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Enter sandman-Please! : the relationship between sleep and job satisfaction in social workers and other clinicians : a project based upon an independent investigation

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Enter Sandman – Please!
The Relationship between
Sleep and Job Satisfaction in
Social Workers and Other
Clinicians

ABSTRACT

This study was undertaken to explore the perceived job satisfaction of social workers and other clinicians, and the relationship of their satisfaction with work to their sleep habits. It was hypothesized that sleep deprivation would negatively impact one's satisfaction with work.

A survey was designed that implemented two previously tested measures, the Pittsburgh Sleep Quality Index (PSQI) and the abridged versions of the Job Descriptive Index and the Job In General scale (aJDI/aJIG). The survey was sent to social workers as well as other professionals employed in human services work.

The findings showed the respondents to be significantly sleep deprived as compared to the general adult population in the United States. Of further significance, a higher rating of sleep quality correlated with higher overall job satisfaction scores.

ENTER SANDMAN – PLEASE! THE RELATIONSHIP BETWEEN SLEEP AND JOB SATISFACTION IN SOCIAL WORKERS AND OTHER CLINICIANS

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
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TABLE OF CONTENTS

ACKNOWLEDGEMENTS ii

TABLE OF CONTENTS iii

LIST OF TABLES iv

CHAPTER

I INTRODUCTION 1

II LITERATURE REVIEW 4

III METHODOLOGY 17

IV FINDINGS 22

V DISCUSSION 31

REFERENCES 35

APPENDICES

Appendix A: Human Subject Review Approval Letter.. 38
Appendix B: Recruitment Email 39
Appendix C: Recruitment Flyer 40
Appendix D: Informed Consent 41
Appendix E: Survey 43

CHAPTER 1

INTRODUCTION

> "…The innocent sleep, sleep that knits up the ravelled sleeve of care, the death of each day's life, sore labor's bath, balm of hurt minds, great nature's second course, chief nourisher in life's feast" (Shakespeare, Macbeth, 2.2.35-39)

I am a full–time graduate student, a part-time bartender, a wife, a sister, a daughter, and a pet owner to name but a few parts of my identity. It is the combination of being a student and holding down a part-time job that seriously impede on my ability to get a relaxing and rejuvenating night's sleep. I generally get home from work in the wee hours of the morning and more often than not awake in the wee hours of the morning for school related needs (my clinical internship, attending classes, and studying). In the fog that is sleep deprivation I began to think… .

Upon entering Smith School for Social Work, students are reminded that self-care is of the utmost importance. Just walk across the Smith campus or any campus where graduate students are studying in this field and the topic of self-care will undoubtedly surface. "I finally put my books down last night, it was an effort of self-care," "mindfulness training and yoga are excellent methods of self-care," "write a journal and try to get your feelings on paper; it's important for self-care." What is self-care and how does one attain it? The Webster's New Universal Unabridged Dictionary defines self-care as the following: "n.] a prefix used in hyphenated compounds…many of those of which the meanings are self-evident follow" (Webster, 1983, p. 1645). What follows are approximately 180 hyphenated compounds within which self-care is included. An

Internet search of the definition of self-care produced the following: "No single definition of self-care has been broadly accepted" ("Self-care behavior," n.d.); "The care of oneself without medical, professional, or other assistance or oversight" ("Self-care," n.d.); "care for one-self" ("Self-care," n.d.). I find some of these definitions particularly troubling. A trip down memory lane to an English class years ago has me remembering that when one is defining a word, one should not use the word itself in the definition. That does not seem to be the case here. Self-care is described as self-evident and without a common definition. During a recent classroom discussion on vicarious trauma (also known as secondary trauma) a professor remarked, "We all know that self-care is important." This statement seems to reflect innate knowledge that persons in the helping profession should take the time to care for themselves.

We are left with the sentiment that self-care in the social work profession is subjective to one's preferences and is easily figured out. Is self-care subjective? Certainly there are aspects of taking care of oneself that are considered healthy and obvious such as eating properly, exercising, and getting enough sleep.

Job Satisfaction, Self-Care, and Burnout – Relationship to Sleep?

During the last twenty years, research has been considerable in the area of job satisfaction in the social work field (Acker, 1999). Job satisfaction can be defined as the degree of positive affect toward the overall job or its components (Weisman, Alexander, & Chase, 1980). Research has shown that there are certain factors correlated to job satisfaction in the social work field. Such factors include the ability to help patients and their families, adequate resources—including supervision and peer support, job challenge, and satisfaction with pay (Kadushin & Kulys, 1995; Acker, 1999, Um &

Harrison, 1998). It follows that social workers who are dissatisfied with their jobs are more vulnerable to burnout. The term burnout refers to a cluster of physical, emotional, and interactional symptoms, including emotional exhaustion, a sense of lacking personal accomplishment, and depersonalization of clients (Maslach & Jackson, 1982). But what if a social worker or other mental health professional is sleep deprived? How does one's sleep affect job satisfaction?

The purpose of the current study was to explore the correlation between sleep and job satisfaction for social workers and other mental health professionals. The current study was devised following a conversation about self-care. I believe that sleep is but one form of self-care. I have found no previous research that examines the possible correlations between sleep and job satisfaction in the field of social work. To be sure, the topics of sleep and of job satisfaction have been studied separately and to a great extent. With previous research on social workers' job satisfaction serving as a reference point, the intent of this study was to look more closely at what a specific variable such as sleep could signify about one's perceived job satisfaction, if anything.

CHAPTER 2

LITERATURE REVIEW

There is a great deal of literature that pertains to job satisfaction amongst social workers. There is also a wealth of literature that investigates sleep -- its importance and the implications of poor sleep. The present study's focus is an examination of the relationship between the two: that is, social workers' perceived job satisfaction and their sleep patterns. For the purpose of this literature review, the above-mentioned subjects of job satisfaction in the social work field and sleep in general will be reviewed for salient points.

Sleep

A 2008 study conducted by the Center for Disease Control found that 29% of adults in the United States sleep less than seven hours a night and that 50-70 million have chronic sleep and wakefulness disorders (p. 2532, 2009). This makes sleep deprivation one of the most common problems in the United States (U.S. Surgeon General, 2004). Interestingly a 2004 report conducted by the World Health Organization estimated that 3.6 million years of productive healthy life are lost as a result of primary insomnia (World Health Organization, 2008). Primary insomnia is understood as impairment resulting from problems falling and staying asleep or nonrestorative sleep (American Psychiatric Association, 2004). An estimated 30-35% of people meet the criteria for a diagnosis of primary insomnia (Breslau, Roth, Rosenthal, & Andreski, 1996). Despite being associated with numerous physical and mental health problems, many researchers

believe that poor sleep is under-recognized as a public health issue and one that demands further study (CDC, 2009; Pilcher, Schoeling, & Prosansky, 2000; Lee & Kryger, 2008; Bastien, Vallieres, & Morin, 2004).

The 2003 National Sleep Disorders Research Plan commissioned by the National Institutes of Health succinctly echoes these concerns: "Sleep problems and disorders have major impacts on society, but have not received sufficient attention in clinical practice, in the education of health care providers and future biomedical researchers, or in public health education and intervention programs" (National Institutes of Health, 2003, p. 9). The report outlines sleep problems in three broad categories: sleep restriction, primary sleep disorders, and secondary sleep disorders. Sleep restriction is the most prevalent category characterized by imposed or self-imposed lifestyles and work schedules (NIH, 2003). For this category it is noted, "…many children, adolescents, and adults regularly fail to get sufficient sleep to function effectively during waking hours" (NIH, 2003, p. 9). According to the DSM-IV-TR (2000) primary sleep disorders are those in which another mental disorder, a general medical condition, or a substance is not responsible. Secondary sleep disorders are those in which another mental disorder, general medical condition, or a substance is responsible for sleep disturbances. Primary sleep disorders are thought "…to arise from endogenous abnormalities in sleep-wake generating or timing mechanisms, often complicated by conditioning factors" (American Psychiatric Association, 2000, p. 597). Primary sleep disorders are sub-divided into dyssomnias and parasomnias (APA, 2000). Dyssomnias are classified as

> …primary disorders of initiating or maintaining sleep or of excessive sleepiness and are characterized by a disturbance in the amount, quality, or timing of sleep (APA, 2000, p. 598).

Parasomnias are

> …disorders characterized by abnormal behavioral or physiological events occurring in association with sleep, specific sleep stages, or sleep-wake transitions. In particular, these disorders involve activation of the autonomic nervous system, motor system, or cognitive processes during sleep or sleep-wake transitions (APA, 2000, p. 631).

Individuals who are experiencing dyssomnia related disorders generally complain of insomnia or excessive daytime sleepiness whereas individuals experiencing parasomnia related disorders generally complain of unusual behavior during sleep (APA, 2000).

What are the dangers of sleep deprivation? A 2009 article by the National Sleep Foundation outlined the dangers of deficient sleep as:

- Increased risk of motor vehicle accidents
- Increase in body mass index- a greater likelihood of obesity due to an increased appetite caused by sleep deprivation
- Increased risk of diabetes and heart problems
- Increased risk for psychiatric conditions including depression and substance abuse
- Decreased ability to pay attention, react to signals or remember new information (para. 5).

As noted above an increased risk of motor vehicle accidents is one danger of sleep deprivation. Horne and Reyner (2001) have completed numerous studies on sleep deprivation and driving. In their article, *Sleep-related Vehicle Accidents: Some Guides for Road Safety Policies* (2001), they estimated that 20% of accidents occurring outside of urban environments in the UK were directly related to sleepiness. It was noted, "…long, undemanding, monotonous driving, typified by rural highways and motorways, facilitates sleepiness as does other monotonous tasks" (Horne & Reyner, 2001, p. 63). Unfortunately, many car accidents are wrongly attributed to other causes such as driver

inattention and human error and this has meant that the statistics about sleep related car accidents are most likely underrepresented (Horne & Reyner, 2001; Chipman & Jin, 2008). However, the data that are available are still alarming. In a study of 746 Ontario residents completed in 2007, 15% of respondents reported that they had fallen asleep or nodded off during the previous year (Vanlaar, Simpson, Mayhew, & Robertson, 2007). The dangerousness of drowsy driving cannot be underlined enough; sleep related vehicle accidents are more liable to end in death given the high rates of speed in which crashes occur (Horne & Reyner, 2001). This is but one extrapolation of the dangers associated with sleep deprivation. It is also an important factor to consider for the current study given the implications that commuting time and job demands may interfere with one's sleep and their ability to drive safely.

Armed with information about the dangers of sleep deprivation, a logical question would be, how much sleep is enough? To answer this question we must first understand the process of sleep. In a groundbreaking article that has been cited over 1000 times since it was first published in 1982, a model for sleep regulation proposed by Alexander Borbely outlines a two-process model for sleep regulation (Borbely, 2009; Borbely & Achermann, 1999; Glickman, 2010). The two-process model posits that "sleep propensity in humans is determined by a homeostatic process (S) and circadian process (C); the interaction of S and C determines the timing of sleep and waking" (Borbely & Achermann, 1999, p. 565). In the article, *The Sleep-Wake Cycle and Its Clinical Implications in Understanding and Managing Insomnia*, Dr. Thomas Roth (2006) briefly explains the homeostatic process.

> The locus of sleep control is believed to be the ventrolateral preoptic (VLPO) area of the anterior hypothalamus. Given its role, it is often referred to as the "sleep switch." The VLPO is predominantly GABAergic. [That is predominantly transmitting or secreting gamma-amniobutyric acid, an amino acid]. The other parts of this sleep-wake homeostatic control switch are several nuclei with a variety of transmitter systems (e.g., histamine and serotonin) that maintain wakefulness and inhibit sleep. The homeostat, or sleep drive, accumulates while we are awake, reaching a peak in the evening, and dissipates when we sleep. It is estimated that 8 hours of consolidated sleep are needed to fully discharge the homeostat. Adenosine, a neuromodulator, has been hypothesized to be involved in the homeostatic process by accumulating during wakefulness and inhibiting the wake-promoting neurons that inhibit the sleep-promoting neurons of the VLPO. Thus, the homeostat resembles all other drive states by accumulating during abstinence (wakefulness) and discharging during consumption (sleep). [para. 3].

It is also important to note in addition to this description that sleep homeostasis is influenced by an individual's prior sleep and wake cycles. This is opposed to the circadian process that functions independently of sleeping and waking (Borbely & Achermann, 1999).

The human circadian rhythm functions on an approximate 24-hour cycle. The term circadian is derived from Latin, circa "around" and diem or dies "day." Circadian rhythms are "physical, mental, and behavioral changes that follow a roughly 24-hour cycle, responding primarily to light and darkness in an organism's environment" (National Institutes of General Medical Science, 2010, para. 1). The homeostatic process involved in sleep regulation is largely dependent on sleep history, an individual's sleep-wake cycle. However the circadian process is largely independent of sleep history and represents the endogenous biological clock, or circadian pacemaker, located in the superchiasmatic nucleus (SCN) (Glickman, 2010; Borbely & Achermann, 1999). The SCN is located in the hypothalamus near the optic nerves. The optic nerves translate signals from the eyes to the brain about incoming light; information that the SCN also

receives due to the relative location to the optic nerves. As the SCN receives information about incoming light, it signals the brain to increase the production of melatonin as the day becomes darker. Melatonin is a hormone that makes one drowsy (NIGMS, 2010, para. 8).

In conclusion, it is the interaction of the homeostatic process and the circadian process that regulates sleep. In their article, *Sleep Homeostasis and Models of Sleep Regulation,* Borbely and Achermann (1999) explain the interaction of the two processes. In the course of awakening, rising homeostatic sleep pressure (the urge to awake) is compensated by the declining circadian sleep propensity. Conversely, "During sleep the rising circadian sleep propensity may serve to counteract the declining homeostatic sleep pressure, thereby ensuring the maintenance of sleep" (Borbely & Achermann, 1999, p. 566). This section also illustrated that these processes take about 8 hours to complete, the recommended amount of sleep for adults.

Job Satisfaction

The previous section identified issues related to sleep -- such as, how and why we sleep, how much sleep is recommended, and the risks of sleep deprivation. In this section job satisfaction and factors that have been studied in relation to job satisfaction will be reviewed. Though the current study is interested in examining job satisfaction amongst social workers as a profession, much of the literature on the topic of job satisfaction also makes reference to burnout concordantly. Both concepts will be discussed within this literature review with the assumption that they are separate but related functions. Also included are past studies that have examined correlations between sleep and professions other than social work and similar mental health professions. Their inclusion in this

literature review was done in order to understand research that has similarities to the current study.

In the article, *Job Satisfaction, Burnout, and Turnover in Health Care Social Workers,* the authors examined the findings of two surveys of job satisfaction and burnout conducted 10 years apart (Siefert, Jayaratne, & Chess, 1991). This article discussed the compared findings of each study in regards to the factors that were associated with job satisfaction and burnout (Siefert, Jayaratne, & Chess, 1991). One finding showed that respondents' reported job satisfaction changed very little between the two surveys, with 32.5 percent being very satisfied and 53.2 percent being somewhat satisfied with their jobs in the 1979 survey, as compared to 31.5 percent and 51.4 percent in the respective categories in the 1989 survey (Siefert, Jayaratne, & Chess, 1991). Significant predictors of overall job satisfaction were concern about financial rewards and conflict with professional values (Siefert, Jayaratne, & Chess, 1991). A 1995 study, *Job Satisfaction Among Social Work Discharge Planners*, found that sources of satisfaction were autonomy, the ability to help patients and families, job challenge, and concrete resource provision (Kadushin & Kulys).

In one study of job satisfaction, *The Impact of Clients' Mental Health Illness on Social Workers' Job Satisfaction and Burnout,* 128 social workers were administered a questionnaire that included three scales: an involvement scale, a job satisfaction measure (JIG), and the Maslach Burnout Inventory [MBI] (Acker, 1999). The social workers in this study worked with clients diagnosed with severe mental illness (hereafter referred to as SMI). SMI is categorized by schizophrenic spectrum disorders, major affective disorders, and poor functional capacities for daily living (Acker, 1999). Individuals who

suffer with SMI often need concrete services that help them to function better in the community. Examples of such services are helping clients to find appropriate living situations, applying for benefits such as social security disability, working with clients to increase their interpersonal skills, and helping clients to attain wraparound services such a visiting nurse to monitor medication, and community support groups that further clients' ability to live successfully in the community. In this study, correlations between a social worker's degree of involvement with clients with SMI and job satisfaction were examined as well as correlations between the social workers' involvement with SMI clients and burnout. Overall, results indicated that social workers working with clients with SMI were relatively satisfied with their work. In regards to this finding about work satisfaction, adequate mechanisms of support (e.g.: supervision, peer support, and organizational support and resources) were associated with significantly higher scores on the job satisfaction scale. The social workers' scores on the burnout dimensions (depersonalization, emotional exhaustion, and personal accomplishment) ranged from "low scores on the depersonalization scale to moderate scores on the emotional exhaustion scale to high scores on the personal accomplishment scale" (Acker, 1999, p. 115). Though the social workers overall scored low on the depersonalization scale, indicating that this subscale of burnout was less a factor than the other two subscales, the hypothesis that involvement with clients with SMI would be positively correlated to emotional exhaustion and depersonalization was confirmed (Acker, 1999). Also indicated in the study were findings that recent graduates, "…who were young and had less work experience and less family responsibilities, were more likely to consider quitting their job than those who were older, had higher levels of education, and more

work experience" (Acker, 1999, p. 115). Of significance in this study is the confirmation of emotional exhaustion and depersonalization amongst the social workers, symptoms of burnout.

A study completed in 2007 by Leone, Huibers, Knottnerus, & Kant has some interesting applications to the Acker (1999) study. This study indicated that prolonged fatigue may further impact symptoms of burnout such as those experienced by the clinicians in the Acker (1999) study. Leone et al. (2007) compared the course of burnout and fatigue for employees from 45 different companies and organizations over the course of three years. Participants received an extensive questionnaire that contained questions on health factors (e.g., burnout, fatigue), work factors, and non-work factors (Leone et al., 2007). A baseline measurement was made to determine which of three groups the workers fell into: pure fatigue, pure burnout, burnout and fatigue, neither burnout nor fatigue (Leone et al., 2007). Measurements were then followed up at the -12, -24, and 48-month marks (Leone et al., 2007). The findings for this study indicate the employees who at baseline were in the burnout and fatigue group had the most chronic symptoms, "…indicating the fairly chronic and stable nature of this condition" (Leone et al., 2007, p. 36). It was the pure burnout group that recovered the fastest over the course of the study according to the follow-up measures (Leone et al., 2007). Of the pure burnout cases, 27% were pure burnout at the 12-month follow-up, 19% at the 24-month follow-up, and 14% at the 48-month follow-up (Leone et al., 2007). The percentage of pure fatigue group at these same intervals was 31%, 36%, and 28%. Again the most chronic of the cases was the burnout and the fatigue group with the percentages staying relatively the same at 56%, 57%, and 50% (Leone et al., 2007).

Another interesting point of the study was that the attrition rate for participation in the study was the highest in the burnout and fatigue group. Demographically, the participants who dropped out were younger, scored lower on professional efficacy, and scored higher on exhaustion, cynicism, prolonged fatigue, and subjective fatigue (Leone et al., 2007). This data set is reminiscent of the Acker (1999) study, which found amongst its participants that the younger, less professionally experienced, less educated individuals were more likely to be dissatisfied with their jobs and quit. Both the Acker (1999) and Leone at al., (2007) studies are an excellent illustration of the intersection between job satisfaction and fatigue and burnout.

The importance of the following study by Um and Harrison (1998) is two-fold. First, this study looked primarily at the development and evaluation of a model that outlines the processes of burnout experienced by social workers (Um & Harrison, 1998). The study tested chain hypotheses, notably: that "…role conflict and role ambiguity should increase the probability that individuals will experience job strain" (Um & Harrison, 1998, p. 103); "…the occurrence of job strain in and performance of job duties would result in job dissatisfaction" (Um & Harrison, 1998, p. 103); "…social support would influence burnout and job dissatisfaction negatively and to influence coping process positively" (Um & Harrison, 1998, p. 103); and finally that "…coping processes influenced by social support played a mediating role between job strain and job satisfaction" (Um & Harrison, 1998, p. 103). The second factor that makes this study relevant is this: one result in particular was unexpected and contradicted previous research (Um & Harrison, 1998). "Burnout (emotional exhaustion) did *not* show a strong relationship with job dissatisfaction…the simple correlation of emotional exhaustion and

job dissatisfaction was .297 ($p < .01$), but this effect turned out to be nonsignificant when social support and coping skills were intervened between them" (Um & Harrison, 1998, p. 112). The implication of these data is that social support acts as a significant moderator of burnout (Um & Harrison, 1998).

A study by Partinen, Kaprio, Koskenvuo, and Langinvainio (1983) revealed differences in the occurrence of sleep disturbances in various occupations. After controlling for the effects of work schedules, part of the variance across occupations was explained by the amount of physical activity and certain psychological factors. It was found that "…disturbed nocturnal sleep was associated with heavy [physical] work, whereas difficulty falling asleep and early morning wakening were linked to mental strain" (Partinen et al., 1983). The authors of the study, *Effects of Age, Working Hours, and Job Content on Sleep: A Pilot Study* (Marquie, Foret, & Queinnec, 1999) found that regardless of what the participants' age or work schedule was, subjects who said that "…their work required mental or physical effort reported more sleep problems than the others, and the difference was even more significant when these requirements were rated as difficult or stressful" (Marquie et al., 1999, p. 426). Both the Marquie et al. (1999) and Partinen et al. (1983) studies have findings that refer to work that require mental strain or effort. Though these studies did not include social workers in their sample, these findings are nonetheless interesting to consider for their implications to social work. Practitioners in the social work field are educated in analysis, intervention strategies, theoretical applications to casework, and various techniques such as attention, concentration, and observation in their work with clients. Certainly social work can be viewed as an occupation that generally necessitates mental effort over physical.

There has been research in the field of social work that has implications for diversity and job satisfaction. One such study, *Personal and Organizational Diversity Factors' Impact on Social Workers' Job Satisfaction: Results from a National Internet-Based Survey* (Acquavita, Pittman, Gibbons, & Castellanos-Brown, 2009), I've chosen to include not only for its attention to a diverse sampling population but also for the use of internet surveying in gathering data. The study boasted 1,600 participants (Acquavita et al., 2009). Examined were the "…relationship[s] among minority status, workplace racial composition, perceived inclusion, organization diversity, and job satisfaction for social work professionals employed in organizations" (Acquavita et al., 2009, p. 151). Previous research has suggested that heterogeneous workgroups produce less satisfied workers (Milliken & Martins, 1996; Wharton, Rotolo & Bird, 2000). The significance of this study was that it addressed the concept of inclusion/exclusion with a general social work population (Acquavita et al., 2009). Outcomes of the three studies suggest that further research needs to be conducted, as the research done thus far has produced mixed findings such as the Acquavita, et al. (2009) finding that "…racial composition of the workplace was not found to be predictive of job satisfaction" (Acquavita et al., 2009, p. 151). This is consistent with the research that was examined in Mor Barak & Levin (2002). A contradictory finding in a study conducted by Milliken & Martins (1996) indicated that workplace racial composition does impact job satisfaction.

To conclude, the literature has indicated that job satisfaction in the field of social work can be influenced by variables such as workplace composition (Milliken & Martins, 1996), supervision and collegial support, adequate resources, job challenge, and adequate pay (Kadushin & Kulys, 1995; Acker, 1999, Um & Harrison, 1998). Furthermore,

studies that investigated sleep in professions other than social work and human services outlined the dangers of sleep deprivation (Marquie, Foret, & Queinnec, 1999). It appears that the relationship between the two could produce important findings for the field of social work. The study reported here surveyed social workers and other mental health professionals regarding their sleep habits and job satisfaction. To my knowledge, such a study has not been conducted to date.

CHAPTER 3

METHODS

Methodology

Formulation

This study is an exploratory investigation designed primarily to examine the possible relationships between subjectively reported sleep habits and the perceived job satisfaction of social workers and other mental health professionals. Given the sample of clinicians surveyed for this research, the secondary aim of the project was to examine factors such as gender and years of experience in the mental health field and the relationship of such factors to subjective sleep habits and perceived job satisfaction. To this end, the study implemented a mixed method design that included both quantitative and qualitative components.

Subjects

Social workers and other mental health professionals were recruited who met the following inclusion criteria: graduate level students in an accredited program working towards a degree in the mental health field with some clinical internship experience, clinicians who received at least a graduate level degree in the field of mental health, clinicians who held licensure in the field of mental health. The sample was originally designed to include only social workers and students working towards this degree, but to achieve a minimum sample size of 50, the inclusion criteria were expanded to include

other mental health professionals such as psychologists and licensed mental health counselors. After receiving approval from the Human Subjects Review Committee (Appendix A), I sent out twenty-two recruitment emails (Appendix B) to mental health professionals that were known to her as personal contacts. These emails gave a brief introduction to the study, identified participant characteristics, and listed a link to the on-line survey. This technique of convenience sample recruitment from personal contacts was utilized to ensure that some research participants would be located, and with the intent that these personal contacts would forward the recruitment email resulting in a snowball sampling technique to other possible study participants. In addition to the recruitment emails, I also contacted by telephone the clinical directors of three outpatient agencies with whom I worked with over the tenure of my second clinical internship. Two of three individuals gave me permission to display recruitment flyers (Appendix C) in the employee areas of the particular agency. In addition to this, these individuals also requested a copy of the recruitment email that they then forwarded to their employees. Both the recruitment email and the recruitment flyer were implemented at these agencies to reach potential participants that fell into two categories: those who regularly used their email and the internet and for those who did not. Lastly, a recruitment letter was sent to the department head of a local university's psychology program. With his permission, the email was forwarded to appropriate clinical staff and the entirety of the students in the doctoral program for psychology. The recruitment approaches made to private clinicians, agencies that provided out-patient mental health services, and a major university were done with the expressed hope of reaching a diverse sample that would include wide range in terms of ages of participants, years of experience in the mental health field, variations

in the clinical populations that participants worked with as well as differences in gender and ethnicity.

Data Collection and Instruments

This study used an on-line survey provider, Surveymonkey.com, to survey the participants. Both the recruitment email and the recruitment flyer listed a link that participants could either click on (as in the recruitment email) or manually type into their internet browser to reach the survey website. Participants were first directed to a simple yes or no question that assessed if they met the inclusion criteria to continue in the study. Following this, all qualified participants, were directed to the study's informed consent (Appendix D). If participants agreed to the informed consent they were then directed to the study's survey. After participants completed the survey they were thanked for their participation. At the completion of the survey process the researcher downloaded all surveys. All of the surveys were stripped of identifying information such as email and IP addresses so as to maintain anonymity prior to downloading. The process of stripping identifying information from the surveys was completed independently of this researcher by the survey site, Surveymonkey.com. An Excel file that contained the raw data from the surveys was sent to an independent analyst for review, who compiled frequencies from the raw data. This analyst also scored the two test measures that were used in the survey to determine individual participant scores on these measures.

Three sets of questions were included in the 22 question on-line survey (Appendix E). The survey questions included a demographics section. This section of the survey was designed to gather such demographic data as respondents' gender, age, and years of experience in the mental health field. Preceding the demographics questions were two

standardized measures. These measures were: the Pittsburgh Sleep Question Inventory (PSQI), the abridged versions of the Job Descriptive Index and the Job In General Questionnaire (aJDI/aJIG). I contacted Bowling State University via email to request permission to use their standardized measure, the PSQI. One of the stipulations made by the authors of the PSQI in granting their consent to use their measure in the current study was that two questions had to be added to the demographics section of the current research project. These questions were: "What is your primary home zip code?", "What is your primary work zip code?". There were no fees associated with using this measure for student researchers.

The aJDI is a standardized 5 question measure while the aJIG is one question. The aJDI/aJIG is offered for use at no cost with the stipulation that it be correctly cited in the reference section of the research paper. Longer versions of the Job Descriptive Index (72 items) and the Job In General Index (18 items) are available. Regardless of which lengths of measures are used, the JDI and JIG are complementary and are always distributed together. For this study, the abridged versions of the measures were used to minimize participant fatigue as the measures were being used in conjunction with other measures and questions. The aJDI measures job satisfaction using five facets: work on present job, present pay, and opportunities for promotion, supervision and coworkers. The one question aJIG measures overall job satisfaction. The Job Descriptive Index has been is use for forty years and remains one of the most utilized measures for job satisfaction. The PSQI is a self-rated questionnaire that assesses sleep quality and sleep disturbances over the course of a one-month period. The questions in the measure fall into seven categories: sleep quality, sleep latency, sleep duration, habitual sleep

efficiency, sleep disturbances, use of sleep medication, daytime dysfunction. An overall score is used to determine poor sleep quality (less than or equal to 5) versus good sleep quality (greater than 5).

Data Analysis

At the completion of the survey process, an Excel file containing raw data from all the surveys was downloaded. As noted above, any identifying information about the participants such as email or IP addresses had already been stripped by the survey website, surveymonkey.com prior to download. I sent the Excel file containing the raw date to an independent consultant for analysis – initially, compiling a table of frequencies from the raw data. Then, using the scoring rubrics for each of the standardized measures, overall scores for the PSQI and the aJDI/aJIG were created for each participant. After review of this information, I requested that further correlational analysis be conducted to examine the relationship between sleep and job satisfaction. Results of these assessments are reported in the following chapter.

CHAPTER 4

FINDINGS

Demographics

The demographics collected for this study's participants were: the respondents' gender, race, age, licensure type, years in practice, and primary population worked with. For the most part, participants were female, and self-identified as white/Caucasian; they ranged in age from 27 – 60; their median number of years in practice was 10; the populations worked with varied considerably. (See Table 1 in following page.)

Abridged Job Descriptive Index and Job in General Findings

When asked about job satisfaction, most respondents said positive things about their work: for example, challenging (29 of 34 – yes); satisfying (28 of 34 –yes); gives sense of accomplishment (30 of 34 – yes). Conversely, when asked if their jobs were dull or uninteresting most participants answered no (27 of 34 and 31 of 34 respectively). These responses were derived from a subscale of the abridged Job Descriptive index (aJDI) that inquired about respondents' work at their jobs. Each of the five subscales is scored separately and range from 0-15, with a higher number indicating greater satisfaction. Of the 34 respondents who answered all questions on the work at present job subscale, the scores showed a high level of satisfaction with a mean score of 13.25.

Two subscales of the aJDI, supervision and people at work, yielded expected findings: the literature has shown that positively regarded supervision and collegial relationships are predictors of increased job satisfaction (Kadushin & Kulys, 1995;

Table 1

Demographic Characteristics of Participants

Variable	Frequency	Percent	Cum. Percent
Ethnicity			
Skipped Question	8	20.0	20.0
European American	1	2.5	22.5
Latina	1	2.5	25.0
Middle Eastern, Jewish	1	2.5	27.5
White/Caucasian	29	72.5	100.0
Gender			
Skipped Question	7	17.5	17.5
Female	27	67.5	85.0
Male	6	15.0	100.0
Licensure Type			
Skipped Question	7	17.5	17.5
LCSW	7	17.5	35.0
LICSW	8	20.0	55.0
LMHC	1	2.5	57.5
MSW	6	15.0	72.5
PhD Psychologist	5	12.5	85.0
Working towards MSW	5	12.5	97.5
Psy.c	1	2.5	100.0
Populations worked with primarily			
Skipped Question	7	17.5	17.5
Medical/In-patient Psychiatric	6	15.0	32.5
Children & Adolescents	11	27.5	60.0
Children – dealing w/ sexual abuse	1	2.5	62.5
College Age/College Students	5	12.5	75.0
Adult	3	7.5	82.5
Middle Class Educated	1	2.5	85.0
Dual Diagnosis	2	5.0	90.0
Court mandated	1	2.5	92.5
All (children, couple, families)	3	7.5	100.0

Acker, 1999, Um & Harrison, 1998). Responses showed that supervisors praised good work (27 of 33 - yes), were up-to-date (22 of 33 - yes) and were not found to be annoying (22 of 33 - no) or bad (27 of 33 - no). A mean score of 11.78 was found for the 33 participants who answered this subscale. Responses for the people at work subscale showed that respondents found people at their present jobs to be helpful (31 of 34 - yes), responsible (31 of 34 - yes), and intelligent (33 of 34 - yes).

Two of the subscales for the aJDI presented interesting findings when juxtaposed to the others. Of the five subscales that make-up the aJDI, the present pay subscale and the opportunities for promotion subscale were areas that did not show overwhelmingly positive responses for job satisfaction. The present pay subscale was comprised of five variables: income adequate for normal expenses, fair, insecure, well paid, and underpaid. Responses were roughly split amongst the variables. Nineteen responses indicated that income was adequate for normal expenses while 14 participants did not think this was true or were not sure. In regards to fair pay, 14 participants thought that their pay was fair while more than half of the 32 responses showed that participants did not believe their pay was fair (12) or were not sure (6). Furthermore, a majority of participants did not believe that they were well-paid (22 of 32 - no). When participants were asked if they believed they were underpaid, the group was split (19 - yes, 10 – no; 4 - unsure). While a majority of respondents did not believe that their pay was fair or that they were well paid, these participants were less likely to indicate that they were underpaid. These responses may indicate that social workers and other mental health professionals enter their chosen careers with the expectation that they will not be highly paid, but believe that their services are not unfairly compensated. A recent media story reported by the website

the Huffington Post regarding the ten worst paying college degrees listed social work number one. The May 2010 article noted that social workers can expect a starting salary of $33,000.00 with a mid career salary of $40,000.00. However the National Association for Social Workers took exception to this article. In their rebuttal, written less than one week after the Huffington Post ran the original article, spokespersons for the NASW pointed out that only social workers with a bachelor's degree were figured into the findings. In addition, the NASW also cited their own findings regarding expected pay for social workers. The NASW 2009 Compensation & Benefits Study: Summary of Key Compensation Findings was prepared for the 2010 Social Work Congress. Amongst the reported findings were that the median base salary for a social worker as of October 1, 2009 was $55,000. The range between the 25th percentile and the 75th percentile was $41,000 - $71,000 (NASW, 2009). To restate, the current study's findings regarding attitudes towards present pay is expected given the commonly held belief that social workers, though providing an important service, are underpaid for their efforts.

When asked about opportunities for promotion, most respondents said that such opportunities were not available: for example, good opportunities for job promotion (20 of 33 - no); good chance for promotion (21 of 33 - no). When asked if they believed that there were opportunities for promotion based on ability the group was roughly split (16 - no, 13 - yes, 5 - unsure). Interestingly, given the findings thus far regarding opportunities for promotion, a majority of respondents did not feel that they were in a dead-end job (21 of 33 - no) or that their present job had unfair promotion policies (26 of 33 - no). It may be that the social workers and other mental health professionals who took this survey simply did not feel that promotional opportunities were available in their particular work

settings and were realistic about opportunities for advancement. It may also be that a social desirability response set was operating for some of the respondents. Sixteen respondents indicated that they did not feel that promotion was available on ability. However, given their answers to that question, no one indicated that there were unfair promotion policies in their present jobs. Rather a majority of respondents said there was not an unfair promotion policy (26 of 33 - no) while a small number were not sure (7 of 33 - unsure).

Overall job satisfaction scores were computed using the participants' responses to the abridged Job in General scale (aJIG). This scale has a range of 0-24, with a higher number indicating greater overall job satisfaction. Participants were asked to rate each item in terms of the item's applicability to the job most of the time. Responses to the aJIG were generally favorable: for example, good (30 of 34 - yes); better than most (27 of 33 - yes); enjoyable (24 of 32 - yes). Two item questions on this measure, "makes me content" and "excellent," were not as clear indicators of satisfaction as some of the other item questions. Eighteen participants of 32 said that their jobs made them content. The other 14 respondents to this item indicated that they were not content (8) or could not answer a definitive yes or no (6). For the item question "excellent," 12 participants believed their job could be described as excellent most of the time while 15 believed it could not and 6 participants were not sure. For the 30 participants who completed this measure, the mean job satisfaction score was 20 with a median score of 21.5. The range of scores was 10-24.

Pittsburgh Sleep Quality Index Findings

In rating overall sleep quality, the majority of respondents believed that they slept fairly well (21 of 36). Only five respondents believe that they slept very well while 10 respondents said that they slept fairly badly and very badly. Given that 36 respondents answered this question fully, the 10 respondents who indicated that they slept fairly badly or very badly comprised nearly one-third of the sample. Although the above responses suggest that more respondents than not believed their sleep to be fairly good, data analysis revealed a wholly different picture. Individual scores for the PSQI range from 0 (better) – 21 (worse). The range of scores for the respondents in the current study was 1-14 with a mean of 7.68. Given the range of 0-21, the PSQI scoring rubric indicates that a score of <5 equates to good sleep quality while a score of >5 equates to poor sleep quality. This sample had 10 respondents considered to have good sleep quality (27.8%) while 26 respondents were considered to have poor sleep quality (72.2%).

Participants in this study slept a mean of 7.0147 hours a night with a median score of 7 hours. The standard deviation was .84822. Of the 34 respondents to this item, a range of 5 hours of sleep per night to 9 hours of sleep was reported. Twenty-nine of the 34 respondents slept between 5 hours and 7.5 hours per night. Given the information that a recommended 8 hours of sleep per night is optimal, the majority of respondents in this study are considered sleep deprived. The majority of respondents fell asleep between the hours of 10:30 pm –11:30 pm (23 of 36). The mean score, in minutes, that it took for the respondents to fall asleep was 21.81 with a median score of 20 minutes. The range for this group was between 1 minute and 75 minutes.

The respondents were asked questions about their sleep hygiene. These questions asked respondents to indicate how many times in the past month each variable had interfered with their sleep. When asked how many times in the past month they had trouble staying awake while driving, eating meals, or engaged in social activity 16 respondents indicated that this had occurred less than once a week (11 of 36) and up to once or twice a week (5 of 36). Though this question does not allow for a delineation of the findings between driving, eating, and social activity, the dangers of falling asleep while driving are arguably the worst scenario. Given the statistics about drowsy driving, this is an expected yet troubling finding.

When asked how many times in the past month they could not get to sleep within 30 minutes, the majority of respondents indicated that this was not a frequent problem (8 - not during the past month, 15 - less than once a week). However, six respondents said that this occurred 3 or more times a week. Although they represented a minority of the respondents in this category, this finding has potentially more serious implications for them. Difficulty falling asleep, staying asleep, and early morning wakening are possible symptoms of depression (APA, 2000). To continue with this frame of reference, 20 of 36 respondents said that they woke up in the middle of the night or early morning once or twice a week (5 of 36) and up to three or more times a week (15 of 36). Interestingly, 20 of 36 respondents also said that they experience bad dreams less than once a week (9 of 36), once or twice a week (9 of 36), and up to three times or more a week (2 of 36). As with difficulty falling asleep, staying asleep, and early morning awakening, frequent bad dreams have associations with depression and anxiety (APA, 2000).

When asked to give specific examples of other troubles that participants experienced during sleep that were not included in the study, the following were noted: anxiety, anxiety related to work, emergency calls, invasive thoughts, job and other situational difficulties, night sweats, ruminating thoughts, nightmares, talking while asleep. One participant poignantly explained,

> "My pattern tends to be: I get home around 8:00 pm from sessions and need to write my therapy notes. I try to do that but am too tired so I get them started. I often fall asleep around 10:00 or 11:00 with the light on, then wake up at 3:00 am or so, and need to finish getting ready for bed. Then I have trouble sleeping and lie awake for an hour or more. Once I do go to sleep I usually then sleep until 7:30 or 8:00 am. So I sleep in chunks. When I wake up, first thing I need to do is finish my therapy notes before starting my day and going to the next day's sessions. It never ends."

After careful review of the frequencies, as written about above, further analysis was done to explore the possibilities of significant relationships between respondents' answers to the Pittsburgh Sleep Quality Index and the abridged versions Job Descriptive Index and the Job In General scale.

T-tests were run to determine if there were any differences in the mean scores on any of the job satisfaction subscales by the good sleep quality (<5) and poor sleep quality (>5) scores of the PSQI. These subscales were "Work on present job," "Present pay," "Opportunities for job promotion," "Supervision," and "People at work." There was a significant difference in the "Work on present job" subscale by the quality of sleep ($t(27.63) = 2.632$, $p = .014$, two-tailed). Those respondents with good sleep quality had a higher mean score ($m = 14.78$) than those with poor sleep quality ($m = 12.68$).

A significant difference was also found in the abridged Job in General scale and quality of sleep ($t(27.83) = 3.198$, $p = .003$, two-tailed). Those with good sleep quality

had a higher mean score (22.78) versus those with poor sleep quality (m = 18.81). This finding suggests that those who slept better had higher overall job satisfaction scores.

T-tests were also run to determine if there were differences in the mean scores on any of the job satisfaction subscales (as noted above) by years of experience. The "years of experience" demographic was split into two groups, those with less than 10 years and those with more than 10 years. A significant difference was found in the "present pay" subscale for the two groups (t (28) =2.274, p=.031, two tailed). To reiterate, the "present pay" subscale had a range of 0 (lowest satisfaction) – 15 (highest satisfaction). The more experienced group had a higher mean satisfaction score (9.5) than the less experienced group (5.65).

CHAPTER 5

DISCUSSION

The purpose of this study was to explore the perceived job satisfaction of social workers and the relationship of their satisfaction with work to their sleep habits. When asked about sleep, participants' overall findings indicated that they were sleep deprived as a group, sleeping an average of seven hours per night, as opposed to the at least eight hours required for optimum health and functioning. In fact, 26 of 36 respondents scored for poor sleep quality according to the PSQI. It is unfortunate that so many participants in this sample are not sleeping well. However, the literature about sleep deprivation holds this to be an expected finding, as sleep deprivation is one of the most common problems in the United States (U.S. Surgeon General, 2004) with 30-35% of people meeting criteria for a diagnosis of primary insomnia (Breslau, Roth, Rosenthal, & Andreski, 1996). Still, if the expected rate in the population as a whole is 30-35% sleep deprived, the respondents to the present study were 73% deprived -- or roughly twice the rate of deprivation found for the general population.

The literature also indicates that the dangers of poor sleep are abundant. Such dangers include: increased risk of motor vehicle accidents, increased risk for obesity, diabetes, heart problems, increased risk for psychiatric conditions (including depression and substance abuse), and decreased ability to pay attention, react to signals, or remember new information (Horne & Reyner, 2001; Chipman & Jin, 2008; National Sleep Foundation, 2009). Given the high cognitive demands that are required of social workers

-- such as being present with clients, maintaining vigilance for non-verbal cues of clients, advocacy, and the analysis and cognitive processing of session content, sleep deprivation could negatively impact one's ability to carry out such tasks. Such negative impacts may in turn have possible negative implications for job satisfaction.

In regards to perceived job satisfaction as indicated by scores of the abridged Job in General measure, participants were relatively satisfied with their current jobs. The maximum score of the aJIG is 24. The mean score for the group was 20, with a median score of 21.5. If the respondents are satisfied despite the lack of financial and promotional opportunities, in their current positions, the other intrinsic rewards they reported receiving in their work must explain their levels of satisfaction. These findings support the notion that as a whole social workers and other professionals in human services tend to be empathic and altruistic persons. It is a main tenet of social work ethics that a primary concern is for our clients and our commitment to our clients. The Code of Ethics of the National Association of Social Workers says that, "Social workers' primary responsibility is to promote the well-being of clients. In general, clients' interests are primary" (NASW, 2008, p. 7).

There were two areas related to job satisfaction that were particularly striking but not unexpected. As a group, the respondents were unsatisfied with their pay and the opportunity for promotions. Twenty-two of the thirty-two respondents had worked in the field of human services for between one and seven years. In addition to this, the mean age of participants was 38 with a median of 33 years old and a standard deviation of 10 years. These two findings indicate that many of the participants were young and new to the field. Important to also take into consideration was the finding that respondents in the

current sample with less than 10 years experience showed significantly lower job satisfaction in regards to their present pay than their counterparts with more than 10 years experience. It is possible to speculate, given the review of previous literature, that being younger and newer to the field can ultimately be two variables that negatively impact one's job satisfaction, as these individuals are more likely to be paid less, have less experience, and work with higher risk and more challenging populations (Acker, 1999).

The research question posed for this study explored the subjectively reported sleep habits and perceived job satisfaction of social workers and other professionals in the field of human services. By implementing previously tested measures, the Pittsburgh Sleep Quality Index and the abridged versions of the Job Descriptive Index/ Job In General scale, reliable and valid findings were made in regards to the two areas of exploration. Frequencies of responses were used to determine trends in respondents' answers in regards to the above-mentioned measures and the demographic questions that were posed. An independent t-test was run that also produced useful findings about the correlation between sleep and job satisfaction for this group.

A possible limitation of this study concerned two questions that were asked in the demographics sections. Per my contractual agreement to use the PSQI with its author, Bowling Green State University, two questions regarding zip codes were asked. The first question asked participants to list their "primary home zip code" while the second question asked participants to list their "primary work zip code." The Human Subjects Review Committee approved both questions for use in the research. However, I believe that these questions may have been uncomfortable for some of the participants. Although 40 participants initially began the survey, only 31 participants answered these two

questions. I believe that some participants might have felt that these questions could have been used to identify them in what was otherwise an anonymous survey. I never intended to make respondents' zip codes available to other than the Bowling Green State University developers, who would have no way of identifying the anonymous participants, but did not clarify this point in the preamble to the survey.

Further limitations of this study include the lack of a diverse sampling group, and the relatively small number of participants, thereby restricting the generalizability of the findings. The sample group overwhelmingly identified as "white/Caucasian" and was predominantly female. Furthermore, the purposive, snowball sampling method of recruiting participants on the basis of convenience also limits generalizability of the study's findings.

Nevertheless, there are many implications for the current study. Certainly sleep deprivation is of great concern and the current sample's overall sleep deprivation exceeds that which is being seen in adults throughout the United States. It is unknown whether the current sample is or is not representative of social workers throughout the nation who are of similar ages and experience levels. However, even if social workers overall are at or somewhat below the national average deprivation level, the implications that sleep deprivation could have for social work and the greater field of human services are startling. Given the emotional and intellectual demands placed on workers whose jobs require that they sometimes must judge whether a client is suicidal or homicidal, whether abuse or neglect is an imminent risk to a child or elderly person, greater focus on the importance of adequate sleep is a crucial priority for much more than job satisfaction – though that is an important goal, as well.

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Appendix A

HSR Approval Letter

SMITH COLLEGE
School for
Social Work

Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

February 3, 2010

Jaime Knox

Dear Jaime,

Your revised materials have been reviewed. You did an excellent job in clarifying, expanding, and correcting the materials. We are happy to give final approval to your very interesting and useful study. I am glad that you found our comments useful. I'm sure a long letter from us at first is overwhelming but we do try to help students move the process along. We appreciate your careful attention to the suggestions we made.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B

Sample Recruitment Email

Dear Social Worker and other Mental Health Professionals:

My name is Jaime Knox and I am a graduate student at the Smith College School for Social Work. I am conducting research for a master's thesis. This research will explore questions about sleep habits and job satisfaction for both licensed mental health professionals and graduate students working towards a degree in the mental health field.

I would be grateful if you could spare 20 minutes of your time to complete a survey to help with my research about sleep habits and job satisfaction.

If you are willing to aid in this research by filling out the survey, I ask that you are a licensed mental health professional (i.e. MSW, LCSW, LICSW, Ph.D, etc.) or are a graduate student from an accredited program who has worked in a clinical internship.

To reach this survey, please click on the following link:
To be determined once an account is created with Survey Monkey
Upon clicking on this link you will be directed to a welcome page with further instructions.

Your confidentiality is maintained by using a third source, Survey Monkey, to complete the surveys. Further assurances about confidentiality will be available in an informed consent letter should you proceed with the survey.

Thank you for your time. If you have any questions or concerns, please contact me at, jknox@smith.edu or the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Cordially,
Jaime Knox

Appendix C

Sample Recruitment Flyer

PARTICIPANTS NEEDED FOR A BRIEF ON-LINE SURVEY

Hello! My name is Jaime Knox and I am graduate student at the Smith College School for Social Work.

I am conducting a research for a master's thesis about the sleep patterns and job satisfaction of licensed mental health professionals and graduate students working towards a degree in the mental health field.

Your participation is greatly appreciated and should take only 20 minutes of your time.

To reach this survey, please go to the following website:
To be determined

Your confidentiality is maintained by using a third source, Survey Monkey, to complete the surveys. Further assurances about confidentiality will be available in an informed consent agreement should you proceed with the survey.

Thank you for your time. If you have any questions or concerns, please contact me at, jknox@smith.edu or the Smith College School for Social Work Human Subjects Review Committee at 413-585-7974.

Appendix D

Sample Informed Consent

Dear Potential Research Participant:

My name is Jaime Knox and I am a graduate student at Smith College School for Social Work. I am conducting a research study on the correlation between sleep and job satisfaction for social work and other mental health professionals as well as graduate students working towards a degree in the fields of social work and psychology. The information that I obtain for this study will be included in my Master's thesis, and for possible later publications and/or presentations.

I would greatly appreciate the opportunity to include you in my survey and learn from your experiences. If you choose to participate, I will ask you to answer a brief internet survey with questions about your sleep habits and questions regarding your job satisfaction. In addition, I will ask you to provide information about yourself including, gender, age, race, ethnicity, and years of experience in the mental health field so that I can accurately describe my sample in the final report. In its entirety, this survey shall take approximately 20 minutes to complete.

I anticipate that there will be minimal risks, if any, incurred from participating in this study. To the best of my knowledge, a review of the literature on the correlations of sleep and job satisfaction has indicated that mental health professionals are notably absent as sample populations. Your participation in this study would therefore be a particular benefit as a contribution for yourself and your colleagues in the field of mental health. I will not be able to provide financial compensation for your participation.

As the surveys will be completed on-line through a provider (SurveyMonkey), your anonymity will be protected. The data provided to me upon completion of surveys will be stripped of identifying information about which participants provided the information. Federal guidelines require that the electronic data I collect be kept for a period of three years. Again, this information will have no identifying information about you personally, and will be securely stored; neither I nor anyone else will have any way of knowing which participants provided what responses.

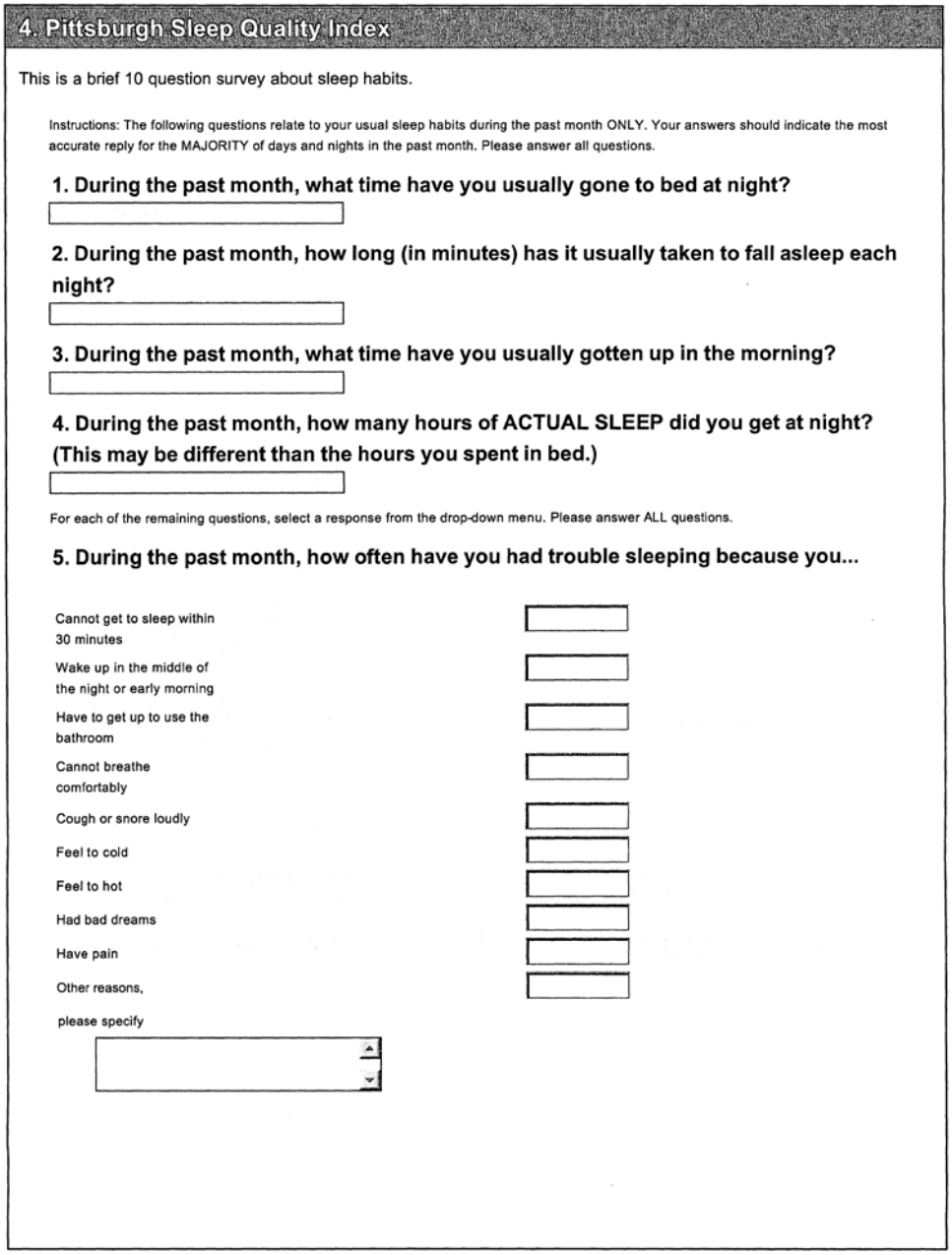
Your participation in this study is completely voluntary and you also have the option to skip any question(s) and/or withdraw while answering the survey. Please note that once you "hit" send, you will no longer be able to withdraw your participation, as the data are stored anonymously with no way to identify individual surveys.

If you have any questions, concerns, or would like to simply follow-up please feel free to contact me at jknox@smith.edu. You are also welcome to contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY SUBMITTING YOUR ANSWERS TO THIS SURVEY YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THIS STUDY.

Appendix E

Sample Survey



4. Pittsburgh Sleep Quality Index

This is a brief 10 question survey about sleep habits.

Instructions: The following questions relate to your usual sleep habits during the past month ONLY. Your answers should indicate the most accurate reply for the MAJORITY of days and nights in the past month. Please answer all questions.

1. During the past month, what time have you usually gone to bed at night?

2. During the past month, how long (in minutes) has it usually taken to fall asleep each night?

3. During the past month, what time have you usually gotten up in the morning?

4. During the past month, how many hours of ACTUAL SLEEP did you get at night? (This may be different than the hours you spent in bed.)

For each of the remaining questions, select a response from the drop-down menu. Please answer ALL questions.

5. During the past month, how often have you had trouble sleeping because you...

Cannot get to sleep within 30 minutes

Wake up in the middle of the night or early morning

Have to get up to use the bathroom

Cannot breathe comfortably

Cough or snore loudly

Feel to cold

Feel to hot

Had bad dreams

Have pain

Other reasons,

please specify

6. During the past month, how would you rate your sleep quality overall?

- ◯ Very good
- ◯ Fairly good
- ◯ Fairly bad
- ◯ Very bad

7. During the past month, how often have you taken medicine to help you sleep (prescribed or "over the counter")

- ☐ Not during the past month
- ☐ Less than once a week
- ☐ Once or twice a week
- ☐ Three or more times a week

8. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

- ◯ Not during the past month
- ◯ Less than once a week
- ◯ Once or twice a week
- ◯ Three or more times a week

9. During the past month, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

- ◯ No problem at all
- ◯ Only a very slight problem
- ◯ Somewhat of a problem
- ◯ A very big problem

10. Do you have a bed partner or room mate?

- ◯ No bed partner or room mate
- ◯ Partner/ room mate in other room
- ◯ Partner in same room, but not same bed
- ◯ Partner in same bed

11. If you have a room mate or bed partner, ask that person how often in the past month you have...

Loud snoring	☐
Long pauses between breaths while asleep	☐
Legs twitching or jerking while you are asleep	☐
Episodes of disorientation or confusion during sleep	☐
Other restlessness while you sleep	☐

Please specify

5. Brief 6 question job satisfaction survey

1. WORK ON PRESENT JOB

Think of the work you do at present. How well does each of the following words or phrases describe your work? Check:

'Yes' if it describes your work

'No' if it does not describe your work

'?' if you cannot decide

	Yes	No	?
Satisfying	◯	◯	◯
Gives sense of accomplishment	◯	◯	◯
Challenging	◯	◯	◯
Dull	◯	◯	◯
Uninteresting	◯	◯	◯

2. PRESENT PAY

Think of the pay you get now. How well does each of the following words or phrases describe your present pay? Please answer for each of the phrases.

	Yes	No	?
Income adequate for normal expenses	◯	◯	◯
Fair	◯	◯	◯
Insecure	◯	◯	◯
Well paid	◯	◯	◯
Underpaid	◯	◯	◯

3. OPPORTUNITIES FOR PROMOTION

Think of the opportunities for promotion that you have now. How well does each of the following words or phrases describe your opportunities for promotion? Please answer for each of the phrases.

	Yes	No	?
Good opportunities for promotion	◯	◯	◯
Promotion on ability	◯	◯	◯
Dead-end job	◯	◯	◯
Good chance for promotion	◯	◯	◯
Unfair promotion policy	◯	◯	◯

4. SUPERVISION

Think of your supervisor and the kind of supervision that you get on the job. How well does each of the following words or phrases describe your supervision? Please answer for each of the phrases.

	Yes	No	?
Praises good work	◯	◯	◯
Tactful	◯	◯	◯
Up-to-date	◯	◯	◯
Annoying	◯	◯	◯
Bad	◯	◯	◯

5. PEOPLE AT WORK

Think of the majority of people that you work with now or the people that you meet in connection with your work. How well does each of the following words or phrases describe these people? Please answer for each of the phrases.

	Yes	No	?
Boring	◯	◯	◯
Helpful	◯	◯	◯
Responsible	◯	◯	◯
Intelligent	◯	◯	◯
Lazy	◯	◯	◯

6. JOB IN GENERAL

Think of your job in general. All in all, what is it like most of the time? Please answer for each of the words.

	Yes	No	?
Good	◯	◯	◯
Undesirable	◯	◯	◯
Better than most	◯	◯	◯
Disagreeable	◯	◯	◯
Makes me content	◯	◯	◯
Excellent	◯	◯	◯
Enjoyable	◯	◯	◯
Poor	◯	◯	◯

6. Demographics

Just a few questions to understand the characteristics of my participants better! Thanks!

1. What type of licensure do you hold (or are you working towards) in the mental health field? (ex: MSW,LICSW,PhD)

2. How long have you practiced in the mental health field?

3. What is your age?

4. How do you identify your gender?

5. What is your race?

6. What client population do you work with primarily?

7. Primary home zip code?

8. Work zip code?

9. Are there any questions that I did not cover in the survey that you believe would've been important or do you have any final thoughts you would like to offer?

Lastly, I would be interested in brief 5-10 minute phone call follow-ups for any interested participants. The conversations will be a way to expand on the survey or could serve to clarify any questions that arose for you. If you are interested please either email me at jknox@smith.edu or call me at 413-687-2682.

Thank you for taking the time out of your day to complete this survey and assist me in my research.