

**AN EXPLORATION OF THE RELATIONSHIPS BETWEEN SELF COMPASSION
AND BURN OUT, SECONDARY TRAUMATIC STRESS AND COMPASSION
SATISFACTION AMONG PROVIDERS WHO WORK WITH CHILDREN AND
FAMILIES WHO HAVE EXPERIENCED TRAUMA**

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Binlin Xia
Smith College School for Social Work
Northampton, Massachusetts 01063
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Binlin Xia
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ABSTRACT

The field of social work education has witnessed a soaring need to help providers cope with the negative emotional impact of working with clients who have experienced trauma. This study explored the association between self compassion and the experience of burn out (BO), secondary traumatic stress (STS) and compassion satisfaction (CS) among mental health providers who specifically work with children and youth who have experienced trauma. This quantitative study employed a survey in addition to two open-ended questions in a sample of 60 participants using a convenience sampling process.

The findings suggest that self compassion serves as a strongly correlated concept when examining providers' level of BO, STS and CS. Specifically, the more self compassion one is, the less BO and STS one experiences in one's work with children and families who have experienced trauma. In order to minimize BO and STS and maximize CS, programs and individuals should stress the importance of self compassion by strengthening the six sub constructs of self compassion with the understanding of its varied presentations among differences in gender, income level, ethnic group and working hours.

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CHAPTER I

Introduction

The purpose of this study was to explore the association between self compassion and the experience of burn out (BO), secondary traumatic stress (STS) and compassion satisfaction (CS) among mental health providers who specifically work with children and youth who have experienced trauma. A review of the literature indicated that social workers are especially subject to the impact of secondary traumatic stress, and burn out due to the need to work directly with clients with trauma histories and the need to negotiate the complex interpersonal relationships those clients encounter (Bride, 2007; Wee & Myers, 2002). Among all the factors that may contribute to the level of BO, STS and CS, inspired by the new ideas in positive psychology, this study attempted to understand one specific psychological factor, self compassion, and its possible effects on the emotional aspects of working with children and families who have experienced trauma and how this association may vary with different demographic factors.

In order to explore the experience of BO and STS, and to seek for ways of coping with these types of experiences, this study asked the following questions: 1) how does the level of providers' self compassion affect their respective experiences of STS, BO and CS while working with children and families who have experienced trauma? Demographic information was compared, including gender, specifically if there was a difference between female and male providers' level of self compassion and its associations with their respective levels of STS, BO and CS. Additional questions were examined, such as if having a higher educational degree,

higher income, more hours directly interacting with the clients or more practice experience in the field impact the associations between their level of self compassion and the level of STS, BO and CS. 2) Among the sub-constructs of self compassion (self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification), are there elements that are more closely related to the providers' levels of burn out, secondary traumatic stress and compassion satisfaction, if there is any? 3) Lastly, two qualitative questions were asked: What are the personal qualities that the providers can identify to deal with the above experiences in working with this population? What kind of services and training do the providers hope to acquire in order to help manage the emotional aspects of doing this work?

This study utilized a cross sectional research design using a quantitative survey. The survey was composed of a demographic section and two existing scales: 1) Self Compassion Scale, and 2) Professional Quality of Life Scale. It employed a non-probability snowball sampling technique. The sample size was 60 providers working directly with children and youth who had experienced trauma. The sample was predominantly female (86.7% female and 13.3% male) and a little over two-thirds white (68.3%). Pearson correlations statistical analysis was conducted through SPSS in order to understand the correlations between the level of BO, STS, CS and self compassion level.

The findings indicated that this sample had a relatively high level of self compassion (53.3% participants have high level of self compassion, 40% reported a medium level of self compassion), relatively low BO (51.7% participants have low BO and 48.3% participants have medium BO), relatively low STS (50% participants experience low STS, 50% participants experience medium level of BO), and relatively high CS (63.3% has a medium level of CS, 36.7% has a high level of CS). Statistical tests between self compassion and BO, STS and CS

were conducted and indicated a strong negative association between self compassion and STS, a strong negative association between self compassion and BO. Both associations were statistically significant; there was a statistically significant moderate positive association between self compassion and CS. Gender served as a factor that can affect this association: the significant associations between self compassion and BO, STS and CS are only present among female participants. Ethnicity also served as an influential factor in the associations between levels of self compassion and STS, BO and CS. Those with lower levels of income reported self compassion levels that were more strongly associated with BO and STS than those who had medium level of income. Also, the length of work schedule also affected the association: the longer one worked the more negative the association between self compassion and BO was.

The implication of the finding was that social work education programs as well as service providing agencies should introduce the concept of self compassion to students and employees in order to help them cope with the negative influences of burn out and secondary traumatic stress from their daily encounter with children and families who have experienced trauma. The findings also pointed out the specific sub-construct of self compassion that training designers should pay special attention toward, when designing relevant curriculum. The nuances of the association between self compassion and BO, STS and CS divided by the different demographic features of the sample can aid training designers understand the different facets of the association between self compassion and BO, STS and CS to design more humanistic and need-based training for providers working with children and families who have experienced trauma.

CHAPTER II

Literature Review

Introduction

The purpose of this study was to explore how self compassion may affect the level of STS, BO and CS among providers for children and families who have experienced trauma. This chapter will review literature on each concept and identify the connections between existing literature to the research questions in this study.

This chapter is divided into six sections. The first three sections examine the key variables of this study, STS, BO and CS as well as studies relating to the factors that contribute to these phenomena. The fourth section reviews previous studies on strategies to cope with BO and STS and to increase CS. The fifth section introduces the concept of self compassion in positive psychology and considers its potential as a factor to help relieve STS and BO.

Secondary Traumatic Stress (STS)

With the development of research in traumatology and the identification of PTSD, researchers discovered a phenomenon that specifically applies to trauma: trauma can spread within the interpersonal system, no matter whether it is within the family or between client and the helper (Figley, 1995). Figley (1995) has pointed out that STS could be operationally defined as compassion fatigue (CF). Therefore, instead of STS, many studies use CF to refer to the same kind of condition that defines the experience generally as “the over exposure to human suffering” (Geoffrion, Morselli & Guay, 2015; Salloum, Kondrat, Johnco & Olson, 2014; Conrad & Keller-Guenther, 2006; Kapoulis & Corcoran, 2015; Craig & Sprang, 2010). For instance, in one study, CF was used in place of STS (Conrad & Keller-Guenther, 2006). Yet according to Stamm (1999), despite their interchangeable use, CF is a conceptually broader term that can include STS

as one component and BO as the other (Yetwin & Iverson, 2014). Figley (1995), leaning toward using these two concepts interchangeably, only acknowledges that STS may have negative connotations and asserts that CF is the more accurate and widely accepted term among the practitioners (Kapoulis & Corcoran, 2015). Another concept, vicarious trauma, is also closely linked with STS. Yet the former concept differs from STS in its emphasis on changes in cognitive schema and belief systems of those who are exposed directly to traumatic materials (Baird & Kracen, 2006; Brady, Guy, Poelstra & Brokaw, 1999). But, it is important to note that, many studies measure these two constructs as if they are one, creating issues that stem from the conceptual vagueness in this field of research.

STS in an individual is the result of a spreading process of trauma, a consequence of that individual's exposure to people who have experienced trauma. The identifying symptoms include sleep difficulties, intrusive images or active avoidance of materials that may remind the person with STS of other people's traumatic experiences. This condition often occurs when the helper tries to empathize with the client's traumatic materials (Figley, 1995; Craigie, et al. 2015). One study even claims that the more empathetic therapists are toward their clients, the more likely they are in terms of internalizing the clients' trauma (Conrad & Keller-Guenther, 2006), in turn causing negative effects on therapists. Yet one recent empirical study also shows that empathy can mitigate the negative influences of STS by improving self-other awareness and emotional regulation, two cognitive components of empathy (Wagaman et al., 2015). The conflicting findings of these two studies further necessitated the importance of studying the role of empathy in influencing the professional functioning of therapists.

The Prevalence of STS

In order to understand the significance of STS in the helping professionals, the prevalence

of STS has been empirically studied by researchers (Bride, 2007; Cornille & Meyers, 1999; Wee & Myers, 2002; Craig & Sprang, 2010; Sprang, Clark & Whitt-Woosley, 2007; Tehrani, 2010; Wagaman, 2015). Due to the nature of their work, social workers are involved with many clients who may have trauma histories and the social workers' experience of STS may be especially important to identify. Bride (2007) surveyed 600 master level social workers randomly selected from 2,886 social workers licensed in a state in the southern United States on their experience of STS when they were working with clients who have experienced trauma. The study suggests that the likelihood of experiencing PTSD symptoms in the social work population is twice as high as that of the general population (Bride, 2007). Specifically, in the sample, "70.2 percent of the social workers experienced at least one symptom in the previous week, 55 percent met the criteria for at least one of the core symptom clusters, and 15.2 percent met the core criteria for a diagnosis of PTSD" (Bride, 2007, p. 67). This study result indicates that a majority of social workers in the sample working with traumatized population show symptoms of STS and a small percentage exhibit symptoms as severe as PTSD. In terms of the severity of their presenting symptoms, many respondents demonstrated low levels of symptoms and a smaller portion of respondents demonstrated more severe symptoms of STS. Another study also found high levels of prevalence for STS and BO in a sample of case management workers working with clients who have experienced trauma in Oklahoma City (Wee & Myers, 2002).

Many studies have shown that social workers who work with children and families experience an even higher level of STS as shown in many studies (Osofsky, 2008; Salloum, Kondrat, Johnco & Olson, 2015). Despite the significant impact on these providers who work with this population, there has been very limited published research examining this negative

impact on the profession and the professionals (Eastwood & Ecklund, 2008). Conrad and Keller-Guenther (2006) conducted a study among the child welfare workers in 12 different Colorado counties over a 10 months time span, during which all participants were invited to complete the Compassion Satisfaction and Fatigue Test created by Figley and Stamm (1996). The result of the study shows that the child welfare workers in Colorado are at significant risk for developing compassion fatigue. Specifically, almost 50% of the child welfare workers reported “high” or “extremely high” risk for CF, while only about 7.7% reported “high” or “extremely high” risk of burn out. Participants with high levels of compassion satisfaction experience significantly low levels of BO or CF (Conrad & Keller-Guenther, 2006, p. 1077). Meyers and Cornille’s (1999) study corroborates this finding, specifically targeting on child protective workers’ experience of secondary traumatic stress. The researchers point out that child protective service workers experience a higher level of secondary traumatic stress than those working in the outpatient services, which may be owing to factors other than STS such as depression due to long work hours, poor administrative support and personal trauma (Meyers & Cornille, 1999). These studies indicate the pressing need to understand the particular severity of STS and BO among the providers who are specifically working with children and families who have experienced trauma.

Contributing Individual Factors to STS

This section will describe studies that have investigated the specific factors that contribute to the high rate of secondary traumatic stress or compassion fatigue among providers working with children. De Figueiredo, Yetwin, Sherer, Radzik and Iverson (2014) conducted one cross-sectional mixed method study to understand the perception of CF, CS and BO among clinical providers from a variety of disciplines working with highly traumatized youth, using

online surveys and focused groups. This study shows the interrelated cross-feeding contribution of various individual, professional and organizational factors such as: personal traumatic history, the interaction between personal and work life stress factors, self-imposed pressure to achieve, the duration of time the worker has been working in the position, caseload diversity, grappling with policies perceived as not taking clients/providers into account, disconnection between the priorities of administrators, funding sources and policy makers and front-line clinical needs (De Figueiredo, et al., 2014).

Several studies seek to understand the reasons for the high turnover and high STS level among the child protective service (CPS) workers. Overlapping with the findings of De Figueiredo, et al.'s (2014) study, the Meyers and Cornille's (1999) study found that the amount of time the CPS worker spent in the field is positively correlated with their levels of secondary traumatic stress symptoms. Those who spent more than 40 hours per week reported more "irritability, jumpiness, exaggerated startle response, trouble concentrating, hyper-vigilance, nightmares, and intrusive thoughts and images" (Meyers & Cornille, 1999, p. 3). If the CPS worker's family of origin is characterized by an enmeshed interaction style, rather than a disengaged one, such workers will also be more subject to STS reactions (Meyers & Cornille, 1999). In addition, having a personal trauma history or a serious physical injury will also increase the risk to experience the symptoms of STS; Gender also can make a difference, as female staff members generally experience more secondary traumatic stress than their male peers (Meyers & Cornille, 1999).

Figley's (1995) study shed light on the risk factors for CF, including:

Measuring your self-worth by how much you help others; having unrealistic expectations of yourself and others; being self critical and a perfectionist; fearing others will judge you if you show 'weakness'; being unable to give or receive

emotional support, overextending yourself and letting work bleed over into your personal time (Figley, 1995, p. 3).

Although this study does not address risk factors of child protection workers per se, it relates the symptoms of compassion fatigue to how a person sees oneself in relation to others, rather than looking solely on environmental factors. Combining these two areas of research, these studies indicate that CF is borne out of a plethora of individual psychological and socio-demographic factors.

Personal identity and/or occupational identity, which is the system of meanings one attributes to one's working role, plays a central role in the psycho-social adjustment and life satisfaction of an individual. Based on this awareness, Geoffrion et al. (2015) wrote a paper conceptualizing the association between the levels of CF and occupational identity among child protection workers. Drawing on identity theories and definitions of CF, the authors argued that the child protection workers are subject to the impact of CF not due to direct imprint of trauma, but to a process of meaning making out of the work related stress (Geoffrion et al., 2015). There is a bi-directional relationship between self, psychological state, and the levels of CF (Geoffrion et al., 2015). Hypothesizing from identity theory, the authors propose that two important strategies of relieving compassion fatigue could incorporate "restructuring the hierarchical order of identities" and increasing the consistency between one's professional identity and one's organizational values and occupational culture. Critiquing on previous studies that only concentrate on environmental factors, the authors rationalize the subjective perspectives of the workers as equally influential constructs as the organizational, occupational and socio-cultural construct and illustrate their connected nature. From my perspective, as valuable as this paper is in pointing out this modulating effect of professional identity in shaping child protective worker's experience of compassion fatigue, it fails to verify its hypothesis through empirical

data.

Another study investigate specifically whether the utilization of evidence based practice has an impact on the levels of compassion fatigue, burn out and compassion satisfaction (Craig and Sprang, 2010). Conducted among a national sample of trauma therapists who worked primarily in community based behavioral health providers, this study found that evidence based practices lower burn out and compassion fatigue and increase compassion satisfaction (Craig and Sprang, 2010). The researchers suggest that, despite doubts on an impairment of the spontaneity and creativity of the therapeutic engagement, evidence based practice is a protective style of therapist-patient engagement because, with the prescriptive procedures, the practitioners feel more equipped to deal with the complexities and horrors of trauma.

Burn Out (BO)

As another type of negative experience of working with the traumatized population, burn-out is defined as encompassing three aspects: “emotional exhaustion, cynicism (a distant attitude toward the job), and reduced professional efficacy” (Maslach, 2001, p. 403). Conceptually, because of their distinct meaning and composition, one should not group trauma related stress conditions such as STS or CF with BO. First of all, burn out (BO) has a distinctive definition. The cause of BO is oftentimes the long term involvement in emotionally demanding situations (Figley, 1995). Considered as mainly a work-related stress problem, BO affects job performance, job absenteeism and actual turnover. The key feature of BO is the feeling of emotional exhaustion, to the point that the workers feel that they can no longer sustain themselves on the job. Work behaviors that illustrate the effects of BO include “chronic tardiness, missing work, poor completion rates or low performance, work errors, or isolation with others” (Wagaman et al., 2015, p. 202), and feelings of disillusionment and despair (Jacobson,

Rothschild, Mirza & Shapiro, 2013). BO frequently occurs among social workers through the accumulating emotional demands, frustrating job setbacks, or difficult situations or individuals over a long period of time (Wagaman et al., 2015). Social work is a highly stressful profession where workers experience a higher level of distress and emotional exhaustion (Adams, Boscarino and Figley, 2006; Boscarino, Figley & Adams, 2004; Lloyd, King, & Chenoweth, 2002). It is also suggested that social workers experience a higher level of burn out compared to other professionals due to their constant need to serve client and the complex social situation they confront when dealing with these relationships (Lloyd, King, & Chenoweth, 2002). Secondly, CF or STS differ from BO in the different time frame in regards to their development. While CF or STS have the potential to develop suddenly from a single episode of exposure to a traumatic event, BO requires a longer process in which the accumulated stress and strain from the job erodes the commitment of a professional from work (Conrad & Kellar-Guenther, 2006).

Previous studies divide the factors contributing to professional burn out into organizational and individual factors (Newell & MacNeil, 2010). Organizational factors encompass overly high caseloads, inability to control agency policy or procedures, unfairness in the structure and discipline of an organization, poor supervision and peer support as well as an insufficient amount of professional development training (Barak, Nissly, & Levin, 2001; Maslach & Leiter, 1997).

Maslach, Schaufeli and Leiter (2001)'s study suggests that as long as social workers do not feel comfortable working with their colleagues, do not have adequate and supportive supervisors, are not promoted when they deserve it, and do not have supportive working conditions, they are likely to experience some degree of dissatisfaction, burnout, and turnover (Maslach et al., 2001). Furthermore, the findings also suggest that the extent to which the social workers can act independently in their work is an important predictor of their satisfaction and burnout (Maslach

et al., 2001). In addition, the extent to which social workers view their salary as adequate for the work they do is an important factor to keep them in their jobs (Maslach et al., 2001).

The individual factors include disharmonious co-working relationships, individual personality and coping methods and difficulty interacting relationship with clients and understanding clients and their situations (Barak, Nissly, & Levin, 2001; Lloyd, King, & Chenoweth, 2002; Thorton, 1992). Vredenburgh, Carlozzi and Stein (1999) conducted a study among counseling psychologists and concluded that age is inversely correlated with the level of burn out, that is, the older the worker, the less likely he or she will experience burn out.

According to a review of many studies on the relationship between BO and stress among social workers, other risk factors for BO also include “the lack of challenge on the job, low work autonomy, role ambiguity difficulties in providing services to clients, and low professional esteem” (Lloyd & King, 2011, p. 263). The mitigating effect of autonomy and control for burn out is also confirmed in two other studies (Abu-Bader, 2000; Vredenburgh et al., 1999). Other than these individual causes, organizational factors such as quality of supervision, opportunity for promotion, working conditions and comfort at work as well as workload (Abu-Bader, 2000) can all contribute to BO among social workers.

Maslach and Pines (1977) conducted a study that took place at a day care setting among child care workers. The researchers surveyed the workers about their background, characteristics of their current job, attitudes and feelings about child care work. The study found that their experience of BO is directly associated with staff-child ratio (Maslach & Pines, 1977). As predicted, having the chance to take time out during work and having a lower number of children on the caseload are related to less BO. Factors that will help reduce emotional exhaustion, which

is the characteristics of BO, include a less structured environment and the number of staff meetings relating to better working conditions.

In a study on general job stress, Chirkowska-Smolak (2012) explored the development of BO through its relationship with work engagement and organizational factors, which include job demands and job resources (control, relations with coworkers and superiors, rewards, fairness, and values). The findings show that BO and work engagement are not necessarily opposite poles of the same dimension, rather they are independent constructs that are correlated with each other (Chirkowska-Smolak, 2012).

Compassion Satisfaction (CS)

Compassion satisfaction is the positive experience and personal growth derived from directly working with traumatized populations (Figley, 1995). Specific factors relating to improved compassion satisfaction (CS) are identified and discussed by several researchers.

Killian (2008) qualitatively examines the experiences and symptoms of CF by clinicians working with trauma survivors and quantitatively identifies resources to improve their resilience in work. The quantitative portion of the study involved recruiting a sample composed of 104 therapists who specialized in the treatment of children who have experienced sexual abuse trauma or adults with domestic violence trauma (Killian, 2008). The results showed that social support and a locus of control at the work place (eg. having their own work space, being able to anticipate or control how many hours they work each day, having a say or input at work) serve as protective factors for CS. Higher hours of clinical contact with clients is negatively associated with CS (Killian, 2008). One study found that level of compassion satisfaction decreases in those who have more than one year of experience working in the child-welfare, while it increases when there is a greater level of trauma-informed self care, which are self care practices specifically

attributed to working with traumatized populations (Salloum, Kondrat, Johnco & Olson, 2015). These types of strategies will be discussed in the next section of this chapter. It is important to note that ways to increase compassion satisfaction seems to align with the practices of lowering burn out. Salloum et al. (2015) also argued that, due to this connection, “low compassion satisfaction is a risk factor for the development of burn out,” although no claims of causation could be made (p 59).

Coping Methods for STS and BO

In response to the importance of coping methods, researchers sought to understand the efficacy of various types of coping strategies to enhance resilience among workers who help or work with population who have experienced trauma. In his groundbreaking publication on STS and CF, Figley (1995) delineates an etiology model for compassion fatigue and offered several useful interventions to deal with such symptoms. He emphasizes the importance of voicing and recognizing such process in one’s self through completing the self-test for psychotherapists (Figley, 1995). The mastery of self management and self soothing techniques are also crucial intervention plans if the self awareness for compassion fatigue is achieved. Thirdly, a process of desensitization from one’s own traumatic suffering and memories is vital, and oftentimes, this means that the practitioner will need to seek for external assistance to address the traumatic symptoms.

A series of articles explored the effectiveness of different types of self care activities to counter the impact of STS, BO and CF (Bober & Regher, 2006; Brady, 1999; Killian, 2008; Eastwood & Ecklund, 2008; Salloum et al., 2015). Bober and Regehr (2006) conducted a cross-sectional study that traces the association between coping strategies such as self-care activities, supervision, leisure activities and clinician’s experience of compassion fatigue. The

researchers received 259 responses from social workers, nurses, psychologists and physicians. Surprisingly, the researchers failed to find an association between time devoted to coping strategies and the traumatic scores, indicating that the coping strategies that are normally associated with stress reduction cannot alleviate symptoms of compassion fatigue (Bober and Regehr, 2006). The results of the study specifically points to the effects of the clinical hours professionals spent per week working with traumatized individuals and advocates for a regulation of distribution of workload so as to limit the exposure to traumatizing materials for each workers. Such emphasis on supports provided by the workplace correspond to Brady, Guy, Poelstra and Brokaw's (1999) study, which indicates that in order to reduce the impact of compassion fatigue, the work place should create an atmosphere of emotional safety, physical safety and consistent respect.

Despite a few studies that argue for the contrary (Bober and Regehr, 2006; Kilian, 2008), many researchers have pointed out the efficacy of self care activities in coping with CF and BO. Self care activities have been proven to relieve the degree of CF among providers working with children (Eastwood & Ecklund, 2008). Eastwood & Ecklund (2008) conducted a study among childcare workers working at the residential treatment centers for severely emotionally disturbed children about their risk for compassion fatigue and self care strategies. The study found that three self care strategies including "having a hobby one engages in, reading for pleasure, and taking pleasure trips and/or vacations" can significantly ameliorate the impact of compassion fatigue risk level (Eastwood & Ecklund, 2008, p. 116). Each practice implies that the individual is actively taking time to focus on activities outside of work.

Responding to the specific challenges faced by child welfare workers, one study explored the effectiveness of trauma informed self care practices, cultivating an awareness of one's own

emotional experience and engaging in self care activities such as: “requesting/expecting regular supervision/supporting consultation, utilizing peer support, attending regular safety training for child welfare workers and working with a team within the child welfare agency and provider community” (Salloum et al, 2015, p. 57). Specifically, the originality of this study is reflected in the new scale measuring different trauma informed self-care practices developed by these researchers along the lines of the practice recommendations in child welfare trauma training tool kit. The researchers distinguished specific trauma informed self care strategies which differ from traditional self care strategies such as seeking trauma specific training, attending trauma informed self care, seeking personal therapy and developing work-life balance. This study’s participants were composed of 85 case managers and 19 supervisors from three South Florida child welfare organizations. Using hierarchical multiple regression analysis, the result of the study shows that the practice of trauma informed self care activities is unrelated to the level of secondary traumatic stress, but is positively associated with the decrease of burn out. One other study (Meadors & Lamson, 2008) also show that training programs that specifically target on interventions for compassion fatigue achieve success in preventing it among health-care workers working with children with severe medical conditions.

Self Compassion

Instead of viewing self-esteem as the hallmark of psychological health, Neff (2009) views self compassion, a concept originated from Buddhism, as an alternative way of thinking about one’s self in healthy attitude. According to Krieger, Hermann, Zimmermann & Holtforth (2015), although self compassion and self-esteem can both lower negative affect and boost positive affect, only self compassion can exert such effects when researcher control for self-esteem in the experiment. When self compassion is controlled, self-esteem does not have the same effect on

the participants' emotional state. Self-compassion and self-esteem differ primarily because of the word "compassion" (Krieger et al, 2015). People who have compassion tend to care about and are more sensitive toward other people's suffering as well as their happiness (Krieger et al, 2015). When one is compassionate toward others applies this compassion to oneself, one is self-compassionate.

Rather than criticizing oneself harshly while trying to help others, people with self-compassion adopt a more compassionate, non-judgmental attitude toward themselves. Self-compassion is also distinct on its emphasis on a process of meta-cognitive activity in one's related experience to the other, so that one sees one's own suffering in a larger context with greater clarity (Neff, 2003). In sum, defined by Kristin Neff (2003), self-compassion involves:

Being touched by and open to one's own suffering, not avoiding or disconnecting from it, generating the desire to alleviate one's suffering and to heal oneself with kindness. Self-compassion also involves offering non-judgmental understanding to one's pain, inadequacies and failures, so that one's experience is seen as part of the larger human experience (p. 87).

Specifically, Neff (2003) categorizes self-compassion into three major elements: self-kindness, common humanity, and mindfulness. Self-compassion involves an attitude toward oneself that extends from understanding personal suffering as resulting from imperfections and inadequacies as a common human condition. The core process in self-compassion is to be mindful of one's own suffering, a mindfulness process of "clear seeing and acceptance of mental and emotional phenomena as it arises" (Neff, 2003, p. 88) Brought to the public attention by Jon Kabat-Zinn, he introduced mindfulness as a non-judgmental acknowledgment of present-moment reality as it actually is, thereby setting up the groundwork for changing the present moment reality and one's relationship to it (Newsome, Waldo & Gruszka, 2012). In addition to the theoretical formulation from Neff, Newsome, Waldo and Gruszka (2012) have also demonstrated

through their empirical study that mindfulness-based group practice can relieve stress and increase self-compassion among a sample of trainees in the helping professions. Instead of ignoring one's weakness to maintain self-esteem, self compassion emphasizes the virtue of patience and gentleness in improving oneself to optimal functioning. Mindfulness based group practice has also been demonstrated to be effective in shifting the practitioner's understanding of the difficult situations, thereby reducing stress and "lessening the impact of those situations on one's well being" (Newsome et al, 2012, p. 3). It has also been suggested that self compassion is connected to the alleviation of a variety of psychological maladjustment such as self criticism, depression, rumination, thought suppression, anxiety and neurotic perfectionism and an increase in feeling connected with others (Neff, 2007; Thompson & Waltz, 2008; Krieger, Hermann, Zimmermann & Holtforth, 2015). Given self compassion's healing power over so much negative psychological functioning, this author sees the potential connections between self compassion and BO and STS.

Self compassion is not just a generic term. It also incorporates several interrelating sub-constructs: self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification (Neff, 2003). Among these six components of self compassion, the one that is most extensively studied is the practice of mindfulness and its relations to psychological well-being (Dorian & Killebrew, 2014). Dorian and Killebrew (2014) evaluated the outcomes of a 10-week mindfulness training class on mindfulness theory, research and practice offered at a professional psychology program for female trainees in California. The researchers asked the participants to submit weekly journals so as to gather their personal reflections of the courses. The results of the study show that these female students stated that mindfulness helped them "to gain acceptance (willingness to see things as they are), compassion for self and others (letting go

of negative judgments), and increased their capacity for attention and awareness” (Dorian & Killebrew, 2014, p. 158). Such progress was shown by all participants in the study in at least half of these positive emotional experiences. This study implies that the specific precedence for self criticism among women rather than men corresponds to the findings among the literature on STS and BO that women providers are more likely to experience these negative affects.

Thompson and Waltz (2008) investigated the associations between self compassion and post traumatic stress symptoms and then integrated self-compassion based training into trauma treatment. The study results showed that among the three sub-scales of trauma symptoms, the only scale that was significantly associated with self compassion was the severity of the avoidance symptom. As such, those who have a higher score in self compassion are less likely to engage in avoidant behaviors which leads to a more natural exposure process to pain and emotional suffering. The implication of this study is that those who struggle with STS or CF could benefit from having high levels of self compassion.

BO, STS and CS in Relation to Self Compassion

This section will explore the relationship between STS and self compassion by joining the literature from both realms. As suggested by Figley (1995), STS is especially facilitated through the act of empathy or the concern for others. In this case, in order to understand self compassion’s role in managing STS, it is important to understand the interplay between self compassion and the compassion for others.

Neff and Pommier (2013) investigated the link between self compassion and concern for the well-being of the others among a sample of college undergraduates, community adults and mediators. The results show that among all participants, self compassion is significantly linked to perspective taking skills and forgiveness of others. There were also divergences among

undergraduates, community adults and Buddhist meditators. Among undergraduates, self compassion was not significantly correlated with compassion for others; for community adults and Buddhist meditators, however, self compassion was significant associated with all other variables related to compassion for others. In this sense, due to participant's different professional roles, the level of their self compassion is differentially linked to their level of concerns for others. Other factors that may affect the community member's concern for others is age, as the community adults show a greater tendency to be concerned about others than college undergraduates. There are also gender differences in the study results: compared with men, women are more concerned about the suffering of others and experience more distress when confronted with other people's distress. People who are better able to forgive others and better able to take perspectives will also likely to be better in their ability to hold fewer grudges toward themselves. Yet at same time, from this author's perspective, this protective factor for STS and BO may be balanced out by having more concern for others, since that may increase the hazards for STS.

Similarly, Welp and Brown (2014) conducted a study on the relationship between self compassion, empathy and pro-social behavior. The results show that higher levels of self compassion predicted greater willingness to help another person, but it simultaneously lowers the level of empathy for that person and increases victim blaming. Counter to the conventional thinking that a higher level of victim blaming causes people to help less, the research shows that people with high level of self compassion tend to help more despite believing that those whom they help should take responsibility for their own faults. The study also shows that people with higher self compassion is related to less felt personal distress when dealing with another person's emergency. The study also shows that people with higher self compassion only predicts a higher

likelihood to help when those whom they helped are at fault for their behavior. The implication of this study points to the likelihood that high levels of self compassion may further debilitates the helper by taking on more cases for helping and may be more likely to exhaust themselves from work.

Lindsay and Creswell (2014) investigated the connection between self affirmation, self compassion and pro-social behavior. Constructed in an empirical experimental setting, the researchers ask the participants to write about important values of self, and observes their behaviors in a laboratory shelf collapse incident, which is a situation when the laboratory shelf surprisingly collapsed when the study participants were completing the survey (Lindsay & Creswell, 2014). This part of the study shows that self compassion acts as a moderator for self affirmation and pro-social behavior, that as self affirmation rises pro-social behavior also increases. The other aspect of this study is to explore the association between self compassion and self affirmation through understanding whether self affirmation increases the level of compassion more toward the self than the other. The results confirmed that self affirmation increases self compassion among participants originally low in this area. That is to say, the more self affirmation and self compassion one has, the deeper one will engage in work of benefiting others. From this author's perspective, since pro-social behavior is in the nature of working with those who have experienced trauma, the implication of this study is that self compassion will make one more vulnerable to the stress since it encourages one to do more work.

Despite these controversies, other researchers have also suggested that compassion fatigue can be alleviated through self compassion (Germer & Salzberg, 2009) and still other researchers have indicated that self compassion can help prevent teacher's burn out (Vicki Zakrzewski, 2012). However, none of these researchers have empirically examined the relationship between

self compassion and CS, STS and BO. In order to bridge the gap in the literature and resolve the controversies that can be gleaned from the literature, this study aims to explore the association between self compassion and BO, STS and CS through an examination of quantitative evidence and understanding the self-care strategies used by these providers of traumatized children and families through qualitative evidence.

In response to the literature on risk factors and coping strategies for BO and STS, providers working directly with children and their specific challenges with BO and STS, as well as theories on self compassion, the research question for this study are as follows: (1) How does the level of providers' self compassion affect their respective experiences of STS, BO and CS while working with children and families who have experienced trauma. Demographic information will be compared, including gender, specifically if there is a difference between female and male providers' level of self compassion and if it affects their level of STS, BO and CS. Additional questions will examine if having a higher educational degree, higher income or more practice experience in the field impact levels of STS, BO and CS. Other variables such as type of work setting and client age range will also be explored. (2) Among the sub-constructs of self compassion (self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification), are there elements that are most closely related the providers' levels of burn out, secondary traumatic stress and compassion satisfaction, if there is any? (3) What are the providers' strategies to deal with the above experiences and what do they believe their organizations can do to improve their experiences?

Since there has been little prior empirical research specifically targeted to the relationships between these variables among the specific population of providers working with children and families who have experienced trauma, this study seeks to explicate the underlying associations.

Given the past research I reviewed in this chapter, this study hypothesized a negative correlation between self compassion and BO and ST, as well as a positive correlation between self compassion and CS with variations in these correlations between different demographic groups. The study methodology will be outlined in the next chapter.

CHAPTER III

Methodology

The review of the literature indicates that there have been few studies specifically dedicated to the impact and experience of providers who specifically work with children and families who have experienced trauma. The focus of this study was to understand the factors that contribute to providers' secondary traumatic stress (STS), burn out (BO) and compassion satisfaction (CS) and specifically how self compassion affects the providers with regard to the above emotional aspects of working with this population. The research questions were as follows: 1) How does the level of providers' self compassion affect their respective experiences of STS, BO and CS while working with children and families who have experienced trauma? Demographic information will be compared, including gender, specifically if there is a difference between female and male providers' level of self compassion and its associations with their respective levels of STS, BO and CS. Additional questions will be examined, such as if having a higher educational degree, higher income, more hours directly interacting with the clients or more practice experience in the field impact the associations between their level of self compassion and the level of STS, BO and CS. 2) Among the sub-constructs of self compassion (self-kindness, self-judgment, common humanity, isolation, mindfulness and over-identification), are there elements that are most closely related to the providers' levels of burn out, secondary traumatic stress and compassion satisfaction, if there is any? 3) What are the personal qualities that the providers can identify to deal with the above experiences in working with this population? What kind of services and training the providers hope to acquire from the agencies in order to help themselves deal with the emotional aspect of doing this work?

Research Design

The study followed a cross-sectional mixed method research design with both qualitative and quantitative questions. It used a non-probability snowball sample of providers working with children and families who have experienced trauma. An online survey was employed to gauge the worker's experience in regard to their levels of self compassion and their levels of burn out, secondary traumatic stress and compassion satisfaction. The purpose of using this design was to explore whether self compassion can affect the other three variables with regard to the quality of the providers' professional lives working with people who have experienced trauma. The use of an online survey was used to help to lower the researcher visibility and allow for participant anonymity.

Research Hypothesis

The null hypothesis for the first research question was that self compassion has no relationship with the level of BO and STS and CS. The alternative hypothesis of this first research question was that self compassion is negatively associated with the level of BO and STS and is positively associated with CS. Different demographic groups exhibited varying levels of differences when it comes to the associations. Some hypotheses that were tested in the study were as follows: Female providers' self compassion level is more negatively related to the level of BO and STS and is more positively associated with CS than their male counterparts. The level of self compassion in participants with higher income levels and higher educational achievement and the amount of time they have worked in the field is more negatively related to the level of BO and STS and is more positively associated with CS. There is no significant associations between the levels of self compassion and the levels of BO, STS and CS among providers who are from different ethnicities and providers who possess clinical licensure or not.

The level of self compassion of those who spend more hours doing direct practice each week is more positively related to the level of BO and STS than those who work in less hours. The null hypothesis of the second research question was that there is no relationship between self compassion and the level of BO, STS and CS.

The alternative hypothesis of the third research question was that higher levels of self kindness is most closely related to lower levels of BO and STS and higher levels of CS. The null hypothesis of the third research question was that there is no one single sub-construct of self compassion that is more closely related to levels of BO, STS and CS.

The fourth research question needed to be examined qualitatively, through thematic content analysis.

Recruitment and Sampling

A non-probability, snowball sampling method was used to recruit participants. The inclusion criteria to participate included: 1) being at least 22 years old and, 2) holding at least a high school diploma, 3) have been working for at least six months to provide direct services to children and families who have experienced trauma, 4) are currently providing direct services to children and families who have experienced trauma. The exclusion criteria included 1) those who do not provide direct services (for example, administrators), and 2) workers who have less than six months of experience working in the field. Before the recruitment process began, an application was submitted and approved by the Human Subjects Review Committee at Smith College School for Social Work (Appendix A). The recruitment process was completed electronically through the use of email to two main groups. The two recruitment emails were outlined in the Appendix B. The first group included this author's colleagues at her current placement who work at the Italian Home for Children, a Community Based Acute Treatment

Center. The second group was professional contacts, friends and colleagues who met the recruitment criteria. Both group of contacts were encouraged to send their recruitment email to their friends and colleagues who may meet the recruitment criteria. Reminder emails were also sent to engage as many participants as possible to become involved in the process. Both the recruitment email and the reminder email contained a link to the online survey.

The recruitment process is planned with consideration of the potential risks the participants are going through, and is designed with the understanding that there could be minimal risk for participants to be reminded of the degree of stress they have experienced from their work. This is accomplished through a informed consent for the participants to read after they were indicated as being eligible to participate in the study (Appendix C). Participation may also cause them to think about challenging or stressful cases. It is possible that participation in this study may stimulate concerns or questions about their work. This possibility will be addressed with participants in the informed consent screen prior to their agreement to participate in this study. Additionally, at the end of the survey, the researcher attached a series of suggested tips and coping strategies to help reduce their burn out and/or secondary traumatic stress.

Another consideration in the recruitment process is ways of preserving the anonymity and confidentiality of the participants. Since the survey is designed to retrieve needed data without any identifying information, the participant's anonymity could be ensured. In addition, the confidentiality of the participants will be protected by safe storage of the data, as well as immediate deletion once the study is completed. In the report phase, the data will be shared in aggregate and no identifying information would be shared.

Sample

The sample contained 60 responses. Over the eight weeks during which the survey was online, 70 people started the survey, with 60 people completed the survey. The survey was considered complete as long as the participants completed all of the quantitative questions. Three participants chose not to respond to the qualitative questions. This is a sample largely composed of females, with only 8 male participants out of the 60 participants. The age of the sample ranges from 23 to 65, with an average age of 32.9 years old and the mode of age being 30. With regard to educational level, two thirds of the sample has a masters degree, which was specifically 66.7% of the participants. Additionally, Master Level Interns made up 19.3% of the sample. Almost 60% (59.6%) held a clinical license. Two-thirds (68.3%) of the sample reported identifying as being White/Caucasian. Participants also reported as Black and African American (5%), Latino American (10%), Asian (10%), Mixed Race (3%), and Other (1.7%). The income level of the sample ranges from no income to more than \$100,000, with the mode of the sample income level being between \$40,000 and \$49,999. The years of experience of working with this clinical population ranges from more than 9 years to 6 month. The years of experience of working with this clinical population ranges from 6 months to more than 9 years. Table 1 outlines the demographic data of study participants including gender, ethnicity, and income.

Table 1 *General Demographics*

Characteristics		<i>f</i>	%
Gender			
Male		8	13.3
Female		52	86.7
Race/Ethnicity			
Caucasian/White		41	68.3
Black/African American		3	5
Latino		6	10
Asian		6	10
Mixed Race		3	5
Other		1	1.7
Income			
Lower Level	No Income	8	13.3
	\$20,000-\$29,999	4	6.7
	\$30,000-\$39,999	9	15
Middle Level	\$40,000-\$49,999	13	21.7
	\$50,000-\$59,999	9	15
	\$60,000-\$69,999	3	5
Higher Level	\$70,000-\$79,999	28	16
	\$80,000-\$89,999	17	9.7
	\$90,000-\$100,000	14	8
	I prefer not to share	8	13.3
	Other	1	1.7

Survey Instrument

The survey had a total of 71 items, including 69 single choice items and 2 open-ended questions to obtain qualitative data. The survey is comprised of four sections: the first section is demographic information (13 items); the second section is the self-compassion survey (26 items); the third section is the professional quality of life survey (30 items) and the last section is the two open-ended qualitative questions. Please refer to Appendix D for a copy of the survey.

This survey took approximately 15 minutes to complete. The following paragraphs describe each section of the survey and instruments used.

The demographic section contains 13 questions, including questions related to age, gender, income, years of practice, the age group of primary clientele, educational level, their areas of expertise and the type of setting in which they work.

The section measuring the participants' level of self compassion has 26 questions. This section utilizes the Self Compassion Scale (Neff, 2003), which is a five point Likert scale (1=Almost Never, 5=Almost Always). It prompts the readers to imagine themselves in a hypothetically very difficult situation and consider their reactions and attitudes toward themselves. It probes participant's ratings on six major areas: self kindness (eg. "I try to be loving toward myself when I am feeling emotional pain"), self judgment (eg. "I am disapproving and judgmental about my own flaws and inadequacies"), common humanity (eg. "When things are going badly for me, I see the difficulties as part of life that everyone goes through"), isolation (eg. "When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world"), mindfulness (eg. "When something upsets me I try to keep my emotions in balance") and over-identified (eg. "When I'm feeling down I tend to obsess and fixate on everything that's wrong").

The third section used the profession Quality of Life 5 Scale (Stamm, 2005) that measures the levels of burn out, secondary traumatic stress and compassion satisfaction the participants' experience. It includes 30 questions that evaluates the participant's attitude or experience with his or her work. As in the previous section, this scale also uses a five point Likert scale (1=Never, 5=Very Often). The topic area touches upon inquiries such as what one's feelings are when one helps other people or what one's own evaluation of one's performance at work is,

etc. The Professional Quality of Life 5 is a validated and reliable scale that has been examined (Boscarino & Figley, 2006) and is used by many studies.

The fourth and final section is the two open ended question that aims to gather qualitative data. In line with the literature that categorized coping strategies into personal and organizational ones, this part of the survey contains one question that addresses coping through reflecting on personal qualities that help one to cope. The second question asked about the specific services one would hope to utilize to cope with the emotional experiences from their work.

Data Collection

After receiving approval letter (Appendix A) from the Human Subject Committee at the Smith College School for Social Work, data collection began. Prospective participants were contacted through a recruitment email that contained the link to the online survey (Appendix D). All surveys were distributed through SurveyMonkey, an online survey hosting services. After the participant completed four eligibility questions, they were directed to the page with the informed consent. The informed consent explained the purposes of the study and ensured that the participant could quit at anytime in the process. Potential benefits, risks and confidentiality were also discussed. Once they approved and consented to participate in the study, the participants clicked the “I agree” option and proceed to the online survey. However, if they clicked “I disagree,” they were taken out of the survey immediately and directed to a thank you screen. At the end of the survey, the participant received the researcher’s appreciation as well as three relevant book recommendations to help them better understand the concepts contained in the survey, such as self compassion and secondary traumatic stress.

The survey was anonymous and did not collect any identifying information such as names or contact information of participants. In addition, the participants' confidentiality was protected through secure storage of the survey data online during the recruitment and offline during the data analysis process. The contact information of the researcher, however, was provided on all recruitment materials and within the survey in case there is any need to contact the researcher or to address any questions or concerns about the study. The survey was open online from December 14 , 2015 to February 12 , 2016.

Data Analysis

The goal of the data analysis was to determine the potential associations between the level of self compassion to the level of burnout, compassion satisfaction and secondary traumatic stress among providers who work with children and families who have experienced trauma. The potential associations between the demographic factors such as gender, experience in the field, income level, educational level and self compassion were also explored. The data on the six sub-scales of self-compassion were also computed to determine the strength of connection between each sub-scale and the level of secondary traumatic stress, burn out and compassion satisfaction using canonical correlations. The scales for this study were analyzed using descriptive and correlational statistics through SPSS software. The two open ended questions were reviewed using theme/content analysis.

CHAPTER IV

Findings

The purpose of the study was to uncover the associations between the level of self compassion and the level of burn out (BO), compassion satisfaction (CS) and secondary traumatic stress (STS). Additionally, this study explored how different demographic factors shape the distribution of these potential associations. This study also sought to find out if there were differences among the sub-constructs of self compassion and which one is most closely related to the levels of BO, CS and STS. Lastly, this study gathered some qualitative data to understand the ways practitioners cope with the negative emotional experiences of working with children and families who have experienced trauma. The findings of this sample are derived from both quantitative source and qualitative sources, and will be presented accordingly. The quantitative data answers the research question about the possible associations between self compassion and the experiences of burn out, secondary traumatic stress and compassion satisfaction through correlational analysis of the sample in general. Then, these associations were analyzed between groups composed of different demographics. The demographic data are presented with descriptive statistics. The qualitative responses were used to answer one of the research questions related to the coping strategies of burn out and secondary traumatic stress in the sample. This chapter is divided into sections and will outline the findings in this way: 1) Demographics, 2) Data corresponding to research questions, 3) Qualitative responses.

Demographics

A total of 60 participants participated in this study. In the previous chapter, Table 1 outlined the demographic data including gender, ethnicity and income level. To summarize the demographic data, there were 52 female (86.7%) and 8 male (13.3%) participants in the study.

The age of the participants ranged from 23 to 65 of age, with an average age of 33 years and the mode of the age being 30 years (15%). The second most frequent age in the sample was 25 (11.7%).

Over two-thirds of the participants reported being Caucasian (68.3%). The other ethnic backgrounds reported were Asian (10%), Latino (10%), Black/African American (5%), Mixed Race (5%), and Other (1.7%).

A little over one fifth of the participants in the sample earn an income between \$40,000 to \$49,999 (21.7%), which is the mode of income level in this sample. For the purpose of data analysis, this author has divided income into three ranges. Those who reported in the upper income level (over \$70,000) represented 8.3% of the sample. Those in the middle range (\$40,000-\$69,999) represented 41.7% of the sample, and 35% reported earning between (\$0-\$39,999), which is considered the lower range of income in this study. It is important to note that 15% of the sample selected to not share their income information.

Table 2 demonstrates the participants' education level, average hour spent per week directly with clients and the amount of participants who possess a clinical licensure. A little over one-fifth (21.7%) of the sample spends 21 to 25 hours a week directly working with clients and 20% of participants reported working between 11 to 15 hours. For convenience of data analysis, this study have divided the sample into three segments: those who work between 0-15 hours were considered to have a shorter schedule; those who work between 16 to 30 hours had a medium work schedule; those who work for 31 hours and more had a longer work schedule.

This is a sample with a relatively high educational level. Eighty five percent of the study participants held masters or Ph.D degrees or were a Master's Level student. For the convenience of data analysis, the sample was divided into those who have high school level of

education and those who have undergraduate level of education and those who have graduate level of education. Almost three-fifths (58.3%) of participants held a clinical license.

Table 2

Demographics Divided by Working Hour and Educational Level

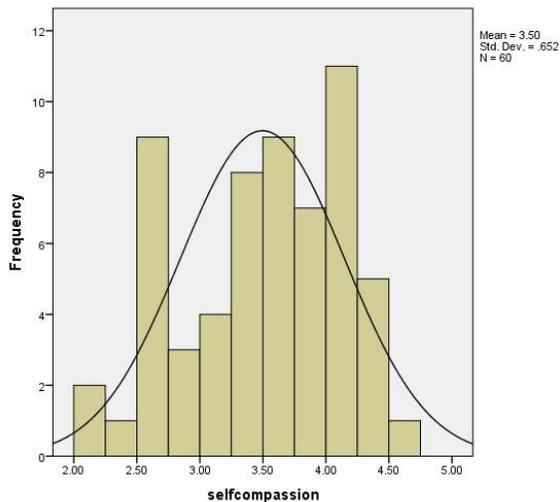
Characteristic		<i>f</i>	%
Average Hours Worked			
Short Work Schedule	0-5 hours	5	8.3
	6-10 hours	10	16.7
	11-15 hours	12	20
Medium Work Schedule	16-20 hours	7	11.7
	21-25 hours	13	21.7
	26-30 hours	6	10
Long Work Schedule	31 hours +	7	11.7
Education Level			
High School Level	High School Diploma	1	1.7
Undergraduate Level	Bachelor Degree	5	8.3
	Master Level Student	12	20
Graduate Level	Master Degree	39	65
	Ph.D. Degree	2	3.3
Clinical Licensure			
Yes		35	58.3
No		25	41.7

The Levels of Self Compassion, Secondary Traumatic Stress, Burn Out and Compassion Satisfaction

The sample was composed of participants who are self compassionate. According to Neff, a score between 1 and 2.5 indicates a low level of self compassion, and a score between 2.5 to

3.5 indicates a medium level of self compassion and a score above 3.5 equals a high level of self compassion. The self compassion findings are outlined in Table 3 and the histogram of participants' self compassion level are presented in Figure 1.

Figure 1: Histogram of Participants' Self Compassion Level



A little more than half of the participants (53.3%) exhibited a high level of self compassion, 40% of the participants reported medium level of self compassion and 6.7% reported low self compassion.

Table 3

The Level of Self Compassion in this Sample

Characteristic	<i>f</i>	%
Self Compassion Level		
Low Self Compassion	4	6.7
Medium Self Compassion	24	40
High Self Compassion	32	53.3

The six sub-constructs of self compassion are detailed in Table 4. On average among these sub-constructs, participants in this study showed high isolation score (3.75) and low self-kindness score (3.14). This sample also presents with a relatively high level of mindfulness

(3.61).

Table 4

Sub-Constructs of Self Compassion

<u>Characteristic</u>	<u>min</u>	<u>max</u>	<u>mean</u>
Self Judgment	1.2	4.8	3.4967
Over Identification	1.5	5.0	3.6125
Isolation	1.0	5.0	3.7500
Mindfulness	2.25	5.0	3.6125
Self Kindness	1.6	4.8	3.1400
Common Humanity	1.5	5.0	3.3667

Table 5 shows the levels of burn out and secondary traumatic stress. This sample has relatively low burn out and low secondary traumatic stress levels. There were no participants in the sample who reported a high level of secondary traumatic stress or suffer from a high level of burn out. 51.7% of the participants reported a low level of burn out, and 48.3% of the participants reported a medium level of burn out. In terms of secondary traumatic stress, 50% of the participant experience low level of secondary traumatic stress and the other 50% of the participants experience medium level of secondary traumatic stress.

This sample does not include any participant who presents with a low level of compassion satisfaction. Almost two thirds (63.3%) of the sample reported a medium level of compassion satisfaction, and a little over one third (36.7%) of the sample reported a high level of satisfaction. The absence of any participant with a low level of compassion satisfaction and high burn out or secondary traumatic stress speaks to the general satisfaction of the participants with their work in this sample.

Table 5:

The Burn Out, Secondary Traumatic Stress and Compassion Satisfaction Level

Characteristic	<i>f</i>	%
Burn Out Level		
Low Burn Out	31	51.7
Medium Burn Out	29	48.3
Secondary Traumatic Stress Level		
Low Secondary Traumatic Stress	30	50
Medium Secondary Traumatic Stress	30	50
Compassion Satisfaction Level		
Medium Compassion Satisfaction	38	63.3
High Compassion Satisfaction	22	36.7

Tests of Hypothesis:

The First Research Question

The findings of this study are presented to answer the research questions. The first research question was: How does the level of providers' self compassion affect their respective experiences of STS, BO and CS while working with children and families who have experienced trauma? The null hypothesis of this research question was that self compassion has no relationship with the level of BO and STS and CS. The alternative hypothesis of this study was that self compassion is negatively associated with the level of BO and STS and is positively associated with CS. In order to test this hypothesis, Pearson correlation was conducted to evaluate the strength and direction of association between self compassion and STS, BO and CS. Table 6, Table 7 and Table 8 illustrated the results of the data analysis on these three measures. Shown in Table 6, the *r* between the self compassion and burn out is -.643 and the alpha value is less than 0.05, indicating a statistically significant strong negative association between self compassion and BO.

Table 6

Correlations between Self Compassion and Burn out

Scales	<i>f</i>	Self Compassion	Burn out
Self Compassion	60	1	-.632**
Burn Out	60	-.632**	1

** . Correlation is significant at the 0.01 level (2-tailed).

Shown in Table 7, the *r* between the self compassion and STS is -.554 and the alpha value is less than 0.05. This indicates a strong negative association between self compassion and STS, and this association is statistically significant.

Table 7

Correlations between Self Compassion and Secondary Traumatic Stress

Scales	<i>f</i>	Self Compassion	Secondary Traumatic Stress
Self Compassion	60	1	-.554**
Secondary Traumatic Stress	60	-.554**	1

** . Correlation is significant at the 0.01 level (2-tailed).

Shown in Table 8, the *r* between the self compassion and compassion satisfaction is .454 and the alpha is less than 0.05, indicating a statistically significant moderate positive association between self compassion and CS.

Table 8

Correlations between Self compassion and Compassion Satisfaction

Scales	<i>f</i>	Self Compassion	Compassion Satisfaction
Self Compassion	60	1	.454**
Compassion Satisfaction	60	.454**	1

** . Correlation is significant at the 0.01 level (2-tailed).

Based on these results, this researcher accepted the alternative hypothesis that the level of self compassion is negatively associated with BO; additionally, accepted the alternative

hypothesis that the level of self compassion is negatively associated with STS; and, lastly, accepted the alternative hypothesis that the level of self compassion is positively associated with CS.

The Second Research Question

The second research question seeks to understand the associations between self compassion and burn out, secondary traumatic stress, and compassion satisfaction among different demographic groups. To answer the question, the null hypothesis was that there is no difference between different demographic groups when it comes to the association between self compassion and STS, BO and CS. The alternative hypothesis, however, was that different demographic groups exhibit varying levels of differences when it comes to the associations: (1) The significance of the association between self compassion level and the BO STS and CS is more evident among female providers than their male counterparts. (2) There is no significant association among different ethnic background's levels of self compassion and their levels of BO, STS, and CS. (3) People who have a higher income level will report self compassion that is more negatively associated with BO and STS and more positively associated with CS than people with lower income. (4) The more hours the providers have worked per week, their levels of self compassion was more negatively related to the BO and STS level and positively related to their CS level. (5) Those who have higher educational achievement' self compassion level is more negatively associated with the levels of BO and STS of those who have lower levels of BO and STS, and more positively associated with the levels of CS of those who have lower levels educational achievement. (6) Those who have a clinical licensure's self compassion level is more positively associated CS, and more negatively associated with BO and STS than those who do not have a clinical licensure. Table 9 shows the results of statistical analysis of the

association between self compassion and CS, BO and STS.

Table 9

Correlations between Self Compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between Genders

Scales	<i>f</i>	Self Compassion	CS	BO	STS
Male					
Self Compassion	8	1	.443	-.690	-.446
Female					
Self Compassion	52	1	.464**	-.631**	-.569**

** . Correlation is significant at the 0.01 level (2-tailed).

Statistical analysis indicates that the p value of the association between self compassion and CS, BO and STS among the group of male workers is not significant. But since the r value is between -1.0 and +1.0, the levels of self compassion and the levels of CS, BO and STS is correlated. However, female participants showed both significant and correlated association between self compassion and CS, BO and STS: as indicated by the statistical analysis, the strong negative association between STS and self compassion was significant only among the females ($r=-.569, p<0.01$). The moderate positive association between CS and self compassion ($r=.464, p<0.01$) was also only significant among the females. Also, the strong negative association between BO and self compassion ($r=-.631, p<0.01$) was only significant among the females. The results prove the hypothesis that the association between levels of self compassion and levels of BO, STS, CS was only significant among the females and was not significant among their male counterparts.

Table 10 shows the results of a comparison of associations between the levels of self compassion and level of BO, STS and CS among different ethnic groups.

Table 10

Correlations between Self Compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between Ethnic Groups

Scales	<i>f</i>	Self Compassion	CS	STS	BO
White/Caucasian					
Self Compassion	41	1	.494**	-.538**	-.644**
Black/African American					
Self Compassion	3	1	.708	-.966	-.652
Latino					
Self Compassion	6	1	.101	-.623	-.928**
Asian					
Self Compassion	6	1	.478	-.960**	-.742
Mixed Race					
Self Compassion	3	1	.608	.608	.716
Other					
Self Compassion	1	1	C	C	C

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

c. Cannot be computed because at least one of the variables is constant.

Among 41 white participants, with regard to self compassion, the data showed a positive connection between self compassion and compassion satisfaction ($r=.494$, $p<0.01$). Still within the groups of white clinicians, there was a strong negative correlation between self compassion and burn out ($r=-.644$, $p<0.01$), self compassion and secondary traumatic stress ($r=-.538$, $p<0.01$). As for the group of Black and African American participants, there are no statistically significant correlations between self compassion and CS, BO and STS. For the group of Latino participants, their levels of self compassion was negatively associated with BO ($r=-.928$, $p<0.01$) with a near perfect association, and such association is significant. With an equal strong correlation, Asian Participants' self compassion level was significantly strongly negatively associated with STS levels ($r=-.960$, $p<0.01$). As to the mixed race participants, there was also no statistically significant correlations between self compassion and CS, BO and STS. In sum, there are some variations among different ethnic groups when it comes to the

association between levels of self compassion and STS, BO and CS. The hypothesis that ethnic background has no influence on the associations between self compassion and CS, BO and STS is rejected, since different ethnicities demonstrated diversified presentations on each measure. Ethnicity serves as an influential factor in the associations between levels of self compassion and STS, BO and CS.

Table 11 shows the results of a comparison of the levels of self compassion and levels of BO, STS and CS between different income levels.

Table 11

Correlations between Self compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between Income Levels

Scales	<i>f</i>	Self Compassion	CS	STS	BO
Income					
Lower Level	21	1	.417	-.757**	-.710**
Self Compassion					
Income					
Middle Level	25	1	.483*	-.533**	-.469*
Self Compassion					
Income					
Higher Level	5	1	C	C	C
Self Compassion					

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

c. Cannot be computed because at least one of the variables is constant.

For the purpose of this study, participants were divided into three groups by the differences in their income: those who had a lower level of income earned between no income to \$39,999 a year; those who had a medium level of income earned between \$40,000 a year to \$69,999 a year; and those who earned between \$70,000 a year and \$100,000 a year qualify having a high level of income. In the sample, 8 participants chose not to share their income information. Due to the missing of participants who have a higher level income in this sample, the association between self compassion and STS, BO and CS cannot be calculated through the

data analysis software. The self compassion level of participants who have a lower level of income was not significantly associated with their levels of BO, STS and CS. However, this group of participant showed a strong negative association between their self compassion level and their levels of STS ($r = -.757, p < 0.01$), BO ($r = -.710, p < 0.01$), and both associations are statistically significant. In addition, the level of self compassion of participants with a medium level income was positively correlated with CS ($r = .483, p < 0.05$), negatively correlated with BO ($r = -.469, p < 0.05$) and STS ($r = .533, p < 0.01$). The hypothesis that higher income level associates more negatively with BO and STS and more positively with CS than people who earn less needs to be rejected, since (1) there was no sufficient data for those who had higher level income, (2) the association between self compassion and STS was significant for both participants who had a lower and medium level of income; yet the correlation between self compassion and STS among those who had a lower level of income was even stronger than those who had a medium level of income. Similarly, the correlation between self compassion and BO was stronger among those who had lower levels of income than those who have a medium level of income.

Table 12 illustrates the correlations between self compassion and BO, STS and CS among different groups of people with different lengths of work schedule.

Table 12
Correlations between Self Compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between the Length of Work Schedule

Scales	<i>f</i>	Self Compassion	CS	BO	STS
Short Work Schedule					
Self Compassion	27	1	.419*	-.581**	-.468*
Medium Work Schedule					
Self Compassion	26	1	.380	-.612**	-.650**
Long Work Schedule					
Self Compassion	7	1	.756*	-.933**	-.717

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

For purposes of this study, work schedule was divided into three lengths of schedule, short, medium, and long. Participants who had a shorter work schedule worked between 0-15 hours directly with clients each week; participants who had a medium work schedule work between 16-30 hours each week; participants who worked for 31 hours and above were considered to have a long work schedule. The level of self compassion for those who work for a short schedule was significantly negatively correlated with BO ($r=-.581$, $p<0.01$) and STS ($r=-.468$, $p<0.05$), and also was significantly positively correlated with CS ($r=-.419$, $p<0.05$). Similarly, those who had a medium length of work schedule's self compassion level was significantly negatively correlated with BO ($r=-.612$, $p<0.01$) and STS ($r=-.650$, $p<0.05$), but was significantly correlated with CS. Those who have a long work schedule's level of self compassion was not significantly correlated with BO ($r=-.933$, $p<0.01$) and was significantly positively correlated with CS ($r=-.717$, $p<0.05$), but their level of self compassion was not significantly correlated with STS. The hypothesis that the longer one works the more negative the association between self compassion and BO is can be proved through the above data analysis. Because not only does the association between BO and self compassion was significant for participants working for short, medium and long hours, the longer hours one work, the more correlated the two variables were. However, a similar kind of association was not present between compassion satisfaction and self compassion, or between secondary traumatic stress and self compassion.

Table 13 illustrates the correlations between self compassion and BO, STS and CS among different groups of people with different level of education.

Table 13

Correlations between Self Compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between education level

Scales	<i>f</i>	Self Compassion	CS	BO	STS
High School Diploma Self Compassion	2	1	C	C	C
Undergraduate Diploma Self Compassion	44	1	.431**	-.571**	-.507**
Graduate and Above Self Compassion	14	1	.407	-.897**	-.801**

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

c. Cannot be computed because at least one of the variables is constant.

Participants were divided according to their highest level of achievement in education. Those who had a undergraduate diploma, including master level interns' self compassion was significantly negatively correlated with BO ($r=-.571$, $p<0.01$) and STS ($r=-.507$, $p<0.01$), and also was significantly positively correlated with CS ($r=.431$, $p<0.01$). Those who had a graduate level of education, including people who already had a masters and those who already had acquired a Ph.D, exhibited a pattern of significant strong negative association between self compassion and BO ($r=-.897$, $p<0.01$) and self compassion and STS ($r=-.801$, $p<0.01$). There was no significant association between CS and self compassion among those who had a graduate and above level of education. Because of the limited number of participants only possessing a high school degree, no results of association can be yielded for comparison. These results prove that the hypothesis is true: the level of self compassion for those who had a higher level of education was more negatively associated with the levels of BO and STS than those who only had a undergraduate degree, and more positively associated with the levels of CS of those who only had a undergraduate degree. The associations between compassion satisfaction and their self compassion was not significant. Table 14 shows the correlations between self compassion

and BO, STS and CS among people who possessed a clinical license and those who did not.

Table 14

Correlations between Self Compassion and Burn Out, Secondary Traumatic Stress and Compassion Satisfaction between Possession of a Clinical License

Scales	<i>f</i>	Self Compassion	CS	STS	BO
No					
Self Compassion	25	1	.522**	-.593**	-.696**
Yes					
Self Compassion	35	1	.401*	-.578**	-.541**

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

The data analysis suggests that the self compassion level of those who possess a clinical license was significantly positively associated with their levels of CS ($r=.401$, $p<0.05$), and their self compassion level was significantly negatively associated with their levels of STS ($r=-.578$, $p<0.01$) and BO ($r=-.696$, $p<0.01$). Similarly, the self compassion levels of those who do not possess a clinical license was significantly positively associated with their levels of CS ($r=.522$, $p<0.01$), and their self compassion level was significantly negatively associated with their levels of STS ($r=-.593$, $p<0.01$) and BO ($r=-.541$, $p<0.01$). With regard to the hypothesis, the data analysis shows that the self compassion level's association to their levels of BO, STS of those who did not have a clinical license was slightly more negatively correlated than those who did; and those who did not possess a clinical license' self compassion level's association to their levels of CS were slightly less positively correlated than those who do hold a license.

The Third Research Question

The third question seeks to understand the correlations between various sub-constructs of self compassion and BO, STS and CS. Table 15 shows the correlation between self compassion's six sub-construct's relation to burn out, secondary traumatic stress and compassion satisfaction.

Table 15

Correlations between Self compassion and Burn out, Secondary Traumatic Stress and Compassion Satisfaction among different sub-constructs

<u>Scales</u>	<i>f</i>	<i>Burn Out</i>	Secondary Traumatic Stress	Compassion Satisfaction
Self Judgment	60	-.520 (**)	-.546 (**)	.282
Over Identification	60	-.435 (**)	-.485 (**)	.352 (**)
Isolation	60	-.568 (**)	-.549 (**)	.420 (**)
Mindfulness	60	-.398 (*)	-.289 (*)	.230
Self Kindness	60	-.634 (**)	-.351 (**)	.519 (**)
Common Humanity	60	-.386 (*)	-.336 (**)	.312

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

According to a canonical correlational analysis, three constructs have significant correlations with BO, STS, and CS. Those constructs are 1) over identification, 2) isolation and 3) self kindness.

Qualitative Data

Two open-ended questions aimed to gauge participants' reflections of their experience of working with children and families who have experienced trauma, to specify strategies, personal qualities and agency structures they rely on to deal with the emotional aspects of the work. The first question had 48 responses, and asks the participants to explain the personal qualities they use to cope with the emotional aspects of their work. The second question also had 48 answers and prompts the participant to describe the kinds of services and supports that they envision would help them to work with families and children who have experienced trauma.

Eleven respondents answered the first question indicating their choice of coping strategy as doing mindfulness meditation/spirituality. Eight respondents proposed that one cluster of important qualities that help them cope is empathy, compassion and kindness. Six respondents revealed that their family and friends play an important role in supporting their emotional

welfare and spending quality time with family and friends proves to be very helpful to relieve stress. Four respondents proposed that they separate their work from life to help them relieve their stress and negative emotional experience from work. Three respondents shared that having a reflective distance and frequently engage in reflective thinking is very helpful to them. Three additional respondents believed that their curiosity and positive nature help them cope.

The second question probed participants' ideas of what they think the agencies need to do in order to help them cope with these experiences. Twenty one participants shared that additional training in response to how agencies can become more involved in helping employees feel less STS or BO. However, their ideas of the types of training differ. Among these twenty one participants, fourteen participants specifically stated the importance of an agency providing trauma-informed training. Other participants also mentioned the importance of self-care trainings and vicarious trauma related trainings. Eight participants maintained that it is important to have regular supervision to help cope with BO and STS. The rest of the answers overlapped with some of the answers of the first question, mentioning meditation, mindfulness, regular exercise and healthy food choices.

CHAPTER V

Discussion

The purpose of this study was to understand the role of self-compassion in the experience of burn out, compassion satisfaction, and secondary traumatic stress, which are the emotional experiences that providers for children and families who have experienced trauma may have gone through. In addition to understanding the connection between the variables, this study also had two qualitative questions that explored participants' understanding of personal coping strategies and possible agencies' support in alleviating the impacts of burn out and secondary traumatic stress. This chapter is comprised of a discussion of research findings as they related to the existing literature, organized by the three research questions. In addition, this chapter will cover the limitations of this study, along with the implications of the study for the field of social work practice and suggestions for future research.

Discussion of Research Findings

Research Question One:

The sample presents with a high level of self compassion across the participants, as more than half (n=32) of the participants demonstrated having a high level of self compassion and 40% of the participants showed having a medium level of self compassion. This sample shows a relatively low burn out rate among the sample participants, with more than half of the participants (51.7%) scoring toward the lower range of burn out score and 48.3% of the participants scoring at the medium range of burn out score. This result is counter-intuitive in the sense that previous literature suggested that the burn out rate among social worker is higher than other professionals, due to the need to serve marginalized populations and the complex social relationships they need to confront. This sample, on the other hand, presents with a

relatively low burn out rate. One speculation of this study result is that because this is a convenience sample and due to the voluntary nature of their participation, the participants may have a more positive concept of their work experience in order to want to take part in the survey. Another speculation could be the various levels of education experiences, degrees, and settings in this study might differ from a study and sample of all social workers. Similar findings, as indicated by Bride's study (2007), social workers also experience a higher level of secondary traumatic stress than other professionals, which counters this study's results, which showed that the participants have a relatively low level of secondary traumatic stress.

The data analysis to the first research question yielded a statistically significant strong negative association between self compassion and BO, which means that the higher one's self compassion level is, the less burn out one will experience. The relationship between self compassion and secondary traumatic stress was similar to this pattern, as the data analysis of this sample indicated a statistically significant strong negative association between self compassion and STS. This also suggested that the more self compassionate one was, the less secondary traumatic stress one would experience. Self compassion and compassion satisfaction, on the other hand, yielded a statistically significant moderate positive association. As such, the more self compassionate one is, the more compassion satisfaction one gleans from one's work. Such study results may be attributed to the healing effect of self compassion to the stress generated by directly working with children and families who have experienced trauma. According to research conducted on self compassion and its positive effects, self compassion has a lot of positive implications on mental health well-being including an increase in happiness, optimism, gratitude and general positive affect (Neff, Rude & Kirkpatrick, 2006; Neff & Costigan, 2014). The data from this study further confirms the positive implications for health of self compassion

through its negative association with burn out and secondary traumatic stress and its positive association with compassion satisfaction. One study specifically examines such associations between self compassion and mental health well-being among a sample of social work students (Ying, 2009). Other research has also found that self compassion is inversely correlated to negative states of mind such as anxiety, depression and stress (Neff, 2003a). The findings of this study confirms the positive effects of self compassion in reducing STS and BO, which are negative mental states caused by direct exposure to trauma.

Figley (1995) has pointed out the powerful influence of the personal meaning making system on one's experience of compassion fatigue. It is argued that one's measuring of one's helpfulness, one's unrealistic expectations of oneself and others, one's being highly critical of one's faults and the relentless pursuit of perfection may contribute to one's susceptibility to compassion fatigue. Geoffrion et al. (1995) expanded this argument by introducing professional identity as a system of meaning one attributes to their role at work and pointed out its influence on their experience of professional life. Both scholars point out the need to acquire a healthier attitude toward one's self at work and to restructure the meanings made by the person in relation to their work in order to improve their experience at work. This current study confirms both study results that being more self compassionate will likely to have some positive effects on having more compassion satisfaction from work and decreasing one's experience of burn out and secondary traumatic stress.

This study further examines the variation of the associations between self compassion and BO, STS and CS among different demographic groups marked by gender, income level, educational level, length of work schedule and possession of clinical license. Referring to Meyers & Cornille's (1999) study that shows the amount of time the social worker spent in the

field is positively associated with secondary traumatic stress, the findings of this study indicated that the amount of time spent directly working with clients who have experienced trauma will intensify the negative association between time spent in the field and the level of secondary traumatic stress. Meryers & Cornille (1999) also find out that gender play a role in influencing the experience of STS in that females have a higher risk in developing secondary traumatic stress compared with their male colleagues. This finding seems to reflect a pattern in this current study that the association between levels of self compassion and levels of BO, STS and CS is only significant among the females and was not significant among the males. However, this study had so few male participants that no conclusions or comparisons can be drawn.

Research Question Two:

The second research question aims to understand the specific sub-construct of self compassion that affects BO, STS, and CS. Three constructs that have significant correlations to BO, STS and CS are 1) over identification, 2) isolation and 3) self kindness. This finding implies the importance of social support in helping the providers decrease their level of BO and STS and increase their compassion satisfaction in working with children and families who have experienced trauma. Also, one speculation of self kindness as the central factor to affect the association between self compassion and BO, STS and CS is that self kindness is a central piece of self compassion, according to its definition. Therefore, relating to oneself kindly will help alter the relationship between one and one's work, so as to change one's experience of one's work. In addition, this sample overall has a relatively high isolation score (3.75) and mindfulness score (3.61). Mindfulness was seen as a process of recognizing mental and emotional phenomena non-judgmentally (Neff, 2003). Therefore, this research speculate, with a relatively high level of self compassion in this sample, the process of mindfulness may have

counteract some negative effects of isolation.

Research Question Three: Qualitative Findings

Participants were asked (1) What are some personal qualities that they have used to cope with the emotional aspects of the work (2) What are some structural changes or support that they envision their agencies can provide to help them cope with BO and STS. Participants mentioned that mindful meditation could help them improve their emotional well-being and retrieve peace of mind, which confirms this study because mindfulness is a sub-construct of self compassion. Participants also mentioned that empathy, compassion and kindness aid them to counter the negative emotional impact of working with children and families who have experienced trauma. This item, when understood broadly, matches with the other construct of self compassion that is self kindness. Family and friends' supports were another important strategy used by participants in this study, which corroborated the value of self-care activities mentioned by Eastwood & Ecklund (2008).

In order to reduce the impact of compassion fatigue, it is important for work settings to consider creating an atmosphere of emotional safety, physical safety and consistent respect. These findings suggested the importance of training and supervision opportunities from agencies, which matched with the point of views of the participants from this study (Salloum et al., 2015; Meaders & Lamson, 2007).

Study Limitation

This first limitation of this study is related to the sampling method. Using convenience snowball sampling, this study can only glean information from a limited number of participants, with many participants from a very similar background (i.e. working in the same agency). This sampling method in turn limited the diversity of the participants in this study, recruiting a sample

that has a relatively high level of self compassion and a relatively low level of burn out and secondary traumatic stress.

Another limitation of this study was that this sample was comprised of primarily of female participants, which decreases the validity of the study result of the association between self compassion and that of the male participants'. The study sample size was also small, which makes it difficult to make generalizations when comparing the study to existing research.

Lastly but not least, the theoretical construct of this study, secondary traumatic stress, sometimes was used interchangeably with compassion fatigue in other literature. This conceptual vagueness sometimes will disrupt the connections between knowledge and create barriers to connect the result of this current study to these previous ones.

Implications for Social Work Practice

Due to the fact that high self compassion is directly correlated with less risks for BO and STS, the first implication for social work practice of this study would be to implant self compassion related information in graduate training programs of social work, as well as agency settings to help raise awareness and education related to the importance of self compassion. Since the increase in the amount of time that one works directly with clients per week will intensify the negative association between self compassion and the levels of burn out, as well as self compassion and the level of secondary traumatic stress, it is important for agency to design different intervention strategies for providers with different work schedules. Also, the association between participants' self compassion levels and their levels of BO, STS of those who did not have a clinical license was slightly more negatively correlated than those who did not. This also has implications for agencies to develop different strategies when recruiting new employees

with different licensure status. It is also implied from this study that agencies should provide more trainings on trauma or compassion fatigue to providers who work with clients who have experienced trauma.

Recommendations for Future Research

The study results show that self compassion seems to have an effect on helping the service providers for children and families who have experienced trauma to improve their compassion satisfaction and decrease the likelihood for them to experience any negative emotional experiences such as STS and BO. Future research may focus on exploring more demographic factors that affect the association between self compassion and BO and STS. Due to the lack of male participants, participants who only has a high school diploma and participants who have high income in this study, future studies may also explore these question with a larger random sample. Also, due to the lack of consistency of definitions in the previous literatures, it is advised that future scholars should develop clearer definitions to compassion fatigue, secondary traumatic stress and burn out, through refining its operational definitions in studies, in order to better understand their influences to providers who work with children and family who have experienced trauma.

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Appendix A: Human Subjects Letter of Approval



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

November 23, 2015

Binlin Xia

Dear Binlin,

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: Shella Dennery, Research Advisor

Appendix B: Recruitment Emails

Recruitment Email for Staff at Italian Home for Children

Dear Staff at the Italian Home for Children,

My name is Binlin Xia and I am currently a second year social work student at Smith College School for Social Work. I am also currently a clinical intern working at the Boston Center CBAT unit. I am writing to request your participation in my study on the experiences of compassion satisfaction, burn out and secondary trauma, and the levels of self compassion of human service providers.

I am recruiting participants who are currently directly working, for a minimum of six months, with children and families who have experienced trauma. At the Italian home for children, you are eligible to participate in my study if you are currently a dorm staff/childcare worker or clinician who holds at least a high school diploma and are at least 22 years old. Bachelor, master and doctoral level providers and graduate level interns are also eligible to participate.

Participation in this study includes completing an online survey. The online survey is administered by a confidential research site and will be entirely anonymous. The survey is total of 71 items and will take approximately 15 minutes to complete. There is no compensation for participating in this study. After the study is completed, the researcher will report the study results back to the agency, but no demographic data will be shared, to ensure the confidentiality of the participants.

If you are interested in participating, please go to the online link below. The link to the survey is: <http://www.surveymonkey.com>. After clicking the link, you will be directed to the inclusion criteria page, and then to review the informed consent. The survey will not start until you offer the informed consent.

Please also forward this email to any providers that you may know (including colleagues, friends and family) who may be willing to participate in this study.

I will send a reminder email in two weeks to follow-up. Please feel free to contact me with any questions or concerns.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Thank you in advance for your time and participation.

Sincerely,
Binlin Xia
bxia@smith.edu
Phone: xxxxxxxxxxxx

Recruitment Email for Colleague and Friends

Dear Colleagues and Friends,

My name is Binlin Xia and I am currently a second year social work student at Smith College School for Social Work. I am writing to request your participation in my study on the experiences of compassion satisfaction, burn out and secondary trauma, and the levels of self compassion of providers for children and families who have experienced trauma.

I am recruiting participants who are currently working with children, adolescents and/or families who have experienced trauma. You are eligible to participate in my study if you are currently a practicing service provider for the above population with at least six months of experience, having at least a high school diploma and are at least 22 years old. Bachelor, master, and doctoral level providers, and graduate level interns are also eligible to participate.

Participation in this study includes completing an online survey. The online survey is administered by a confidential research site and will be entirely anonymous. The survey is a total of 71 items and will take approximately 15 minutes to complete. There is no compensation for participating in this study.

If you are interested in participating, please go to the online link below. The link to the survey is: <http://www.surveymonkey.com>. After clicking the link, you will be directed to the inclusion criteria page, and then asked to review the informed consent. The survey will not start until you offer the informed consent.

Please also forward this email to any providers that you may know (including colleagues, friends and family) who may be eligible and willing to participate in this study.

I will send a reminder email in two weeks to follow-up. Please feel free to contact me with any questions or concerns.

If you are interested in knowing the result of the study, feel free to contact me and I will send you the study result once it is ready.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Thank you in advance for your time and participation.

Sincerely,
Binlin Xia
bxia@smith.edu
Phone: xxxxxxxxxxxx

Follow Up Recruitment Email for Staff at Italian Home for Children

Dear Staff at the Italian Home for Children,

My name is Binlin Xia and I am currently a student at Smith College School for Social Work. I am writing as a reminder and to request your participation in my study on the experiences of compassion satisfaction, burn out and secondary trauma, and the levels of self compassion among the human service providers. If you have already completed this survey, I thank you for your participation. If you have not done so yet, please consider participating in this study. At Italian home for children, you are eligible to participate if you have been working for at least six months and are currently a dorm staff/child care worker or a clinician who holds at least a high school diploma and are at least 22 years old. Bachelor, masters, and doctoral level providers and graduate level interns are also encouraged to participate.

The survey is still online and you can participate in this study by clicking the following link: [www. Surveymonkey.com](http://www.Surveymonkey.com). After clicking the link, you will be directed to the inclusion criteria page, and then asked to review the informed consent. The survey will not start until you offer the informed consent.

This survey will be entirely anonymous, containing a total of 71 items and will take approximately 15 minutes to complete. There is no compensation for participating in this study. The study result will eventually be reported back to the Italian Home for Children, but no demographic information will be shared to ensure your confidentiality.

This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Please forward this email to your family, friends or colleague who are eligible and may be interested in participating in this study.

Sincerely,
Binlin Xia
bxia@smith.edu
Phone:xxxxxxxxx

Follow Up Recruitment Email for Colleague and Friends

Dear Colleagues and Friends,

My name is Binlin Xia and I am currently a student at Smith College School for Social Work. I am writing as a reminder and to request your participation in my study on the experiences of compassion satisfaction, burn out and secondary trauma, and the levels of self compassion

among the human service providers. If you have already completed this survey, I thank you for your participation. If you have not done so yet, please consider participating in this study. You are eligible to participate if you have been working for at least six months and are currently directly working with children and family who have experienced trauma and you hold at least a high school diploma. Bachelor, masters, and doctoral level providers and graduate level interns are also encouraged to participate.

The survey is still online and you can participate in this study by clicking the following link: [www. Surveymonkey.com](http://www.Surveymonkey.com). After clicking the link, you will be directed to the inclusion criteria page, and then asked to review the informed consent. The survey will not start until you offer the informed consent.

This survey will be entirely anonymous, containing a total of 71 items and will take approximately 15 minutes to complete. There is no compensation for participating in this study. This study protocol has been reviewed and approved by the Smith College School for Social Work Human Subjects Review Committee (HSRC).

Please forward this email to your family, friends or colleague who are eligible and may be interested in participating in this study.

Sincerely,
Binlin Xia
bxia@smith.edu
Phone:xxxxxxxxx



2015-2016

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

.....

Title of Study: Self compassion and its Relations to the Experience of Secondary Traumatic Stress, Burn Out and Compassion Satisfaction among Providers Working Directly with Children and Families who have Experienced Trauma

Investigator(s):

Binlin Xia

Smith College School for Social Work xxx-xxx-xxxxx

.....

Introduction

- You are being asked to be in a research study of the experience of secondary traumatic stress and burn out and compassion satisfaction and their level of self compassion among providers who work with children and families.
- You were selected as a possible participant because (1) you are at least 22 years old, (2) work as a direct service provider for children and families who have experienced trauma for at least six month; (3) hold at least a high school diploma; (4) bachelor, master, doctoral providers and graduate-level interns are eligible to participate in this study.
- You are not eligible to participate in this study if you are not directly working with children and and families who have experienced trauma or have less than six months of experience working with this population.
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to understand the factors that influence the quality of professional experience of providers working with children and families who have experienced trauma as well as the coping strategies they used to deal with these emotional aspects of their work.
- This study is being conducted as a research requirement for *my master's in social work degree*

- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: In this survey, you will be asked to complete demographic information for yourself and your job, as well as complete questions related to burn out, secondary trauma, and compassion satisfaction. You will also be asked to see how much self compassion you have toward yourself. Lastly, you will be asked two open ended questions regarding to the challenges of working with traumatized children and your ways of coping. The survey is a total of 71 items and will take approximately 15 minutes to complete.

Risks/Discomforts of Being in this Study

- There are potential minimal risks for your participation in this study. Due to the nature of the survey questions, it is possible that you may experience mild discomfort in thinking about your current or past work experiences. However, the benefits of participating in this study are that you will be contributing to the field of mental health and will be introduced to resources that aim to alleviate while you reflect on your professional experiences. Compensation will not be provided for participation in this study.

Benefits of Being in the Study

- The benefits of participation are: You will be introduced to resources that aim to alleviate while you reflect on your professional experiences. Compensation will not be provided for participation in this study.
- The benefits to social work/society are: You will be contributing to the field of mental health as well as social work education. You will also be helpful to the related agencies to develop programs that can improve the quality of life.

Confidentiality

- This study is anonymous. We will not be collecting or retaining any information about your identity.
- Your participation will be kept confidential.

The survey does not contain names, email addresses, IP addresses or any other information that matches your response to you as an individual. In papers and presentations, the data will be presented in the aggregate, ensuring that your demographic information will not be personally identifiable. The results from this survey will only be accessible to my research advisor and me. Materials from this study will be stored in a secure locked/password protected location for three years as required by Federal regulations to ensure that confidentiality is maintained. Materials that are kept longer than three years will be kept secured and will be destroyed when no longer needed.

- 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 period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected

during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

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. Once you have begun the survey, you may decide that you do not wish to continue with the survey at any time without affecting your relationship with the researcher of this study or Smith College.

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 me, Binlin Xia at bxia@smith.edu or by telephone at xxx-xxxxxxx. If you would like a summary of the study results, one will be sent to you once the study is completed. 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

I encourage you to save a screen shot of this screen or print a copy of this informed consent for your records.

I have shared some information and referral services below about self compassion and compassion fatigue for your reference.

Book Recommendations and Referral List:

Book Recommendations:

Neff, K. (2011). *Self-compassion: The proven power of being kind to yourself.* New York, NY: William.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma.* New York, NY: W.W. Norton & Company.

Germer, C. K. (2009). *The mindful path to self-compassion.* New York, NY: Guilford Press.

Online resource to read more about stress and compassion fatigue from the American Institute of Stress

<http://www.stress.org/military/for-practitionersleaders/compassion-fatigue/>

Therapy Referral Information in Massachusetts:

<http://www.therapymatcher.org/therapist-in-cambridge-ma.htm>

<https://therapists.psychologytoday.com/rms/>

BY CHECKING “I AGREE” AND CLICKING “NEXT” YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION, THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS, AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

I AGREE I DO NOT AGREE

Next

Appendix D: Online Survey

Welcome Screen

Welcome to the survey on understanding the experience of burn out, secondary traumatic stress, and compassion satisfaction among human service workers who provide direct services to children and families who have experienced trauma. Thank you in advance for agreeing to participate in this study. This survey should take about 15 minutes to complete and your answers will be kept anonymous and confidential. The next screen will ask you four questions to determine if you are eligible to participate in this study. If you are eligible, you will be guided to the informed consent and then the survey. The next screen will take you to the questions that determine your eligibility. Please click “Next” to begin.

Please contact me if you have any questions about the study or survey.

Thank you for taking time to participate.

Binlin Xia
bxia@smith.edu
Phone:xxxxxxxxx

Screening Criteria

I am currently working directly with children and family who have experienced trauma
I have been working with this population for at least six months?
I at least hold a high school diploma?

I am at least 22 years old?

I agree that I meet **ALL** of these criteria I meet some or none of these criteria
If a participant clicks the first button indicating that they meets all of these criteria, they will be taken to the informed consent page. If a participant clicks the second button and indicate that they meet some or none of these criteria, they will be exited from the survey and directed to a thank you screen.

Screen if the Participants do not Meet the Criteria:

Dear Participant,
Thank you for your interest in this study. Unfortunately, one of your answers to the screening questions does not match the recruitment criteria for this study and you are not eligible to participate. Thank you so much for your time! Please contact me if you have any questions.

Book Recommendations and Referral List:

Book Recommendations:

Neff, K. (2011). *Self-compassion: The proven power of being kind to yourself*. New York, NY: William.

Rothschild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York, NY: W.W. Norton & Company.

Germer, C. K. (2009). *The mindful path to self-compassion*. New York, NY: Guilford Press.

Online source to read more about stress and compassion fatigue from the American Institute of Stress

<http://www.stress.org/military/for-practitionersleaders/compassion-fatigue/>

Therapy Referral Information in Massachusetts:

<http://www.therapymatcher.org/therapist-in-cambridge-ma.htm>

<https://therapists.psychologytoday.com/rms/>

Sincerely,
Binlin Xia
bxia@smith.edu
Phone:xxxxxxxxxx

Section I:

1. Age: ____ (Fill in the blank)
2. Gender: Female Male
3. Race and ethnicity: Caucasian Black/African American Latino Asian
 Other: ____ (Fill in the blank)
4. Income Level: \$20,000-\$29,999, \$30,000-\$39,999, \$40,000-\$49,999,
 \$50,000-\$59,999, \$60,000-\$69,999, \$70,000-\$79,999, \$80,000-\$89,999,
 \$90,000-\$100,000 Other I prefer not to share
5. Years of experience working with the children and families who have experienced trauma:
__ Years __ Months (Fill in the blank)
6. Average hour per week spent with the client:
 0-5 hours per week, 6-10 hours per week, 11-15 hours per week, 16-20 hours per week,
 21-25 hours per week, 26- 30 hours per week, 31 hours and more
7. Primary client age group (click all that apply): 0-2 3-5 6-12 13-15 16-18
8. What level of education do you have (Check all that apply)
 High school Diploma Bachelor degree Master level student/Intern Master Degree
 PHD/Doctoral level
9. Bachelor's degree (if applicable) is in what field of study: Social Work Psychology Mental health Counseling
 Education Other ____ (Fill in the blank)
10. Masters degree (if applicable) is in what field of study: Social Work Psychology Mental Health Counseling
 Education Other ____ (Fill in the blank)
11. Do you hold a clinical license? Yes No
12. Are you currently working at the Italian Home for Children? Yes No
13. If no, what type of setting do you work?
 Residential treatment School Hospital Child welfare Outpatient Treatment
Other: ____ (Fill in the blank)

Section II: (Neff, 2003)

How I typically act toward myself in difficult times?

Please read each statement carefully before answering. Please use the following scale to indicate how often you behave in the stated manner:

1. Almost Never
2. A few times
3. Somewhat often
4. Often
5. Almost Always

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.

15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

Section III: (Stamm, 2009)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a provider. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days

1=Never

2=Rarely

3=Sometimes

4=Often

5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I help.
3. I get satisfaction from being able to help people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I help.
7. I find it difficult to separate my personal life from my life as a provider.
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.
9. I think that I might have been affected by the traumatic stress of those I help.
10. I feel trapped by my job as a provider.
11. Because of my work, I have felt "on edge" about various things.
12. I like my work as a provider.
13. I feel depressed because of the traumatic experiences of the people I help.
14. I feel as though I am experiencing the trauma of someone I have helped.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with helping techniques and protocols.

17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. I feel worn out because of my work as a provider.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed because my case load seems endless.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.
24. I am proud of what I can do to help.
25. As a result of my helping, I have intrusive, frightening thoughts.
26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a provider.
28. I can't recall important parts of my work with trauma victims.
29. I am a very caring person.
30. I am happy that I chose to do this work.

Section IV: Two Qualitative Questions

1. What personal qualities do you have or utilize to cope with the emotional aspects of your work?

2. What type of services, training, or supports (either personally or in your professional work setting) would help to enhance your work with children and families who have experienced trauma?