Compassion Satisfaction, Compassion Fatigue, Work Life Conditions, and Burnout Among Frontline Mental Health Care Professionals

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Abstract

Frontline mental health care professionals (FMHPs) in a variety of roles such as nursing, social work, psychology, psychiatry, case managers and mental health workers are often required to provide a high degree of care to clients over time which can result in physical and psychological complaints often referred to as compassion fatigue (CF). The aim of this nonexperimental, cross sectional study was to determine the relationships among compassion satisfaction (CS), compassion fatigue (CF), work life conditions and burnout among FMHPs. The Professional Quality of Life Revision IV (ProQOL), the Areas of Work Life Survey, Maslach Burnout Inventory-General Survey and a Demographic Data sheet were completed by 169 FMHPs. Consistent with our hypothesis, higher levels of compassion satisfaction, lower levels of compassion fatigue, and higher overall degree of fit in the six areas of work life were predictive of lower burnout in FMHPs.

Introduction

Frontline mental health care professionals (FMHPs) from a variety of different disciplines such as nursing, social work, psychology, psychiatry, case management, and mental health provide direct care to individuals with complex mental health needs requiring a high degree of supportive and long-term therapy. Over time, this degree of intensive involvement with clients may result in professionals experiencing nightmares, grief, anxiety (Clark & Gioro, 1998), depression, sleep disturbances, relational conflicts, and physical complaints often referred to as compassion fatigue (CF), vicarious traumatization, or secondary traumatic stress (STS) (Bride, 2004; Steed & Downing, 1998). Multiple terms are used in the literature to describe this construct, but for simplicity sake, the term CF will be used for this study. The financial costs to an organization of having staff that are experiencing CF include higher rates of physical illness, greater use of sick time (Austin, Goble, Leier, & Byrne, 2009; White, 2006), higher turnover rates (Austin et al., 2009; White, 2006), and lower morale and productivity, which are indicative of burnout (Stamm, Varra, Pearlman, & Giller, 2002; White, 2006). Being affected with a stress-related condition, such as CF or burnout, does not only affect the health care workers themselves but also anyone around them including patients who report lower satisfaction with services (Austin et al., 2009; Phelps, Lloyd, Creamer, & Forbes, 2009; White, 2006).

Definitions of Compassion Fatigue, Compassion Satisfaction, Burnout, and Areas of Work Life

The phrase *compassion fatigue* (CF) was first used by Joinson (1992) in reference to the experiences of nurses with burnout. Figley (2001) elaborated on the term with his description of the Compassion Stress/Fatigue Model. In most situations, the act of being compassionate—"bearing the suffering of others" (Figley, 2002, p. 1434)—has implications such as becoming preoccupied with traumatized patients, which may lead to CF. CF is defined as "a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders and persistent arousal associated with the patient" (Figley, 2002, p. 1435).

According to Phelps et al. (2009), compassion satisfaction (CS) refers to the positivity involved in caring and it is

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often gauged by the Compassion Fatigue and Satisfaction Test (Stamm, 2005). Simply put, CS involves "the ability to receive gratification from caregiving" (Simon, Pryce, Roff, & Klemmack, 2006, p. 6).

Burnout is defined as "a psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job" (Leiter & Maslach, 2004, p. 93). Burnout consists of three components, emotional exhaustion, cynicism, and personal efficacy. However, emotional exhaustion is considered the central element of burnout resulting in cynicism about one's work and low efficacy (Leiter, Harvie, & Frizzell, 1998; Leiter & Maslach, 2004; Maslach & Leiter, 1997).

Maslach and Leiter (1997) identified six areas of work life in which mismatches between the person's expectations and the job are considered to be predictive of burnout, whereas a match is believed to enhance work engagement. These six areas are defined as follows: *Workload* (job demands placed on an employee given a specified amount of time and resources), *Control* (opportunity for employees to make important decisions about their work, as well as their range of professional autonomy and ability to gain access to resources necessary to do their job effectively), *Rewards* (recognition for work contributions, i.e., financial, social, and/or internal), *Community* (quality of the social context in which one works, including relationships with managers, colleagues, and subordinates), *Fairness* (the extent that openness and respect are present in the organization and the decision-making process), and *Values* (represent the congruence between the organization's priorities and values and those of the employee).

Literature Review

Research studies on CF, CS, and Burnout

A selective review of the literature will address studies on CF, CS, and burnout with a focus on several studies that address the relationship between CF, CS, and burnout. A significant body of research has documented the prevalence of burnout among nurses (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Janssen, deJonge, & Bakker, 1999; Laschinger, Shamian, & Thompson, 2001; Leier & Maslach, 1988) and among mental health professionals including social workers, psychologists, case managers, and occupational therapists (Acker, 2011; Lasalvia et al., 2009; Leiter & Harvie, 1996; Paris & Hoge, 2010).

There is a limited amount of literature focusing on CF and even less literature that focuses on CS. Austin et al. (2009) found that nurses who considered themselves as having CF felt a difference in the way they performed their work; for example, they felt as though they were distancing themselves from their patients, which also resulted in pessimistic views toward positive change.

Abendroth and Flannery (2006) investigated the risk of CF among nurses working in a hospice setting as these nurses tend to encounter more patient deaths than nurses in other specialties. They found that 80% of their study sample was at moderate to high risk for CF.

Yoder (2010) studied nurses who described factors that triggered CF or burnout. The factors were organized into three categories: caring for patients, system problems, and personal issues. The second category of trigger situations, system issues, included high census, heavy patient assignments, high acuity, overtime, and extra work days.

The results of survey data collected from 280 Canadian mental health professions (certified clinical counselors, psychologists, psychiatrists, social workers, community agency counselors, and other individuals) who were identified as trauma therapists concluded that therapists with past personal histories of trauma who worked in community agencies with high caseloads of traumatized clients had increased levels of CF (Buchanan, Anderson, Uhlemann, & Horwitz, 2006).

There are several studies on the relationship between CF, CS, and burnout. In determining the association between CF, CS, and burnout with characteristics of the mental health professional, Sprang, Clark, and Whitt-Woosley (2007) concluded that female workers were more likely to exhibit CF and that specialized training in trauma generally increased levels of CS. These researchers also studied the association between the three variables and location. In comparison to mental health professionals in more urban areas, rural health care professionals had the highest likelihood of experiencing burnout. However, in terms of CF and CS, workers in urban, rural, and rural with urban influence areas showed no significant differences.

Craig and Sprang (2010) investigated the impact of using evidence-based practices on CF, burnout, and CS in a random, national sample of self-identified trauma specialists. Younger professionals reported higher levels of burnout and more experienced providers endorsed higher levels of CS. The utilization of evidence-based practices predicted statistically significant decreases in CF and burnout and increases in CS.

Alkema, Linton, and Davies (2008) studied how self-care, CF, burnout, and CS were linked in health care professionals from a variety of disciplines working in home hospice environments. Practices of self-care and aiding those in helping professions to find satisfaction and rewards in their work appeared to protect workers from burnout and CF and promoted CS.

Murray et al. (2009) studied the associations between STS and burnout, CF, and CS among nurses who care mostly for trauma patients. Three factors were shown to be predictive of burnout and CF: more hours/shift, medicinal use, and less established relationships with coworkers, whereas experience in trauma nursing, education, and age were shown not to be correlated with burnout or CF. STS, burnout, and CF were not found in participants with CS. Factors that appeared to be predictive of CS included having a lower education

level, meditation practices, and stronger social support and ties to coworkers. Nurses with CS appeared to not be affected by STS, burnout, or CF. This study highlighted the potential in social support in both alleviating work stress-related conditions and promoting CS for nurses who interact substantially with trauma patients. Based on a study by Collins and Long (2003), it was concluded that CF and burnout were not as likely in health care professionals of a trauma and recovery team demonstrating higher levels of CS.

Research Studies on CF, CS, and Burnout and Areas of Work life

The organizational and structural correlates of job-related stress have begun to receive attention (Bober & Regehr, 2006; Regehr & Cadell, 1999). Examples of organizational components include areas of work life, social support, and work environment (Bell, Kulkarni, & Dalton, 2003). There is limited research on CS, CF, and areas of work life. Most of the literature has focused on areas of work life and burnout.

Lee and Ashforth's (1996) meta-analysis of the correlates of burnout confirmed that supervisor and coworker support and peer-team cohesion are associated with lower burnout. Nurses representing various clinical hospital areas reported work life stressors related to "meeting patients' needs self-expectations, quantitative workload, and colleagues' inexperience" (Hall, 2004, p. 5). Oncology nurses in Brazil identified their five highest stressors as watching suffering and being unable to help, workload, equipment unavailability, lack of effort from leadership in problem situations, and the nurses themselves making errors (de Carvalho, Muller, & Bachion, 2005).

Lasalvia et al. (2009) explored the relative weight of job-related characteristics and perceived organizational factors in predicting burnout in staff working in community-based psychiatric services. Burnout was mostly predicted by a higher frequency of face-to-face interaction with users, longer tenure in mental health care, weak work group cohesion, and perceived unfairness.

Aiken et al. (2002) reported high levels of emotional exhaustion and greater job dissatisfaction in nurses with high patient-care workloads, and Janssen et al. (1999) found that emotional exhaustion or burnout is predicted primarily by a lack of social support and demanding work.

Laschinger, Leiter, Day, and Glin (2009) found that the most important predictors of work life dissatisfaction and low commitment in nurses included empowerment, supervisor incivility, and cynicism (a component of burnout). However, emotional exhaustion and cynicism (both components of burnout) and supervisor incivility were the most important indicators of turnover intentions (leaving the job position).

Leiter and Maslach (2004) examined the relationships among the six areas of work life and burnout using data from several databases ($N = 6,815$). The six areas of work life were all found to be significantly related to burnout but mismatch in workload, fairness, and control were most strongly related to emotional exhaustion. Cynicism had the strongest relationship with fairness and values. Finally, personal efficacy had the strongest relationship with control and values.

Maslach and Leiter's (2008) recent longitudinal research showed that scores on the six areas of work life can serve as early predictors of burnout. Within the nursing literature, several studies have demonstrated relationships between the person–job match in the six areas of work life and burnout in new graduate nurses, experienced acute care nurses (Cho, Laschinger, & Wong, 2006; Greco, Laschinger, & Wong, 2006) and mental and physical health through burnout in a sample of Ontario nurses (Laschinger & Finegan, 2005). Also, high turnover intentions through burnout were found in a sample of Canadian nurses from the Atlantic provinces (Leiter & Maslach, 2009). Laschinger and colleagues have found that empowerment was a significant predictor of overall person–job match in the six areas of work life in several studies (Cho et al., 2006; Laschinger, 2010; Laschinger, Wong & Greco, 2006).

In a study by Killian (2008), 20 frontline licensed social workers, psychologists, professional counselors, and marriage therapists identified several key risk factors in developing work stress and CF. The most frequently occurring are listed first: high caseload demands and/or workaholism, personal history of trauma, regular access to supervision, lack of a supportive work environment, lack of supportive social network, social isolation, worldview (overabundance of optimism, or cynicism, etc.), and the ability to recognize and meet one's own needs (i.e., self-awareness). In addition, Killian (2008) administered a questionnaire composed of instruments measuring social support, personal trauma history, affective coping style, and self-care strategies, burnout, emotional self-awareness, work environment stressors and resources, and work drain to 104 therapists comprising licensed social workers, psychologists, professional counselors, and marriage therapists. Level of reported social support from friends, family, and community was the most significant predictor of CS; working a greater number of hours per week with traumatized clients reduced levels of reported CS, and having a greater sense of control or efficacy at the workplace (being able to have a say about what happens at work, having one's own space to work, etc.) was associated with higher CS. Work drain, therapists' sense of powerlessness regarding other social welfare or judicial systems that are failing their clients, emotional self-awareness, and therapists' history of traumas were the most significant predictors of CF. The findings suggest that work life conditions play a role in both CS and CF.

CS can ameliorate the harmful effects of CF, burnout, and work life dissatisfaction. In a study addressing CF/STS of oncology social workers, CS was found to be inversely associated with CF and burnout (Simon et al., 2006). A stronger

association was found between CS and burnout, in comparison to CF/STS. As burnout increased, satisfaction with work decreased; however, job satisfaction had less of an impact on CF. Furthermore, a moderate association existed between burnout and CF/STS, suggesting that workers with CF/STS are at increased risk for developing burnout and job dissatisfaction. Devilly, Wright, and Varker (2009) found that stressors caused by the work environment were better indicators of CF and burnout for mental health care professionals than familiarity with patients' trauma.

In summary, there is an abundance of literature on burnout; less literature on CF and very little on CS. Few studies looked at the relationships among CS, CF, and burnout in health care environments. There were very few studies found on the relationships among CS, CF, burnout, and work life satisfaction. Those who studied CF postulated that the pleasure derived from work will mitigate the stress experienced in the work setting and help prevent CF and burnout. Based on the literature, it would appear that management of CF could decrease burnout and work life dissatisfaction. For example, in a health care environment, the negative components of CF, such as boredom, anxiety, loss of compassion, and discouragement could be reduced when administrators promote a work environment that increases the match between the person's expectations and the six areas of work life in order to enhance work engagement. Although the literature showed studies on workers from a variety of disciplines, including social workers, therapists, and general mental health professionals, the nursing discipline was more heavily weighted. In summary, more studies are needed that look at CS, CF, and burnout in a variety of different health care disciplines. In particular, studies are needed to explore the relationships among CS, CF, burnout and the six areas of work life satisfaction among FMHPs.

Theoretical Framework

The framework for this study was derived from the Professional Quality of Life (PQL) Model by Stamm (2009) and the Compassion Stress/Fatigue Model described by Figley (2001). The overall concept of PQL is complex because it is associated with characteristics of the work environment (organizational and task wise), the individual's personal characteristics, and the individual's exposure to primary and secondary trauma in the work setting. The elements of PQL include CS, CF, and burnout. Figley (2001) defined compassion stress as "the cumulative demands of experiencing and helping the suffering" and CF as "a state of exhaustion and dysfunction, biologically, physiologically, and emotionally, as a result of prolonged exposure to compassion stress" (p. 34). Work-related trauma has a distinctive aspect of fear associated with it. Although it is rarer than overall feelings of what we can call burnout, it is very powerful in its effect on a person. Eventually, the emotional and physical well-being of the care giving professional can
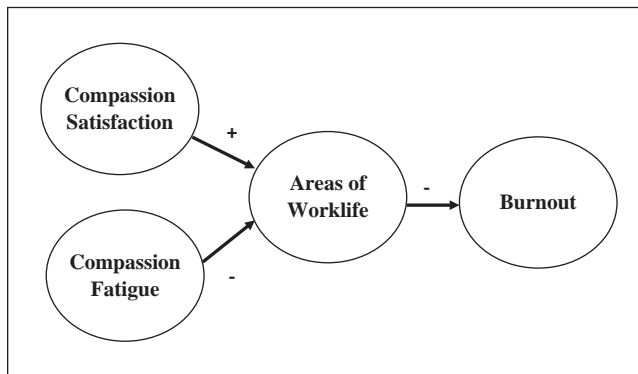

Figure 1. Hypothesized model.

be compromised leading to burnout. Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively (Stamm, 2009). These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a nonsupportive work environment. CS is the positive aspects of helping others and CF is the negative one. The work life environment and the client (or the person helped) all have a role to play. The overall degree of congruence between the person's expectations and their job in these six areas of work life influence the extent to which CF contributes to burnout (Maslach & Leiter, 1997).

Four factors that place mental health professionals working with mental health clients with trauma histories at higher risk for CF are (a) being empathetic, (b) having a history of traumatic experiences, (c) having unresolved trauma, and (d) assisting in events in which children are involved (Baird & Kracen, 2006; Figley, 2001; Simon et al., 2006). Factors that affect the severity of these symptoms include the duration of the experience; potential for recurrence; whether the worker was exposed to death, dying, or destruction; and the degree of moral conflict. Other contributing factors are "feelings of professional isolation, emotional drain from empathizing, long hours with few resources, unreciprocated giving and attentiveness, and failure to live up to one's own expectations for effecting positive change" (Figley, 2001, p. 11).

Hypothesis With Rationale

We hypothesized that higher levels of CS, lower levels of CF, and increased person–job match in the six areas of work life predict lower burnout (lower emotional exhaustion and lower cynicism) in mental health professionals (see Figure 1). Based on our theoretical framework and review of the literature, we reasoned that FMHPs who experience a higher degree of CS in their work would also experience more positive work environment or person–job match in the areas of work life, which would decrease job burnout (lower emotional exhaustion and cynicism). Those FMHPs

who experience higher CF in their work would perceive their work environment more negatively and encounter lower person–job match, which in turn contributes to greater job burnout (higher emotional exhaustion and cynicism).

Method

Study Design and Sample

A nonexperimental, predictive survey design was used for this study. A survey questionnaire was distributed by mail to a convenience sample of all 430 FMHPs selected from human resources staff lists at one community mental health site, one community mental health crisis site, and one mental health outpatient and one inpatient mental health unit at a hospital site in Southwestern Ontario. For the purpose of this study, FMHPs were defined as individuals whose primary role is to provide *direct client care either on a one to one and/or group* basis to individuals with mental health needs. In Southwestern Ontario, direct client care is provided in mental health services by a variety of disciplines including nursing (registered nurses [RN] and registered practical nurses [RPN]), allied health (including social work, psychology), case managers (from a variety of educational backgrounds), and mental health workers (from a variety of educational back grounds). Therefore, the above-mentioned disciplines were defined as FMHPs and both full-time and part-time employees were included.

Sample Size Calculation

To determine the appropriate sample size for this study, a power analysis was conducted. Based on an alpha of .05, a power level of .80, and four predictors (Faul, Erdfelder, Lang, & Buchner, 2007), the calculation revealed that 85 participants were required to detect a moderate effect size (.15).

Measures

CF and CS were measured using the Compassion Satisfaction (CS) and Compassion Fatigue/Secondary Traumatic Stress (CF/STS) subscales of the Professional Quality of Life (ProQOL)–Revision IV Questionnaire (Stamm, 2005). The ProQOL is a revised version of Figley's (1995) Compassion Fatigue Self-Test and is composed of three subscales. The first subscale, *CS*, is defined as the pleasure derived from being able to do one's work well. Higher scores on this subscale represent greater satisfaction with one's ability to be an effective caregiver. The *CF/STS* subscale measures work-related secondary exposure to extremely stressful events and higher scores represent greater CF/STS. *Burnout*, defined as feelings of hopelessness and difficulties in dealing with work, is the final subscale and was not used in this study. The ProQol is a 30-item self-report measure with 10 items per subscale. Using a 6-item Likert-type scale (0 = *never* to

5 = *very often*), respondents are asked to indicate how frequently each item was experienced in the previous 30 days. Scores on each subscale are obtained by summing the items. Cronbach's alpha reliability estimates for the subscales are reported as .87 for CS and .80 for CF/STS (Stamm, 2005). Stamm reported that a multitrait, multimethod approach to convergent and discriminant validity supports the discriminant validity of the ProQOL but factor validity studies have not been reported (Bride, Radey, & Figley, 2007).

The Areas of Work Life Scale (AWS) measures person–job match or congruence in six areas of work life: workload, control, reward, community, values, and fairness (Leiter & Maslach, 2000). This measure consists of 29 items measured on a 5-point Likert-type scale with ratings from 1 (*strongly disagree*) to 5 (*strongly agree*). Person–job match is reflected in a score >3.0, and a low score (<3.00) identifies a mismatch (Leiter & Maslach, 2004). In this study, a score was created to represent the overall degree of person–job match in the six areas of work life by summing the six subscale means of the AWS (possible score range of 6-30). The reported subscale reliability coefficients range from .70 to .95.

Burnout was measured by the Maslach Burnout Inventory–General Survey (MBI-GS) as it is the most frequently used measure of burnout (Schaufeli, Maslach, Leiter, & Jackson, 1996). The MBI-GS construes burnout as a three-dimensional construct that includes emotional exhaustion as the core dimension, depersonalization or cynicism (which refers to a detached attitude toward one's job), and reduced personal accomplishment or efficacy (feelings of lack of achievement or productivity at work. (Maslach, Jackson, & Leiter, 1996). The three subscales measure three dimensions of the burnout–engagement continuum: emotional exhaustion (5 items), cynicism (5 items), and personal efficacy (6 items). Items are framed as statements of job-related feelings, which are rated on a 6-point frequency scale ranging from 0 (*never*) to 6 (*every day*). Burnout is reflected in higher scores on exhaustion and cynicism and lower scores on personal efficacy. Cronbach's alpha reliability estimates for the subscales ranging from .77 (efficacy), .88 (cynicism), to .92 (exhaustion) have been previously reported (Maslach et al., 1996). The emotional exhaustion and cynicism subscales were used to measure burnout for testing the hypothesis as both are considered to be core elements of burnout (Leiter, Harvie, & Frizzell, 1998; Leiter & Maslach, 2004; Maslach & Leiter, 1997). Recent reports of conflicting findings of high personal efficacy associated with high burnout (Singh, Suar, & Leiter, 2012) and our limited sample size precluded using personal efficacy in the hypothesis testing regressions.

A 16-item demographic questionnaire was included to obtain information about the following: age, gender, position, type of employment, employment status, site of employment, number of assigned clients, years of experience in their profession (in mental health and in their current setting), highest level of education, amount of overtime, reason for missing work, history of trauma related to

Table 1. Demographic Characteristics (*N* = 169).

Variable	Raw count	Percentage	Variable	Raw count	Percentage
Gender			Amount of overtime		
Female	138	81.7	Increased	37	21.9
Male	31	18.3	Remained the same	54	32.0
Education			Decreased	12	7.1
High school	2	1.2	Not applicable	65	38.5
Diploma	71	42.0	Reason for missing work		
Bachelor degree	62	36.7	Physical illness	94	55.6
Masters	23	13.6	Injury (work related)	1	0.6
PhD	6	3.6	Family situation	13	7.7
Other	5	3.0	Mental health day	13	7.7
Position			Other	9	5.3
Nurse (RN/RPN)	69	40.8	More than one	12	7.1
Allied health	29	17.2	Never missed	27	16.0
Case manager	30	17.8	History of trauma		
Mental health worker	41	24.3	Yes	47	27.8
Site			No	119	70.4
Hospital inpatient	58	34.3	Childhood		
Hospital outpatient	39	23.1	Yes	29	17.2
Community crisis	24	14.2	No	134	79.3
Community	48	28.4	Accident		
Employment status			Yes	7	4.1
Full time	115	68.0	No	156	92.3
Part time	25	14.8	Work related		
Casual	28	16.6	Yes	12	7.1
Enrolment in educational program			No	151	89.4
Yes	22	13.0	Other		
No	147	87.0	Yes	16	9.5
Specialized trauma training			No	147	87.0
Yes	36	21.3			
	132	78.1			

childhood (physical abuse, sexual abuse, psychological abuse, emotional abuse, neglect), accidents (e.g., motor vehicle accident), work-related (e.g., falls), and some other form of trauma, specialized trauma training, and enrolment in educational program.

Data Collection and Analysis

A modified Dillman approach, with two questionnaire mailings was used (Dillman, 1991, 2007). Participants received a package that included a letter of information about the study, coded questionnaires, and a researcher-addressed, stamped envelope to return the completed questionnaires. A follow-up thank you card and a reminder letter were sent to all participants 2 weeks after the initial survey mailing. Two weeks after the reminder letters were mailed, a follow-up letter and replacement questionnaires with a return envelope were sent to nonrespondents. There was a 45% response rate for a sample of 195. Management (*n* = 9), clerical (*n* = 7), and other (*n* = 10) were excluded as their primary role was not the provision of *direct client care either on a one to one and/or group* basis to individuals with mental health needs.

Therefore, a final sample of 169 was analyzed. Coding was facilitated for the follow-up of participants who did not return the questionnaires.

Descriptive statistics and reliability estimates were computed for all study variables. Pearson correlations and hierarchical multiple regression were conducted to examine the hypothesis using the Statistical Package for Social Sciences (SPSS) version 16.0.

Results

Descriptive Results

Characteristics of the study respondents are described in Tables 1 to 3. Participants included 138 females (81.7%) and 31 males (18.3%), with an average age of 43.8 years (*SD* = 11.61). With regard to education level, the majority of respondents had either a diploma (42.0%) or a bachelor's degree (36.7%). The majority in these two groups included RNs educated at the bachelor's degree level and RPNs educated at the diploma level and social workers, mental health workers, and case managers educated at a bachelor's degree

Table 2. Frequencies and Percent Employment Status by Type of Position (*N* = 169).

Position	Full time, N (%)	Part time, N (%)	Casual, N (%)
Nurse (RN/RPN)	38 (55.9)	11 (16.2)	19 (27.9)
Allied health	23 (79.3)	3 (10.3)	3 (10.3)
Case manager	27 (90)	2 (6.7)	1 (3.3)
Mental health worker	27 (65.9)	9 (22.0)	5 (12.2)

Table 3. Means and Standard Deviations for Major Study Variables (*N* = 169).

	n	Mean	*SD*
Compassion Fatigue Subscales			
Compassion Satisfaction	169	36.92	6.25
Trauma/Compassion Fatigue	169	11.83	6.74
AWS Subscales			
Workload	169	3.18	0.73
Control	169	3.62	0.79
Reward	169	3.60	0.77
Community	169	3.78	0.69
Values	169	3.73	0.67
Fairness	169	3.42	0.88
AWS Total	169	21.33	3.34
MBI Subscales			
Emotional Exhaustion	166	2.27	1.31
Cynicism	166	1.72	1.33
Personal Efficacy	166	4.52	0.83
Demographic variables			
Age	158	43.80	11.61
Years in profession	167	17.23	11.45
Years in mental health	165	13.98	9.86
Years in current setting	165	6.67	7.02
Number of missed shifts	165	3.01	3.44
Number of assigned clients	146	14.30	16.10

Note. AWS = Areas of Work Life Scale; MBI = Maslach Burnout Inventory.

level. Other participants had varying levels of education: high school only (2, 1.2%), master's (23, 13.6%), PhD (6, 3.6%), and other (5, 3.0%). These groups included mental health workers educated at the high school level and case managers educated at a postsecondary school certificate level designated as other. The groups educated at the master's level included mainly social workers and psychologists, and those at the PhD level were psychologists. Only 22 (13.0%) participants reported that they were currently enrolled in an educational program, whereas 36 (21.3%) indicated that they have had specialized training in trauma. The most frequently held position was RN/ RPNs; (40.8%), and the remaining were divided among several health care professions: allied health (social work, psychology), case manager, and mental health worker. With regard to work experience, the mean length of years in the profession was 17.23 (*SD* = 11.45), with a mean of 13.98 (*SD* = 9.86) years in mental health and 6.67 (*SD* = 7.02) years in the current setting.

The place of work was almost an even spread across the four sites with inpatient and community agencies reporting the highest numbers of participants. Respondents were primarily full-time (68.0%). The remainder worked either part time (14.8%) or casual (16.6%). Part timers are guaranteed 2 to 3 days (8 hours/day) a week and casual workers are employed on average 1 day (8 or 12 hours/day) a week. Table 2 includes a breakdown of employment status by position.

Of the 60.0% participants who reported the amount of overtime work, 21.9% indicated it had increased in the past year, whereas 7.1% said that it had decreased. The average number of assigned clients was 14.30 (*SD* = 16.10). For the 78.8% of participants who reported missing work in the past year, the most commonly cited reason was physical illness (55.6%). Other reasons for absence from work were presented: family situation (7.7%), mental health day (7.7%), injury (0.6%), for more than one reason (7.1%), and other (5.3%), with the mean number of days missed being 3.01 (*SD* = 3.44). A total of 47 (27.8%) participants reported that they had a history of trauma, and when asked the type of trauma, 17.2% indicated the trauma was related to childhood, accidents (4.1%), work related (7.1%), and 9.5% indicated that they had experienced some other form of trauma.

The means and standard deviations for the major study variables are included in Table 3. Mean emotional exhaustion in this sample was 2.27 (*SD* = 1.31), which is lower than other samples of acute care nurses in studies by Laschinger

et al. (2006; *M* = 3.17, *SD* = 1.50) and Leiter and Maslach (2009; *M* = 2.65, *SD* = 1.47). However, mean burnout was higher (*M* = 1.96, *SD* = 1.25) than in a comparable sample of Italian mental health professionals (Lasalvia et al., 2009). Scores on the individual subscales of the AWS were higher (ranging from 3.18 to 3.78) than in Laschinger et al.'s sample (ranging from 2.73 to 3.57). Leiter and Maslach reported AWS subscale means were also lower, ranging from 2.77 to 3.47. The means for CS (*M* = 36.92, *SD* = 6.25) and CF (*M* = 11.83, *SD* = 6.74) were also similar to means reported in the Stamm (2005), 37 (*SD* = 7) for CS and 13 (*SD* = 6) for CF. A survey distributed to a random sample of licensed social workers and psychologists found similar means, 41.4 (*SD* = 6.62) for CS for those without special trauma training (Craig & Sprang, 2010). A survey of mental health providers in a rural southern state fared better than the participants in this study and the reported national norms in the ProQol manual (2005), 39.3(*SD* = 7.1) for CS and 10.64 (*SD* = 6.1) for CF (Sprang, Clark, & Whitt-Woosley, 2007).

Table 4 includes a correlation matrix presenting the correlations and Cronbach alphas of major study variables and their subscales. CS was significantly and positively associated with person–job matching in the six areas of work life (*r* = .52, *p* < .01) including all of the AWS subscales, whereas CF was negatively associated with person–job match in all but one (values) of the six areas of work life (*r* = −.34, *p* < .01). Both CS (*r* = −.52, *p* < .01) and CF (*r* = .59, *p* < .01) were

Table 4. Alphas for Scales and Subscales and Correlations Among Major Study Variables.

Variables	α	1	2	3	4	5	6	7	8	9	10	11	12
1. Tenure in Profession	—												
2. Compassion Satisfaction	.88	.12	—										
3. Compassion Fatigue	.85	−.06	−.23**	—									
4. Areas of Work Life:	.88	−.13	.52**	−.34**	—								
5. Workload	.74	−.07	.42**	−.45**	.61**	—							
6. Control	.70	−.11	.42**	−.19*	.77**	.40**	—						
7. Reward	.81	−.01	.54**	−.28**	.83**	.40**	.58**	—					
8. Community	.79	−.01	.40**	−.25**	.65**	.30**	.33**	.56**	—				
9. Values	.78	−.22**	.29**	−.05	.72**	.29**	.51**	.48**	.32**	—			
10. Fairness	.82	−.22**	.25**	−.26**	.81**	.32**	.53**	.63**	.41**	.62**	—		
Burnout:													
11. Emotional Exhaustion	.92	−.19*	−.52**	.59**	−.52**	−.70**	−.36**	−.38**	−.36**	−.19**	−.29**	—	
12. Cynicism	.89	−.07	−.70**	.39**	−.63**	−.47**	−.47**	−.60**	−.51**	−.35**	−.40**	.60**	—
13. Personal Efficacy	.81	−.03	.61**	−.21**	.52**	.37**	.45**	.51**	.37**	.32**	.28**	−.35**	−.53**

*Correlations are significant at the .05 level (2-tailed).
**Correlation is not significant at the .01 level (2-tailed).

Table 5. Coefficients for Final Model Hierarchical Multiple Linear Regression Analysis.

Variables	R^2	Adjusted R^2	B	β	t	p
Tenure in Profession	.036	.030	−.019	−.163	−2.943	.004
Compassion Satisfaction	.284	.275	−.056	−.271	−4.212	<.001
Compassion Fatigue	.503	.494	.083	.428	7.561	<.001
Areas of Work Life	.545	.534	−.101	−.253	−3.833	<.001

Note. Dependent Variable: Emotional Exhaustion (Maslach Burnout Inventory).

significantly associated with emotional exhaustion as well as cynicism (CS: $r = −.70$, $p < .01$; CF: $r = .39$, $p < .01$).

Hypothesis Test

Two separate hierarchical linear multiple regressions were used to test the hypothesis with emotional exhaustion and cynicism each as the dependent variable. Years of experience in respondents' respective professions was used as a control variable in the first regression because there was a significant negative correlation between years in the profession and emotional exhaustion (burnout). With emotional exhaustion (burnout) as the dependent variable, the independent variables were entered into the regression equation in separate blocks in the following order: years of experience in the profession, CS, and CF followed by areas of work life. In the final model (Table 5), the number of years in the profession accounted for 3.6% of the variance in emotional exhaustion (burnout; $R^2 = .036$, $F_{(1, 162)} = 6.105$, $p = .015$) and was also a significant predictor of emotional exhaustion (burnout; $β = −.163$, $t = −2.993$, $p = .004$). The addition of CS explained a further 24.8% of the variance ($R^2 = .284$, $F_{(2, 161)} = 31.952$, $p < .001$) and it was also a significant predictor ($β = −.271$, $t = −4.212$, $p < .001$) of emotional exhaustion (burnout). CF explained another 21.9% of

the variance ($R^2 = .494$, $F_{(3, 160)} = 53.961$, $p < .001$) and was a significant independent predictor ($β = .428$, $t = 7.561$, $p < .001$) of emotional exhaustion (burnout). The addition of areas of work life explained another 4.2% of the variance and was a significant independent predictor ($β = −.253$, $t = −3.833$, $p < .001$) of emotional exhaustion (burnout). Tenure in the profession, CS, CF, and overall person–job match in the areas of work life accounted for 54.5% of the variance in emotional exhaustion (burnout; $R^2 = .545$, $F_{(4, 159)} = 51.64$, $p < .001$). The combination of compassion satisfaction, compassion fatigue, and person–job match in the areas of work life explained 50.9% of the variance in emotional exhaustion (burnout). All were significant independent predictors of emotional exhaustion (burnout).

With cynicism as the dependent variable, variables were entered in the following order: CS, CF followed by areas of work life (Table 6). CS explained 48.6% of the variance ($R^2 = .486$, $F_{(1, 164)} = 155.018$, $p < .001$) and was a significant predictor ($β = −.491$, $t = −8.540$, $p < .001$) of cynicism (burnout). CF explained another 6.5% of the variance ($R^2 = .541$, $F_{(2, 163)} = 96.009$, $p < .001$) and was a significant independent predictor ($β = .171$, $t = 3.277$, $p < .001$) of cynicism (burnout). The addition of areas of work life explained another 7.0% of the variance and was also significant independent predictor ($β = −.320$, $t = −5.406$, $p < .001$) of cynicism

Table 6. Coefficients for Final Model Hierarchical Multiple Linear Regression Analysis.

Variables	R^2	Adjusted R^2	B	β	t	p
Compassion Satisfaction	.486	.483	−.104	−.491	−8.540	<.001
Compassion Fatigue	.541	.535	.034	.171	3.277	.001
Areas of Work Life	.611	.604	−.127	−.320	−5.406	<.001

Note. Dependent Variable: Cynicism (Maslach Burnout Inventory).

(burnout). CS, CF, and overall person–job match in the areas of work life accounted for 61.1% of the variance in cynicism (burnout; $R^2 = .611$, $F_{(3, 162)} = 51.64$, $p < .001$). All were significant independent predictors of cynicism (burnout). Therefore, our hypothesis was supported in that higher levels of CS, lower levels of CF, and higher overall person–job match in the six areas of work life were predictive of lower burnout (both lower emotional exhaustion and lower cynicism) in frontline mental health professionals.

Relationship of Demographic Variables to Major Study Variables

Significant differences were found in AWS and personal efficacy (PE, one of the three components of burnout) in terms of both position and site. There was a significant effect for position on the AWS, $F_{(3,163)} = 3.906$, $p = .003$. Post hoc comparisons using the Tukey HSD test indicated that the RN/RPN group ($M = 20.31$, $SD = 3.53$) rated AWS significantly ($p = .002$) lower than mental health workers ($M = 22.58$, $SD = 3.21$). There was also a significant effect for position on PE, $F_{(3, 160)} = 3.05$, $p = .022$. Similarly, the RN/RPNs ($M = 4.31$, $SD = 0.79$) rated PE significantly lower ($p = .019$) than mental health workers ($M = 4.78$, $SD = 0.83$). In terms of the worksite, there were also significant effects on AWS, $F_{(3, 166)} = 4.76$, $p = .003$, and PE, $F_{(3, 168)} = 3.05$, $p < .030$. Respondents at the inpatient hospital setting ($M = 20.33$, $SD = 3.13$) rated areas of work life significantly ($p = .003$) lower than the community mental health respondents ($M = 22.58$, $SD = 3.36$). Respondents at the inpatient hospital setting ($M = 4.29$, $SD = 0.84$) also rated PE significantly ($p = .02$) lower than the community mental health ($M = 4.78$, $SD = 0.86$) respondents. Although differences were not significant, $F_{(2,162)} = 2.622$, $p = .076$, full-time FMHPs reported the highest emotional exhaustion ($M = 2.39$, $SD = 1.31$) followed closely by part-time workers ($M = 2.21$, $SD = 1.42$); casual workers reported the lowest ($M = 1.76$, $SD = 1.04$).

Although, there was no significant difference in CF in those with or without a trauma history ($t = 1.74$, $df = 164$, $p = .085$), CF scores were higher ($M = 13.63$, $SD = 6.67$) in those with a trauma history than those without ($M = 11.36$, $SD = 6.74$). In addition, participants with a trauma history also reported higher emotional exhaustion ($M = 2.58$, $SD = 1.35$) than those without ($M = 2.16$, $SD = 1.29$) although this difference approached significance ($t = 1.88$, $df = 161$, $p = .06$). Interestingly, those with a trauma history also rated AWS

lower ($M = 20.60$, $SD = 3.60$) than those without a trauma history ($M = 21.59$, $SD = 3.20$) and this difference was not significant ($t = −1.71$, $df = 164$, $p = .09$). There were no significant differences in the major study variables by employment status, education, or gender. Age was negatively correlated with emotional exhaustion ($r = .22$, $p < .01$), and as stated earlier tenure in the profession was significantly and negatively associated with emotional exhaustion ($r^2 = −.19$, $p < .01$).

Discussion

This study provides some new insights in to how CS and CF are related to mental health professionals' work life and burnout. This is the first study linking CS and CF to overall person–job match in the six areas of work life for FMHPs. Our findings are similar to Killian (2008), who reported that work life conditions play a role in both CS and CF. Similar to findings of other studies, increased overall congruence in the six areas of work life predicted lower burnout (Lasalvia et al., 2009; Laschinger et al., 2006; Leiter & Maslach, 2004; Leiter & Maslach, 2009). Specifically, we found that higher levels of CS, lower levels of CF, and increased person–job match in the six areas of work life predicted lower burnout in FMHPs, supporting our hypothesis. These findings support some of the elements of our theoretical framework linking CS and CF with emotional exhaustion (burnout) as well as the connection of person–job congruence in the areas of work life to these concepts.

Professionals With Histories of Trauma

Both personal and situational factors in the work place influence the development of burnout among frontline staff nurses (Laschinger & Finegan, 2005). For example, risk factors for burnout included having recently had a personal loss for medical reasons in oncology social workers (Simon et al., 2006). Moreover, the beliefs of therapists (e.g., "There is a solution to every client's problem") toward the general therapeutic procedure was identified as predictive of whether or not a worker was susceptible to CF and burnout (McLean, Wade, & Encel, 2003). In fact, McLean et al. (2003) suggested that therapist beliefs affected the development of burnout and CF more so than situational variables, such as the main type of client to which they interact. Participants in their study included psychologists, social workers, and mental health workers from other areas (e.g., nursing).

Despite the fact that there was no significant difference in CF in those with or without a trauma history, CF scores were higher in those with a trauma history than those without. Participants with a trauma history also reported higher emotional exhaustion and rated AWS lower than those without a trauma history. The findings suggest that with larger samples, these differences might be significant. These findings suggest that professionals with histories of trauma may need additional support or supervision to prevent and/or address CF since high CF scores contributed to higher emotional exhaustion. Professionals with histories of trauma may identify more with their clients who have histories of trauma, which, in turn, may increase their risk for CF. Additional support or supervision may reduce or prevent this risk. This finding connects closely to the existing research. For example, through their meta-analysis, Baird and Kracen (2006) have identified three factors—personal trauma history, perceived coping style, and supervision experiences—as being influential in the development of CF.

Areas of Work Life and Setting

The current study also highlights the special need to address work life satisfaction with RN/RPNs, especially those working in inpatient areas. Previous research has shown that factors such as empowerment, supervisor incivility, and cynicism were important predictors of job satisfaction and commitment in nurses (Laschinger et al., 2009). Additionally, nurses new to the profession, working long hours, and not having the best relationships with their supervisors, as well as those with financial problems, poor self-perceived health, and problems beyond their work life, are more likely to experience burnout (Ilhan, Durukan, Taner, Maral, & Bumin, 2008).

Type of Position

Although differences were not significant, full-time FMHPs reported the highest emotional exhaustion followed closely by part-time workers; casual workers reported the lowest. These findings support previous research (Killian, 2008; Murray et al., 2009; Yoder, 2010) that found working more hours was predictive of CF or burnout. This is contrary to the findings by Benevides-Pereira and Das Neves Alves (2007) that 20 hours or less of work per week was considered predictive of depersonalization, a component of the Maslach Burnout Inventory in health care professionals (i.e., physicians, psychologists, and nurses) working with individuals with HIV.

As indicated in this study, further attention is needed to address CF among FMHPs holding less tenure in their profession. This study supports previous research as level of work experience, in psychiatric nursing, for example (Lauvrud, Nonstad, & Palmstierna, 2009), can be a risk factor for CF. Furthermore, Ilhan et al. (2008) have suggested that nurses new to the profession are more likely to experience burnout. Burnout is also more likely in community psychiatric nurses than in public health nurses (Imai, Nakao, Tsuchiya, Kuroda,

& Katoh, 2004). The present study supported prior research demonstrating that risk factors for CF include decreased years of work experience (Lauvrud et al., 2009) and low levels of CS (Lauvrud et al., 2009).

Limitations

The results of the study are preliminary because of the cross-sectional design, which limits interpretations of causality to the evidence of covariation in the study variables and the foundational theoretical associations (Taris, 2000). Since the study used only self-report measures, common method variance cannot be ruled out; however, Doty and Glick (1998) documented that common method variance is rarely strong enough to invalidate findings. Because the sampling strategy included sampling all FMHPs in the respective organizations, representativeness is limiting generalizability to those organizations. In addition, inequality in sample size regarding gender could limit the interpretations of the findings. Longitudinal studies to test the hypothesized model with a random sample of FMHPs from a larger population of health care facilities are needed to clearly delineate the mechanisms of change and prediction for CF and burnout.

Implications for Practice

Two approaches exist for managing CF and burnout: examining it at an individual level and the less popular approach of examining it at a larger macro basis (Austin et al., 2009). Empirical studies have identified factors that could protect health care workers from work stress-related problems. A number of factors have been suggested to protect workers from burnout, including stronger relationships among colleagues (Abu-Bader, 2000), more supervision (Abu-Bader, 2000), more promotion opportunities (Abu-Bader, 2000), and greater awareness of workers' and colleagues' emotions, particularly of one's troubled conscience occurring when they feel unable to give the quality of care they would like to give (Glasberg, Eriksson, & Norberg, 2007). Other protective factors include high staff/patient ratio and emotional distance between staff and patients (Lauvrud et al., 2009).

In the present study, FMHPs with less tenure and full-time positions are at greater risk for burnout. Building supportive working relationships with more senior colleagues who can mentor and supervise them may reduce and/or prevent CF and burnout.

As concluded by Phelps et al. (2009), the existing literature on this topic is heavily weighted on the recognition of stress-related problems and risk factors in comparison, for example, to the number of studies outlining strategies for early identification of problems. One strategy from this study for early identification of problems could be person–job congruence in the six areas of work life with regard to enhancement of CS and prevention of CF and burnout. The recognition of the six areas of work life expands the range of

options for organizational intervention. Organizations may want to focus on each of the six areas of work life for incongruence between the person's expectations and the job. For example, FMHPS may be able to tolerate greater workload if they have control over their work and feel they are valued for their efforts. Interventions could therefore be aimed at the AWS areas of control and values that are associated with personal efficacy (one of the components of burnout). Interventions aimed at the other areas of work life could be developed to improve overall work life satisfaction.

Conclusion

This is the first study linking CF and CS to overall person–job match in the six areas of work life and burnout in FMHPs. In addition, this study found potential mechanisms linking different variables to be important in influencing the development of CF and burnout. Such factors include personal factors (e.g., history of trauma), work life satisfaction, the type of position held by the professional (e.g., inpatients, full-time vs. part-time), and years of work experience. These results confirm findings from previous research by Killian (2008), Lauvrud et al. (2009), and Murray et al. (2009). A longitudinal, randomized study is needed to test the hypothesized model to clearly delineate the mechanisms of change and prediction on how these variables interrelate and combine to predict burnout. By having a strong understanding of both risk and protective factors for stress-related conditions, it becomes possible to apply such knowledge in the development of interventions and strategies. More studies are required in the future that outline ways health care institutions can help their workers avoid developing stress-related risks, such as CF and burnout. In conclusion, it is important to investigate the mental health of FMHPs in order to develop strategies to mitigate factors that lead to CF and burnout. Ultimately improving the mental health of FMHPs will enhance the quality of care delivered to clients.

Declaration of Conflicting Interests

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