MENTAL HEALTH CASE MANAGERS: AN ANALYSIS OF COMPASSION FATIGUE AND WELLBEING

by

Tamunosaki Bilaye-Benibo

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Approved by:

_____
Dr. Teresa L. Scheid

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Dr. Zinobia Bennefield

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Dr. Elizabeth Stearns

ABSTRACT

TAMUNOSAKI BILAYE-BENIBO. Mental Health Case Managers: An Analysis of Compassion Fatigue and Wellbeing. (Under the direction of DR. TERESA L. SCHEID)

Compassion fatigue is a phenomenon wherein employees in "helping professions" develop decreased capacity for empathy due to repeated/extended exposure to client trauma and suffering. In addition to negatively impacting relationships with their clientele, compassion fatigue may also be associated with decreased wellbeing for case managers. To evaluate this connection, I drew data from the Mental Health Provider Survey collected by Dr. Teresa Scheid. Using this data, I summarized the type of work done by case managers, and created a reliable measure of compassion fatigue using items in the dataset. I then validated the measure using already-present scales of emotional exhaustion and depersonalization. Finally, I used Pearson's correlation to analyze the relationship between this measure of compassion fatigue and established measures related to wellbeing. The correlation performed as predicted, with compassion fatigue being positively correlated with emotional exhaustion and depersonalization, and negatively correlated with measures of wellbeing. All correlations were statistically significant. This thesis provides an example of a reliable and valid measure of compassion fatigue, and demonstrates the relationship compassion fatigue to mental health case manager wellbeing.

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INTRODUCTION

In the field of mental healthcare, case managers serve a pivotal role as the primary liaison between the mentally ill and the healthcare system. Like many occupations where employees have regular contact with clients, case management requires substantial emotion work and emotional labor. Emotion work is defined as the management of the degree or quality of emotion or feeling, sometimes to maintain/manage relationships with others (Hochschild 1979). Emotional labor is defined as "the process by which workers are expected to manage their feelings in accordance with organizationally defined rules and guidelines" (Wharton 2009:147). Emotional labor and emotion work are often conflated, but both are included here because for case managers they are not interchangeable. Case managers do emotion work when trying to maintain relationships with clients, but also perform emotional labor in ways dictated by organizational oversight (Kondrat and Early 2010; Scheid 2003). The high level of emotional work and emotional labor required for case management work can produce a psychological and emotional response known as compassion fatigue, which may then affect the overall wellbeing of case managers. Compassion fatigue is, put simply, the reduced capacity for empathy experienced by those who work with traumatized or suffering people (Harr et al 2014). Direct care workers like case managers are particularly susceptible to compassion fatigue. (Harr et al 2014). Wellbeing can be broadly understood. as a state of sustained stable physical and/or psychological health (Waterman 2008). I believe that compassion fatigue is an important influence on the wellbeing for mental health case managers.

With this thesis, I intend to contribute to research on the connections between compassion fatigue and wellbeing for mental health case managers. To this end, I will be creating a reliable measure of compassion fatigue and validating it using scales that measure the adjacent concept of burnout. I will do so using the 2000 dataset collected by doctor Teresa Scheid and her colleagues from the Mecklenburg County Mental Health Center. This data set contains a wide range of items and scales that measure various aspects of the emotion work case managers do, making it especially useful for this thesis. Because wellbeing is a composite of many factors, I have selected scales from the data that I believe to be critical, useful components of wellbeing: staff autonomy and job satisfaction. For case managers, the ability to do their jobs helping other effectively

The reason for the focus on compassion fatigue comes from current gaps in literature. Much of the current literature on compassion fatigue tends to center on work done by social workers (Harr et al 2014; Zeidner and Hadar 2014). While the work of social workers is very similar to that done by mental health case managers, it is not entirely interchangeable. Similarly, much of the present literature regarding case management frames the emotional consequences of their work in terms burnout or emotional exhaustion (Kondrat and Early 2010, Scheid 2003). Rarely is compassion fatigue discussed in terms of mental health case managers, or vice versa. This may be because compassion fatigue is often assumed to be a part of the emotional exhaustion and depersonalization associated with psychological burnout. Burnout is defined as “a prolonged psychological response to workplace stressors” (Kim et al 2011:258). Maslach

et al (2001) state that burnout can be understood in terms of several dimensions. Two of these dimensions, represented in this dataset by the emotional exhaustion and depersonalization scales, parallel compassion fatigue most closely. Thus, I have chosen to use them to validate my created measure of compassion fatigue. I will elaborate on the relationship in the literature review.

However, compassion fatigue is still distinct from measures of emotional exhaustion and depersonalization. Compassion fatigue mainly affects direct care workers like case managers, due in part to their proximity to client trauma. This trauma can range from psychological, physical, or some combination. Care workers, such as social workers or mental health case managers, are expected to help their clients cope with this trauma. Care work also often requires its employees to face this trauma/suffering directly and empathetically. Over time this results in negative emotional impacts for them, such as compassion fatigue (Harr et al 2014). For this reason, I believe compassion fatigue to a potentially more accurate and relevant measure of the effects of emotional labor/emotion work on case manager wellbeing. However, burnout is more common within the literature, including the dataset used for this thesis. As such, it is necessary to create a reliable and valid measure of compassion fatigue. With this intent in mind, the research objectives are as follows:

1. Describe the emotional work of mental health care case managers working with clients who have severe mental illness
2. Develop a reliable and valid indicator of compassion fatigue which is linked to the work of mental health case managers

3. Examine the relationship between compassion fatigue and well-being (which is assessed by levels of job satisfaction and autonomy).

BACKGROUND AND SIGNIFICANCE

In order to organize the literature, I will first describe the work that mental health case managers do using relevant literature. Then I will discuss compassion fatigue, explaining why it is conceptually unique, and what distinguishes it from burnout. I will then discuss wellbeing, a multifaceted concept that covers a wide range of aspects in the lives of case managers.

Case Managers

Case management, when given further attention, is rather complex occupation. Case management is "a problem-function designed to ensure continuity of services and to overcome system rigidity, fragmented services, and misutilization of certain facilities, and inaccessibility." (Dill 1987:62) Put another way, case managers are not only crucial to maintaining their clients' health and stability, they are also stabilizing agents of the mental healthcare system. The role of the case manager for the client is that of a surrogate primary group member (such as a parent, sibling, or close friend), while the role of the case manager for the organization is as the front line and inter-group liaison (Baker and Weiss 1984; Harris and Bergman 1987; Kanter 1985; Levine 1979). Case managers must engage in extended interpersonal contact with client, manage problems that affect daily, and treat each client as a long-term commitment (Dill 1987). Moreover, case manager responsibilities bear a striking resemblance those of other types of care work, such as social work, counseling, and community advocacy. All of these responsibilities must be undertaken while working with clients who often have severe persistent mental illness and live under the poverty line. Mental health case

managers also employ client assistance that extends beyond clients' mental health needs. Case managers are expected to assist clients with managing their mental illness, but also help with circumstances related their mental illness. Scheid (2004) elaborates that case managers assist clients with housing, accessing entitlements, substance abuse services, emergency services. Case managers also assist with referrals, advocacy and coordination with other related agencies (Scheid 2004). To that list Castellano (2011) adds that case manager are also potential advocates to for mental ill clients in the criminal justice system.

Additionally, important to understanding mental health case managers' work is the associated stigma related to their clients. In a 2010 article, Kondrat and Early discuss "working alliance" or the balance that case managers must negotiate and maintain with their patients. When case management and mental health stigma were considered in tandem, Kondrat and Early (2010) found that together they were a significant predictor of working alliance. Put another way, case managers most effectively relate to/assist their clients when they help said clients manage the impact of stigma. The implication here is that in order to do their jobs well, case managers must also manage external social pressures experienced by their clients. Additionally, despite the work they do, case managers do not have the prestige of other positions in the medical field. This is due in part to lower education prerequisites and lower pay for case managers. The combination of low status, poor working condition, and difficult clients all have the potential to impact wellbeing. This can be incredibly taxing emotionally, leading to outcomes such as compassion fatigue.

Compassion Fatigue

Compassion fatigue is important because it has the potential to encapsulate the complex array of negative emotional impacts that may come from case management work. Case managers work with clients who have persistent, severe mental illness. Either because of their mental illness, or exacerbated by it, clients are often socioeconomically disadvantaged. For example, a client with severe schizophrenia may have difficulty finding a steady means of income due to both the positive and negative symptoms of their illness, and the stigma surrounding that illness (Scheid 2004). Case managers are expected to engage with these clients in a way that is deeply empathetic, employing multiple types of emotion work in order to manage a myriad of potential situations with clients. This can lead to case managers experiencing emotional exhaustion, depersonalization, and ultimately burnout (about which there is substantial research). I argue that compassion fatigue is a concept distinct from burnout. Harr et al (2014) explain that while burnout and compassion fatigue have overlapping symptoms (e.g. emotional exhaustion), it is important to regard that them as separate influences. Burnout happens over an extended length of employment, when individual and organizational demands are at odds (Harr et al 2014). Symptoms of burnout include a reduced sense of accomplishment, job dissatisfaction, and a sense of lack of fulfillments. A crucial difference between burnout and compassion fatigue is that burnout can occur with employees of any job, while compassion fatigue is found mainly among direct care workers in helping professions (Harr et al 2014). Harr et al (2014) elaborate that compassion fatigue comes from direct engagement with client

pain/suffering/marginalization. Most simply, it can be defined as the "reduced capacity for or interest in being empathic" (Adams, Boscarino & Figley 2006; Figley 1995"). Compassion fatigue is a unique concept in that it describes the negative impacts of working with people who have high levels of trauma, suffering, or negative life events. Compassion fatigue is higher in these care workers who work with needy populations (Kanter 2007; Sabin-Farrell & Turpin 2003). Some factors that Harr et al and other scholars describe as contributing to compassion fatigue include lack of work satisfaction and lack of control of work stressors. Additionally, Forster (2009) links compassion fatigue to moral stress that comes from ethical/value conflicts while working with their clients. This means that care workers such as case managers are at higher risk on compassion fatigue when organizational demands supersede the care workers' personal ethics or judgement.

Scheid (2003) elaborates on the effects of organizational intervention and interference in her study on the effect of Managed Care on mental healthcare workers. She argues that the increased corporatization of medical/healthcare systems, as exemplified by managed care, runs contrary the needs of mentally clients and the mental healthcare system. Some aspects of managed care can be useful, such as performance accountability and outcome assessment. But the system stresses cost reduction and efficiency above all else, excluding the community-centered treatment that is necessary in mental health settings. While managed care operates under the pretense that it is patient-centered, the current model often interferes with effective patient care. Relevant to the present study, Scheid (2003) found that providers

experienced decreased quality of life since the implementation of managed care. Providers felt decreased involvement in their jobs, job role clarity, autonomy, and satisfaction with the nature of their work. Providers also felt burned out and experienced a significant increase in emotional exhaustion. The combination of emotional labor, organizational intervention/interference, client demands and risks, and relatively low pay, all contribute to burnout and high job turnover (Scheid 2003). Since Scheid's (2003) work, compassion fatigue has gained much more attention as a factor influencing health care workers. In this thesis, I will use Scheid's data to not only examine the emotional labor of case managers, but to develop reliable and valid measure of compassion fatigue.

Wellbeing

Wellbeing is defined as a state of sustained stable health (physical/emotional/mental), characterized by happiness and feeling free from tension (Waterman, 2008; Watson, Clark, & Stasik, 2011). For example, Bennefield (2018) uses positive affect, defined as "happiness, feeling satisfied and free from tension, and a hopeful outlook on life." Bennefield (2018) states that this measure for wellbeing was chosen because much of the literature characterized wellbeing, specifically psychological wellbeing, as the absence of mental illness or distress. The important lesson learned from this study is that wellbeing is not consistently measured within academic canon, and is even defined differently across disciplines. So measurable proxies, such as positive affect, are necessary to communicate the effects of certain variables on wellbeing. The second lesson, that wellbeing is impacted by external

circumstances, would appear obvious, but wellbeing is often colloquially understood to be an internal physical/mental/emotional homeostasis. Documentation of external influences and pressures allows for more solution-based action and research for how to improve wellbeing for a given person or population. The third lesson is that wellbeing can be measured in terms of different, generally positive aspects, rather than the simple absence of negativity. For the purposes of this thesis, I consider autonomy and job satisfaction to be critical components of wellbeing for mental health case managers. According to Harr et al (2014) and Zeidner and Hadar (2014), job satisfaction and autonomy are important to consider when understanding the relationship between compassion fatigue and psychological health/wellbeing. While I understand that these concepts do not fully encompass the vastness of wellbeing, they suitable and useful as proxies within this thesis.

Autonomy is broadly defined as self-government, or the ability of the self to determine course of action, free from external constraints (Nickel 2007). In the context of occupational/work literature, autonomy refers specifically to the relative level of discretion that an employee would have at their job, specifically over their tasks and time (Adler 1993). Autonomy within the workplace is an important part of case manager wellbeing, because a significant source of stress is borne from restricted autonomy. The respondents to Scheid's (2004) survey indicated that the decreased autonomy that came from managed care preceded negative emotional outcomes. Harr et al (2014) connected work autonomy more explicitly to compassion fatigue. They state that conflict between the worker's desire to help and organization obstacles is one

factor that could negatively affect wellbeing and increase the risk of compassion fatigue in care workers. The opposite is also true. When workers can help their clients to the best of their ability and knowledge without excessive oversight or restriction, their wellbeing improves (Scheid 2004). Autonomy therefore is an important factor, related to case manager wellbeing.

The other facet of wellbeing in this thesis is job satisfaction. Job satisfaction can be defined as "the pleasurable emotional state resulting from the appraisal of the extent to which the work environment fulfills and individuals requirements." (Lofquist and Dawis 1969:47). Job satisfaction is borne from a combination of work factors, such as environment, working conditions, relationships with supervisors and coworkers, and pay. Job satisfaction is important because case manager may be competent at their job, and derive satisfaction from helping others, but still dread coming to work each day. Wellbeing extends beyond job satisfaction, but job satisfaction is still an important part of wellbeing for case managers.

RESEARCH OBJECTIVES

The first research objective for this thesis is to describe the types of emotion work done by case managers, and how frequently they do so. Often, a case manager must play a combination of occupations roles simultaneously, all with the requisite emotional work and emotional labor. It is this emotional labor that I argue impacts case manager wellbeing via compassion fatigue.

The combination of a larger-than-desired case load and extensive time spent doing engaged emotion work with high need, often traumatized, mentally ill clients can impact case managers negatively. Compassion fatigue is one such negative impact, unique to care workers like case managers. Again, compassion fatigue is characterized by a decreased capacity for empathy experienced by those who work with traumatized patients. It is this decreased empathy that makes compassion fatigue sound similar to emotional exhaustion and depersonalization. However, the degree of trauma experienced by those with severe mental illness, and by extension those who work with them, makes compassion fatigue a distinct result of the emotion work associated with mental health case management. For example, case managers may find themselves indifferent or dismissive to client complaints of self-harm or suicidal ideation, coldly parsing the "real" from the "attention seeking". Compassion fatigue is a response specifically to repeated exposure to trauma/suffering. Thus my next goal is to demonstrate that it is a distinct concept.

As such, the second research objective of this thesis is to develop a reliable measure of compassion fatigue. I will use questions in the dataset which assess various

components of compassion fatigue to develop a valid and reliable measure. The next step is to use the preexisting emotional exhaustion scales to validate the new measure of compassion fatigue once it is confirmed to be a reliable measure. The third and final objective is to use this created measure to examine the relationship between compassion fatigue and wellbeing. Based on the literature, I would hypothesize that higher levels of compassion fatigue would coincide with higher emotional exhaustion, and lower wellbeing. This hypothesis is borne of Harr et al's (2014) acknowledged parallels between burnout (represented here by emotional exhaustion) and compassion fatigue, as well as the buffering/moderating effects of job satisfaction and professional autonomy (represented by staff autonomy). Because the Mental Health Service Provider Survey data is cross sectional, I cannot establish any casual effect. I can still, however, provide analysis on the nature of the relationship between compassion fatigue and wellbeing.

METHODS AND DATA

The data used in this thesis are from the Mental Health Service Provider Survey (MHSPS), originally collected by Teresa Scheid via questionnaire distributed to 96 direct care workers in the Mecklenburg County Mental Health Center (Scheid 2004). The survey was designed for the purpose of collecting data on occupation experiences and work experiences. The survey also contained items about program philosophy, goal incongruence, and evaluations of organizational effectiveness. Scheid distributed the survey in 1998 to establish a baseline, and again in 2000 to compare to the original sample and observe the effects of managed care. Though the survey was originally distributed to 96 direct care providers, including case managers, the final number of respondents was 47. Scheid attributes this to high turnover, as nearly half of the 1998 respondents had left their jobs by 2000. The final sample was made up of 68% women and 27.7% men, with the remaining percentage consisting of those who did not answer the question. The ethnoracial breakdown is 66% white, 27.7% black, and 2.1% Hispanic, which is representative of the surrounding population (Scheid 2003). Over 50% of the sample were 40 year of age or older. The descriptive statistics of the relevant items and basic demography can be found in Table I and Table II in the appendix on pages 34 and 35.

This thesis is based in the latter survey distribution from the year 2000. The data from the latter survey contain responses given by case managers working under managed care, suggesting greater organizational control of day to day activities. The working condition and experiences reflect that control, leading to higher occurrence of

negative emotional impacts. Additionally, the data is nearly all quantitative (with a few open-ended questions), which facilitates the intended qualitative analysis.

To create measure of compassion fatigue, I first selected variable from Scheid's 2000 dataset that theoretically appear to measure compassion fatigue. *Compassion Fatigue*, the decreased capacity for empathy experienced by those who work with traumatized clients, does not have a preexisting scale in the MHSPS dataset. However, because the dataset has multiple items asking about case manager work, the nature their work, and the effects of their work on them, I believe that creating reliable and valid measure of compassion fatigue is possible. The items listed below are found in the burnout section of the questionnaire, but are theoretically more closely related to compassion fatigue (Harr et al). They indicate resistance, resentment, and indifference about work, most of which is direct interaction with clients. Most importantly, the items indicate increasing emotional distance from clients. In the questionnaire respondents are asked to circle all that apply, creating a simple yes/no binary. A cumulative scale would be appropriate here, with the implication that the more items in the scale with which a respondent agrees, the higher their level of compassion fatigue. There are twelve items in total in the scale. The coding of these items is such that the number 0 refers to "no," while 1 refers to "yes." This being a cumulative scale, the highest compassion fatigue score that any single respondent could have is 12, while the lowest is 0. The frequencies for these specific items can be found in Table III in the appendix on page 35. The selected items for compassion fatigue are as follows:

- Resistance to going to work every day

- A sense of failure
- Anger or resentment
- Discouragement or indifference
- Tired and exhausted all day
- Loss of positive feelings towards clients
- Postponing client contacts, resisting phone calls/visits
- Stereotyping clients
- Inability to concentrate on or listen to what a client is saying
- Cynicism toward clients, a blaming attitude
- Increasingly going by the book
- Avoiding discussion of work with colleagues

Reliability refers to the consistency of a constructed instrument in measuring a concept. There are several ways to statistically assess reliability, such split-half or test-retest. The statistical measure used here is based on Cronbach's alpha, which is a numerical value that indicates the internal consistency. A high alpha such as 0.75, would indicate high reliability and internal consistency. For this thesis, Cronbach's alpha will measure how closely the items in the new scale measuring compassion fatigue relate to each other, assessing whether they are measuring the same phenomenon. The next step is to establish the validity of my compassion fatigue measure. In order to establish validity, it is important to understand it. Validity refers to the accuracy measurement born from using the correct instruments. There are four types of validity: Face, Content,

Construct, and Criterion. Face validity is the process of seeing if indicators of a concept make sense logically, at face value. In the context of this thesis, the indicators of compassion fatigue appear to be reasonable ways to measure compassion fatigue. For example, (insert source) indicates that a lack of autonomy at work is a substantial predictor for compassion fatigue. So, using the autonomy scale that at is already present in the dataset makes logical sense, as that decision is supported by the literature.

Content validity is when an instrument contains sufficient content to measure a complex concept. In other words, an instrument has content validity when it contains enough varied, yet relevant, information to address the concept in question. While autonomy is an important to understanding compassion fatigue, developing a measure that only uses autonomy to measure compassion fatigue would be erroneous.

Both face and content validity are important, but the core of this thesis is construct validity. Construct validity is high when the observations made with the instrument closely match the construct that instrument claims to measure. If low autonomy, high emotional exhaustion, and high depersonalization can be used collectively to measure the complex concept of compassion fatigue, then a person who states experiencing high compassion fatigue could assumed to be experiencing any or all of the aforementioned traits. This is the goal of this thesis: to create a measure of compassion fatigue that has high construct validity.

Criterion validity occurs when the constructed measure of a concept yields results comparable to measures that are already established/legitimized. In the context

of this thesis, the measures created for compassion fatigue would achieve criterion validity if it yields results comparable/similar to the burnout scales already established in the codebook of the MHSPS.

So, after confirming the reliability of my created measure for compassion fatigue, I seek to validate it by comparing the it to emotional exhaustion and depersonalization. These are preexistent scales from within the MHSPS, both confirmed to be highly reliable (Cronbach's alpha of 0.9067 and 0.7607). Additionally, emotional exhaustion and depersonalization are two of the Maslach(2001) burnout scales, confirmed to be valid and widely applicable. Because the effects of compassion fatigue can be read as similar to those of emotional exhaustion and depersonalization, these scales would be effective in assessing the validity of the newly created compassion fatigue scale. This is the scale as follows:

- Emotional Exhaustion
    - I feel emotionally drained from work.
    - I feel used up at the end of the workday.
    - I feel fatigued when I get up in the morning and have to face another day on the job.
    - Working with people all day is really a strain for me.
    - I feel burned out from my work.
    - I feel frustrated by my job
- Depersonalization
    - I feel I treat some recipients as if they were impersonal objects

- I've become more callous toward people since I took this job.
- I worry that this job is hardening me emotionally.
- I don't really care what happens to some recipients.
- I feel recipients blame me for their problems.

Next are the scales that I am using as proxies for wellbeing. These scales already exist in the dataset; they, too, are confirmed to be reliable and valid. Wellbeing is quite broad and multifaceted, but these scales, staff autonomy and job satisfaction, are key to the wellbeing of mental health case managers. The specific items in these scales are listed below. Autonomy will be represented by *staff autonomy*, while job satisfaction will be measured by *satisfaction with nature of work* and *overall job satisfaction*.

Staff Autonomy refers to the perceived amount of freedom or restriction that case managers have in doing their jobs and assisting their clients as they see fit. In the original dataset, the responses are a scale ranging from 1(strongly disagree) –5(strongly agree) with higher numbers indicating a greater sense of staff autonomy.

- I can usually use new work techniques without having to okay it with a supervisor first.
- How things are done around here is left pretty much up to the person doing the work.
- People around here are allowed to do almost as they please.
- Around here there are many things you can't do without first checking it out with several other people.

- A person can make his/her own decisions here without checking with anybody else.

Job Satisfaction is the feeling of fulfillment that comes from several aspects of work life working in one's favor. In the original dataset the scales range from 1 (strongly disagree) to 7 (strongly agree) with higher numbers indicating greater job satisfaction. The job satisfaction scales were created by taking the mean of the individual items listed. In the MHSPS dataset, job satisfaction itself is quite complex, and divided in the many subscales. For the sake of both simplicity and relevance to this thesis, I have chosen two of the job satisfaction scales. The subscales are as follows:

- Satisfaction with Nature of Work
  - I sometimes feel my job is meaningless.
  - I like doing the things I do at work.
  - I feel a sense of pride in doing my job.
  - My job is enjoyable.
- Overall Job Satisfaction
  - Overall, I am satisfied with my current work situation.

In addition to the other variables, I have selected key variables as potential controls in analyzing the relationship of compassion fatigue to wellbeing.

- Percentage of time spent with clients.
- Case Load

FINDINGS

In the 2000 version of the MHSPS, there are items that specifically refer to the frequency of certain types of emotion work such as rapport, support, encouragement, trust and, of course, compassion. As the tables below indicate, the case managers responded “always” or “almost always” when asked how often they employed these types of emotion work to manage their relationships with their clients. An example of this is compassion, which 68.1% of the respondents stated using “always” when working with clients. The notable exception would be the use of more coercive emotion work with clients, which most respondents stated using “never” or “once in a while”. For example, 38.3% of respondents stated that they never utilized manipulation with their clients, while 42.6% reported doing so “once in a while”. These results were obtained by running a frequency of the relationship variables in SPSS. This may imply that while case managers do high levels of layered emotion work, the engagement itself is done on more positive terms.

Additionally, case managers may experience incongruence between their assigned caseload and their ideal caseload, often because a larger caseload may decrease the amount of time spent with each client. The MHSPS dataset demonstrates this in Tables IV, V, VI in the appendix on pages 37 and 38. Both the mean and the median ideal caseload, 25.44 and 22.5 were substantially lower than the mean and median actual caseload (30.71 and 35, respectively). This would seem to indicate that most of the case managers would prefer fewer clients. However, the Pearson correlation in Table III displays a statistically significant negative correlation between

ideal number of clients and percentage of time spent with clients. It is the only significant correlation between these four items describing case manager work. This means that as the number of ideal clients increases, the percentage of time spent face-to-face with clients decreases, and vice versa. One interpretation of this output is that those who would desire a smaller caseload may feel they are spending too much of each day with their clients. Case managers in this sample reported spending an average of half their time (49.55%) meeting directly with clients.

As stated previously, I selected twelve items from the dataset that aligned with the description of compassion fatigue in prior literature. Using *SPSS 25*, I ran a reliability assessment for compassion fatigue with the selected questions. As seen in Table VII (appendix, page 39), the resultant Cronbach's alpha was quite high at .804, being the standardized alpha being marginally lower at 0.797. An alpha this high could suggest that the measure is very reliable, but it could also suggest some abnormal covariance. Put another way, the high Cronbach alpha could mean that two or more of the variables are overlapping/interchangeable, which would be indicated by a covariance of 1.0. So, I reran the test, testing for covariance, and found that the covariance between the items was low; none rose above approximately .3. This means that while the internal reliability is high, it is not because multiple variables are overlapping and interchangeable. Rather it is because they are measuring the same latent phenomenon, which I believe to be compassion fatigue. In Table VIII (appendix, page 39), the last two items used to create the compassion fatigue scale ("Increasingly going by the book" and "Avoiding discussion of work with colleagues") result in a lower Cronbach's alpha. This

indicates that the removal of these items would result in a stronger Cronbach's alpha, and a more reliable measure. However, I have chosen to keep them as part of the measure for two reasons. The first is that they are still conceptually valuable aspects of compassion fatigue, as they illustrate the distancing and isolation that is symptomatic of compassion fatigue (Harr et al 2014). The second is that the current alpha, 0.805, is still quite strong. The removal of the aforementioned items would only increase the alpha to 0.805 and 0.819, respectively. The benefits of leaving these items in the measure outweigh those of removing them.

Compassion fatigue, when correlated with the scales of emotional exhaustion and depersonalization was found to be strongly and positively correlated with both. Additionally, for both scales, compassion fatigue was found to correlate significantly at the 0.01 level. I used Pearson's correlation to validate the compassion fatigue measure. The correlation coefficients are quite high (.663 for emotional exhaustion, and .535 for depersonalization), suggesting that there is significant overlap between compassion fatigue and these measures of burnout. One explanation for this overlap is that the items for compassion fatigue were drawn from the section of the MHSPS that contains multiple measures of burnout. However, the items chosen for compassion fatigue do not come from the emotional exhaustion and depersonalization scales, and are in a separate subsection of the survey. So, the high positive correlations cannot be said to come from the scales sharing items. Instead, they likely come from the conceptual parallels between compassion fatigue and burnout as described by the literature. The results here suggest that compassion fatigue is a valid measure. While there is some

overlap, it is still functionally distinct from emotional exhaustion and depersonalization. As a reminder, compassion fatigue is not a measure of burnout, despite those theoretical similarities. Compassion fatigue's relationship wellbeing is distinct from burnout in that compassion fatigue is linked directly to care workers' experiences with client trauma and suffering.

To represent wellbeing in this thesis, I used preexistent scales of autonomy and job satisfaction (itself a combination of satisfaction with nature of work and overall job satisfaction). Using Pearson's correlation, I found these measures of wellbeing to be negatively correlated with compassion fatigue. The correlations for satisfaction with the nature of work and overall job satisfaction were -0.478 and -0.527, respectively. For autonomy, the correlation was -0.638. These numbers are not only strong correlations practically, they are also statistically significant at the 0.01 level. As predicted, compassion fatigue is negatively associated with wellbeing for mental health case managers in Scheid's MHSPS dataset, and significantly so. Case managers experiencing high levels of compassion fatigue also tend to experience decreased satisfaction with the nature of their work (which as stated previously, is nearly 70% direct contact with clients), decreased overall job satisfaction, and have less autonomy. As seen in Table IX (appendix, page 39), all of the scales associated with wellbeing have significant negative correlations with emotional exhaustion and depersonalization as well, lending further credibility to the created measure of compassion fatigue.

DISCUSSION

Compassion fatigue's relationship to both scales of burnout and the scales of wellbeing performed as predicted. As suggested by the literature, particularly Harr et al (2014), compassion fatigue runs parallel to burnout. Though, again, they are not interchangeable because compassion fatigue is phenomenon specific to care workers who engage with the trauma of suffering populations. In addition to Harr et al (2014), Zeidner and Hadar (2014) cite job satisfaction and autonomy as factors that are associated with less severe compassion fatigue. As such, I predicted that compassion fatigue would be positively correlated with the measures of burnout, such as emotional exhaustion and depersonalization. I also predicted that compassion fatigue would negatively correlate with measures of wellbeing. The results of both the reliability assessment and the validity assessments support these hypotheses. This means that, for the population of case managers in the MHSPS, higher compassion fatigue coincides with higher emotional exhaustion and depersonalization and lower job satisfaction and autonomy. Despite the seeming importance of emotion work and emotional labor, compassion fatigue had much stronger and more significant correlations with measures of burnout and proxies for wellbeing. This may also coincide with the Zeidner and Hadar (2014) assertion that care workers derive pleasure or satisfaction from working with clients, despite the engagement with trauma and risk for compassion fatigue. This suggests that there is a complex process here that warrants future exploration: the interplay between compassion fatigue, its foundations, and its buffers.

LIMITATIONS

Like every research endeavor, however, this thesis contains limitations. The first limitation is the age of the data. The questionnaire data used in this thesis were originally collected in 1998 and 2000. While it is plausible that a newer survey would yield similar results, it is also important to note that the survey data was collected at the advent of managed care. The original purpose, in fact, was to track the perceived changes wrought by the transition to managed care. In the 20 years since, respondents to a more recent survey may have slightly different responses. The high turnover remains, potentially caused by compassion fatigue and related factors. Thus, there is some doubt as to whether very many employees from prior to the implementation of managed care are still working in the field. The survey data prove useful here, but it is important to acknowledge the temporal context of the data collection.

Additionally, due both to the single location and the loss of nearly 50% of the sample between 1998 and 2000, the sample consists of 47 respondents. Though the survey questionnaire contains hundreds of items, the number of respondents is quite small. As such, the scope of this thesis had to be adjusted to accommodate the smaller sample size.

CONCLUSION

The goal of this thesis was to better understand the nature of the relationship between compassion fatigue and wellbeing for mental health case managers. Additionally, this thesis sought to more effectively evaluate potential consequences, for both case managers and their clients, of compassion fatigue's relationship to wellbeing. The measure of compassion developed in this thesis are important for mental health case managers on the theoretical, methodological, and practical levels. The findings of this thesis support the theoretical relationship between compassion fatigue and wellbeing, while also reinforcing compassion fatigue as a phenomenon distinct from emotional exhaustion and depersonalization. Methodological, this thesis demonstrates a way by which a compassion fatigue measure can be created from a quantitative dataset. Though Scheid's MHSPS dataset has a relatively small number of respondents same process of creating a compassion fatigue measure can be repeated with a larger sample or similar dataset. Compassion fatigue as an additive scale, where a higher total would suggest higher compassion fatigue. Finally, this thesis also has potential to benefit healthcare workers in general. There is an increased need to address the welfare of all healthcare professionals, both for their sake and the sake of the patients (Krisburg 2018; Bodenheimer and Sinsky 2010). This thesis has the potential to help those beyond mental health case management, providing a template for evaluating compassion fatigue and wellbeing for other healthcare professionals and care workers. Overall this thesis demonstrated that compassion fatigue is a distinct phenomenon, that has an indispensable connection to the wellbeing of mental health case managers.

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APPENDIX

Table I. Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Resistance to going to work every day	46	0	1	0.3913	0.49344
A sense of failure	46	0	1	0.2826	0.45524
Anger or resentment	46	0	1	0.4565	0.50361
Discouragement or indifference	46	0	1	0.587	0.49782
Tired and exhausted all day	46	0	1	0.4565	0.50361
Loss of positive feelings towards clients	46	0	1	0.2174	0.41703
Postponing client contacts, resisting phone calls/visits	46	0	1	0.087	0.28488
Stereotyping clients	46	0	1	0.1739	0.38322
Inability to concentrate on or listen to what a client is saying	46	0	1	0.1304	0.3405
Cynicism toward clients, a blaming attitude	46	0	1	0.1087	0.3147
Increasingly going by the book	46	0	1	0.1087	0.3147
Avoiding discussion of work with colleagues	46	0	1	0.2174	0.41703
encouragement	45	1	3	2.7111	0.58861
support	45	1	3	2.8	0.45726
trust	45	1	3	2.8667	0.40452
rapport	45	1	3	2.8444	0.42403
compassion	45	1	3	2.6222	0.64979
persuasion	45	0	3	2	1.02247
advising	45	0	3	2.3111	0.82082
mediation	45	0	3	1.7333	0.96295
manipulation	44	0	3	0.7955	0.85125
control	45	0	3	0.8444	0.85162
Compassion Fatigue	46	0	11	3.2174	2.82774
Emotional exhaustion	45	0.44	5.33	2.4228	1.48017
depersonalization	45	0	3.8	0.9244	1.01917
satisfaction with nature of work	47	1	4.25	2.6489	0.76553
overall satisfaction with career	47	0	45	3.2553	6.67399
autonomy	47	1.6	4.4	3.2979	0.70387
Valid N (listwise)	42				

Table II. Basic Demographics

		Frequency	Percent	Valid Percent	Cumulative Percent
Gender					
Valid	Male	13	27.7	28.9	28.9
	Female	32	68.1	71.1	100
	Total	45	95.7	100	
Missing	missing	2	4.3		
Total		47	100		
Ethnicity					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	31	66	68.9	68.9
	Black	13	27.7	28.9	97.8
	Hispanic	1	2.1	2.2	100
	Total	45	95.7	100	
Missing	missing	2	4.3		
Total		47	100		
Age					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	missing	13	27.7	27.7	27.7
	25	1	2.1	2.1	29.8
	27	2	4.3	4.3	34
	31	1	2.1	2.1	36.2
	35	2	4.3	4.3	40.4
	36	1	2.1	2.1	42.6
	37	2	4.3	4.3	46.8
	39	1	2.1	2.1	48.9
	40	4	8.5	8.5	57.4
	42	2	4.3	4.3	61.7
	45	3	6.4	6.4	68.1
	46	1	2.1	2.1	70.2
	47	1	2.1	2.1	72.3
	48	1	2.1	2.1	74.5
	49	1	2.1	2.1	76.6
	50	5	10.6	10.6	87.2
	51	1	2.1	2.1	89.4
	52	2	4.3	4.3	93.6
	53	1	2.1	2.1	95.7
	58	2	4.3	4.3	100
	Total	47	100	100	

Table III. Compassion Fatigue Frequencies

			Frequency	Percent	Valid Percent	Cumulative Percent
Resistance to going to work every day						
Valid		0	28	59.6	60.9	60.9
		1	18	38.3	39.1	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
A sense of failure						
Valid		0	33	70.2	71.7	71.7
		1	13	27.7	28.3	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Anger or resentment						
Valid		0	25	53.2	54.3	54.3
		1	21	44.7	45.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Discouragement or indifference						
Valid		0	19	40.4	41.3	41.3
		1	27	57.4	58.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Tired and exhausted all day						
Valid		0	25	53.2	54.3	54.3
		1	21	44.7	45.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Loss of positive feelings towards clients						
Valid		0	36	76.6	78.3	78.3
		1	10	21.3	21.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		

Table III. Compassion Fatigue Frequencies (continued)						
Total			47	100		
Postponing client contacts, resisting phone calls/visits						
Valid		0	42	89.4	91.3	91.3
		1	4	8.5	8.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Stereotyping clients						
Valid		0	38	80.9	82.6	82.6
		1	8	17	17.4	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Inability to concentrate on or listen to what a client is saying						
Valid		0	40	85.1	87	87
		1	6	12.8	13	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Cynicism toward clients, a blaming attitude						
Valid		0	41	87.2	89.1	89.1
		1	5	10.6	10.9	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Increasingly going by the book						
Valid		0	41	87.2	89.1	89.1
		1	5	10.6	10.9	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		
Avoiding discussion of work with colleagues						
Valid		0	36	76.6	78.3	78.3
		1	10	21.3	21.7	100
	Total		46	97.9	100	
Missing	System		1	2.1		
Total			47	100		

Table IV. Emotion Work Frequencies (%)

	Never	Once in a While	Most of the Time	Almost Always	Always
Encouragement	0	6.4	14.9	74.5	N/A
Support	0	2.1	14.9	78.7	N/A
Trust	0	2.1	8.5	85.1	N/A
Rapport	0	2.1	10.6	83	N/A
Compassion	0	8.5	19.1	N/A	68.1
Persuasion	6.4	29.8	17	N/A	42.6
Advising	2.1	14.9	29.8	N/A	48.9
Mediation	6.4	40.4	21.3	N/A	27.7
Manipulation	38.3	42.6	6.4	N/A	6.4
Control	36.2	44.7	8.5	N/A	6.4

Table V. Case Manager Work Frequencies

	Valid (n)	Missing (n)	Mean	Median	Minimum	Maximum
How large is your current caseload?	38	9	30.71	35	0	70
Given the nature of the clients you serve, what would your ideal caseload be?	34	13	25.44	22.5	3	85
Number of difficult clients	34	13	10.82	6	0	50
What percentage (%) of your time is spent in direct contact with clients? (exclude telephone contact)	38	9	49.55	50	5	90

Table VI. Case Manager Work Correlations

		A	B	C	D
A	Pearson Correlation	1	0.322	0.093	-0.218
	Sig. (2-tailed)		0.077	0.612	0.222
B	Pearson Correlation	0.322	1	-0.106	-.377*
	Sig. (2-tailed)	0.077		0.575	0.044
C	Pearson Correlation	0.093	-0.106	1	-0.051
	Sig. (2-tailed)	0.612	0.575		0.784
D	Pearson Correlation	-0.218	-.377*	-0.051	1
	Sig. (2-tailed)	0.222	0.044	0.784	

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

**. Corr0elation is significant at the 0.01 level (2-tailed).

***. Correlation is significant at the 0.001 level (2-tailed).

Note: A = How large is your current caseload?

Note: B = Given the nature of the clients you serve, what would your ideal caseload be?

Note: C = Number of difficult clients

Note: D = What percentage of your time is spent in direct contact with clients? (exclude telephone contact)

Table VII. Compassion Fatigue Reliability

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	Number of Items
0.805	0.797	12

Table VIII. Compassion Fatigue Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Increasingly going by the book	3.1087	7.521	0.218	0.276	0.808
Avoiding discussion of work with colleagues	3	7.511	0.136	0.411	0.819

Table IX. Compassion Fatigue, Measures of Burnout, and Measures of Wellbeing

		A	B	C	D	E	F
Compassion Fatigue	Pearson Correlation	1	**.663****	**.535****	-.478**	-.527**	-.638**
	Sig. (2-tailed)		0	0	0.001	0	0
Emotional Exhaustion	Pearson Correlation	.663**	1	.663**	-.405**	-.539**	-.631**
	Sig. (2-tailed)	0		0	0.006	0	0
Depersonalization	Pearson Correlation	.535**	.663**	1	-.562**	-.401**	-.393**
	Sig. (2-tailed)	0	0		0	0.006	0.008
Satisfaction with Nature of Work	Pearson Correlation	-.478**	-.405**	-.562**	1	.660**	.457**
	Sig. (2-tailed)	0.001	0.006	0		0	0.001
Satisfaction with My Current Work Situation	Pearson Correlation	-.527**	-.539**	-.401**	.660**	1	.454**
	Sig. (2-tailed)	0	0	0.006	0		0.001
Autonomy	Pearson Correlation	-.638**	-.631**	-.393**	.457**	.454**	1
	Sig. (2-tailed)	0	0	0.008	0.001	0.001	

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

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

***. Correlation is significant at the 0.001 level (2-tailed).

Note: A= Compassion Fatigue

Note: B= Emotional Exhaustion

Note: C= Depersonalization

Note: D= Satisfaction with Nature of Work

Note: E= Satisfaction with My Current Work Situation

Note: F= Autonomy