5-2012

Working in the Trenches: Compassion Fatigue and Job Satisfaction among Workers Who Serve Homeless Clients

Alena M. Howell
St. Catherine University

Working in the Trenches:
Compassion Fatigue and Job Satisfaction among Workers Who Serve Homeless Clients

Submitted by Alena M. Howell
May, 2012

MSW Clinical Research Paper

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in Saint 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 their findings. This project is neither a Master's thesis nor a dissertation.

School of Social Work
St. Catherine University & University of St. Thomas
Saint Paul, MN

Committee Members:
Dr. P. Vang, Ph. D., (Chair)
Rachel Bean, BA
Ryan Stopera, MSW, LGSW

Abstract

The experiences of compassion fatigue and job satisfaction among workers who serve homeless clients is explored. The purpose of this study was to explore the relationship between workers' experiences of compassion fatigue and workers' experiences of job satisfaction as they engage with homeless clientele with multifarious presenting concerns. Specifically, this study sought to determine if a relationship between the compassion fatigue and job satisfaction existed, and to determine the nature of possible correlations between the variables. Using a quantitative design, employees of a local, targeted agency that serves homeless clientele were targeted and administered two survey instruments. Data was collected and analyzed using inferential statistics, including chi-square calculations. These findings indicated that a correlative relationship exists between workers' experiences of compassion fatigue and experiences of job satisfaction, although the correlation appears to be weak. The findings point to the need for continued efforts to identify and treat compassion fatigue among workers, and the continued need to investigate the role of compassion satisfaction opportunities as they influence experiences of job satisfaction.

Table of Contents

List of Figures

Introduction and Research Question

In 1963, author James Baldwin wrote, "one can give nothing whatever without giving oneself, that is to say risk oneself" (Sprange, 2007, p. 259). In work with homeless clientele, social workers are charged with staring down the face of the human condition, human cruelty, violence, trauma, intolerance and injustice, and to bear witness to and alleviate the suffering of the presenting individual, who has a face, a name, a family, and a birth-right to respect and dignity. When treading such strong currents, and trying to keep others afloat all the while, fatigue is inevitable.

The core of social service professions is empathic concern for others, a willingness to meet an individual where he or she is, and begin the ascension to a healthier existence alongside them. By the very nature of the work, one exposes oneself to the trauma of another. This is no small feat, especially in workers who serve homeless clients, who often experiencing complex and compounding challenges. Figley (2002) states "In our effort to view the world from the perspective of the suffering, we suffer" (p. 1434).

Working with such a unique and multifarious population such as homeless individuals requires certain abilities. Among them, the ability to ascribe meaning to difficult and challenging material, to integrate that meaning into one's worldview, and to serve the next client as vigorously as one did on the first day on the job. Understanding associations between compassion fatigue and job satisfaction among workers who serve homeless clients is vital to understanding the interaction and delivery of services in the worker-client relationship, the quality and effectiveness of services provided, and the overall health of social service workers.

The purpose of this study was to explore if there exists a connection between one's experience of compassion fatigue throughout the course of work with homeless clientele and level of satisfaction in one's place of employment. This study sought to determine if an association exists between job satisfaction, measured by perceptions of feeling valued in the workplace, personal recognition and appreciation, and supportive allies in the workplace, and compassion fatigue, the result of repeatedly bearing witness to the suffering of others. A constructivist self-development theory framework is used to structure the ideas presented in this research. A review of current literature establishes the importance of a well-rounded understanding of compassion fatigue to the adaptability and overall health of the worker, the responsiveness and ethical treatment of the client, and to the profession as a whole.

For the purposes of this study, homeless is defined as individuals experiencing a lack of adequate housing, with access to heat, facilities and shelter. The term "worker" is used to encompass those who are employed in social service agencies and practice social service delivery with clients. Compassion fatigue is defined as "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance or numbing of the reminders, persistent arousal associated with the patient…It is a function of bearing witness to the suffering of others" (Figley, 2002, p. 1435).

Clare Winnicott best described the importance of a comprehensive understanding of compassion fatigue and its implications for the field of social work in her 1964 paper, titled "Development Towards Self-Awareness" (Kanter, 2007, p. 293). She said "To sum up, what are the positive gains to be had from doing a job as

difficult as social work? ...Perhaps that most important thing is that it gives us an opportunity for personal growth which is beyond what we could achieve in our own private lives because it enables us to share in the experiences of others and to add these to the sum total of what we are. This is both a privilege and a responsibility…In other words, there is no final examination for social work" (Kanter, 2007, p. 293).

Literature Review

What is Compassion Fatigue?

"In the 90's, we called it burnout, and wore it like a badge of honor because it meant we were working hard and really cared" (Fahy, 2007, p. 201). There currently exist several names for the phenomenon known as compassion fatigue, most commonly attributed to the work of Figley (1995). When asked why they entered the helping profession, many workers typically remark "to help others" and, "to make a difference" (Radey, 2007, p. 207). Those who work with people in need are often profoundly connected to their work. Mathieu (2007) calls the helping professions "a calling, a highly specialized type of work that is unlike any other profession" (p. 1).

Compassion is defined as a "deep sense or quality of knowing of the suffering of another, coupled with the wish to relieve it…It is associated with feelings of condolence, pity, sympathy, empathy, and commiseration" (Radey, 2007, p. 207). To be of assistance to others requires that workers have the ability to connect and demonstrate compassion towards clients. This empathy and compassion for clients is necessary to facilitate the "excising of wounds in the past, but leaves the worker vulnerable to residual wounding" (Bourassa, 2009, p. 220). Those in the helping professions are typically guided by their sense of compassion and altruism, important factors to meaningful and effective practice (Radey, 2007, p. 207). Mathieu (2007) remarks that the most disturbing effect of compassion fatigue is that it "attacks the very core of what brought us into this work: our empathy and compassion for others" (p. 1).

Compassion fatigue, as experienced by those working in the helping professions, is specifically defined as "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance or numbing of the reminders, persistent arousal associated with the patient…It is a function of bearing witness to the suffering of others" (Figley, 2002, p. 1435). It is often thought of as a natural risk and consequence of working with traumatized individuals.

The preoccupation referred to in compassion fatigue can be with individual clients or experienced as the effect of a culmination of clients (Volk, 2010, p. 1). Compassion fatigue is also commonly interchangeably referred to as secondary trauma stress, vicarious trauma, emotional contagion, co-victimization or savior syndrome (Johne, 2006, p. 2). These terms all generally refer to the same phenomenon, referred to here as compassion fatigue. Compassion fatigue differs from burnout and counter transference, although some similarities are apparent.

Compassion fatigue can be thought of as a transformation within the worker as a result of exposure to the client's trauma material. It can be experienced during the client's retelling of the traumatic incident, and can increase with repeated exposure to the client or the traumatic material (Young, 2007, p. 15). Young (2007) describes compassion fatigue as the result of the worker being "exposed to trauma thru listening and trying to help" (p. 2). Smith (2007) compares the idea of compassion fatigue to that of a kitchen sifter;

> "As these histories are shared with us they go into the topside of the sifter. Then our self-care strategies work to turn the crank, refining and lightening the material, which passes through the underside, filtered of its deleterious effects upon us. If this process is effective,

> then we do not experience an overflow, the debilitating effects of compassion fatigue…" (pg. 193).

Smith (2007) reports that "sifters" can accumulate and overflow, causing a lack of attention to self care and ultimately lack of the ability to be in the present moment with the client (pp. 193-196). Compassion fatigue is unique to the helping professions in that it is often considered the natural consequence of bearing the suffering of others by knowing about their trauma and attempting to help (Adams, 2006, p. 103). A salesman, for example, may not be as at-risk for compassion fatigue because their job duties do not daily call for them to bear witness to someone else's distressing material. Those in the helping professions, in contrast, are charged with "seeing the world from the point of view of the distressed" (Radey, 2007, p. 211). During this process Radey (2007) explains we "experience a relative degree of demand to resolve or solve the stressors causing a client's distress. In doing so we are working with the same set of experiences-most often distressing to clients-that has a subsequent effect on us" (p. 211).

One of the fundamental facets of the concept of compassion fatigue is that it is grounded in empathic communication. Therapeutic work with traumatized individuals involves and is most effective when the worker is able to connect and empathize with the traumatized individual (Radey, 2007, p. 207). Empathic communication involves listening, validating, and normalizing the trauma material for the client (Naturale, 2007, p. 175). In order to relieve the symptoms of the traumatic material for the client, the worker must expose themselves to the traumatic material through listening to disturbing stories, recreating the traumatic experiences during exposure therapy, revisiting the distressing incidents in therapeutic work, or

merely vicariously learning of the trauma material. It is essential to effective practice with traumatized clients that workers attempt to see the trauma material from the client's perspective. In attempting to excise the injuries of the traumatized, the worker opens themselves up to the probability of experiencing parallel effects of their client's trauma (Bourassa, 2009, p. 220). Bride (2007) states that to be effective, the worker "must share in the emotional burdens to help facilitate the process" of healing (p. 155).

Differentiating Compassion Fatigue, Burnout, and Counter Transference

Figley (1995) first differentiated between compassion fatigue, burnout, and counter transference. Burnout was initially studied with relevance to nurses who had begun to meet their limits in attending the needs of their patients (Buttery, 2005, p. 4). Burnout, consisting of three salient components, was defined by Maslach, et al. in 1996 as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (p. 4). Workers in many varied fields can experience burnout, as it is not limited to the helping professions. The car salesman previously referenced, for example, may experience burnout in his or her work with potential consumers. Stresses related to the work environment are thought to be causal to burnout syndrome, while changes in cognitive schemas of the worker as a result of exposure to traumatic client material is attributed to compassion fatigue (Abbott, 2009).

Burnout and compassion fatigue, though often erroneously used interchangeably, are differentiated by causal onset, presentation, internal implications for the worker, duration of onset following exposure and healing time. The three

components of burnout combine to produce in the worker feelings that they are emotionally bankrupt, depersonalization resulting in contemptuous attitudes towards clients, coworkers and the organization, and the worker's depreciation of their personal successes and accomplishments with respect to their work with clients (Abbott, 2009).

Compassion fatigue exists on a continuum, can begin suddenly and with pronounced acuity, or can be gradual and cumulative (Mathieu, 2007, p. 3). Compassion fatigue can occur after exposure to only one incident (Naturale, 2007, p. 179). In contrast, burnout builds gradually and over time, and the amount of time to heal from burnout is more pronounced than in compassion fatigue (Abbott, 2009, p. 10).

With distinction, compassion fatigue produces in the worker negative changes to their cognitive schemas, or views of themselves and the world around them, and feelings of helplessness and hopelessness in reference to their capacity to be of assistance to others who they are charged with caring for (Volk, 2010). Johne (2006) described compassion fatigue as "death by a thousand cuts" (p. 3). Workers who experience compassion fatigue continue to try to give of themselves, while those who experience burnout generally do the opposite (Stevens-Guille, 2003, p. 1). In simplest terms, burnout can be thought of as externally directed, focusing on what is troublesome in the outward environment of the worker, while compassion fatigue is internally directed, with implications for the worker's internal compass, core beliefs about themselves and the world, and their ability to make meaning of their experiences.

The distressing effect of compassion fatigue is in the experience of similar symptoms of the client, without necessarily identifying with the client or the traumatic experience. Contrarily, counter transference involves the experience of the worker in seeing the identity of oneself in the client or client's trauma material originating in the worker's family of origin issues (Kanter, 2007). Kanter (2007) describes counter transference as occurring irrespective of empathy for the particular client situation. In the experience of counter transference, the worker's own unresolved trauma or family of origin issues are what cause the material presented by the client to be distressing. Counter transference encompasses

> "a broad range of subjective reactions, whether conscious or unconscious…These reactions may consist of fantasies, thoughts, attitudes, affects, counter-reactions, counter-resistance, behavior and behavioral enactments…specific counter transference reactions may involve displacements of affective or ideational phenomena from historically important relationships of the therapist" (Brandell, 2004, p. 105).

Counter transference begins in the worker's own material, whereas compassion fatigue begins in the client's material. Counter transference is highly avoidable in workers with appropriate boundaries, whereas compassion fatigue can easily occur in a worker who has already resolved their own issues of trauma.

Symptoms of Compassion Fatigue

While every worker experiencing compassion fatigue will have their own exclusive symptoms and varying degrees of expression, some traits have been commonly linked to compassion fatigue throughout current literature. Manifestations of compassion fatigue can be physical, emotional, behavioral, cognitive, or a number of combinations thereof. The most common physical

symptoms include difficulty sleeping, poor appetite, exhaustion, and symptoms that reflect the physical distress the client experienced during the traumatic event (Smith, 2007, p. 193).

Mathieu (2007) cites common expressions of compassion fatigue as

> "reduced ability to feel empathy and sympathy…dread of working with certain clients, diminished sense of enjoyment in career, disruption to worldview, heightened anxiety or irrational fears, intrusive imagery or dissociation, hypersensitivity or insensitivity to emotional material, difficulty separating work life from personal life, absenteeism…impaired ability to make decisions and care for clients…problems with intimacy or personal relationships" (p. 2).

Other emotional and behavioral symptoms include disturbing dreams, chronic overworking, emotional numbing, avoiding, flooding or blocking, agitation, irritability, isolation, chemical dependency and substance abuse, blaming, frustration, poor work performance, desensitization, lack of empathy, decreased tolerance, foreshortened future and numerous other personal and interpersonal issues (Johne, 2006). These themes are commonly cited in literature pertaining to compassion fatigue. Abbott (2009) observed a number of workplace behaviors indicative of compassion fatigue, such as employees discussing other employees or clients disgracefully with other employees, over-enthusiasm for the end of the work day or cancellations or no-shows in the worker's schedule, staying late, not leaving one's desk for meal times, skipping meals to accommodate client scheduling, and arriving late to work (p. 7).

Of more significant recourse, perhaps, are the cognitive effects of compassion fatigue on the worker, including ceaseless ruminating, memory gaps, cynicism,

negative self-image, confusion, decreased concentration, apathy, decreased personal accomplishment, boredom, depression, hopelessness, risk of suicide (Johne, 2006) disillusionment about the work, callousness and skepticism towards the organization, thinking about work without intending to, and derision with friends and family (Abbott, 2009, p. 8). Naturale (2007) reports that those who suffer from compassion fatigue also exhibit "shifts in cognitive schemas, emotional states, sense of meaning, personal safety, spiritual beliefs" and ability to trust (p. 174). Figley (2002) informs the reader that "memories that invoke traumatic responses are the hallmark of compassion fatigue" (p. 1440).

Those on the front lines of direct service bear the brunt of compassion fatigue. Volk (2010) asks us to consider the following examples of compassion fatigue;

> "A female case manager working with women who have been sexually assaulted assumes that all the men she encounters are unsafe. A counselor finds himself thinking 'Yeah, right—whatever,' in response to a story told by a friend…with whom he has always had a trusting relationship…A social worker whose favorite way to relax is to spend time with her children finds herself wishing they would go away" (p. 1).

Tyson (2007) reports that symptoms of compassion fatigue can "parallel a client's diagnosis of PTSD, and can transcend mirroring to effect alterations in clinician self-identity, cognitive schemas, interpersonal relationships, physical health, mental health, job morale, worldview and spirituality" (p. 184). Suffering from compassion fatigue can result in elevated levels of "emotional distress, psychosocial impairment, limitations on daily activity and lost workdays" (Radey, 2007, p. 208). Genuine self care is effectively missing in those suffering from compassion fatigue.

Stevens-Guille (2003) reports that those who suffer from compassion fatigue "continue to give of themselves and feel as though they have failed at their profession" (p. 1). The definitive materialization of compassion fatigue is evidenced by poor self care and extreme self-sacrifice on the part of the worker (Johne, 2006, p. 2). Instead of thinking of compassion fatigue as a hazard of the work, many workers blame themselves for not being able to do enough (Buttery, 2005).

Buttery (2005) describes her experience with compassion fatigue simply and succinctly; she advises "my soul felt weary" (p. 4). Quantilla (1989) interviewed several front line workers, and found that many who experienced compassion fatigue often developed less trusting relationships with clients and coworkers, at times resulting in workers realizing "they couldn't do this anymore" (p. 3). These workers inherently struggled to integrate their experiences and assign meaning to traumatic events they bore witness to. Compassion fatigue, like any kind of exhaustion, causes in the worker "decreased interest in bearing the suffering of others" (Figley, 2002, p. 1434).

The careers of those in helping professions are ones that come into contact with, almost daily, human suffering and emotional anguish (Young, 2007). Historically, those who enter the helping professions have a tendency to be unyielding in their pursuit to ameliorate the suffering of others. Among those suffering from compassion fatigue, the persistence to address the needs of the client culminates in critical losses for oneself. Compassion fatigue sets in "when our heart gives up when it continues to give and give and give" (Radey, 2007, p. 211).

Empathy and emotional energy are essential to work with traumatized individuals, and are a required cost of the necessary work (Figley, 2002, p. 1436). Compassion fatigue has inimitable impacts on the empathic functioning of the worker, resulting in devastated assumptions of imperviousness, core beliefs about self, and worldview. Ultimately, these changes have negative implications for the effectiveness of the worker, including increased risk of critical errors, poor treatment planning, and possible maltreatment of clients (Bride, 2007, p. 156). Workers experience difficulty examining their own ideas and assumptions, necessary to positively affect compassion fatigue, when they feel as though what they are able to give is not enough (Stevens-Guille, 2003).

Workers experiencing compassion fatigue may also indicate perceived threats to personal safety where none exist, and development of "survivor missions" (Tyson, 2007) in order to ascribe meaning to the traumatic material. In this way, they overcompensate for the trauma experienced, and dedicate more time and effort, at times in vain, to relieving the injustices of the world. They may lose their ability to be empathic without becoming overburdened. Workers experiencing compassion fatigue routinely question themselves, their efficacy, adequacy and their power to affect change (Bourassa, 2009, p. 221). Many workers who have experienced compassion fatigue describe feeling like a "helpless bystander" (Tyson, 2007, p. 189).

Workers who are aware of their experience of compassion fatigue may be troubled by the risk of trauma material losing its intensity and becoming "commonplace" (Smith, 2007) or worry about their own culpability in becoming less reactive to trauma narratives (Tyson, 2007, p. 187). This risk is among the many

ambiguous losses that occur with the onset of compassion fatigue. While experiencing compassion fatigue, the "prolonged empathic immersion interferes with the clinician's ability to be fully conscious and involved in their own life experiences, causing dissociation from the self and distance from others" (Tyson, 2007, p. 185). Often times, dissociation from the self can include guilt over not having experienced the trauma and suffering of the client, and continuing to bear witness to it with no real and immediate recourse for alleviating it.

Mathieu (2007) reports that those in helping professions "often do work that other people don't want to hear about, or spend their time caring for people who are not valued or understood in our society, for example, individuals who are homeless, abused, incarcerated or chronically ill" (p. 3). Common dissociation with friends and family involve a perceived lack of understanding about what workers experience throughout the course of their day. Buttery (2005) reports that she realized she was experiencing compassion fatigue when she "started reacting to what I thought were petty complaints from my family, thinking, 'Gee, if you heard what I heard today, you'd be thankful for what you had'" (p. 5).

Of pertinent concern is workers' tendency to experience a pessimistic change in their worldview as a result of compassion fatigue. A worker who suffers from compassion fatigue experiences changes in their "sense of safety, meaning, and trust in the world (which are) no longer homeostatic" (Tyson, 2007, p. 183). This can result in grief over the loss of idealism, optimism, coherence of one's life, faith in a "just world" (Yalom, 1980), and threats to the romanticized worldview held by the worker at the onset of work, which held a sense of meaning and purpose for the

worker (Tyson, 2007). Contrarily, Smith (2007) suggests that workers may be "discouraged about the future of specific clients, or the world in general," but may be able to separate their concern for their own future from their work (p. 197).

Causes of Compassion Fatigue

Figley (2002) produced an etiological model of compassion fatigue that describes eleven variables that predict and suggest treatment for compassion fatigue. Among these variables, Figley (2002) includes empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, and life disruptions (pp. 1436-1438). Figley presents the following model to predict and chart the onset of compassion fatigue.

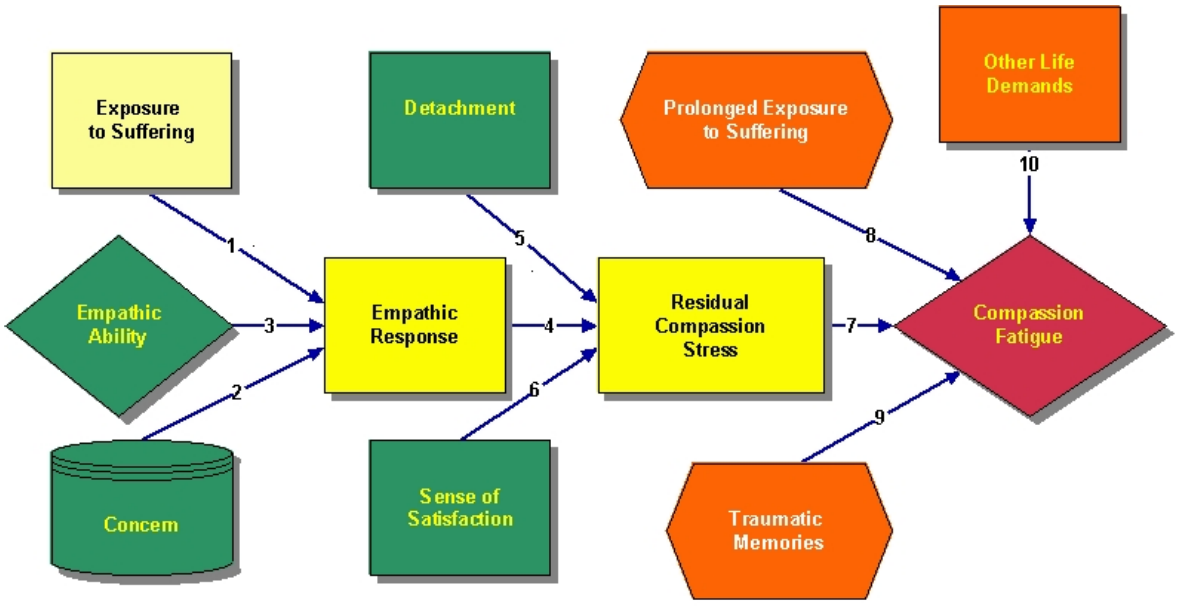

Figure 1. Compassion Stress and Fatigue Model (Figley, 1995, 1997, 2001).

Young (2007) expands on Figley's (1995) theory of exposure to clients, and reports that the amount of time spent engaging with clients experiencing trauma correlates to the experience of compassion fatigue among workers (p. 113). Tyson

(2007) reported that "prolonged immersion" by a worker to a client suffering trauma increased compassion fatigue levels significantly (p. 188). Eastwood (2008) reported that more emotionally charged work with the client created higher levels of compassion fatigue, only to be compounded by the amount of time spent engaging with the client (p. 105). Snyder (2009) described the contagion effect, in which negative affect parallels the emotional response to the negative emotions of another (p. 375). The contagion of the negative affect can easily lead to compassion fatigue in workers who experience high levels of exposure to clients experiencing trauma.

Abbott's (2009) work supports these statements, and suggests that workers in community agencies experience higher levels of compassion fatigue than workers in private settings due to the increased incidence of high risk clientele utilizing community agencies versus private practice facilities (p. 12). Abbott (2009) also suggests that workers who spend more time in direct service experience higher levels of compassion fatigue, with workers on the front end of services, who are the initial point of contact for traumatized clients, reporting the highest levels (p. 27).

While the causes of compassion fatigue can be innate to tasks of the helping professions, some researchers have also distinguished personal characteristics of the worker as causal to compassion fatigue. Fahy (2007) argues that in addition to the deleterious nature of the helping professions, "cultural norms that are shifting" can contribute to the complexity and difficulty of the work, and in turn lead to compassion fatigue (p. 200). With social workers increasingly delivering direct mental health services, it follows that social workers are finding themselves increasingly at risk for compassion fatigue (Naturale, 2007, p. 174). Adams (2006)

suggests that social workers often experience working conditions that include larger caseloads with fewer or inadequate resources available to their clients and themselves (p. 104).

There are varying arguments in current literature that suggest that compassion fatigue is either an unavoidable product of the helping professions, a deficiency innate in individuals who choose to enter the helping professions, or some combination thereof. Young (2007) and Adams (2006) suggest a risk for compassion fatigue regardless of personal trauma or history. In reference to his previously cited "self-care sifter," Smith (2007) reports the "sheer quantity of psychological, environmental and physical trauma that clients may share can overburden the self-care sifter" (p. 193). Snyder (2009) refers to the overburdening of the self-care processes that result in compassion fatigue as the "presumable emotional toll" to therapeutic work with traumatized individuals (p. 384). Smith suggests merely sitting with a client in a tremendous amount of pain can "create a black hole for energy" (p. 197). While simply being in the presence of a client experiencing emotional pain or trauma can begin accumulate into compassion fatigue, beginning the work of attempting to excise the wounds of our clients opens workers up to greater risk.

Many times clients will report traumatic stories unsolicited. Buttery (2005) reports that chemical health workers may enter the field believing they will be working strictly with their clients' addiction, only to find themselves hearing accompanying stories of violence, trauma, suffering and disenfranchised grief (p. 4). Continually being submerged in a client's existential crisis in meaning-making of

their traumatic experiences can easily overburden our self-care processes (Tyson, 2007, p. 1).

The practice of therapeutic work exists in the social context of "relational embeddedness," which suggests that trauma experienced by the client and any work engaging trauma done by the worker can result in the worker experiencing parallel symptoms (Tyson, 2007, p. 188). The concept of therapeutic work being socially constructed and relational in practice is vital to effective engagement with traumatized clients, but also leaves the worker open to residual wounding. Tyson (2007) refers to this phenomenon as an "emotional contagion," with both the client and the worker "engaging in mourning of actual and ambiguous losses" of the traumatic event (p. 185). Adams (2006) suggests a physiological response by the worker to the shared traumatic material. In a process framework, "challenging environments…require individuals to respond both physiologically, through alterations in the neuroendocrine and hormonal systems, and psychologically, usually through alterations in cognitive functioning" (Adams, 2006, p. 104).

Several studies suggest that human-induced trauma is more difficult to process and leads to higher incidences of compassion fatigue than trauma induced by natural disasters or other unforeseen events (Naturale, 2007, p. 179). Studies by Abbott (2009) and Tyson (2007) report that stories of human-induced trauma, particularly when involving aspects of human cruelty, result in higher risk levels of compassion fatigue for the worker. Abbott (2009) goes on to suggest that work with specialized populations, such as children, deepens the risk of compassion fatigue as a result of decreased depersonalization compared to work with adults (p. 9).

Abbott's (2009) work suggests a "non-relevance of demographic factors" in predicting compassion fatigue (p. 15). Her work in this area is supported by numerous other authors, including Bourassa (2009), who describes compassion fatigue as a "maladaptive stress response considered inevitable, and can occur regardless of age, gender, ethnicity, level of education, and is sudden and acute in nature" (p. 218). Bourassa (2009) reports that compassion fatigue is a "unique condition," in which there are no preexisting factors, personal characteristics or unresolved psychic conflicts that can accurately predict and describe its onset (p. 219). Radey (2007) reports that practice realities in current times include increases in "destructive relationships and behaviors" in clients, which produces higher risk engagement for workers through no fault of their own, born out the desire to help alleviate the suffering of others (p. 208).

Other authors have suggested that those who enter the helping professions have an innate identification with vulnerable populations, putting them at predisposed risk for experiencing compassion fatigue. Adams (2006) reports that exposure to traumatic material does not necessarily lead to compassion fatigue (p. 106). Gentry (2010) suggests those who enter helping professions may enter already compassion fatigued. Gentry reports such individuals may have "a strong identification with helpless, suffering or traumatized people or animals" due to their own upbringing or beliefs about caring for others (p. 1). They may lack effective self-care practices and experience compassion fatigue prior to the onset of their work (Gentry, 2010). Johne (2006) agrees with Gentry's work, stating "most people stricken with compassion fatigue have a latent vulnerability to it" (p. 2).

Additionally, compounding risk factors for compassion fatigue inherent in the individual include less experience on the job (Abbott, 2009, p. 13), taking on too much responsibility, setting unattainable goals, allowing work to endanger personal safety (Quantilla, 1989, p. 1), low social support, history of personal trauma, unresolved past trauma, poor self-care, inability or refusal to control work stressors, or a lack of satisfaction for the work (Radey, 2007, p. 207). Adams (2006) suggests that current negative life events also elevate the risk of compassion fatigue (p. 106). Tyson (2007) reports that age, social support, and experience on the job are not adequate safeguards against compassion fatigue (p. 184). The construct of "shared trauma" also results in increased risk for compassion fatigue. "Shared trauma" exists when both worker and client have experienced the same or a similar traumatic event, such as a terrorist attack, a natural disaster, a sexual assault, or painful childhood experiences (Tyson, 2007, p. 183).

Interestingly, Sprange (2007) suggested that women experience higher rates of compassion fatigue than men (p. 259).

Personal characteristics of the worker may also lead to higher risk of compassion fatigue. Snyder (2009) determined that workers' emotional reactions to clients were highly correlated to their feelings of personal accomplishment. As levels of personal accomplishment lessened, workers increasingly engaged in protecting their own egos by dehumanizing their clients, such as speaking of them negatively to other workers, avoiding interaction with specific clients, less objective viewing of the situation, and ultimately poorer service (Snyder, 2009, p. 376). Sprange's (2007) work generally supports these statements, and reports that personal coping styles and

the ability of the worker to make meaning in the face of difficult circumstances are truer determinants of emotional functioning and risk of compassion fatigue than those inherent in the work of helping (p. 261).

Compassion Fatigue and Work with the Homeless

Several unique implications exist for compassion fatigue in those who work with homeless populations. Physical location in which one resides has a dramatic effect on how an individual experiences and makes meaning of one's life. Miller (1997) states "personal dignity, human freedom, and the ability to cope with adversity are not simply intrapsychic activities rather, self-perception, human initiative and social interaction are always formulated in relationship to the environment in which one is living" (p. 1). Individuals without this central nucleus from which to base their lives often struggle with complicated needs and suffer from cutting trauma as a result of their status as homeless.

Homelessness can be characterized numerous ways. Differences in personal, organizational, state and federal definitions exist abound. Length of time experiencing homelessness plays a role in the definitions of an individual's homeless experience, and can often be a contributing qualifier in eligibility for services. Lee (2008) cites three main types of homelessness, each qualified with an accompanying length of time:

> "(1) the *transitionally homeless*, so labeled because they are 'in transition' between stable housing situations and whose brief homeless spells often amount to once-in-a-lifetime events, (2) the *episodically homeless*, suffering from persistent residential instability, who cycle in and out of homelessness over short periods; and (3) the *chronically homeless*, who have fewer but much longer

> spells and for whom homelessness approximates a permanent condition" (p. 8).

Those who fall under the definition of chronically homeless often experience more trauma due to their length of risk. They are also most often the focus of public policy attention due to their "visibility and disproportionate use of services" (Lee, 2008, p. 8). Cathy Ten Broeke, who works on public policy with issues of homelessness, reported that in the last five years, 266 individuals experiencing homelessness in Hennepin County, MN, have accumulated more than 70,000 nights in jail, shelter, and detoxification facilities combined, and in turn have cost the county $4.2 million (2010, p. 1).

There exists at least one type of trauma for clients of homeless service providers; the trauma of being homeless. The problems homeless clients face are often "multifaceted, complex, and chronic" in nature (Young, 2007, p. 1). Homeless individuals are at increased risk for traumatic events simply due to their unhoused status. Additionally, their risk can be compounded by issues such as lack of adequate resources, including food and shelter, lack of access to health care, mental health issues, tumultuous relationships, or substance abuse issues. Resolutions to these complex issues are often complicated, and involve many facets of change. For example, an individual who suffers from chemical dependency issues may have their symptoms aggravated by abstinence, which may in turn create other coping crises (Fahy, 2007).

Homeless individuals experience "high frequency of trauma events," which exposes those who work with homeless individuals to higher frequencies of compassion fatigue through their attempts to help (Young, 2007, p. 1). Often clients

who experience chronic issues are motivated to seek assistance from service providers when situations reach crisis status. Crisis counseling often involves listening , informing, validation and normalization of experiences and feelings (Naturale, 2007, p. 175). Workers are often charged with "listening and reflecting, providing support and assisting in problem solving and behavioral change" (Snyder, 2009, p. 375). This process can be exacerbating when progress in problem solving and behavioral change comes slowly and necessitates repeated attempts. In such situations, which are not entirely uncommon for workers whose clients experience homelessness, compassion fatigue can easily set in. Since homeless individuals' problems are frequently complex and multifaceted in nature, their solutions need to be complex and multifaceted in nature as well. The intensity, nature, complexity, chronicity and sheer volume of presenting issues can easily overwhelm workers and lead to compassion fatigue.

Some variables that may lead to compassion fatigue are unique to work with homeless populations. Due to constant exposure, there exists a risk of habituation of trauma in workers, a hardening of the worker's empathic abilities. At times, a worker's experience can be compounded by personal experience, such as might be present in a worker who has struggled with substance abuse and works with clients who are chemically dependent. In this situation, Buttery (2005) suggests that workers may be good at what they do due to an intimate understanding of the issue, but may also be vulnerable to compassion fatigue because of the nature of shared trauma (p. 4). The abusiveness and abrasiveness of some homeless clients can also increase the risk of compassion fatigue (Quantilla, 1989, p. 3). It is often a natural

defense mechanism of traumatized and victimized individuals to become abrasive as a mechanism for ensuring boundaries.

In an outreach capacity, homeless service providers expose themselves to additional risks for compassion fatigue due to the environments in which their work takes place. There are inherent risks to working in an outreach setting, as it includes individuals who do not present themselves in the office as ready for various stages of change, often involves entering unsafe locations or engaging unfamiliar people, can include witnessing violence and drug or other illegal activity, and often involves clients who may be too disorganized to respond to services while living in a high degree of chaos (Young, 2007, p. 63).

Young (2007) states that "due to the chronicity of the needs of homeless clients, those serving them are at increased risk for compassion fatigue" (p. 2). Additionally, homelessness is a variable issue that does not end by solving the housing needs or chemical dependency needs, or any needs of one particular client. The problem of homelessness is cyclical and revolving. Many formerly homeless people may experience homelessness again in their lifetimes. In addition, many new individuals will become homeless, and the work continues. The compassion fatigue that results as a symptom of working with homeless individuals is not a dichotomous variable, it exists on a continuum, just as homelessness does.

Implications of Compassion Fatigue for Clinical Social Work and Helping Professions

The implications for compassion fatigue on effective practice with homeless individuals are extensive, and involve effects on the client, the worker and the

profession. It has been previously noted that when a clinician experiences compassion fatigue, the dehumanization of clients can occur as an ego defense mechanism of the worker. Miller (1997) tells us "part of dehumanizing of homeless people is to assume they lack the ability to make choices" (p. 1). This leads to offering fewer options and eventual harm to the principle of self-determination.

Much of the work in helping homeless individuals is premised on an egalitarian relationship between the worker and the client, as demonstrated in narrative therapy, motivational interviewing, and the harm reduction model (Fahy, 2007, p. 203). In these theories, the clinician is seen as a conduit between the status quo and the desired status of the client. Compassion fatigue leads to overstretched and overwhelmed workers, who are unable to maintain their "aliveness" and "presentness," of significant clinical relevance to the health of the worker and the progress of the client (Tyson, 2007, p. 184). Empathic response, a tool necessary for engagement and successful interventions with clients, is disturbed when a worker is unable or unwilling to acknowledge their potential for compassion fatigue (Tyson, 2007). Empathic response is a tool necessary for fostering an effective therapeutic relationship (Bourassa, 2009, p. 220).

Ethical issues are also evident in workers suffering from compassion fatigue. Workers suffering from compassion fatigue

> "tend to engage in more boundary violations and more substance abuse, and find it difficult to maintain a therapeutic relationship…(they have) a tendency to misdiagnose more often, abuse clients, and leave the professional field…Other ethical issues arise when the social worker begins to avoid their client for fear of listening to the client's traumatic recount. Or the social worker may appear visibly disturbed by the event,

> which will prevent the client from discussing the traumatic event" (Bourassa, 2009, pg. 220-221).

Figley's (1995) work supports Bourassa's (2009) claims, citing "mistakes, misjudgments and blatant clinical errors" on the part of the worker suffering from compassion fatigue (Figley, 1995, p. 1440). As a product of wishing to be helpful, clinicians who have not addressed their compassion fatigue risk over-identifying with their clients, and in turn feeling powerless to help, struggling to see possibilities for change, struggling to see their own ability to affect change and feeling guilt for not having experienced that same trauma as the client has endured (Smith, 2007, p. 195).

For the worker, confronting trauma with a client, particularly shared trauma, can result in a shift in the "intersubjective ground in the clinical space" (Tyson, 2007, p.183). Compassion fatigue can lead to the worker's avoidance of their own vulnerabilities, leading to poor expression of the authentic self in therapeutic work, lack of "presentness," demoralization, and inability to derive a sense of meaning and purpose in their work (Tyson, 2007, pg. 184-185).

If these tasks are not accomplished, we risk losing valuable workers as they leave the field of social work behind. Without a comprehensive examination of compassion fatigue, we fail to understand how to utilize our best practices, fail to put forth our best service, and fail to intervene where most needed. Kanter (2007) describes as the reality of the helping professions, that "over time, we learn that we cannot resolve all conflicts, resolve all situations or help all clients" (p. 293). Fahy poignantly states that the truth about compassion fatigue is that "we can no longer

sacrifice the health and wellness of our workers for interventions that are not helpful to the client" (p. 203).

Conceptual Framework

A constructivist self-development theory outlines the concepts of this research. Constructivist self-development theory is also interchangeably referred to as personal development theory, self-development theory, with its overarching name commonly called constructivism (Nichols, 2010). Constructivist theory is borne out of Immanuel Kant's philosophy of perception and social embeddedness (Nichols, 2010, p.94). Kant's theories regarded knowledge as "a product of the way our imaginations are organized," and therefore the assignment of meaning of people, events and situations as arbitrary to our personal organization of imagination (Nichols, 2010, p. 94). Everything that we experience is filtered through our existing perceptions of the world around us, including concrete objects, social constructs and ideas.

Ideologically, constructivism is centered around the "nature of reality and being, metaphysics and ontology, and the nature and acquisition of human knowledge, epistemology" (Cooper, 2008, p. 176). Constructivism originates in post-modern theory, where absolute truths do not exist and realities of the world are ever-changing based on the subjective perceptions of the individual creating them. In constructivist theory, there exist as many realities as there are perceivers of them (Cooper, 2008, p. 177). George Kelly was the first to introduce the idea of personal construct theory into psychotherapy and clinical interventions in 1955 (Nichols, 2010, p. 94). Kelly introduced constructivism as it relates to personal development, organization of events, and assignment of meaning. Cooper (2008) reports the conceptual framework

of constructivism "asserts that 1) the individual is an active participant in the construction of his or her reality; 2) cognition, behavior and affect are interactive; 3) an individual's development across the life span is significant; and 4) internal cognitive and affective structures determine behavior and behavioral change" (p. 177).

Payne (1991) explains that Kelly's personal construct theory proposes that "people manage their behavior according to 'constructs' in their mind about how to behave, which have been developed from past experience…we construct events differently from each other and looking at and changing people's constructs may help change behavior" (p. 153). Kelly suggested that as each individual makes meaning of events they experience, they form a set of constructs which guide their behavior, predict future actions and explain patterns of thought (Payne, 1991). Kelly adapted his theory into psychotherapy to conclude that assisting the client in ascribing new meaning to events or creating new constructs could improve the way the individual interacts with the world around them and create more fulfilling experiences. In constructing new meanings, we shed new light on the difficult "whys" of the world.

Kelly termed the attribution of new meaning to events "reframing," or a re-labeling of behavior to give it new meaning (Nichols, 2010, p. 94). Narrative therapy dominantly uses a constructivist approach, in which an individual recounts their life stories, and the worker's duty becomes assisting the individual in reframing the experiences in a more meaningful way. The therapeutic dialogue in constructivist theory is the conversation between the worker and client. This dialogue is a process known as "deconstruction," whereby the worker frees the client "from the tyranny of

entrenched beliefs" (Nichols, 2010, p. 96). Traumatic experiences are often part of a client's story, and it becomes the duty of the worker to assist the client in reframing the experience to make it more meaningful and provide the client with more satisfying ways in which to integrate the traumatic material into their new constructs.

At times, it is useful in a constructivist approach to utilize a technique known as "externalization," during which the worker helps the client identify the problem as outside of the individual, not internally manifested (Nichols, 2010, p. 96). For example, a worker may help a client externalize chemical dependency as a disease that the client is suffering from rather than a manifestation of personal defects.

As it relates to clinical social work, constructivist theory focuses on the stories that people tell to themselves and to others, with attention to the underlying cognitive processes at work. Constructivist theory emphasizes the subjectivity of perception, with the resulting experience of a problem as framed by the underlying perception. Cooper (2008) reports that the goal is to "help clients understand how and why they constructed their particular reality or story and the consequences of that particular construction" (p. 145). Perceived realities are then reconstructed to give attention to strengths of the person, and ascribe new meaning to entrenched beliefs. Taylor's 1990 work identified five "narrative processes" that can be used to assign new meaning to trauma material, including

> "comparing oneself with those who are less fortunate, selectively focusing on positive attributes of oneself in order to feel advantages, imagining a potentially worse situation, constructing benefits that might derive from the victimizing experience, manufacturing normative standards than makes one's adjustment seem 'normal'" (Cooper, 2008, p. 145).

Additionally, Taylor found that individuals who were unable to cope as well often

> "have difficulty retrieving positive memories, continue to search for meaning and fail to find satisfactory resolution, make unfavorable comparisons between life after the distress and life before, see themselves as blameworthy, see themselves as victims and have little hope that things will change" (Cooper, 2008, p. 147).

In the use of narrative therapy within a constructivist framework, significant weight is placed on the development of an egalitarian relationship and empathic response of the worker to the client's stories. The worker is charged with listening to the problem-saturated stories and assisting the client in creating new stories full of meaning and strength. The focus of the work shifts from the problematic situation to the assumptions that people have about their problems.

As it pertains to compassion fatigue and work with the homeless, constructivist self development theory describes the subjective perceptions of the worker, and a failure to ascribe meaning to distressing situations presented by the client's trauma material. As a client shares his or her trauma material, the worker risks exposure to compassion fatigue when he or she is unable to successfully integrate new meaning to the distressing material, both for the client and for the worker. When a worker is unable to look beyond their own thoughts and behaviors to the ways in which they have subjectively interpreted the client's related experience, they open themselves up to compassion fatigue.

Workers exhibiting compassion fatigue often experience difficulty ascribing meaning to their clients' experiences and to their experience of hearing the trauma material, difficulty viewing the client in a favorable light, experience a shift in their cognitive schemas, feel guilty for not having the same or similar experiences as the

suffering client, and have little hope that they will be able to positively affect change in the client and in the world. All of these characteristics are diagnostic of compassion fatigue.

Conversely, the worker can overcome compassion fatigue by effectively assigning new meaning to the traumatic material presented, both for themselves and for the client. By utilizing constructivist tools, such as deconstructing, reframing and externalizing, the worker can begin to heal from the effects of compassion fatigue, as they create new stories full of meaning, experience satisfaction for their work, and restoration in their belief in themselves to positively effect change in the world.

As a review of current literature on compassion fatigue suggests no concrete explanation or predictive demographic factors for compassion fatigue, it may be suggested that the difference in subjective perceptions of workers contribute to their level of risk for compassion fatigue. As subjective perceptions are, by their very nature, ever-changing, it may be difficult to ever determine predictive factors of a worker's self-construct leading to compassion fatigue.

Methods

This research study was approved by the executive director of the target agency that serves homeless individuals and families. An email was sent out to employees of the agency informing them of the outlined research and its underlying goal, to answer the question: What is the relationship between job satisfaction and compassion fatigue in workers who serve homeless clients? Hard copies of two surveys were sent to all employees of the agency via intradepartmental mailboxes. The Job Satisfaction survey (Appendix A), as produced by the Wellness Councils of America and used with permission with appropriate citation, was used to measure workers' levels of job satisfaction. The ProQOL R-IV Survey (Appendix B), produced by Beth Hudnall Stamm and used with permission with appropriate citation, was used to measure compassion fatigue, compassion satisfaction and job burnout among workers. Surveys were returned anonymously via drop box in the common mailroom.

Sample

The sample of this research was a non-probability availability sample, as it is impossible due to time, financial and feasibility constraints to develop a complete sample and survey all workers who serve homeless individuals. The researcher aimed to capture 30-35 respondents from one local agency serving homeless individuals and families in multiple capacities. The researcher sent out 75 surveys to workers in direct service to homeless clientele, and received 26 surveys completed in the specified two-week time frame. Availability samples are generally characterized as appropriate in social research when it is difficult or impossible to build a complete sample (Monette,

2008, p. 145). Availability sampling includes pulling respondents from candidates available or convenient to the researcher.

Protection of Human Subjects

The workers who were the focus of this research were protected from risks to employment primarily through anonymity. A list of resources on compassion fatigue was offered to respondents to minimize risk associated with responding to associated questions. Additionally, resources on this agency's employee support program, DOR, were included.

Data Collection Instruments and Process

Quantitative data analysis was used for interpreting the implications of the research. Inferential statistics were used to measure the association between job satisfaction and compassion fatigue, compassion satisfaction and burnout.

For the purposes of this research, the independent variable is job satisfaction, an interval level measurement. The Job Satisfaction survey produced five subgroups, labeled as great job, good job, ok job, bad job and depressing job. Each respondent's level of satisfaction with their job was placed into one of these five subgroups, as determined by their yes/no responses to the thirty items on the Job Satisfaction survey.

The dependent variable is compassion fatigue, an ordinal level of measurement. The Professional Quality of Life Revised Fourth Edition (ProQOL R-IV) was used to measure respondents' levels of compassion fatigue on a 6-point Likert scale. The instrument includes thirty items, with reverse scoring included for five items to act as a control. Ten items each measured compassion fatigue,

compassion satisfaction, and job burnout, for a combined total of thirty items. The scoring chart was included so that respondents could measure their scores if they wished to. As evidenced by the calculations in the margins of the returned surveys, many of the respondents did calculate their own scores out of personal interest. Scoring, as determined by the author of the ProQOL R-IV, breakdowns as follows; on the compassion satisfaction scale, scores 41 and above indicate high compassion satisfaction, scores 32 thru 40 indicate average compassion satisfaction, and scores below 32 indicate low compassion satisfaction. Job burnout scoring breakdown is as follows; scores 28 and above indicate high burnout, scores 19 thru 27 indicate average burnout, and scores below 19 indicate low burnout. Compassion fatigue scoring breakdown is as follows; scores 17 and above indicate high compassion fatigue, scores 8 thru 16 indicate average compassion fatigue, and scores below 8 indicate low compassion fatigue.

Data Analysis

The collected data was entered into the SPSS Version 19 program, and chi-square analysis were used to analyze the data. Inferential statistics were collected to allow generalizations from the sample data to the larger population. Several chi square analyses were used to determine if an association between job satisfaction and compassion fatigue exists in workers who serve homeless clients, as well as among other variables. Chi-squares do not indicate the strength of the relationship, but rather infer whether an association exists. Small values of chi-square suggest little or no relationship exist between the two tested variables, whereas large values for chi-square calculations suggest than an association is likely (Monette, 2008, p. 413).

Findings

The sample population was extremely small, with 26 respondents to the 75 surveys distributed, creating a 35% response rate for the present study. Figures 2-5 demonstrate the demographic distribution of the sample population.

Age Range Frequency Distribution

Age in years	Frequency	Percent
18-19	0	0
20-24	7	26.9
25-29	4	15.4
30-34	6	23.1
35-39	0	0
40-44	2	7.7
45-49	2	7.7
50-54	3	11.5
55-59	1	3.8
60-65	0	0
65+	1	3.8
Total	26	100.0

Figure 2. Age Range Frequency Distribution

The sample population proved to be rather youthful, with 65.4 % of the sample population following between the ages of 20-34. Only 26.9% of the respondents reported being over 40 years old, as evidenced in Figure 2.

Gender Frequency Distribution

Gender	Frequency	Percent
Male	11	42.3
Female	15	57.7
Total	26	100.0

Figure 3. Gender Frequency Distribution

The sample population exhibited a fairly equal distribution of male and female respondents, with the percentages breaking down to 42.3 percent of male respondents and 57.7 female respondents, as demonstrated in Figure 3.

The frequency distribution of the sample population is quite unique and reflects the general diversity presented at the targeted agency, as demonstrated in Figure 4. Of the respondents, 34.6% reported their ethnicity as African American, 53.8 reported their ethnicity as Caucasian, and 11.5 chose to self-identify. Of the three respondents who answered "I identify as_____," all three described themselves as biracial.

Ethnicity Frequency Distribution

Ethnicity	Frequency	Percent
African American	9	34.6
Asian	0	0.0
Hispanic	0	0.0
Native American	0	0.0
Caucasian	14	53.8
I identify as _____.	3	11.5
Total	26	100.0

Figure 4. Ethnicity Frequency Distribution

One interesting trend that emerged from the demographic data was the high level of educational achievement for the majority of respondents. As demonstrated in Figure 5, of the total respondents, 84.6% reported that they had completed a Bachelor's degree. Two respondents reported completing post-college graduate degrees.

Education Frequency Distribution

Highest Education Completed	Frequency	Percent
Some high school or less	0	0.0
High school graduate	0	0.0
Attended some college	2	7.7
Associate's degree	0	0.0
Bachelor's degree	22	84.6
Post College Graduate	2	7.7
Total	26	100.0

Figure 5. Education Frequency Distribution

Generally, the demographic statistics of the present study reflect a work environment at the targeted agency that is relatively youthful, relatively closely split between male and female employees, demonstrates comparative ethnic diversity, and is decidedly educated. While these demographic statistics describe an interesting sample population, no causal link between demographic factors and the experiences of job satisfaction and compassion fatigue can be drawn due to the correlative nature of the data analysis tools. Additionally, as previously discussed in the literature review, demographic factors have traditionally proven to be unreliable predictors of compassion fatigue as evidenced by numerous previous studies, including Abbott's 2009 study, "Prevalence of compassion fatigue and burnout in behavioral health workers," (p.15).

Descriptive statistics provided in Figure 6 show standard measurements for each of the four scales used. With a mean score of 48.38 out of 60, the sample population's reported generally high levels of job satisfaction. In a line by line

analysis of the data not presented here, respondents overwhelmingly (100%) agreed with the statements "I am engaged in meaningful work," and "I respect the work of my peers." Additional line by line analysis revealed that the majority (96.3%) of respondents agreed with the statements "I feel free to be who I am at work," "My manager cares about me as a person," and "I know someone at work who encourages my development."

The statement that received the highest disagreeable response was "I feel involved in decisions that affect our organizational community," with 46% of respondents disagreeing with this statement. The next two highest percentages of disagreeable responses were to the statements "I look forward to going to work on Mondays," and "I feel informed about what's going on," with 42% and 38% respectively, of respondents disagreeing with these statements. All except four respondents (84.6%) rated their job satisfaction level in the "great job" or "good job" categories, with one outlier reporting a "depressing job," with a score of 16, as demonstrated in Figure 6.

Descriptive Statistics by Measure

Scale	n =	Mean	Standard Deviation	Minimum	Maximum
Job Satisfaction	26	48.38	11.129	16	60
Burnout	26	20.62	5.913	9	30
Compassion Satisfaction	26	35.58	9.795	11	50
Compassion Fatigue	26	13.85	7.024	2	30

Figure 6. Descriptive Statistics by Measure

The sample population reported a mean burnout scale score of 20.62, as shown in Figure 6. This value officially falls under the "average burnout" category,

but is on the cusp of "low burnout," as reported by the measure's scoring standards. The low degree of standard deviation shows that the majority of respondents report average to low burnout in their positions.

The sample population reported a mean compassion satisfaction scale score of 35.58, with a standard deviation of 9.795, as shown in Figure 6. This mean score falls into the "average compassion satisfaction" category, as reported by the measure's scoring standards. Due to the relatively high measure of standard deviation, characteristics of the experience of burnout are difficult to draw about the sample population as a whole.

As demonstrated in Figure 6, the mean score for the compassion fatigue scale was 13.85, which falls into the "average compassion fatigue" category as outlined by the measure's scoring standards. Standard deviation for compassion fatigue was reported at 7.024, which makes generalizations about the sample population's experience of compassion fatigue difficult to draw.

Inferential Statistics by Measure

Scale	Chi-square	Critical value	df	*p*-value	Min. expected cell frequency	n =
Job Satisfaction	18.154	22.36	13	0.152	1.9	26
Burnout	6.00	25.00	15	0.980	1.6	26
Compassion Satisfaction	4.46	27.5	17	0.999	1.4	26
Compassion Fatigue	6.69	26.3	16	0.979	1.5	26

Figure 7. Inferential Statistics by Measure

The Job Satisfaction scale has 14 cells with expected frequencies less than 5. The minimum expected cell frequency is 1.9. As shown in Figure 7, the actual value

of 18.54 is less than the critical value of 22.36 with 13 degrees of freedom, so we reject the null hypothesis that job satisfaction is independent of the other measures, $\chi^2(18.154, df= 13, N = 26)$ $p = 0.152$, $p > .05$. This is not statistically significant, as the p value of 0.152 is greater than .05.

Job Satisfaction Scores & Burnout Scores Crosstabs

	Burnout Scores			
Job Satisfaction Scores	0-18	19-27	28 & above	Totals
50-60	10*	4	0	14
40-49	0	4	4	8
30-39	1	2	0	3
20-29	0	0	0	0
0-19	0	0	1	1
(N)	*11*	*10*	*5*	*26*

Figure 8. *The correlation between job satisfaction scores and burnout scores is .001.

The Burnout scale has 16 cells that have expected frequencies less than 5. The minimum expected cell frequency is 1.6. As shown in Figure 7, the actual value of 6.00 is less than the critical value of 25.00 with 15 degrees of freedom, so we reject the null hypothesis that burnout is independent of job satisfaction, $\chi^2(6, df= 15, N = 26)$ $p = 0.980$, $p > .05$. This is not statistically significant as the p value of .980 is greater than .05. As shown in Figure 8, the data tended to show that those with higher job satisfaction scores had generally lower burnout scores. However, the correlation value is .001, indicating an extremely weak correlation between job satisfaction and burnout. This data generally suggests that little to no relationship exists between burnout and job satisfaction, as the correlation value is near .000.

Job Satisfaction Scores & Compassion Satisfaction Scores Crosstabs

	Compassion Satisfaction Scores			
Job Satisfaction Scores	0-31	32-40	41 & above	Totals
50-60	2	2	10*	14
40-49	3	5	0	8
30-39	1	1	1	3
20-29	0	0	0	0
0-19	1	0	0	1
(N)	*7*	*8*	*11*	*26*

Figure 9. *The correlation between job satisfaction scores and compassion satisfaction scores is .000.

The compassion satisfaction scale has 18 cells with expected frequencies less than 5. The minimum excepted cell frequency is 1.4. As demonstrated in Figure 7, the actual value of 4.46 is less than the critical value of 27.5 with 17 degrees of freedom, so we reject the null hypothesis that compassion satisfaction is independent of job satisfaction, $\chi^2(4.46, df= 17, N = 26)$ $p = 0.999$, $p > .05$. This is not statistically significant, as the p value of 0.999 is greater than .05. As demonstrated in Figure 9, the data preliminarily indicated that those with higher job satisfaction scores generally had higher compassion satisfaction scores. The correlation value of this relationship is .000, indicating little or no correlation exists between job satisfaction and compassion satisfaction. This data generally implies that little to no relationship exists between compassion satisfaction and job satisfaction. This data is not considered statistically significant.

Job Satisfaction Scores & Compassion Fatigue Scores Crosstabs

	Compassion Fatigue Scores			
Job Satisfaction Scores	0-7	8-16	17 & above	Totals
50-60	2	10*	2	14
40-49	1	2	5	8
30-39	2	1	0	3
20-29	0	0	0	0
0-19	0	0	1	1
(N)	*5*	*13*	*8*	*26*

Figure 10. *The correlation between job satisfaction scores and compassion fatigue scores is .520.

The compassion fatigue scale has 17 cells with expected frequencies less than 5. The minimum expected frequency is 1.5. As shown in Figure 7, the actual value of 6.69 is less than the expected value of 26.3 with 16 degrees of freedom, so we reject the null hypothesis that compassion fatigue is independent job satisfaction, χ^2(6.69, df= 16, $N = 26$) $p = 0.979$, $p > .05$. This is not statistically significant, as the p value of 0.979 is greater than .05. This data suggest that a relationship exists between job satisfaction and compassion fatigue, but is not considered statistically significant. As indicated in Figure 10, the data tended to show a relationship between average levels of compassion fatigue and high levels of job satisfaction. The correlation value is .520, which indicates a positive correlation between job satisfaction and compassion fatigue. This data does not presume a causal relationship, but rather a correlated relationship between job satisfaction and compassion fatigue among the sample population. This data suggests that the hypothesis of a relationship existing between compassion fatigue and job satisfaction is supported, but weakly with rather insignificant values.

Burnout Scores & Compassion Fatigue Scores Crosstabs

	Compassion Fatigue Scores			
Burnout Scores	0-7	8-16	17 & above	Totals
28 & above	0	1	4	5
19-27	4	2	4	10
0-18	1	10*	0	11
(N)	*5*	*13*	*8*	*26*

Figure 11. *The correlation between burnout scores and compassion fatigue scores is .004.

As shown in Figure 11, the data tended to indicate a weak relationship between those with low levels of burnout and average levels of compassion fatigue. Those who experienced high levels of burnout similarly appeared to experienced high levels of compassion fatigue. The correlation value is .004, indicating a little to no correlation between burnout and compassion fatigue. This data does not presume a causal relationship, but rather little to no correlated relationship between burnout and compassion fatigue among the sample population.

Burnout Scores & Compassion Satisfaction Scores Crosstabs

	Compassion Satisfaction Scores			
Burnout Scores	0-31	32-40	41 & above	Totals
28 & above	2	3	0	5
19-27	5	4	1	10
0-18	0	1	10*	11
(N)	*7*	*8*	*11*	*26*

Figure 12. *The correlation between burnout scores and compassion satisfaction scores is .000.

As shown in Figure 12, the data tended to show that those with higher compassion satisfaction scores had generally lower burnout scores. The correlation value is .000, indicating a no correlation between compassion satisfaction and burnout.

Discussion and Implications

Interesting trends in the data suggest averages levels of compassion fatigue, burnout and compassion satisfaction among the sample population. When analyzed line by line, data trended toward higher levels of compassion satisfaction, lower levels of burnout, and indistinguishably average levels of compassion fatigue. These trends would suggest that the workers of the targeted agency are experiencing average levels of compassion fatigue, and relatively high levels of job satisfaction, which appear relatively in sync as correlated concepts.

After analyzing the data, the answer to research question; "what is the relationship between job satisfaction and compassion fatigue among workers who serve clients experiencing homelessness?" seems to be that a weak correlation exists between job satisfaction and compassion fatigue. The correlation value for that relationship is .520, as indicated in Figure 10, which does indicate that a positive correlation between job satisfaction and compassion fatigue exists. The data suggests that the hypothesis of a relationship existing between compassion fatigue and job satisfaction is generally supported, but with a weak, rather insignificant value. A larger sample will have to be drawn to determine any further information about the relationship between compassion fatigue and job satisfaction at the targeted agency.

Conversely, workers at the target agency reported high levels of compassion satisfaction, which may influence the workers' ratings of job satisfaction. However, the correlation value for this relationship is .000, indicating essentially no correlation between job satisfaction and compassion satisfaction. One theory that emerges is that the higher levels of job satisfaction may be influenced by higher levels of compassion

satisfaction opportunities, and that more compassion satisfaction opportunities exist in compounded work, such as work with homeless populations that the targeted agency serves, as comparable to other fields. Additional research with a larger sample population would be needed to test this phenomena.

As noted in the results of the job satisfaction survey, the majority of respondents reported that they are engaged in meaningful work and respect the work of their peers. This type of environment supports the development of compassion satisfaction, as demonstrated by the findings. Additionally, the majority of respondents agreed with the statements "I feel free to be who I am at work," "My manager cares about me as a person," and "I know someone at work who encourages my development." These statements reflect the perception of a supportive work environment, which in turn may lead to more favorable perceptions of job satisfaction, as reflected in the findings.

Sprange's 2007 work, which reports that personal coping styles and the ability of the worker to make meaning in the face of difficult circumstances are truer determinants of emotional functioning and risk of compassion fatigue than those inherent in the work of helping, suggest that the sample population, which was revealed to be relatively highly educated, experience less compassion fatigue and more compassion satisfaction by virtue of their learned abilities to make meaning of difficult presenting situations. The perceived support of managers and feelings of being supported in the work environment likely mitigates some of the compassion fatigue and burnout experienced by the sample population.

Strengths

Strengths of the current study include several trends suggested by the data. Unfortunately, none of the inferential statistics proved to generate statistically significant results, but appear to demonstrate some correlations.

Limitations

As there is no way to survey all workers who serve homeless clients, the results of this research are limited in their implications. Additionally, as there is no control group, and the research relies on an ordinal dependent variable, a causal link cannot be established. The research, by nature of design, can only be extended to determine if a correlation exists between job satisfaction and compassion fatigue.

Additionally, the very small sample size limits the statistical significance of the data gathered. Although some correlations appear to exist, they cannot claim statistical significant and therefore are of no relevance for larger application. Ultimately, more research needs to be done around the field of compassion fatigue and job satisfaction in the field of clinical social work in order to draw statistically relevant and more widely applicable findings.

Implications for Clinical Social Work

As a profession, clinical social work risks losing valuable and skilled workers to the deleterious effects of compassion fatigue. More importantly, we risk the quality of service to some of the most vulnerable clients at the hands of compassion fatigue.

Implications for clinical social work based on the present study include suggestions for further inquiry based on presented findings, including further study into the relationship of supervisory relationships and feelings of being supported in

the work environment mitigating some of the effects of compassion fatigue and burnout. More in-depth research would need to be done around the concepts of compassion fatigue and job satisfaction to determine the strength of any further correlations. Additionally, further study into the occurrence of compassion satisfaction opportunities as they affect the experiences of compassion fatigue and burnout among workers across varied fields would be relevant.

References

Abbott, C.A. (2009). *Prevalence of compassion fatigue and burnout in behavioral health workers.* Unpublished graduate thesis. Prescott College, Tucson.

Adams, R. E., Boscarino, J.A., & Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry, 76,* 103-108.

Berzoff, Joan, Flanagan, Laura Melano, & Hertz, Patricia (2008). *Inside out and outside In.* Lanham, MD: The Rowan & Littlefield Publishing Group, Inc.

Bourassa, D.A. (2009). Compassion fatigue and the adult protective services social worker. *Journal of Gerontological Social Work, 52 (3),* 215-229.

Bride, B.E., & Figley, C.R. (2007). The fatigue of compassionate social workers: An introduction to the special issue on compassion fatigue. *Clinical Social Work Journal, 35,* 151-153.

Bride, B.E., Radey, M., & Figley, C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal, 35,* 155-163.

Buttery, Helen (2005). When caring hurts: Compassion fatigue strikes addiction workers. *Crosscurrents, Autumn,* 4-5.

Campbell, Laura (2007). Utilizing compassion fatigue education in hurricanes Ivan and Katrina. *Clinical Social Work Journal, 35,* 165-171.

Cooper, Marlene G., & Lesser, Joan Granucci (2008). *Clinical social work practice: An integrated approach.* Boston, MA: Pearson Education Inc., publishing as Allyn & Bacon.

Eastwood, C. D., & Ecklund, K. (2008). Compassion fatigue risk and self-care practices among residential treatment center childcare workers. *Residential Treatment for Children & Youth, 25 (2),* 103-122).

Fahy, Annie (2007). The unbearable fatigue of compassion: Notes from a substance abuse counselor who dreams of working at Starbuck's. *Clinical Social Work Journal, 35,* 199-205.

Figley, Charles R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *In Session: Psychotherapy in Practice, 58(11),* 1433-1441.

Heading Home: Minnesota's Roadmap for Ending Homelessness. Heading Home Minnesota (2010).

Homelessness in Minnesota 2009: Results of the Wilder statewide survey. Wilder Research (2010).

Ivey, Allen E., & Ivey, Mary Bradford (2007). *Intentional interviewing and counseling: Facilitating client development in a multicultural society.* Belmont, CA. Thomson Brooks/Cole.

Johne, Marjo (2006). Compassion fatigue: A hazard of caring too much. *Medical Post, 42 (3),* 1-4.

Kanter, Joel (2007). Compassion fatigue and secondary traumatization: A second look. *Clinical Social Work Journal, 35,* 289-293.

Lee, B.A., & Greif, M.J. (2008). Homlessness and hunger. *Journal of Health and Social Behavior, 49 (1),* 3-19.

Mathieu, Francoise (2007). Running on empty: Compassion fatigue in health professionals. *Rehab and Community Care Medicine, Spring,* 1-6.

Miller, D.E. (1998). Shelter Blues: Sanity and Selfhood among the homeless. *Journal of Contemporary Ethnography, 27 (3),* 1-4.

Miller, D.E. (1998). Something left to lose: Personal relations and survival among New York's homeless. *Journal of Contemporary Ethnography, 27 (3),* 1-4.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. (2008). *Applied social research: A tool for the human services.* Belmont, CA: Thomson Brooks/Cole.

Naturale, April (2007). Secondary traumatic stress in social workers responding to disasters: Reports from the field. *Clinical Social Work Journal, 35,* 173-181.

Nichols, Michael P. (2010). *Family therapy: Concepts and methods.* Boston, MA: Pearson Education Inc., publishing as Allyn & Bacon.

Payne, Malcom (1991). *Modern social work theory: A critical introduction.* London: TheMcMillan Press Ltd.

Quantilla, Michael (1989). The limits of compassion helping the homeless in L.A. can become unbearable burden, some Samaritans find. *Los Angeles Times.* August 2, 1989. Los Angeles, CA: Tribune Publishing Company.

Radey, M., & Figley, C.R. (2007). The social psychology of compassion fatigue. *Clinical Social Work Journal, 35,* 207-214.

Sermons, M. W., & White, P. (2011). State of Homelessness in America: A research

report on homelessness. *National Alliance to End Homelessness & Homelessness Research Institute*, 1-42.

Smith, Bryce D. (2007). Sifting through trauma: Compassion fatigue and HIV/AIDS. *Clinical Social Work Journal, 35,* 193-198.

Snyder, Jason (2009). The role of coworker and supervisor social support in alleviating the experience of burnout for caregivers in the human-services industry. *Southern Communication Journal, 74(4),* 373-389.

Sprange, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma, 12 (3),* 259-280.

Stevens-Guille, Betty (2003). Compassion fatigue: Who care for the caregivers? *Canadian Business and Current Affairs, 59 (6),* 13.

Ten Broeke, Cathy (2010). Fighting homelessness: The cost of homelessness. *Downtown Journal: Voices.* Retrieved September 19, 2011, from http:www.headinghomehennepin.org

Tyson, Jeni (2007). Compassion fatigue in the treatment of combat-related trauma during wartime. *Clinical Social Work Journal, 35,* 183-192.

Volk, Katie (2010). When the engine gets too hot: Burnout, compassion fatigue and vicarious trauma. *Homelessness Resource Center.* Retrieved September 19, 2011, from http://www.nrchi.samhsa.gov

"What is compassion fatigue?" Compassion Fatigue Awareness Project, 2010. Retrieved September 19, 2011, from http://www.compassionfatigue.org

Young, S. D. (2007). *Psychotherapists working with homeless clients: The experience of stress, burnout symptoms, and coping.* Unpublished doctoral dissertation. Antioch University, Seattle.

Appendices

Appendix A: Job Satisfaction Survey

		Yes	No
1	I look forward to going to work on Monday morning.		
2	I feel positive and up most of the time I am working.		
3	I have energy at the end of each work day to attend to the people I care about.		
4	I have energy at the end of each work day to engage in personal interests.		
5	I have time and energy I my life to read books that interest me.		
6	Most interactions at work are positive.		
7	I have good friends at work.		
8	I feel valued and affirmed at work.		
9	I feel recognized and appreciated at work.		
10	Work is a real plus in my life.		
11	I'm engaged in meaningful work.		
12	I feel free to be who I am at work.		
13	I feel free to do things the way I like at work.		
14	My values fit with the organizational values.		
15	I am aligned with the organizational mission.		
16	I trust our leadership team.		
17	I respect the work of my peers.		
18	I have opportunities to learn what I want to learn.		
19	I feel involved in decisions that affect our organizational community.		
20	Creativity and innovation is supported.		
21	I feel informed about what's going on.		
22	I know what is expected of me at work.		
23	I have the materials and equipment I need in order to do my work right.		
24	I have the opportunity to do what I do best every day at work.		
25	My manager cares about me as a person.		
26	I know someone at work who encourages my development.		
27	My opinions count.		
28	My coworkers are committed to doing quality work.		
29	My manager reviews my progress.		
30	I am fairly compensated.		

Give yourself two points for each statement you answered positively. Use the following scale to evaluate your job.

50-60 points: Great Job **40-49 points:** Good Job **30-39 points:** OK Job
20-29 points: Bad Job **1-19 points:** Depressing Job

Appendix B: ProQOL R-IV

ProQOL R-IV
PROFESSIONAL QUALITY OF LIFE SCALE
Compassion Satisfaction and Fatigue Subscales—Revision IV

Helping people put you in direct contact with their lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. I would like to ask you questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the ***last 30 days***.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

_____1. I am happy.
_____2. I am preoccupied with more than one person I help.
_____3. I get satisfaction from being able to help people.
_____4. I feel connected to others.
_____5. I jump or am startled by unexpected sounds.
_____6. I feel invigorated after working with those I help.
_____7. I find it difficult to separate my personal life from my life as a helper.
_____8. I am losing sleep over traumatic experiences of a person I help.
_____9. I think that I might have been "infected" by the traumatic stress of those I help.
_____10. I feel trapped by my work as a helper.
_____11. Because of my helping, I have felt "on edge" about various things.
_____12. I like my work as a helper.
_____13. I feel depressed as a result of my work as a helper.
_____14. I feel as though I am experiencing the trauma of someone I have helped.
_____15. I have beliefs that sustain me.
_____16. I am pleased with how I am able to keep up with helping techniques and protocols.
_____17. I am the person I always wanted to be.
_____18. My work makes me feel satisfied.
_____19. Because of my work as a helper, I feel exhausted.
_____20. I have happy thoughts and feelings about those I help and how I could help them.
_____21. I feel overwhelmed by the amount of work or the size of my caseload I have to deal with.
_____22. I believe I can make a difference through my work.
_____23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
_____24. I am proud of what I can do to help.
_____25. As a result of my helping, I have intrusive, frightening thoughts.
_____26. I feel "bogged down" by the system.

_____27. I have thoughts that I am a "success" as a helper.
_____28. I can't recall important parts of my work with trauma victims.
_____29. I am a very sensitive person.
_____30. I am happy that I chose to do this work.

Copyright Information

Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring:
a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

Appendix C: Agency Approval Letter

January 25, 2012

Attn: College of Saint Catherine Institution Review Board
Re: Howell, Alena Clinical Research Proposal

I, executive director of this agency, grant permission for Alena Howell, graduate student at the College of Saint Catherine, to conduct her study, entitled "Job Satisfaction and Compassion Fatigue among Workers Who Serve Homeless Clients," with the employees of this agency via intradepartmental mailboxes.

I have read the research proposal and grant permission for this study to be completed in the 2011-2012 academic year. I understand that any data collected will be disseminated and destroyed by June 30th, 2012.

Signature removed to protect anonymity in publication.