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Joshua Beebe
Compassion Fatigue and Compassion
Satisfaction: Experiences of Helping
Professionals in the Homeless Workforce

Abstract

Homeless workforce staff perform their duties with clients for whom themes of crisis, suffering and distress are common. Such working conditions are characteristic of settings in which workers are vulnerable to workplace stress and burnout. Compassion for those we help can affect us in positive and negative ways. Using a cross-sectional design, 44 homeless workforce staff in one large agency completed a 87-item online questionnaire designed to examine burnout and secondary trauma and whether the personal characteristics of empathy and reactivity would be associated with improved workplace functioning (less burnout and greater job satisfaction). Contrary to our expectations, this sample had average levels of burnout and secondary traumatic stress, both falling in the 50th percentile. Professional satisfaction (CS) scores also fell in the 50th percentile.

Recent work by Ferris et al. (2016) suggests that mission identification is a potent mediator of the potentially negative effects of difficult work environments. We found that personal characteristics of the worker may also impact stress scores and we recommend that both of these dimensions be included in future studies of this population. This study would not have been possible without the support of staff and administration of Boston Health Care for the Homeless. This organization, whose history and contributions to the care of homeless adults and families have set international standards for such programs, welcomed the study and promoted its completion

**COMPASSION FATIGUE AND COMPASSION SATISFACTION:
EXPERIENCES OF HELPING PROFESSIONALS
IN THE HOMELESS WORKFORCE**

A project based upon an investigation at Boston
Healthcare for the Homeless, Boston, Massachusetts,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

Joshua Beebe

Smith College School for Social Work
Northampton, Massachusetts 01063

2016

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This paper is dedicated to my uncle, Ricky Beebe, and grandfather, Asa Beebe, whose lives and memory have given me the heart and strength to be a social worker.

First and foremost, I would like to thank the staff who participated in this study and who shared their experiences working in the homeless workforce. The study could not have been attempted without the support and encouragement of Boston Healthcare for the Homeless in Boston, Massachusetts. I would also like to thank my amazing thesis advisor, Elizabeth Irvin, PHD, LICSW who provided unconditional support, understanding, and encouragement.

To my family and friends who believed and supported me with their unending love, thank you. This thesis would not be possible without their collected strength and support.

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CHAPTER I

Introduction

Homelessness deprives individuals of...basic needs, exposing them to risky, unpredictable environments. In short, homelessness is more than the absence of physical shelter, it is a stress-filled, dehumanizing, dangerous circumstance in which individuals are at high risk of being witness to or victims of a wide range of violent events. (Fitzpatrick, LaGory, & Ritchey, 1999, p. 438-47)

Staff in the homeless workforce perform their duties with clients for whom themes of crisis, suffering and distress are common. Such working conditions are characteristic of settings in which workers are vulnerable to workplace stress and burnout. Compassion for those we help can affect us in positive and negative ways. There is a substantial literature on compassion fatigue among first responders which suggests that both risk and protective factors play a role in whether or not compassion fatigue (CF) will develop. This study explores compassion fatigue in the homeless workforce and examines personal characteristics hypothesized to serve a protective function, specifically interpersonal reactivity, empathy, and prior exposure to life-threatening experiences. Forty-four volunteers completed an 87-item online survey during a 5 week period in the winter of 2016. In addition to providing demographic information, respondents answered questions about personal empathy (Davis, 1980) and completed the Professional Quality of Life Scale (Stamm, 2010) as well as a brief trauma questionnaire (Schnurr, Spiro III, Vielhauer, Findler, & Hamblen, 2002).

This researcher has a personal interest in the field. As an MSW candidate at Smith College School for Social Work I had the extraordinary opportunity to complete a clinical

internship at Boston Healthcare for the Homeless Program and to bear witness, first hand, to the nature of care-giving work there. Themes of crisis, suffering, and distress were common among the homeless adults and families we served, and I witnessed firsthand how helping professionals provide services to this community. It was an extraordinary learning experience and also provided an opportunity for me to observe, record, and take action in the form of this research project which I hope will add data to the growing literature on evidence-based practices to support helping professionals serving the homeless community.

CHAPTER II

Literature Review

This review will be presented in three sections: 1) a review of the concept of compassion fatigue, including the impact of CF on organizations, 2) literature examining the impact of homelessness on client adjustment and suffering, and 3), studies specifically exploring CF in the homeless caregiving workforce.

Compassion Fatigue

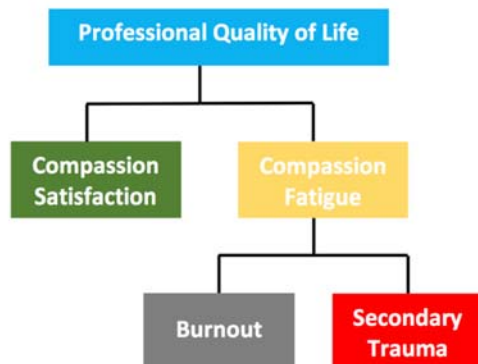
Charles Figley, one of the pioneering researchers in secondary traumatic stress, coined the term “compassion fatigue” to emphasize the normative development of chronic stress that may develop when caregivers perform their duties with clients for whom themes of crisis, suffering and distress are common. Compassion fatigue is characterized as “the negative aspects of providing care to those who have experienced extreme or traumatic stressors... includ[ing] feelings of being overwhelmed by the work that are distinguished from feelings of fear associated with the work" (Stamm, 2010, p. 21).

Compassion fatigue (CF) symptoms include exhaustion, hyper-vigilance, avoidance, and numbing (Baird & Kracen, 2006). Heightened emotions such as anger, grief, despair, frustration, emotional and physical exhaustion, depersonalization, reduced sense of personal accomplishment, high stress, diminished capacity for empathy and compassion, work related trauma, and health problems have also been reported (Newell & MacNeil, 2010; Stamm, 2010; Tehrani, 2007; Whitfield & Kanter, 2014). Reoccurrence of nightmares and flashbacks to traumatic events have also been documented as have increased rates of substance abuse and compulsive behaviors and poor self-care (“Compassion Fatigue Awareness Project,” n.d., 2013).

Compassion Fatigue Model

Professional quality of life for those providing care has been a topic of growing interest over the past twenty years. Research has that shown those who help people that have been exposed to traumatic stressors are at risk for developing negative symptoms associated with burnout, depression, and posttraumatic stress disorder. Typically known as secondary traumatization or vicarious traumatization, in this body of literature the positive feelings about people's ability to help are known as compassion satisfaction (CS). The negative, secondary outcomes have variously been identified as burnout (BO), countertransference, compassion fatigue (CF) and secondary traumatic stress (STS), and vicarious traumatization (VT).

Figure 1: Diagram of Professional Quality of Life (Stramm, 2009-2012)



While the incidence of developing problems associated with the negative aspects of providing care seems to be low, they are serious and can affect an individual, the care they provide, and their organizations. The positive aspects of helping can be viewed as altruism; feeling good that you can do something to help. “The negative effects of providing care are aggravated by the severity of the traumatic material to which the helper is exposed, such as direct contact with victims, particularly when the exposure is of a grotesque and graphic nature. The

outcomes may include burnout, depression, increased use of substances, and symptoms of posttraumatic stress disorder” (Stramm, 2010, p. 8).

Compassion fatigue has two main components, both of which can be measured using standardized tools: 1) compassion satisfaction, and its negative, 2) compassion fatigue (Stamm, 2010). Compassion satisfaction (CS) refers to positive feelings about a person’s ability to help and the pleasure helping professionals derive from being able to do their work well (Stamm, 2010). Compassion fatigue (CF) has two measurable components easily recognizable by workers and managers: burnout (BO) and secondary traumatic stress (STS). Burnout, from a researcher perspective, is associated with personal feelings of hopelessness and difficulties dealing with work or in doing the job effectively (Stamm, 2010). Secondary traumatic stress is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995, p.7).

The Compassion Stress and Fatigue Model identifies 10 variables thought to contribute to compassion fatigue (Figley, 2002). These are: empathic ability, empathic concern, exposure to the client, empathic response, compassion stress, sense of achievement, disengagement, prolonged exposure, traumatic recollections, and life disruption.

Empathic ability is "the aptitude of the psychotherapist for noticing the pain of others" (Figley, 2002, p. 1436). This allows the helping professional to be emphatic and to connect with the patient so the work is meaningful. The ability to empathize is critical to both helping others and being vulnerable to the cost of caring.

Empathic concern is "the motivation to respond to the people in need" (Figley, 2002, p. 1436). However, direct exposure to the suffering of patients also puts workers at risk factor for

developing compassion fatigue. Perron, Alexander-Eitzman, Gillespie, & Pollio (2008) examined the marginalization of the homeless population and its potential impact on the morale of the homeless workforce. People who are experiencing homelessness are stigmatized by society, are often present with complex needs, and with transitioning into homelessness are marked by high levels of psychological distress (Ferris et al., 2016). Empathic response is the extent to which the helping professional makes an effort to reduce the suffering through empathic understanding (Figley, 2002). Such responses are the foundation of the therapeutic alliance.

Compassion stress is "the residue of emotional energy from the empathic response to the client and is the on-going demand for action to relieve the suffering of a client" (Figley, 2002, p.1437). With stress, significant intensity can have a negative impact on personal energy levels and on the immune system.

Buffers to the development of compassion fatigue have also been identified. These include a positive sense of achievement (Tehrani, 2007) and a helping professional's ability to disengage from themselves and the patient's sessions in which service is being delivered (Figley, 2002). Self-care, the capacity to disengage from work and to live lives outside of work, has been emphasized by many researchers as key both protective and reparative (2002; Tehrani, 2007; Whitfield & Kanter, 2014; Sansbury, Graves, & Scott, 2015).

Traumatic recollections, defined as "memories that trigger the symptoms of PTSD and associated reactions, such as anxiety and depressions" (Figley, 2002, p.1438), may result from something the patient disclosed or an event that happened in session with the patient. Such memories may provoke an emotional reaction in the helping professional and associated with emotional distress.

The last variable in the model, life disruptions (such as unexpected changes in schedule,

routine, and managing life responsibilities that demand attention) exacerbate stress reactions and have been associated with development of compassion fatigue (Figley, 2012; Sprang, Clark, & Whitt-Woosley, 2007).

Institutional Risk Factors

It has been estimated that 50% of helping professionals are at high risk of developing signs of STS or the related condition of PTSD (National Child Traumatic Stress Network, 2011). Risk factors are generally described in the literature from two perspectives; the individual and the organization. Organizational factors that have been found to contribute to the development of compassion fatigue include excessively high caseloads, lack of control or influence over agency policies and procedures, unfairness in organizational structure and discipline, low peer and supervisory support, and poor agency and on-the-job trainings (Barak, Nissly, & Levin, 2001; Maslach, Schaufeli, & Leiter, 2001; Newell & MacNeil, 2010).

Caseload/client characteristics, especially prolonged exposure to the suffering of others over a protracted period of time, is a strong predictor for development of CF. (Figley, 2002; Newell & MacNeil, 2010; Brady et al., 1999; Creamer, 2002; Myers & Cornille, 2002; Simonds, 1996; Wee & Myers, 2002). Baird & Kracen (2006) conducted an extensive review of the literature and concluded that “there is persuasive evidence that the amount of exposure to the traumatic material of the patients does increase the likelihood of secondary traumatic stress” (p. 184).

From an administrative agency perspective, warning signs compassion fatigue in the workforce include frequent absenteeism, chronic tardiness, chronic fatigue, evidence of poor patient care, and low completion rates of clinical and administrative duties (Maslach, Schaufeli, & Leiter, 2001; Maslach & Leiter, 1997; Newell & MacNeil, 2010). Unchecked, affected

workforce will experience heightened stress, difficulty with concentration and memory, and, of great risk to clients, withdrawal from acting compassionately (Whitfield & Kanter, 2014).

Several institutional factors have been identified that can help protect caregivers from developing compassion fatigue. These include having consistent supervision and realistic work expectations. Consistent, regular supervision which allows helping professionals process traumatic, stressful events and which provides support for the work being completed are characteristic of protective work environments (Tehrani, 2007; Whitfield & Kanter, 2014). A focus on self-care is also protective. Realistic work expectations include manageable workloads and work responsibilities; the number of hours worked, and clearly defined professional boundaries (Tehrani, 2007; Whitfield & Kanter, 2014). With that in mind, agencies that can be flexible to support their staff, providing time off, shifting schedules, and ability to support changes in workload are all examples of practices organizations can utilize to minimize compassion fatigue. Organizations that place importance on education about Compassion Fatigue, its symptoms, and methods to reduce compassion fatigue have been emphasized by numerous authors (Figley, 2012; Whitfield & Kanter, 2014, Stamm, 2010).

Compensatory strategies for managing CF

There are many forms of self-care and harm reduction models to manage compassion fatigue. Self-care and social supports have been emphasized in the literature as both protective and compensatory strategies (Figley, 2002; Whitfield & Kanter, 2014). These include but are not limited to exercise, spiritual connections, therapy, assessing workload, monitoring changes in one's trauma-related thinking and feelings, being aware of one's own mental health and holding it as priority, having and using peer support, learning about secondary trauma, positive supervision, enjoying a well-balanced work/life balance, and mindfulness (Whitfield & Kanter, 2014, Stamm,

2010). With regard to individual treatment, desensitization to traumatic stressors and exposure dosing to maintain desensitization are identified as effective strategies (Figley, 2002).

Impact of CF on the individual and on the organization

Stamm, who identifies compassion fatigue as burnout and secondary traumatic stress, identified how it CF impacts the individual if left untreated and unheard. Caregivers who report high levels of burnout but low levels of secondary traumatic stress report having difficulty finding meaning and significance in their work, as if nothing they do matters (Stamm, 2010). Some measures to counteract these feelings of burnout are a shift in schedule or workload, or taking time off from work to recharge. Helping professionals who have high levels of secondary traumatic stress, but low levels of burnout have been exposed to traumatic or stressful events and patients (Stamm, 2010). A caregiver in this situation enjoys the work they do but report higher levels of stress. Peer and supervision support can support helping professionals' process these traumatic and stressful events.

Caregivers who are experiencing high levels of burnout and secondary traumatic stress are more distressed and report feeling overwhelmed and useless in the work setting and have fear related to an event that the individual was exposed to at work, either from clients or institutional factors (Stamm, 2010). Recognizing burnout is a key supervisory responsibility as is identifying this with the supervisee and providing support for the employee to take steps to support their mental health. This should include providing educational information to employees about self-care and the nature of risks in the particular work environment. Such resources are readily available through the Compassion Fatigue Awareness Project (<http://www.compassionfatigue.org>) and provide information for workers, supervisors, and agency administration. Organizational symptoms of compassion fatigue include high

absenteeism, constant changes in co-workers relationships, inability for teams to work well together, desire among staff members to break company rules, outbreaks of aggressive behaviors among staff, inability of staff to complete assignments and tasks, inability of staff to respect and meet deadlines, lack of flexibility among staff, negativism towards management, strong reluctance towards management, strong reluctance toward change, inability of staff to believe improvement is possible, and lack of a vision for the future (Compassion Awareness Project, 2013).

Homelessness as Trauma

Despite ongoing issues with stigma, the general US population is concerned and empathetic towards the social issue of homelessness (Manrique, 1995; Link et al., 1995). The individual, systematic, and institutional work needed to support this population is enormous.

Goodman, Saxe, and Harvey (1991) argue that homelessness itself is a risk factor for psychological trauma and development of emotional distress. Homelessness disrupts social bonds and intimate, long-lasting relationships and attachments (disaffiliation), and creates a sense of powerlessness and learned helplessness. Families are broken up while seeking shelter or in transitional housing. Separation from close friends and loved ones, a disruption social roles and patterns, promotes distrust and can lead to isolation. How individuals and families who are experiencing homelessness navigate, access, and utilized services frequently renders them unable to control their day to day routines and lives. Other sources of stress include the sudden or gradual loss of one's home and traumatic experiences in shelter care.

People who are experiencing homeless do not have their own safe space to retreat to and are stripped of accustomed social roles, basic needs, and dignity. The loss of personal control and learned helplessness is associated with development of an entrenched and pervasive

passivity that furthers the cycle of homelessness (Bauer, Baggett, Stern, O'Connell, & Shtasel, 2013). In addition to exposure to the trauma of homelessness, in this population, mental health and substance use are in higher rates in this population than those who are housed.

Individuals who experience homelessness are at risk for higher rates of mental health issues, trauma, and substance use. In a point in time survey of sheltered homeless adults, 34.7% were rated as having active substance use issues (Baylor, 2014). Substance Abuse Mental Health Services (2011) documents the incidence of trauma across the lifespan of homeless individuals. Over 92% of mothers who are homeless have experienced severe physical and/or sexual abuse during their lifetime. Homeless youth, when compared to house peers, have higher rates of mood disorders, suicide attempts, conduct disorders, and posttraumatic stress disorder (PTSD). Female and male veterans returning from active duty who are experience homelessness may suffer from combat-related trauma, military sexual trauma, and Traumatic Brain Injury (TBI) in addition other traumatic stressors.

Empirical evidence of the impacts of homelessness on the individual

Schutt, Meschede & Rierdan (1994) interviewed 218 homeless adults in Boston shelters in 1990 and documented higher levels of distress than those whose housing had been stabilized. In addition, health problems, being a member of a minority group, and childhood trauma were associated with more distress. Social supports lowered distress and suicidality.

Trauma exposure is high among homeless adults. Hopper, Bassuk, & Oliver (2010), in an exhaustive review of the existing literature, concluded that, due to the high rates of trauma within the homeless population, Trauma Inform Care (TIC) practices should be implemented in programs and organizations who treats individuals who are experiencing homelessness.

Staff in the homeless workforce performs their duties with clients for whom themes of crisis, suffering and distress are common. Such working conditions are characteristic of settings in which workers are vulnerable to workplace stress and burnout. Compassion for those we help can affect us in positive and negative ways (Stamm, 2010; Figley, 2002; Sprang, Clark, & Whitt-Woosley, 2007; Newell & MacNeil, 2010).

Compassion Fatigue in the Homeless Workforce

Two databases, PsychInfo and PubMed, were searched to identify research on compassion fatigue among helping professionals, with special interest in the homeless workforce. Search terms included: homeless, homelessness, compassion fatigue, burnout, professional burnout, vicarious trauma, secondary traumatic stress, and secondary stress. Many articles discussed compassion fatigue and burnout among first responders and front line workers in many fields. However, only a handful of articles addressed CF in the homeless workforce.

Hagen & Hutchison (1988) identified 25% of their homeless workforce sample as having experienced a moderate level of emotional exhaustion. Winter (2012) interviewed administrative staff at Boston Healthcare for the Homeless, United Neighborhood Health Services, and the Harborview Medical Center in Seattle who identified CF in the workforce within their own individual agencies. Both articles identified strategies to help reduce compassion fatigue, feelings of burnout and secondary traumatic stress, emphasizing ongoing staff training and an enhanced focus on strengthening the homeless services workforce.

The literature also observes how team structure impacts development of compassion fatigue and describes best practices to minimize compassion fatigue. These include diverse multidisciplinary teams, strong supervision, formal staff support, informal staff support and a focus on trainings. Research on case management recommend contextual case management, a

mindful of culture, positive engagement-relationships and advocacy, and a coordinated and well-managed system of ethics and communication within the organization (Olivet, McGraw, Grandin, & Bassuk, 2010. Milaney, 2012a; 2012b).

Sutton-Brock (2014) found that the majority of the caseworkers in their sample met criteria for burnout: 38.8% experienced high rates of overall burnout; 72.2% experienced moderate and high levels of burnout. Organizational difficulties associated with moderate and high BO groups included: navigating through complex levels of multiple systems of care, low client program compliance, and limited or compromised resources (Sutton-Brock, 2014). Young (2011) investigated psychotherapists' experience working with homeless clients. Participants identified the sources of their burnout with complex work environment, individual coping, and organizational coping.

In early 2016, a team of researchers led by Ferris observed compassion fatigue and job satisfaction of helping professionals providing direct care within the homeless sector. They identified the important theme of organizational identity as a mediating factor in the development of CF. Using mixed methods approach of cross sectional survey (n=60) and individual interview (n=26) participants were asked to reflect on levels of client suffering and attribute emotions in a hypothetical client task, feelings of burnout, job satisfaction, and organizational identification (Ferris et al., 2016). A significant relationship was found between perceived higher client suffering, higher job satisfaction, and lower levels of burnout. Caregivers working with this population were able to recognize the suffering their clients were experiencing, but rather than adding stress, helping professionals felt it as a motivating force to conduct work and add to their organization identity. Ferris and colleagues found that "a mediating role for organizational identification, such that recognizing suffering predicted greater identification with

the organization, which fully mediated the relationship between suffering and job satisfaction, and also between suffering and burnout” (Ferris et al., 2016, p.1). They coined this as the "Florence Nightingale effect." This in turn impacted and increased levels of job satisfaction while reversing feelings of burnout.

This small group of important studies documents a complex interaction between organizational, individual, and caseload characteristics in the evolution of compassion fatigue. The next section describes our study, undertaken at Boston Healthcare for the Homeless Program, which examines compassion fatigue (CF) in a workforce specializing in the care of adults and families who are experiencing homelessness.

CHAPTER III

Methodology

Overview

The purpose of this study was to explore the experience of compassion fatigue among helping professional working with adults or families who are experiencing homelessness. The study asks if helping professional in the homeless workforce experience compassion fatigue and, if they do, can we identify protective and risk factors that affect the development of burnout and secondary traumatic stress. The following domains were examined: interpersonal reactivity and empathy, exposure to trauma, and personal factors such as age, education, department, location, and years worked in the field. The study hypothesized that high levels of empathy and high exposure to trauma will act as a risk factor in the development of CF. We also examined personal characteristics and support characteristics in the work environment which may act as protective factors or buffers against the development of CF.

This is a collaborative study with Boston Health Care for the Homeless Program. With the input of Director of Behavioral Health, the Chief Operating Officer, Director of Human Resources and Head of the Research Department at Boston Healthcare for the Homeless (BHCHP), staff were invited to participate via email. Participation was voluntary and anonymous. Potential participants were asked to click on a link to an online questionnaire hosted on SurveyMonkey (Appendix D). Due to an initially low response rate, the invitation email to the staff was sent out several times, and the researcher promoted at Behavioral Health Team meeting and Jean Yawkey Way Clinic Staff Meeting.

Research Design

This exploratory study utilized cross-sectional methods with the aim to produce generalizable findings.

Sample

A non-probability convenience sample was used to recruit helping professional from BHCHP. Seventy potential participants visited the online survey and attempted the screening questions; all of them met the eligibility requirements as determined by the initial screening questions (Appendix D). The responses of twenty-eight subjects were excluded; a) eligible to participate but did not answer questions beyond the screening questions (n=20), and those who started the survey, but did not complete a sufficient number of items (n=8). Forty-four participants signed the informed consent and completed the online survey (N=44).

Inclusion criteria. Eligibility to participate in the study was determined by the following criteria: 1) to be 18 years of age or older, 2) able to read and write in English, 3) be currently employed by BHCHP, and 4) be a willing participant in the study as indicated by agreeing to the letter of informed consent.

Exclusion criteria. Subjects not meeting inclusion criteria and anyone who did not agree to participate by signing the informed consent.

Recruitment Procedures

An agency-wide email was sent to all employees describing the project and inviting them to participate (Appendix E). A link for the online survey was included in the email. A second email was sent two weeks later. Data was collected for one month in the winter of 2016.

Ethics and Safeguards

Risk of participation. It was felt that participation in the study would possibly increase awareness about personal distress of some potential respondents. A list of online educational and support resources and self-care suggestions were provided to respondents; these were listed on the informed consent page (Appendix B). Additional resources included directions for how to access employee assistance support within BHCHP, and a suggestion to discuss any issues with their supervisor.

To avoid any bias or influence to participate in this study, care was taken to assure participants of the voluntary and anonymous nature of participation in both the recruitment email and the letter of consent, specifically indicating that their supervisors nor the agency would know if they choose to participate or not.

Benefits of participation. It was hoped that participants would gain satisfaction by knowing that they contributed to a research project that had the potential to inform best-practices within the agency. Participants could also gain insight and awareness about their own responses and adjustment in this work environment.

Informed Consent Procedures

The Informed Consent was presented in an electronic format. Participants could print a copy of the informed consent. Agreement to enroll in the study was indicated by clicking on the "I agree" button in the online survey, after which participants were automatically directed to the survey. Potential participants who declined the informed consent did so by clicking "I do not agree" and were automatically directed to an exit screen. A copy of the Informed Consent may be found in Appendix B. See Appendix C for a copy of the BHCHP Research Department Confidentiality Agreement

Confidentiality

Data were collected anonymously. Only the researcher and his faculty advisor had access to the raw data files. Data were reviewed to insure that no personally identifiable information was inadvertently entered by the participant. Once cleaned, the data were aggregated for analysis. No individual data was shared with agency management.

Data Management

Data were collected using SurveyMonkey Secure Sockets Layer (SSL) encryption. SSL encryption protects respondents' information using both server authentication and data encryption, ensuring that user data is safe, secure, and available only to authorized persons as it moves along communication pathways between the respondents' computer and SurveyMonkey servers (SurveyMonkey, 2012). Data were downloaded onto encrypted electronic media in the researcher's possession. Specifically, files will be exported through an encrypted channel in Excel format and stored in a password protected file on the researcher's computer. No documents related to the study were stored in "the cloud" or similar media. Survey settings were configured so that IP addresses and other potentially identifying information such as email addresses were not collected. All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations in the event that materials are needed beyond this initial study after which they will be destroyed.

Subjects' responses were associated with an automatically generated code number, preserving anonymity even to the researcher. The Smith College School for Social Work faculty advisor, this researcher, and data analyst handled the same anonymous data, and per thesis guidelines have signed a confidentiality agreement in order to protect the rights of participant

anonymity. In all future use of this data, whether it is in presentations, publications, or MSW thesis, data were aggregated to preserve anonymity.

Human Subjects Review

The Human Subject Review Board (HSRB) at Smith College, Northampton, Massachusetts approved this study after assuring that all materials met Federal and college standards for the protection of human subjects. A copy of the HSRB approval letters are provided in Appendix A. The study was conducted at Boston Healthcare for the Homeless. A copy of the confidentiality agreement may be found in Appendix C.

Quantitative Measures

A 99-item questionnaire included open-ended and multiple choice items, including: a) three previously validated Likert-type measures; b) 13 demographic questions, and c) 12 questions about support in the work environment. The demographic questions were created by the researcher based on his review of the literature. This researcher obtained permission to use White's (2012) work environment questions, revised and repurposed for this study.

Demographic data. Demographic information collected included: age, education, total years worked in the homeless workforce, years worked at BHCHP, average hours worked per week during the past six months, current department, current work sites, description of work activity, weeks worked in the past 6 months, hours spent face to face with patients, and patient population (adults, children & families, or both).

Work environment. White studied compassion fatigue among medical interpreters (2012) and included questions about the work environment as part of examining potential protective features. Based on our literature review, 3 additional questions were added to the White strategy. Questions were aimed at trying to identify both risk and protective factors

within the work environment of this particular population. This tool was approved by Smith College School of Social Work Human Subject Review Board. At the launch of the survey, this tool was removed at the request of BHCHP.

Validated Measures Used in the Study

This is a mixed method study using standardized measures to confidentially assess compassion fatigue. Three previously validated questionnaires were employed after receiving permission from measure authors.

Professional Quality of Life Scale (ProQOL), a 30-item questionnaire using a 5-point like-type rating scale (Stamm, 2010). This is a widely used measure of the positive and negative effects of working and supporting individuals who have experienced stressful events. The measure was originally called the “Compassion Fatigue Self Test” and was developed by Charles Figley in the late 1980's. In 1993, Stamm added the component of compassion satisfaction. By the late 1990's the survey was renamed to ProQOL, and now has been translated into 11 different languages. The inter-scale correlations show 2% shared variance ($r = -.23$; $\text{co-}\sigma = 5\%$; $n = 1187$) with Secondary Traumatic Stress and 5% shared variance ($r = -.14$; $\text{co-}\sigma = 2\%$; $n = 1187$) with Burnout. The shared variance between these two scales is 34% ($r = .58$; $\text{co-}\sigma = 34\%$; $n = 1187$).

This scale is widely used to measure compassion fatigue and compassion satisfaction. There are over 100 published research studies that use the ProQOL scale or a previous version of it; demonstrating its good constructed validity (Stamm, 2010). Internal reliability in the standardized scales was above the acceptable cutoff of 0.6: CS = 0.883, BO = 0.718, and STS = 0.792.

Individuals may take the ProQOL as part of a personal assessment of their status, or it may be used as a research tool, as in this study. A simple conversion chart helps individuals place

their scores within the (Stramm, 2010). For purposed of this study, raw scores are converted to t-scores in order to be able to evaluate findings against the larger population. The mean score for any of the scales is 50 with a standard deviation of 10. The cut scores for the compassion satisfaction (CS) scale are 44 at the 25th percentile and 57 at the 75th percentile. The cut scores for the burnout (BO) scale are 43 at the 25th percentile and 56 at the 75th percentile. And, the cut scores for the secondary traumatic stress (STS) scale are at 42 for the 25th percentile and 56 for the 75th percentile (Stamm, 2009-2012).

The Interpersonal Reactivity Index (IRI) is a 21-item questionnaire that uses a 5-point like-type rating scale to examine empathy from a multidimensional perspective (Davis, 1980; Davis, 1983). The scale was developed to examine the relationship between self-esteem, social functioning, emotionality, and sensitivity to others Cronbach's alpha was run for each measure and scores suggest that the items have a high internal consistency for all measures. Cronbach's Alpha for the PT is 0.777 and for EC scale is 0.530. The IRI has demonstrated good intra-scale and convergent validity as indicated by correlations with other established empathy scales (Davis, 1980). The IRI had been validated cross culturally with the Italian population (Albiero et al., 2006) and the Spanish population (Mestre, Frías-Navarro & Samper 2004).

A revised version was used in this study, examining only two of the dimensions (perspective taking and empathic concern) after a strategy used by White (2012) in her study examining compassion fatigue among professional medical interpreters.

The Brief Trauma Questionnaire is a 17-item, dichotomous questionnaire developed for use by the by staff at United States Veteran Affairs National Center for PTSD. The BTQ is a 10-item self-report questionnaire derived from the Brief Trauma Interview (BTI; Schnurr, Spiro III, Vielhauer, Findler, & Hamblen, 2002). This questionnaire purpose is to assess exposure to

traumatic events described in Criterion A.1 for the diagnosis of PTSD in the DSM-V. In a study conducted by Schnurr and colleagues (2002), Kappa coefficients examining internal reliability for the presence of trauma meeting DSM-IV criterion A.1 were above .70 (range = .74-1.00) for all events except illness (.69) and "other" life-threatening events (.60). Criterion validity demonstrated that PTSD symptom severity was related in expected ways to two measures derived from the BTI.

The original plan was to use the BTQ to assess traumatic exposure and the dimension of criteria A for PTSD in DSM-V in the study sample. However, a typographical error in the online version of the questionnaire altered the meaning of column B and C question modifiers, and the results could not be used.

Qualitative Measures

Most of the qualitative measures were within the Work Environment questions were removed at the request of BHCHP. However, one question, which was optional to complete, asked participants to speak about their experiences working with the homeless population as it relates to their own compassion fatigue and compassion satisfaction.

Participants

Demographic data for participants were analyzed using descriptive statistics. Forty-four subjects completed the questionnaire successfully. The age of respondents ranged from 21 to 69 (N=44, m=40.39 years). The number of months worked with the homeless population ranged from 3 months to 30 years (N=44, m= 9.01 years, mode=2.5 years). Participants work sites included Medical Team (n=24), Behavioral Health (n=10), Case Management (n=3), Financial (n=3), Administration (n=3), Management (n=1), and Oral Health Team (n=1).

Years in the homeless workforce. 45.5% of respondents have worked in the homeless workforce less than 5 years (n=20), 31.8% for 5 to 15 years (n=14), and 22.7% for more than 15

years (n=10). Years worked and ages are protective factors in developing compassion fatigue (Stamm, 2010). As helping professionals aged and work in their specific field longer, supportive and protective factors such as developing personal coping skills and identifying their support network become stronger with age and years worked in their desired field.

Education. In this sample, 4.5% of respondents hold a high school diploma as their highest form of education (n=2), 4.5% of respondents obtained their associates degree (n=2), 34.1% of respondents hold their bachelors degree as their high degreed received (n=15), 43.2% of respondents obtained their master's degree (n=19), 6.8% of participants obtained their doctorate degree (n=3), and 6.8% of participants obtained their professional degree or other form of education (n=3).

Departments. In the survey that participants completed, subjects identified which department they work for at BHCHP. 54.5% of participants worked on the medical team (n=24), 22.7% of participants work within Behavioral Health (n=10), 6.8% of participants work for Case Management (n=3), 6.8% of participants work within the financial department (n=3), 4.5% of subjects are part of administration (n=2), 2.3% of respondents are part of management (n=1), and 2.3% of participants are working with the Oral Health Team (n=1).

Strengths and Limitations of the Methods

Strengths. The primary aim of this study was to explore a methodology for examining protective and risk factors for the development of compassion fatigue (CF) among helping professionals in the homeless workforce. Collaboration with Boston Healthcare for the Homeless Program was invaluable in this effort; the study could not have been completed without the agency support. Standardized tools were used in the study which provides an opportunity to compare study findings with previous studies.

Limitations. The primary limitation was the small sample size. Cells could not be created to compare groups on many of the organizational dimensions of the study. In addition, objective dimensions of the work environment could not be explored in this study and the inclusion may have identified protective factors in the work environment that would have been of value to agency planners.

Methodological bias. The study's methodology had biases. First, selection bias was generated since this sample was relatively small in size and was nonrandomized. In addition, potential participants were limited to those in one agency, and only those with the time and interest to participate, and who had access to a computer with internet could participate. This researcher is limited experience with the population being studied which may have led to the possibility of neglecting to ask questions about certain aspects of the participants' experiences out of bias caused by his own personal experiences and identity. In order to be mindful about this, this researcher connected with several helping professional working with the homeless population during the development of the survey to gain a better understanding of what questions would be most relevant for this population. This researcher agreed to and signed the BHCHP Research Department Confidentiality Agreement (Appendix C) in order to conduct the research at Boston Healthcare for the Homeless. Some conditions of that agreement affected data that could be collected.

CHAPTER IV

Findings

Quantitative Data

This cross-sectional, exploratory study examined the phenomena of compassion fatigue and compassion satisfaction in a workforce specializing in the care of homeless adults and families. The study surveyed the workforce at BHCHP asking questions about empathy, Compassion Fatigue, and compassion satisfaction, and demographic characteristics. Responses to the IRI (empathy) and ProQOL sections of the survey were scored using strategies specific to each scale (Stamm, 2010; (Davis, 1980).

Compassion Fatigue Frequencies

Individual scores for the three domains of compassion fatigue (CF) scale were scored using published strategies (Stamm, 2010). Raw scores were converted to T-scores for each of the three sub scales: Compassion Satisfaction (CS), Burnout (BO), and Secondary Trauma (STS) in order to be able to scale the results to standardized measures:

Table 1

ProQOL: Compassion Satisfaction, Burnout, and Secondary Trauma T-Scores (CF),

Scales	N	Mean	Median	Range
Compassion Satisfaction	40	50	50.05	29.12-69.08
Burnout	40	50	49.74	24.57-68.62
Secondary Traumatic Stress	38	50	49.90	30.14-73.60

Stamm in the ProQOL manual describes for each subscale where the T-Scores would fall in the bottom quartile (25th Percentile), the mean (50th percentile) and the top quartile (75th percentile) (2010). The mean of the Compassion Satisfaction (CS) sub-scale for this sample falls within the average level (50th percentile) of CS, while the range of scores is in the 25th percentile to the 75th percentile.

The T-Scores for Burnout (BO) falls in the average level (50th percentile) of Burnout, while the range of scores is in the 25th percentile to the 75th percentile of Burnout. Lastly, the mean of Secondary Traumatic Stress, the second domain of Compassion Fatigue, is also in the average level (50th percentile) of Secondary Traumatic Stress, while the range of scores is within is in the 25th percentile to the 75th percentile of Secondary Traumatic Stress.

The Interpersonal Reactivity Index (IRI) Frequencies

Totals were computed for the IRI creating ratings for the dimensions of perspective-taking (PT) and empathic concern (EC). The higher the score, the greater the presence of the dimension (Davis, 1983).

Table 2

Interpersonal Reactivity Index (IRI :) Empathy Scales, (N = 44)

Scales	Mean	Median	SD	Range
Perspective Taking (PT)	19.83	19.83	3.48	14—26.83
Empathic Concern (EC)	22.23	22.00	3.72	15—34.00

Higher scores on PT are hypothesized to be a protective factor in the development of CF. Lower scores for EC are also hypothesized as protective factors in the development of CF, but higher scores of EC are hypothesized to be associated with higher scores or work satisfaction (compassion satisfaction subscale).

From the data collected, T-test, One Way ANOVA, and 2 tailed Pearson r tests were performed. T-test and one way ANOVA were used to explore significance differences between the three subscales of the ProQOL (compassion satisfaction, burnout, and secondary traumatic stress), and groups created from demographic data. Grouped data includes: a) work setting, b) working at one site vs. many sites; c) working at the main sites vs. satellite sites; d) number of work sites; e) direct care role vs. other role; and f) supervisory role vs. non-supervisory role.

A t-test was run to assess differences in secondary traumatic stress (STS) scores among direct care and non-direct care staff, with direct care staff having a lower mean STS score (m=51.58) than indirect staff (m=36.56) (t(36)=3.170, p=.003, two-tailed),

Pearson’s correlations (2-tailed) were conducted to examine the association between compassion fatigue subscale t-scores (CS, BO, STS) and work-force characteristics such as

lifetime months worked in the homeless workforce, hours worked per week, and time spent providing face-to-face services. No significant association was found.

There was a significant positive correlation between work satisfaction (CS) and average hours worked per week ($r=.415$, $p=.009$, two-tailed). No association was found between lifetime months in the homeless work force and compassion fatigue subscales.

Table 3

Lifetime months worked in the homeless workforce

Scale	Pearson Correlation	Sig. (2-tailed)
Burnout:	$r(38) = -.031,$	$p=.848$
Secondary Stress:	$r(36) = -.059,$	$p=.725$
Compassion Satisfaction	$r(38) = -.070,$	$p=.688$

A significant positive weak correlation between Compassion Satisfaction (CS) and the Empathic Concern (EC) was found ($r=.364$, $p=.021$, two-tailed).

Table 4

Relationship between ProQOL sub-scales and Empathic Concern Scale

Scale	Pearson Correlation	Sig. (2-tailed)
Burnout (BO)	$r(39) = -.123,$	$p=.456$
Secondary Stress (STS)	$r(37) = -.116,$	$p=.493$
Compassion Satisfaction (CS)	$r(40) = .364,$	$p=.021$

Qualitative Data

Participants were asked if there was anything else from their experiences working with the homeless population that they would like to add. Of the 44 participants, 13 answered the optional question. Themes most often noted were the importance of self-care and the feelings of frustration when trying to navigate government sponsored programs on behalf of clients.

CHAPTER V

Discussion

Overview

Several significant findings emerged in the study that was not expected. Based on the literature review it was hypothesized that burnout and secondary trauma scores would be impacted. However, this group had low burnout (BO) scores and low secondary trauma (STS) scores, both falling in the bottom 25th percentile. Direct care staff had significantly lower STS scores than indirect. Similarly, professional satisfaction scores for the sample fell in the bottom quartile. Job satisfaction was positively impacted by the average hours worked per week.

The literature suggests the greater exposure to clients for whom themes of crisis, suffering and distress are common would be associated with greater secondary traumatic stress and burnout scores. However, our findings suggest that additional factors mediate this response in this sample. Recent work by Ferris et al. (2016) suggests that mission identification is a potent mediator of the potentially negative effects of difficult work environments. While this dimension was not explicitly explored in this sample, participants were from a single program, the Boston Healthcare for the Homeless, an organization whose history and contributions to the care of homeless adults and families have set standards for such programs. Our results also suggest that some personal characteristics of the worker may also impact stress scores and we recommend that both of these dimensions be included in future studies of this population.

This study supports literature on the association between compassion satisfaction (work satisfaction) and empathic characteristics of the individual worker. Stamm (2010) has identified a similar pattern and elaborates further on the link between empathic concern and compassion

satisfaction. He used the analogy of helping professionals who work with burn victims. Initially with this difficult work environment, high exposure to trauma is present, causing an increase in feelings of burnout and secondary traumatic stress. However, the longer one stays with the same patients and population, opportunities emerge where progress and good work can be experienced by the helping professional. This leads to increased levels and development of compassion satisfaction increase with positive interventions.

This study demonstrated an important relationship a between compassion satisfaction scores (CS) and the average hours worked per week, but in an unexpected direction ($r=.415$, $p=.009$, two-tailed). Research suggests that prolonged and frequent exposure to traumatic experiences expressed by patients can lead to burnout, secondary traumatic stress, and vicarious trauma (Figley, 2002; Stamm, 2010; Winter, 2012; Devilly, Wright, & Varker, 2009). For this sample, the more time spent per week with patients the higher levels of satisfaction (CS). Future studies should consider and examine how patients' suffering can inspire and provide staff to work on behalf of their clients. When a client enters a Boston Healthcare for the Homeless program (BHCHP) their issues of homelessness are salient; staff exposure to the suffering associated with homelessness is clearly at work. As employees and staff members the suffering and trauma of their patients is also salient. Witnessing this human experience and having space and support to act can generate and increase levels of work satisfaction (CS) and mediate development of burnout and secondary stress.

The mission of the pioneering organization where this study was conducted is committed to serving homeless individuals and families with high quality healthcare, advocacy, and mental health services (BHCHP, 2014). Someone who chooses to work at this organization is also choosing to serve that mission, promoting a strong organizational identity. Ferris and colleagues

found that “a mediating role for organizational identification, such that recognizing suffering predicted greater identification with the organization, which fully mediated the relationship between suffering and job satisfaction, and also between suffering and burnout” (Ferris et al., 2016, p.1). They coined this as the "Florence Nightingale effect." The results of our study support this observation. Themes of alignment with patients and rewarding experiences to work with the homeless population emerged. One helping professional stated that "It is a privilege. The vast majority of patients are very grateful for the care they receive. I have a positive professional relationship with the majority of my vulnerable patients." These theme support both the quantitative data and Ferris and their colleagues' (2016) novel finding of the "Florence Nightingale' effect".

Research suggests that institutional support for self-care is also an important and effective tool to reduce and maintain low levels of compassion fatigue and this was supported by narrative comments of participants in our study. Participants elaborated on their coping strategies such as taking space, self-care, and identifying limits of helping professionals.

Strengths and Limitations

Strengths There are several strengths that add to this study's success. Having the opportunity to conduct this study at Boston Healthcare for the Homeless (BHCHP) was a privilege. BHCHP is a nation-leading integrated healthcare provider serving over 12,000 patients across Eastern Massachusetts. With a workforce of over 400 employees, being able to conduct a study within the agency provided access to helping professionals providing direct care to patients who are experiencing homelessness daily was a gracious opportunity to have them participate in this study.

Another strength of this study was adapting the survey from the previous pilot study conducted by White (2012) in her study piloting measures to examine CF among professional medical interpreters. In addition, the use of a well validated measure for the components of CF allowed us to examine study results against known dimensions. Adding more sections for an open response section, a limitation noted by White in her study, provided space to speak to the participants' experiences. Lastly, this study was able to add to the growing field of compassion fatigue and supported the more recent novel finding of "Florence Nightingale' effect" (Ferris et al., 2016).

Limitations The limitations of this study are worth noting for the future research done in this field. Both analysis and generalizability of the study findings are limited by the small sample size which did not permit exploration of some of the study objectives.

Another limitation of the study was created by the way the IRI and the Brief Trauma Questionnaire (BTQ) were presented online. Due to human error, one question was missing from the final version of the IRI in the online survey, resulting in a decreased Cronbach's Alpha. Additionally, the BTQ was not translated accurately when added to the online survey resulting in the inability to use the data given by participants. This limited the analyses related to prior exposure to traumatic events that was part of the original design.

Lastly, due to the nature of the impact of compassion fatigue on work, potential participants (agency staff) who may have been experiencing CF may not have been able to participate in the study because of their high levels of burnout and secondary traumatic stress. This argues for a more systematic approach to recruiting homeless workforce employees in future studies.

Implications for Social Work

Social workers, as part of the homeless provider workforce, are also a population at risk for developing compassion fatigue. This project has the potential to better inform social workers about these risks. In addition, social workers are in a position to provide support to their colleagues. Finally, as therapists for other professionals, it is critical for clinical social workers to develop a framework which includes research-based information about the impact of compassion fatigue. It is hoped that findings from the study will be used to support further research and inform social workers' evidence-based practice with this vulnerable population..

Recommendations for Future Research

After conducting this research, there are several suggestions this researcher has to improve this research and to add to the examination of work-related stress. Examining the work environment is crucial for identifying protective and risk factors within the workplace and can provide valuable guidance to program managers. I would also recommend the inclusion of more open-ended questions to allow more space for participants to speak to their own struggles and triumphs.

Future studies would benefit from focus groups to identify important issues that may fall outside of the current theoretical scope of variables to be considered in examining work-place stresses. Given that there is a strong interaction between workplace variables such as case load and the types of support and education that are available to staff, it is inevitable that the variability in workplace characteristics is likely to vary across organizations.

Inclusion of a standardized measure of prior personal exposure to life threatening events is likely to improve our understanding of the complex interaction between personal and workplace contributions to development of CF. In addition, we do not have a standardized tool

with which to examine caseload stressors in the clinical workplace. Such a tool would be very helpful in untangling contributions to personal satisfaction and stress in the workplace.

Finally, collaborative projects such as this one are extremely important to research in this complex area. Such collaborations provide a rich opportunity to expand our understanding of these complex phenomena while also providing valuable information for program development that supports the needs of both staff and patients.

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APPENDIX A:

**SMITH COLLEGE HUMAN SUBJECTS REVIEW COMMITTEE
APPROVAL LETTERS**



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950F (413) 585-7994

February 5, 2016

Joshua Beebe

Dear Joshua,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

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.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Elizabeth Irvin, Research Advisor



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 26, 2016

Joshua Beebe

Dear Josh:

I have reviewed your amendments and they look fine. The amendments to your study are therefore approved. Thank you and best of luck with your project.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.

Co-Chair, Human Subjects Review Committee

CC: Elizabeth Irvin, Research Advisor

APPENDIX B: I

INFORMED CONSENT MATERIALS



2015-2016

Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

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Title of Study: Compassion Fatigue Among Helping Professionals Working within the Homeless Community

Investigator(s): Joshua Beebe, Smith College MSW Candidates, Smith College School for Social Work, jbeebe@smith.edu

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Introduction

You are being invited to participate in a research study that examines the experiences of professionals who work with adults and families who are experiencing homelessness. We ask that you read this form and ask any questions that you may have before agreeing to participate in the study.

Purpose of Study

The purpose of the study is to examine the phenomena of compassion fatigue among helping professionals working in the homeless community. The study has been approved by the Smith College School for Social Work Human Subjects Review Committee. The data collected from this study will be used to complete my Master's in Social Work (MSW) thesis and the results may be published or presented to professional meetings.

Description of the Study Procedures

If you agree to be in this study, you will be asked to do the following things: take a 30-45 minute online anonymous survey asking about your experience working with individuals who are experiencing homelessness.

Risks/Discomforts of Being in this Study

There is a chance that some participants may feel some discomfort as a result of participating in the survey. Participating in this survey could raise a participant's awareness about possible personal experience with compassion fatigue. A list of educational and support resources about compassion fatigue and self-care are listed at the end of this Informed Consent and you are encouraged to review them.

Benefits of Being in the Study

The benefits of participation are to gain insight and having an opportunity to talk about issues that may be important to your work life. The benefits to social work/society are to broaden the understanding of compassion fatigue with helping professionals working within the homeless community.

Confidentiality

This study is anonymous. We will not be collecting or retaining any information about your identity or your work site. All data will be aggregated in reports to further protect respondents' confidentiality.

Payments/Gifts

You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time without affecting your relationship with the researcher or with Smith College, or with your employer. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right to not answer any individual question, as well as to stop the survey all together at any time. If you choose to stop your participation, simply close the form on your computer. Data you enter will not be retained unless you go to the last page of the survey and click "DONE." Once you have clicked "done" it will not be possible to withdraw from the study. This is because participation in the study is entirely anonymous and we would not have anyway of knowing which data were entered by you.

Right to Ask Questions and Report Concerns

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact us, Joshua Beebe at jbeebe@smith.edu. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

By clicking the "I Agree" button below, you indicate that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You may print a copy of this form to keep for your records.

I AGREE

I DO NOT AGREE

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EDUCATIONAL RESOURCES

<http://www.compassionfatigue.org/pages/symptoms.html>

<http://www.giftfromwithin.org/html/What-is-Compassion-Fatigue-Dr-Charles-Figley.html>

RESOURCES AT YOUR WORK SITE

BHCHP maintains a free Employee Assistance Program (EAP) accessible through Human Resources.

APPENDIX C:

BHCHP RESEARCH CONFIDENTIALITY AGREEMENT

Research Department Confidentiality Agreement

NOW THEREFORE, in consideration of the mutual promises contained herein and other good and sufficient consideration, the receipt and adequacy of which is hereby acknowledged, the Parties hereto agree as follows:

I. Purpose

This Agreement is intended to set forth the responsibilities and obligations of Joshua Beebe (“Researcher”) and the host organization, the Research Institute at Boston Health Care for the Homeless Program (“BHCHP” or “The Institute”).

II. Compensation

This Agreement applies to both compensated and uncompensated Researchers of The Institute.

III. Research

- a. Design: Researcher and The Institute have a shared goal of increasing the availability of literature pertaining to health care for the homeless population. Except as otherwise specified by contract, the Director of The Institute or his/her designee will be responsible for formulating and/or approving the parameters of each research project or question.
- b. Writing: The responsibility for writing the final report and any other manuscripts or presentations that arise under this Agreement will vary on a case by case basis. Both parties will have the opportunity to review and comment on advance drafts of any written work product that results under this Agreement.
- c. Editorial Responsibility: Notwithstanding any agreement to the contrary, The Institute will have final editorial responsibility for all products produced under this Agreement. No publication will issue absent prior consent of The Institute.
- d. Acknowledgement: The Researcher agrees to acknowledge The Institute in writing on any report or publication resulting under this Agreement. Acknowledgement may include, but is not limited to, naming The Institute as First Author, Contributing Author or Research Partner. It is the obligation of both Parties to discuss and to agree to the Acknowledgement prior to publication.
- e. Logos: When appropriate, the logo of Boston Health Care for the Homeless Program (“BHCHP”) shall be included with any final publication. It is the obligation of both Parties to discuss and to agree to whether the logo of BHCHP shall be included in any document arising under this Agreement prior to publication.

IV. Confidentiality

Researcher agrees to the following:

- a. Program Information: During the course of Researcher's association with BHCHP Researcher acknowledges that s/he will perform services which may require BHCHP to disclose confidential and proprietary information to Researcher. "Confidential Information" shall mean any information regarding BHCHP's operations, employees, students, volunteers and patients, including without limitation, salary rates, employment records and disciplinary actions, and research and development information which may be disclosed to Researcher by BHCHP either directly or indirectly in writing, orally or by drawing or inspection. Researcher agrees at all times during the term of his/her association and thereafter to hold in strictest confidence, and not to use or to disclose to any third party without written authorization of BHCHP, any Confidential Information disclosed to Researcher during the course of Researcher's association with BHCHP. Researcher further agrees that all Confidential Information shall at all times remain the property of BHCHP.
- b. Patient Information: Researcher recognizes that BHCHP receives, and in the future will receive, from patients, patients' confidential medical and mental health information and records, and other proprietary information belonging to individual patients ("Patient Health Information"). Researcher agrees at all times during the term of his/her association and thereafter to hold in the strictest confidence, and not to disclose to any person, firm or entity, any Patient Health Information, or to use any Patient Health Information except as necessary in carrying out Researcher's work for BHCHP under this Agreement and only if such use is consistent with BHCHP's agreement with the individual patient regarding the use of the individual's Patient Health Information.
- c. Computer Access: Researcher recognizes that BHCHP provides certain computer tools such as electronic mail (email) and Internet access to enhance communication and research enabling employees to achieve high productivity and to deliver quality patient care. Researcher agrees to abide the BHCHP Policy for Use of Electronic Mail System and the Internet, which in pertinent part, provides for confidentiality of Patient Health Information when using the computer, the use of passwords to prevent unauthorized access to accounts, and a prohibition on the sharing of passwords and the use of passwords of other BHCHP employees.

Researcher's Name _____

Researcher's Institution _____

Signature _____ Date _____

Jessie Gaeta, Director

The Institute

Signature _____ Date _____

APPENDIX D:
SURVEY QUESTIONS

ELIGIBILITY CRITERIA

* 1. You may have received more than one notice inviting you to participate in this research.
Have you already completed this study before? If so, please respond "Yes."

- Yes
- No

* 2. Are you 18 years of age or older?

- Yes
- No

* 3. Are you able to read and write in English?

- Yes
- No

* 4. Are you currently employed by Boston Healthcare for the Homeless?

- Yes
- No

Informed Consent

2015-2016
SMITH COLLEGE
Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA

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* 1. By clicking the "I Agree" button below, you indicate that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You may print/download a copy of the Constant Page for your records at <https://drive.google.com/open?id=0BytdVcMrNG63SFd6Ukc5YWhKS2c>.

I AGREE

I DO NOT AGREE

DEMOGRAPHIC INFORMATION

1. What is your age?

Age, in years

2. Please click on the drop down box and check the box that describes your highest level of education

3. How long have you worked with the homeless population?

Tip: Please include your current employment at BHCHP as well as any other work (paid or volunteer) with adults or families experiencing homelessness.

Years

Months (0 to 11)

4. How long have you been employed by BHCHP?

Tip: If you have worked off and on for BHCHP, and are currently employed at BHCHP, to answer this question, please add up all of the years that you have worked for BHCHP.

Years

Months

5. On average, during the past six months, how many hours a week have you worked for BHCHP?

Hours a week

6. Please indicate the BHCHP site where you currently work.

TIP: If you are assigned to more than one site, please select the site where you currently spend the greatest amount of time.

Other (please specify)

7. Please indicate the BHCHP site where have worked the most during your employment with BHCHP.
TIP: Some staff rotate across sites. Some work in only one setting. Please tell us which setting you have spent the most time in during your employment with BHCHP.

Other (please specify)

8. What Department do you currently work in at BHCHP?

Tip: Please remember that all of your responses are confidential.

Other (please specify)

9. What Department have you worked for the longest at BHCHP?

TIP: Some staff have remained in the same job over time, some have changed positions. Please tell us which Department you have spent the most time in during your employment with BHCHP.

Other (please specify)

10. What kind of work do you currently do for BHCHP?

Tip: If you have more than one job or more than one responsibility, please describe those in the section(s) below. (For Example: Registered nurse, personnel manager, supervisor of order department, clinician, clinical supervisor, nursing aide, Medical assistant secretary/administrative assistant, physician, case manager, cafeteria staff, etc.)

Primary functions/job:

Other functions/job:

Other functions/job:

11. What job or position/role have you held the longest at BHCHP?

TIP: Help us understand where you have spent most of your time in your work with BHCHP.

Primary functions/job:

Other functions/job:

Other functions/job:

12. What are the most important activities or duties of the position you have held the longest? (For example: patient care, directing hiring policies, supervising clinical staff, budgets, supervising direct care staff, supervising clinical staff, providing medical care, reconciling financial records, maintenance, food service, etc.)

Primary activities:

Other activities:

Other activities:

13. In your current position, how many hours a week would you say you spend, on average, providing face-to-face services to patients/clients? TIP: This could include clinical services, or other types of services that include face-to-face contact with clients.

Average hours per week
providing face-to-face
services

14. Are the patients you work with adults, children, or both?

- Adults
- Children and their Families
- Both children and adults

INTERPERSONAL REACTIVITY INDEX

Instructions: Please indicate the degree to which you feel that the following statements describe you.

1=Does Not Describes Me at All

2=Does Not Describe Me Well

3=Describes Me Somewhat

4=Describes Me

5=Describes Me Very Well

1. I daydream and fantasize, with some regularity, about things that might happen to me.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I often have tender, concerned feelings for people less fortunate than me.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I sometimes find it difficult to see things from the "other guy's" point of view.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Sometimes I don't feel very sorry for other people when they are having problems.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. I really get involved with the feelings of the characters in a novel.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. I try to look at everybody's side of a disagreement before I make a decision.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. When I see someone being taken advantage of, I feel kind of protective towards them.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. I sometimes feel helpless when I am in the middle of a very emotional situation.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. I sometimes try to understand my friends better by imagining how things look from their perspective.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Becoming extremely involved in a good book or movie is somewhat rare for me.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Other people's misfortunes do not usually disturb me a great deal.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. If I'm sure I'm right about something, I don't waste much time listening to other people's arguments.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. After seeing a play or movie, I have felt as though I were one of the characters.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. When I see someone being treated unfairly, I sometimes don't feel very much pity for them.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I am often quite touched by things that I see happen.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. I believe that there are two sides to every question and try to look at them both.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. I would describe myself as a pretty soft-hearted person.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. When I watch a good movie, I can very easily put myself in the place of a leading character.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. When I'm upset at someone, I usually try to "put myself in his shoes" for a while.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me.

Does Not Describes Me at All	Does Not Describe Me Well	Describes Me Somewhat	Describes Me	Describes Me Very Well
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PROFESSIONAL QUALITY OF LIFE (ProQOL)

Instructions: Please indicate the degree to which the following statements describe you.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always

1. I am happy.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I am preoccupied with more than one patient that I help.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. I get satisfaction from being able to help patients I serve.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. I feel connected to others.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. I jump or am startled by unexpected sounds.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. I feel invigorated after working with those I help.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. I find it difficult to separate my personal life from my life as a helping professional.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. I am not as productive at work because I am losing sleep over traumatic experiences of patients I help.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. I feel trapped by my job as a helping professional.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. Because of my experiences supporting patients who are homeless, I have felt "on edge" about various things.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. I like my work as a helping professional.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. I feel depressed because of the traumatic experiences of the people I serve.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. I have beliefs that sustain me.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

16. I am pleased with how I am able to keep up with supportive techniques and protocols.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. I am the person I always wanted to be.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. My work makes me feel satisfied.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. I feel worn out because of my work as a helping professional.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. I have happy thoughts and feelings about those I serve and how I could help them.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. I feel overwhelmed because my case load seems endless.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. I believe I can make a difference through my work.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I served.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

24. I am proud of what I can do to help.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

25. As a result of my helping, I have intrusive, frightening thoughts.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. I feel "bogged down" by the system.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

27. I have thoughts that I am a "success" as a helping professional.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. I can't recall important parts of my work with trauma victims.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. I am a very caring person.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. I am happy that I chose to do this work.

Never	Rarely	Sometimes	Often	Almost Always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. Is there anything else that you would like to tell the researcher about your experience working with patients who are experiencing homelessness?

PERSONAL HISTORY OF TRAUMA EXPOSURE (BTQ)

1. Have you ever served in a war zone, or have you ever served noncombat job that exposed you to war-related casualties (for in a example, as a medic or on graves registration duty)?

Yes No

2. (If yes) Did you think your life might be/were seriously injured?

Yes No Not applicable

3. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?

Yes No

4. (If yes): Did you think your life might be/were seriously injured?

Yes No Not applicable

5. Have you ever been in a major natural or technological disaster such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?

Yes No

6. (If yes): Did you think your life might be/were seriously injured?

Yes No Not applicable

7. Have you ever had a life-threatening illness such cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?

Yes No

8. (If yes): Did you think your life might be/were seriously injured?

Yes No NA

9. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?

Yes No

10. (If yes): Did you think your life might be/were seriously injured?

Yes No Not applicable

11. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members, or strangers?

Yes No

12. (If yes): Did you think your life might be/were seriously injured?

Yes No Not applicable

13. Has anyone ever made or pressured you into having some type of unwanted sexual contact?

Yes No

14. (If yes): Did you think your life might be/were seriously injured?

Yes No Not applicable

15. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?

Yes No

16. (If yes): Were seriously injured?

Yes No Not applicable

17. Has a close family member or friend died violently, for example, in a attack serious car crash, mugging, or attack?

Yes No

Thank You

Thank you for taking the time to participate in this study. Please feel free to contact me with any questions or comments about the study. Please click "Done" to submit the completed survey.

Thank you,

Josh Beebe, MSW Candidate
Smith College School for Social Work
jbebee@smith.edu

NO participate

Thank you for your interest in this research.

You selected "I DO NOT AGREE" on the Informed Consent page, indicating that you do not want to participate in this survey. This is the end of the survey.

Disqualification page

Thank you for your interest in this research. The answers that you provided on page one (Eligibility) indicate that you are not eligible to participate in this study. If you feel this is an error, please use the PREV (previous) button to go back and consider your responses to the eligibility questions.

Thank you.

APPENDIX E: RECRUITMENT EMAIL

SUBJECT: A Survey That Serves You!!
TO: [Insert email address]

Hello All,

I am writing to let you know about a research study that I hope you will consider participating in. The study surveys staff members who work with homeless adults or families. Participation involves completing an online survey, and would take about 30 minutes of your time. By conducting this study, I hope to learn more about a phenomenon known as “compassion fatigue.” While a great deal is known about compassion fatigue among first responders and medical personnel, virtually no research has been undertaken to explore compassion fatigue among helping professionals working with individuals experiencing homelessness. Understanding more about how compassion fatigue may impact the homeless workforce is important because it allows workers and managers to promote protective strategies in the work place that educate and support workers.

This research has been approved by the Human Subject Review Committee at Smith College School for Social Work in Northampton, MA where I am a candidate for the degree Master of Social Work. Permission was also obtained from BHCHP to let employees know about this study using agency email. Participation is entirely voluntary and completely anonymous. No one will know if you choose to participate or not. You will not know who participates, nor will managers or the researcher. I hope you will consider enrolling. The study is open beginning today, and will close on Friday, March 18, 2016 at midnight. You can learn more about the study by clicking on this secure link [<https://www.surveymonkey.com/r/G2PPCZ8>]. If you decide to participate, please do so when you can set aside 30 minutes because it is only possible to enter the study once. Thank you so much for your time and interest.

Sincerely yours,

Joshua Beebe, Clinical Social Work Intern
Boston Healthcare for the Homeless, JYP Clinic
780 Albany St
Boston, MA 02118
jbeebe@bhchp.org

Smith College School for Social Work
jbeebe@smith.edu