

Summer 2018

The Role of Self-Care as it Pertains to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Among Suicide Prevention Crisis Hotline Staff

Crystal T. Henson

Western Kentucky University, cth0329@yahoo.com

Follow this and additional works at: <https://digitalcommons.wku.edu/diss>

 Part of the [Clinical Psychology Commons](#), and the [Counseling Psychology Commons](#)

Recommended Citation

Henson, Crystal T., "The Role of Self-Care as it Pertains to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Among Suicide Prevention Crisis Hotline Staff" (2018). *Dissertations*. Paper 150.
<https://digitalcommons.wku.edu/diss/150>

This Dissertation is brought to you for free and open access by TopSCHOLAR®. It has been accepted for inclusion in Dissertations by an authorized administrator of TopSCHOLAR®. For more information, please contact topscholar@wku.edu.

THE ROLE OF SELF-CARE AS IT PERTAINS TO COMPASSION SATISFACTION,
BURNOUT, AND SECONDARY TRAUMATIC STRESS AMONG SUICIDE
PREVENTION CRISIS HOTLINE STAFF

A Dissertation
Presented to
The Faculty of the Department of Psychology
Western Kentucky University
Bowling Green, Kentucky

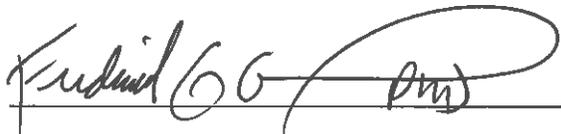
In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Psychology

By
Crystal T. Henson

August 2018

THE ROLE OF SELF-CARE AS IT PERTAINS TO COMPASSION SATISFACTION,
BURNOUT, AND SECONDARY TRAUMATIC STRESS AMONG SUICIDE PREVENTION
CRISIS HOTLINE STAFF

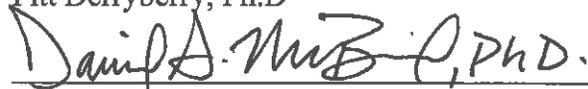
Date Recommended June 20, 2018



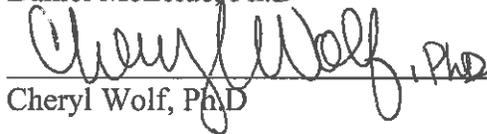
Frederick Grieve, Ph.D, Director of Dissertation



Pitt Derryberry, Ph.D



Daniel McBride, Ph.D



Cheryl Wolf, Ph.D


Dean, Graduate Studies and Research Date

Table of Contents

Chapter One: Introduction	1
History of Suicide Prevention Crisis Lines	1
Workforce	4
Burnout, Secondary Traumatic Stress and Compassion Satisfaction	5
Self-Care	10
Limitations of Existing Research	12
Purpose of the Study	12
Chapter II: Methods	15
Participants and Design	15
Measures	16
Demographics	16
Burnout, Secondary Traumatic Stress and Compassion Satisfaction	16
Self-Care	17
Self-Care Embedment	18
Procedure	18
Chapter III: Results	20
Preliminary Analysis:	20
Hypothesis Testing	21
Chapter IV: Discussion	26
Clinical Implications	28

Other Implications	28
Strengths and Limitations	28
Future Research	30
Conclusion	31
References	32
Appendix A: Demographic Questionnaire	38
Appendix B: Professional Quality of Life Scale (ProQOL)	40
Appendix C: Self-Care Awareness Worksheet (SCAW)	44
Appendix D: Self-Care Questionnaire (SCQ)	49
Appendix E: IRB Approval	52
Appendix F: Email sent to NASCOD Listserv	54
Appendix G: Implied Consent Document	56

List of Tables

Table 1: Descriptive Statistics SCQ, SCAW, ProQOL factors CS, BO, STS17

Table 2: Correlations among Variables18

Table 3: Regression Equation with Self-Care Participation and Self-Care
Embedment.....18

Table 4: Regression Equation with Compassion Satisfaction and Burnout19

Table 5: Regression Equation with Compassion Satisfaction and Secondary Traumatic
Stress20

Table 6: Regression Equation with Compassion Satisfaction and Self-Care
Participation21

THE ROLE OF SELF-CARE AS IT PERTAINS TO COMPASSION SATISFACTION,
BURNOUT, AND SECONDARY TRAUMATIC STRESS AMONG SUICIDE
PREVENTION CRISIS HOTLINE STAFF

Crystal T. Henson

August 2018

Pages 57

Directed by: Frederick G. Grieve, Pitt Derryberry, Cheryl Wolf, Daniel McBride

Department of Psychology

Western Kentucky University

The present study was designed to explore the role of an agency/supervisor to increase self-care participation among suicide prevention crisis hotline staff. The impact self-care participation was found to increase compassion satisfaction while decreasing both burnout and secondary traumatic stress in this population of helpers. Self-care is meant to be a preventative measure to help increase an individual's overall well-being and can also impact job satisfaction. As helpers, self-care is often recommended to those individuals with whom they are working; however, helpers have historically not followed their own recommendations. Research has shown that those helpers with higher levels of compassion satisfaction are able to identify the positive aspects of helping and combat the negative aspects, such as burnout and secondary traumatic stress.

This study had three hypotheses. The first hypothesis was that those agencies that embedded self-care into their training, supervision, and daily operations would have staff with higher levels of self-care participation. The second hypothesis was that those staff with higher levels of compassion satisfaction would have lower levels of burnout and secondary traumatic stress. The third hypothesis was that those staff who had higher frequencies of self-care engagement would have higher scores of compassion satisfaction.

One hundred and sixty-two participants completed a demographics survey, the Professional Quality of Life Scale (PROQOL), the Self-Care Awareness Worksheet, and the Self-Care Questionnaire. A correlation and a simple regression equation were completed for each hypothesis. Results indicated that self-care embedment significantly predicted engagement in self-care participation. It was also found that higher scores of compassion satisfaction resulted in lower scores of both burnout and secondary traumatic stress. It was also found that a higher frequency of self-care participation resulted in higher scores of compassion satisfaction.

The results of this study imply that supervisors and agencies can impact the amount of self-care their staff participate in, potentially resulting in staff who have higher levels of compassion satisfaction and lower levels of burnout or secondary traumatic stress.

Chapter One: Introduction

As the 10th leading cause of death among all Americans ages 10 to 64, suicide has become an important public health issue in the United States (National Center for Injury Prevention, 2015). Every year more than 41,000 Americans die by suicide. However, death by suicide is only part of the problem. Many more people attempt suicide, or live with daily thoughts of suicide, than actually die by suicide. According to the Centers for Disease Control and Prevention (CDC), in 2015 more than one million adults self-reported a suicide attempt and over nine million adults reported having thoughts of suicide (National Center for Injury Prevention, 2015). Some of those individuals who are experiencing thoughts of suicide reach out to suicide prevention crisis hotlines for assistance. Across the country, there are hundreds of crisis centers that answer the calls/chats/text messages of individuals who are experiencing suicidal ideation. Each individual presents with his or her own story and a varying degree of suicidality. Each staff member presents with his or her own ability to respond and assist the individual in crisis.

History of Suicide Prevention Crisis Lines

Suicide prevention centers have been in existence in the United States for over 50 years (Bridgewater, 1964). The first suicide prevention center was opened in Los Angeles, California in 1958. The Los Angeles Suicide Prevention Center (LASPC) opened under the direction of Dr. Edwin Shneidman, Dr. Norman Farberow, and Dr. Robert Litman. The LASPC was funded through the National Institute of Health (NIH) and provided research in the area of suicidology, training in suicidology, and education to the public about suicide and suicide prevention. Dr. Shneidman and Dr. Norman began

their work by analyzing suicide notes left behind by veterans, in hopes of identifying how suicidal behavior could be prevented. It was their belief that the pre-suicidal individuals could be assisted before they presented to a hospital. With that theory, the LASPC started the first suicide prevention crisis hotline (Bridgewater, 1964).

This led to crisis hotlines opening up across the country (American Association of Suicidology, 2016). Many of these hotlines were created by small faith-based communities and several nonprofit agencies. As Dr. Shneidman performed more research and was appointed the co-director of The Center for Suicide Prevention at the NIH, he believed it was imperative to create a national organization that focused on research, practice, and education in suicidology (American Association of Suicidology, 2016). In 1968, he went on to found the American Association of Suicidology (AAS). The AAS not only created a place for centers to come together to network and learn from one another; but also provided a set of standards for crisis centers to meet to obtain certification. AAS created standards for both crisis centers and individual crisis workers. To date, over 1,000 individuals and over 250 organizations are currently members of the AAS (American Association of Suicidology, 2016).

In the 1970s, the National Institute of Mental Health (NIMH) established the Center for Studies of Suicide Prevention. This movement was continued forward in the 1980s when the Centers for Disease Control and Prevention (CDC) brought public attention to the increase in youth suicide rates, resulting in the formation of the Task Force on Youth Suicide (U.S. Department of Health and Human Services, 2012). By the mid-1990s, survivors of suicide loss had formed grassroots organizations and utilized strategies set forth by the United Nations to gain the attention of politicians. Suicide was

recognized as a national health problem in the United States. Organizations were able to establish public-private partnerships that would be responsible for promoting suicide prevention (U.S. Department of Health and Human Services, 2012).

With a new national focus on suicide prevention, the first national hopeline network was launched in 1999, 1-800-SUICIDE. This network was created to link crisis centers together and allows those in crisis an easy way to reach out for help in their area. The hopeline network was developed and funded by the Kristin Brooks Hope Center, a non-profit organization whose goal was to educate the community about suicide prevention (IMAlive, 2016). In 2001, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the first national crisis line, 1-800-273-TALK, now known as the National Suicide Prevention Lifeline. This network of certified crisis centers uses area codes to link each caller to the crisis center in the appropriate geographic area. The network consists of over 150 crisis centers in 49 states, and operates 24 hours a day, seven days a week. The Lifeline network has answered over five million crisis calls since it began (Draper, 2015).

The 2012 National Suicide Prevention Strategy published by the U.S. Surgeon General (U.S Department of Health and Human Services, 2012) recognized crisis hotlines as an integral part of suicide prevention. As technology has advanced, so has access to suicide prevention resources. Along with face to face interventions, many centers now offer online chat or text messaging for individuals in crisis as well as telephonic services. Additionally, some centers provide follow-up calls for those who are deemed during hotline calls to be at high risk for a suicidal crisis, or for those who have recently been assessed by a mobile crisis team.

Workforce

At their inception, crisis lines utilized nonprofessional volunteer staff from the community. Not only did this provide a cost-effective workforce, but also it allowed clinicians to dedicate more time to research and to work with the clients who presented to the center in need of face-to-face crisis intervention. As the number of crisis centers grew, it was necessary to hire more professional staff to train, supervise, and support these volunteers. Centers were able to secure more funding from both private and government sources to provide services 24 hours a day, seven days a week, 365 days a year. As more funding was available, crisis centers began hiring a larger number of professional staff. Current crisis lines still use a variety of workforce individuals ranging from volunteers to master's or doctoral level clinicians (Lester, 2002).

The newest movement in suicide prevention is the use of those individuals with “lived experience” (National Action Alliance, 2014). These are individuals who have previously attempted suicide and/or struggled with suicidal ideation, who use their experience to help others to prevent a suicidal crisis. It was only as recently as 2012 that the lived experience movement grew in regard to suicide prevention. Groups of those with lived experience were a spinoff of the groups created by suicide loss survivors. It was recognized that those individuals who had previously struggled with suicidality, could help identify more ways to target both suicide prevention and intervention. In 2014, the AAS established their lived experience division and the National Alliance for Suicide Prevention developed their Suicide Attempt Survivors Task Force (National Action Alliance, 2014).

Crisis hotline staff are in a unique situation in that they are dealing with individuals in crisis but are unable to see these individuals and often are unsure if they made a difference for the caller. In the most extreme calls, the staff may be on the line with a caller when a suicide attempt is made or a death by suicide occurs (Stamm, 2012). These staff are available to provide immediate support, assist in problem solving and the use of coping skills, facilitate referrals or interventions from community resources, and assist in safety plan development all via telephone/text/or on-line chat to individuals who are in need of assistance (Suicide Prevention Resource Center, 2016). However, their impact can be limited by poor telephone service, technology issues, a high volume of calls with inadequate staffing, and the inability to respond quickly to a suicidal caller who is not easily located by crisis center staff or the police.

Burnout, Secondary Traumatic Stress, and Compassion Satisfaction

In the past 10 years, research regarding the results of helpers being exposed to others' trauma has shown there can be both positive and negative aspects of helping. The combination of the positive and negative aspects of helping is known as professional quality of life and is composed of both compassion satisfaction (the positive aspects of helping) and compassion fatigue (the negative aspects of helping; Stamm, 2012). Research has shown that helpers of all types are at risk for negative consequences after being repeatedly exposed to stressful events. This includes both being involved on the front line of the crisis or dealing with the aftermath of a crisis (DePanfilis, 2006; MacRitchie & Leibowitz, 2010; McKim & Smith-Adock, 2013; Sodeke-Gregson, Hottum, & Billings, 2013; Thieleman & Cacciatore, 2014).

Compassion fatigue is stress that is caused due to working with others who have experienced trauma and results in negative cognitive, emotional, and behavioral effects for the helper. It is considered one of the negative aspects of helping others and consists of two parts: burnout and secondary traumatic stress (Stamm, 2010). Burnout is defined as a prolonged response to ongoing chronic interpersonal and emotional stressors on the job and typically has a gradual onset (Stamm, 2010). It is often associated with feelings of hopelessness, cynicism, exhaustion, and inadequacy (Maslach, Schaufeli, & Leiter, 2001; Stamm, 2010). Exhaustion can result in professionals disengaging both cognitively and emotionally from their work. When this occurs, the service provided to the client is impacted. Cynicism can present as depersonalization resulting in the professionals showing less empathy and becoming more jaded or apathetic towards those they are trying to help. Professionals may begin to doubt themselves and may question their competence (Maslach et al., 2001).

Many factors have been identified as contributing to burnout. These include caseload size, institutional stress, inability to keep clear boundaries with clients; unrealistic goals set by clinicians, lack of supervisory and social support, and human service work in general (Aguilera, 1998; Newell & MacNeil, 2010; Stamm, 1997). Burnout often leads to individuals leaving their job (DePanfilis, 2006; Wagaman, Geiger, Shockley, & Segal, 2015).

The second component of compassion fatigue is secondary traumatic stress (Stamm, 2010). Secondary traumatic stress, also known as vicarious trauma, is about work-related secondary exposure to traumatic or stressful events (Stamm, 2010). secondary traumatic stress is a result of feeling emotionally traumatized by hearing an

individual's firsthand experiences. It often has a sudden or rapid onset and may influence the way the professional sees the world. Professionals who develop secondary traumatic stress may experience some of the same symptoms as their clients including: nightmares, intrusive thoughts, anger, and irritability, (Joinson, 1992; Pearlman, 1995; Sadler-Gerhardt & Stevenson, 2012; Sodeke-Gregson et al, 2013). Individuals who have their own trauma history may be more vulnerable to developing secondary traumatic stress (Ray, Wong, White, & Heaslip, 2013; Sodeke-Gregson et al, 2013; Stamm, 2010).

Killian (2008) performed a multi-method study focusing on therapists' stress and their coping abilities when working with trauma survivors, resulting in the identification of factors related to resilience and burnout. The study was comprised of 104 therapists who worked with children who experienced sexual abuse and adult survivors of domestic violence. Data were gathered using both semi-structured interviews and self-report questionnaires regarding caseloads, work stress, coping styles, emotional self-awareness, compassion satisfaction, compassion fatigue, burnout, and trauma history. Results revealed that therapists identified job stress through bodily symptoms, sleep disturbances, mood change, increased distractibility, and difficulty concentrating.

This group identified key risk factors in the development of work stress and compassion fatigue including: high caseload demands, overworking, personal trauma history, poor or irregular access to supervision, lack of supportive work environment, social isolation, overabundance of optimism or cynicism, and poor self-awareness (Killian, 2008). Reported effective self-care strategies included processing with peers/supervisors, spirituality, exercise, and spending time with family. Social support was the most significant factor associated with higher scores of compassion satisfaction.

Other researchers described that the positive aspect of helping, compassion satisfaction, can provide resilience for the worker and can serve as a protective factor against the negative aspects of helping others. Larsen and Stamm (2008) define compassion satisfaction as the feeling of fulfillment that therapists derive from doing their work well. It is the feeling of gratification that one gets from helping others. Research has shown that those individuals who report higher levels of compassion satisfaction report lower levels of burnout and compassion fatigue (Ray et al., 2013; Stamm, 2010; Stamm, 2010; Thieleman & Cacciatore, 2014). Research conducted by Salloum, Kondrat, Johnco, and Olson (2015) showed a positive relationship between self-care and compassion satisfaction among child welfare workers. Goncher, Sherman, Barnett, Haskins & Roberts (2013) showed that emphasis placed on self-care practice among graduate trainees in clinical psychology during training resulted in a greater professional quality of life for the trainees.

Sprang, Clark, and Whitt-Woosley (2007) explored the relationship between compassion fatigue, compassion satisfaction and burnout in a group of 1121 mental health providers in a rural southern state. They found that females reported higher levels of compassion fatigue than their male counterparts. They also found that therapists with specialized training in trauma work reported higher levels of compassion satisfaction than those without specialized training. Caseloads that consisted of more clients diagnosed with Post Traumatic Stress Disorder (PTSD) resulted in clinicians reporting higher levels of compassion fatigue and lower levels of compassion satisfaction. Psychiatrists reported the highest levels of compassion fatigue in the population studied. It was hypothesized that this was likely due to the lack of resources in the rural area studied. Resulting in

psychiatrists having a much larger patient caseload and fewer other professionals available to help share the burden. They were also in positions that made them the primary person responsible for managing the high-risk situations, resulting in higher levels of job stress.

Sodeke-Gregson and colleagues (2013) determined that higher perceived levels of management support and supervisor support predicted lower risk of burnout and higher levels of compassion satisfaction. It was also noted that those therapists who had a personal trauma history were at higher risk of developing symptoms of secondary traumatic stress. They reported that, among 253 United Kingdom (UK) therapists working with adult trauma clients, 70% received scores on the Professional Quality of Life Scale indicating they were at a high risk of secondary traumatic stress. Those therapists who reported spending time pursuing research and development activities, having higher perceived management support, and utilizing supervision obtained scores that indicated lower levels of burnout and higher levels of compassion satisfaction. In this particular study, those therapists who were at the highest risk for secondary trauma were receiving the most individual supervision, engaging in the most self-care activities, and reported a personal trauma history. Maltzman (2011) reported that staff who identified feeling supported, validated, and valued by their direct supervisor felt better able to deal with their jobs and the demands of their jobs.

Stamm (2010) addressed the importance of the organizations that employ telephone crisis counselors recognizing and discussing with those employees the positive and negative consequences of the job they do. Stamm suggests the following as potential protective factors that can be implemented at an organizational level: 1) verify there is a

clear understanding of the role and expectations between both the employee and the organization; 2) develop and implement clear policies regarding boundaries and procedures; and 3) recognize and discuss the potential for both compassion satisfaction and compassion fatigue.

Self-care

Self-care is vital for individuals in the helping professions not only to be able to perform at their best but also to maintain their own psychological well-being. Self-care is defined as ongoing activities performed deliberately to stay emotionally and psychologically healthy (Malinowski, 2014; Sadler-Gerhardt & Stevenson, 2011). Unlike coping skills, which are used during stressful situations, self-care is the preventative measure used before the stress is felt. In his book, *Self-Care for the Mental Health Practitioner*, Malinowski (2014) divides self-care into three parts: knowledge and awareness of the job hazards and self-care principles, recognition that the vulnerabilities and hazards of the job should be taken seriously, and the constant awareness and practice of self-care. Even though self-care is recognized as important, therapists report that self-care is a neglected area in training both in school and the workforce (Killian, 2008). The American Counseling Association (2014) includes self-care in its code of ethics under professional responsibility to help ensure the best physical and emotional well-being of their counselors (2014).

Salloum and colleagues (2015) explored the role of trauma-informed self-care (TISC) on compassion satisfaction, burnout and secondary trauma among 104 child welfare workers and supervisors in a private child welfare organization in South Florida. Their results suggested that those workers who reported higher levels of self-care also

reported lower levels of burnout and higher levels of compassion satisfaction. There was no reported relationship with secondary trauma. In their study, self-care included such positive strategies as seeking supervision, receiving additional training on secondary trauma, utilizing a team, and balancing work and life.

Even though research suggests, and therapists agree, that the use of self-care is a viable way to combat burnout and compassion fatigue, many therapists do not engage in these activities on a regular basis (Barnett & Cooper, 2009; Sadler-Gerhardt & Stevenson, 2011). Bober and Regehr (2006) completed a self-report survey of 259 clinicians who worked with victims of violence. Their goal was to assess whether clinicians believed in the forms of prevention, whether they engaged in the activities, and whether engaging in the activities lead to lower levels of distress.

Leisure activity, self-care, and seeking out supervision were identified as areas that the clinicians believed were useful in the prevention of vicarious trauma. However, there was no significant association between believing in the benefits of these activities and time allotted for engagement in the activities, in all areas except supervision. Those clinicians who reported believing supervision was useful in the prevention of vicarious trauma were more likely to obtain supervision. This study found no significant relationship between the amounts of time spent engaging in these activities and reported levels of trauma symptoms (Bober & Regehr, 2006).

Barnett and Cooper (2009) stated that self-care should be an essential part of one's professional identity used to prevent burnout, impairment, or distress. They recommended that both self-care and signs of compassion fatigue should be a topic that is addressed in academic and career training programs and continued into postgraduate

training and supervision. It is also suggested that faculty and supervisors role model self-care behaviors for their students and supervisees.

Limitations of Existing Research

There is research to support a relationship between compassion satisfaction, burnout, and compassion fatigue (Sodeke-Gregson, Hottum, & Billings, 2013; Sprang, 2007; Stamm, 2012). However, there is limited research to show whether there is a relationship between self-care engagement and compassion satisfaction. The current research also presents recommendations that self-care and its importance be addressed in training and supervision (Goncher, Sherman, Barnett, Haskins, & Roberts, 2013; Stamm, 2012); however, outcomes of this implementation have not been located in current research. There is no identified research to explore what agencies can do to influence individuals' engagement in self-care.

Purpose of the Study

Research has shown that helping professionals who work with individuals who have experienced trauma are at risk for higher levels of burnout and compassion fatigue and report lower levels of compassion satisfaction (Killian, 2008). Those individuals who report a history of trauma are often at higher risk than their peers of developing burnout and compassion fatigue (Killian, 2008). Research has also shown that utilizing self-care can increase compassion satisfaction and reduce rates of burnout and compassion fatigue. Furthermore, research has suggested that self-care and its importance be addressed in training programs and throughout each phase of an individuals' career in order to promote participation in self-care activities (Goncher, Sherman, Barnett, Haskins, &

Roberts, 2013). However, many individuals neglect to allot time in their schedule for dedicated self-care.

The following study was designed to examine the role self-care plays on levels of compassion satisfaction, burnout, and secondary traumatic stress on suicide prevention crisis hotline staff when self-care is embedded into training, supervision, and daily operations.

Hypotheses. H₁: Staff who work in centers/agencies that have self-care embedded in their training, supervision, and daily operations will have higher levels of self-care participation. H₀: There is no difference in staff self-care participation in regard to embedment in training, supervision, and daily operations.

H₂: Those staff with higher scores of compassion satisfaction will have lower scores in burnout and secondary traumatic stress. H₀: There will be no difference between staff with higher scores of compassion satisfaction and lower levels of burnout and secondary traumatic stress.

H₃: Those staff who have higher frequency of self-care participation will have higher scores of compassion satisfaction. H₀: There will be no relationship between frequency of self-care participation and scores of compassion satisfaction.

Variables. The independent variable for H₁ is embedment of self-care into center/agency training, supervision, and daily operations. The dependent variable for H₁ is the amount of time staff spends participating in self-care activities. The independent variable for H₂ is compassion satisfaction score. The dependent variables for H₂ are burnout and secondary traumatic stress scores. The independent variable for H₃ is

frequency of self-care participation. The dependent variable for H₃ is compassion satisfaction score.

Chapter Two: Methods

Participants

Participants were 194 current staff of suicide prevention crisis hotlines whose agencies/centers were current members of the National Association of Crisis Directors (NASCOD). These individuals were selected to allow the broadest range of potential demographics from across the United States. This allowed for a variety of agencies/centers to participate and resulted in gaining information from all levels of staff, from volunteers to mental health professionals. Participants were recruited through a private listserv for crisis line directors and supervisors.

An a priori power analysis was conducted using G*Power 3.0. It showed that, with an effect size of .15, an alpha probability of .05, and three predictors, a sample size of 119 yields a power of .95.

Of the 194 participants, 162 completed surveys were used in the analysis. The discarded responses included 27 participants who did not complete any surveys beyond the demographics information and five participants who only completed the demographics survey and one additional measure. The mean age of participants was 33 years old, with a range of 19 to 79 ($SD = 11.84$) years. Participant ethnicity breakdown was as follows 110 (68%) Caucasian participants, 21 (13%) African American participants, nine (5%) Asian participants, nine (5%) Multi-racial participants, seven (4%) Hispanic participants, five (3%) participants who identified as "Other," and 1 (1%) Latino participant. Participants included 143 (88%) females, 16 (10%) males, and three (2%) participants that identified as "other." The level of education included 18 (11%) participants with some college education, 69 (43%) participants with a college degree,

and 74 (46%) participants with a graduate degree. Roles of participants included 34 (21%) volunteer staff, 81 (50%) direct care staff, 29 (18%) supervisory staff, and 17 (11%) staff who were considered upper management. The mean number of years working in mental health was 6.52, with a range of 0 to 46 ($SD = 8.62$) years.

Measures

Demographics. Participants were asked to complete a demographics survey and report their age, ethnicity, gender, education level, staff type (volunteer, direct care, supervisor, upper management), and years of experience in mental health. See Appendix A.

Burnout, Secondary Traumatic Stress and Compassion Satisfaction. To assess symptoms of burnout, secondary traumatic stress, and compassion satisfaction, participants completed the Professional Quality of Life Scale, Version 5, (ProQOL; Stamm, 2010). Respondents were asked to answer 30 questions about themselves and their current work situation in three subscales: Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Example questions include “I feel connected to others,” “I feel trapped by my job as a helper,” and “I feel depressed because of the traumatic experiences of the people I help.” The questions were answered on a five-point, Likert-type scale ranging from 1 (*Never*) to 5 (*Very Often*). Scores were obtained by first reverse scoring the identified items, summing the total for each subscale, and then converting the Z scores to t-scores with raw score mean of 50 and the raw score standard deviation of 10. Scores above 57 were considered high scores on all subscales. High scores on the Compassion Satisfaction subscale represented a greater satisfaction with the participant’s role as a helper. High scores on the Burnout subscale mean the participant was at high

risk for burnout. High scores on the Secondary Traumatic Stress subscale are meant to cause participants to examine how they feel about the work performed or the work environment to determine if further action needs to take place. The ProQOL has good internal consistency with a Cronbach's alpha of .88 for Compassion Satisfaction, .75 for Burnout, and .81 for Secondary Traumatic Stress (Stamm, 2010). See Appendix B.

Self-Care. The Self-Care Awareness Worksheet (SCAW; Saakvitne & Pearlman, 1996) was created to assess frequency of self-care participation. This measure was used in the current study to examine the participants' level of self-care participation. The SCAW is a self-report questionnaire that measures to what extent an individual engages in self-care activities. On the SCAW, self-care is divided into six subscales: physical, psychological, emotional, spiritual, work, and balance. Participants are asked to report the frequency of engagement for each activity. Answers are reported on a five-point Likert-type scale, and options include *Frequently*, *Occasionally*, *Rarely*, *Never*, and *It Never Occurred to Me*.

Each subscale focused on different areas of self-care: Physical Self-Care addresses nutrition and exercise; Psychological Self-Care addresses activities that enhance mental wellbeing; Emotional Self-Care addresses activities that involve self-understanding and connection with others; Spiritual Self-Care addresses activities that pertain to personal beliefs; Work or Professional Self-Care addresses activities that contribute to job satisfaction; and Balance addresses sense of stability in one's personal and professional roles. Examples for the subscale items include "eat healthy," "write in a journal," and "meditate."

High scores indicate higher levels of self-care participation (Saakvitne & Pearlman, 1996). The SCAW was used to determine overall involvement in self-care activities and does not provide psychometric indicators (Alkema, Linton, & Davies, 2008; Saakvitne & Pearlman, 1996). See Appendix C.

Self-Care Embedment

To determine the level of self-care embedment in training, supervision, and daily operations, eight questions were created for this study. This measure is the Self-Care Questionnaire (SCQ). These questions include: 1) Self-care and its importance were discussed during my center/agency job training; 2) My supervisor regularly encourages engagement in self-care activities; 3) My supervisor asks about my engagement in self-care activities; 4) I am encouraged to participate in daily self-care activities; 5) My supervisor actively practices self-care; 6) My agency/center promotes the engagement of self-care activities; 7) My agency/center has an area devoted to participating in self-care; and 8) I engage in self-care. Answers were reported on a five-point Likert-type scale, and options included *Strongly Disagree*, *Disagree*, *Neutral*, *Agree*, and *Strongly Agree*. See Appendix D.

Procedure. Once Institutional Review Board (IRB) permission was obtained (see Appendix E), an email was sent to the National Association of Crisis Organization Directors (NASCOD) listserv that contained an electronic link to the implied consent document (see Appendix F), demographic survey, ProQOL scale, SCQ, and SCAW. Participants completed the demographic survey first and the ProQOL, SCQ, and SCAW in random order to control for order effects. The entire procedure took 15 to 20 minutes to complete. Participants were not compensated. If any participants felt distress due to the

nature of the information gathered, they were encouraged to contact their supervisor to discuss resources. They were also given the contact information of the researcher in the event they chose not to reach out to their own supervisor.

Chapter Three: Results

Preliminary Analysis.

Burnout, Secondary Traumatic Stress, Compassion Satisfaction. The ProQOL was used to determine Burnout, Secondary Traumatic Stress, and Compassion Satisfaction scores. It was scored in three steps. The first step was to reverse identified items. The second step was to sum the items by subscale. The third was to convert the Z scores to t-scores. According to the ProQOL manual, for each respective factor a sum of scores equaling 42 or higher was considered to be a high level, a sum of scores between 41 and 23 was considered to be an average level, and a sum of scores 22 and less was considered a low level (Stamm, 2010). Internal consistencies were completed for each of the factors. Reliability scores (Cronbach's alpha) for the three factors of the ProQOL were as follows: Compassion Satisfaction = .90, Burnout = .66, Secondary Traumatic Stress = .78.

Self-Care. The SCAW was used to determine overall self-care participation. Scores were summed and divided by the total number of items to determine an overall self-care participation score. Reliability score for this measure resulted in a Cronbach's alpha = .93.

Self-Care Embedment. The SCQ was used to determine self-care embedment. Scores were summed and divided by the total number of items to determine an overall self-care embedment score. Reliability score for this measure resulted in a Cronbach's alpha = .85. The descriptive information for each factor and measure is included in Table 1.

Table 1

Descriptive Statistics SCQ, SCAW, ProQOL factors CS, BO, STS

	N	Minimum	Maximum	M	SD
SCQ	162	1.00	5.00	3.83	0.77
SCAW	161	2.55	4.72	3.80	0.41
CS	162	24.00	50.00	41.22	5.54
BO	162	12.00	36.00	23.52	4.62
STS	162	11.00	44.00	21.03	5.34

Note. SCQ = Self-Care Questionnaire, SCAW = Self-Care Awareness Worksheet, CS = Compassion Satisfaction, BO = Burnout, STS = Secondary Traumatic Stress

Hypothesis Testing

To determine if self-care embedment had any significant relationship on staff participation in self-care, a correlation was completed between self-care embedment and the reported level of self-care participation. Self-care embedment and staff participation in self-care were significantly correlated, $r = .29, p < .001$. Results are reported in Table 2. A linear regression analysis was calculated to test the hypothesis that increased self-care embedment in training and daily operations increases staff's participation in self-care. A significant regression equation was found, $R^2 = .09, F(1, 159) = 14.77, p < .001$. It was found that self-care embedment significantly predicted participation in self-care ($\beta = .29, p < .001$). The results are reported in Table 3.

Table 2

Correlations Among Variables

	SCE	SCP	CS	BO	STS
SCE		.29**	.25**	-.29**	-.11
SCP			.37**	-.44**	-.15
CS				-.52*	-.17**
BO					.55**
STS					

Note. SCE = Self-Care Embedment, SCP = Self-Care Participation, CS = Compassion Satisfaction, BO = Burnout, STS = Secondary Traumatic Stress * $p < .05$, ** $p < .01$

Table 3

Regression Equation with Self-Care Participation and Self-Care Embedment

<i>Predictor Variable</i>	<i>B</i>	<i>SE B</i>	<i>Beta</i>	<i>t</i>	<i>sig.</i>
SCE	.156	.041	.292	3.84	< .001
Overall <i>R</i>	.292				
Overall <i>R</i> ²	.085				
Adjusted <i>R</i> ²	.079				
Overall <i>F</i> (1, 159)	14.77				< .001

Note. SCE = Self-Care Embedment

To determine if compassion satisfaction scores had any significant relationship between burnout scores and secondary traumatic stress scores, first a correlation was completed among these variables. compassion satisfaction and burnout were significantly correlated,

$r = -.52, p < .01$. Results are reported in Table 2. compassion satisfaction and secondary traumatic stress were significantly correlated, $r = -.17, p < .05$. Results are reported in Table 2. Two separate linear regression analyses were calculated to test the hypothesis that increased compassion satisfaction resulted in a decrease in both burnout and secondary traumatic stress. A significant regression equation was found for compassion satisfaction and burnout, $R^2 = .52, F(1, 160) = 59.52, p < .001$. It was found that compassion satisfaction significantly predicted burnout ($\beta = -.521, p < .001$). Results reported in Table 4. A significant regression equation was found for compassion satisfaction and secondary traumatic stress, $R^2 = .03, F(1, 160) = 4.59, p < .03$. It was found that compassion satisfaction significantly predicted secondary traumatic stress ($\beta = .075, p < .03$). The results are reported in Table 5.

Table 4

Regression Equation with Compassion Satisfaction and Burnout

Predictor Variable	B	SE B	Beta	t	sig.
CS	-.434	.056	-.521	-7.715	< .001
Overall R	.521				
Overall R ²	.271				
Adjusted R ²	.267				
Overall F (1, 160)	59.52				< .001

Note: CS = Compassion Satisfaction

Table 5

Regression Equation with Compassion Satisfaction and Secondary Traumatic Stress

Predictor Variable	B	SE B	Beta	t	sig.
STS	-.161	.075	-.167	-2.142	.034
Overall R	.292				
Overall R ²	.085				
Adjusted R ²	.079				
Overall F (1, 160)	4.59				< .03

Note. STS = Secondary Traumatic Stress

To determine if the frequency of self-care participation had any impact on compassion satisfaction scores, first a correlation was completed among these variables. Self-care participation and compassion satisfaction were significantly correlated, $r = .38$, $p < .01$. Results are reported in Table 2. A significant regression equation was found for self-care participation and compassion satisfaction, $R^2 = .14$, $F(1, 159) = 25.21$, $p < .001$. It was found that self-care participation significantly predicted compassion satisfaction ($\beta = .370$, $p < .001$). The results are reported in Table 6.

Table 6

Regression Equation with Compassion Satisfaction and Self-Care Participation

Predictor Variable	B	SE B	Beta	t	sig.
SCP	4.967	.989	.370	5.021	< .001
Overall R	.370				
Overall R ²	.137				
Adjusted R ²	.131				
Overall F (1, 159)	25.21				< .001

Note. SCP = Self-Care Participation

Chapter Four: Discussion

The purpose of this study was to explore the role self-care plays on levels of compassion satisfaction, burnout, and secondary traumatic stress along with the impact embedding self-care into training, supervision, and daily operations has on frequency of self-care participation among suicide prevention crisis hotline staff. Previous research has shown that those individuals who have higher levels of compassion satisfaction have lower levels of burnout and secondary traumatic stress, resulting in higher job satisfaction. Self-care has also shown to impact an individual's ability to avoid burnout and secondary traumatic stress. However, this study looked specifically at suicide prevention crisis hotline staff, a population of clinicians who experience, on a daily basis, high stress situations. If supervisors are able to influence the amount of self-care in which their staff participate, it is possible that this can result in staff with higher levels of compassion satisfaction. Staff with higher levels of compassion satisfaction are at less risk of developing burnout and secondary traumatic stress, perhaps resulting in staff remaining in their positions longer and truly enjoying the work they do every day.

There were three hypotheses under study. Regarding hypothesis 1 staff who worked at centers/agencies that have self-care embedded in their training, supervision, and daily operations will have a higher frequency of self-care participation results of this study supported the hypothesis that self-care embedment significantly predicted staff's participation in self-care activities. Supervisors have the ability to impact their staff's participation in self-care by emphasizing its importance during training, while following up during supervision, and modeling self-care and encouraging self-care participation. This supports the results found by Goncher and colleagues (2013), where it was shown

that an emphasis on self-care practice among graduate trainees in clinical psychology during training resulted in greater professional quality of life for trainees.

Hypothesis 2, which stated that staff with higher scores of compassion satisfaction will have lower scores in burnout and secondary traumatic stress, was supported in that compassion satisfaction was found to significantly predict both burnout and secondary traumatic stress scores. This finding supports the previous research where it was shown that higher levels of compassion satisfaction resulted in lower levels of burnout and compassion fatigue (Ray et al., 2014; Stamm, 2010; Thieleman & Cacciatore, 2014). Those staff with higher compassion satisfaction scores are better able to manage the stress associated with their jobs as care providers and have a lower risk of developing burnout and secondary traumatic stress.

Hypothesis 3, which stated that staff who have higher frequency of self-care participation will have higher scores of compassion satisfaction, was supported in that those individuals with higher frequency of self-care engagement had higher compassion satisfaction scores. This finding supports the study completed by Salloum and colleagues (2015), where it was suggested that those workers who reported higher levels of self-care also reported lower levels of burnout and higher levels of compassion satisfaction. Staff who have higher levels of self-care participation resulted in higher compassion satisfaction scores, implying that self-care participation can impact compassion satisfaction scores, and encouraging staff to participate in self-care activities may result in happier, healthier staff who remain in their jobs longer and are better able to help their callers.

Clinical Implications

The findings of this study can be applied to both current and future suicide prevention crisis hotline staff. Agencies and supervisors may be able to influence the overall well-being of their staff by not only discussing self-care during training, but also having staff complete a self-care plan that can be reviewed in supervision and utilized by staff to help prevent burnout and secondary traumatic stress. Staff should also continue to be encouraged to engage in self-care throughout their shift, including debriefing with a supervisor after a particularly difficult or triggering call (Stamm, 2012). Supervisors who ask about, model, and encourage staff participation in self-care may be able to help increase the compassion satisfaction scores of their staff. The ProQOL can be utilized to help monitor compassion satisfaction, burnout, and secondary traumatic stress across time.

Other Implications

Prior to this research, the SCAW reported no psychometric indicators. The results of this study yielded a reliability score resulting in a Cronbach's alpha = .93. This supports the use of the SCAW as a way to measure a helpers level of self-care participation.

Strengths and Limitations

The current study has several strengths. This study looks specifically at suicide prevention crisis hotline staff. This is a population that is rarely examined outside of the community itself. As suicide prevention becomes a more mainstream topic, it is important to look specifically at the staff who are fielding these calls and providing interventions (Connor, Pitofsky, & Price, 2018; Miller, 2018). This will allow

supervisors, agencies, and individuals ways to further implement preventative measures to help combat both burnout and secondary traumatic stress.

Participants were recruited from around the United States, rather than recruiting from a specific geographic area. Including multiple centers/agencies allowed for the inclusion of a variety of different training and supervising techniques to be included in the research. It also allowed the inclusion of individuals who participate in different types of self-care and generalizes across the U.S.

As with any study, the current study has several limitations. Participants were recruited from agencies/centers that were part of NASCOD. This left several centers/agencies across the country unable to participate in this study if they were not NASCOD members. Also, given the number of staff who are members of NASCOD, only a small percentage of them participated in this study resulting in a low response rate. Also, due to the population being a small subset of helpers, it can be difficult to generalize these results to other groups.

A second limitation was the use of self-report measures. When using self-report data, the participants may answer randomly or answer in a way that they believe is socially desirable (Schwarz, 1999); however, a social desirability bias measure was not used to assess this. A third limitation was the measure used to assess level of self-care embedment. Despite eight questions being created for this scale, due to technical difficulties with Qualtracs, one question was left out of the analysis. The question was administered to the participants, however, no data for this question pulled for analysis. This question was question 2: My supervisor regularly encourages engagement in self-care activities. This resulted in only seven questions from the scale being included in

analysis. With the inclusion of seven questions, the reliability score for this measure resulted a Cronbach's alpha = .85. It was also important to note that, to date, no other scale has been developed to determine the level of self-care embedment in agency training, supervision, and daily operations.

An additional limitation includes none of the participants in this study had a low self-care participation score, low compassion satisfaction score, high burnout score, or high secondary traumatic stress score. It is possible that those staff who have lower self-care participation scores also had higher burnout and secondary traumatic stress scores, resulting in them choosing not to participate in the study. Alternatively, the crisis center staff and volunteers who remained in their jobs and participated in this study were those who were better at mediating their burnout and secondary traumatic stress through self-care whereas those with high levels of burnout and secondary traumatic stress left the job and were not available to participate in this study. Including current and past crisis center workers may have better assessed differences in the levels of compassion satisfaction, burnout, and secondary traumatic stress among those who stayed and those who left the jobs.

Future Research

Future studies should focus on the development of a specific measure to assess self-care embedment. The seven questions used for this study could be expanded to more specifically evaluate self-care embedment. This could include looking at qualitative data to determine the frequency of self-care embedment throughout training, supervision, and daily operations.

Future research may also focus on specifically targeting staff who have been identified as having a low compassion satisfaction score and high burnout or secondary traumatic stress scores to measure the impact self-care participation has on these factors which include past staff who left their jobs because of burnout and secondary traumatic stress. It may also be beneficial to create an instrument to prospectively assess self-care participation on compassion satisfaction, burnout, and secondary traumatic stress along with including a social desirability bias measure.

Conclusions

The current study found that self-care embedment in training, supervision, and daily operations can increase the frequency of self-care participation among suicide prevention crisis hotline staff. It was also found that those individuals who had higher levels of self-care participation had higher levels of compassion satisfaction.

Additionally, it was found those individuals with higher compassion satisfaction scores had lower scores of burnout and secondary traumatic stress. Results of this study provided new knowledge in regard to the embedment of self-care participation into training, supervision, and daily operations for suicide prevention crisis hotline staff. It also provides further evidence to support the importance of engaging in self-care participation to help clinicians avoid burnout and secondary traumatic stress.

References

- Aguilera, C. (1998). *Crisis intervention theory and methodology* (8th ed.). St. Louis, Missouri: Mosby, Inc.
- Alkema, K., Linton, J. M., & Davies, R. (2008). A Study of the Relationship Between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals. *Journal of Social Work in End-Of-Life & Palliative Care*, 4, 101-119. doi:10.1080/15524250802353934
- American Association of Suicidology. Retrieved from <http://www.suicidology.org/>
- American Counseling Association (2014). ACA Code of Ethics. Alexandria, VA: Author.
- Barnett, J. E., & Cooper, N. (2009). Creating a culture of self-care. *Clinical Psychology: Science & Practice*, 16, 16-20. doi:10.1111/j.1468-2850.2009.01138
- Bober, T., & Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6, 1-9.
doi: 10.1093/brief-treatment/mhj001
- Bridgewater, A. (1964). *A brief history of the suicide prevention center of Los Angeles 1950-1964*. (Unpublished doctoral dissertation)
<http://digitallibrary.usc.edu/cdm/ref/collection/p15799coll39/id/229158>
- Connor, A., Pitofsky, M., & Price, L. (2018, June 8). We're so extremely busy: More calling suicide prevention hotlines since celebrity deaths. *USA Today*. Retrieved June 13, 2018, from <https://www.usatoday.com/story/news/2018/06/08/anthony-bourdain-kate-spade-deaths-uptick-suicide-prevention-calls/684708002/>

- Depanfilis, D. (2006). Compassion fatigue, burnout, and compassion satisfaction: Implications for retention of workers. *Child Abuse & Neglect*, 30, 1067-1069.
doi:10.1016/j.chiabu.2006.08.002
- Draper, J. (2015, January 05). National Suicide Prevention Lifeline: The first ten years. Retrieved from <https://www.sprc.org/news/national-suicide-prevention-lifelinefirst-ten-years>
- Goncher, I. D., Sherman, M. F., Barnett, J. E., Haskins, D., & Roberts, M. C. (2013). Programmatic perceptions of self-care emphasis and quality of life among graduate trainees in clinical psychology: The mediational role of self-care utilization. *Training and Education in Professional Psychology*, 7, 53-60.
doi: 10.1037/a0031501
- IMAlive (2016). An online crisis network. Retrieved from <http://www.hopeline.com/>
- Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22, 116-122.
doi:10.1097/00152193-199204000-00035
- Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, 14, 32-44. doi: [10.1177/1534765608319083](https://doi.org/10.1177/1534765608319083)
- Larsen, D., & Stamm, B. H. (2008). Professional quality of life and trauma therapists. In S. Joseph & P. A. Linley (Eds.), *Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress* (pp. 275-293). Hoboken, NJ: John Wiley & Sons Inc.
- Lester, D. (2002). *Crisis intervention and counseling by telephone*. Springfield, Illinois: Charles C. Thomas Publisher, LTD.

- Malinowski, A. J. (2014). *Self-care for the mental health practitioner: The theory, research, and practice of preventing and addressing the occupational hazards of the profession*. Philadelphia, Pennsylvania: Jessica Kingsley Publishers.
- MacRitchie, V., & Leibowitz, S. (2010). Secondary traumatic stress, level of exposure, empathy and social support in trauma workers. *South African Journal of Psychology, 40*, 149-158. doi: 10.1177/008124631004000204
- Maltzman, S. (2011). An organizational self-care model: Practical suggestions for development and implementation. *The Counseling Psychologist, 39*, 303-319. doi: 10.1177/0011000010381790
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422. doi: 10.1146/annurev.psych.52.1.397
- McKim, L. L. & Smith-Adcock, S. (2013). Trauma counselors' quality of life. *International Journal of Advanced Counseling, 36*, 58-69. doi: 10.1007/s10447-013-9190-z
- Miller, H. (2018, February 05). Calls to National Suicide Prevention Live Tripled After Logic's Grammy Performance. Retrieved from https://www.huffingtonpost.com/entry/suicide-prevention-logic-grammys_us_5a772d87e4b06ee97af3bf08
- National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. (2014). *The way forward: Pathways to hope, recovery, and wellness with insights from lived experience*. Washington, DC: Author.

National Center for Injury Prevention and Control, Division of Violence Prevention, (2015). Suicide facts at a glance. Retrieved from

<http://www.cdc.gov/ViolencePrevention/pdf/Suicide-DataSheet-a.pdf>

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventative methods, for clinicians and researchers. *Best Practices in Mental Health, 6*, 57-68.

Pearlman, L. A. (1995). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (Ed.), *Secondary traumatic stress* (pp. 51-64). Baltimore, MD: Sidran Press.

Ray, S. L., Wong, S., White, D., & Heaslip, K. (2014). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology, 19*, 255-267.
doi: 10.1177/1534765612471144

Saakvitne, K. W. & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York, New York: W. W. Norton & Company Inc.

Sadler-Gerhardt, C. J. & Stevenson, D. L. (2012). When it all hits the fan: Helping counselors build resilience and avoid burnout. *VISTAS, 1*, 1-8.

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout, and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, 54-61.
[doi:10.1016/j.chilyouth.2014.12.023](https://doi.org/10.1016/j.chilyouth.2014.12.023)

- Schwarz, N. (1999). Self-reports: How the questions shape the answers. *American Psychologist*, 54, 93-105. doi:10.1037//0003-066x.54.2.93
- Sodeke-Gregson, E. A., Hotttum, S., & Billings, J. (2013). Compassion satisfaction, burnout, and secondary traumatic stress in UK therapists who work with adult trauma clients. *European Journal of Psychotraumatology*, 4. doi: [10.3402/ejpt.v4i0.21869](https://doi.org/10.3402/ejpt.v4i0.21869)
- Sprang, G., Clark, J. J., & Whitt-Woosley, A. (2007). Compassion fatigue, compassion satisfaction, and burnout: Factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259–280. doi: 10.1080/15325020701238093
- Stamm, B. H. (1997). Work-related secondary traumatic stress. *PTSD Research Quarterly*, 8, 1–3.
- Stamm, B. H. (2010). *The concise ProQOL manual*, (2nd Ed.) Pocatello, Idaho: ProQOL.org.
- Stamm, B. H. (2012). Helping the helpers: Compassion satisfaction and compassion fatigue in self-care, management, and policy of suicide prevention hotlines. *Resources for Community Suicide Prevention*, Pocatello, Idaho: Idaho State University.
- Suicide Prevention Resource Center (2015). A continuum of behavioral health crisis services. Retrieved from <http://www.sprc.org>
- Thieleman, K. & Cacciatore, J. (2014). Witness to suffering: Mindfulness and compassion fatigue among traumatic bereavement volunteers and professionals. *Social Work*, 59, 34-41. <https://doi.org/10.1093/sw/swt044>

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention (2012). 2012 *national strategy for suicide prevention: Goals and objectives for action*. Washington, DC.

Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*, 201-209. doi: 10.1093/sw/swv014

Appendix A
Demographics Survey

Demographics

Directions: please select/enter the answer that best describes you:

1. Age: _____

2. Race/Ethnicity:

Hispanic Asian African American
Caucasian
Latino Multi-Racial Other _____

3. Years working in Mental Health: _____

4. Which best describes your role:

Volunteer Direct Care Supervisor Upper Management

5. Level of Education:

High School Diploma Some College College Degree Graduate Degree

6. Gender:

Female Male Other

Appendix B

Professional Quality of Life Scale (ProQOL)

Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (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 helper. 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 helper.
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 helper.
11. Because of my helping, I have felt "on edge" about various things.
12. I like my work as a helper.

13. I feel depressed 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 helper.
20. I have happy thoughts and feelings about those I help and how I could help them.
21. I feel overwhelmed because my work 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 helper.
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.

© B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5(ProQOL)*. /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Appendix C

Self-Care Awareness Worksheet (SCAW)

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care.

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently 4 = Occasionally 3 = Rarely 2 = Never 1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)

___ Eat healthy

___ Exercise

___ Get regular medical care for prevention

___ Get medical care when needed

___ Take time off when needed

___ Get massages

___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun

___ Take time to be sexual—with yourself, with a partner

___ Get enough sleep

___ Wear clothes you like

___ Take vacations

___ Take day trips or mini-vacations

___ Make time away from telephones

Psychological Self-Care

- ___ Make time for self-reflection
- ___ Have your own personal psychotherapy
- ___ Write in a journal
- ___ Read literature that is unrelated to work
- ___ Do something at which you are not expert or in charge
- ___ Decrease stress in your life
- ___ Let others know different aspects of you
- ___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
- ___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
- ___ Practice receiving from others
- ___ Be curious
- ___ Say “no” to extra responsibilities sometimes

Emotional Self-Care

- ___ Spend time with others whose company you enjoy
- ___ Stay in contact with important people in your life
- ___ Give yourself affirmations, praise yourself
- ___ Love yourself
- ___ Re-read favorite books, re-view favorite movies

- ___ Identify comforting activities, objects, people, relationships, places and seek them out
- ___ Allow yourself to cry
- ___ Find things that make you laugh
- ___ Express your outrage in social action, letters and donations, marches, protests
- ___ Play with children

Spiritual Self-Care

- ___ Make time for reflection
- ___ Spend time with nature
- ___ Find a spiritual connection or community
- ___ Be open to inspiration
- ___ Cherish your optimism and hope
- ___ Be aware of nonmaterial aspects of life
- ___ Try at times not to be in charge or the expert
- ___ Be open to not knowing
- ___ Identify what is meaningful to you and notice its place in your life
- ___ Meditate
- ___ Pray
- ___ Sing
- ___ Spend time with children
- ___ Have experiences of awe

- ___ Contribute to causes in which you believe
- ___ Read inspirational literature (talks, music, etc.)

Workplace or Professional Self-Care

- ___ Take a break during the workday (e.g. lunch)
- ___ Take time to chat with co-workers
- ___ Make quiet time to complete tasks
- ___ Identify projects or tasks that are exciting and rewarding
- ___ Set limits with your clients and colleagues
- ___ Balance your caseload so that no one day or part of a day is “too much”
- ___ Arrange your work space so it is comfortable and comforting
- ___ Get regular supervision or consultation
- ___ Negotiate for your needs (benefits, pay raise)
- ___ Have a peer support group
- ___ Develop a non-trauma area of professional interest

Balance

- ___ Strive for balance within your work-life and workday
- ___ Strive for balance among work, family, relationships, play and rest

Source: Transforming the Pain: A Workbook on Vicarious Traumatization. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

Appendix D

Self-Care Questionnaire (SCQ)

Self-care Questionnaire

Please answer each question regarding your most recent experience.

1) Self-care was discussed during my job training.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

2) My supervisor regularly encourages engagement in self-care activities.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

3) My supervisor asks about my engagement in self-care activities.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

4) I am encouraged to participate in daily self-care activities.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

5) My supervisors actively practice self-care.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

6) My agency/center promotes the engagement of self-care activities.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

7) My agency/center has an area devoted to participating in self-care.

1	2	3	4	5
Strongly Disagree	Disagree		Neutral	Agree Strongly
Agree				

8) I engage in self-care:

1
Never

2
Rarely

3
Monthly

4
Weekly

5
Daily

Appendix E:
IRB Approval



*INSTITUTIONAL REVIEW BOARD
OFFICE OF RESEARCH INTEGRITY*

DATE: October 23, 2017

TO: Crystal Henson, MA
FROM: Western Kentucky University (WKU) IRB

PROJECT TITLE: [1142751-1] The Role of Self-Care as it Pertains to Burnout, Compassion Fatigue, and Compassion Satisfaction Among Suicide Prevention Crisis Hotline Workers

REFERENCE #: IRB 18-143
SUBMISSION TYPE: New Project

ACTION: APPROVED
APPROVAL DATE: October 23, 2017

REVIEW TYPE: Exempt from Full Board Review

Thank you for your submission of New Project materials for this project. The Western Kentucky University (WKU) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Exempt from Full Board Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by an *implied* consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this office prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Paul Mooney at (270) 745-2129 or irb@wku.edu. Please include your project title and reference number in all correspondence with this committee.

Appendix F

Email sent to NASCOD Listserv

Hello!

My name is Crystal Henson and I am a PsyD student at Western Kentucky University. I am currently working on my dissertation regarding self-care and suicide prevention crisis hotline staff. I am asking that you complete a quick survey (10-20 minutes) regarding your work experience and self-care engagement. Please feel free to forward this email to your staff if they are not currently on the NASCOD listserv. The survey can be accessed by following the link below.

Thank you in advance for your assistance, and thank you for the work you do saving lives everyday!

https://wku.co1.qualtrics.com/jfe/form/SV_50kTjP3bQZ2vdGJ

Crystal Henson, MA
Clinical Psychology Doctoral Candidate
Western Kentucky University

Appendix G
Implied Consent Document

IMPLIED CONSENT DOCUMENT

Project Title: The Role of Self-Care as it Pertains to Burnout, Compassion Fatigue, Secondary Traumatic Stress, and Compassion Satisfaction Among Suicide Prevention Crisis Hotline Staff

Investigator: Crystal Henson, MA

Faculty Advisor: Dr. Rick Grieve, Psychology Department, (270) 745-4417, rick.grieve@wku.edu

You are being asked to participate in a project conducted through Western Kentucky University. The University requires that you give agreement to participate in this project.

You must be 18 years old or older to participate in this research study.

The investigator will explain to you in detail the purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. You may ask any questions you have to help you understand the project. A basic explanation of the project is written below. Please read this explanation and discuss with the researcher any questions you may have. You are encouraged to keep a copy of this form for your records.

Nature and Purpose of the Project: The purpose of this study is to look at self-care and its impact on burnout, compassion fatigue, secondary traumatic stress, and compassion satisfaction among suicide prevention crisis hotline staff.

Explanation of Procedure: I am asking you to complete an online survey. This survey will take no more than 20 minutes.

Discomfort and Risks: There are no foreseeable risks associated with the research project and the probability and magnitude of harm or discomfort anticipated is minimal.

Benefits: The benefit of participating is the contribution to help identify the protective role self-care can have in a professional's overall wellbeing.

Confidentiality: The survey does not contain any identifiable information, anonymity is assured, and all data will be reported in aggregate.

Refusal/Withdrawal: Refusal to participate in this study will have no effect on any future services you may be entitled to from the University. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

Your continued cooperation with the following research implies your consent.

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT
THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY
THE WESTERN KENTUCKY UNIVERSITY INSTITUTIONAL REVIEW BOARD
Paul Mooney, Human Protections Administrator
TELEPHONE: (270) 745-2129