Article

Factors Predicting Burnout Among Chaplains: Compassion Satisfaction, Organizational Factors, and the Mediators of Mindful Self-Care and Secondary Traumatic Stress

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Abstract

This study predicted Burnout from the self-care practices, compassion satisfaction, secondary traumatic stress, and organizational factors among chaplains who participated from all 50 states (N = 534). A hierarchical regression model indicated that the combined effect of compassion satisfaction, secondary traumatic stress, mindful self-care, demographic, and organizational factors explained 83.2% of the variance in Burnout. Chaplains serving in a hospital were slightly more at risk for Burnout than those in hospice or other settings. Organizational factors that most predicted Burnout were feeling bogged down by the "system" (25.7%) and an overwhelming caseload (19.9%). Each self-care category was a statistically significant protective factor against Burnout risk. The strongest protective factors against Burnout in order of strength were self-compassion and purpose, supportive structure, mindful self-awareness, mindful relaxation, supportive relationships, and physical care. For secondary traumatic stress, supportive structure, mindful self-awareness, and self-compassion and purpose were the strongest protective factors. Chaplains who engaged in multiple and frequent self-care strategies experienced higher professional quality of life and low Burnout risk. In the chaplain's journey toward wellness, a reflective practice of feeling good about doing good and mindful self-care are vital. The significance, implications, and limitations of the study were discussed.

Keywords

Mindful self-care, Burnout, compassion satisfaction, compassion fatigue, secondary traumatic stress, chaplains

Occupational Burnout was first recognized as a concern among healthcare and other helping professionals in the 1970s (Pines & Maslach, 1978; Vachon, 1978). Extensive interviews with helping professionals revealed that they often feel emotionally depleted with reduced motivation from protracted distress while helping clients. Subsequent research identified the following features now recognized as comprising Burnout: emotional exhaustion, cynicism and ineffectiveness (Craig & Sprang, 2010; Maslach, 2003), and lack of personal accomplishment, organizational recognition, and support (Vachon, 1995). Compassion fatigue (CF), first described by Figley (1995) now comprises two elements: Burnout and secondary traumatic stress (Stamm, 2010).

Burnout

Burnout (BO) was originally conceptualized as a response to job stress produced by the demands of helping clients in great need (Maslach & Jackson, 1982). However, further research showed that institutional and organizational factors seemed to also contribute to Burnout (Maslach & Florian, 1988; Maslach & Leiter, 1997; Vachon, 1995). Cost-effectiveness measures, prominent in healthcare, can lead to understaffing and high caseloads, which may

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undercut the professional's ability to properly function and feel a sense of self-efficacy (Lewandowski, 2003). Vachon's (1995) exhaustive review of the international literature on occupational stress conducted supports her conclusion that in addition to personal variables, organizational and societal issues are major causes of worker stress which can lead to Burnout.

Secondary Traumatic Stress

Like Burnout, secondary traumatic stress (STS) was primarily conceptualized as a response to the stress of interpersonal interactions between helper and client. Unlike Burnout, STS continues to be viewed mainly as a response to dealing with clients, specifically people who have been traumatized. Figley (1995) described STS as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other" (p. 7). STS is also distinguished from Burnout in that its core symptoms are similar to the symptoms of post-traumatic stress disorder (PTSD), including flashbacks, nightmares, and intrusive thoughts (Figley, 1995). Figley (1995) and most other authors consider STS and PTSD to be the same phenomenon.

Helping professionals afflicted with STS can still provide care for clients, albeit in a compromised way (Garfield, Spring, & Ober, 1995). Alkema, Linton, and Davies (2008), in their work on self-care among hospice professionals, found the constructs Burnout and STS overlapped, representing similar responses to differing environmental stressors: Burnout representing a response to occupational stress and STS a more personal emotional response to traumatic stress. Research has shown that chaplains and other clergy who deal with persons exposed to extreme stressors are susceptible to traumatic reactions and other stressors that impact the quality of their lives (Weaver, Koenig, & Ochberg, 1996). To focus only on Burnout and STS would neglect the increase in quality of life that is derived from feeling good about doing good—compassion satisfaction.

Compassion Satisfaction

Chaplains, like other helping professionals, benefit from many intrinsic emotional rewards from caring for patients and other clients. Compassion satisfaction (CS) is the term used to describe this powerful phenomenon (Stamm, 2002). The ability to feel good about one's contribution at work can assist in better overall mental well-being. Radey and Figley (2007) argue that, "[C]ompassion, altruism, sympathy, and empathy are critical to human survival and facilitate human flourishing. Our compassionate core requires us to either avoid negativity or to transform it. Given that empathetic practitioners will face negativity, the chaplain profession requires a constant source of inspiration that increases our positivity" (p. 214). CF and CS may be experienced at the same time. Numerous studies demonstrate a strong negative correlation between CF and CS (Abendroth & Flannery, 2006; Alkema et al., 2008; Craig & Sprang, 2010; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2011). Hence, if CS is nurtured by the worker and the organization, it is expected that there will be less CF present (Bride & Figley, 2007).

Self-Care and Organizational Factors

Much literature on professional quality of life in healthcare focused on the organizational and individual factors and their interactive effect on Burnout, STS, and CS (Harr, 2013; Kearney, Weininger, Vachon, Harrison, & Mount, 2010; Slocum-Gori et al., 2011; Smart et al., 2014; Whitebird, Asche, Thompson, Rossom, & Heinrich, 2013). However, self-care interventions, a proactive means of treating STS and Burnout, have not been studied with validated instruments. Kearney et al. (2010) did a literature review of self-care among physicians and found that supportive relationships were key to the prevention of Burnout. CS and the practice of self-care appear to be reinforcing. Research has pointed to self-care interventions as a means of increasing CS and decreasing STS and Burnout (Alkema et al., 2008). Mindfulness, meditation, and creative writing were statistically significant in a randomized control trial (Baird & Kracen, 2006). However, the literature is mixed on which interventions work and what are appropriate measures of success (Blanc, Hox, Schaufeli, Taris, & Peeters, 2007; Fillion et al., 2009; Ruotsalainen, Verbeek, Mariné, & Serra, 2015). Nonetheless, self-care has not been operationalized with a validated instrument in any of the known literature.

Mindful self-care is seen as the foundational work required for physical and emotional well-being. Self-care is associated with positive physical health, emotional well-being, and mental health (Cook-Cottone & Guyker, 2018; Linehan, 2015). Likewise, Shapiro, Brown, and Biegel (2007) define self-care as positive activities that help to manage stress, include getting enough rest, eating a well-balanced diet, exercising, and utilizing a support system. The steady and intentional practice of mindful self-care is seen as protective by preventing the onset of mental health symptoms, job/school Burnout, and improving work and school productivity. The Mindful Self-Care Scale (MSCS) is intended to help individuals identify areas of strength and weakness in mindful self-care behavior as well as to assess interventions that serve to improve self-care. The scale addresses six domains of self-care: physical care, supportive relationships, mindful awareness, self-compassion and purpose, mindful relaxation, and supportive structure (Cook-Cottone & Guyker, 2018).

When professional staff members feel that they have a lack of control, insufficient resources, unmanageable caseloads, threats to their personal safety, and little authority in decision making, they tend to become discouraged and disempowered at work (Gold, 1998). Abendroth's (2005) literature review revealed that healthcare professional work-related variables such as long work hours, high patient caseloads, multiple deaths occurring within a short period of time, and shift work have stressful effects on the individual, which can then lead to Burnout and STS. They also encounter the effects of daily life stressors such as family, home, work, and community commitments. As a result, it is imperative that self-care interventions can be objectively measured and that chaplains are equipped with assessment tools to be proactive with their self-care efforts to manage and combat the stressors in their personal and professional life.

Chaplains

Chaplains serve in many different settings. In a pediatric setting, the majority of chaplains (72%) reported high levels of STS (Meadors & Lamson, 2008). Hospice chaplains ($n = 49$) reported high levels of stress, with a small but significant proportion reporting moderate-to-severe symptoms of depression, anxiety, STS, and Burnout (Whitebird et al., 2013). Burnout was associated with high caseloads and feeling bogged down by the "system" (Abendroth, 2005). STS risk among chaplains and other respondents

after the September 11, 2001 New York Twin Towers terrorist attack was studied, and it was reported that 55% of the sample ($n = 403$) were in the moderate-to-high STS risk category (Stephen, Flannelly, Weaver, & Figley, 2003). Taylor, Weaver, Flannelly, and Zucker (2006) studied Jewish chaplains using Figley's (1995) Compassion Satisfaction and Fatigue Test and found that CS was in the high range specified, and STS and Burnout were both low. In a study of 331 professional chaplains, using Figley's (1995) test, social support was negatively correlated to Burnout and STS; number of years in the same employment position was positively correlated with Burnout (Galek, Flannelly, Greene, & Kudler, 2011). STS was positively associated with amount of time spent per week counseling patients who had had a traumatic experience.

Theoretical Framework

In this study, a synthesis of Maslow's hierarchy of needs (Benson & Dundis, 2003), mindful self-care by Cook-Cottone and Guyker (2018), compassion fatigue by Figley (1995), and compassion satisfaction by Stamm (2010) provided the theoretical framework for understanding needs and motivations relevant to helping professionals such as chaplains. Figure 1 illustrates the theoretical framework for the study. The premise of Maslow's model is that deficiency motivations must be met before higher motivations manifest (Maslow, 1968). Maslow's hierarchy of needs is often represented in a pyramidal structure with deficiency
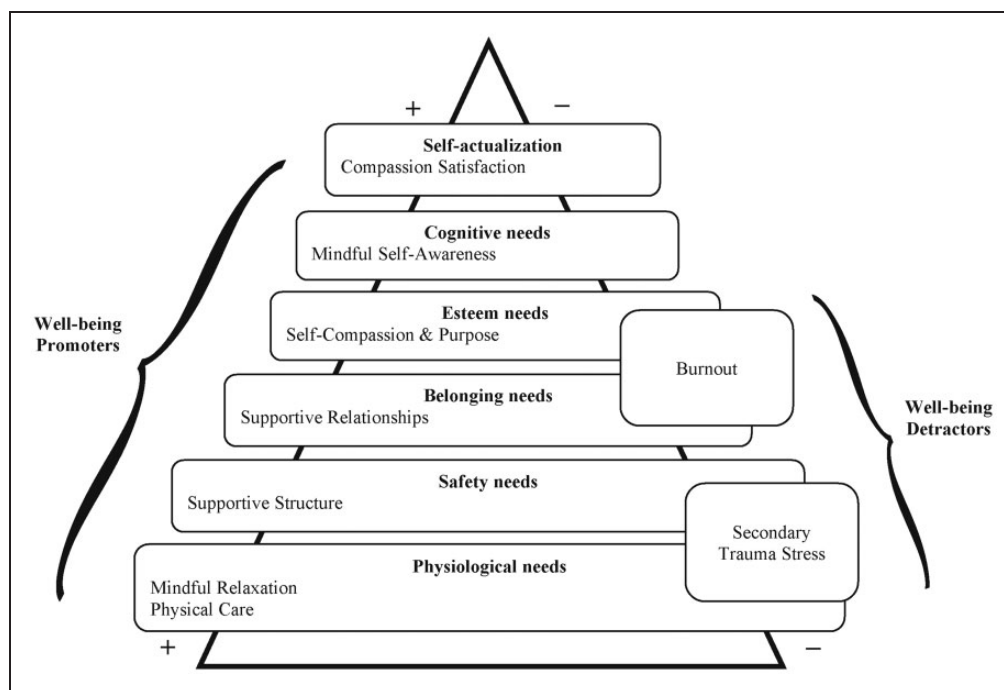

Figure 1. Proposed conceptual model based on adaptation of Maslow's hierarchy of needs.

motivations at the base (physiological, safety, belonging, esteem), culminating in a growth motivation (self-actualization). Compassion satisfaction and mindful self-care are promoters of well-being. Compassion fatigue, including Burnout and secondary traumatic stress, are detractors of well-being.

Two main theoretical perspectives have been proposed to explain the phenomenon of compassion fatigue in professional helpers (Figley & Kleber, 1995). The resource depletion perspective suggests that helpers become worn out, physically and mentally, by exposure to distressed clients and addressing their care needs. Burnout appears to fit conceptually with this resource depletion framework. By contrast, the emotional contagion perspective refers to the affective process in which a helper, caring for traumatized persons, feeling emotional responses parallel to that person's actual or anticipated emotions (Hatfield, Cacioppo, & Rapson, 1993). Secondary traumatic stress appears to fit conceptually with this emotional contagion framework.

Effective coping may reduce the intensity of compassion fatigue. Theoretically, an effective self-care plan and supportive work setting that addresses helper deficiency needs would foster self-actualization, thereby increasing compassion satisfaction. Chaplains who are self-actualized conceptualize their work as a "calling" that enhances life meaningfulness—compassion satisfaction (Stamm, 2010). Figure 1 illustrates the factors in the work environment either promote well-being through compassion satisfaction (CS) and mindful self-care or distract from well-being through STS or Burnout.

Cook-Cottone and Guyker (2018) developed the Mindful Self-Care Scale (MSCS). Mindful self-care as "an iterative process that involves (a) mindful awareness and assessment of one's internal needs and external demands and (b) intentional engagement in specific practices of self-care to address needs and demands in a manner that serves one's well-being and personal effectiveness" (p. 1). With its roots in Mindfulness-Based Stress Reduction, mindful self-care is an integration of mindfulness and practices indicated in more traditional conceptualizations of self-care (Cook-Cottone & Guyker, 2018; Linehan, 1993, 2015; Norcross & Guy, 2007; Richard & Shea, 2011; Riegel, Jaarsma, & Stromberg, 2012).

One of the common objections of helping professionals to practicing self-care is that it is viewed as an another task to complete (Hotchkiss, 2017). "So rather than a set of prescribed behaviors performed to attain an externally constructed objective, mindful self-care is a set of practices that support positive embodiment, a way of inhabiting the body" (Cook-Cottone & Guyker, 2018, p. 1). Without positive embodiment, an individual may experience a sense of disconnection, Burnout, conflict, substance-use problems, and disordered eating (Cook-Cottone & Guyker, 2018; Homan & Tylka, 2014).

A growing body of research indicates that activities that focus on mindfulness may serve to enhance quality of life, as well as mental and physical health (Linehan, 1993; McCusker et al., 2016; Riegel et al., 2012). Mindfulness includes many different facets within the context of stress management and self-care such as self-awareness, self-regulation, or coping. Within this context self-awareness is viewed as the foundation of self-care (Shapiro et al., 2007). Self-awareness, one-mindedness, and active practices such as meditation and yoga are increasingly acknowledged for their effectiveness as self-care practices (Linehan, 1993; Norcross & Guy, 2007; Sayrs, 2012; Shapiro & Carlson, 2009). Especially in the emotionally intense area of spiritual care, the ability to peacefully inhabit one's body, maintain good boundaries, and be fully present during the compassionate care for patients and family is essential.

The MSCS is intended to help individuals identify areas of strength and weakness in mindful self-care to improve strategies. The subscales fit well with Maslow's theory. Six self-care domains and corresponding Maslow needs are: physical care and mindful relaxation (physiological needs), supportive structure (safety needs), supportive relationships (belonging needs), mindful awareness (cognitive needs), and self-compassion and purpose (esteem needs) (Maslow, 1968).

Purpose and Hypotheses

The purpose of this study was to examine the relationship between self-care practices and the professional quality of life of chaplains. Like other clergy, chaplains typically help patients and family members navigate the emotional distress of grief and loss (Flannelly et al. 2003; Fogg et al. 2004). Chaplains also address a range of other emotional reactions of patients and families, including anxiety, depression, and loneliness. Because of the nature of their work, chaplains deal with these and other emotional issues on a much more regular basis than other clergy (Flannelly, Weaver, & Handzo, 2003; Fogg, Flannelly, Weaver, & Handzo, 2004; Moran et al., 2005), which may contribute to chaplain Burnout.

A hypothesized model of compassion satisfaction, mindful self-care, secondary traumatic stress and Burnout is illustrated in Figure 1. The following hypothesis were proposed. Age, years of experience, education, board certification status, practice setting, and employment status would be predictors of Burnout (Hypothesis 1). Experiencing compassion satisfaction, practicing multiple and frequent self-care strategies would lower Burnout risk among chaplains; secondary traumatic stress would increase Burnout risk (Hypothesis 2). The following sub-hypotheses provide the opportunity to test each component independently. CS and MSCS would be positively correlated (Hypothesis 2a). STS and MSCS will be negatively correlated (Hypothesis 2b). BO and MSCS would be

negatively correlated (Hypothesis 2c). CS, MSCS and STS would predict Burnout (Hypothesis 2d). STS and MSCS practices would mediate a relationship between CS and Burnout (Hypothesis 3).

Method

Participants

A research proposal was approved by IRBs of Cornerstone University's and the Association of Professional Chaplains (APC). Invitations to participate in the study were sent to the 5,361 chaplains affiliated with the APC. The guidelines laid out for survey research were followed (Kelley, Clark, Brown, & Sitzia, 2003). Chaplains participated from all 50 states, Australia, Canada, Hong Kong, and the Netherlands. Table 1 shows selected demographics. A total of 534 chaplains provided completed surveys (10.1% response rate). Table 1 shows selected demographics. Females (55.8%) were the majority. The mean age of the sample was 56.6 years (SD = 10.82). Respondents were primarily employed full time (74.9%) or part time (12.7%). Most chaplains served in a hospital (62.4%) or hospice (16.2%). The mean years of professional experience was 15.7 (SD = 9.94, ranging from 1 to 40 years).

Measures

Demographics. Demographics gathered in the survey were age, gender, ethnicity, and highest education attained. Professional characteristics assessed were employment status, board certification status, practice setting, and years of experience in spiritual care.

Mindful Self-Care Scale (MSCS). The MSCS is a 33-item scale that measures the self-reported frequency of self-care behaviors. This scale is the result of an Exploratory Factor Analysis (EFA) of a large community sample (Cook-Cottone & Guyker, 2018). The MSCS total and sub-scales have strong internal consistency reliability. Cronbach's coefficient alpha was .89 for the total MSCS. The subscale alphas were Physical Care (.78), Supportive Relationships (.83), Mindful Awareness (.87), Self-Compassion and Purpose (.86), Mindful Relaxation (.78), and for Supportive Structure (.77). The MSCS also show construct validity. An assessment of how chaplains are able to advocate for their well-being within their institution is important. The Supportive Structure subscale assess for this aspect.

Professional Quality of Life (ProQOL). Stamm's (2002) approach to operationalizing Compassion Satisfaction (CS), Secondary Traumatic Stress (STS), and Burnout (BO) was selected. The scale has been utilized internationally and has been psychometrically validated in various

Table 1. Chaplain Demographics (N = 534, M_{age} = 56.6 years old).

Measure	n	%
Gender		
Female	303	56.7
Male	218	40.8
Other	13	2.4
Employment Status		
Full time	407	76.2
Part time	69	12.9
Per diem	44	8.2
On leave	14	2.6
Education		
Bachelors or equivalent (4 years)	5	.9
Masters of Arts or equivalent (5-6 years)	61	11.4
Master of Divinity or equivalent (7 years)	359	67.2
Doctorate or equivalent (8 years or more)	109	20.4
Ethnicity		
American Indian or Alaskan Native	2	.4
Asian or Pacific Islander	10	1.9
Black or African American	47	8.8
Hispanic or Latino	13	2.4
White or Caucasian	429	80.3
Prefer not to answer	18	3.4
Other	15	2.8
Practice Setting		
Hospital	334	62.5
Hospice	93	17.4
Skilled nursing	28	5.2
Faith community	16	3.0
Private practice	11	2.0
Outpatient clinic	8	1.5
Psychiatric setting	8	1.5
Assisted living	7	1.3
Military	4	0.7
Other	25	4.7

populations. It contains 30 items in total, 10 items for each variable (with five-point Likert measures). Each scale has a maximum of 50 points. This sample had the following alpha reliabilities: CS (α = .87), STS (α = .82) and BO (α = .82). An EFA was run and KMO results were: CS (.922), STS (.899), and BO (.861).

Overview of Analysis

The ProQOL, MSCS were scored using the prescribed coding methods in their manuals. A missing value analysis was performed in SPSS version 24. Surveys that were missing more than 5% of responses were removed from the

analyses. Retired chaplains were removed from the dataset. A hierarchical multiple regression was conducted to test the proposed model in Figure 1. This regression process assessed the combined effect of CS, STS, and MSCS on Burnout while controlling for the effects of age, education, certification status, employment status, practice setting, and years of experience. A direct method was used for the multiple linear regression analyses. Inspection of P-P plots and a scatterplot of the standardized residual values indicated that the assumptions were met. Examination of bivariate scatter plots did not reveal any extreme data values. The PROCESS tool version 3.0 by Hayes and Rockwood (2017) was used to test whether STS and MSCS practices mediated a relationship between CS and Burnout.

Results

Professional Quality of Life and Mindful Self-Care

Table 2 shows bivariate correlations, mean, standard deviation, and range of all study variables. The multiple regression model 1 for the control variables only, was run to predict Burnout from age, years of experience, education, board certification status, practice setting, and employment status. Table 3 shows the demographic and professional variables of Model 1 that predicted Burnout, $F(7, 535) = 9.379$, $R^2 = .109$. While age ($\beta = -.262$) predicted Burnout in model 1, only board certification status ($\beta = .072$) and hospital setting ($\beta = .042$) remained small, yet significant, predictors of Burnout in the final model, Model 3. The null hypothesis of Hypothesis 1 was rejected for only board certification status and hospital practice setting.

Experiencing compassion satisfaction, practicing multiple and frequent self-care strategies lowered Burnout risk; secondary traumatic stress increased Burnout risk. Hypothesis 2a through 2d were all confirmed. MSCS was strongly correlated with both CS ($r = .519$) and negatively correlated with both STS ($r = -.261$) and BO ($r = -.586$). The null hypotheses were all rejected. Bivariate correlations among variables are shown in Table 2. This study found: a negative correlation between CS and STS ($r = -.322$); a negative correlation between CS and Burnout ($r = -.725$); a positive correlation between STS and Burnout ($r = .578$). In addition, CS, MSCS, and STS were predictors of Burnout.

Table 3 presents the hierarchical regression results. Model 2 included all variables in control variable model 1 plus the variables of the proposed model: CS, STS, and MSCS. Model 2 explained 71.5% of the variance in Burnout. Model 3 included all variables in model 2 plus two organizational factors encountered by chaplains, an "overwhelming caseload" and "feeling bogged down by the system." These two work-related variables were

selected within the ProQOL instrument and analyzed for their associations with Burnout since the literature reports caseload and organizational frustration as Burnout factors. Model 3 explained 83.2% of the variation in Burnout with a prediction error of only 2.01, by including the above organizational factors, which explained an additional 11.6% of the variance in Burnout. CS (39.0%), STS (21.0%), and MSCS (20.1%) had the most predictive value. Figure 2 illustrates the approximate, proportional effects of CS, STS, MSCS, an overwhelming caseload ($\beta = .072$) and feeling bogged down ($\beta = -.060$).

The lower section of Table 2 reports the published ProQOL norms for comparison. Using the risk categories established by Stamm (2002), chaplain Burnout risk results were: low (65.7%), moderate (34.3%) and high (0%). Stamm (2002) warns that moderate risk scores may still warrant concern.

Self-Care Practices

Data analysis also revealed an overall pattern of self-care being practiced by study participants. The self-care practices categorized as supportive relationships were the most frequently practiced (4.51 days per week). The categories of mindful self-awareness (3.85 per days week), self-compassion (3.81 days per week), supportive structure (3.69 days per week) were practiced with nearly equal frequency. Mindful relaxation (2.66 days per week) and physical care (2.39 days per week) practices had the lowest frequency of endorsement among participants.

To explore whether STS and MSCS practices mediated between CS and Burnout, the PROCESS tool 3.0 was run with each self-care practice and STS (Hayes & Rockwood, 2017). Figure 3 shows the model and a breakout of the effect of each MSCS practice. The relationship between CS and Burnout is mediated by MSCS and STS since total effects ($\beta = -0.712$, $p < 0.01$) are greater than the direct effects in the case of each practice. Hypothesis 3 was confirmed since the indirect effect of STS and all self-care practices on Burnout were all significant ($p < 0.01$) in order of strength, STS ($\beta = -.119$); Self-Compassion & Purpose ($\beta = -.113$); Mindful Self-Awareness ($\beta = -.076$); Supportive Relationships ($\beta = -.066$); Supportive Structure ($\beta = -.065$); Mindful Relaxation ($\beta = -.064$); and Physical Care ($\beta = -.031$).

Discussion

The purpose of this study was to examine the relationship between self-care practices and the professional quality of life of chaplains. Chaplains experiencing compassion satisfaction and practicing multiple and frequent self-care strategies had lower Burnout risk. Secondary traumatic stress and all mindful self-care practices mediated the relationship between compassion satisfaction and risk

Table 2. Pearson's Correlations, Means, Standard Deviations Among the Measures, Professional Quality of Life, Mindful Self-Care Scale and Subscales (N = 534).

Measure	Mindful Self-Care and Subscales							Professional Quality of Life		
	MSCS	PC	SR	MS	SC	MR	SS	CS	STS	BO
Mindful Self-Care (MSCS)	1	—	—	—	—	—	—	—	—	—
Physical Care (PC)	.687***	1	—	—	—	—	—	—	—	—
Supportive Relationships (SR)	.692***	.283***	1	—	—	—	—	—	—	—
Mindful Self-Awareness (MS)	.755***	.328***	.489***	1	—	—	—	—	—	—
Self-Compassion & Purpose (SC)	.825***	.378***	.543***	.681***	1	—	—	—	—	—
Mindful Relaxation (MR)	.805***	.424***	.473***	.534***	.637***	1	—	—	—	—
Supportive Structure (SS)	.673***	.325***	.420***	.527***	.477***	.455***	1	—	—	—
Compassion Satisfaction (CS)	.519***	.205***	.369***	.439***	.580***	.420***	.362***	1	—	—
Secondary Traumatic Stress (STS)	-.261***	-.087*	-.149***	-.294***	-.222***	-.185***	-.323***	-.322***	1	—
Burnout (BO)	-.586***	-.252***	-.436***	-.515***	-.565***	-.452***	-.494***	-.725***	.578***	1
Practiced Self-Care (days/week)	—	2.39	4.51	3.85	3.81	2.66	3.69	—	—	—
M	115.30	22.95	20.15	15.52	22.90	19.03	14.74	40.38	20.28	21.19
SD	17.69	5.7	3.51	2.90	4.23	4.58	2.94	4.92	5.20	4.84
Range possible	33–165	8–40	5–25	4–20	6–30	6–30	4–20	10–50	10–50	10–50
Range actual	58–161	10–38	10–30	7–20	10–30	6–30	4–20	17–50	10–46	10–48
Reliability coefficient (α)	.872	.775	.834	.872	.855	.780	.826	.874	.823	.824
Validity coefficient (KMO)	.816	.774	.826	.816	.880	.851	.790	.763	.795	.861
Comparative Scoring (Mean)										
Bottom-quartile	85.21[1]							22[2]	22[2]	22[2]
Mid-point	98.5							37	37	37
Top-quartile	111.8							42	42	42

Notes. ProQOL = Professional Quality of Life; MSCS = Mindful Self Care Scale; PC = Physical Care; SR = Supportive Relationships; MS = Mindful Self-Awareness; SC = Self Compassion and Purpose; MR = Mindful Relaxation; SS = Supportive Structure; CS = Compassion Satisfaction; STS = Secondary Traumatic Stress; BO = Burnout
[1]Cook-Cottone, C. P., Guyker, W. (2017). The Mindful Self-Care Scale: Mindful self-care as a tool to promote physical, emotional, and cognitive well-being.
[2]Stamm, B. (2010). The Concise ProQOL Manual (2nd ed.). Retrieved from www.proqol.org/ (accessed October 2017).
*Correlation is significant at the 0.05 level (2-tailed).
**Correlation is significant at the 0.001 level (2-tailed).

Table 3. Hierarchical Regression Analysis of Predictors of Burnout with Standardized Beta Coefficients ($N = 534$).

Predictor variables	Model 1	Model 2	Model 3
Age	−.262***	−.043	−.016
Years of Experience	.012	−.027	−.015
Education[a] (1, MA; 5, PhD)	−.013	.000	.003
Board Certification Status[b] (1, Affiliated, non-BCC; 6, BCC)	.124**	.084*	.072**
Practice Setting			
Hospice (1, Yes; 0, No)	.054	.022	.015
Hospital (1, Yes; 0, No)	.090	.055*	.042*
Employment Status (1, On-leave; 3, Full-time)	−.095*	−.039	.018
Compassion Satisfaction		−.470***	−.390***
Mindful Self-Care		−.238***	−.201***
Secondary Traumatic Stress		.344***	.210***
Overwhelming caseload			.199***
Feeling bogged down by the "system"			.257***
R^2	.109	.715	.832
R^2 Change	.109	.606	.116
Standard Error of the Estimate	4.598	2.606	2.008

[a]Education (1, Bachelors (4 years); 2, Masters of Arts (5–6 years); 3, Master of Divinity (7 years); 4, Doctorate (8 years or more))
[b]Board Certification Status (1, Non-Board Certified; 2, Preparing for Board Certification; 3, Provisional Associate Certified Chaplain; 4, Associate Certified Chaplain; 5, Provisional Board Certified Chaplain; 6, BCC = Board Certified Chaplain)
***$p < .001$, **$p < .01$, *$p < .05$.
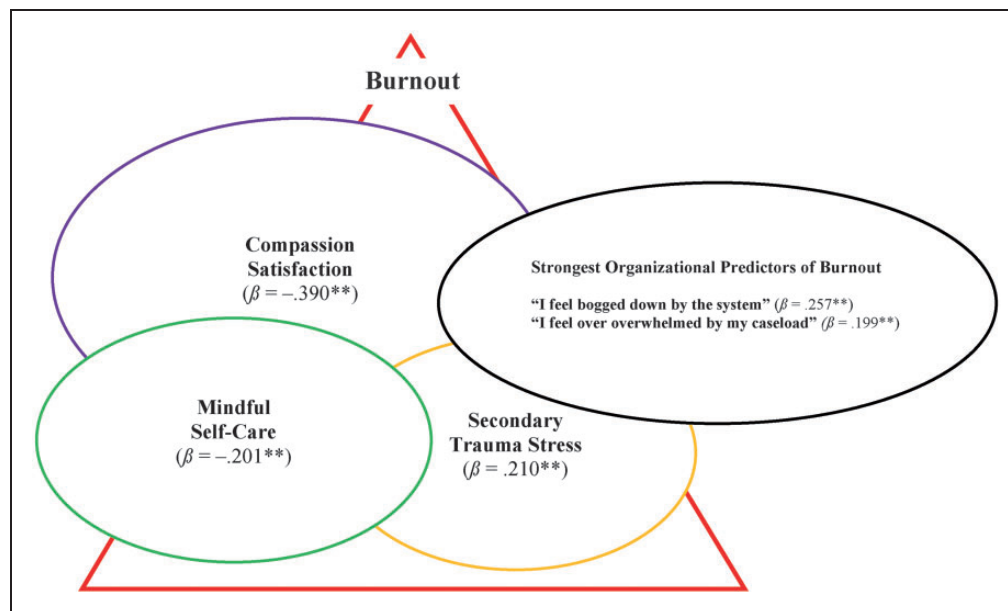
Figure 2. Predictive factors of Burnout illustrated in approximate proportional effect.

for Burnout. Self-compassion & purpose ($\beta = −.113$) and mindful self-awareness ($\beta = −.076$) were the strongest mediators between compassion satisfaction and Burnout. This finding confirms the centrality of calling in the chaplain's life and self-awareness for positive embodiment and well-being.

Each of these findings support the theoretical premise, based on Maslow's model, that deficiency motivations must be met before higher motivations manifest and that compassion satisfaction is an expression of chaplain self-actualization. When chaplains feel a sense of joy and purpose, and have their needs met as conceptualized in the Maslow
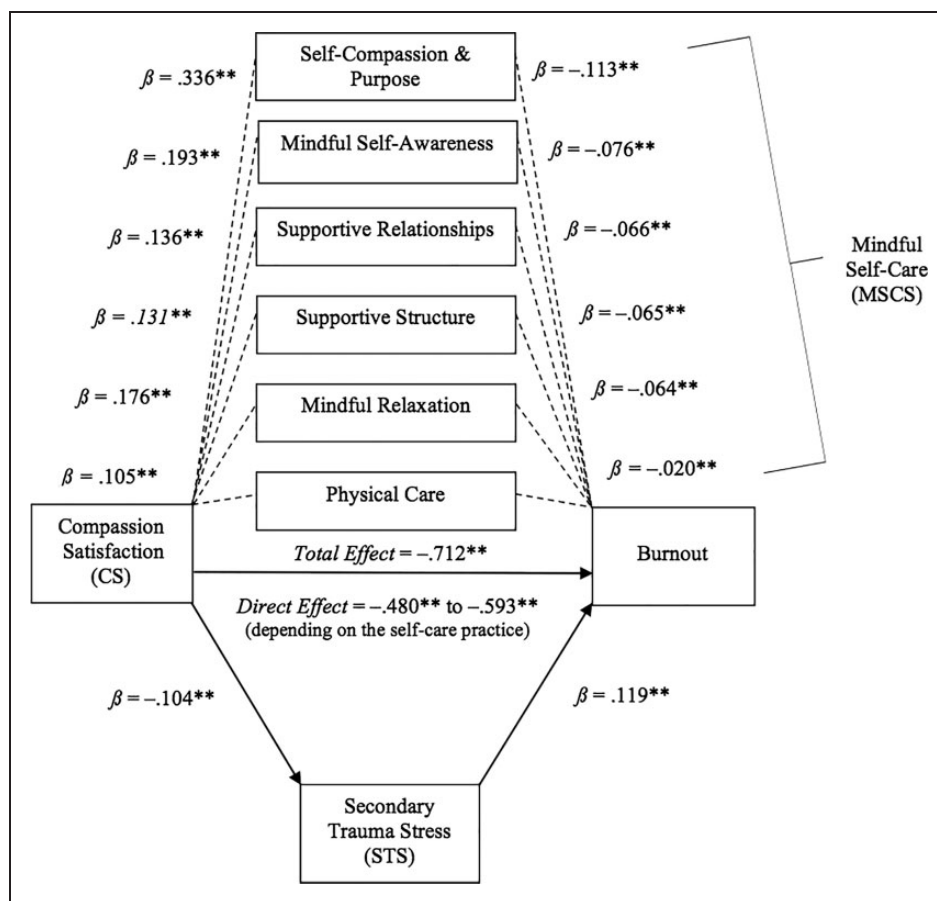
Figure 3. Mediating effects of STS and Mindful Self-Care practices with standardized beta coefficients.

hierarchy, they can buffer the impact of compassion fatigue (secondary traumatic stress and Burnout). This supports prior findings that being satisfied and finding meaning in their work can be a protective factor against stress and Burnout (Pereira, Fonseca, & Carvalho, 2011; Pinikahana & Happell, 2004) and extant research showing a positive correlation between professional well-being and work meaningfulness (Leiter, Harvie, & Frizzell, 1998; Tzeng, Ketefian, & Redman, 2002).

While chaplains in this study exhibited moderate secondary traumatic stress and Burnout according to Stamm's (2010) normed data, they were also found to have high levels of compassion satisfaction. The difference in the strength of the correlation between compassion satisfaction and both secondary traumatic stress ($r = -.322$, $p < .001$) and Burnout ($r = -.725$, $p < .001$) are congruent with the existing literature in differentiating between these two constructs (Alkema et al., 2008; Slocum-Gori et al., 2011; Whitebird et al., 2013). Thus, it is likely that these are non-random results.

While all mindful self-care factors mediated between compassion satisfaction and Burnout, self-compassion and purpose, mindful self-awareness, supportive relationships, supportive structure, mindful relaxation were the

strongest protective factors, in order of strength, against Burnout. Burnout risk is reduced by the feeling that a chaplain's work is a calling that they enjoy. The foundational role of self-awareness is also supported in this study. The three strongest variables associated with lower Burnout risk were "I had a calm awareness of my body ($r = -.498$), thoughts ($r = -.469$), and feelings ($r = -.469$)." Shapiro et al.'s (2007) report that self-awareness is the foundation of self-care finds more evidence in this study. Attending to one's body, reactions, and feelings is central to the task of developing an individualized self-care plan. Helping professionals can only advocate for their well-being if they are in the present moment and in touch with their body in a holistic way.

Self-care was being practiced by chaplains. The three most frequently practiced self-care strategies were: self-compassion and purpose; mindful self-awareness; and supportive relationships. One explanation for this outcome is that opportunities to practice some strategies (self-compassion, supportive relationships, mindful self-awareness) are more frequent and organic than other strategies (exercise and mind−body practice).

There are implications of this study for healthcare and other organizations that employ chaplains. This study

supported the finding that organizational interventions such as maintaining realistic caseloads, addressing frustrating systemic issues and providing staff support appear just as vital as an individual self-care for reducing the impact of compassion fatigue. The signs of Burnout are may be more observable than those of traumatic stress. Burnout had the stronger association to both compassion satisfaction and mindful self-care than traumatic stress. This is most likely attributed to the conceptual differences between the two constructs.

Secondary traumatic stress measures the impact of work-related, secondary exposure to stressful events and includes such concerns as decreased empathetic attunement, sleep difficulties, and avoidance behaviors (Stamm, 2010). These signs may not be as clearly visible as Burnout is on the faces of those exhausted. Supportive structure ($r = -.323$, $p < .001$) and mindful self-awareness ($r = -.294$, $p < .001$) were the strongest protective factors against secondary traumatic stress. Supportive structure includes the concepts of professional boundaries, manageable work hours, such as being able to say "no" to inappropriate requests from patient and families. These supportive structures are the joint responsibility of the professional and the organization. This healthy alliance is a key factor in reducing traumatic stress risk.

The negative relationship between mindful self-care and secondary traumatic stress was significant but with a small effect ($R^2 = -.069$). Secondary traumatic stress appears less amendable to mindful self-care activities practiced while at work and in the process of everyday life (Hotchkiss, 2018) since secondary traumatic stress fits conceptually within the emotional contagion framework (Hatfield et al., 1993). Thus, necessary interventions may extend beyond individual self-care to include peer or professional counseling since these are the most appropriate inventions for those experiencing distressing thoughts and feelings from the caregiving (Whitebird et al., 2013).

In contrast, symptoms of Burnout appear to be more amendable to bodily rest, caring for one's self since the negative relationship between mindful self-care and Burnout was significant with larger effect ($R^2 = -.343$). Strong correlations between Burnout and all self-care strategies further demonstrate that the symptoms of physical, emotional exhaustion characteristic of Burnout are best addressed through an effective self-care plan and a supportive work culture. Burnout appears to fit conceptually with the resource depletion framework (Figley, 2002). Bolstering one's personal care and advocating for one's well-being is a primary means of reducing Burnout. While resource depletion may increase the risk of ineffective coping, the person's choice of self-care strategy may support coping even when resources are low. In particular, individuals who use effective coping and self-care maintain energy and engagement in demanding circumstances (Matthews, Zeidner, & Roberts, 2012). Blanc et al. (2007)

examined a team-based Burnout intervention program for oncology nurses and found that both education and action steps for building a self-care plan were effective in reducing Burnout risk.

Whitebird et al. (2013) found that respondent's suggestions for reducing work-related Burnout and stress focused on organizational changes and self-care opportunities. Efforts to reduce the risk of compassion fatigue among health care professionals should focus on education and staff interventions that address these areas. If self-care is just a workshop that one hears on orientation or during CE units, not much impact will be felt. However, leaders are encouraged to take an honest look at how the organization's culture promotes or distracts from a professional's well-being. The gift of the helping professions is the daily practice of a compassionate way of life while being honest about our limits and doing our best to nurture our own bodies and souls. Hence, organizations should ensure that supportive structures such as peer support are in place to help staff when trauma occurs. Since secondary trauma is sustained by a helping professional's fearful thinking processes (Stamm, 2010), opportunities should be provided in the work setting for mindful relaxation and supportive structures to counter the traumatic effect of these thoughts. Self-awareness when being "triggered" by clients is a vital self-care tool to reduce the risk of secondary traumatic stress.

Only two factors from the demographic and professional variables remain significant in the final model: board certification status and hospital setting. Becoming a Board-Certified Chaplain (BCC) explained a 7.2% increase in Burnout. The most probable explanation for this result is that becoming a BCC increases spiritual care competencies, leading to potential promotion opportunities and increased work responsibilities, which may increase the BCC's risk for Burnout. The process of board certification with the APC, and other associations, includes a deep reflection into all chaplain competencies including "calling," exploration of values, and self-care planning to avoid Burnout.

Working in hospital also explained a small (4.2%) increase in the risk of Burnout. The typical medical center, and its associated acute care elements, adds stressors that might increase Burnout risk. Conversely, working in a hospice was not associated with increased Burnout risk, suggesting that the meaningfulness of helping patients and families through the emotionally tender dying process increases compassion satisfaction, which buffers against Burnout risk. This finding is congruent with another study which found that although hospice workers reported high levels of stress, a small minority reported symptoms of Burnout and secondary traumatic stress, far lower than published norms (Whitebird et al., 2013).

This study supports the importance of helping professionals both to cope with the unique stressors of their

work and to recognize and connect to their work's positive and affirming aspects. Mindful efforts to celebrate feeling good about doing good are equally vital to well-being since compassion satisfaction was the strongest predictor of Burnout risk. The use of mindful personal self-care activities may be complemented by various workplace care interventions. These may include public recognition of "wins": helpful and successful interventions with patients and families by supervisors. The interdisciplinary team provides a consistent opportunity for professionals to share meaningful or significant encounters with patients and families with colleagues.

Chaplains also have a key role in interdisciplinary teams to encourage self-compassion and mindful practice such as the loving kindness meditation. The value of supportive relationships, mindful relaxation and supportive structure in the practice setting is clear. Supportive relationships such as mentors, buddies, and supervision are key aspects that help professionals sustain their compassionate care. Chaplains who feel most supported in their spiritual care work were most likely to have higher compassion satisfaction and lower Burnout. Organizations should be equipping their staff with continuing education and other opportunities to increase their mindfulness and self-awareness practices.

Limitations

As with any study, this study had several limitations, including inability to account for possible confounding variables such as degree of client demands, other personal factors, or organizational changes that could influence responses to the assessment. Social desirability may have influenced the self-assessment measures. Chaplains who are not practicing effective self-care might have been reluctant to take the survey. Also, the cross-sectional design measured participants' well-being at a single moment in time. A low overall return rate of 10.1%, may belie selection bias that further limits the validity and generalizability of findings across practice settings. However, generalizability is increased by chaplains participating from all 50 states.

Conclusion

In summary, chaplains who felt good about helping their clients and worked in a supportive setting tended to take care of themselves better and have lower risk for Burnout. This finding supports the central hypothesis that chaplains who engaged in multiple and frequent self-care strategies would experience higher professional quality of life. Healthcare organizations have begun to recognize that the pursuit of wellness among their staff is a win for both patients and staff. Staff wellness should be encouraged intentionally and holistically. Productivity increases and attrition decreases since healthy staff are productive.

In the chaplain's journey toward wellness, a reflective practice of feeling good about doing good and mindful self-care are vital.

Conflict of Interest

No conflict of interest has been declared by the author.

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