, the researcher read the survey transcripts over several times, highlighting codes that emerged throughout the data and found patterns in participants’ answers. The original coding process helped to identify major theme areas to focus on through repeated codes, a code needed to be present at least three times to become a theme. After the most common themes were identified, the researcher examined each further to interpret meaning. After the initial coding, the data was again re-coded to ensure there were no missed codes or themes present in the data.

Demographics information. Survey respondents ($n = 86$) answered demographic questions related to their education, residential care work experience, current professional role, and client milieu served at work (See tables 1 and 2). Education-wise, 26(30%) had attained a post-graduate degree, 21(24%) were college graduates, and 20(23%) had some attended some college.

With regard to residential care or related experience, respondents had varying degrees of experience in the field or agency: 26 (30%) had 11 or more years, 14 (16%) possessed between eight and 10 years, and 11(13%) had 5 to 7 years of experience. The smallest number of respondents had the least experience, with 14 (16%) having less than one year of work experience in the field or organization.

Of the 86 who identified their current position or role within their organization, nearly half of the respondents 36(42%) were direct care workers/youth counselors. Nearly one-third

identified themselves as “Other” [22 (26%)]. The responses in the “Other” category were mostly that of school staff (e.g., teachers, teaching assistants, and paraprofessionals). There were also other positions identified in the “Other” category, such as aftercare coordinators, registered nurses, and substance abuse coordinators. Additionally, nearly one-third of participants identified themselves as therapists or case managers.

With regard to the population of clients primarily served, an overwhelming majority [77 (90%)] reported that they worked primarily with male clients (See Table 2). None of the participants worked with both male and female clients. This sample also primarily served middle and high school aged youth with 70(81%) reporting they worked with high school youth and 35(41%) middle school aged youth.

Table 1

Description of Participants' Demographic Information

	n = 86
Highest level of education	
Post-graduate degree	26(30%)
College graduate	21(24%)
Some college	20(23%)
High school diploma or GED	9(10%)
Some post-graduate work	7(8%)
Vocational training	3(3%)
Amount of experience in residential care	
0-3 months	3(3%)
4-6 months	4(5%)
7 months-1year	7(8%)
2-4 years	21(24%)
5-7 years	11(13%)
8-10 years	14(16%)
11+ years	26 (30%)
Professional role within organization	
Direct care worker/youth counselor	36(42%)
Other	22(26%)
Caseworker/case manager	11(13%)
Therapist	11(13%)
Clinical Supervisor/director	8(9%)
Unit Coordinator	7(8%)

Note. GED = Graduate Equivalency Degree

Table 2

Description of Clients that Participants Serve

n = 86	
Gender of clients	
Male	77(90%)
Female	9(10%)
Both	0(0%)
Other	0(0%)
Age range of clients	
High school aged	70(81%)
Middle school aged	35(41%)
18+ years old	18(21%)
I serve all ages	4(5%)
Elementary school aged	0(0%)

Findings

The findings section presents the quantitative and qualitative findings that were analyzed from an online survey (See Table 3). A total of 97 participants started the survey, with 88 making it past the inclusion criteria. There was a steady drop-off throughout the survey as participants were not required to answer every question in the survey. In the qualitative portion, there were three major areas of emphasis that emerged from this data (1) burnout effects; (1) compassion fatigue effects; and finally, (3) mitigating factors. Within these three main themes, several sub-themes were also identified. Under the theme of burnout effects, two subthemes emerged: quality of work and organizational needs. Under the theme of compassion fatigue effects, two subthemes emerged: worker-client relationship and self-care. Lastly, under the theme of mitigating factors, one subtheme emerged, which was organizational support and incentives.

Table 3

Summary Table of Findings for Effects on Client Care

Area of emphasis	Thematic categories
Burnout effects	Quality of work Organizational needs
Compassion fatigue effects	Worker-client relationship Self-care
Mitigating factors	Organizational support and incentives

Note. Respondents were not required to answer every question, therefore N fluctuates

Burnout

Participants were asked three questions that were designed to better understand their experiences with burnout throughout their professional career within their current work setting. Participants were asked yes/no questions to identify if they have felt burnout in the past, are currently experiencing burnout, or feel they are at risk of developing burnout ($n = 81$) (See Table 4). The majority of the respondents [71(88%)] identified that they had felt burnout at

some point in their current work setting. However, only 32(40%) of participants reported that they are currently feeling burnout in their work setting. Over half of respondents [47(59%)] reported that they felt as though they were at risk of developing burnout in the future.

Table 4

Participants' Responses to Questions Related to Burnout

n = 81	
Have you ever experienced burnout	
Yes	71(88%)
No	10(12%)
Are you currently experiencing burnout	
Yes	32(40%)
No	49(60%)
Do you feel you are at risk of developing burnout	
Yes	47 (59%)
No	33(41%)

Burnout effects. *Exhaustion, cynicism, and inadequacy* were identified in the literature as the three major components of burnout. To measure participants' levels of each, they were given a series of Likert scale questions that were formulated using the *Bergen Burnout Inventory* as a guide (Salmela-Aro, et al., 2010). These questions were designed to measure their current levels of *exhaustion, cynicism, and inadequacy* (See tables 5-7). Participants were asked to rank to what degree they agreed or disagreed with each particular statement in the inventory; an example of a statement from the inventory is "I am overwhelmed with my current work responsibilities".

Exhaustion, or the depletion of emotional resources, is a core component of burnout (Maslach, et al., 2001) To measure levels of *exhaustion*, respondents were asked to what degree they currently felt overwhelmed by their responsibilities, slept poorly due to work circumstances, or felt bad for neglecting friends and family due to work ($n = 81$) (See Table 5). Over one-third (37%) of respondents reported that they "somewhat agree" that they were currently overwhelmed by work responsibilities. Twenty-seven (33%) reported that "somewhat agree" that they did

sleep poorly because of work circumstances. Furthermore, almost half of the respondents (47%) reported that they “completely disagree” that they felt bad for having to neglect friends and family due to work.

Cynicism (depersonalization), or uncaring cynical attitudes towards clients or customers, is another main component of burnout as discussed by Maslach (2001). To measure levels of *cynicism*, respondents were asked to what degree they felt dispirited at work and thought of leaving, felt that they have gradually less to give at work, and felt that they have lost interest in their clients and co-workers ($n = 81$) (See Table 6). Twenty-three (28%) said they “completely disagree” that they felt dispirited at work and felt like leaving their job, with only 6(7%) stating that they “completely agree”. When asked about having gradually less to give at work, over half (61%) of respondents reported that they either “completely disagree” or “somewhat disagree.” Lastly, nearly two-thirds of the respondents [53(66%)] also reported that they either “completely disagree” or “somewhat disagree” that they had lost interest in clients and co-workers.

Inadequacy (inefficacy), or feelings of reduced personal accomplishment is the last of the core components of burnout (Maslach, et al., 2001). To measure levels of *inadequacy*, respondents were asked to what degree they currently question the value of work, feel less appreciated at work, and feel that that they have reduced dedication and job performance ($n = 81$) (See Table 7). One-third (33%) reported that they “somewhat agree” that they question the value of work. When asked about feeling less appreciated at work, the answers were evenly distributed across all Likert options with 19(23%) who “completely disagree,” 14(17%) who “somewhat disagree,” 13(16%) who were “neutral,” 18(22%) who “somewhat agree,” and 17(21%) who “completely agree.” Nearly one-third (30%) of respondents said they “completely

disagree” that their dedication and job performance had reduced, with only 5(6%) reporting that they “completely agree.”

Table 5

Participants’ Experiences with Symptoms of Exhaustion

	n = 81
Overwhelmed by work responsibilities	
Completely disagree	12(15%)
Somewhat disagree	10(12%)
Neutral	22(27%)
Somewhat agree	30(37%)
Completely agree	9(7%)
Sleep poorly because of work circumstances	
Completely disagree	21(26%)
Somewhat disagree	23(28%)
Neutral	8(10%)
Somewhat agree	27(33%)
Completely agree	2(2%)
Feel bad for neglecting friends and family	
Completely disagree	38(47%)
Somewhat disagree	21(26%)
Neutral	12(15%)
Somewhat agree	7(9%)
Completely agree	3(4%)

Note. Respondents were not required to answer every question, therefore N fluctuates

Table 6

Participants’ Experiences with Symptoms of Cynicism

	n = 81
Feel dispirited at work and think of leaving	
Completely disagree	23(28%)
Somewhat disagree	16(20%)
Neutral	14(17%)
Somewhat agree	22(27%)
Completely agree	6(7%)
Have gradually less to give at work	
Completely disagree	25(31%)
Somewhat disagree	24(30%)
Neutral	10(12%)
Somewhat agree	17(21%)
Completely agree	5(6%)
Lost interest in clients and co-workers	
Completely disagree	25(31%)
Somewhat disagree	28(35%)
Neutral	14(17%)
Somewhat agree	10(12%)
Completely agree	3(4%)

Note. Respondents were not required to answer every question, therefore N fluctuates

Table 7

Participants' Experiences with Symptoms of Inadequacy

n = 81	
Frequently question the value of work	
Completely disagree	18(22%)
Somewhat disagree	19(23%)
Neutral	9(11%)
Somewhat agree	27(33%)
Completely agree	2(2%)
Feel less appreciated	
Completely disagree	19(23%)
Somewhat disagree	14(17%)
Neutral	13(16%)
Somewhat agree	18(22%)
Completely agree	17(21%)
Dedication and job performance reduced	
Completely disagree	24(30%)
Somewhat disagree	27(33%)
Neutral	8(10%)
Somewhat agree	17(21%)
Completely agree	5(6%)

Note. Respondents were not required to answer every question, therefore N fluctuates

Contributing factors. To better understand what particular aspects of work life contribute most to participants' burnout, they were asked to rank their opinions of the top five contributing factors in the development of job burnout on a scale of 1 through 5, with 1 being the strongest contributor. The participants were given a list of 22 options to choose from, or they could choose the "Other" option and specify their own ideas. The participants answers were scored and illustrated in Table 8 ($n = 77$).

Three-fourths (75%) of the participants identified inadequate rate of pay/pay raise as one of their top five factors, with 16(28%) rating this as the number one contributing factor. Excessive workload and paperwork was the second most likely choice in participants' top five with over half (54%) of participants selecting it as one of their top five. Of these, almost half (46%) ranked this as their second most likely contributor to burnout. Nearly half (49%) of participants identified the high emotional demands of work in their top five. Its particular rank order was somewhat evenly distributed, with the most people 10(26%) ranking it fourth. Inadequate support from supervisors was identified as the 4th most likely contributor with

26(33%) of participants selecting it, 12(46%) of these ranked it the second most likely contributor. The fifth most identified contributor to job burnout was identified as aggressive behaviors from clients. Nearly one-third of participants selected this for their top five, 7(30%) of participants ranked this 5th.

The least likely contributors to burnout were identified as inadequate support from outside of work, inadequate self-care training, and listening to/re-experiencing the traumatic experiences of clients with 3(4%) of participants selecting each as a factor in their top five. Of 13% of participants those who selected “Other”, 4(5%) of participants identified turnover as a contributor in the “Other” category.

Table 8

Description of Participants' Top Five Contributors to Job Burnout

	n = 77					
	n	Ranked 1st	Ranked 2nd	Ranked 3rd	Ranked 4th	Ranked 5th
Inadequate rate of pay/pay raise	58(75%)	16(28%)	14(24%)	9(16%)	8(14%)	11(19%)
Excessive workload/paperwork	42(54%)	17(40%)	9(21%)	8(19%)	1(2%)	7(17%)
High emotional demands of work	38(49%)	8(21%)	9(24%)	7(18%)	10(26%)	4(11%)
Inadequate support from supervisors	26(33%)	4(15%)	12(46%)	4(15%)	3(12%)	3(12%)
Aggressive behaviors of clients	23(29%)	4(17%)	2(9%)	6(26%)	4(17%)	7(30%)
Inadequate support from co-workers	22(33%)	5(28%)	7(32%)	3(14%)	3(14%)	4(18%)
Inadequate resources for job demands	21(27%)	6(29%)	5(24%)	3(14%)	4(19%)	3(14%)
Lack of possibility for professional growth	17(22%)	1(6%)	1(6%)	6(35%)	5(29%)	4(24%)
Lack of power in decision-making	17(22%)	2(12%)	2(12%)	2(12%)	7(41%)	4(24%)
Non-aggressive behaviors of clients	15(19%)	1(7%)	4(27%)	4(27%)	4(27%)	2(13%)
High caseloads	13(17%)	0(0%)	1(8%)	7(54%)	3(23%)	2(15%)
Unrealistic expectations from supervisors	13(17%)	1(8%)	2(15%)	3(23%)	2(15%)	5(33%)
Inability to take time off	12(16%)	2(17%)	1(8%)	2(17%)	4(33%)	3(25%)
Lack of role definition	12(16%)	0(0%)	1(1%)	2(17%)	4(33%)	5(25%)
Personal mental health issues	11(14%)	1(9%)	3(27%)	1(9%)	4(36%)	2(18%)
Other	10(13%)	4(40%)	1(10%)	4(40%)	0(0%)	1(10%)
Unfair job demands	7(9%)	1(11%)	0(0%)	1(11%)	3(43%)	2(18%)
Not enough quality time with clients	5(6%)	1(20%)	0(0%)	1(20%)	2(40%)	1(20%)
Feel unprepared to respond to clients' needs/behaviors	5(6%)	1(20%)	1(20%)	2(40%)	1(20%)	0(0%)
Inadequate training to deal with clients	4(5%)	0(0%)	0(0%)	0(0%)	3(75%)	1(25%)
Inadequate support from outside of work	3(4%)	0(0%)	1(33%)	0(0%)	1(33%)	1(33%)
Inadequate self-care training	3(4%)	0(0%)	0(0%)	0(0%)	3(100%)	0(0%)
Re-experiencing trauma of clients	3(4%)	1(33%)	0(0%)	1(33%)	0(0%)	1(33%)

Burnout effects. Qualitative methods were utilized to assess burnout's effect on client care within the participants' organization. Participants were asked if symptoms of burnout

affected their ability to provide adequate care to the clients in their organization, and then were asked to explain why or why not. A total of 63 participants responded to this question, with a majority or 41(65%) answering “yes” it did affect their quality of work within the organization and with clients. Two themes emerged from the data set, which were: the effects on quality of work and organizational needs.

Quality of work. The first theme presented was burnout’s effect on participants’ quality of work within their organization. Overall, participants felt that they had less patience, compassion, and were overall more short-tempered with clients. One participant stated, “... when you are tired, you lose interest, frustration levels increase and you lose sight of the goals you and the clients are working toward.” Participants also felt that they were less therapeutic and more easily frustrated and avoidant with clients. For example, one participant stated, “The effects of burnout tend to turn a person inward and put up walls to stop negative feedback from coming in, reducing the ability to empathize with residents situations.” Others suggested that they either have not experienced burnout or they do not allow it to affect their quality of work with clients. One participant stated, “I have learned how to balance my workload/time off in order to take care of burnout. Otherwise I don’t think I would still be in the field.”

Organizational needs. Another theme that emerged was organizational needs. Many participants felt underappreciated by administration and supervisors, and also felt that they were overloaded with too many work responsibilities. For example, one participant stated, “I feel that staff are underappreciated and [corporate positions] do not value the work that those who work face-to-face with the clientele experience day-to-day...when staff do not feel appreciated or have too much of a work load they do not provide the best quality of work to the clients.”

Participants also felt that organizational stress was a major issue as they were often not able to get their paperwork done leaving them feeling drained and unmotivated to work with clients. One participant stated, “There are times that the burnout causes me to not care as much or feel like the clients need to “suck it up” when it comes to behaviors/emotions.” Another stated, “...client care is the easiest part of the job. Paperwork, lack of co-worker support, not enough manpower, and vague role delineation are the main issues.” Other participants felt that they were able to mitigate burnout through collaboration with their team, using coping strategies, and not letting outside things affect their mission with clients. For example, one participant stated, “... [I] have learned the importance of humor and other healthy coping strategies. Work in a collaborative environment and foster collaboration/support amongst the team.”

Compassion Fatigue

Participants were asked three questions that were designed to better understand participants experience with compassion fatigue throughout their professional career within their current work setting. Participants were asked questions to identify if they have felt compassion fatigue in the past, are currently experiencing compassion fatigue, or feel that they are at risk of developing compassion fatigue ($n = 78$) (See Table 9). Over two-thirds of the respondents [54(69%)] identified that they had felt compassion fatigue at some point in their current work setting. However, only 16(21%) of participants reported that they are currently feeling compassion fatigue in their work setting. Nearly half of respondents [38(49%)] reported that they felt as though they were at risk of developing compassion fatigue in the future.

Table 9

Participants' Responses to Questions Related to Compassion Fatigue

n = 78	
Have you ever experienced compassion fatigue	
Yes	54(69%)
No	24(31%)
Are you currently experiencing compassion fatigue	
Yes	16(21%)
No	62(79%)
Do you feel you are at risk of developing compassion fatigue	
Yes	38(49%)
No	40(51%)

Compassion fatigue effects. When a person is affected by compassion fatigue, they often suffer from a series of symptoms that can affect both their personal and professional lives. To better understand to what degree the participants in this study were affected by these symptoms, they were asked a series of Likert questions from the Professional Quality of Life Scale. The participants were asked focus on their current work setting and choose the alternative that best describes their situation. The data collected is presented in Table 10 below.

The highest mean score identified was that participants felt invigorated after working with those that they help with $M = 3.27$. Nearly three-fourths of participants identified that they either “Often” or “Sometimes” feel this way in their current work setting. Feeling preoccupied with more than one person I help also had a high mean score of 3.01, with nearly two-thirds reporting that they “Often” or “Sometimes” feel this way. Participant’s lowest mean score was identified as 1.29 for having intrusive or frightening thoughts as a result of helping clients. Over three-fourths of participants stated they “Never” experienced this in their current work setting.

Table 10

Description of Mean Scores for Compassion Fatigue Effects

	n = 77					
	M	Never	Rarely	Sometimes	Often	All of the time
I feel invigorated after working with those I help	3.27	4(5%)	12(15%)	26(33%)	31(40%)	5(6%)
I am preoccupied with more than one person I help	3.01	5(6%)	20(26%)	27(35%)	21(27%)	6(5%)
I feel “bogged down” by the system	2.87	16(21%)	12(15%)	23(29%)	20(26%)	7(9%)
I feel worn out because of my work as a helper	2.83	10(13%)	15(19%)	34(44%)	21(16%)	3(4%)
I feel overwhelmed because my case or workload seems endless	2.81	16(21%)	17(22%)	16(21%)	22(29%)	6(8%)
I feel trapped in my job as a helper	2.24	25(32%)	23(29%)	17(22%)	3(4%)	0(0%)
Because of those I help, I feel on edge about various things	2.22	25(21%)	21(27%)	23(29%)	8(10%)	1(1%)
I find it difficult to separate work and personal life	2.14	24(31%)	27(35%)	20(26%)	6(8%)	1(1%)
I jump or am startled easily	2.09	23(29%)	33(42%)	17(22%)	5(6%)	1(1%)
I think I might have been effected by the traumatic stress of those I help	1.86	34(44%)	24(31%)	17(22%)	3(4%)	0(0%)
I can't recall important parts of my work with clients	1.81	38(49%)	24(31%)	10(13%)	2(3%)	3(4%)
I feel depressed because of the experiences of those I help	1.74	39(50%)	23(29%)	14(18%)	1(1%)	1(1%)
I am not as productive at work because of loss of sleep over someone I help	1.54	45(58%)	25(32%)	7(9%)	1(1%)	0(0%)
I feel I am experiencing the trauma of those I help	1.41	54(69%)	19(24%)	2(3%)	3(4%)	0(0%)
I avoid activities and situations because they remind me of frightening experiences of those I help	1.38	56(73%)	16(21%)	2(3%)	3(6%)	0(0%)
I have intrusive frightening thoughts as a result of my helping	1.29	62(79%)	14(11%)	3(4%)	2(3%)	0(0%)

Contributing factors. To better understand what particular aspects of work life contribute most to participants feeling compassion fatigue, participants were asked to rank their opinions of the top five contributing factors in the development of compassion fatigue on a scale of 1 through 5, with 1 being the strongest contributor. Participants were asked to rank their opinions of the top five contributing factors in the development of compassion fatigue on a scale of 1 through 5, with 1 being the strongest contributor. The participants were given a list of 22 options to choose from, or they could choose the “Other” option and specify their own ideas. The participants’ answers were scored and illustrated in Table 11 ($n = 77$).

Nearly two-thirds (65%) of the participants identified the high emotional demands as one of their top five contributing factors to the development of compassion fatigue, with 13(26%) ranking this as the number one factor. The next most popular answer chosen was excessive workload/paperwork with 29(28%) of the participants selecting it for their top five, and close to

half of those (41%) ranking it as their number one factor. Inadequate rate of pay/pay raise was the third most selected contributor with 25(32%) of participants selecting this for their top five, and 7(28%) ranking it third. Inadequate support from co-workers was the fourth most selected contributor with nearly one-third (31%) of participants selecting this for their top five; 6(25%) ranked this as their second most likely contributor and 7(29%) ranked it fifth. Inadequate support from supervisors also identified by nearly one-third [24(31%)] of participants as one of their top five, 7(29%) of those ranked it as the number one most likely contributor.

The least likely contributors were identified as inadequate training to effectively deal with client-related issues and lack of training or experience leaves them unprepared to assist/respond to clients' needs with 5(6%) of participants placing each in their top five. Some of the things identified in the "Other" category were poor self-care, lack of respect from administration, and high turnover rates.

Table 11

Description of participants' Top Five Contributors to Compassion Fatigue

	n	Ranked 1 st	Ranked 2 nd	Ranked 3 rd	Ranked 4 th	Ranked 5 th
High emotional demands of work	50(65%)	13(26%)	11(22%)	11(22%)	9(18%)	6(12%)
Excessive workload/paperwork	29(38%)	12(41%)	9(31%)	3(10%)	0(0%)	5(17%)
Inadequate rate of pay/pay raise	25(32%)	2(8%)	6(24%)	7(28%)	5(20%)	5(20%)
Inadequate support from co-workers	24(31%)	3(13%)	6(25%)	3(13%)	5(21%)	7(29%)
Inadequate support from supervisors	24(31%)	7(29%)	6(25%)	5(21%)	2(8%)	4(17%)
Re-experiencing trauma of clients	22(29%)	5(23%)	5(23%)	3(14%)	6(27%)	3(14%)
Aggressive behaviors of clients	21(27%)	7(33%)	3(14%)	6(29%)	3(14%)	2(10%)
Inability to take time off	20(26%)	4(20%)	3(15%)	5(25%)	5(25%)	3(15%)
Inadequate resources for job demands	19(25%)	7(37%)	4(21%)	2(11%)	4(21%)	2(11%)
Lack of power in decision-making	19(25%)	3(16%)	1(5%)	1(5%)	8(42%)	6(32%)
High caseloads	18(23%)	0(0%)	3(17%)	6(34%)	4(22%)	5(28%)
Non-aggressive behaviors of clients	18(23%)	5(28%)	7(39%)	2(11%)	1(6%)	3(17%)
Personal mental health issues	15(19%)	0(0%)	5(33%)	2(13%)	4(27%)	4(27%)
Unrealistic expectations from supervisors	15(19%)	0(0%)	3(20%)	2(13%)	5(33%)	5(33%)
Lack of role definition	12(16%)	1(9%)	0(0%)	2(17%)	2(17%)	6(50%)
Inadequate support from outside of work	9(12%)	3(33%)	1(11%)	3(33%)	1(11%)	1(11%)
Not enough quality time with clients	9(12%)	0(0%)	0(0%)	6(67%)	2(22%)	1(11%)
Inadequate self-care training	9(12%)	1(11%)	0(0%)	2(22%)	1(11%)	5(56%)
Other	7(9%)	2(29%)	0(0%)	1(14%)	4(57%)	0(0%)
Inadequate training to deal with clients	5(6%)	0(0%)	1(20%)	1(20%)	2(40%)	1(20%)
Feel unprepared to respond to clients' needs/behaviors	5(6%)	0(0%)	1(20%)	1(20%)	2(40%)	1(20%)

Compassion fatigue effects. Participants were also asked to identify if they felt compassion fatigue affected their ability to provide adequate care to their clients. A total of 62 people responded to this question, with 30(62%) stating yes it does affect their ability. Two major themes emerged from the responses which were the impact on the worker-client relationship and self-care.

Worker-client relationship. Several participants highlighted the impact that compassion fatigue has on their relationship with clients. Many stated that they felt overwhelmed and emotionally fatigued with clients, causing them to become hardened, less compassionate, and avoidant of clients' altogether. Respondents indicated in their responses that client behaviors and traumatic experiences can become draining, causing workers to "shut off" or feel helpless. One participant stated, "I enjoy being able to be compassionate about helping each student I work with but the repetition sometimes causes moments of feeling inadequate myself due to their

pain.” Another stated, “I feel that oftentimes people tend to tune out to some discussions in order to not feel the emotions that go along with the clients’ history or trauma. If we are not in tune with our clients and all the details it affects their ability to grow and become healthier.”

It is important to note that not all employees in this study felt the effects of compassion fatigue. Some participants were able to manage the daily stressors of the job more easily. Some participants stated they have not yet experienced compassion fatigue and can separate their work and personal lives. For example, one participant stated,

I don’t believe I have experienced compassion fatigue to the point of it interfering with my care of the clients, I am empathetic and emotional about their personal problem issues, but up to this point, I feel it has only increased my need and want to help them.

Another stated, “I try to put my issues aside and put on a good front. It works.”

When asked if participants can see it affecting others in the workplace, there was an overwhelming response of yes. Participants noted that they are constantly seeing other staff in their organization projecting their frustrations onto the youth in care and struggling to connect with youth in times of need. One participant stated, “Hell yes, some people are just zombies walking around here and they haven’t even put in as much time as me.” Another stated,

Others often have a shorter temper with others and struggle to see the situation from a therapeutic standpoint, but rather see tough situations with clients as the client being “wrong” or “defiant”...[and] teach the client a lesson by giving them consequences.

Self-care. Self-care was also brought up a lot in the responses of those who felt they either have never experienced compassion fatigue or were able to mitigate the effects that it has on themselves and their relationships with clients. Having a good self-care plan and good self-awareness helps them to stay focused on the clients and mitigate compassion fatigue. One

participant stated, “Whatever the clients have done is a “part” of them but not all of them. These are things they have done that do not affect me other than having to discuss it with them.”

Another stated, I think that self-awareness and emotional competence help to diminish the impact of compassion fatigue on client care...I have learned that you don’t have to “feel like it” in order to be compassionate and available, I just decide to be and am.”

Other participants highlighted the importance of having good personal and emotional boundaries to mitigate compassion fatigue. For example, one participant stated, “I have developed a “shell” if you will for keeping the bad things that have happened to my clients from impacting me personally. I keep a well-defined internal emotional boundary as a professional.” Another stated, “I leave my problems from home at the door when I walk into my job and do the same when I leave.” Without good self-care, participants identified workers to be more likely to quit, creating turn-over. Staff observed others using unhealthy methods to separate themselves from the youth. One participant stated, “Yes. People are drinking to deaden their feelings.”

Mitigating Factors

Organizational support and incentives. Participants were asked to identify in their own words what they thought would help them to combat burnout and compassion fatigue. Sixty-one people responded to this question and one major theme emerged from their responses, which was the need for more organizational support and incentives. The majority of participants felt like they wanted more appreciation and recognition for their hard work with clients. Many feel that management and corporate are “just in it for the money” and have lost sight of the importance of those who deal directly with the youth daily. For example, one participant stated, “The “higher-ups” acting like the work we do actually matters, rather than the focus being on the dollars.” Other participants felt like they could use support from supervisors. One participant

stated, “I think letting us know that we are doing a good job. I think knowing that you are making a difference means a lot to most people.”

Several participants identified that they would like more time off and better pay. Participants highlighted the importance of supervisors ensuring people were able to use their vacation time when they requested it in advance and didn’t have to “pay” for it in the form of extra work before and after vacation. One participant exemplified this by stating, “Higher wages, ability to take time off without having to be overworked before or after your vacation.” Similarly, another stated in response to the question, “Time off, program support, being able to take time off and not come back to a backlog of work.”

Discussion

The purpose of this study is to explore what factors contribute to burnout and compassion fatigue in a residential treatment setting, what factors may help to minimize risk for the development of compassion fatigue in a residential treatment setting, and how these two issues affect client care. This study served to identify how burnout and compassion fatigue affect the clients in care, the residential care workers, and the organization as a whole. It also provided data to better understand what factors most contribute to residential care workers development of burnout and compassion fatigue, and how these issues can be addressed at a personal, professional, and organizational level. There has been very few research studies done on burnout and compassion fatigue on residential care workers specifically, however much of the data found in this study can align with previous studies done on similar types of human service organizations. There were some new and interesting findings that were unique to this study that may be helpful in combating the deleterious effects that burnout and compassion fatigue have on residential care workers.

Burnout

This study aimed to identify the prevalence of burnout in residential care workers. Although only 60% of care workers identified that they were currently experiencing burnout, the majority (88%) stated that they have experienced it at some point in the past. Furthermore, 59% of care workers reported that they felt as though they were at risk of developing burnout. This is unsupported by current research as Sepulveda (2003) found 71% of residential care workers in her study were in the “extremely low risk” range for burnout.

The data in this study may not align with previous research because participants had to self-identify burnout by simply answering “yes” or “no” versus being measured by a burnout

scale. Furthermore, self-assessment of burnout is situational and subjective, meaning participants' answers could be skewed because of something that happened that particular day or week, whereas an inventory could possibly be designed to account for those variations. This study does show that burnout is a prevalent problem within residential care settings.

Burnout Effects

Previous research breaks down burnout into three major components: exhaustion, cynicism, and inadequacy. This study aimed to better understand the symptoms behind these components and how prevalent these are in residential care workers. The inventory that was used to design the questions in this study broke each component down into three main symptoms. Overall, participants in this study reported average levels of exhaustion and depersonalization, and overall low levels of cynicism. The main findings indicated that over one-third of participants in this study felt that they were both overwhelmed with work responsibilities and slept poorly due to work circumstances, which are both core components of exhaustion. These results are both supported and unsupported by previous literature. Excessive workloads and large caseloads have been found in the literature to be associated with higher levels of exhaustion (de Figueredo et al., 2014; Vassos & Nankervis, 2012). In previous literature, cynicism is often present if exhaustion is present; this wasn't the case with this study (Alarcon, 2011). Therefore, it is possible for residential care workers to feel burnout and exhaustion while remaining dedicated and committed to their job and clients. This could possibly be because residential care workers enter into the field with a wish to help others and the satisfaction that comes along with helping clients helps to offset other stressors.

The findings pertaining to these core components of burnout were quite dispersed, which could be the result of a few different things. First, all previous studies identified in the literature

review looked at these three components as a whole, whereas this study broke each of them down into specific symptoms that have been identified as part of each component (Salmela-Aro et al., 2010). Furthermore, the three phenomena are each components of burnout, meaning all three do not have to be present in order for one to feel burnout effects. Secondly, because this study did not aim to measure levels of exhaustion, cynicism, inadequacy, but gauge participant's experiences with their symptoms, participants' answers to these questions could be situational. For example, a participant may still be experiencing exhaustion without sleeping poorly because of work. Furthermore, burnout is a subjective experience, so certain symptoms may have a deeper effect on one person than another. Lastly, those who identified higher levels of exhaustion symptoms, but low cynicism symptoms may be in earlier stages of burnout. Moreover, just because this sample population is not experiencing all symptoms, does not mean that they are not burned out, it simply means that their attitudes about their job and clients are remaining positive, even with other possible burnout stressors present (Alarcon, 2011).

Contributing Factors

Previous literature demonstrates the importance of better understanding how burnout effects the worker on and off the job, however this study aimed to better understand the leading contributing factors to burnout in residential care workers specifically. The top five factors that the sample population identified as the leading causes to burnout were as follows: (1) inadequate rate of pay/pay raise; (2) excessive workload/paperwork; (3) the high emotional demands of the work; (4) inadequate support from supervisors; and (5) the aggressive behaviors of clients. This is both supported and not supported by several different studies (Alarcon, 2011, de Figueredo et al., 2011; Rose et al., 2013; Vassos & Nankervis, 2012). Several studies found similar factors as predictors of burnout in workers; however some of the factors identified did not come up in any

of the studies (Alarcon, 2011; de Figueredo et al., 2014; Rose et al., 2013; Vassos & Nankervis, 2012).

Previous research has aimed at better understanding what causes burnout in several different human service professions. This study's target population was residential care workers, where limited research is available for burnout and compassion fatigue within this population. Excessive workload and lack of support from supervisors were both found in several studies to be significant predictors of burnout in human service work (Alarcon, 2011; de Figueredo et al., 2014; Rose et al., 2013; Vassos & Nankervis, 2012). Human service workers are often bombarded with many roles and responsibilities, making it very difficult for them to find a good balance between paperwork and time with clients. Previous research found that good supervision and a more supportive work environment mitigated burnout effects, which could help residential care workers find a balance both in and out of work (Vassos & Nankervis, 2012). Furthermore, a supportive work environment can help residential care workers learn new skills to better adapt to stressful situations, find a work/life balance, and provide better overall care to clients. Similar to previous literature, participants in this study also identified aggressive behavior as a contributing factor to burnout (Vassos & Nankervis, 2012). However, previous literature found that it could be mitigated by better training on how to more effectively respond to clients' needs (Vassos & Nankervis, 2012). Lastly, inadequate rate of pay/pay raises seemed to be a unique variable to this study. This may be partly because many human service workers may not get into the field for the pay, but more for the intrinsic satisfaction that the work gives. However, once burnout sets in, more pay could make the burnout feel more worthwhile for workers.

Quality of work. The qualitative data that was found in this study highlighted how burnout in residential care workers negatively impacts the quality of client care. This is supported by the literature as many identify burnout as detrimental to one's quality of work within their organization (de Figueredo et al., 2014; McLindon & Harms, 2011). Participants in this study identified burnout as causing them to be less therapeutic and more short-tempered with clients. They also stated that their overwhelming workload often leaves them with less time and energy to give to their clients. Like previous research, participants identify that burnout makes them feel as though they have less and less to give to clients and their organization (McLindon & Harms, 2011). Furthermore, high stress levels arise due to worries about the not knowing how to effectively deal with client's behaviors and needs or deal with the personal impact of these experiences (de Figueredo et al., 2014; McLindon & Harms, 2011).

When aligned with previous research, it is obvious that neglecting burnout within an organization has detrimental effects on client care standards. In residential treatment, these client care standards are extremely important as treatment is costly and workers should be better-equipped to work with youth with high needs. It also highlights the importance of a supportive work environment and better training on the unique issues and demands that working in this type of environment and with this population of clients presents for workers (McLindon & Harms, 2011).

Organizational needs. This study showed how important the organizations role is in combating burnout within their employees. An overwhelming majority of the sample population felt underappreciated in their work and felt overloaded with too many work responsibilities. This aligns with several previous research studies that identified role ambiguity and workload to be predictors of burnout (de Figueredo et al.; 2014; Ray et al., 2013). When employees feel

overwhelmed at work, they have a hard time compartmentalizing their job tasks, and can easily lose sight of their organization's mission, which is often to provide quality services to the clients in their care.

One unique finding in this study was that over one-third of participants felt that burnout did not affect the quality of work they provide. These participants identified being able to find balance and separate work and personal life to be helpful. This shows that there are employees who are able to manage the difficult parts of residential care work without letting it affect the services that they are providing youth. It is important for organizations to better understand how these staff in particular are able to manage the stressors of residential care work, to help others within the organization that are being negatively affected by burnout.

Compassion Fatigue

Research has indicated that compassion fatigue can have detrimental effects on the employee, clients in care, and the organization as a whole (Sepulveda, 2003). Over two-thirds of respondents in this study identified that they had felt compassion fatigue at some point at their current organization, however only 21% felt that they were currently feeling symptoms of compassion fatigue. This somewhat aligns with previous research as Sepulveda (2003) found around one-fourth of her participants in the extremely high risk range and another fourth in the extremely low risk range for compassion fatigue.

Because residential care workers work with a number of highly traumatized individuals daily, this also increases their risk (de Figuieredo et al., 2014). These studies highlight the importance of supervisors understanding how each employee is managing symptoms of compassion fatigue on a constant basis because its development can be quick and it can go on for long periods of time undetected. Also, compassion fatigue is often misunderstood by those

suffering from it because it comes in the form of many symptoms; therefore creating an informed work environment on the effects of compassion fatigue is imperative.

Figley (1995) noted the negative effects that compassion fatigue has on employees in human service organizations such as: re-experiencing trauma reactions of clients, loss of compassion or interest in clients, loss of understanding about the roots of children's behaviors. The main compassion fatigue symptoms that were identified by participants in this study as problematic were as follows: (1) feeling invigorated after working with clients and (2) feeling preoccupied with more than one client in and out of work. Overall, the participants in this study seemed to be moderately effected by compassion fatigue symptoms, some more than others. This study aimed at better understanding what components of compassion fatigue are affecting residential care workers. The ambiguity of the answers may be due to this study looking at individual symptoms of compassion fatigue versus scoring employees compassion fatigue levels by using an inventory. Furthermore, many employees are unsure what compassion fatigue is and often don't understand that they are being affected by it, so more training and awareness is key in helping them understand and combat its effects.

Contributing Factors

Although previous literature on compassion fatigue has not been primarily focused on residential care workers, previous research has identified many personal, client-related, and organizational factors that contribute to compassion fatigue (Adams et al., 2006; Cieslak et al., 2014; de Figueiredo et al., 2014; Knight, 2013; Meyer et al., 2014; Ray et al., 2013). The top five factors that were identified as lead contributors to compassion fatigue in this study were as follows: (1) the high emotional demands of the work; (2) excessive workload/paperwork; (3) inadequate rate of pay/pay raise; (4) inadequate support from co-workers; and (5) inadequate

support from supervisors. This is supported by a previous study done by Adams and colleagues (2006), who found the development of compassion fatigue to be the result of a mixture of factors in both the workers personal and professional lives. This study shows the importance of the dual responsibilities that both the organization and the worker have in managing the negative effects that compassion fatigue can have.

Previous research highlights the importance of awareness of compassion fatigue within human service organizations so that workers can better recognize when they are experiencing the symptoms (de Figuieredo et al., 2014). The qualitative data in this study also highlights the importance of residential care workers need to critically assess their countertransference from clients so they can better communicate their needs to their supervisors and receive helpful feedback. Organizations need to make sure that they are assessing workers regularly for symptoms of compassion fatigue, providing training on awareness, and offering support and guidance to those who are struggling to manage the stressors that come with residential care work.

Compassion Fatigue Effects

The qualitative data in this study highlighted the importance of understanding the effects that compassion fatigue has on client care. Over half of the participants in this research stated it that it does affect the quality of care they provide clients, namely the worker-client relationship. The respondents also identified good self-care practices as a necessity to help them manage daily work stressors, but most wished that the organization would also offer more training or help with self-care practices. The results from this study align with previous research as they also noted how important self-care is in helping to manage the stressors that come with working with traumatized clients (de Figuieredo et al., 2014; Ray et al., 2013). Similar to previous research,

the narratives clearly revealed that the work is emotionally draining and workers feel that they have less to give to clients (de Figueredo et al., 2014). They also revealed how difficult it is to remain compassionate and empathetic to clients' experiences because of the overwhelming workload and feelings of helplessness that comes with re-experiencing clients' trauma with them (de Figueredo et al., 2014). Enhancing the training standards and awareness of compassion fatigue within the organization is key in helping employees to be better able to self-identify and manage compassion fatigue symptoms.

Worker-client relationship. The qualitative data in this highlighted how the emotionally demanding nature of residential care work causes staff to feel drained, empty, and emotionally hardened over time. This aligns with previous literature as other human services workers who work with traumatized youth identified how exhausting it can be helping their clients because their list of needs seems endless (de Figueredo et al., 2014). Participants also highlighted the lack of support that they get from others within their organization as problematic because helping clients manage so many different stressors in their lives creates a burden on the workers who are helping them, leaving them feeling lost with clients with no one to seek for consultation or support.

Self-care. Self-care is an important preventative factor in mitigating compassion fatigue symptoms in residential care workers. The narratives in this study clearly revealed that some workers are able to manage the stressors that are brought on by all facets of their work by employing self-care strategies. Similarly, de Figueredo and colleagues highlighted the importance of self-care, supervision, training, and other supportive strategies to mitigate compassion fatigue effects. Residential care workers should be well trained in trauma-informed

care and the impact of trauma care on providers to help them manage the intense emotions that trauma exposure brings about in their clients and themselves.

Mitigating Factors

Organizational support and incentives. Participants in this study identified one main theme to help them combat compassion fatigue and burnout, which was organizational support and incentives. This was supported by several previous studies (de Figuieredo et al., 2014; Ray et al., 2013; Sepulveda, 2003). Ray and colleagues identified several mitigating factors in their study such as stronger relationships among colleagues, more supervision, more promotion opportunities, and greater awareness of colleagues' emotions (2013). The narratives in this study highlighted the importance of appreciation and recognition for their hard work in the form of higher pay, more time off, more support from supervisors, less job demands, equal role distribution, and empowerment of the direct care workers.

Organizational support needs to come from many different avenues if it is expected to help all employees. This study highlighted the importance of individualizing incentives based on the worker's needs. Some participants wanted incentives in the form of higher pay, time off, and more breaks during the work day, while others were looking for other forms of support such as more supervision, equalizing job demands, and having more overall respect for the workers. Organizations would benefit from communicating with their workers to see what they are most needing to combat compassion fatigue and burnout to reduce overall dissatisfaction, turn-over, and the negative effects that they have on clients.

Strengths and Limitations

This study had several strengths. First, the mixed-methods design allowed for a wider variety of data. Furthermore, the qualitative portion allowed participants the opportunity to

expand on their thoughts freely, which ultimately added to the richness of the data. Secondly, because this was an online survey that was not time sensitive, it allowed participants to take their time answering the questions. Furthermore, because it was done anonymously, participants were potentially more at ease with sharing sensitive or difficult information and opinions. Lastly, because the residential agencies that were used in this study had many employees who worked directly with the youth in care, this study was able to gain a much bigger sample population.

One major limitation for this study was that convenience sampling was utilized, therefore generalizability was decreased. Secondly, because participants were not required to answer all the questions in the survey, there was a significant drop off for the qualitative portion of the survey. Another limitation was that there was an uneven distribution of experienced and less experienced staff that completed the study, with the majority having 2+ years of experience, so data was missed out on those who were newer to residential care work.

Implications for Social Work Practice and Policy

Residential care work can prove to be very difficult for workers because of the difficult population of youth that reside at these facilities. Most youth who are placed in residential treatment centers have failed in most other less restrictive settings, which is often the result of them having complex trauma and multiple stressors to manage. This makes this population of youth very difficult to manage and treat. The residential care workers in these facilities are often overloaded with too many responsibilities and job demands as well as struggle with having to balance several different work roles. It is imperative to address these aspects of residential care work in order to decrease the prevalence of burnout and compassion fatigue.

One suggestion to help mediate the negative effects of burnout and compassion fatigue is to increase awareness within organizations of these two issues and how they affect the care that

workers provide to their clients. If organizations provide better training, education, and support to their workers this would give employees the opportunity to communicate what support systems they need to help find balance in their work. Furthermore, this could help them to remain level-headed with their clients, find a better work-life balance, and lower turn-over rates within these facilities.

Future research in this area using a larger sample and several different residential agencies would be recommended to increase generalizability. This study lacked a good mixture of new and seasoned workers, which could help to better understand who is most susceptible to these symptoms. Another helpful suggestion for future research would be to further study the workers who are not developing burnout and compassion fatigue to find out what factors they are employing to avoid these two things from developing. This could help to enhance knowledge of specific personality characteristics that may aid in the preventing these two phenomena from developing altogether.

Another suggestion would be to do a longitudinal study over the course of a residential care workers career to better understand the long-term development of compassion fatigue and burnout. It would be also important to take a deeper look into the relationship between compassion fatigue and burnout to see if there are any major correlating factors in their development.

Conclusion

In conclusion, this study provided valuable information regarding burnout and compassion fatigue in residential care workers. Much of the previous literature available on burnout and compassion fatigue has been focused on other human service professions (e.g. nursing, psychology, disability workers, etc.). This research helps to shed light on the impact

that these two phenomena have on residential care workers specifically as well as how their presence within an organization can affect the quality of client care provided. Furthermore, the findings were able to show what factors may help to mitigate these issues within human service organizations working with high-risk, high-needs clients.

Because burnout and compassion fatigue are prevalent in human service organizations, especially those who serve a client population with complex trauma and multiple life stressors, it is important that these issues are addressed at a personal, professional, and organizational level. Awareness and support in the form of training and education on these issues is crucial in helping workers to, not only understand what these things are, but recognize when they are being affected by them. Due to the high prevalence of clients with trauma needing services, more research should be conducted to help better educate professionals on how to manage the stress that this type of work can produce in order to better serve the clients in care.

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Appendix A

CONSENT FORM
UNIVERSITY OF ST. THOMAS

The Impact of Compassion Fatigue and Burnout among Residential Care

Workers on Client Care: Implications for Social Work Practice

IRB NetID: 701864-1

I am conducting a study on the impact of burnout and compassion fatigue among residential youth care workers on client care, and I invite you to participate in this research. Your agency was selected as a possible participant because it is a residential treatment facility that provides services to youth. This study is being conducted by Amanda Hanson, a graduate student at the School of Social Work, College of St. Catherine/University of St. Thomas and is being supervised by Kari L. Fletcher, Ph.D., LICSW, a faculty member in the School of Social Work. Please read this form and ask any questions you may have before agreeing to be in the study.

Background Information:

The purpose of this study is to learn the effects that burnout and compassion fatigue among residential care workers have on client care. Participants for this study will be asked to complete a survey that assesses their current levels of burnout and compassion fatigue as well as explores what factors contribute to the development of these, and the implications that these two issues have on client care. Approximately 60-80 people are expected to participate in this research. By participating in this research you are helping to advance the knowledge of compassion fatigue and burnout and how they affect client care in a residential treatment setting. This research can help benefit not only residential care workers, but other mental health professionals who are experiencing burnout and compassion fatigue in their work.

Procedures:

If you agree to be in the study, I will ask you to do the following things: complete a survey including: a list of demographic questions about your education and professional experience, questions about the types of clients you primarily serve, questions designed to assess your current burnout level and what factors you feel contribute to burnout, questions designed to assess your current level of compassion fatigue and what factors you feel contribute to compassion fatigue, and a set of questions asking your opinions on how burnout and compassion fatigue affect client care within your organization. This survey should take approximately 15-20 minutes to complete.

Risks and Benefits of Being in the Study:

This study has minimal risks to you. You may discover that you are experiencing compassion fatigue symptoms or realize that you are more burned out than you expected. If any of the questions in the survey or any of the open-ended questions start causing you stress you may choose to forego answering any question and/or may stop taking the survey at any time. If you are feeling symptoms of compassion fatigue or burnout please feel free to seek assistance from the resources that are listed at the end of the survey.

There are no direct benefits to you for participating in this research.

Compensation:

All participants who complete the survey can choose to be entered into a drawing to win one of two \$25 dollar Amazon gift cards.

Confidentiality:

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you in any way.

The raw data collected during this study will be kept on a password protected secured personal computer in file of which only myself and my graduate professor has access. I will finish analyzing the data by May 1st, 2015. I will destroy all original reports and any identifying information that can be linked to you by June 1st, 2015.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with your current professional organization or University of St. Thomas. Should you decide to withdraw data collected about you, you are free to withdraw anytime up until 4/1/15; the raw data that you provided will still be used in this study, but there will be no possible way for you to be identified. Should you decide to participate, you are also free to skip any of the questions asked in the survey.

Contacts and Questions

If you have any questions please feel to contact me, Amanda Hanson, at hans4008@stthomas.edu. If you have questions later, you may contact me at _____. As I am currently a graduate student at the University of St. Thomas, you may also contact my faculty advisor Kari L. Fletcher at (651) 962-5807 or by email at kari.fletcher@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I consent for my answers to the survey questions to be analyzed and reported in the findings.

Signature of Study Participant

Date

Print Name of Study Participant

**Signature of Parent or Guardian
(If applicable)**

Date

**Print Name of Parent or Guardian
(If Applicable)**

Signature of Researcher

Date

Appendix B

Letter of permission from participating organization

1-1-15

I, XXX XXXX, confirm that permission has been given by (participating organization) Human Resources, Quality Assurance, and management teams for Amanda Hanson to complete a research survey on their employees concerning burnout and compassion fatigue on residential care workers and its effect on client care. All parties concerned understand that a survey will be provided to staff via email and that data management will be controlled by Amanda and her research committee at the University of St. Thomas.

(Participating Organization) agrees that although we will not have the rights to the raw data collected, we will receive a copy of the final report after all potentially identifying information has been removed. We also understand that Amanda's name and other identifying data will be kept confidential until all data is collected.

Thank you,

XXX-XXXX (Executive Director)

Appendix C

The Impact of Compassion Fatigue and Burnout among Residential Care Workers on Client Care: Implications for Social Work Practice

Eligibility Criteria:

1.) I am currently working in a residential treatment center for youth:

A) Yes

B) No

2.) I am currently in a role within my agency that provides direct treatment services to youth either clinical or non-clinical:

A) Yes

B) No

Welcome! Thank you for your participation in my research study regarding the effects that compassion fatigue and burnout in residential care workers has on the quality of client care. I am interested in learning more about your experiences with compassion fatigue and burnout in your setting and how that affects your work with clients in your care. Your participation for this study is voluntary and you may quit the survey at any point in time. You are also able to skip any questions that you do not feel comfortable answering. A list of available resources is provided at the end of the survey for you. Thank you again for your participation.

Demographic Questions

1.) What is the highest level of education you have completed?

A) High School Diploma or GED

B) Some college

C) Vocational training

D) College Graduate

E) Some postgraduate work

F) Postgraduate Degree

2.) Please indicate the amount of experience you have working with youth in a residential care setting or other similar type of organization.

- A) 1-3 months
- B) 4-6 months
- C) 7 months-1 year
- D) 2-4 years
- E) 5-7 years
- F) 8-10 years
- G) 11+ years

3.) Please identify what role fits your position best within your professional organization.

- A) Direct care worker/youth counselor
- B) Unit Coordinator
- C) Therapist
- D) Caseworker/Case manager
- E) Clinical Supervisor/Director
- F) Other: Please specify

Client-related questions

4.) Please indicate the gender of clients that you primarily serve.

- A) Male
- B) Female
- C) Both
- D) Other: Please Specify

5.) Please indicate the age range of clients that you primarily serve.

- A) Elementary school aged
- B) Middle school aged
- C) High School aged

D) 18+ years old

F) I serve all ages

Questions related to Burnout

Please answer the following questions by choosing the alternative that best describes your current situation on the following scale:

1- Completely Disagree

2- Somewhat Disagree

3- Neutral

4- Partly Agree

5- Completely Agree

- 1.) I am overwhelmed with my current work responsibilities.
- 2.) I feel dispirited at work and I think of leaving my job.
- 3.) I often sleep poorly because of the circumstances at work.
- 4.) I frequently question the value of my work.
- 5.) I feel that I have gradually less to give in the work setting.
- 6.) My expectations to my job and to my performance have reduced.
- 7.) I constantly have a bad conscience because my work forces me to neglect my close friends and family.
- 8.) I feel that I am gradually losing interest in my clients and other employees at work.
- 9.) I feel less appreciated at work now than in the past.

Have you ever experienced feelings of burnout in your current work setting?

A) Yes

B) No

Do you feel you are currently experiencing burnout regarding your current residential care job?

A) Yes

B) No

Do you feel you are at-risk of becoming burnt out with your current work role?

A) Yes

B) No

What do you believe to be the top 5 factors that contribute to burnout in residential care workers? Please choose your top five answers from the options below and rate them from 1 to 5 (1 being the strongest contributor).

Excessive workload/paperwork

Inadequate resources to complete job demands

High caseloads

Inadequate support from coworkers

Inadequate support from supervisors

Inadequate support outside of work

Personal mental health issues/trauma experiences

Inadequate rate of pay/pay raises

Inability to take time off

The high emotional demands of the work

Lack of possibilities for professional growth

Unrealistic expectations from supervisors

Lack of role definition

Lack of power in decision-making within the workplace

Unfair job demands between workers

Don't get enough quality time with clients

Aggressive behaviors of clients/Fear of getting hurt

Listening to/Re-experiencing the traumatic experiences of clients

Non-aggressive challenging behaviors of clients

Inadequate training to effectively deal with client-related issues (i.e. trauma, behavior management techniques)

Inadequate training on self-care

Lack of training or experience makes me feel unprepared to assist/respond to clients' needs

Questions related to Compassion Fatigue

As you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in both positive and negative ways. Below are some questions about your experiences as a helper. Consider each of the following questions about you and your current work situation and select the number that most accurately reflects how frequently you experience these things.

Please answer the following questions by choosing the alternative that best describes your current situation at work on the following scale:

1- Never

2- Rarely

3- Sometimes

4- Often

5- Very Often

1) I am preoccupied with more than one person I help.

2) I jump or am startled by unexpected sounds.

3) I feel invigorated after working with those I help.

4) I find it difficult to separate my personal life from my work life.

5) I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.

6) I think that I might have been affected by the traumatic stress of those I help.

7) I feel trapped in my job as a helper.

8) Because of my helping, I have felt "on edge" about various things.

9) I feel depressed because of the traumatic experiences of the people I help.

10) I feel as though I am experiencing the trauma of someone I have helped.

- 11) I feel worn out because of my work as a helper.
- 12) I feel overwhelmed because my case or work load seems endless.
- 13) I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
- 14) As a result of my helping, I have intrusive, frightening thoughts.
- 15) I feel “bogged down” by the system.
- 16) I can’t recall important parts of my work with clients.

Have you ever experienced feelings of compassion fatigue in your current work setting?

A) Yes

B) No

Do you feel you are currently experiencing compassion fatigue regarding your current residential care job?

A) Yes

B) No

Do you feel you are at-risk of developing compassion fatigue within your current work role?

A) Yes

B) No

What do you believe to be the top 5 factors that contribute to compassion fatigue in residential care workers? Please choose your top five answers from the options below and rate them from 1 to 5 (1 being the strongest contributor).

Excessive workload/paperwork

Inadequate resources to complete job demands

High caseloads

Inability to take time off

Inadequate support from coworkers

Inadequate support from supervisors

Inadequate support outside of work

Inadequate consultation/supervision time

Personal mental health issues/trauma experiences

The high emotional demands of the work

Unrealistic expectations from supervisors

Lack of role definition

Lack of power in decision-making within the workplace

Don't get enough quality time with clients

Aggressive behaviors of clients/Fear of getting hurt

Listening to/Re-experiencing the traumatic experiences of clients

Non-aggressive challenging behaviors of clients

Inadequate training to effectively deal with client-related issues (i.e. trauma, behavior management techniques)

Inadequate training on self-care

Lack of training or experience makes me feel unprepared to assist/respond to clients' needs

Questions related to Client Care

- 1) Do symptoms of burnout affect your ability to provide adequate care to the clients in your organization? Why or why not? Please describe.**
- 2) Do symptoms of compassion fatigue affect your ability to provide adequate care to the clients in your organization? Why or why not? Please describe.**
- 3) Do you see burnout and compassion fatigue affecting other's ability to provide adequate care to the clients in your organization? If so, how? Please describe.**
- 4) What do you believe to be the top 5 symptoms for you when you are experiencing burnout and/or compassion fatigue? Please choose your top five answers from the options below and rate them from 1 to 5 (1 being the strongest contributor).**

I am more short-tempered with clients and co-workers

I am angrier at work

I am more depressed

I am less invested in my organization

I am scared to come to work

I am less invested in clients

I avoid clients or feel disinterested in client's experiences

I struggle to maintain clear boundaries with clients

I am more likely to call in sick

I feel like finding a new job

I am more likely to use punitive interventions with clients

I am more likely to have poor judgment with clients

I am more likely to use physical methods with clients (escorts, physical restraints)

Other: Please specify _____

5.) What do you think would most help you combat burnout and compassion fatigue? Why? Please describe.

6.) Is there any additional information that you would like to share about your experiences with compassion fatigue and burnout?

Thank you for taking time to complete this survey! If you are experiencing symptoms of burnout and/or compassion fatigue here are some available resources for you to seek help and support.

Compassion Fatigue Resources

- www.compassionfatigue.org
- **The Crisis Connection** at 612-379-6363 or toll free at 1-866-379-6363
- Caregiver Wellness
Compassion Fatigue and Chronic Sorrow Workshops
Jan Spilman, MEd. RCC
PO Box 44062
Burnaby, BC V5B 4Y2
(604) 297-0609
www.caregiverwellness.ca
caregiverwellness@shaw.ca

- **Compassion Unlimited**

J. Eric Gentry Ph.D.

3205 South Gate Circle #21

Sarasota, Fl 34239

(941) 720-0143

(941) 827-9459 (fax)

www.compassionunlimited.com

- **Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder In Those Who Treat The Traumatized by: Charles Figley**

Job Burnout Resources

- <http://www.mayoclinic.org/healthy-living/adult-health/in-depth/burnout/art-20046642>

- http://www.zurinstitute.com/burnout_resources.html

- **Curing Burnout: Recover From Job Burnout and Start Living A Healthy Work Life Balance Today By: Susan S. Tanner**