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The Impact of Employee Wellness Programs on Mental Health Workers' Reported Symptoms of Compassion Fatigue and Burnout

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**The Impact of Employee Wellness Programs on Mental Health
Workers' Reported Symptoms of Compassion Fatigue and Burnout**

by

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MSW Clinical Research Paper

Presented to the Faculty of the

School of Social Work

University of St. Thomas and St. Catherine University

St. Paul, Minnesota

in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for the MSW students at the University of St. Thomas/St. Catherine University 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

Burnout and Compassion fatigue are topics which are covered in the literature and academic programs. Wellness in order to combat these is also an important topic for helping professionals. This study examined employee wellness programs and their effect on mental health workers' compassion fatigue and burnout. A mixed-methods model used the Professional Quality of Life (ProQOL) survey and five open-ended questions relating to the wellness activities. Many barriers and incentives to use of the wellness programs were found and scores were compared with other demographic and programmatic information. Further research should continue to examine mental health workers, specifically, and the impact of environmental support. Continued use of Moos' Work Environmental Scale (WES) would be beneficial to agencies employing a large number of mental health workers.

Dedication

To my parents, Doug Dooley and Ginny D'Angelo, who raised me on social work values, and loved me unconditionally through cancelled dinner dates and missed holidays over the last year.

To my brother, Nate Dooley, who reminds me every day that “it takes all kinds.”

Appreciation

Tesia Vitale: for patiently helping me to understand and analyze the data for this project.

Princess Cramer-Drazkowski, you are my soul sister.

Dr. Valandra: for gently pushing me to complete this project; and for encouraging me to take my career as far as the eye can see.

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The importance of managing stress and burnout in the helping professions is encouraged in social work, psychology, and counseling curriculum, professional organizations, and has been the topic of various workshops and conferences. If left untreated, the effects of stress on workers can directly impact their delivery of client care. Previous studies have produced the Maslach Burnout Inventory (MBI), and the Professional Quality of Life Survey (ProQOL) which has been useful in studying what contributes to the phenomenon of Compassion Fatigue and Burnout.

Many variables exist when attempting to understand this complex issue including what constitutes Compassion Fatigue and what distinguishes it from Burnout; the best way to measure this intangible concept; and what workers and their support systems do to address the complications that arise when working in a vulnerable career. Francoise Mathieu (2007), a trained specialist in compassion fatigue stated, "...the most insidious aspect of compassion fatigue is that it attacks the very core of what brought us into this work: our empathy and compassion for others". This holistic health issue will be examined in this paper by attempting to understand how employee wellness programs in mental health agencies affect the compassion fatigue and burnout levels of its workers.

Literature Review

Helping professionals are encouraged to take care of themselves, engage in self-care and address any personal issues that may interfere with their work with vulnerable populations. Ting (2011) studied self-reports of depressive symptoms and reasons for avoiding care in Bachelor of Social Work (BSW) students. Lack of time, stigma, confidentiality and the need for perfection and control were among the reasons for avoiding support services in that sample of students (Ting, 2011). The students were enrolled in a social work program, where they learn of these barriers for their clients, yet they still suffered from the same barriers for themselves. In addition, when these students graduate and enter the field, they will further encounter stress. One study found that “work-related stressors...were not as important in predicting burnout as the ways...people cope with those stressors” (Acker, 2010, p. 417). Various studies suggested that the type of support workers receive within their place of employment can help to reduce stress, burnout and turnover intention (Acker 2010; Ting 2011; Kim & Lee 2009). The following paper will examine the current literature which study burnout and compassion fatigue along with literature on employee wellness and assistance programs and environmental support.

Compassion Fatigue and Burnout

Three significant data collection instruments were found in the course of reviewing the literature. Perhaps cited most frequently, was the Maslach Burnout Inventory (MBI) developed by Christina Maslach and Susan Jackson in 1981 (Acker, 2010; Kim & Lee, 2009; Acker, 1999; Leiter, 1990). Moos' 1974 Work Environment Scale was found to be useful when studying employees' preferences in work settings.

The terms stress, burnout, compassion fatigue and secondary trauma are all used interchangeably to examine worker competence in the literature. Most of the studies reviewed contain overlapping definitions of burnout and compassion fatigue. Cicognani, Pietrantoni, Palestini, and Prati (2009) recognize that while burnout and compassion fatigue promote similar feelings, there is a “central difference” in the severity and longevity of the symptoms (Cicognani, et al., 2009). With the support of previous literature (Cherniss, 1980, and Figley, 1995), Cicognani, et al. identify burnout as prolonged and chronic, whereas compassion fatigue is identified as a more acute condition resulting from sudden exposure to a stressful event.

Burnout has several components including psychological and physical symptoms. Some psychological symptoms include emotional exhaustion, depersonalization and feeling a lack of personal accomplishment (Acker, 2010; Maslach, 2007). Burnout can affect the human body in many ways such as increasing the chances of acquiring the common cold, frequent headaches and severe fatigue (Acker, 2010). Burnout was related to lower self-esteem, an increase in interpersonal problems and substance abuse in health professionals. Much like burnout, compassion fatigue also has several components. In fact, many of the symptoms of burnout and compassion fatigue overlap. Mathieu (2007) includes emotional exhaustion, increased cynicism and loss of empathy along with physical symptoms in her description of compassion fatigue symptoms. Sprang, Clark, and Whitt-Woosley (2007) reports that compassion fatigue “signifies more progressed psychological disruptions [and] can be used interchangeably with secondary traumatic stress disorder”. Due to the crossover of definitions and the author’s preference for

Cicognani, et al.'s distinction between the terms, burnout and compassion fatigue will not be used interchangeably in this paper.

Professional Quality of Life (ProQOL) Survey

Beth Hudnall Stamm developed the Professional Quality of Life (ProQOL) survey which provides a score for compassion fatigue, burnout, and compassion satisfaction. This tool has been used in other studies examining the compassion fatigue and burnout of child welfare workers across the United States (Sprang, Craig, and Clark, 2011), emergency workers in Italy (Cicognani, et al., 2009), rural mental health providers in the southern United States (Sprang, et al., 2007), and human rights workers in Kosovo (Holtz, Salama, Lopes Cardozo, and Gotway, 2000). Each of those studies found the scores to be useful when compared to other variables in predicting worker burnout. In Sprang, et al.'s studies they suggested that agency setting and supervisors can impact mental health workers' risk for burnout and compassion fatigue (Sprang, et al., 2011; Sprang, et al., 2007). Non-US studies further assert that limited exposure to trauma victims or post-trauma work, along with a sense of community among workers, and education about PTSD are also protective factors (Holtz, et al., 2000; Cicognani, et al., 2009). The ProQOL is most often used for research studies, to assess a specific staff group's professional quality of life, and for personal use and monitoring of symptoms (Stamm, 2005). The ProQOL is the third revision of the Compassion Fatigue test (CFST or CSF) first developed in 1995 by Figley & Stamm. After market testing revealed "that focusing the overall effort toward a positive...professional quality of life" the name of the scale was changed and the test was shortened to 30 items from 66 items (Stamm, 2005).

While Maslach's MBI has been cited more frequently, the validity of Stamm's ProQOL has also been established with more than 200 articles in the literature (Stamm, 2005). This author found the ProQOL scale to be most useful when examining the effects of employee wellness programs on mental health workers' reported symptoms of burnout and compassion fatigue. This tool is explained in further detail in the Methods section.

Wellness Programs

In recent years, the importance of employee wellness programs in the workplace has received more attention, emphasizing the importance of supportive environments in all industries (Lindahl, 2011, LeCheminant, and Merrill, 2012). Much of the literature reports strategies for implementing programs (Lindahl, 2011, Malouf, 2011, Neely, 2012). The populations studied are also diverse in setting and agency size; ranging from a small engineering company (LeCheminant, et al., 2012) to full time university employees (Anshel, 2011) and hospital workers (Mahdavinejad, Bemanian, Farahani, Tajik & Taghavi, 2011). Other studies examined multinational companies (Malouf, 2011) as well as a large U.S. employer in financial services (McPherson, Goplerud, Derr, Mickenberg & Courtemanche, 2010) demonstrating Lindahl's (2011) assertion that any business size or type can benefit from employee wellness programs.

This review did not reveal literature which studied mental health workers, however the most similar and comparable populations were nurses and hospital workers (Mathieu, 2007, Mahdavinejad, et al., 2011). "O'Donnell suggested that health promotion can be facilitated through...the creation of opportunities that open access to environments that make positive health practices the easiest choice" (as cited in

LeCheminant & Merrill, 2012). In Mathieu's expertise, she points out that, "...within an agency, there will be, at any one time, helpers who are feeling well and fulfilled in their work, a majority of people feeling some symptoms and a few people feeling like there is no other answer available to them but to leave the profession" (2007). Because these three categories of employees are always present in an agency, it is important to examine barriers and motivations of workers to use such programs.

Mathieu's conclusion is important because even though wellness programs are offered, not every employee will utilize them. This study will examine employees who use wellness programs and those who do not; and ask mental health workers to report their symptoms of burnout and compassion fatigue. Mathieu also reports that "...eight out of ten nurses accessed their EAP (Employee Assistance Program) which is over twice as high as EAP use by the total employed population" (2007), suggesting that when supports are offered, employees will use them. Employee Assistance Programs are similar support services as Employee Wellness Programs; however they are usually an outside agency which can offer therapy and other assistance services. For the purpose of this study, Employee Wellness Programs will refer to supportive programming in the workplace.

Environmental Support

As previously mentioned, several of the studies discuss implications for employers to form a sense of community in order to support mental health workers and contribute to a decrease in compassion fatigue and burnout symptoms (Sprang, et al., 2011; Cicognani, et al., 2009; Sprang, et al., 2007; Holtz, et al., 2000). The Work Environment Scale (WES) was developed by R.H. Moos and colleagues in 1974 and was

cited in many articles by Moos, et al. and other authors through the 1980s. In Moos and Schaefer (1987) they cite the human relations approach as a way to “employ a framework that looks at work in a holistic context and encompasses both staff and patient outcomes”. Others who have used the WES examined expectations of employees regarding their work environment and then later what it was actually like (Booth, Norton, Webster, and Berry, 1976). Turnipseed (1994) used the WES along with Maslach’s MBI to assess burnout and the relationship with work environment finding that indeed components of the work environment will impact workers’ burnout scores. Pretty and McCarthy (1991) also contribute to this area with their study in a corporate environment with the Sense of Community Index (SCI) in addition to the WES. These variables and hypotheses of previous studies will inform those examined in this study when asking mental health workers about the impact of employee wellness programs on their burnout and compassion fatigue.

Definitions

Burnout and compassion fatigue will be used and operationally defined as follows: *Burnout* is a prolonged, chronic feeling of stress, dissatisfaction with job, increased cynicism and lack of hope. *Compassion Fatigue* is characterized as a sudden, acute feeling of stress, frustration and resulting from a stressful event. *Employee Wellness Programs* is defined as those activities which are sponsored by the employing agency and initiated on site or executed during work time. The term *Mental Health Workers* refers to practitioners who work with clients living with a severe and persistent mental illness (SPMI). This typically means the clients have a diagnosis on axis I and/or axis II according to DSM-IV TR criteria. Finally, *direct practice* is defined as interface

between practitioner and client in their home, office, community, or other setting. This differs from indirect practice which often refers to policy or program administrators.

Research Question and Hypothesis

Most companies provide referral and independent access to an outside Employee Assistance Program as well as insurance benefits which offer incentives for attending a gym or fitness facility. Outside agencies which provide support for employees will not be focus of this study, however they may be available for the respondents surveyed. The research question guiding this study is: what is the impact of Employee Wellness Programs on mental health workers' reported symptoms of compassion fatigue and burnout? The hypothesis for this study is that employees who utilize wellness activities initiated from within their agency of employment will report lower levels of compassion fatigue and burnout than their counterparts who do not take part.

Conceptual Framework

A Conceptual Framework is used to highlight the researcher's lens when examining a social problem. It is important to have a basic understanding of the conceptual theory used in a study in order to fully realize the scope of the problem and the position taken by the researcher. Hypotheses and research questions are formed based in the chosen framework. This study examines burnout and compassion fatigue in mental health workers through systems theory. A brief explanation of systems theory and the relevant perspectives for this study are provided in the next section.

Systems Theories

Systems Theory is an umbrella term encompassing many systemic views of human behavior in the social environment. A non-profit mental health agency operates within larger society and within that agency are further subsystems relying on one another. For example, upper management needs supervisors to operate the daily functions of serving clients in the community. Supervisors then assist line staff, including mental health workers, to promote change for their clients while functioning in greater society. “The presence or absence of...social supports within office work environments may determine whether or not employees love or hate their jobs” (Zastrow & Kirst-Ashman, 2004). By applying systems theory to a mental health agency, it can be assumed that when upper management promotes a healthy workplace, mental health workers will avoid burnout and compassion fatigue, thus providing consistent and clinical treatment.

Boss, Doherty, LaRossa, Schumm, and Steinmetz (1993) describe systems theory in terms of a family with members developing patterns of communication and rules that will either facilitate growth or stunt progress. Heads of families often establish rules about what the roles each member of the family will play. Children then are influenced by the established norms and explicit rules of the household. Depending on how these players interact with each other and the developed patterns, families either thrive or become dysfunctional.

Families and mental health agencies are only two examples where systems theories can be applied. Other examples include the federal government, a school district, a hospital, a graduate school cohort, and close personal relationships, among

many others. Zastrow and Kirst-Ashman (2004) outline many key concepts in systems theories. Several that are important when studying the culture of mental health agencies and their support of employees are as follows; *homeostasis* is the tendency for a system to maintain the status quo; *input* “involves the energy, information or communication flow” from outside influences such as funding and policy sources; *output* is processed input, in other words, the hours spent in direct contact with clients or the groups formed for treatment interventions; finally, “*outcomes* measure positive effects of a system’s process” (Zastrow & Kirst-Ashman, 2004, p. 5-6).

Functionalism

The basic theory of this research is the Functionalist Perspective which posits that society is “a system composed of interdependent and interrelated parts” (Zastrow & Kirst-Ashman, 2004). When upper management of a mental health agency promotes a healthy and supportive workplace and workers take advantage of the opportunities, they are more likely to feel well in terms of mental and physical health. In turn, they are less likely to leave their positions and thus their therapeutic relationship with their clients. When clients have consistent care from the same practitioners, they are able to build the relationships necessary for recovery. The next section will apply models of organizational management to the mental health agency system.

Models of Organizational Management

Zastrow and Kirst-Ashman (2004) stress the importance of generalist social workers having a basic understanding of social service organizations. They outline several theories for analyzing organizations, two of which will be applied here to mental health agencies.

Custodial Model. This model posits that employees are happy within a custodial system as they “tend to focus on their economic rewards and benefits” (Zastrow & Kirst-Ashman, 2004, p. 469). Employees of a mental health agency, who have put in many years of service and have a comfortable salary as well as a generous pension to look forward to, are dependent on the agency. Zastrow and Kirst-Ashman (2004) draw on the knowledge of Davis and Newstrom (1989) who point out that employees in situations such as these cannot afford to leave the agency (p. 469). A criticism of this model is that it may not produce productive employees, but “passive cooperation to [the] employer” (Zastrow & Kirst-Ashman, 2004). This model relates to this study and the issue of burnout and compassion fatigue in mental health workers in that it stresses the importance of the monetary reasons for having a career.

Human Relations Model. This model also works in tandem with the custodial model however may provide a more practical way to encourage productivity of employees. It may sound impersonal to think of productivity and products when examining a mental health agency which works directly with vulnerable and marginalized populations. Practically, the clients and their outcomes are the product of a mental health agency and measuring progress looks different than in other industries.

The basic tenet of this model can be illustrated by the sociological study of the Hawthorne Works of the Western Electric Company in Chicago from 1924 to 1927 (Zastrow & Kirst-Ashman, 2004, p. 470). The company experimented with different environmental changes that would increase job satisfaction and thus increase productivity including, lighting and temperature changes (Zastrow & Kirst-Ashman, 2004, p. 470). The criticism of this series of experiments is that just by knowing they were being

observed, employees improved their performance. However, the study was a turning point for understanding environmental impacts on employee productivity as the involvement of the Harvard Business School increased support of this shift in understanding. The researchers continued to study environmental factors at the Hawthorne plant until well into the 1960's. From this and other contributions, the Human Relations model has become a valuable, if not necessary, model asserting that large corporations provide support to employees who produce the company's product. Mental Health agencies seem to be a logical environment for this model to be used for systemic harmony.

Other studies which have looked through the lens of this model found that systemic change and environmental change was more effective than targeting individuals. There are criticisms of this model, as with any, which are important to realize, including that this model stresses the use of social relationships and can be seen as manipulating or dehumanizing workers (Zastrow & Kirst-Ashman, 2004, p. 470). It also notable that a happy workforce is not necessarily a productive workforce (Zastrow & Kirst-Ashman, 2004, p. 470).

Methods

Research Design

This research design included a mixed-method, quantitative and qualitative survey. Respondents completed the Professional Quality of Life (ProQOL) Survey and five open ended questions. Quantitative designs are suggested for topics on which there is a significant amount of data collected (Monette, Sullivan, & DeJong, 2011; Ring,

Gross, & McColl, 2010). Usually a survey or other data collecting instrument has passed the test-retest process confirming its reliability and validity in accurately measuring the intended variables. This researcher chose to use a mixed method by adding five open ended questions to the end of the survey. The five open-ended questions provided data on the availability and usage of the employee wellness programs as well as the respondent's perspective of helpful interventions. According to Monette, et al. (2011), this study reflects a quasi-experimental research design, which is suggested by the authors when a "true experimental design" cannot be used. For instance, in this study while the burnout levels of those who use the employee wellness programs are compared to those who do not, there is no true control group. Many studies and survey instruments have attempted to measure burnout, compassion fatigue, and compassion satisfaction reflected here with the ProQOL and the open response questions. This instrument will be explained in further detail in the data collection instrument section, along with rationale for not using other prominent surveys in the literature.

Sample

This survey yielded fifty-nine total responses (n=59). Respondents were direct practice mental health workers in residential settings including Intensive Residential Treatment Services (IRTS) and Adult Foster Care (AFC); Targeted Case Managers (TCM), Assertive Community Treatment (ACT) team members, and Adult Rehabilitative Mental Health Services (ARMHS) practitioners. Of the respondents, 71% were women, 27% were men, and 2% chose not to answer. Of the fifty-eight (n=58) who responded to the question regarding age, 88% identified as under forty years old and 12% were over forty, but under seventy. Seventy-four percent of the fifty-seven (n=57) responses to the

question regarding years of experience have ten or less years of experience in the field. As a requirement of the agency, these respondents typically, but not always, have 2,000 hours or more experience with mental health work. Workers may have a background in social work, psychology, nursing, psychiatry and other general social services.

Three agencies offering employee wellness programs were invited to participate in the study. One agency reported that due to some changes happening within the company, their employees would not have time to participate. The second agency agreed to only make the survey available to the six supervisees of the director which this writer deemed too small of a sample. The third agency agreed to participate and make the survey available to all employees and will be referred to in this paper as “the agency”. The agency is a major mental health agency in a Midwestern, primarily urban county, which contracts with the government-run county agency to provide services. All three companies were approached with a formal proposal which outlined the voluntary nature of the study and any other requirements by the agency were considered and completed as possible. The agency proposal requested access to employee emails for the strict purpose of sending the survey and inviting voluntary, confidential participation. This writer is an employee of the agency and has worked in several of their programs. Due to this dual relationship and the minority of men over age forty, this writer avoided identifying any respondents by their demographic information. In order to avoid perceived dual relationships, the Associate Clinical Director of the Agency distributed the survey to all employees via company email.

Protection of Human Subjects

Recruitment Process. Agencies which employ mental health workers were approached by this researcher and invited to provide their employees the opportunity to participate in the study. Once approval was obtained from the agency, the survey was sent to the Associate Clinical Director who reviewed the survey for accuracy and appropriateness, then sent the survey to employees via their company email addresses. Respondents were invited to participate in the short survey with no direct benefits offered. They were able to choose to participate voluntarily in the study and were informed of the indirect benefit of contribution to the field of knowledge surrounding burnout and workplace support.

Confidentiality. The identity of participants remained anonymous throughout the research process. Any identifying demographic information that may have been provided by respondents was kept confidential by this researcher. Respondents were informed that their responses were anonymous due to the procedure of the Associate Clinical Director sending the link to the survey so as to avoid this writer manually entering the employees' email addresses.

Informed Consent. An informed consent document was included outlining the following: there are no direct benefits to participating; minimal risk is associated with participation; confidentiality of responses; and the voluntary nature of the study (Appendix A). Respondents were provided with the name and contact information of the researcher, advisor, and St. Catherine University Institutional Review Board chair. Respondents were also provided with the contact information of a crisis resource in the event that the questions revealed issues previously unknown to the respondent. Such

possible issues include, for example, a pre-occupation with certain client(s), emotional concerns not previously addressed, lack of spiritual support, among others unique to the respondent.

Data Collection Instrument

Most recently developed and useful in measuring burnout, compassion fatigue and compassion satisfaction is Stamm's Professional Quality of Life (ProQOL) survey. Maslach and Stamm both look to further understand the stresses that the helping professions place on those who choose this work. Each have their benefits and share similar qualities, but differ slightly. The ProQOL consists of thirty questions looking to measure the three dimensions of compassion satisfaction, compassion fatigue, and burnout. The items were answered with a Likert-type scale as follows: 0=Never, 1=Rarely, 2=A Few Times, 3=Somewhat Often, 4=Often, 5=Very Often. When scoring this survey, items 1, 4, 15, 17 and 29, need to be reversed as follows: 0=0, 1=5, 2=4, 3=3. Items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 measure Compassion Satisfaction. Items 1, 4, 10, 15, 17, 19, 21, 26, and 29 measure Burnout. Items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 measure Compassion Fatigue. This survey and the open ended questions are included in Appendix B. Because Stamm's ProQOL asks questions that measure different types of stress and showing correlation between compassion fatigue and compassion satisfaction, the ProQOL was used for this study.

Data Analysis

Completed surveys were submitted electronically, via the Qualtrics software. First, respondents answered demographic questions including age, gender, education level and discipline, and amount of time they have worked in the field with clients with

mental illness. The next thirty items on the survey were the ProQOL questions and were scored by the researcher using a Microsoft Excel spreadsheet scoring tool acquired publicly from compassion fatigue expert, Francoise Mathieu on her website (Mathieu, 2013). Mathieu discloses that she developed scoring tool for ease of scoring the ProQOL and to prevent manual error. Three scores were then tallied for each respondent; compassion fatigue, compassion satisfaction, and burnout.

Scoring the ProQOL. Results of the completed surveys were organized in an Excel worksheet for readability. In two separate sessions, the responses ProQOL were scored with a colleague using a two screen system. The colleague used a computer to view the respondents' answers in Qualtrics and read them aloud to the researcher who input the responses into Mathieu's Excel scoring spreadsheet. The researcher then obtained the three scores from the scoring tool and recorded them by hand, later inputting this new data into the data spreadsheet. Please note that only the compassion fatigue and burnout scores were analyzed in this study.

Qualitative Data. The final three questions asked respondents to name barriers to their participation in employee wellness activities, incentives to their participation, and suggestions for new activities. Themes were identified for these three questions through content analysis and the data for barriers was recoded into quantitative data. Most respondents identified one theme in their answers which made coding fairly simple. As for incentives and suggestions, there were several answers provided in the responses, so this type of data remained qualitative and themes were identified through content analysis.

SPSS analysis. The Qualtrics software provides for easy transfer of data to the SPSS software and was completed with the guidance of a student research assistant. Due to the nature of the ProQOL and the above outlined process for scoring those questions, the variables of compassion satisfaction, compassion fatigue, and burnout were added to the SPSS data set. Demographic information including gender, age, years of experience in the field, and program where the respondent works were recoded. Based on the open responses for years of experience in the field, this was recoded as follows: 1 - 5 years, 5+ - 10 years, 10+ - 15 years, 15+ - 20 years, and 20+ years. Those who identified that they work in more than one program within the agency were coded as “multiple within the agency”. Others identified that they work in one program at the agency and may have a full or part time job outside of the agency. They were coded as “multiple outside the agency” since in order to participate the respondent has to be employed by the agency in at least one program.

Respondents were also asked what they do when they receive email notifications of activities from the Wellness Committee and their options for answers were: 1) immediately open the email, 2) save to read later, 3) immediately delete the email, or 4) other. These responses were recoded into two options: 1) email was viewed and 2) email was not viewed. The “other” option was coded into “email was not viewed” because the researcher assumed that if the respondent did not open it immediately or read it later, they never viewed the email communicating the activities.

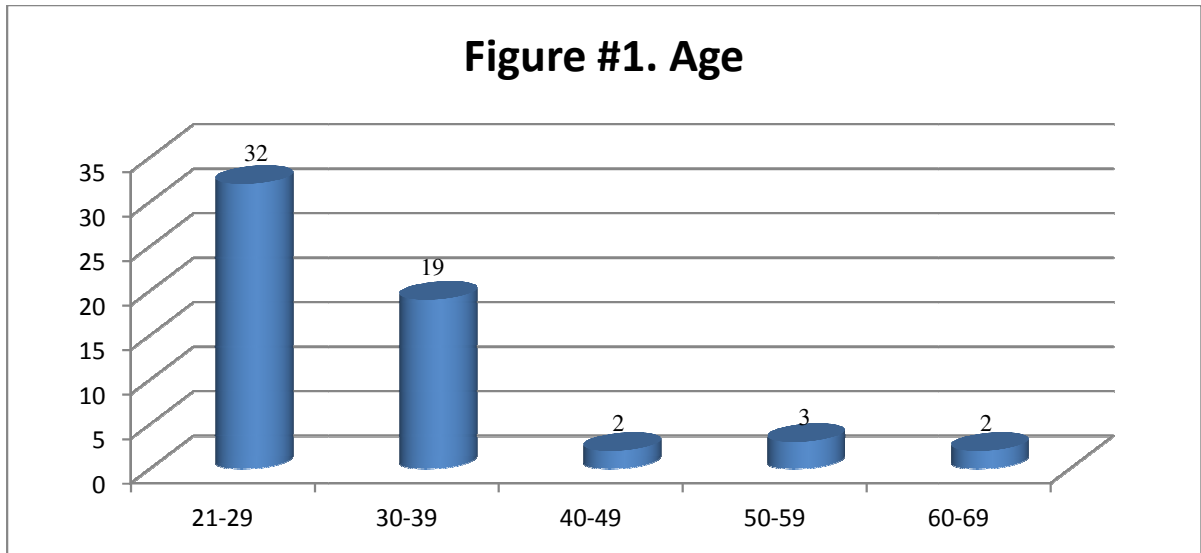
Variables Analyzed. The overall research question guiding this study was: what is the impact of Employee Wellness Programs on mental health workers’ reported symptoms of compassion fatigue and burnout? Several variables were analyzed in

answering the research question. First, the descriptive statistics of gender, age, years of experience, programs where respondents work, what they do with the wellness committee's emails, and the barriers to participation were coded and analyzed. Second, what respondents do with the email notifications was compared to their burnout and compassion fatigue scores (ProQOL scores); program where they work and their ProQOL scores; barriers to participation and ProQOL scores, and program and ProQOL scores. Finally, the qualitative data representing the incentives to participation and the suggestions for activities offered was coded and analyzed.

Findings

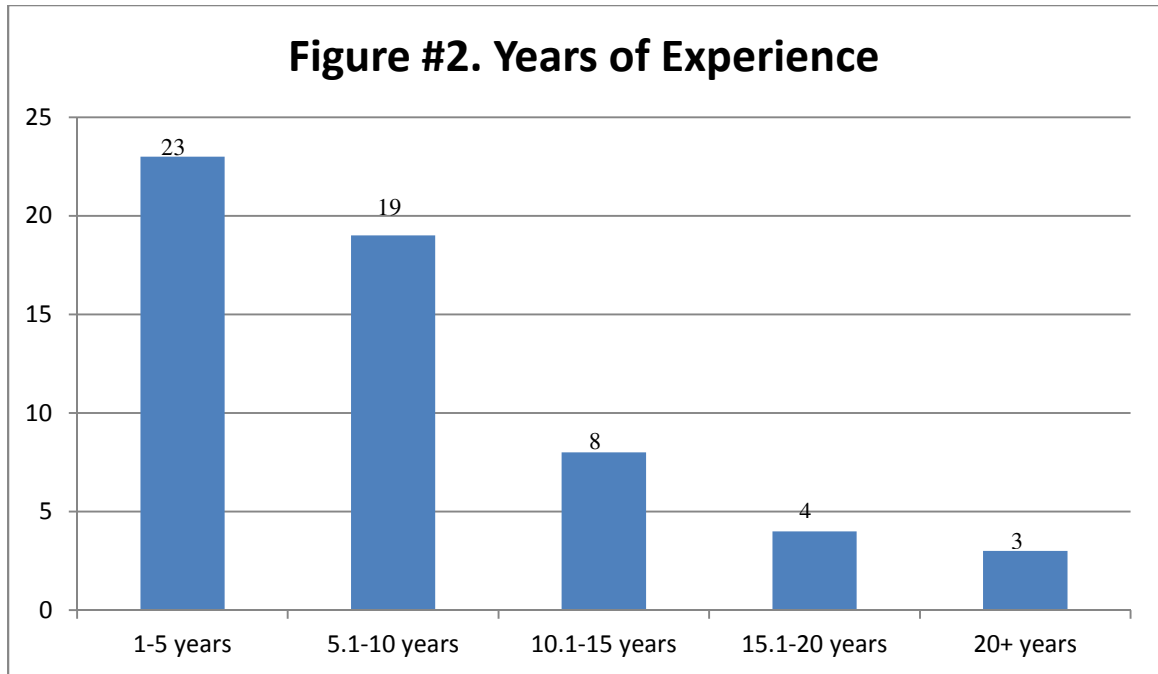
Gender and Age

The majority of participants in this study were women with 42 respondents identifying as female, 16 respondents identifying as male, and one respondent did not enter any data for the question. Options on the survey for gender included four choices; female, male, other, and choose not to answer, with the female and male options the only ones chosen. Respondents ranged in age between 21 – 69 years old. Most employees at the agency who responded to the survey were under 40 as depicted in Figure #1.



Years of Experience

Respondents' years of experience working with clients with mental illness ranged from one to twenty or more years. Most respondents (n=23) have 1 – 5 years' experience followed closely by those (n=19) in the 5+ - 10 years range. Other respondents (n=8) reported that they have between 10+ - 15 years of experience, (n=4) identified having between 15+ - 20 years of experience, and (n=3) identified having more than 20 years' experience working in the mental health field. These results are displayed in Figure #2.



Programs where Respondents Work

Respondents were asked to identify the program in which they currently work. This was an open response question which was converted into twelve categories by the researcher. Fifty-five of the fifty nine respondents answered this question with the most represented program being the agency's largest, Adult Foster Care (AFC) with fifteen respondents. The second most represented program was Targeted Case Management (TCM) with seven respondents. Those working under the umbrella program "Homeless Services" were represented by six respondents and from the Assertive Community Treatment (ACT) team there were five respondents. Employees identifying as working in one or more programs within the agency were represented by five respondents. There was also a category of respondents who work either part- or full-time in one program at the agency, and also work part- or full-time outside the agency. They were categorized as "multiple programs, outside the agency" and four respondents reported this status.

Four Group Residential Housing (GRH) practitioners completed the survey and there were three respondents from both the Intensive Residential Treatment Services (IRTS) program and the UCare program. Community Alternatives for Disabled Individuals (CADI), Adult Rehabilitative Mental Health Services (ARMHS), and Effective Transitions Practitioners had one respondent each.

Table #1. Distribution of Respondents' Programs

Program	Respondents
AFC	15
TCM	7
Homeless Services	6
ACT	5
Multiple within the Agency	5
Multiple outside the Agency	4
GRH	4
IRTS	3
UCare	3
CADI	1
ARMHS	1
Effective Transitions	1

Understanding ProQOL scores

According to industry standards of the Professional Quality of Life survey, the average burnout score is 22 with a standard deviation of 6 and alpha scale reliability of .72. The range of scores considered to be typical is 10 to 27, with 25% of people scoring below and above this range. According to the Professional Quality of Life survey scoring, the average compassion fatigue score is 13 with a standard deviation of 6 and alpha scale reliability of .80. The range of scores considered to be typical is 8 to 17, with 25% of people scoring below and above this range.

Email Action

The four options for the question regarding action taken by respondents when they receive an email from the Wellness Committee were recoded into two options. Most respondents reported that they save the email to read later, this option and “immediately open the email” were recoded into one category. Both of these indicate that the respondent read the email at some point. The options “immediately delete”, “I have never received an email”, and “other” were recoded into a second category indicating that the respondent never viewed the email. It is notable that the option, “I have never received an email from the Wellness Committee” was not chosen by any respondent, indicating that everyone who responded to this survey is aware of the Wellness Committee and its activities whether they participate or not.

Email Action vs. Burnout Score

The mean burnout score for those who view the emails is approximately 21 with a standard deviation of 5.5. The mean burnout score for those who do not view the emails is 24 with a standard deviation of 6.3. The p-value for this T-test is .118 which is greater

than .05 which is not statistically significant. Although the results are not statistically significant, those who utilize the wellness programs by viewing the emails explaining quarterly activities do score lower on the ProQOL's burnout score, supporting this study's hypothesis that those who utilize the programs will have lower burnout scores.

Email Action vs. Compassion Fatigue Score

The mean compassion fatigue score for those who view the emails is approximately 11 with a standard deviation of 5.4. The mean compassion fatigue score for those who do not view the emails is 13 with a standard deviation of 6.6. The p-value for this T-test is .232 which is greater than .05 which is not statistically significant. Although the results are not statistically significant, those who utilize the wellness programs by viewing the emails explaining quarterly activities do score lower on the ProQOL's compassion fatigue score, supporting this study's hypothesis that those who utilize the programs will have lower burnout scores.

Program vs. Burnout Score

The nominal variable in this section measures the program in which respondents work, and the ordinal variable measures the burnout score the respondent received on the ProQOL. "In which program(s) do you work?" was asked as an open-ended question near the end of the survey. Respondents' burnout score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between "program" and "burnout score"? The null hypothesis is: There is no association between "program" and "burnout score".

The mean burnout score for respondents in each program is displayed in figure #3. Effective Transitions, ARMHS, and CADI programs scored 26, 33, and 20, respectively with only one respondent in each program. The program with the highest mean burnout score was IRTS with 25 which falls within the industry standard range and is slightly above the average. Respondents from the Homeless Programs scored an average of 23.8 ranging from 18 to 31. AFC, the largest program and the most represented in this sample, scored an average of 20.8 with the range from 7 to 29 within the program.

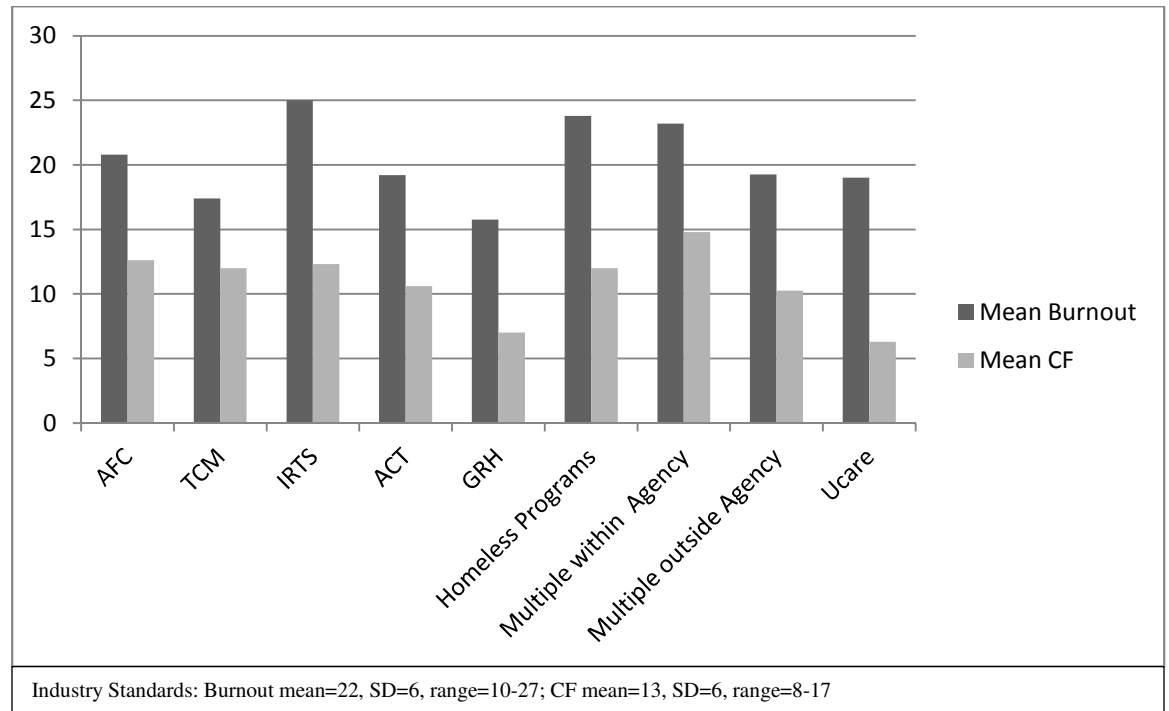
The p-value for the chi-square of the variables “program” and “burnout score” is .049. Since the p-value is less than .05, we reject the null hypothesis. This data supports the hypothesis that there is a relationship between the program where the respondent works and their burnout score.

Program vs. Compassion Fatigue Score

The nominal variable in this section measures the program in which respondents work, and the ordinal variable measures the compassion fatigue score the respondent received on the ProQOL. “In which program(s) do you work?” was asked as an open-ended question near the end of the survey. Respondents’ compassion fatigue score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between “program” and “compassion fatigue score”? The null hypothesis is: There is no association between “program” and “compassion fatigue score”.

The range of scores considered to be typical is 8 to 17, with 25% of people scoring below and above this range. The mean compassion fatigue score for respondents in each program is displayed in figure #3. Effective Transitions, ARMHS, and CADI programs scored 7, 27, and 5, respectively with only one respondent in each program. Those programs with one respondent (n=1) are not depicted in the figure as it may skew the perception of compassion fatigue. The highest mean compassion fatigue score came from those who identified as working in more than one program within the agency. Their average score was 14.8 which falls within the industry standard range and is above the average. The next highest mean compassion fatigue scores came from AFC and IRTS with 12.6 and 12.3 respectively. TCM and Homeless Programs both had a mean score of 12, and ACT had a mean score of 10.6. Those reporting they work for one program at the agency and have an outside job as well, scored an average of 10.25 on the compassion fatigue scale. The GRH program and UCare scored 7 and 6.3 respectively.

The p-value for the chi-square of the variables “program” and “compassion fatigue score” is .442. Since the p-value is greater than .05, we fail to reject the null hypothesis. This data does not support the hypothesis that there is a significant association between the respondents’ burnout score and the programs in which they work. Because the chi-square is not significant we cannot generalize this data to all mental health workers.

Figure #3. Program vs. ProQOL Scores

Barriers to Participation

This question on the survey was an open response with several themes emerging; none and time. The next most frequent response was scheduling/access. Three respondents each reported the following barriers; motivation/energy, activities were unclear/confusing, lack of interest/lack of variety, and other. Responses from the “none” category included such statements as “none, I participate” and “none, I participate fully in the wellness program”. Those whose responses were time-related, included “making time to read the email, let alone complete the activity”, “too much demands of my current position”, and “having enough time to meet the needs of my clients”. Statements typical from the “scheduling/access” category included, “being scheduled to work during the time of the activities” and “I only work part time and they are usually held on a day that

I'm not in. Mondays". Others reporting motivation/energy as a barrier stated, "lack of energy to work out at the end of the work day"; those reporting the activities are unclear said, "...it's kind of a lot to remember all the things that count toward the money" and "...strict criteria to earn the incentive". Lack of interest or lack of variety was another response demonstrated by "not enough variety", "interest", and "trivial nature of the activities". The "other" category included responses that were not represented elsewhere including; "have not been a staff long enough to participate" and "health problems". Four respondents did not answer this question.

Barriers vs. Burnout Score

The nominal variable in this section assesses respondents' barriers to using wellness activities, and the ordinal variable measures the burnout score the respondent received on the ProQOL. "What are barriers to using the wellness programs?" was asked as an open-ended question near the end of the survey. Respondents' burnout score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between "barriers" and "burnout score"? The null hypothesis is: There is no association between "barriers" and "burnout score".

Fifty-five (n=55) total respondents in the barriers category and were analyzed to answer the above research question. Fifteen respondents (27%) reported that they had no barriers (None) and nineteen respondents (35%) reported Time as a barrier to participating in the wellness activities. As depicted in Table #2, of the fifteen respondents, the mean burnout score was 18.2 and of the nineteen respondents reporting time as a barrier, the mean burnout score was 22.5. Nine people reported

scheduling/access as a barrier with a mean burnout score of 19.8; the remaining four barriers had three respondents each and are depicted in table #2. The crosstabulation demonstrates that those who scored higher on the burnout scale reported that Time was a barrier and those who had no barriers scored lower on burnout.

The p-value for the chi-square of the variables “barriers” and “burnout score” is .733. Since the p-value is greater than .05, we fail to reject the null hypothesis. This data does not support the hypothesis that there is a significant association between the respondents’ burnout score and the barriers they reported. Because the chi-square is not significant, this data to all mental health workers.

Table #2. Barriers vs. Burnout Score

Barriers	# Respondents	Mean Burnout Score
None	15	18.2
Time	19	22.5
Scheduling/Access	9	19.8
Motivation/Energy	3	20.6
Activities Unclear	3	26.3
Lack of Interest/Variety	3	22
Other	3	24.6
Total	55	

Industry Standards: Burnout mean=22, SD=6, range=10-27; CF mean=13, SD=6, range=8-17

Barriers vs. Compassion Fatigue Score

The nominal variable in this section assesses respondents' barriers to using wellness activities, and the ordinal variable measures the compassion fatigue score the respondent received on the ProQOL. "What are barriers to using the wellness programs?" was asked as an open-ended question near the end of the survey. Respondents' compassion fatigue score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between "barriers" and "compassion fatigue score"? The null hypothesis is: There is no association between "barriers" and "compassion fatigue score".

Fifty-five (n=55) total respondents in the barriers category and were analyzed to answer the above research question. Fifteen respondents (27%) reported that they had no barriers (None) and nineteen respondents (35%) reported Time as a barrier to participating in the wellness activities. As depicted in Table #2, of the fifteen respondents, the mean compassion fatigue score was 12.5 and of the nineteen respondents reporting time as a barrier, the mean compassion fatigue score was 11.8. Nine people reported scheduling/access as a barrier with a mean compassion fatigue score of 8.7; the remaining four barriers had three respondents each and are depicted in table #2.

The p-value for the chi-square of the variables "barriers" and "compassion fatigue score" is .968. Since the p-value is greater than .05, we fail to reject the null hypothesis. This data does not support the hypothesis that there is a significant association between the respondents' compassion fatigue score and the barriers they reported. Because the chi-square is not significant we cannot generalize this data to all mental health workers.

Table #3. Barriers vs. Compassion Fatigue (CF) Score

Barriers	# Respondents	Mean CF Score
None	15	12.5
Time	19	11.8
Scheduling/Access	9	8.7
Motivation/Energy	3	14
Activities Unclear	3	9
Lack of Interest/Variety	3	11.6
Other	3	10
Total	55	

Industry Standards: Burnout mean=22, SD=6, range=10-27; CF mean=13, SD=6, range=8-17

Years of Experience vs. Burnout Score

The nominal variable in this section assesses respondents' years of experience in the field, and the ordinal variable measures the burnout score the respondent received on the ProQOL. "How many years of experience do you have working with clients with mental illness?" was asked as an open-ended question near the beginning of the survey. Respondents' burnout score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between "years of experience" and "burnout score"? The null hypothesis is: There is no association between "years of experience" and "burnout score".

Fifty-seven (n=57) total respondents answered the years of experience question and were analyzed to answer the above research question. Twenty-three (23) respondents

reported they had 1-5 years of experience with a mean burnout score of 21. Nineteen (19) respondents reported they have more than 5-10 years of experience with a mean burnout score of 19. The remaining three categories: more than 10-15, more than 15-20, and more than 20 years of experience, revealed mean burnout scores of 22, 22, and 20, respectively. The crosstabulation demonstrates that four respondents (n=4) with 1-5 years of experience scored 22 for burnout. There does not appear to be a pattern relating the burnout scores with the years of experience in the field.

The p-value for the chi-square of the variables “years of experience” and “burnout score” is .936. Since the p-value is greater than .05, we fail to reject the null hypothesis. This data does not support the hypothesis that there is a significant association between the respondents’ burnout score and the years of experience they reported. Because the chi-square is not significant we cannot generalize this data to all mental health workers.

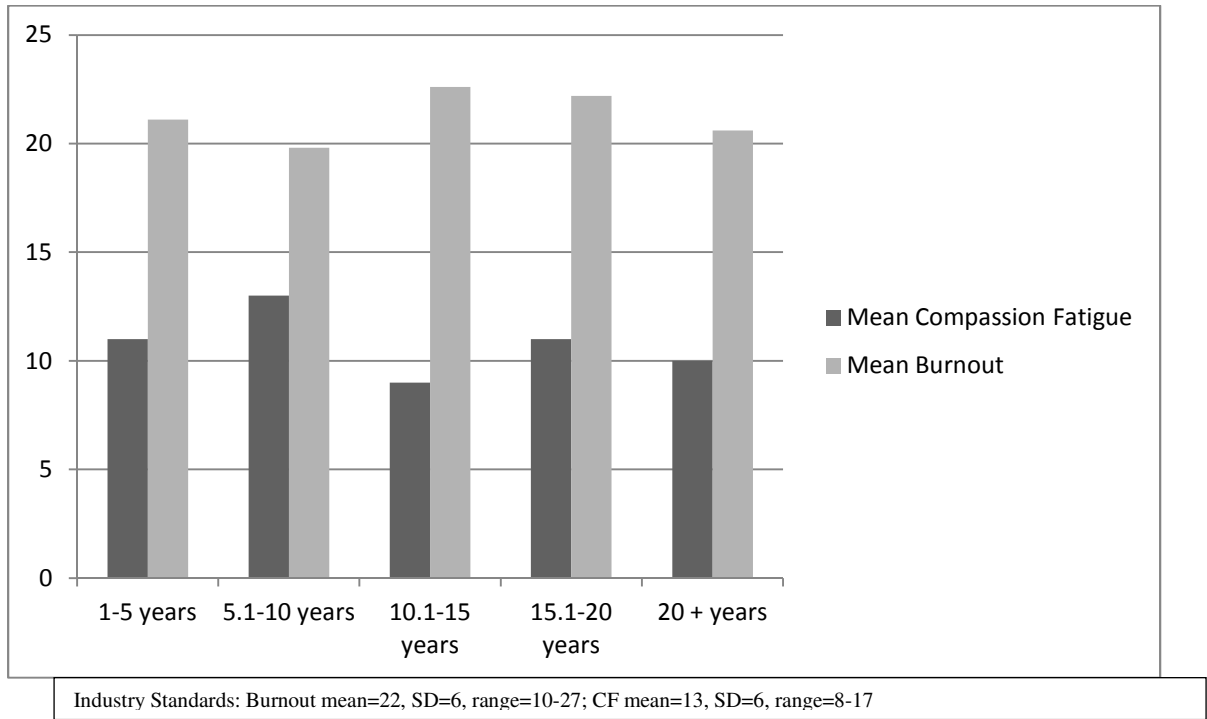
Years of Experience vs. Compassion Fatigue Score

The nominal variable in this section assesses respondents’ years of experience in the field, and the ordinal variable measures the compassion fatigue score the respondent received on the ProQOL. “How many years of experience do you have working with clients with mental illness?” was asked as an open-ended question near the beginning of the survey. Respondents’ burnout score was calculated from the thirty (30) ProQOL questions at the beginning of the survey. The research question answered by comparing these two variables is: Is there an association between “years of experience” and “compassion fatigue score”? The null hypothesis is: There is no association between “years of experience” and “compassion fatigue score”.

Fifty-seven (n=57) total respondents answered the years of experience question and were analyzed to answer the above research question. Twenty-three (23) respondents reported they had 1-5 years of experience with a mean compassion fatigue score of 11. Nineteen (19) respondents reported they have more than 5-10 years of experience with a mean compassion fatigue score of 13. The remaining three categories: more than 10-15, more than 15-20, and more than 20 years of experience, revealed mean compassion fatigue scores of 9, 11 and 10, respectively.

The p-value for the chi-square of the variables “years of experience” and “compassion fatigue score” is .164. Since the p-value is greater than .05, we fail to reject the null hypothesis. This data does not support the hypothesis that there is a significant association between the respondents’ compassion fatigue score and the years of experience they reported. Because the chi-square is not significant the data cannot be generalized to all mental health workers.

Figure #4. Years of Experience vs. ProQOL Scores



Incentives for Participation

Several themes emerged from the open ended question, “what are incentives to participating in the wellness activities”? The number one response to this question was Money with 41 respondents reporting something related to the \$100 quarterly incentive offered by the agency to participate in one of three activities. Internal motivation was another frequently cited incentive, for example: “intrinsic motivation”, “personal incentive”, “increased self-esteem”, and “feeling good about myself”. Other responses included better overall health, “physical/mental fitness”, “health and well-being”, increased positive mood, sleep better”, and “losing weight”. Others said “not sure”, four respondents reported that they do not participate, and four different respondents did not

answer this question. Additional responses fitting with the themes of learning new ideas and sense of accomplishment included, “learning new ideas” and “the achievement”.

Suggestions for Additional Activities

The final open ended question on the survey was asking respondents what additional activities should be offered. As in the incentives section, this question was open to interpretation and several themes emerged. “None”, “I’m not sure”, and “None, I am happy with the wellness program” appeared frequently. Yoga, meditation, relaxation was another theme with responses such as, “mindfulness meditation”, “yoga”, and “relaxation classes.” Others offered on-site work out opportunities including, “exercise work stations, lunch time fitness” and “aerobic classes at the main office like right after work”. Responses from those who work away from the agency’s main office offered environmental improvements, “...six people in a very small office with a very small refrigerator...eat at our desks and all we have is a microwave...we all end up eating fast food often”. Even those at the agency’s main location had environmental improvements in mind, “couches in the kitchen area” and “a quiet room for taking time away from stress”. Other suggestions included, time off, wellness trainings, and spa gift certificates.

Discussion

The following section will discuss the results from this study and relate them back to the literature. There were almost three times as many women (n=42) than men (n=16) who responded to the survey. This supports a national trend of disproportionately more women in the social work and human services field (Center for Health Workforce Studies & NASW Center for Workforce Studies, 2006). In addition, most respondents in this study reported they were under forty years old (n=51) and most of the respondents reported having ten years or less experience in the field (n=42). The average employee who responded to this survey was female, under forty years of age with ten or less years of experience in the field. These demographics describe the stereotypical human services worker without considering race/ethnicity. Keeping in mind this typical respondent, the next sections will discuss variables which help answer the research question regarding the impact of employee wellness programs on mental health workers' compassion fatigue and burnout.

Email Action vs. ProQOL scores

These inferential statistics describe the relationship between employees' awareness of wellness activities communicated through email and their ProQOL scores. The mean burnout score for those who read the emails is 21 and those who do not read the emails score 24. This indicates that those who read the email notifications and presumably participate have lower levels of burnout based on the ProQOL survey. In fact, those who utilize the activities score lower than the industry standard of 22 and even those not utilizing the activities score below the upper mean range of 27. When examining compassion fatigue scores this trend continues with those viewing the

activities reporting a mean score of 11, again below the industry standard mean. Those who do not view the emails reported a score of 13 on compassion fatigue which is below the industry standard mean.

It appears that employees of the agency maintain healthy compassion fatigue and burnout levels. This may be due to the agency providing a supportive workplace to all employees, even if some do not participate or do not participate fully. The agency is following a trend in the US where “over 70% of employers provide EAP” and wellness programs (Jacobson & Sacco, 2012). Simply by having a wellness committee and sending a quarterly newsletter, the agency is attempting to support employees and demonstrate that they care about their employees’ holistic health.

Program vs. ProQOL scores

These inferential statistics describe the relationship between the department in which the respondents’ work and their ProQOL scores. Those who work in AFC, the largest program and most represented in this sample, scored an average of 20.8 for burnout and 12.6 for compassion fatigue. These are both within the industry standard range and slightly below average. The AFC program is an entry level position with the agency requiring basic knowledge of mental health and a bachelor’s degree in a related field, with these counselor’s under greater supervision and concrete crisis protocol. These scores suggest that employees working in this program are supported and that those in this sample are not at significant risk for long term problems. Effective supervision was mentioned as a buffer for child welfare workers (Sprang, et al., 2011), a comparably stressful position as mental health workers, demonstrating another important

aspect of environmental support. Kim and Lee (2009) also stress the importance of supervisory communication when they examined burnout and turnover intention.

The IRTS program scored the highest for burnout at an average of 25 and an average compassion fatigue score of 12.3. This program is a short-term residential placement for clients who need transition from the hospital back to their community living situation. The practitioners who work in this program are required by the agency to have 2,000 hours of prior mental health experience and are given the responsibility of often making quick decisions in crisis situations. It can be assumed that there is more ongoing stress in this program and may explain the higher burnout score. However, practitioners in this program scored just below the industry standard mean for compassion fatigue. This suggests that these practitioners are not as affected by the daily interactions with clients (compassion fatigue) and experience more symptoms of long term job stress (burnout).

Another notable comparison is the scores of those who work in multiple programs within the agency (multiple within agency) and those who work in one program at the agency and have an additional job (multiple outside agency). Those who identified as “multiple within agency” had the highest mean compassion fatigue score at 14.8 and a mean burnout score of 23.4. These scores are higher than those who identified as "multiple outside agency" with a mean compassion fatigue score of 10.25 and a mean burnout score of 19.25. As noted in Cicognani, et al. (2009) “volunteer emergency workers appear to enjoy a better quality of life...compared to full time rescue personnel”. The finding in this study suggests that those who have another position outside the

agency, and thus less exposure to the agency's clientele, may also enjoy a better quality of life, according to the ProQOL scores.

Barriers vs. ProQOL scores

When examining these inferential statistics the following question was asked: do certain barriers contribute to specific ProQOL scores? The relationship was not significant in this study and the null hypothesis was rejected, however it is still important to note that 37% of respondents reported that time was a barrier. Large caseloads and meeting the complicated needs of clients often is identified as the priority during the workday for mental health workers. Often they immediately transition to personal life responsibilities and don't have time to focus on self-care. The demands on clients are often similar to those of the mental health workers who support them. When mental health workers do not have time for self-care, their burnout and compassion fatigue vulnerability may increase. Ting's 2011 study implied the importance of clinicians assessing self-stigmatization, or the barriers to seeking help. Additionally, those who may identify strongly as caregivers are at increased risk for not seeking supports (Ting, 2011).

Strengths and Limitations

While there are several limitations of this study, the main strength is that the environmental support of mental health workers has received little attention. Strengths include the reliability of the ProQOL and the multiple dimensions it measures. This was helpful when analyzing different variables against burnout scores and compassion fatigue scores. For example, when looking for relationships between program and ProQOL scores it was found that the burnout score supported the hypothesis that there would be a

relationship between the two. Alternately, the compassion fatigue score did not support the hypothesis and was not statistically significant.

When conceptualizing this study it was presumed that an emerging strength would be the case study aspect of examining one agency. It was hoped that a clear picture of the perception of the environmental support at the agency would be presented. However, this ended up being a limitation of the study due to the small sample size, similar to the low response rate in Kim and Lee (2009), and the results cannot be generalized to all mental health workers broadly or to all at this agency.

Another limitation which is always present is the possibility of respondents interpreting questions differently from each other and differently than the researcher intended. Several respondents did not answer one or two questions and therefore, their data was not analyzed in some of the inferential statistics.

Implications for Further Research

Further studies of mental health workers' compassion fatigue and burnout should continue to examine workplace support. Moos' WES and the ProQOL continue to be valuable tools for major academic research as well as on-site agency knowledge gathering. More research is necessary in order to fully support mental health workers in their stressful positions. Addressing workplace support and expanding the study to other mental health agencies would be helpful, in addition to comparing agencies who do not have wellness programs and those who do.

Future researchers who may be looking for richer data could ask respondents to rate how likely they would be to use suggested activities. For example, the following

activities could be presented to workers: fill-in staff for vacations and sick leave, peer support network, on-site therapists or therapy groups, team building activities, leadership opportunities, lunchtime yoga, chair massages, or compassion fatigue/burnout trainings and refreshers. Another route that may be effective is again asking respondents their likelihood of using the wellness activities for additional incentives including, spa or coffee gift certificates, gift baskets, additional paid time off, or office supplies with the company logo.

Implications for Practice

Mental health workers should be aware that the ProQOL can be taken periodically to assess feelings toward their work. By assessing this, workers can seek out their EAP or other resources to help manage their stress. Stamm (2005) stresses that the ProQOL can be used for a number of helping professionals in a variety of settings and its utility makes it easy to administer. Employers of mental health workers should be aware of the impact of work environment on their employees' productivity. Kim and Lee (2009) discuss the importance of supervisory communication in providing a supportive work environment, increasing likelihood of employee retention, and, ultimately, providing better outcomes for clients. Also, if employers cannot fix the barriers expressed by employees, merely addressing them with other ideas or solutions can be seen as an improvement. Finally, educators should be realistic with students who plan to enter the field of mental health in regard to entry-level job prospects, salaries, caseloads, wellness, and self-awareness. In reference to Ting's 2011 study again, social work students suffered from the same stigmatizing barriers to accessing mental health care as clients often experience. In conclusion, mental health workers, employers, and educators all

play a part in the holistic health of workers. When environmental support and wellness are priorities of employers, they become priorities of mental health workers.

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Appendix A
Employee Wellness Programs' Effect on Mental Health Workers'
Symptoms of Burnout and Compassion Fatigue
INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating burnout and compassion fatigue among mental health workers. This study is being conducted by Jessica Dooley, LSW, a graduate student at St. Catherine University under the supervision of Valandra, LISW, PhD., a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you work for an agency which provides direct mental health services. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to examine the impact of employee wellness programs on mental health workers' report of burnout and compassion fatigue. Approximately 50 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to complete the following survey which includes the Professional Quality of Life Survey (ProQuol) and five open response questions. This study will take approximately 10 minutes over 1 session.

Risks and Benefits of being in the study:

The study has minimal risks. You may discover that you are more stressed or burned out than you expected. If any of the questions on the burnout inventory or answering the open response questions causes stress in and of itself, please feel free to seek assistance from The Crisis Connection at 612-379-6363.

There are no direct benefits to you for participating in this research. By participating in this and other studies of a similar nature help to advance the knowledge of useful interventions and prevention of stress, burnout, and compassion fatigue. The usefulness of this knowledge is not limited to mental health workers, but also to child protection workers, human rights workers, trauma responders, and hospital personnel.

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented.

I will keep the research results in a fingerprint locked personal computer in St. Paul, Minnesota and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 1, 2013. I will then destroy all original reports and identifying information that can be linked back to you by June 1, 2013.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with your employer or the University of St. Thomas/St. Catherine

University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

New Information:

If during course of this research study I learn about new findings that might influence your willingness to continue participating in the study, I will inform you of these findings.

Contacts and questions:

If you have any questions, please feel free to contact me, Jessica Dooley, LSW at dool6762@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Valandra, LICSW, PhD., Valandra@stthomas.edu, will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher(s), you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study by completing the following survey.

Signature of Participant

Date

Jessica Dooley, LSW

11/3/12

Signature of Researcher

Date

Appendix B

ProQOL survey, demographics, and open-ended questions

Demographic questions:

What is your gender? A) Female, B) Male, C) Other, D) Choose not to answer

What is your age? A) 21-29, B) 30-39, C) 40-49, D) 50-59, E) 60-69, F) 70+, G) Choose not to answer.

How many years have you worked with clients with mental illness?

In which program do you work?

The Professional Quality of Life Survey (ProQOL) Questions

The questions are measured on a Likert-type scale as follows: 0=Never, 1=Rarely, 2=A Few Times, 3=Somewhat Often, 4=Often, 5=Very Often. This statement precedes the survey questions: “[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you [help] has both positive and negative aspects. We 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 current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.”

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 case[work]load 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.

What do you do when you receive an email from the Wellness Committee? A)

- immediately open the email, B) save and read later, C) immediately delete the email, D) I have never received an email from the Wellness Committee, E) Other.

What are barriers to your participation in the wellness activities?

What are incentives to your participation in the wellness activities?

What do you feel should be added to the activities provided by the Wellness Committee?

Appendix C

Typical Activities offered by the Agency's Wellness Committee

- Logging a workout on www.mapmyrun.com.
- Tracking and Improving water consumption and self-reflection
- Attending a mindfulness workshop
- Attending a financial planning workshop
- Participating in the company's 5k

Also included is a quarterly Wellness newsletter with health tips, recipes, tips for “fitting in fitness”. The wellness committee also sends out instructions for submitting proof of participation in order to earn the quarterly incentive demonstrated in the following excerpt:

Instructions:

All submissions must include a completed Gold, Silver OR Bronze Wellness Package Form. Please place this form on the top of the documents you are submitting. The form will need to be completed in full to be accepted. The Wellness Package Forms are attached to this email or can be found on ADP.

In addition to the completed Wellness Package Form you will need to provide supplemental documents as proof of participation. Examples include but are not limited to: Receipts, Brochures, Verification Signatures and Dates (located on Wellness Package Form) signed by trainer or instructor, ticket stubs, business cards etc.).