

A Short-Term, Cost-Effective, Institution-Based Resiliency Program to Reduce Compassion Fatigue: A Pilot Study

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Abstract

Objective: The study evaluated a short-term, cost-contained, resiliency program to reduce compassion fatigue (CF), burnout (BN), and secondary trauma (ST) among healthcare providers.

Background: Many healthcare providers experience CF, BN, and ST. Resiliency programs reduce these concerns, but are infrequently implemented due to costs and limited staff time. Therefore, the authors developed a short-term, cost-contained resiliency program to address these barriers to implementation.

Method: 21 participants received 2 60-minute interventions, completed the Professional Quality of Life Scale-V, and rated their intent to use the self-care skills they learned.

Results: Experimental subjects demonstrated significant decreases in CF and BN; effect sizes were large. Reductions in ST did not reach statistical significance, yet decreased three times more among experimental vs. control subjects. Participants' intentions to use skills were rated near the maximum possible.

Conclusion: The resiliency program was welcomed by management and staff, using internal facility resources, with minimal costs and staff time needed. Given its demonstrated efficacy, healthcare administrators may consider similar programs to decrease CF, BN, and ST, and improve staff performance, satisfaction, health, and retention.

Keywords: Resiliency; Health Care; Burnout; Compassion Fatigue; Secondary Trauma Stress

Abbreviations

CF: Compassion Fatigue; BN: Burnout; ST: Secondary Trauma Stress; ProQOL-V: Professional Quality of Life Scale-V

Introduction

Compassion is a trait that commonly leads individuals to seek healthcare careers [1]. Healthcare providers in direct patient care have frequent opportunities to express compassion within quality patient-caregiver relationships [2,3]. For healthcare providers, professional quality of life is "the quality one feels in relation to one's work as a helper" [4] (p. 8). Professional quality of life encompasses both positive and negative attributes. Positives include meaningful work, intrinsic motivation, and professional support; negatives include excessive workload, emotional challenges, and a lack of professional support [4,5]. Positive aspects may engender compassion satisfaction; negatives may engender compassion fatigue (CF) [4]. Healthcare providers may also absorb emotional pain from patients, increasing burnout risks [6]. Burnout (BN) manifests as apathy, exhaustion, and detachment, impeding work performance [4,6].

The terms BN and CF have been used interchangeably, yet some have made distinctions [4,5]. Stamm [4] considered BN a subset of CF along with secondary trauma stress (ST). BN typically arises gradually; it limits healthcare providers' hope and satisfaction with their work [4,6-8]. In contrast, ST arises rapidly from exposure to patient trauma or serious illnesses; effects include sleep and eating difficulties, intrusive images, avoidance of work responsibilities, and shunning meaningful patient-caregiver relationships [4]. In short, the literature suggests attention to three related constructs: CF, BN, and ST.

Direct healthcare providers most at risk for CF, BN, and ST include those: with baccalaureate rather than graduate degrees [9]; in inpatient vs. outpatient settings [9]; in secondary trauma [4], cancer, end of life [8,9], and medically futile care [10]. To prevent CF, ST, and BN, researchers have suggested, along with increased awareness of causes and symptoms of CF, ST, and BN, that healthcare providers need to practice and receive support in self-care behaviors [8,11-13]. Studies underscore the importance of preventing CF, ST, and BN, because these phenomena entail significant costs, including decreased worker productivity, staff retention problems resulting in healthcare provider shortages, diminished attention to holistic care, and shortages of experienced healthcare providers to provide complex care [7,8,10]. Nonetheless, healthcare administrators and practitioners have noted difficulties in supporting healthcare providers in practicing self-care to decrease and prevent CF, ST, and BN, including healthcare providers' wide scope of practice, changing complexities of medical care, program costs, limited staff time, and staffing shortages [7,8,14]. Hence, although the need is well established to teach and encourage healthcare providers to engage in self-care practices, barriers to doing so exist in many healthcare workplaces, especially costs and limited staff time.

Preventing CF, BN, and ST has significant positive implications for healthcare providers and healthcare quality. Yet due to known barriers, healthcare provider self-care programs require realistic, short-term, and cost-effective options likely to be adopted by administrators and healthcare providers who must balance multiple priorities. Some have considered the most practical options for healthcare provider self-care training. Aycock and Boyle [7] surveyed oncology nurses nationwide to identify readily available resources for addressing CF. Resources included on-site options, such as employee assistance programs and collegial support; educational programs, such as end of life nursing care training and emotional self-care development; and specialized retreats. Of 103 survey respondents, half reported having ready opportunities for learning and advancing coping skills and emotional self-care practices, with less availability but a desire for educational programs and specialized retreats [7].

Potter, *et al.* [9] concluded that the evidence justifies the costs of group self-care interventions in healthcare environments to prevent CF. Ruyschaert [6] concluded that, "it makes sense to focus on resources to strengthen prevention, the protective skills of the healthcare provider, and focus on compassion satisfaction" (p. 163). Hart and colleagues [15] emphasized the need for medical administrators to educate themselves on cost-effective, readily available interventions for nurse retention.

In spite of these clear recommendations to implement cost-effective programming to reduce healthcare providers' CF, BN, and ST, few studies have examined affordable, time limited, institution-supported self-care practices [16,17]. One study introduced an institution-based resiliency program to help nurses recover from stressors that engender CF [17]. The program offered education on CF and chronic stress, and supported healthcare providers through self-care practices. This program included only four sessions, 90 minutes each. Practices included self-regulation, intentionality, self-validation, connection, and self-care. Although the program lowered CF scores, participants found the intervention of limited use because of the time commitment. They requested fewer or shorter sessions.

Due to documented concerns about staff time and programming costs, utilizing readily available institutional resources for time-limited, self-care programming could prove cost-effective, welcome by healthcare providers, and capable of promoting sustainable interdisciplinary relationships that provide informal staff-to-staff care [15,17]. In particular, two articles [16,18] considered the workplace as a community of support for healthcare providers. Others have recommended that healthcare providers be taught simple methods that encourage them to utilize already acquired self-care practices within personal routines to enhance the compassion, confidence, and competence of their work, and to reduce potential CF, BN, and ST [6,7,9,14,16]. Similarly, Aycock and Boyle [7] suggested building on

healthcare providers' personal strengths, including religious faith, music and art, physical care practices, and balance. Others [3] identified successful self-care resiliency strategies that include leisure activities, cultural activities such as music, literature, and art, and contact with colleagues. Still others [19] suggested creative interventions led by existing staff to build a greater sense of hope among providers.

Evidence-based, cost-effective self-care practices

Two cost-effective self-care practices promoted often in healthcare that align with the above recommendations involve music and spirituality [20]. Music and spirituality interventions offer hope, meaning, and purpose [21,22] and can be cost-effective because they are generally available within healthcare institutions [3,7]. Music therapists' interventions promote peace and allow for cognitive, emotional, and physiological connectedness with others [23,24] and one's higher power [22,25,26]. Chaplains help healthcare providers to cope and find meaning and purpose in their work [14,27]. Both music professionals and chaplains are usually available to assist with self-care strategies within healthcare environments, without needs for costly contracts to hire additional staff.

In particular, music assisted relaxation and supportive music with imagery promote physiological self-regulation, helping healthcare providers to explore and experience supportive emotions [25] and encouraging self-validation of strengths and resources [25]. Music assisted relaxation is easily incorporated into mindfulness-based stress reduction interventions to promote resiliency and lessen the stressors that lead to CF [3,7,17,22]. Active music making, such as group drumming, decreases stress, increases energy, and improves group cohesion [23]. Investigators [28,29] have also confirmed that group singing and songwriting effectively aid in stress relief and grief expression among healthcare providers.

On the other hand, chaplains may teach spiritual self-care practices that: encourage the exploration, identification, and practice of finding meaning/purpose [27]; promote self-validation of one's professional work, resilience against judgmental challenges from peers and patients, commitment to professional values, and connections with patients [3,17,30]; and may be addressed via individual reflection, connection with others, physical activity, creative arts, humor, counseling, and within individual and group activities [27]. Spiritual renewal practices include identifying and validating successes with clients, exploring disillusionments, developing a personal renewal of hope, and defining personal values [3,17].

Research questions and hypotheses

Research suggests the need to identify CF, BN, and ST among healthcare providers and supports resiliency programming and self-care practices, especially music and spiritual interventions. Yet research indicates that self-care programs are not often implemented within healthcare facilities due to costs and staff time limitations. Finding short-term, cost-effective, institution-based methods to promote self-care, using existing healthcare providers' self-care practices and existing personnel, may alleviate this obstacle. Yet minimal research has evaluated short-term, cost-effective, institution-based resiliency training programs to decrease CF, ST, and BN. Therefore, the present study performed this evaluation.

The current study accordingly asked: Will healthcare providers' CF, BN, and ST scores decrease through a short-term, cost-contained, institution-based resiliency training program? It was hypothesized that by participating in a short-term resiliency training program, healthcare providers would experience decreased CF, BN, and ST scores; and that healthcare providers would rate the resiliency training program as beneficial, indicating their intent to implement the practices learned.

Materials and Methods

Participants

The facility's Institutional Review Board and Nursing Research and Evidence-Based Practice Committee approved this study. Direct healthcare providers were recruited from a large, Midwestern tertiary care center in the United States via fliers distributed to those in secondary trauma care, intensive care, terminal illness, and end of life care specialties, specifically nurses and nursing-related professionals, physicians and physician-related professionals, chaplains, social workers, and ancillary therapists. Men and women, ages 18 and

older, were eligible for the study. The pilot was designed for up to 35 persons; 34 healthcare providers volunteered. Due to schedule and job changes, 21 completed the study. Participants completed written informed consent for the study.

Materials

The following materials were used.

Professional Quality of Life Scale (ProQOL-V): The ProQOL-V is a self-report screening tool that examines CF, BN, and ST [4]. The ProQOL-V is designed to assess the three constructs over time. The ProQOL-V has been used with more than 1,000 participants and has good construct validity and inter-scale correlations between CF, BN, and ST scores [4]. Individuals' results are reported as t scores.

Follow-up survey: A follow-up survey, created by the principal investigator, asked participants about their intention to use practices taught during the resiliency training program and the program's overall benefit in their lives. The survey also asked for open-ended feedback about participants' experiences participating in the resiliency training program.

Resiliency program resources: Inexpensive and readily available program resources were selected, with research evidence supporting their efficacy. Participants in the experimental group received resiliency training program materials via auditory, nutritional, visual, and written self-care resources. Food and drink appropriate to time of day were available at program sessions for self-regulation. Self-regulation and self-validation resources included written information on relaxation techniques and music assisted relaxation, plus a compact disc of the music assisted relaxation used during the sessions. Intentionality and self-validation resources included spiritual self-reflection questions, a mantra, and a pocket reminder stone.

Procedures

The principal investigator contacted managers of targeted areas at University of Iowa Hospitals, who presented fliers to healthcare providers in their departments. The flier described the resiliency training program, its goals, dates, and location. To participate, healthcare providers contacted the principal investigator via email or phone. The principal investigator used screening questions to determine if healthcare providers met inclusion criteria and explained that providers would be randomly assigned to either a control or experimental group. For those meeting inclusion criteria, the principal investigator described the study, research question, timeline, assessment tools, and sessions, and obtained their written consent.

Preceding the resiliency training program, control participants completed the baseline ProQOL-V and, four weeks later, a follow-up ProQOL-V. The resiliency training program had three distinct start dates to allow more participants to find time in their busy work schedules to attend. A maximum of 15 participants were allowed in each of the three resiliency training program groups.

During resiliency training program week 1, experimental subjects completed the baseline ProQOL-V. During weeks 2 and 3, resiliency training program sessions occurred. All subjects attended these sessions. During week 3, all participants completed follow-up surveys. During week 4, experimental subjects completed the follow-up ProQOL-V. The two resiliency training program training sessions each lasted 60 minutes. A licensed chaplain and board certified music therapist, members of the facility's psychosocial services staff with advanced experience in self-care practices, led the sessions. The first session included interventions for intentionality and self-regulation. Intentionality interventions explored supportive professional dialogue and challenged participants to engage in this practice. Self-regulation interventions included education about the cognitive, emotional, and physiological effects of stress, plus a music assisted relaxation exercise. The second training session included interventions for self-validation and commitment. Self-validation interventions consisted of explorations of spirituality, unresolved grief, and forgiveness, plus active music making, songwriting, and therapeutic singing. Commitment interventions included a professional covenant; participants also identified practices for intentionality, self-regulation, and self-validation.

Statistical analysis

Table 1 presents participants' sociodemographic data. From the pre and post ProQOL-V, change scores were computed within the control and experimental groups. Change scores were contrasted, separately within the experimental and control groups, via paired samples t tests, using one-tailed alpha levels since the hypothesis included the expected direction of difference. Overall means and standard devia-

tions of follow-up survey questions were calculated. Finally, participants’ written comments were compiled.

Professional Role	Men	Women	Control	Experimental
Physician/Physician Assistant	1	2	1	2
Nurse/Nursing Assistant	0	10	3	7
Social Worker	0	2	2	0
Chaplain	2	1	2	1
Ancillary Therapist/Staff	0	2	1	1
Total	3	18	9	12

Table 1: Participant Sociodemographics (N = 21).

Results and Discussion

Of 21 participants, 10 were nurses, three physicians, two social workers, three chaplains, and three ancillary staff. There were three men and 18 women. Nine participants were in the control group, 12 in the experimental group. See table 1. Table 2 presents pre-post means, change scores, and effect sizes of the three ProQOL-V outcome variables. For experimental subjects, a statistically significant increase occurred in compassion satisfaction and statistically significant decrease in BN. Effect sizes for these desirable changes were large. Although ST change did not reach significance, in line with the hypothesis the decrease was three times larger in the experimental vs. control group and the effect size of the change was moderate. Among control subjects, there was a statistically significant increase in compassion satisfaction, of large effect size, yet as predicted the minimal changes in BN and ST were not significant among control subjects.

	Pre Score	Post Score	Change Score	t test(df)	Cohen’s d
Control Subjects					
Compassion Satisfaction	40.67 (5.50)	41.22 (5.76)	-0.56	-1.89(8) ^a	-1.34 ^b
Burnout	22.67 (5.32)	21.89 (6.68)	0.78	0.60(8)	0.43
Secondary Trauma Stress	20.56 (5.79)	20.11 (5.23)	0.44	0.50(8)	0.36
Experimental Subjects					
Compassion Satisfaction	38.50 (5.55)	40.92 (4.40)	-2.42	-1.88(11) ^a	-1.13 ^b
Burnout	28.17 (6.39)	23.42 (5.93)	4.75	2.51(11) ^a	1.51 ^b
Secondary Trauma Stress	23.75 (4.73)	22.42 (6.20)	1.33	1.32(11)	0.78 ^c

Table 2: Pre-Post Means, Change Scores, and Effect Sizes of Outcome Variables (N = 21).

^a: p < .05, one tailed; ^b: Large Effect Size; ^c: Medium Effect Size.

Table 3 presents follow-up survey responses. On a 5-point scale, subjects rated their intentions to use the four resiliency training program elements-self-regulation, intentionality, self-validation, and commitment-at means of nearly 5. All scores were 4s or 5s, except one 3 for self-validation. Participants’ mean rating of the resiliency training program’s benefits was 4.6 of 5. Participants’ open-ended, anonymous comments were universally positive. Samples included: “I learned new coping techniques”; “The group support and validation and compassion were great”; “Please do more of these for all the staff!”

	1 Strongly Disagree	2 Disagree	3 Neither Agree nor Disagree	4 Agree	5 Strongly Agree	Mean
Self-Regulation	0	0	0	8	9	4.53
Intentionality	0	0	0	7	10	4.59
Self-Validation	0	0	3	7	9	4.47
Commitment	0	0	0	5	12	4.71
Overall Benefit of the Program	0	0	0	7	10	4.59

Table 3: Follow-up Survey: Participants’ Intent to use Methods Taught in the Resiliency Training Program (N = 21).

The current study hypothesized that, by participating in a short-term, cost-effective, institution-based resiliency training program, healthcare providers would experience decreased CF, BN, and ST scores; and that healthcare providers would find the resiliency training program beneficial with intentions to implement the self-care practices they learned. Results confirm these hypotheses. Experimental subjects experienced: a significant increase in compassion satisfaction of large effect size, indicated by a decrease in CF; a significant decrease in BN of large effect size; and a decrease in ST three times larger than in the control group and of moderate effect size, declining to a low level based on ProQOL-V norms [4]. Participants rated the resiliency training program as beneficial, with the mean rating at 4.6 out of 5. They indicated intentions to use all four self-care practices taught during the resiliency training program, with each practice having a mean rating of close to 5 out of 5.

Control subjects experienced a significant decrease in CF of equivalent magnitude to experimental subjects (-1.89 vs. -1.88). Perhaps by inclusion in the study, control subjects felt validated as caregivers. By their knowledge that their facility was addressing emotional coping issues and that they were welcome to participate in the resiliency program somewhat later, control subjects may have felt that their compassionate acts were being recognized and valued, translating into greater compassion satisfaction among them. Importantly, control subjects did not experience decreases in BN or ST, whereas the experimental subjects did. This suggests that the resiliency training program practices were likely responsible for the BN and ST decreases among the experimental subjects, underscoring the resiliency training program’s value.

Considerations

The number of participants was relatively small, N = 21, appropriate to a pilot study. Because the resiliency training program appeared effective, it would be worthwhile to repeat it with more participants. Resiliency training program participation strongly reduced CF and BN, with large effect sizes, but reduced ST less, where changes did not reach statistical significance and were of medium effect size. Thus, exploring other cost-effective, readily available tools to improve the impact of the resiliency training program on ST may prove valuable for future researchers.

Although the pilot concluded with 21 participants, the principal investigator received multiple requests within the institution to offer additional resiliency training program sessions. Administration was supportive; thus, the principal investigator continued the resiliency training program for three additional years, with 475 staff attending. Follow-up surveys with these additional attendees indicated much appreciation for the resiliency training program. Therefore, it appears that this short-term, cost-effective resiliency training program was welcome by busy healthcare providers and perceived as valuable enough that, by word of mouth alone, it became a sought after experience within the healthcare setting. It is likely that similarly wide acceptance may occur in other healthcare settings.

Limitations

This study entailed several limitations. First, it included a small sample, N = 21. Some individuals were unable to attend due to professional responsibilities and the program’s time of day. Time of day was notable, creating conflicts with work schedules and commutes. In

the future, the program could be offered at different times of day or several times throughout the workweek. Second, participants' professional roles may be a limitation, as each discipline involves variable professional duties and stressors. With a larger sample, results could be stratified by discipline to assess differential impacts. Third, sample size did not permit sufficient statistical power for multivariate repeated measures analyses. Such procedures provide more accurate results and better control of Type I statistical errors and would be recommended in future research. Fourth, to protect participants' anonymity, minimal sociodemographic data were collected. Factors such as education, relationship status, family stressors, income, and ethnicity may affect individuals' responses to workplace stressors and resiliency interventions. In future studies, sociodemographic factors might be obtained to better understand impacts of workplace stress and resiliency training program components on persons from various backgrounds. Finally, although the resiliency training program was designed to be short-term to promote accessibility and cost-effectiveness in modern healthcare environments, longer term follow-up could demonstrate whether or not participants' intentions to practice the skills truly translate into sustained action.

Conclusion

This study explored a short-term, cost-effective, institution-based resiliency training program in improving healthcare providers' CF, BN, and ST. Results indicated that the resiliency training program decreased CF, BN, and ST. The program was rated as highly beneficial by participants, who indicated their intent to use the self-care practices learned. The resiliency training program was designed to address key obstacles noted in prior research as limiting resiliency training program implementation, namely staff time commitments and institutional costs. The present resiliency training program utilized available facility resources, was short-term and involved short session times. Minimal costs and staff time were needed. Therefore, healthcare administrators may wish to consider similar programs to decrease staff CF, BN, and ST and to improve staff performance, satisfaction, retention, and health status. These benefits appear to justify the minimal costs of a short-term, institution-based resiliency training program.

Conflict of Interest

The authors have no financial interests or any conflicts of interest regarding this work.

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