Statement of the Research Problem

Work related stress can contribute to job performance issues, as well as burnout and high turnover within an organization (Gellis, 2002). This is a relevant concern for hospital social workers. In addition to the high levels of occupational stress characteristic of hospital organizational cultures, social workers also face daily indirect exposure to the traumatic events and illnesses of their patients (Dane & Chachkes, 2001). Helping professionals exposed to indirect trauma have reported symptoms including intrusion, avoidance, sleep disturbance, and dissociation, and are at risk for secondary traumatic stress (Bride, 2004; Figley, 1995; McCann & Pearlman, 1990).

This phenomenon is a concern for social work since the social worker’s self is a vital instrument in every client interaction; the consequences of indirect trauma exposure may negatively impact the health and functioning of the social worker. Despite this, few studies examine this risk of exposure on hospital social workers (Cunningham, 2003). Better understanding the impact of indirect trauma and factors increasing hospital social workers’ vulnerability for stress reactions could aid in preserving the well-being of social workers and support the quality of their work as well as their longevity in the profession. This exploratory study examines the predictive contribution of empathy, emotional separation (or differentiation), occupational stress and social support to secondary traumatic stress and cognitive disturbance in hospital social workers.

Research Background and Hypotheses

Indirect traumatic stress reactions such as secondary traumatic stress or compassion fatigue have been described as a consequence for the professional who helps others experiencing pain and distress (Figley, 1999). Given the potential impact of secondary traumatic stress on social workers, it is crucial that we understand both the route of vulnerability and potential predictive factors in the development of indirect traumatic stress reactions. Empathy is a crucial component in the helping relationship and is theoretically thought to represent the primary conduit for secondary traumatic stress reactions (Figley, 2002). Empathy has been defined as a personality characteristic that
describes the ability to emotionally, cognitively, and communicatively respond to others while maintaining objectivity (Williams, 1989). Figley (2002) has developed an etiological model for compassion fatigue in which empathic ability, empathic concern, and the ability to perceive and respond to pain in others, are part of effective therapeutic work and primary factors in creating risk for compassion fatigue. However, little is known empirically about how and if empathy acts as the gateway of vulnerability for indirect traumatic stress reactions in professionals (Jenkins & Baird, 2002).

Figley (2002) also notes that emotional experiencing of client suffering and disengagement from the client are factors that either contribute to or prevent development of indirect traumatic stress reactions. It seems possible that this idea of disengagement (or emotional separation) may significantly contribute to the development of reactions such as secondary traumatic stress (or compassion fatigue) in the hospital social worker. A social worker’s inability to establish boundaries between self and others while remaining empathically engaged could negatively influence self awareness and the ability to self protect (Corcoran, 1983; Wilson & Lindy, 1999). This suggests the ability to maintain differentiation and modulate emotional proximity to the patient rather than empathy itself may influence vulnerability for secondary traumatic stress. Indeed, Corcoran (1989) explored the role of empathy and emotional separation in association with the development of burnout and found both to have a significant correlation with level of burnout reported. However, once emotional separation was controlled, empathy lost its significance. This was not true for emotional separation, which maintained significance when empathy was controlled. These findings indicate the need for further exploration of the roles of empathy and emotional separation play as contributors to the development of secondary traumatic stress.

A review of relevant literature exploring risk and protective factors endorses social support as a variable consistent in tempering indirect traumatic stress reactions (Bride, 2004; Lerias & Byrne, 2003). Occupational stress also has been shown to increase reports of related phenomena (i.e., post traumatic stress disorder, burnout) (Boudreaux, Mandry, & Brantley, 1997; Regehr, Hemsworth, Leslie, Howe & Chau, 2004) and is highly characteristic of healthcare organizations (Revicki & Gershon, 1996). Occupational stress has received attention in the literature as a contributory variable in increasing the propensity for traumatic stress in professionals (Regehr, Hemsworth, Leslie, Howe & Chau, 2004; Boudreaux, Mandry & Brantley, 1997). Therefore, these two variables were also considered to be important and included in this study.

**Research Questions**

This study explored the contributions of empathy, emotional separation (or differentiation), occupational stress, and social support as predictor variables in hospital social workers’ secondary traumatic stress and cognitive disturbance. The following research questions were among those examined:

Q 1: Will Emotional Separation be a stronger predictor than Empathy of Secondary Traumatic Stress reported by hospital social workers?
Q 2: Will Emotional Separation be a stronger predictor than Empathy of Cognitive Disturbance reported by hospital social workers?

Q3: Will Emotional Separation and Occupational Stress be stronger predictors than Empathy or Social Support of Secondary Traumatic Stress reported by hospital social workers?

Q4: Will Emotional Separation and Occupational Stress be stronger predictors than Empathy or Social Support of Cognitive Disturbance reported by hospital social workers?

Methodology

This exploratory study employed a descriptive, cross-sectional survey design utilizing a sampling frame of social workers employed in one of five Trauma Centers included in the study.

Following the receipt of approval or waiver from the Institutional Review Boards at all institutions, the primary investigator provided an explanation of the study at hospital staff meetings. An introductory letter and study measures were placed in employee mailboxes of social workers absent from these meetings. All social workers scheduled to work during the data collection period were eligible to participate (possible n = 166). The voluntary and anonymous nature of the survey was stressed and survey materials did not request any personal identifiers. Participants could return completed surveys to the investigator by mail using pre-paid envelopes or by using drop-off boxes centrally located in their hospitals of employment.

Independent variables

Empathy. This variable was defined as cognitive and affective dispositional empathy, and measured by the overall score on the Interpersonal Reactivity Index (Davis, 1983) which consists of subscales measuring affective and cognitive empathy.

Emotional separation. This variable was defined as the degree to which one is able to emotionally differentiate from another while being empathic, and measured by the Maintenance of Emotional Separation Scale (Corcoran, 1983).

Occupational stress. This variable was defined as the strain produced in response to exposure to and interaction with work environment stressors and measured by the Work Related Strain Inventory (Revicki, May, Whitley, 1991).

Social support. This variable was defined as the subjective assessment of the quality and adequacy of social support reported by hospital social workers, and measured by the overall score on the Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet & Farley, 1988).
Dependent variables

Secondary traumatic stress. This variable was defined as the emotional and behavioral symptoms in response to work-related indirect trauma exposure, and measured by the Secondary Traumatic Stress Scale (Bride, Robinson, Yegidis & Figley, 2004). Cognitive disturbance. This variable was defined as the cognitive changes in one’s beliefs and personal assumptions as a response to work-related indirect trauma exposure, and measured by the World Assumption Scale (Janoff-Bulman, 1989). Lower scores on the World Assumption Scale indicate higher levels of cognitive disturbance.

Statistical Analysis

All data were thoroughly screened prior to analysis to assure that assumptions were met for subsequent analytic procedures. Descriptive analysis was utilized to explicate sample and variable characteristics. Correlation analyses examined bivariate relationships among the independent variables, and with the dependent variables. A Stepwise regression analysis was conducted for each of the research questions to examine the predictive ability of the independent variables on each dependent variable.

Results

One hundred and twenty one surveys were returned from the hospitals, yielding a response rate of 73%. Participants reported an average of 15.8 (SD = 9.76) years of total social work experience, with an average of 9.3 (SD = 8.36) years in hospital social work. The majority of respondents were master prepared social workers and female. The overall sample reported spending 26% of their time in emergency departments, 45% of their time on inpatient units, and the remainder of their time in clinics or in the community. Social workers were asked about frequency of exposure to patient death, violent trauma, and condition trauma (chronic, deteriorating, medical or psychiatric illness or substance abuse; patients without resources to meet basic or medical needs for which there are no solutions). For this sample, patient death was most strongly correlated with secondary traumatic stress (r = .293, p < .01) and cognitive disturbance (r = -.226, p < .05). Patient condition trauma was also significantly correlated with secondary traumatic stress (r = .236, p < .01) as was violent trauma to patients (r = .215, p < .05) for hospital social workers.

The following section describes the results of multivariate analysis conducted for each of the previously stated research questions:

Q1: Stepwise regression results were significant (F (1, 113) = 72.79, p < .001) and showed emotional separation as the only significant predictor of secondary traumatic stress (β = -.626, p < .001), explaining approximately 39% of the variance (Adjusted R² = .386). Decreased emotional separation correlated with increased secondary traumatic stress (r = -.632, p < .01). This finding supports emotional separation as being a stronger predictor of secondary traumatic stress compared to empathy.
Q2: Emotional separation was the only significant predictor of cognitive disturbance ($\beta = .290, p = .002$), and explained approximately 8% of the variance $(\text{Adjusted } R^2 = .076)$ ($F(1, 111) = 10.15, p = .002$). Decreased emotional separation correlated with increased cognitive disturbance ($r = .266, p < .01$). Although emotional separation performed more strongly than empathy in this regression model, it explained little of the variance in secondary traumatic stress. This finding suggests that secondary traumatic stress and cognitive disturbance appear to be separate constructs.

Q3: When occupational stress and social support were added to the regression equation, the strongest predictor of secondary traumatic stress remained emotional separation ($\beta = -.626, p < .001$). Occupational stress was also a significant predictor ($\beta = .395, p < .001$) in Model 2; together these variables explained approximately 50% of the variance ($F(1, 110) = 26.55, p < .001$). Decreased emotional separation ($r = -.632, p < .01$) and increased occupational stress ($r = .601, p < .001$) correlated with increased secondary traumatic stress. Empathy was again not significant, and social support was also not included as a significant predictor of secondary traumatic stress in this regression equation.

Q4: Emotional separation was no longer a significant predictor of cognitive disturbance once occupational stress and social support were added to the regression model. Occupational stress emerged as the most significant predictor of cognitive disturbance ($\beta = -.384, p < .001$) in the first regression model ($F(1, 109) = 18.84, p < .001$), explaining 14% of the variance (Adjusted $R^2 = 14$). Social support ($\beta = .269, p = .005$) joined occupational stress ($\beta = -.271, p < .001$) as a significant predictor in Model 2; together explaining 20% of the variance (Adjusted $R^2 = 20$). Emotional separation performed differently relative to cognitive disturbance and secondary traumatic stress; occupational stress was a significant predictor for both dependent variables, albeit of varied strength.

Study limitations

The nature of this study limits generalizability. Due to the cross-sectional study design, causality cannot be assumed. The sampling method allowed for self-selection, which has the potential of selection bias. Data collection instruments utilized self-report, a method that is vulnerable to distortion and memory limitations of respondents. Empathy performed so weakly in this study, and results associated with cognitive disturbance were weak, which raises the concern that the data collection instruments may have lacked sensitivity in detecting the constructs under study. Due to time constraints and the need to limit the number of variables included in the study, only a portion of potential predictors were examined.

Utility for social work practice

Study results have implications for the theoretical understanding of the onset of indirect traumatic stress reactions, as well as implications for social work education, hospital social workers, and hospital organizations. The findings suggest emotional
separation rather than empathy may more accurately create the conduit for indirect traumatic stress reactions. According to these results, social workers need to be able to emotionally separate from their patients during empathic connections while utilizing support resources to minimize indirect trauma reactions. Social work educators need to prepare students to expect exposure, recognize stress symptoms and learn ways to minimize indirect traumatic stress.

Social work students also need assistance in developing professional boundaries and the ability to proactively emotionally differentiate from their clients while walking the internal tightrope between empathy and emotional separation. Preparing students with knowledge about organizational stress, and assisting them with developing a proactive coping plan may help to preserve a life balance and their own well-being as they enter field placements and the demanding organizational culture that constitutes the hospital work environment.

Also indicated is the need for established hospital social workers to utilize ongoing self-assessment (Clark & Gioro, 1998). They ought to approach their work with a conscious commitment to tend to their own well-being despite the demands of the work and the environment. Social support appears to assist in reducing the impact of indirect trauma exposure, but does not immunize the social worker. The role of occupational stress in creating vulnerability in this population suggests that hospital administrators ought to assess the structure and characteristics of the work environment for contributory risk factors (Bell, Kulkarni & Dalton, 2003). Social workers also need to keep hospital administrators informed so they can be better attuned and responsive to their employees. These findings make a contribution in helping us to understand what may be necessary to protect the well-being and effectiveness of the social worker, the profession’s greatest asset.
References


