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**FACULTY OF GRADUATE AND
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The Costs and Benefits of Compassion for Ottawa's Frontline Shelter Workers

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The Costs and Benefits of Compassion for Ottawa's
Frontline Shelter Workers

Ann MacDonald

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Thesis presented to the Faculty of Human Sciences
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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
LIST OF TABLES.....	vi
ABSTRACT.....	vii
CHAPTER I: Literature Review.....	1
Caring for the Homeless.....	1
The Historical Background.....	1
The “Homeless” Defined.....	2
The Stress of Homelessness.....	2
The Stress of Human Service Work.....	3
Research Leading to Compassion Fatigue.....	4
The Exploratory Stage.....	4
The Empirical Stage.....	5
Situational Factors in Frontline Stress.....	5
Individual Factors in Frontline Stress.....	7
Secondary Traumatization.....	8
Post-Traumatic Stress Disorder.....	10
Compassion Fatigue.....	10
Expanding the Framework.....	12
Job Engagement.....	12
Compassion Satisfaction.....	12
Ameliorating Factors in Employee Stress Responses.....	13
Organizational.....	13

Group.....	15
Individual.....	15
Spirituality.....	17
Spirituality Defined.....	18
Religion Defined.....	18
Spirituality and Religion as Adaptive.....	19
Helping as Adaptive.....	20
Burnout as Spiritual Distress.....	21
A Holistic Conception of Spirituality.....	23
Spiritual Well-Being and Quality of Life.....	23
Hypotheses.....	25
CHAPTER II: Method.....	27
Purpose and Procedure.....	27
Instruments.....	27
Independent Variables.....	28
Observable Variables.....	28
Latent Variables.....	28
Dependant Variables.....	29
Data Analysis.....	31
Ethics Approval.....	33
CHAPTER III: Results.....	34
Preliminary Analysis.....	34
Hypothesis 1: Spirituality Measures and ProQOL Measures.....	37

Hypothesis II: Gender Differences with Spirituality and ProQOL Measures.....	43
Hypothesis III: Living Alone / With Others with Spirituality and ProQOL Measures.....	43
Hypothesis IV: Prior Traumatic Events with Spirituality and ProQOL Measures.....	44
Hypothesis V: Aggression with Spirituality and ProQOL Measures.....	46
CHAPTER IV: Discussion.....	49
Hypothesis I: Spirituality Measures and ProQOL Measures.....	50
Hypothesis II: Gender Differences with Spirituality and ProQOL Measures.....	53
Hypothesis III: Living Alone / With Others with Spirituality and ProQOL Measures.....	53
Hypothesis IV: Prior Traumatic Events with Spirituality and ProQOL Measures.....	54
Hypothesis V: Aggression with Spirituality and ProQOL Measures.....	55
Limitations of the Study and Further Directions.....	56
Conclusions.....	57
REFERENCES.....	60
APPENDIX A: Information and Consent.....	79
APPENDIX B: Questionnaire.....	80
APPENDIX C: Recruitment Poster.....	83
APPENDIX D: Observable Variable Template.....	84

LIST OF TABLES

1. Numeric and Percentage Frequencies
2. Regression Table for CF / Faith / Location / Age
3. Regression Table for CF / CommSpir / Location / Age
4. Regression Table for CF / Hope / Location / Physical
5. Regression Table for Burnout / Faith / Location / Age
6. Regression Table for CS / Faith / Location / Age
7. Regression Table for CS / Faith / Location / Gender
8. Regression Table for CS / Faith / Location / Birth
9. Regression Table for CS / Hope / Location / Living
10. Regression Table for CS / Hope / Location / Illness / Loss / Breakup / Accident / Other
11. Regression Table for CF / Hope / Location / Physical
12. Regression Table for Burnout / Hope / Location / Verbal
13. Regression Table for Burnout / Hope / Location / Physical

ABSTRACT

The purpose of this preliminary study is to assess levels of compassion fatigue, burnout, and compassion satisfaction in frontline shelter workers, with consideration of demographic and spiritual characteristics as possible ameliorating factors. The study participants are frontline workers in three emergency men's shelters in Ottawa. Research in related fields, particularly health care and mental health, indicates a prevalence of compassion fatigue and burnout among human service personnel, either as a result of direct exposure to acts of aggression (primary exposure) or as a result of working with persons in distress (secondary exposure). The Professional Quality Of Life Scale was used to assess the responses of frontline shelter workers on measures of compassion fatigue, burnout, and compassion satisfaction. The Spiritual Well-Being and Community Spirituality Scales were used to assess spirituality on the domains of faith, hope and love.

Chapter I

Literature Review

Caring for the Homeless

The historical background. Homelessness is a relatively new phenomenon in Canada. In the early 1980's, two parallel urban trends -deinstitutionalization and gentrification - left people outside the mainstream of society, without a sustainable livelihood or adequate housing. The result was an epidemic of homelessness (Rapley, 2003). At St. Brigid's Church in Ottawa, the number of people knocking on the rectory door had become overwhelming. Fr. Jack Heffernan, the parish priest at the time, sent out a plea for assistance. On February 7, 1983, a small band of volunteers gathered in the church basement to prepare and serve soup and sandwiches to hungry guests. The Shepherds of Good Hope Annual Report (2005) defines this event as "the inaugural moment" in a collective response that would, within eighteen months, become incorporated as the Shepherds of Good Hope. Ottawa's pressing requirement for emergency services was supplemented by Shepherds, a need that Salvation Army and Union Mission, the two older, established organizations, could no longer contain.

Over the next decade, grass roots confraternities sprang up across the continent to care for increasing numbers of homeless people. Ortiz (1995) described this new initiative as a departure from traditional organizations. With workforces comprised mainly of laypersons and volunteers, and a dependence on donated goods and services, these organizations became natural sites for delivering services, using innovative approaches to alleviate social ills. As simple soup kitchen operations evolved to include emergency shelters and support services networks, paid employment became a necessity,

and a new category of human service provider, the frontline shelter worker, was born. In the three Ottawa-based shelters being researched, Shepherds of Good Hope has 96 frontline workers, Salvation Army has 35, and The Ottawa Mission has 35.

The “homeless” defined. A 1997 Health Canada discussion paper defined the “homeless” as families, the working poor, people with disabilities or mental illness, seniors, youth and young individuals, who do not have sufficient funding to secure and maintain decent housing. In the US, the American National Coalition for the Homeless (2006) identified special populations of homeless people: veterans, HIV/AIDS victims, domestic-violence victims, substance abusers, and individuals with SPMI (severe and persistent mental illness); 39% are children under the age of 18 years; 41% are single men; 14% are single women.

The stress of homelessness. The lives of homeless people are rife with suffering and trauma. In the United States, Kressler et al. (1994) found that, compared with the general population, homeless men are at particular risk for physical assault and rape. Homeless women are at risk for physical assault, physical threats, witnessing a trauma event, sexual molestation, and rape. These results were corroborated by a New Zealand-based study (Buhrich, Hodder and Teesson, 2000) that found all homeless women and over 90 % of homeless men reported at least one event of trauma in their lives. Fifty-eight percent suffered serious physical assault. Half the women and 10% of the men reported that they had been raped. This study also found that among the factors that contribute to the high incidence of distress among the homeless are schizophrenia, alcohol and drug addiction, the activity of seeking-out illegal substances, cognitive impairment, physical frailty, and the fact that homeless people spend more time in public

spaces (Buhrich, et al., 2000). On the Canadian scene, a descriptive study of the homeless population in Ottawa, (Farrell, Aubry, Klodawsky, and Petty, 2000), found other sources of stress related to life events in the preceding year, including lack of employment, living conditions (eviction, inability to find housing, release from hospital or jail), loss of contact with family and friends, involvement with the legal system, and victimization (criminal, sexual, physical, emotional, and partner abuse). In an Ottawa study on the homeless terminally ill, Podymow, Turnbull and Coyle (2006) found a heavy burden of illness, with mental illness, or addiction to drugs or alcohol in 82% of the population. The mean age in this population was 49 years. In a follow-up study published by the Canadian Medical Association (Turnbull, Muckle, and Masters, 2007) it was observed that the addiction profile of homeless persons has shifted from the predominant use of alcohol, to the use of even more deleterious poly-substances (opiates, crack, and crystal methamphetamines). In recent years, advocates and homeless-shelter workers are reporting incidents of hate violence against homeless individuals. The National Coalition for the Homeless (June, 2006) reported 86 hate crimes in 22 American states and Porto Rico during the previous year. The ages of the victims ranged from 22 to 70 years. The actions perpetrated against them included being harassed, kicked, set on fire, and beaten to death.

The stress of human service work. Studies of human service personnel who work directly with clients in distress have found they are at risk of experiencing negative consequences as a result of their involvement. A Danish prospective study of different occupational groups in the human service field used the Copenhagen Burnout Inventory to find that high scores on emotional demands, work demands and role conflict, and low

scores on meaning of work were significantly associated with high levels of burnout (Borritz, et al. 2005). Maslach (2001) found that emotional exhaustion is the most obvious feature of burnout, while cynicism and diminished achievement are also part of the complex syndrome.

In the mental health field, McCann and Pearlman (1990) and Pearlman and Saakvitne (1995) described an inner transformation that comes about in therapists as a result of working with traumatized clients. Figley (1995) used the virtue of compassion, a universally espoused ideal, as the basis for developing a concept to describe those inner changes. “Compassion fatigue” describes the sudden debilitating dysfunction experienced as a result of working with clients who have experienced extreme distress. Compassion fatigue is often preceded by burnout.

Like those working in the health care and mental health fields, the frontline workers in shelters are emotionally engaged with those they serve. Concurrent with the physical actions of providing food, clothing, and shelter to those in need, they are involved in relationships that provide empathic communication and a sense of presence. In 2007, frontline workers in Ottawa provided 323, 612 bed-nights (Report Card). There are no studies on the effects of the frontline for shelter workers, but given the number of distressed individuals with whom they have contact, it is probable that they do experience burnout and compassion fatigue.

Research Leading to Compassion Fatigue

The exploratory stage. The effects of working with people in distress have been documented for thirty years. The field of traumatology describes the secondary stress experienced by workers who are involved with suffering clients. Freudenberg (1975)

recognized the relationship between the provider and recipient as integral to the job in care-giving and human service occupations, and developed the concept of “burnout” to describe the negative effects of that relationship. The pioneering phase of traumatology research was clinically rooted and qualitative. It culminated in the development of a Burnout Inventory (Maslach and Jackson, 1981) designed to assess the phenomenon on three core dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment

The empirical stage. In the 1980’s, influences from industry and organizational studies brought about a quantitative shift in traumatology research. Developmental models advanced in the 1990’s supported the notion that burnout is a prolonged response to chronic job stressors. The primary focus of outcome studies was situational factors: job demands, occupational characteristics, and the broader organizational and management context.

The new approaches provided traumatology with a scholarly basis, including research tools and research designs. Burnout came to be viewed as a form of occupational stress that occurred most prominently in the human services professions (Schaufeli and Enzmann, 1998). Maslach, Schaufeli and Leiter (2001) developed an inventory that measured burnout on the dimensions of job satisfaction, organizational commitment, and turnover.

A Swedish study of health care professionals showed that “cutting off” was a pervasive defense in the time preceding burnout (Ekstedt, 2005). In Denmark, another instrument, the Copenhagen Burnout Inventory, was developed to measure a wider range of psychosocial characteristics, including characteristics that are specific to working with

clients (Borritz, et al., 2003). This instrument differentiates between general exhaustion, exhaustion attributed to work, and exhaustion attributed to work with clients.

Situational factors in frontline stress. Other researchers found that situational factors had an influence on frontline stress. A literature review on stress and burnout in hospice volunteers (Glass and Hasting, 1992) identified a number of significant organizational stressors. These stressors were identified as role ambiguity, status ambiguity, stress related to the patient and family, and stress related to personal circumstances. The literature generally supports the belief that lack of support during occupational stress and trauma leads to psychological distress. Research on Florida hospice nurses found that an inability to debrief after a traumatic event diminished internal coping mechanisms (Abendroth, et al., 2006). In a study of the relationship between job stress and satisfaction in American correctional nurses (Flannagan, 2006), the areas of highest stress were identified as workload demands and lack of organizational support. A study on gender and employment as these relate to burnout, Kulik (2006) further elaborated the situational difficulties encountered in volunteer work from the standpoint of 1) the provider organization (lack of appreciation, waste of time, and ambiguity), and 2) the beneficiaries (clients' suffering, clients' demands, and helplessness). Kulik found that for men, there was a positive correlation between difficulties in relations with beneficiaries and burnout, while for women, there was a positive correlation between difficulties with the provider organization and burnout. On the basis of these findings, we are hypothesizing that men will display a higher incidence of compassion fatigue, while women will present with a higher incidence of burnout.

Individual factors in frontline stress. Researchers also recognized that individual factors influence the responses that lead to stress responses. Among these factors are demographic variables, personality traits, and work attitudes. A 2001 study on gender differences in PTSD after motor vehicle accidents found that women were at greater risk for re-experiencing specific symptoms: women were 4.7 times more likely than men to experience avoidance / numbing responses, and 3.8 times more likely to meet the overall arousal criterion (Fullerton, et al. 2001). A literature review of gender differences and responses to trauma, Tolin and Foa (2002) indicated that women are at greater risk of developing PTSD because of the different types of trauma they experience. For example, women are more likely to experience sexual assault. In a preliminary study of the role of trauma memory records and schemas in PTSD diagnosis and prognosis, Simmons and Granvold (2005) used a cognitive model to explain gender differences in the rate of PTSD diagnosis. Their research pointed to differences in the cognitive process. Female trauma survivors are more likely than their male counterparts to view the world as dangerous and are more likely to blame themselves for the trauma. Their negative schemas are consistent with an increased diagnosis of PTSD and a longer length of pathology for females. On the basis of this research, women appear to be more prone to compassion fatigue than men. In the present study, gender differences in response to stress in frontline shelter workers will be examined.

Semmer (1996) developed a personality profile of the stress-prone individual as one exhibiting low levels of hardiness, poor self-esteem, an external locus of control, and an avoidant coping style. Coping studies in the 90's also focused on individual factors in stress responses. Watson and Hubbard (1996) used the "Big Five" model of personality to

assess adaptational style as it relates to the five general personality traits: neuroticism, conscientiousness, extraversion, openness, and agreeableness. Using the same five factor model, Bakker, Van Der Zee, Lewig and Dollard (2006) found positive correlations between neuroticism and burnout, and extraversion and burnout, in counselors who cared for terminally ill patients. They also found that extraversion and agreeableness correlated positively with personal accomplishment, particularly when confronted with a multitude of stressful conditions. This result suggests that the individuals high in extraversion and low in neuroticism are suited to positions within the human service arena. Although outside the scope of the present study, a further implication of their research is the necessity of providing workers who are high in neuroticism and low in extraversion with the training needed to improve their coping skills and reduce their negative emotional responses to work-related stress.

Secondary Traumatization

Patrick (1987) identified the need for hospice staff and volunteers to monitor personal stress response styles, and to implement self-care plans to prevent burnout. By the 1990's, researchers had established that helpers exposed to accounts of extreme events in the lives of trauma survivors experience negative changes in their frame of reference. Figley and Nelson (1989) acknowledged that even professionals are not immune to secondary traumatization. They identified the sympathetic engagement essential to the therapeutic alliance as a potential pathway to secondary traumatic stress disorder for therapists. Stress transmitted secondarily seemed related to shifts in the perception of the helper. Figley defined secondary traumatic stress as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event

experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1995).

In a review of the literature on secondary traumatic stress, Beaton and Murphy (1995) reported that emergency responders and crisis workers absorb the traumatic stress of those they help. They discovered that exposure to trauma often correlates with high incidences of substance abuse and relationship conflicts. Among the psychological indicators of secondary traumatic stress are emotions such as horror, grief, and rage (Clark and Gioro, 1998), nightmares and flashbacks (Figley, 1995), insomnia and headaches (Herman, 1992; Figley, 1995), compulsive behaviors and addiction (Dutton and Rubenstein, 1995), and palpitations and hyper-vigilance (Clark and Gioro, 1998). Other reactions to distressed clients involve cognitive shifts that can result in a sense of helplessness or vulnerability by the worker, chronic suspicion of others, witness-guilt and victim-blaming (Herman, 1992; Dutton and Rubenstein, 1995).

Sometimes personal and professional relationships are affected. Workers may detach from their clients and from their families and colleagues, or they may over-identify with the client (Dutton and Rubenstein, 1995). Several researchers identified secondary traumatic stress as the presence of post-traumatic stress symptoms that are a result of the client’s experience, and an inevitable stress reaction (Pearlman and Saakvitne, 1995; Stamm, 1995). In a later review of the literature, Canfield (2005) reiterated the need for better coping strategies for therapists working with survivors of trauma. As trauma therapists go through the internal process of integrating clients’ stories into their own cognitive schemas, they often experience secondary traumatic stress reactions that negatively impact the treatment process and their own self-experience.

Post-Traumatic Stress Disorder

The American Psychiatric Association's Diagnostic Disorders Manual-DSM (1994) identified two possible ways that post-traumatic stress disorder (PTSD) occurs. Either, one is traumatized directly by being in harm's way, or one is traumatized indirectly or vicariously as a result of engagement with a trauma sufferer. The impact of trauma is described variously: "cumulative" impact refers to the greater impact experienced as a result of frequency of exposure; "additive" refers to the greater impact experienced as a result of exposure to different types of trauma; "summative" refers to the impact carried forward in time (inscribed in memory) as a result of the combination of events and prior impact (Herman, 1992).

Silverman et al. (2001) discovered that adult adversities (death of a child and other traumatic events) were significant predictors of PTSD. The researchers used a logistic regression procedure to do a preliminary exploration of the effects of prior trauma and loss on risk for psychiatric disorders in recently widowed people. Similarly, Zatzick, et al. (2004) used regression analysis to assess 269 injury survivors in two American trauma centers, and found that prior trauma, female gender and nonwhite ethnicity were predictive for high levels of posttraumatic stress.

Compassion Fatigue.

In 1995, Figley developed the concept compassion fatigue to illustrate the debilitating effects of exposure to traumatic material. He developed a scale to measure its symptoms, and described the workers' experience as a form of posttraumatic distress

disorder, manifested as intrusive (re-living the feelings, images and thoughts associated with an event), avoidant (forms of distraction or escape) and arousal (anticipatory, hyper-vigilant) symptoms. This form of vicarious traumatization is a result of being exposed to the traumatic events of others in the line of work (i.e. an emergency room, a disaster zone, etc.). Figley's construct represented a movement away from the pathological emphasis, to a model that identifies and treats stress responses as adaptive. Compassion fatigue differs from burnout in terms of abruptness of onset, and usually is a result of exposure to a client's distress. Burnout, by comparison, is gradual in onset, and is often a precursor to compassion fatigue.

In a study of compassion fatigue in health care professionals, Sabo (2006) described empathy as a double-edged sword. On the one hand, empathy is the essential ingredient in caring work; on the other, the act of caring renders the nurse or clinician vulnerable. In the action of healing the wounds of others, they themselves will be wounded. The term "compassion" describes the emotion whereby nurses enter the world of the client. Over time, compassion can exact an emotional toll, described as compassion fatigue. In the health care context, compassion fatigue refers to the emotional, physical, social, and spiritual exhaustion that overtakes a person, causing a pervasive and sudden decline in his or her ability and energy to feel and care for others (McHolm, 2006). The sufferer loses the ability to experience satisfaction and joy, personally or professionally.

Organizational variables were found to be positively correlated to compassion-fatigue risk. In a study of hospice nurses in Florida (Abendroth and Flannery, 2006), the investigators found that long work hours, high patient caseloads, shift work, and multiple deaths within a short period of time exacerbated the experience of compassion fatigue. As

with post traumatic stress disorder, a primary trauma in the history of the professional was found to be a confounding factor in the treatment of compassion fatigue. The Accelerated Recovery Program, developed at Florida State University's for professionals who are suffering the effects of compassion fatigue (Gentry, et al, 1997), had to incorporate an 'Assessment/Evaluation' session into the treatment protocol when it was discovered that unresolved primary traumatic stress in the life of the clinician significantly impacted the clinician's resiliency from compassion fatigue. The present study hypothesizes that higher incidence of prior traumatic events in the lives of frontline shelter workers will be predictive of higher scores on measures of compassion fatigue and burnout.

Expanding the Framework

Job engagement. Maslach and Leiter (1997) formulated a model that integrated both the individual and situational factors, and reframed burnout as an erosion of job engagement. Their model grouped the situational variables associated with the workplace into six major domains (workload, control, reward, community, fairness, and values) and identified the degree of match or mismatch between the person and his or her environment: the greater the mismatch, the greater the likelihood of burnout; the greater the match, the greater the likelihood of engagement with work. Job demands were related to burnout, while job resources were related to engagement. A further expansion on this concept by Schaufeli and Enzmann (1998) identified burnout and engagement as two prototypes of employee well-being. He operationalized engagement on vigor (high levels of energy), dedication (a strong involvement in one's work), and absorption (immersion).

Compassion satisfaction. Stamm (2002) argued that compassion is a necessary, though not sufficient ingredient in the relationship with the client, and that the symptom-focus in the Compassion Fatigue Scale inflated negative reporting. A phenomenological study in sexual abuse therapists found that many of them experienced positive changes in their beliefs and sense of identity (Steed and Downing, 1998). Stamm (2002) pointed out that many service providers who work with distressed people are doing well, and it is important to factor in the benefits of caring, as well as the costs. A combined sample of American trauma professionals, Canadian business volunteers, South African Red Cross volunteers and Internet respondents from countries of unknown origin, indicated that many caregivers in humanitarian settings do experience compassion fatigue, but they also experience positive benefits, and feel that their work is redemptive (Stamm, 2002). A Compassion Satisfaction Scale was developed by building in positive questions to parallel the negative questions of the original Compassion Fatigue Scale.

Ameliorating Factors in Employee Stress Responses

Researchers have been able to identify factors that seemingly protect frontline workers from the effects of the stresses encountered on the frontline. These factors fall into several broad categories: organizational, group, and individual.

Organizational. The values-expressive character of nonprofit organizations is a quality that distinguishes them from business and government organizations. A case study of a St. Vincent Paul village in San Diego, California (Packard, 2001) showed that awareness of and commitment to the organization's core values (compassion, respect, empathy, empowerment, and dignity) was significantly related to workers having positive views of clients, and being committed to high performance. Using a club theory

perspective, Sherr and Shields (2005) found that in service clubs, the rituals and symbols of the club paralleled those of religious organizations in their effectiveness as mediums for engagement and communication, and for their capacity to reinforce the culture of the club. Organizations that serve the homeless have their own rituals and symbols: logos, brand images, the photo library, work paraphernalia (ID badges/ keys/ pendants/ radios), the sign-in / sign-over rituals, the daily prayer services, the emphasis on teamwork, the organized signature events, the client-focused, shared experiences (often intense, humorous, or traumatic), the legends and reminiscences, all have contributed to building a distinctive organizational culture.

Turkel and Ray (2004) emphasized the importance of an organizational culture that encourages and promotes self-renewal. Failure to take care of the creative foundation creates “dis-ease” at the deepest levels, and leads to burnout and compassion fatigue. Some of their suggestions for creating an harmonious workplace environment are equally applicable to organizations that care for the homeless: forums for public or private sharing of ideas (i.e. regular staff meetings); a place where workers can meditate, rest, reflect during their breaks; attention to the geography of the place (e.g. use of Feng Shui principles in furniture placement, creation of a labyrinth or a healing garden); opportunities for creative activities and spiritual nurturance (e.g. meditation or reflection services); on-site classes (e.g. aromatherapy, art therapy, journaling, yoga); a plan for self-care as part of the annual staff evaluation.

One of the most important organizational best practices is the use of a post-incident de-briefing procedure. A post 9-11 study on compassion fatigue and burnout among clergy and distress relief workers at Ground Zero (Roberts, et al., 2003) suggested

that debriefing procedures ameliorated the effects of exposure to the physical destruction, and to the emotional and spiritual suffering of families.

Group. A study of New York City nurses showed that social support from administrators and colleagues, as well as from the patients themselves, correlated positively with their willingness to care for AIDS patients (Sherman, 1996). A best practices document by the Washington D.C. Health Care Advisory Board (2001) highlighted ‘community in the workplace’ (social support) and ‘affective commitment’ (a sense of connection and cohesion among workers and between workers and the administration) as proven retention strategies in nursing. Seigel et al, (2001) suggested that in religious communities, social connections function as stress buffers and stress deterrents. Bonanno (2004) showed that while qualities of character and personality (hardiness and resiliency) have an impact on responses to secondary trauma, social support also ameliorates the effects of compassion fatigue. A study of workers at battered women’s shelters across the US confirmed social support as predictive of secondary traumatization (Clifford, 2004). Individuals with high levels of social support tended to have fewer symptoms of secondary trauma, while individuals with high levels of social avoidance had more symptoms. The present study hypothesized that for frontline shelter workers, ‘living with others’ as opposed to ‘living alone’ was predictive of higher scores on compassion satisfaction.

Individual. Research also suggests that individual factors influence the susceptibility to workplace stress. Certain qualities that contribute to resilience appear to protect individuals engaged in caring work. One of these qualities is hardiness. Evidence suggests that the personality trait of hardiness helps buffer exposure to extreme stress.

Hardiness consists of three dimensions: being committed to finding a meaningful purpose in life, the belief that one can influence one's surroundings and outcomes, and the belief that one can learn and grow from both positive and negative life experiences (Kobasa, Maddi, and Khan, 1982). Hardy individuals are more confident, and use coping skills and social support to deal with stress (Florian, Mikulincer, and Taubman (1995). King (1998) showed a correlation between hardiness, good social support, and fewer psychological problems. Hardiness is characterized by feelings of control and commitment, and a perception of change as challenge.

Bonanno (2004) wondered if we have underestimated the human capacity to survive after extremely aversive events. Available evidence suggests that the majority of individuals exposed to violent or life threatening events do not go on to develop a stress disorder. For example, 78.2% of individuals exposed to the 1992 Los Angeles riots reported three or fewer PTSD symptoms; 79% of hospitalized survivors of motor vehicle accidents did not meet the criteria for PTSD; 62.5% of Gulf War victims had no psychological distress within one year of their return to the US.

In another study of stress and coping among correctional officers (Triplett, Mullings and Scarborough, 2006) it was revealed that while they experience the same organizational stresses as those identified within the broader occupational literature, correctional officers utilize personal coping mechanisms for reducing the overall level of job stress.

There are multiple pathways to resilience in the face of extreme stress, including hardiness, self-enhancement, positive emotion and laughter. Even repressive coping, though generally viewed as maladaptive, appears to foster adaptation to extreme

adversity (Bonanno,2004). Although outside the parameters of the present study, it would be worthwhile to investigate the role of resilience in shelter workers as a buffer against the negative effects of stress on the frontline.

Spirituality

Spirituality defined. In a preliminary overview of the association between spirituality and mental health, Gilbert (2007) described spirituality as the dimension of our human existence which erects frameworks of meaning and provides motivation in our lives. Spirituality entails a sense of the sacred, with an emphasis on creativity, hope, and reaching beyond ourselves. It also involves connectedness to other people and to nature.

Many of the world's faith traditions promote altruistic behavior in the form of service to others. A sizable literature points to spirituality as a possible precursor to voluntarism (Mattis et al. 2000). A qualitative study of volunteers who worked a crisis hotline demonstrated that they had spiritual motivations for continuing to "work the lines" (Praetorius and Machtmes, 2005). For the purpose of their analysis, spirituality was defined as those aspects of individual feelings, aspirations, and needs which are concerned with efforts to find a purpose and meaning in life experiences, and which may occur without the individual's being related to a church body or making a systematic use of a systematized body of beliefs and practices. The researchers found four main expressions of spiritual motivation: 1) Altruism referred to behavior intended to benefit another, even if doing so entailed risk or sacrifice. It also included those who see their service as a form of gratitude for having been similarly helped when they were in crisis. 2) Realizing personal blessings had two components: a) blessings of personal support systems, and b) blessings of new perspectives on their personal lives. 3) A deeper

understanding of the human condition captured a) the sense of newfound sensitivity and b) other-learning gains as a result of their volunteer work. 4) Realizing the interconnectedness of us all as integral parts of the social fabric also had two components: a) a heightened sense of social justice, and b) a desire to give back to the community (Praetorius and Machtmes, 2005).

The literature in related fields suggests that there are positive correlations between spirituality and helping, and spirituality and physical and psychological well-being. Mofidi et al. (2007) researched optimism, social support and volunteering as mediating factors in the relationship between spirituality and depressive symptoms. The results suggested that while spirituality was not directly related to social support, it was related to optimism. Spirituality may be a source of optimism because it offers a sense of direction, purpose, and certainty. In a preliminary overview of spirituality and mental health, Gilbert (2007) noted the demand for the spiritual dimension to be taken into account in the diagnosis, treatment and care of people with mental ill-health. The present study hypothesized that frontline shelter workers with higher scores on measures of spirituality would have higher scores on the measures of compassion satisfaction, and lower scores on measures of compassion fatigue and burnout.

Religion defined. Within the concept of spirituality, religion usually entails a belief in the transcendent, together with a meta-narrative that seeks to explain the origin of life, and issues around suffering and death. Religion provides a worldview which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings, and which promotes ties of mutual obligation (Gilbert, 2007). The appraised meanings of stressors are commonly influenced by religion (Pargament, 1997). The extent to which

religion is involved in an individual's coping seems predicated on the extent to which religion is part of the orienting system. Pargament (1997) showed that religion is far more likely to be used as a coping resource when it is a salient aspect of the individual understanding of self and world.

Spirituality and Religion as Adaptive.

Research shows that spirituality and religious beliefs and practices improve psychological well-being through raising hope, optimism, and a sense of purpose and meaning in life (Koenig, 1998; Cohen, 2005). A university of Connecticut study on religion as a meaning-making framework in coping with life stress explored the pathways through which religion influenced well-being when an individual encounters adversity (Park, 2005). In Park's study of 169 bereaved college students, religion was related to meaning-making coping in terms of positive re-appraisal and adjustment. While religion was initially associated with more intrusive thoughts, avoidance, and depression in the early stages of the bereavement experience, these effects quickly disappeared or even reversed, indicating a positive association between religion and long-term adjustment. This finding supports the literature that theorizes a positive association of intrinsic religiousness and mental health and well-being generally. Intrinsic religiosity, as contrasted with extrinsic, refers to religion that is unprejudiced and mature (Allport and Ross, 1967).

A related study of "religious /spiritual" coping and perceived stress and psychological well-being (Bong-Jae, 2007) showed that high levels of religiosity were associated with low levels of psychological distress symptoms. This outcome points to the importance of understanding the potential inherent in religious / spiritual coping for

enhancing coping resources and improving adjustment to stressful life events. It also has implications as a therapeutic resource for helping professionals in their interventions, and may be significant in considering recruitment targets and providing support to frontline workers in emergency shelters. The present study hypothesized that higher scores on the Spiritual Well-Being Scale and the Community Spirituality Scale would predict lower scores on compassion fatigue and burnout for frontline shelter workers in Ottawa.

Helping as Adaptive.

Another body of literature suggests that altruism and social interest behaviors have adaptive advantages for the helper. A study of Japanese elderly found that those who helped others had a more favorable health rating than those who were less involved in helping others (Krause et al.1998). This study also found a relationship between religious involvement and helping others more frequently, and religious involvement and better self-reported health.

A study of multiple sclerosis patients who provided a supportive ear to others showed three to seven times the benefit in quality of life outcomes, defined as role performance, self-efficacy, coping ability, and well-being (Schwartz, et al.,1999). The effects were obvious in aspects of subjective well-being such as purpose in life, self-acceptance, and personal growth. These effects revealed that by helping others, patients reframed their own suffering, deriving a stronger sense of meaning in life and a stronger awareness of a higher power (Schwartz, et al.,1999).

A later investigation of altruistic social interest behaviors in Presbyterian church-members across the US revealed that helping others and receiving help were significant predictors of mental health (Schwartz et al., 2003). Giving help was a more important

predictor of better reported mental health than receiving help. Significant predictors of giving help included age, female gender, and being a church elder, endorsing more prayer activities, higher satisfaction with prayer life, and engaging in positive religious coping. The present study investigated the relationship between measures of spirituality and compassion satisfaction in a specific type of helping professional, the frontline shelter worker.

Burnout as Spiritual Distress.

In a review of literature on spirituality, Kelly (2004) recognized the importance of spirituality as a resource and coping mechanism for critical care nurses. This article cautioned that disproportionate attention to the technical aspects of patient care can result in spiritual aridity for both nurse and patient. He also highlighted the necessity of treating burnout as a spiritual crisis. In his book on the status syndrome, Marmot (2005) emphasized that however good technical medicine is, it has no real value without an engagement with the whole person and the family, community and society in which they live. Nobody wishes to work in a service that has no spark, no spirit, and no invigorated life. Meanwhile, convinced that in a multicultural, knowledge-based economy, mental well-being and stability are of vital importance, the British Government has become interested in the concepts of “creativity,” “cohesion,” and “happiness” (Layard, 2005).

Part of discovering our humanity involves consideration of the spiritual dimension of our lives. Using an approach that incorporates a spiritual component, a study conducted in the Netherlands (Van Dierendonck et al., 2005) studied the effects of a psychosynthesis-based, burnout prevention program. The results showed significant changes on three out of four spirituality scales. The spiritual psychosynthesis component

of the program recognizes that there is a connectedness that goes beyond the personal level, and is essential for re-discovering the meaning and purpose in life. Feelings are a critical part of this process (Strohl, 1998). Feelings provide meaning to experience. The ability to identify and regulate feelings, and use the information provided by them is important for social adaptation. As a result of the intervention, significant changes were shown for purpose and meaning in life, inner resources, and transcendence. The only dimension that did not show a significant change was unifying interconnectedness. This type of intervention could have important applications for human service professionals, including frontline workers and other occupations where the potential for compassion fatigue and burnout is high.

A study of United Methodist clergy (Golden, et al., 2004) found that spirituality showed incremental significance in predicting burnout in clergy, even when personality and work-environment variables were controlled for. A later study of burnout and coping among parish-based clergy (Doolittle, 2007) showed that while higher spirituality scores were correlated with greater personal accomplishment, these higher scores were also related to greater emotional exhaustion and depersonalization. The intriguing correlation between higher spirituality and greater depersonalization was explained as enjoyment of the call and a sense of accomplishment on the one hand, and feeling emotionally exhausted, on the other. Coping style was an important intervening variable: coping strategies of venting, disengagement and self-blame were correlated with greater exhaustion and depersonalization, while strategies of acceptance, planning and positive re-framing were correlated with personal accomplishment. The interrelationship of spirituality and coping style suggests that certain qualities (a strong spiritual life, healthy

coping strategies) may be more conducive to the demands of parish life and more resilient to burnout. This is an area worthy of further investigation.

A Holistic Conception of Spirituality

Over the past twenty years, increasing numbers of Canadians identify themselves as more spiritual than religious (Bibby, 2002). In tandem with the changing perception of spirituality is the trend towards recognizing it as integral to professions such as pastoral counseling, nursing and social work. Spirituality is conceived more broadly as the driving force that gives meaning, stability and purpose to life through dimensions that transcend the self (Harmon, 1885; Oldnall, 1996; Reed, 1992). These dimensions can be presence of God, community, family, friends, and nature.

The theistic element is only one component among many (Walton, 1999). The human encounter is another common denominator: hope (Dubrie and Vogelpil, 1980); suffering (Lindholm and Eriksson, 1993); and love, trust, and listening (Oldnall, 1996). Moberg (1986) conceptualized spirituality as having two dimensions: a) a vertical dimension reflecting faith in God; b) a horizontal dimension reflecting hope (purpose in life) and love (relationship with others). In their Spiritual Involvement and Belief Scale, Hatch, Naberhaus, Helmich and Burg (1998) emphasize the communal aspect of faith and spiritual practice.

Spiritual Well-Being and Quality of Life

The Spiritual Well-Being Scale (SWBS) measures the quality of an individual's interior or spiritual life, and is comprised of two sub-scales: a) the Existential Well-Being Scale (EWB) designed to measure an individual's sense of satisfaction or purpose in life,

and b) the Religious Well-Being Scale (RWB), designed to measure the quality of an individual's relationship with God (Bufford et al., 1991).

Rovers and Kocum (2008) clustered views on spirituality around three main themes: theistic (God / Gods / Transcendent Other); existential (meaning / fulfillment / purpose); and community (relationship with self / other / the world). Each theme corresponds to a domain. The domains – faith, hope, and love – are mainstays in a spiritual pathway, and are combined in various ways and depths at different times. Rovers and Kocum proposed a more inclusive model of spirituality that combined elements from the three domains. To that end, they developed a new holistic spirituality model, using the Spiritual Well-Being Scale, with its Religious subscale for faith, its Existential subscale for hope, and a new 7-item Community Scale for love.

Several studies have reported positive associations between spiritual well-being and other measures of quality of life in persons with serious physical illnesses, including heart failure (Beery et al., 2002) and gynecologic cancer (Giobiella et al., 1998). More than religious well-being, existential well-being was found to be significantly related to psychological well-being in a sample of African Americans with HIV AIDS (Coleman and Holzemer, 1998). An earlier study of 66 HIV patients (Carson et al., 1990) found that hope was related more closely to existential well-being than religious well-being.

Research into spiritual well-being and health (Tsuang, et al., 2007) used the Spiritual Well-Being Scale (SWBS) and the Spiritual Involvement Scale (SI) to study the relationship between religious well-being (RWB), existential well-being (EWB), spiritual involvement (SI), and psychiatric disorders identified by the DSM-III- R diagnosis of major depression, alcohol dependence, drug dependence, and nicotine dependence. The

findings indicated statistically significant associations except for major depression. Higher values in RWB, EWB, and SI were associated with reduced risks for the DSM-III-R disorders. Overall, EWB measurements had the strongest associations with 36 measures of health which included physical functioning, bodily pain and emotional role impairment.

Similarly, a study of Croatian war veterans with chronic PTSD (Nad, et al., 2008) showed a stronger correlation of suicidality and the EWB subscale of the SWBS. The relation of lower suicidality with higher EWB implied that a stronger sense of meaning is essential to the veteran's efforts to minimize feelings of helplessness and sense of vulnerability. It was also noted that certain religious activities among veterans are consistent with a model of help-seeking behavior (Davis et al., 2003). Church attendance and reading religious literature are reflective of their low EWB, increasing their interest in ultimate questions about life and its purpose.

In the present study, the relationship between spirituality and quality of life in frontline shelter workers was explored, using the Spiritual Well-Being Scale and the Community Spirituality Scale of the Holistic Spirituality model.

Hypotheses

This study examined the following hypotheses:

Hypothesis 1. Higher scores on each of three measures of spirituality - the Religiosity Subscale (RWB) and Existential Subscale (EWB) of the Spiritual Well-Being Scale (SWB), and the Community Scale of the Holistic Spirituality Model - will be predictive of lower scores on measures of compassion fatigue and burnout, and higher scores on measures of compassion satisfaction for frontline workers.

Hypothesis II. Male gender will be predictive of higher scores on measures of compassion fatigue, and female gender will be predictive of higher scores on measures of burnout.

Hypothesis III. Living alone will be predictive of higher scores on measures of compassion fatigue and burnout, and living with others will be predictive of higher scores on compassion satisfaction.

Hypothesis IV. Higher scores on incidents of aggression against frontline workers will be predictive of higher scores on measures of compassion fatigue and burnout.

Hypothesis V. Higher scores on prior traumatic events will be predictive of higher scores on measures of compassion fatigue and burnout, and lower scores on compassion satisfaction.

Chapter II

Method

Purpose and Procedure

Instruments. The Professional Quality of Life scale was used to investigate the impact of working with the homeless on frontline workers. The scale measures compassion satisfaction, compassion fatigue and burnout in frontline workers. The Spiritual Well-Being Scale and the Community Scale of the Holistic Spirituality Model, were used to assess the role of spirituality as a possible ameliorating factor in levels of compassion satisfaction, compassion fatigue, and burnout.

The research participants were frontline workers from the three emergency men's shelters in Ottawa. A total of 165 questionnaires were distributed: 35 at The Ottawa Mission; 35 at Salvation Army Booth Center; and 95 at Shepherds of Good Hope. The researcher met with the managers in each organization to explain the purpose of the study and its potential benefits for shelter administrators and their frontline employees. Posters advertising the study were circulated throughout the participating shelters. Managers or designates circulated the research packages containing the questionnaire and a stamped return envelope. The questionnaire was comprised of 18 observable variables, the 30-item Professional Quality of Life Scale, the 20-item Spiritual Well-Being Scale, and the newly developed 7-item Community Scale. Completed questionnaires were mailed to the office of the research supervisor.

Each questionnaire contained a letter of Information and Consent with 1) a statement of the purpose and benefits of the study; 2) a statement indicating approval of the research project by the Research Ethics Committee of St. Paul University; 3) a statement explaining the measures; 4) a statement of commitment to confidentiality and implied consent to have questionnaire responses analyzed and reported in an anonymous manner; 5) a statement informing participants of their right not to fill out all or part of the questionnaire, or to withdraw from the study at any time; 6) instructions for completing and returning the questionnaire; and 7) the names and contact information for the researcher, the research supervisor, and the director of research services at St. Paul University.

Independent Variables

In a regression analysis, independent variables are referred to variously, as explainers or explanatory variables, as predictors, or as regressors.

Observable Variables. Information was gathered about each participant's work location, age, gender, place of birth, marital status, education, present living arrangement (alone or with others), religion, length of employment with organization, incidents of aggression (verbal and physical), and other traumatic life events (illness, loss, relationship breakdown, accident/injury, and other).

Latent Variables. The Spiritual Well-Being Scale (SWBS) was used to measure two of the independent latent variables, "faith" and "hope". SWBS is a self-report measure consisting of 20 items rated on a six-point Likert scale. Respondents were asked to circle the choice that best indicated the extent of agreement or disagreement with each statement. The SWBS is designed to assess overall perceived spiritual quality of life

(Ellison, 1983). The SWBS is comprised of two subscales: the Religious Well-Being Scale (RWB) and the Existential Well-Being Scale (EWB). The RWB operationalizes the faith domain of spirituality, and contains questions with direct references to God. The EWB operationalizes the hope and meaning-making domain of spirituality, and contains questions with references to meaning and purpose of life.

Previous research has demonstrated that the reliability of the SWBS is high. The test-retest reliability across four studies, with 1 to 10 weeks between testing sessions, was .93, .99, .99 and .82 (Bufford, Paloutzian and Ellison, 1991). The scale has demonstrated high internal consistency. Across seven samples, the internal consistency coefficients ranged from .94 to .89 (Bufford, et al., 1991). For the purpose of scoring the SWBS, items 1, 2, 5, 6, 9, 12, 13, 16, and 18 are reversed.

The new 7-item Community Spirituality Scale was used to measure “love,” the third independent latent variable. The Community Spirituality Scale is a self-report measure consisting of items rated on a six-point Likert scale (Rovers and Kocum, 2008). Respondents were asked to indicate extent of agreement or disagreement with each statement. This scale operationalizes the love domain of spirituality. It contains questions with references to relationship with God, self and others. In the normative study, Cronbach’s $\alpha = .91$ indicated that the scale has excellent internal consistency.

Dependant Variables

Response Variables. The Professional Quality of Life Scale (ProQOL) was used to assess the impact of working frontline with the homeless in terms of “compassion satisfaction”, “compassion fatigue” and “burnout”. The ProQOL is designed to measure quality of life. It is a self-report measure consisting of 30 items rated on a 5-point Likert

scale. The ProQOL is a revision of the former Compassion Fatigue Self Test (Figley, 1995). The new scale was developed for two reasons: 1) The original scale was found to have subscale psychometric problems (Figley and Stamm, 1996; Jenkins and Baird, 2002; Larsen, Stamm and Davis, 2002); 2) Market testing showed that the less pathologic and more positive focus on professional quality of life would support positive system change for ameliorating or preventing the negative effects of care-giving.

The revised ProQOL was shortened to 30 items. The scale now consists of three subscales: Compassion Satisfaction (CS), Burnout, and Compassion Fatigue (CF). Initial data suggest that the subscales have excellent internal consistency (Stamm, 2005). Early returns on test-retest data suggest good reliability across time with a small standard error of the estimate. The alpha reliabilities for the scales are as follows (see figure 2): compassion satisfaction $\alpha = .87$, burnout $\alpha = .72$ and compassion fatigue $\alpha = .80$.

The construct validity upon which the test is based is well established with over 200 articles noted in the peer-review literature (Stamm, 2002). Using the multi-trait, multi-method mode for convergent and discriminant validity (Campbell and Fiske, 1959), the scales on the ProQOL do, in fact, measure different constructs. The inter-scale correlations are small. Compassion satisfaction has 5% shared variance with burnout and 2% shared variance with compassion fatigue/trauma. The shared variance between burnout and compassion fatigue/trauma is somewhat higher, likely reflecting the distress that is common to both conditions (21%), but the two scales are clearly different.

Researchers are endeavoring to create a composite indicator score, but so far, scores from each scale must be treated separately. For the purpose of scoring the

ProQOL, items 1, 4, 15, 17, and 29 are reversed. It is important to note that 0 remains 0 when scores are reversed, denoting the absence of the construct.

“Compassion Satisfaction” (CS) refers to the pleasure derived from being able to do one’s work well. Higher scores represent a greater satisfaction related to one’s ability to be an effective helper, or to contribute to the work setting or to society at large.

“Burnout” refers to feelings of hopelessness and difficulties in dealing with work or in doing work effectively. The feelings associated with burnout are gradual in onset, and can reflect a high workload, a non-supportive work environment, or the sense that one’s work is unimportant. “Compassion Fatigue (CF), also called secondary trauma (STS) refers to the effects of secondary exposure to extremely stressful events or exposure to others’ traumatic events as a result of one’s work (ambulance workers / police officers / shelter workers). The symptoms are usually rapid in onset and associated with a particular event. Symptoms include intrusive thoughts and images, hyper-vigilance, and avoidance of potential reminders of an event.

It is possible to report simultaneously high scores on CS and CF. This can occur in a situation where, for example, there is an altruistic desire to help in a distressing work environment such as a disaster zone, a refugee camp, or an emergency shelter.

Data Analysis

“R”, a Bell Labs language and environment for statistical computing and graphics was used to analyze the data. Regression analyses were performed to discover the patterns of dependence and influence between the independent variables (also referred to as explanatory, predictor, or regressor variables), and the dependant variables (also referred to as the response variables). In the present study, the “observable” variables

(e.g. demographic variables) and measures of spirituality are the independent variables, and the measures of compassion fatigue, compassion satisfaction and burnout are the dependent variables.

The data set consisted of 71 sets of answers to 74 questions. Unfortunately, only 44 of the records were complete, with all questions answered. The Croon (2002) correction method was implemented. The Croon method required that a factor analysis be carried out for each variable. This too was problematic due to the small data set. In the end, a lack of robustness in the Croon method was indicated by the very large confidence levels shown for the corrected coefficients (Hughes, 2008). According to Lu and Thomas (2007) however, the bias is usually small if the scale corresponding to each latent variable has a large enough number (10-20) of items. In the present study, five of the six latent variables have ten-item scales, and one has a seven-item scale, suggesting that the bias may not be too large.

A regression analysis was carried out to identify the statistically significant relationships between the dependent variables - the respondents' scores on the response variables (compassion satisfaction, compassion fatigue and burnout) measured by the Professional Quality of Life Scale, and the independent variables - the 3 explanatory latent variables (faith and hope, measured by the Spiritual Well-Being Scale, and love, measured by the Community Spirituality Scales), and the 18 explanatory observable variables. Due to the small data set and the evidence of random noise (as measured by the length of the confidence intervals), emphasis was placed on the sign patterns of the coefficients, as opposed to the magnitudes of the coefficients.

Ethics Approval

This research project had the approval of the Saint Paul University Research Ethics Committee. Questionnaires were distributed anonymously and participation was voluntary. Participants were informed of their right to decline to answer any question in the survey, or to withdraw completely from the study. Participants were also provided the contact information for the research team, and directed to consult their respective organizational chaplains if debriefing was necessary.

Chapter III

Results

Preliminary Analysis of Data Set

The main purpose of the study was to assess levels of compassion fatigue, burnout, and compassion satisfaction in frontline shelter workers, with consideration of spirituality as a possible ameliorating factor. Seventy-one questionnaires were returned. Of these, only 44 were complete (had answers to all questions). By default, the regression program deleted cases for which there were missing values on any of the variables. Of the 44 complete records, 26 were from Shepherds of Good Hope, 11 were from The Ottawa Mission, and 7 were from Salvation Army Booth Center. The data set consisted of 22 males and 22 females. Living arrangement showed that 20% of the respondents lived alone and 80 % lived in a conjugal relationship, or with others. Educational level showed 4 with only high school, while 34 (77.3 %) had a college or university education, and 6 had a graduate education. Religious identification indicated that 13 were Roman Catholic; 16 were Protestant; 1 was Jewish; 5 belonged to another affiliation, and 9 stated that they had no religious affiliation. Length of employment ranged from 2 who worked more than 20 years, to 16 who worked for a year or less. Twenty-two of the respondents (50%) reported daily incidents of verbal aggression, while 25% reported weekly incidents of physical aggression. For other traumatic life events, 16% reported accidents, 25% reported serious illness, while 57% reported loss of loved one, and 27% reported other traumatic events. Table 1 illustrates the numerical and percentage frequencies for each of the observable variables.

Table 1.
FREQUENCIES
 COMPLETE RECORDS ONLY (44 SUBJECTS)

LOCATION	COUNTS	PERCENT
SHEPHERDS	26	59
SALLY	7	16
MISSION	11	25
AGE	COUNTS	PERCENT
UNDER 30	22	50.0
30-40	11	25.0
41-50	6	13.6
51-60	3	6.8
61+	2	4.5
GENDER	COUNTS	PERCENT
MALE	22	50
FEMALE	22	50
BIRTH	COUNTS	PERCENT
CANADA	39	89
OTHER	5	11
MARITAL	COUNTS	PERCENT
MARRIED	19	43.2
SINGLE	23	52.3
SEP/DIV/WID	2	4.5
EDUCATION	COUNTS	PERCENT
HIGH SCHOOL	4	9.1
BA/COLLEGE	34	77.3
MA	6	13.6
PHD	0	0.0
LIVING	COUNTS	PERCENT
ALONE	9	20
WITH OTHERS	35	80
RELIGION	COUNTS	PERCENT
CATHOL	13	29.5
PROTES	16	36.4
JEWISH	1	2.3
OTHER	5	11.4
NONE	9	20.5

VERBAL

	COUNTS	PERCENT
NEVER	3	6.8
RARELY	0	0.0
OCCASIONALLY	5	11.4
WEEKLY	14	31.8
DAILY	22	50.0

PHYSICAL

	COUNTS	PERCENT
NEVER	10	22.7
RARELY	11	25.0
OCCASIONALLY	10	22.7
WEEKLY	11	25.0
DAILY	2	4.5

ILLNESS

	COUNTS	PERCENT
NO	33	75
YES	11	25

LOSS

	COUNTS	PERCENT
NO	19	43
YES	25	57

ACCIDENT

	COUNTS	PERCENT
NO	37	84
YES	7	16

OTHER

	COUNTS	PERCENT
NO	32	73
YES	12	27

LENGTHEMP (YEARS)

	COUNTS	PERCENT
0-1	16	36.4
1-2	6	13.6
2-3	7	15.9
3-4	2	4.5
4-6	3	6.8
6-8	4	9.1
8-12	4	9.1
12-16	0	0.0
16-20	0	0.0
20-26	2	4.5

The hypotheses were tested using regression analysis to see the patterns between the independent or explanatory variables (the 18 observable variables and 3 latent variables – faith, hope, and love) and the 3 dependant or response variables (compassion satisfaction, compassion fatigue, and burnout). Multivariate regressions were computed by constructing equations containing one latent explanatory variable and one observable explanatory variable, with location (a constant observable), and the response variable. The objective was to explore the relationship between levels of compassion fatigue, burnout, and compassion satisfaction for frontline workers, controlling for demographic and spiritual characteristics.

For the purpose of this study, confidence levels were established at 95%. If the signs for the lower and upper bounds of the confidence interval were different (negated each other), the confidence level overlapped 0, and the effect was not statistically significant (there was no real effect).

Hypothesis I

Hypothesis I stated that higher scores on each of the three measures of spirituality will be predictive of lower scores on measures of compassion fatigue (CF) and burnout, and higher scores on measures of compassion satisfaction (CS) for frontline shelter workers.

Regression equations were constructed for each response variable (compassion fatigue, burnout, compassion satisfaction) with location (a constant), and each of the other observable variables, in combination with each of the latent variables (faith, hope, community spirituality). The models of compassion fatigue that controlled for faith showed that age was only significant for the 41-50 age group, with a coefficient of -.71,

indicating a significantly lower CF score compared to the reference group, the under 30 year-olds (Table 2). This same age-dependence existed when the model controlled for hope and community spirituality (Tables 3 and 4).

The models of compassion fatigue and hope, and compassion fatigue and community spirituality showed similar significant results for the 41-50 age group, with coefficients of -.63 and -.69, respectively. Those results showed significantly less CF for 41-50 year olds, controlling for the spiritual variables, location, and other age groups.

Table 2.

Regression for CompFatigue ~ Faith + Location + Age

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.18687643	-0.16630783	0.54006069
Faith	0.03971164	-0.14625660	0.22567988
LocationSally	-0.22417298	-0.85659737	0.40825141
LocationMission	-0.43910133	-0.96571616	0.08751351
Age30-40	0.46964634	-0.05668633	0.99597901
Age41-50	-0.71128712	-1.40056048	-0.02201376 *
Age51-60	-0.54125486	-1.41750920	0.33499949
Age61+	-0.54892989	-1.63972009	0.54186031

Table 3.

Regression forCompFatigue ~ Hope + Location + Age

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.2070785	-0.1317252	0.545882227
Hope	-0.1847164	-0.4269451	0.057512294
LocationSally	-0.3441359	-0.9523785	0.264106782
LocationMission	-0.3862627	-0.8794804	0.106955104
Age30-40	0.3717412	-0.1547319	0.898214306

	Coeff	Lower 95%	Upper 95%
Age41-50	-0.6342197	-1.2598400	-0.008599454 *
Age51-60	-0.6272590	-1.4683517	0.213833746
Age61+	-0.4278356	-1.4389507	0.583279475

Table 4

Regression for CompFatigue ~ CommSpir + Location + Age

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.1986238	-0.14332251	0.54057013
CommSpir	0.1325349	-0.08076338	0.34583326
LocationSally	-0.1313378	-0.76707100	0.50439537
LocationMission	-0.4683949	-0.97513110	0.03834126
Age30-40	0.4318128	-0.08535915	0.94898470
Age41-50	-0.6971026	-1.33158982	-0.06261547 *
Age51-60	-0.5902115	-1.43767692	0.25725393
Age61+	-0.316570590	-1.3140309	0.68088969

The faith and community spirituality coefficients did not show significance.

Hope, on the other hand, showed significant results across several of the models, with coefficients ranging from -.27 to -.39, indicating the influence of hope in reducing CF.

The three models showed fairly consistent, albeit non-significant negative sign patterns for the location coefficients, suggesting a tendency for less CF for Salvation Army and Mission, relative to the reference group, Shepherds.

The models of burnout and faith had only one significant result, with a positive coefficient of .62 for the 30-40 age group, indicating more burnout than for the under 30 reference group (Table 5).

Table 5.

Regression for Burnout ~ Faith + Location + Age

	Coeff	Lower 95%	Upper 95%
(Intercept)	-0.105277874	-0.4282431	0.21768732
Faith	-0.128082804	-0.2981393	0.04197367
LocationSally	0.008151568	-0.5701615	0.58646463
LocationMission	-0.088011903	-0.5695686	0.39354484
Age30-40	0.629312181	0.1480135	1.11061090 *
Age41-50	-0.129516517	-0.7598144	0.50078141
Age51-60	0.010367566	-0.7909129	0.81164806
Age61+	-0.316570590	-1.3140309	0.68088969

Both faith and community spirituality had non-significant coefficients across all models of burnout. Hope, however, showed consistently, significant results, with coefficients ranging from -.46 to -.62, clearly indicating less burnout with hope.

As with the CF models, the models of burnout showed non-significance for the location coefficients, with negative sign patterns suggesting a tendency to less burnout for Salvation Army and Mission, relative to Shepherds.

The model of compassion satisfaction, controlling for faith, had significant results for the 30-40, and 41-50 age groups, with coefficients of -.69 and -.88, respectively, indicating lower CS scores for these groups (Table 6). Female gender was also significant, with a coefficient of .52, indicating more CS than for males (Table 7).

Table 6.

Regression for Satisfaction ~ Faith + Location + Age

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.4010316	-0.005045341	0.80710862
Faith	0.3499744	0.136155618	0.56379313 *
LocationSally	-0.1986816	-0.925817616	0.52845437
LocationMission	-0.2061359	-0.811616298	0.39934458
Age30-40	-0.6966390	-1.301795002	-0.09148297 *
Age41-50	-0.8877437	-1.680242350	-0.09524508 *
Age51-60	0.1850887	-0.822393149	1.19257047
Age61+	-0.7764505	-2.030597005	0.47769592

Table 7

Regression for Satisfaction ~ Faith + Location + Gender

	Coeff	Lower 95%	Upper 95%
(Intercept)	-0.20843251	-0.61729975	0.2004347
Faith	0.17510174	-0.02208092	0.3722844
LocationSally	-0.43086341	-1.17288758	0.3111608
LocationMission	0.04930266	-0.55378439	0.6523897
GenderFemale	0.52930661	0.01384742	1.0447658 *

Faith had significance, with coefficients ranging from .17 to .34 for CS models that controlled for varying observable variables, indicating that faith is predictive of more CS (Table 8 is one example).

Table 8.

Regression for Satisfaction ~ Faith + Location + Birth (Sample)

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.13212435	-0.20455282	0.4688015
Faith	0.26274902	0.06151972	0.4639783 *
LocationSally	-0.20022442	-0.94079270	0.5403439
LocationMission	-0.09192682	-0.69915593	0.5153023
BirthOther	-0.68014105	-1.48990522	0.1296231

Hope was also significant, with coefficients ranging from .40 to .47 in models controlling for varying observable variables, indicating that hope has even greater predictive power than faith for CS (Table 9 is one example).

Table 9.

Regression for Satisfaction ~ Hope + Location + Living (Sample)

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.001762590	-0.5451382	0.5486633
Hope	0.461363195	0.1874092	0.7353172 *
LocationSally	-0.211279375	-0.9386509	0.5160922
LocationMission	0.023470331	-0.5499112	0.5968519
LivingWith Others	0.032663657	-0.5873805	0.6527079

For the most part, the positive effect of the spiritual variables on CS was an expected result, with the noteworthy larger effect of hope. Community spirituality was the exception, with no significant effect on CS.

The results for the location coefficient were not significant in the CS models, but the consistent negative sign patterns for Salvation Army suggested a tendency to less CS relative to Shepherds, while Mission had mixed negative and positive coefficients.

Hypothesis II

Hypothesis II stated that male gender will be predictive of higher scores on measures of compassion fatigue, and female gender will be predictive of higher scores on measures of burnout.

The gender coefficients were not significant for the compassion fatigue or burnout models. When controlling for the observable variables, faith and community spirituality did not show significance for CF or burnout models sets, either. Hope, by comparison, had significant, negative results for CF models that controlled the impact of several observable variables, clearly indicating the effect of less CF with hope as a predictor variable. Hope was not significant for models of burnout, however.

Hypothesis III

Hypothesis III stated that living alone will be predictive of higher levels of compassion fatigue and burnout, and living with others will be predictive of higher levels of compassion satisfaction.

While the “living with others” coefficients did not show significance for any of the models, the spiritual coefficients for the three model sets (CF, Burnout, CS) showed a recurrence of the patterns for Hypothesis I. The faith coefficients showed the same non-significance for the CF and burnout models, and showed significance for the CS models, affirming that faith is predictive of more CS (Table 8). Hope had significance across several CF models (with coefficients ranging from $-.27$ to $-.39$), and burnout models

(with coefficients ranging from $-.46$ to $-.62$). Hope also showed a recurrence of significance for CS models (with coefficients ranging from $.40$ to $.47$). Community spirituality showed the previous non-significance for CF and burnout models, and showed the former pattern of significant, positive coefficients for the CS models, calling attention to community spirituality as a predictor of CS.

Hypothesis IV

Hypothesis IV stated that higher scores on prior traumatic events will be predictive of greater compassion fatigue and burnout, and less compassion satisfaction. Prior traumatic events included illness, loss, breakup, accident, and other.

The coefficients for prior traumatic events did not show significance in any of the models. While the faith coefficients were not significant in any of the models, community spirituality showed significance for the CS model. Hope, by comparison, was predictive across all models. Hope had a significant result of $-.28$ (Table 8) for the CF model. Hope also showed significance in the burnout and CS models, with coefficients of $-.53$ (Table 9) and $.45$ (Table 10), respectively, re-affirming the predictive power of hope for reducing burnout and increasing satisfaction in frontline workers.

Table 8**Regression for CompFatigue ~ Hope + Location + Illness + Loss + Breakup + Accident + Other**

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.04913528	-0.4818192	0.58008978
Hope	-0.28055060	-0.5461426	-0.01495865 *
LocationSally	-0.44765824	-1.2001424	0.30482592
LocationMission	-0.39343189	-0.9942493	0.20738547
IllnessYes	0.18877828	-0.4204557	0.79801225
LossYes	0.03535796	-0.5127101	0.58342606
BreakupYes	0.11086749	-0.4096950	0.63142997
AccidentYes	0.33620627	-0.3485709	1.02098344
OtherYes	-0.20446940	-0.7532234	0.34428455

Table 9**Regression for Burnout ~ Hope + Location + Illness + Loss + Breakup + Accident + Other**

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.006603025	-0.3574693	0.3706754
Hope	-0.538237234	-0.7203521	-0.3561224 *
LocationSally	-0.126568321	-0.6425422	0.3894056
LocationMission	-0.132133795	-0.5441107	0.2798431
IllnessYes	0.168063784	-0.2496843	0.5858119
LossYes	0.098092210	-0.2777148	0.4738993
BreakupYes	-0.055444484	-0.4123911	0.3015021
AccidentYes	0.047815105	-0.4217325	0.5173627
OtherYes	-0.113918088	-0.4901954	0.2623592

Table 10**Regression for Satisfaction ~ Hope + Location + Illness + Loss + Breakup + Accident + Other**

	Coeff	Lower 95%	Upper 95%
(Intercept)	-0.10341503	-0.6815707	0.4747406
Hope	0.45442482	0.1652221	0.7436275 *
LocationSally	-0.31748800	-1.1368670	0.5018910
LocationMission	0.09716827	-0.5570610	0.7513975
IllnessYes	0.19182873	-0.4715653	0.8552228
LossYes	-0.05442243	-0.6512131	0.5423682
BreakupYes	0.22961108	-0.3372287	0.7964509
AccidentYes	0.09179557	-0.6538574	0.8374485
OtherYes	-0.06164515	-0.6591826	0.5358923

Hypothesis V

Hypothesis V stated that higher scores on incidents of aggression will be predictive of higher scores on measures of compassion fatigue and burnout. Aggression includes both verbal and physical aggression.

The coefficient for “rarely” having exposure had a significant result relative to the reference category, “never” having exposure (Table 11) in the CF model that controlled for physical aggression, indicating more CF for more exposure. The models of CF with verbal aggression, and burnout with verbal and physical aggression did not show significance for aggression.

Hope had significant results for the CF model that controlled for physical aggression, and for the burnout models that controlled for both verbal and physical aggression, with coefficients of -.33 (Table 11), -.55 (Table 12) and -.54 (Table 13),

respectively, pointing once again to the impact of hope in reducing compassion fatigue and burnout.

Table 11

Regression for CompFatigue ~ Hope + Location + Physical

	Coeff	Lower 95%	Upper 95%
(Intercept)	-0.2259057	-0.77846845	0.32665702
Hope	-0.3342376	-0.58797724	-0.08049795 *
LocationSally	-0.3420087	-0.97508718	0.29106986
LocationMission	-0.3225614	-0.90486386	0.25974099
PhysicalRarely	0.7231349	0.02705823	1.41921155 *
PhysicalOccasionally	0.4139518	-0.23359396	1.06149748
PhysicalWeekly	0.4422117	-0.21867333	1.10309679
PhysicalDaily	-0.2254594	-1.36286574	0.91194692

Table 12

Regression for Burnout ~ Hope + Location + Verbal

	Coeff	Lower 95%	Upper 95%
(Intercept)	0.05622219	-0.5746281	0.6870725
Hope	-0.55227581	-0.7304058	-0.3741459 *
LocationSally	-0.04217500	-0.4892909	0.4049409
LocationMission	-0.09558132	-0.4677756	0.2766130
VerbalOccasionally	-0.41125020	-1.1789299	0.3564295
VerbalWeekly	-0.01987189	-0.6714596	0.6317159
VerbalDaily	0.05487731	-0.5833160	0.6930706

Table 13**Regression for Burnout ~ Hope + Location + Physical**

	Coeff	Lower 95%	Upper 95%
(Intercept)	-0.02485388	-0.4145271	0.3648194
Hope	-0.54295630	-0.7218963	-0.3640163 *
LocationSally	-0.07389843	-0.5203523	0.3725554
LocationMission	-0.06622085	-0.4768669	0.3444252
PhysicalRarely	0.22601797	-0.2648629	0.7168988
PhysicalOccasionally	-0.04006151	-0.4967178	0.4165948
PhysicalWeekly	0.15704157	-0.3090218	0.6231049
PhysicalDaily	-0.43506473	-1.2371761	0.3670466

CHAPTER IV

Discussion

The purpose of the study was to assess levels of compassion fatigue, burnout, and compassion satisfaction in frontline shelter workers, with consideration of spirituality as a possible ameliorating factor. The conceptual framework for the study was the ProQOL Scale, developed as an elaboration of Figley's earlier compassion fatigue construct, and the Holistic Spirituality Model, designed to measure the fundamental components of spirituality: faith, hope, and love. The earliest formulation of the compassion fatigue scale measured the debilitating effects of exposure to traumatic material, describing the workers' experience in terms of intrusive, avoidant, and arousal symptoms. This vicarious effect occurs as a result of being exposed to the traumatic events of others in the line of work (e.g. an emergency room, a disaster zone, an emergency shelter). Figley's construct differed from burnout in the abruptness of its onset. Burnout, by comparison, is gradual, and is often a precursor to compassion fatigue. Burnout is characterized by emotional exhaustion, cynicism, and diminished achievement (Maslach, 2001; Borritz, et.al. 2005). Stamm (1997) argued that compassion is a necessary, though not sufficient ingredient in the relationship with the client, and that the symptom-focus in the Compassion Fatigue Scale inflated negative reporting. Research indicated that while those in helping positions do experience compassion fatigue, they also experience positive benefits, and feel that their work is redemptive (Stamm, 2002). A Compassion Satisfaction Scale was developed by building in positive questions to parallel the negative questions of the original scale, and the ProQOL Scale was developed.

The Holistic Spirituality Model was developed in response to the changing perception of spirituality as the driving force that gives meaning and purpose to life (Harmon, 1885; Oldnall, 1996; Reed, 1992). In 2008, Rovers and Kocum proposed a more inclusive model of spirituality by clustering views on spirituality around three main themes: theistic (God / Gods / Transcendent Other); existential (meaning / fulfillment / purpose); and community (relationship with self / other / the world). The themes correspond to the spiritual domains of faith, hope, and love, respectively. They developed a new holistic spirituality model, using the Spiritual Well-Being Scale, with its Religious subscale for faith, its Existential subscale for hope, and a new 7-item Community Scale for love.

Hypothesis I

Hypothesis I stated that measures of spirituality will be predictive of lower scores on measures of compassion fatigue and burnout, and higher scores on measures of compassion satisfaction.

The CF models had significant results for the 41-50 age group across models that controlled for faith, hope, and community spirituality (with coefficients of -.71, -.62, and -.69, respectively, as shown in Tables 3 and 4, indicating less CF). The combination of age and faith also showed significant results for this group. While it is important to point out that 41-50 year olds only represents 13.6% of the sample, the outcome may also have reflected differences in personal integration levels and coping strategies. A study of burnout and coping (Doolittle, 2007) showed that coping style was an important intervening variable: coping strategies of venting, disengagement and self-blame were correlated with greater exhaustion and depersonalization, while strategies of acceptance,

planning and positive re-framing were correlated with personal accomplishment. The correlations between age and faith, and age and coping strategies, would make an interesting future study.

Some research suggests that individual factors also influence the susceptibility to workplace stress. Qualities described as a feeling of control and commitment, a perception of change as challenge, and a belief that one can grow from both positive and negative life experiences appear to protect individuals engaged in caring work (Kobasa, Maddi, and Khan, 1982). With 41-50 year olds showing less CF, it is possible that this profile is more representative of the older age demographic among shelter workers.

Gender showed significance for compassion satisfaction, with a coefficient of .52, indicating more CS for females relative to males. This is an interesting result. Some researchers in related fields have found that females are at greater risk of re-experiencing PTSD symptoms (Fullerton, 2001), and that the duration of the pathology is longer for female trauma survivors than for male survivors (Simmons and Granvold, 2005), suggesting that females would possibly be more at risk of CF. Conversely, an investigation of altruistic social interest behaviors found that female gender was more predicative of giving help, and that giving help was more predictive of better mental health (Schwartz et al., 2003). This outcome corroborates the result of the present study, and may mean that female frontline workers experience more CS than their male counterparts.

The influence of the spiritual variables was most pronounced in the compassion satisfaction models, where all three variables were predictive of more CS. By comparison, faith and community spirituality had very little impact on the CF and

burnout models. Hope, on the other hand, showed significance for all models, demonstrating the capacity of hope to reduce CF and burnout, on the one hand, and to increase CS, on the other.

Research supports this result. Spirituality and religious beliefs and practices improve psychological well-being through raising hope, optimism, and a sense of purpose and meaning in life (Koenig, 1998; Cohen, 2005). A study on spirituality and helping, and spirituality and physical and psychological well-being (Mofidi et al. 2007) suggested that spirituality was related to optimism. Spirituality may be a source of optimism because it offers a sense of direction, purpose, and certainty. It follows that frontline workers who enjoy a sense of hope and well-being may enjoy more CS, and may be less prone to CF and burnout.

The location coefficients across the three model sets were not significant, but the sign patterns suggested interesting tendencies to more CF and burnout for Shepherds than for Salvation Army and Mission, but also more CS for Shepherds than for Salvation Army. The fact that Shepherds provides services to the most difficult-to-serve population in Ottawa, many who are barred from other housing and shelter organizations for behavioral problems, may contribute to greater CF and burnout for Shepherds' workers. In a related field, investigators found that the experience of CF was exacerbated by long work hours, shift work, and exposure to multiple deaths within a short period of time (Abendroth and Flannery, 2006). These difficulties resemble aspects of the Shepherd worker's experience.

Hypothesis II

Hypothesis II stated that male frontline workers would be predictive of higher scores on compassion fatigue, and female frontline workers would be predictive of higher scores on burnout.

A study on gender and employment revealed that for men, there was a positive correlation between difficulties in relations with beneficiaries (clients' suffering, clients' demands, and helplessness) and burnout, while for women, there was a positive correlation between difficulties with the provider organization (lack of appreciation, waste of time, and ambiguity) and burnout (Kulik, 2006). According to Stamm (2005) beneficiary-specific difficulties are related to compassion fatigue, while organization-specific difficulties are related to burnout. This was the conceptual basis for the hypothesis.

The present study did not support Kulik's findings. The gender coefficients for the compassion fatigue and burnout model sets were not significant. There was a recurrence of some of the earlier outcomes for CF, with the 41-50 age group showing a significant result relative to the under 30 group, and hope showing significant results for the varying model sets.

Hypothesis III:

Hypothesis III stated that living alone would be predictive of higher scores on measures of compassion fatigue and burnout, and living with others would be predictive of higher scores on compassion satisfaction.

This premise was supported by a study of secondary traumatization (Clifford, 2004) in which the results indicated that individuals with high levels of social support

tended to have fewer symptoms of secondary traumatization, while individuals with high levels of social avoidance had more symptoms.

The coefficients for living with others were not significant. Hope continued to show the same strong predictive effect for the CF and burnout model sets, however.

Hypothesis IV

Hypothesis IV stated that higher scores on prior traumatic events would be predictive of higher scores on measures of compassion fatigue and burnout, and lower scores on compassion satisfaction.

Research suggested that prior trauma would be influential in the onset of CF and burnout. Gentry et al. (1997) found that a primary trauma in the history of a helping professional was a confounding factor in the treatment of compassion fatigue, and an Assessment/Evaluation session had to be incorporated into the Accelerated Recovery Program to identify and treat it. In a related field, Zatzick et al. (2004) found that prior trauma was predictive of high levels of posttraumatic stress.

There was a lack of evidence in this study to support that prior trauma was predictive of either compassion fatigue or burnout in frontline workers. In CF models that controlled for the three spiritual variables, the 41-50 age group once again showed significance (with coefficients of -.71, -.63, and -.69), clearly demonstrating that this group is less prone to CF (Table 2). The fact that 50% of frontline workers are under the age of 30 may account for the weaker influence of prior trauma. Silverman et al. (2001) discovered that adult adversities such as the death of a child were significant predictors of PTSD. It is possible that younger workers have not had as much experience with those types of adversity. It is also possible, however, as Bonanno (2004) pointed out, that we

have underestimated the human capacity to survive after aversive events. Available evidence suggests that the majority of individuals exposed to violence do not go on to develop a stress disorder. For example, 78.2% of individuals exposed to the 1992 Los Angeles riots reported three or fewer PTSD symptoms; 79% of hospitalized survivors of motor vehicle accidents did not meet the criteria for PTSD; 62.5% of Gulf War victims had no psychological distress within one year of their return to the US. Another study of stress and coping (Triplett, Mullings and Scarborough, 2006) revealed that while correctional officers experience the same organizational stresses as those identified within the broader occupational literature, they utilize personal coping mechanisms for reducing the overall level of job stress. The possibility that frontline workers also utilize creative, personal strategies to deal with occupational stress should be further explored.

In CF models that controlled for varying observable variables, hope showed significance, with coefficients ranging from $-.18$ to $-.39$. Hope was also predictive in burnout models, with coefficients ranging from $-.46$ to $-.62$.

Hypothesis V

Hypothesis V stated that higher scores on incidents of aggression would be predictive of higher scores on measures of compassion fatigue and burnout.

Emergency responders and crisis workers absorb the traumatic stress of those they help. Exposure to trauma often correlates with high incidences of substance abuse and relationship conflicts (Beaton and Murphy, 1995). Other reactions involve cognitive shifts that result in a sense of helplessness or vulnerability by the worker, chronic suspicion of others, witness-guilt and victim-blaming (Herman, 1992; Dutton and Rubenstein, 1995). This was the theoretical basis for the hypothesis.

In the present study, the “rarely” category of exposure to physical aggression, with a coefficient of .72 was predictive of compassion fatigue. Relative to the reference category, “never,” this effect indicated more CF with more aggression.

For frontline workers, exposure to physical aggression occurs much less frequently (rarely) than exposure to verbal aggression, but the effect is more damaging and difficult to overcome. In a related field, the effects of exposure to traumatic material are described as “cumulative,” referring to impact experienced as a result of frequency of exposure, “additive” referring to impact experienced as a result of exposure to different types of trauma, and “summative” referring to the impact inscribed in memory and carried forward in time (Herman, 1992). The degree to which these same effects are operative in frontline shelter workers needs to be identified, and appropriate safeguards and remedial programs put into place.

Limitations of the Study and Future Directions

One of the most obvious limitations of the study was the small size of the data set. Seventy-one of a possible 165 subjects responded to the survey. Of those, only 44 provided complete records (answered every question). The “R” program, which was used for the data analysis, deleted cases for which there were missing values on any of the variables.

The distribution of questionnaires by managers and team leaders was another potential drawback. Those who responded possibly represented a particular set of characteristics or motivations. Larger samples and more studies could offset the response bias that may have resulted with this approach.

The self-report format was anonymous and unsupervised. It is possible that a more formal administering of the questionnaires (i.e. staff meetings or training sessions) would ensure the participation of a broader spectrum of employees, including those who would fail to participate outside of a structured setting.

Another limitation was the homogeneous nature of the sample, with 50% in the “under 30” age category, and 66% with less than three years of frontline experience. More and larger studies are needed to determine whether this sample was representative of frontline workers as an occupational group.

The ProQOL Scale is a composite of three discrete scales that cannot be compared, and do not yield a composite score. However, burnout and compassion fatigue have a shared variance of 21% (reflecting the distress that is common to both conditions), somewhat obscuring the distinction between the two measures.

This was a preliminary study. The conceptual framework was adopted from the health care, mental health, and the protection services fields. More research needs to be done to understand the costs as well as the benefits for frontline workers in homeless shelters, to make certain that they are validated and supported in their work, and to ensure that they have access to the necessary pastoral and practical resources to stay well.

Conclusions

The study identified several trends from research in related fields on the responses of workers to stress, and the factors that mediate that response.

The effect of physical aggression on worker CF was an expected outcome, given the findings from studies on traumatology and PTSD in other human service fields. While verbal aggression is a distressing experience, it is the much less frequent physical

altercations that have a more deleterious effect on workers. Future research could identify more accurately the indicators signaling the onset of CF and burnout, and facilitate the development of preventative and remedial interventions for shelter workers.

The age dependence, especially as the older group correlated with faith to produce less CF, but also less CS, was an interesting result. Stamm (2005) pointed out that the combined CF /CS effect is not atypical for workers in distressing situations who retain the altruistic desire to help.

The unexpected lack of effect for prior trauma begs the question “why?” Are shelter workers equipped, as Triplett et al. found in the case of correctional officers, with an innate adaptability that protects them over the long term? Is religion a possible consideration? In Park’s study of bereaved college students (2005), religion showed a positive association with long-term adjustment. Is it, as Bonanno wondered, that our survival instincts triumph over even extreme duress? More studies are needed to understand what appears to be a departure from the research findings on CF and burnout in other fields.

The most consistently significant outcome in this study was the effect of hope on the three dependent variables. In multiple combinations of observable variables, the predictive value of hope persisted. While the limitations of the study must be acknowledged, the findings do call attention to the importance of nurturing existential well-being in shelter workers, and restoring it in those whose sense of well-being has been compromised. Suggestions for supporting worker well-being include on-site spiritual care to enable workers to tell their stories and to re-connect with a sense of hope

and empowerment, formal protocol to address compassion fatigue and burnout (i.e. the Accelerated Recovery Program), a workplace policy of critical incident debriefing, benefits provision for spiritual direction or psychological counseling, renewal / mental health days, a self-care component in work evaluation and performance goals, access to self-care opportunities (aromatherapy, journaling, yoga, etc.), in-service training in stress management and self-regulation strategies, environmental considerations (a place where workers can rest or recreate during breaks, creation of a labyrinth or healing garden), and forums for putting forth concerns and suggestions.

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APPENDIX A

Compassion Fatigue and Burnout in Frontline Shelter Workers in Ottawa: Spirituality as an Ameliorating Factor

Information and Consent

This research is studying responses to trauma by shelter employees who work frontline with the homeless in three Ottawa shelters. Participants would benefit from this study by better understanding compassion fatigue, and the role of spirituality as a correlative factor in their responses to stress and trauma. The study may also help shelter administrators to know which strategies or programs can best support for their employees.

The Research Ethics Committee of St. Paul University has approved this study. The study consists of a short, four-part questionnaire. Part one is about such demographic factors as age and gender. Part two considers the positive and negative effects of your work as a frontline employee. Parts three and four look at general spirituality. Participation is completely voluntary. To protect your anonymity and confidentiality, no identifying information will be taken. Participants can withdraw from this study at any time, or can choose not to answer any question in the survey. A decision not to participate will have no consequences for your employment at this time, or at any time in the future.

Know that by completing this questionnaire you are consenting to have your responses used anonymously in the research project. The questionnaire takes approximately twenty minutes to complete. You are asked to complete the questionnaire at your earliest convenience. Once completed, place the questionnaire in the envelope, seal, and mail.

Should you experience distress as a result of answering this questionnaire, the chaplain in your organization will be available to provide a debriefing service.

Thank you for contributing to this research project.

RESEARCHERS

If you have questions about the study, or your participation, please contact:

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APPENDIX B
QUESTIONNAIRE

Part One

1. Age _____
2. Gender _____
3. Place of Birth _____
4. Marital Status _____
5. Education _____
6. Ethnic Origin _____
7. Religion _____
8. Length of Employment with Shepherds _____
9. Have you been involved in critical incidents as an employee of Shepherds _____
10. If so, how often _____
11. In the last five years, have there been other major traumatic events in your life not related to your work at Shepherds _____
12. If so, please specify:
 Serious Illness _____ Loss of Loved One _____
 Relationship Breakdown _____ Accident/Injury _____
 Other _____

Part Two

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you [help] has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the last 30 days.

0=Never- 1=Rarely - 2=A Few Times - 3=Somewhat Often - 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 losing sleep over traumatic experiences of a person I [help].
- ___ 9. I think that I might have been infected by the traumatic stress of those I[help].
- ___ 10. I feel trapped by my work 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 as a result of my work as a [helper].
- ___ 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.

12. I don't enjoy much about life. SA MA A D MD SD
13. I don't have a personally satisfying relationship with God. SA MA A D MD SD
14. I feel good about my future. SA MA A D MD SD
15. My relationship with God helps me not to feel lonely. SA MA A D MD SD
16. I feel that life is full of conflict and unhappiness. SA MA A D MD SD
17. I feel most fulfilled when I'm in close communion with God. SA MA A D MD SD
18. Life doesn't have much meaning. SA MA A D MD SD
19. My relationship with God contributes to my sense of well-being. SA MA A D MD SD
20. I believe there is some real purpose for my life. SA MA A D MD SD

Part Four

For each of the following statements, circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree MA = Moderately Agree A = Agree
 D = Disagree MD = Moderately Disagree SD = Strongly Disagree

1. My community of worship is important for my spirituality. SA MA A D MD SD
2. Praying with another person can bring God closer to me. SA MA A D MD SD
3. Where two or more gather is an important part of my spirituality. SA MA A D MD SD
4. The support of my family brings me closer to God. SA MA A D MD SD
5. Helping the poor is central to my spirituality. SA MA A D MD SD
6. It is important that my partner/significant other support me in my spirituality. SA MA A D MD SD
7. The family that prays together, stays together. SA MA A D MD SD

APPENDIX C

Are you running on empty?

Are you constantly exhausted?

Do you sometimes feel irritable because of work?

Do you dread working with certain clients?

Perhaps you are experiencing Compassion Fatigue.

Researchers at St. Paul University are looking for Frontline Workers to participate in a study of the effects of being Helpers.

Surveys will be distributed at The Ottawa Mission, Salvation Army & Shepherds of Good Hope.

Your participation is anonymous and voluntary.

For more information, contact:

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APPENDIX D

OBSERVABLE VARIABLES TEMPLATE

- 1. Participant Number** 1- 71
- 2. Location** 1 = Shepherds, 2 = Sally, 3 = Mission
- 3. Age** 1= under 30, 2 = 30-40, 3 = 41-50, 4 = 51-60, 5 = 61+
- 4. Gender** 1 = Male, 2 = Female
- 5. Place of Birth** 1 = Canada, 2 = Other
- 6. Marital Status** 1 = Married of C/L, 2 = Single, 3 = Sep. / Div./ Wid.
- 7. Education** 1 = High School, 2 = BA / College, 3 = MA, 4 = PhD.
- 8. Living Alone** 1 = Alone, 2 = With Others
- 9. Religion** 1 = Catholic, 2 = Prot., 3 = Jewish, 4 = Other, 5 = None
- 10. Length of Employment** No of years (rounded off i.e. 9 mo = 1 yr)
- 11. Incidents of Aggression** 1 = Yes, 2 = No

If Yes:

- 12. Verbal** 1 =Daily, 2 =Weekly, 3=Occasionally, 4 =Rarely, 5 =Never
- 13. Physical** 1 =Daily, 2 =Weekly, 3=Occasionally, 4 =Rarely, 5 =Never

Other Traumatic Life Events:

- 14. Serious Illness** 1 = No, 2 = Yes
- 15. Loss of Loved One** 1 = No, 2 = Yes
- 16. Breakup** 1 = No, 2 = Yes
- 17. Accident / Injury** 1 = No, 2 = Yes
- 18. Other** 1 = No, 2 = Yes