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Self-Care among Social Workers Employed in Rural Settings: A Cross-Sectional Investigation

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Abstract. Despite growing recognition about the importance of self-care for social work professionals, research related to the topic has not kept pace with the changing landscape of the profession. Particularly, self-care practices among rural social work professionals have been overlooked in the research. Rural social work practice is, in many ways, decidedly different from practice in more urban areas. Thus, the primary aim of this exploratory study was to investigate the personal and professional self-care practices of rural social workers. Specifically, the study sought to better understand how often social workers engage in self-care and whether or not there are associations between personal and professional demographic variables and self-care practice. Discussion and next-steps for research and implications for practice are included.

Keywords: *self-care, rural social work practice*

Veritably, engaging in adroit self-care practices can be quintessential to adept social work practice (Bent-Goodley, 2018). Several authors have suggested that self-care may help to assuage or prevent professional burnout and other inimical employment issues that may impact professional practice (e.g., Newell, 2018; Pyles, 2018). Professional membership organizations, such as the National Association of Social Workers (NASW, 2008) and the International Federation of Social Workers (IFSW, 2004), have issued edicts about the importance of self-care for social workers. Even popular media outlets, such as *Forbes Magazine* (see Nazish, 2017), have discussed the importance of self-care.

Despite growing recognition about the importance of self-care, research related to the topic has not kept pace (Bloomquist, Wood, Friedmeyer-Trainor, & Kim, 2015; Grise-Owens, Miller, & Eaves, 2016; Lee & Miller, 2013; Miller, Donohue-Dioh, Niu & Shalash, 2018; Newell, 2018). A main topic in the current literature is the need for additional literature about self-care. Of particular scarcity are studies that examine self-care practices among social workers who are employed in rural settings. This is not surprising. Slovak, Sparks, and Hall (2011) found a “paucity of rural focused articles” in social work journals. While their research emphasized rural populations and problems, it follows that the specific needs of rural social work practitioners have also been largely unexamined.

The purpose of this study was to examine the self-care practices of social workers employed in rural settings in one southeastern state (N = 348). Researchers employed an electronic survey to solicit primary data related to personal and professional self-care practices, respectively. After a literature review, this paper discusses the survey results and its implications.

Background

Challenges Facing Social Workers

The challenges facing the contemporary social work workforce are many. What's more, these challenges are well documented. In summary, social workers are faced with a lack of adequate supervision (Calitz, Roux, & Strydom, 2014), perceived salary insecurity and/or low pay (An & Chapman, 2014; Calitz et al., 2014), high or complex caseloads (Blomberg, Kallio, Kroll, & Saarinen, 2015), and professional role ambiguity/conflict (Marc & Oşvat, 2013; Savaya, 2014), among others. These challenges may be compounded for women or practitioners from under-represented groups (e.g., Ayala, Ellis, Grudev, & Cole, 2017). Further, social service employment contexts may be overly sensitive to uncertain political climates and resource restrictions (Miller et al., 2018).

These challenges can have real *consequences* for social workers. For instance, Ting, Jacobson, and Sanders (2011) suggested that because practitioners are exposed to clients' traumatic life experiences, they are at risk for compassion fatigue and/or vicarious trauma. Others have echoed similar sentiments in regard to helping professionals (Figley, 1999; Adams & Riggs, 2008; Craig & Sprang, 2010). High rates of burnout (Newell & MacNeil, 2010), workplace stress (Savaya, 2014), and employee turnover (Calitz et al., 2014) are realities for many social work practitioners. Given these challenges and subsequent consequences, perhaps Vyas and Luk (2011) summarized it best, "social workers are under great pressure in the workplace" (p. 835).

Defining Self-Care

Historically, self-care, as a general construct, has been viewed via a medical perspective, whereby "patients" engage in self-care to address medical ailments (e.g., World Health Organization, 1983; World Self-Medication Industry, 2010). Over time, the concept has evolved. Contemporary conceptions of the term have included a more holistic approach that has encompassed the importance of practitioners, particularly those in helping disciplines/professions (e.g., social workers, nurses, psychologists, therapists, etc.), engaging in self-care as part of ethical, competent practice.

That said, self-care can be somewhat difficult to define (Cleantis, 2017). This difficulty can be attributed to several factors. For example, the very word "self" connotes a level of subjectivity. As well, social contexts and settings may impact the way that individuals conceptualize self-care (e.g., Berman & Iris, 1998; Chapple & Rogers, 1999; Bressi & Vaden, 2017).

Difficulties aside, there is broad consensus that self-care is a multidimensional construct. Lee and Miller (2013) delineated personal and professional domains comprising self-care. Newell (2018) explicated an ecological approach that includes a host of dimensions nestled in psychosocial systems. Grise-Owens et al. (2016) discussed similar aspects of self-care. Perhaps, Dorociak, Rupert, Bryant, and Zahniser (2017) offered the most synthesized definition of self-

care by defining it as a “multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being” (p. 326).

Importance of Self-Care

Though the explicit empirical examination of self-care within social work is in the nascent stages, there is a broader literature to suggest that adroit self-care can mitigate many of the deleterious employment challenges previously discussed. Several studies (e.g., Butler, Carello, & Maguin, 2017; Coleman et al., 2016; Bamonti et al., 2014; Salloum, Kondrat, Johnco, & Olson, 2015) have concluded that lower self-care is related to higher level of burnout and secondary traumatic stress symptoms. Among a sample of hospice workers, Alkema, Linton, and Davies (2008) concluded that that engaging in higher levels of self-care was commensurate to higher levels of compassion satisfaction. Bradley, Whisenhunt, Adamson, and Kress (2013) and Barnett, Baker, Elman, and Schoener, (2007) suggested that a lack of self-care can negatively impact clinical functioning and efficacy. Apt self-care can also redress issues associated with workplace turnover (Bressi & Vaden, 2017), lead to higher levels of professionalism (Asuero et al., 2014), and positively impact self-esteem (Abreu, Barroso, de Fátima Segadães, & Teixeira, 2015), among other positive effects.

Despite the overwhelming positive impact of self-care on professional praxis, engaging in self-care can be difficult. For example, in a study that examined strategies for reducing vicarious trauma in therapists, Bober and Regehr (2006) concluded that while participants viewed self-care as an opposite way to address vicarious trauma, this realization didn't lead to the therapist actually devoting time to self-care. Similarly, Coleman et al. (2016) asserted that “self-care activities can be vague and difficult to prioritize” (p. 1). Likely, these difficulties may be attributed to limited conceptions of self-care. As well, helping professions, in general, and social work, specifically, has not actualized value associated with engaging in self-care (Grise-Owens et al., 2016).

Connecting Self-Care and Rural Practice

The research on self-care practice among social work practitioners is growing, yet there is a deficit of literature that explores self-care practices specific to rural social work practitioners. While rural and urban practitioners may have many commonalities, there are distinct differences in the practice of social work in rural and urban areas that makes it important to examine self-care specific to those who primarily practice in rural areas.

Prior to discussing what we do/do not know about rural social workers and self-care, it is important to discuss and define rural itself. There is not one primary and agreed upon definition of rural (Cromartie & Bucholtz, 2008). Rural communities, however, often have some agreed-upon attributes, as articulated by Wilson & Carr (1999):

Remoteness, low population density, and economic dependence upon one industry are three important attributes that bind...diverse communities into what we identify as rural America [and] these attributes should be added a predominance of low-income families, special population groups, and poor housing opportunities. (p. 139)

Daley (2010) and Ginsberg (2011) echo this, explaining that rural cannot be classified by geography or population alone. It is the complex intersection of geography (which often dictates industry), size/population density, and proximity to metro areas that creates what is considered to be rural in the 21st Century. This uniqueness has confirmed a need for an understanding of social work practice, practitioner behaviors, and self-care all within the context of the rural community (Daley, 2010; Ginsberg, 2011).

The practice of social work in/with rural communities is “a distinct field of professional practice” (Daley, 2010, p. 1). This difference is related to resource availability and allocation, the distinct culture and geography of rural communities, and the role the social worker may play in rural communities (Croxtton, Jayaratne, & Mattison 2002; Mason, 2011; Piche, Brownlee, & Halverson, 2015).

Rural social work practice may be more – or differently – stressful than other social work given that it takes place in smaller communities where practitioners often wear many hats. Piche et al. (2015) suggest that there is an interconnectedness of rural practitioners and their communities. Rural social workers are likely to be embedded in the community, taking on multiple roles that may blur professional and personal boundaries. This can create stress as it “expands the interconnectedness of worker and community members” (Piche et al., 2015, p. 65). This is echoed by Croxtton et al. (2002) who found that rural social workers face some confounding issues with the balance between personal and professional roles that are dissimilar to those who practice in urban areas. Mason (2011) also explores the complexity of rural practice in terms of the role that the social worker plays in his/her/their community, emphasizing how embedded rural practitioners are in the community in which they work. Further, Mason (2011) posits that rural social work is shaped by an uncertainty dissimilar to that of urban practice.

Professional burnout or job-fatigue has been associated with rural social work practice (e.g., Mackie & Berg; 2005, Mackie & Lips, 2010). Mackie and Lips (2010) found burnout to be related to the difficulty to hire/retain social work professionals in rural communities. In Mackie and Berg’s (2005) work focused on both the joy and the frustration of working in rural practice, burnout and isolation emerged as important themes.

The implications derived from the literature are clear. While self-care may be a pertinent tool in addressing the unique challenges facing social workers employed in rural settings, there are few studies, if any, that have explicitly examined this area of inquiry. Given the challenges plaguing social work practitioners, research in this area is justified. This paper seeks to contribute to addressing limitations in the current literature.

Aims of the Current Study

The primary aim of this study was to investigate the personal and professional self-care practices of social workers employed in rural areas in one southeastern state. Specifically, this study sought to address two primary research queries: 1) how often do social workers employed in rural settings engage in self-care; and 2) are there relationships between demographic/professional characteristics and self-care?

Method

Protocols and Sampling Procedures

This paper is part of a larger study that examined the self-care practices of social workers in one southeastern state. To collect primary data, researchers employed a cross-sectional design, utilizing an electronic survey. The survey was sent to various agencies/organizations known to employ social workers. Individuals were asked to forward the survey to other potential participants. Because of this snowball procedure, calculating a response rate to the electronic survey invitation is not possible.

All participants in this study reported being employed in a rural setting. Rurality was operationalized using the rural-urban commuting area (RUCA) codes, matched with participant identified ZIP codes for their *primary practice location*. These RUCA codes are commonly used in a wide variety of “health-related research and program development and implementation” (WWAMI Rural Health Research Center, n.d., par. 1). There are several different ways to categorize rural communities along the rural-to-urban continuum using the RUCA codes. For the purpose of this analysis, RUCA Categorization C was utilized. Categorization B creates three categories: urban, large rural city/town, and small and isolated small rural town. Categorization C uses a dichotomous urban/rural distinction. Of the larger Kentucky data set ($n = 1189$), 350 practitioners were identified as practicing in a primarily rural part of the state. Of these, two respondents were excluded based upon their self-reported answer of “no” to the question *Do you have a social work degree?* Thus, the final n for analysis = 348 rural social workers in Kentucky. A description of the sample is included in the Results section.

Primary data were collected during Winter/Spring 2018 and managed via Survey Monkey™ (SM). Respondents who took part in the study were offered a chance to enter a \$500 incentive drawing for their participation. The incentive link was disconnected from primary survey via a separate online link, making participant responses anonymous. The survey employed features that disabled IP and email address tracking. The protocols and procedures utilized in this study were reviewed and approved by a University Institutional Review Board (IRB).

Measures

The instrument utilized to collect primary data for this study was divided into two sections: 1) general demographic and professional information; and, 2) self-care practices.

Demographic measures. A variety of demographic variables were included to better characterize the sample. Personal characteristics such as gender, race/ethnicity, sexual orientation, and relationship status were measured via dichotomous or ordinal items. Age was measured continuously. Education was measured categorically in which participants selected their highest level of education. Health status was measured by a five-point ordinal scale asking participants to rate their overall health status from excellent to poor. Financial situation was measured using self-reported household income and a categorical item in which participants were asked to select the response that best described their financial status. Selection categories

were as follows: “*I cannot make ends meet,*” “*I have just enough money to make ends meet,*” “*I have enough money, with a little left over,*” or “*I always have enough money left over.*” Additionally, a dichotomous proxy for financial status was created by dividing households into *at/below AMI* and *over AMI*. Lastly, multiple items measured participants’ employer and work environment features.

Self-care practices. The Self-Care Practices Scale ([SCPS]; Lee, Bride, & Miller, 2016) was used to measure self-care among practitioners. SCPS is an 18-item measure (e.g., nine items for personal self-care and nine items for professional self-care), which was designed to examine the frequency of personal and professional self-care, respectively. For the purpose of this study, *professional self-care* was defined as “the process of purposeful engagement in practices that promote effective and appropriate use of the self in the professional role within the context of sustaining holistic health and well-being” (Lee & Miller, 2013, p. 98). Examples of professional self-care items are as follows: *I acknowledge my successes at work* and *I problem solve when I have challenges at work*. Personal self-care was defined as “a process of purposeful engagement in practices that promote holistic health and well-being of the self” (Lee & Miller, 2013, p. 98). Examples of personal self-care items are as follows: *I spend quality time with people I care about* and *I participate in activities that I enjoy*.

SCPS utilizes a five-point Likert scale ranging from 0 (*never*) to 4 (*very often*) and produces three scores: a summative *personal* self-care score (0 – 36) a summative *professional* self-care score (0 – 36), and a *total* score comprised of the sum of personal and professional self-care scores (0 – 72). For all three, higher scores indicate more frequency in self-care practices. For this study, measures for personal (Cronbach’s Alpha = .769) professional (Cronbach’s Alpha = .734), and summative (Cronbach’s Alpha = .834) self-care scores displayed high internal consistency.

Results

Participants

This sample is made up of primarily white, heterosexual social work practitioners. Not surprisingly, this mirror’s the state’s racial makeup which is 88% white (United States Census Bureau, 2017) and the social work profession has long-been a primarily female profession (Shilling, Morrish, & Liu, 2008). Thus, though obtained through a sample of convenience, the sample appears to be fairly consistent with professional and state demographics. Table 1 provides detailed demographic information.

The respondents range in age from 22 to 63, with an average age of 40 (SD = 7.48). Respondents were asked to rate their general health on a scale of one to five, wherein one = excellent and five = poor. On average, respondents report that they are in “very good” health ($m = 2.37$, min = 1, max = 4, SD = .80).

Table 1.

Demographics of the Rural Southeastern Social Worker Sample

Characteristic	N	%
Gender		
Male	43	12.4
Female	305	87.6
Race		
Black (non-Hispanic)	6	1.7
Other	11	3.2
White (non-Hispanic)	331	95.1
Highest Academic Degree		
Bachelor	106	30.5
Master	225	64.7
Doctorate	16	4.6
Not Reported	1	.3
Current Relationship Status		
Married/Partnered	211	60.6
Widowed	15	4.3
Divorced	48	13.8
Separated	5	1.4
Never Married	69	19.8
Sexual Orientation		
Heterosexual/Straight	331	95.1
Gay or Lesbian	5	1.4
Bisexual	12	3.4

Several survey questions asked about income and financial security. Respondents were asked to indicate their gross household income. Respondents were asked to identify the range in which their household income fell. Income categories ranged from \$15,000 – 19,999 (n = 12, or 3.4%) to \$100,000 – 149,999 (n = 57, or 16.4%). The largest response category was \$40,000 – 49,999 (n = 62, or 17.8% of respondents). In addition to income, respondents were asked to describe their current financial situation in terms of the number of sources of income and their perception of financial hardship. Income was also examined in terms of above/below Area Median Income (AMI). The state's AMI (2016) was \$44,811 (United States Census Bureau, 2017). As a proxy for AMI, respondents' self-reported income categories were collapsed to those at/below and those above AMI. Because of the income ranges, the proxy is not exact, categorizing those earning up to 49,999 as at/below AMI and those over 50,000 as above AMI. Categorized as such, 45.5% (158) respondents fall at/below AMI and 54.6% (190) are above AMI. Table 2 provides further details on earnings and financial hardship.

Table 2

Household Finances of the Rural Kentucky Social Worker Sample

Characteristic	N	%
Household earners		
Single earner	158	45.4
Two earners in household	163	46.8
More than two earners in household	27	7.8
Financial Situation		
Cannot make ends meet	24	6.9
Just enough money	100	28.7
Enough, a little left over	167	48
Always have money left over	57	16.4

All sample respondents indicated they had a social work degree. 102 (29.1%) report having a BASW or BSSW degree, 224 (64%) report having a MSW/MSSW degree and 94 (26.9%) indicate that they have another social work degree – this includes a DSW and/or a PhD. These categories were not mutually exclusive, respondents may have checked that they had a BASW, MSW, and PhD in social work. Respondents earned a social work degree as recently as 2017 (n = 72) and up to 30 years ago (1988, n = 1). The average practitioner in the sample earned their highest degree in 2010. On average, respondents have been practicing social work for 10.23 years (min = < 1, max = 36, SD = 9.8). Most respondents (86.5%, n = 201) report working only as a social worker/in a social work setting. This includes those who are self-employed (i.e. private practice). Only 9.8% of respondents (n = 34) indicated they were working in both social work and non-social work capacities. Social workers occupy space in both the private and public sector – and in this sample practitioners were quite evenly split between public employment settings (51.7%) and private employment settings (including private practice) (48.3%). Two-thirds (67.2%) report working in a non-profit setting whereas one third (32.8%) report working in a for-profit setting. Over 80% of respondents indicated they currently have a social work license whereas the remaining 19.5% indicated they have never held a social work license. Only 22.4% of respondents indicated that they supervise other social workers. When asked how many hours per week they typically work, respondents averaged 42.55 hours/week (n = 331, min = 15, max = 70, SD = 6.45).

When asked about the type of work they primarily engage in, respondents spanned the micro-to-macro continuum. Almost half of the respondents (42.2%) indicated that their work was “mostly micro-level” work, another 15.5% indicated that they work primarily at the mezzo-level (with families and small groups), 4.6% indicated that their work was primarily at the macro level, and 37.6% indicated that their work is spread out across more than one area.

Self-Care Practices

Scores for the personal, professional, and summative self-care scales are provided in Table 3.

Table 3

Means and Standard Deviations for the Self-Care Scales

Variable	n	M	SD	min	max
Personal Self-Care	344	23.44	4.87	12	36
Professional Self Care	344	22.40	4.56	14	33
Summative Self Care	344	45.88	8.34	28	65

Note: M = Mean. SD = Standard Deviation. Personal and Professional Self-Care range from 0 – 36; Summative Self Care ranges from 0-72.

Associative Relationships

Correlations were used to examine relationships between each of the self-care scale scores and the following: age, hours per week spent on self-care, health status, and average hours worked each week. Even where tests of normality showed a violation (e.g. significant values on the Kolmogorov-Smirnov Test of Normality) a review of Normal Q-Q plots showed fairly normal distribution of scores for all measures.

Age was positively correlated with the personal self-care score, suggesting that age goes up, so too does personal self-care ($r = .145$, $n = 343$, $p = .007$). Hours spent on self-care and self-care scores were not significant. Self-reported health status was significantly correlated with personal self-care. A lower health score (indicative of better health) was correlated with a higher personal self-care score ($r = -.367$, $n = 348$, $p = .000$). Health was also negatively and significantly correlated with the summative self-care scale ($r = -.244$, $n = 344$, $p = .000$). Significant correlations were found between hours worked and the professional self-care subscale ($r = -.269$, $n = 348$, $p = .000$). Similarly, there was a significant correlation between hours worked and the summative self-care scale ($r = -.189$, $n = 348$, $p = .001$), with higher hours worked associated with lower self-care scores. Personal self-care and hours worked were not significantly correlated.

Group Differences: Personal Attributes

Dichotomous categorical variables. Personal, professional, and summative self-care scores were compared with the dichotomous categorical demographic variables of gender, race (white/not white), and AMI (at/below and above). Significant group differences with dichotomous variables are reported here. An independent sample t-test revealed significant differences on the professional self-care subscale for men and women. There was a significant difference in scores for men ($M = 19.93$, $SD = 5.27$) and women ($M = 22.75$, $SD = 4.35$) $t(50.4) = 3.35$, $p = .002$. Results indicate that men, on average, have lower professional self-care scores than do women. The personal self-care subscale and the summative scale showed no significant differences between men and women. An independent sample t-test revealed significant differences on the personal self-care subscale for those who identify as white ($M = 23.57$, $SD = 4.82$) and non-white ($M = 20.88$, $SD = 5.41$). $t(342) = -2.23$, $p = .026$. White practitioners have

significantly higher personal self-care scores. Summative and professional self-care scores showed no significant difference between groups.

Relationship status. Between groups mean scores for both the professional and personal self-care sub scales were examined within relationship status. Relationship status was recoded such that there were five categories: married/partnered, widowed, divorced or separated, and never married. Separated and divorced were combined due to the small number of respondents who were separated (see Table 1). There was a violation of the assumption of homogeneity of variance, leading to the use of the Welch and Brown Forsythe tests instead of the ANOVA. The tests were examined for significant differences in scores between the groups. The Welch and Brown Forsythe tests were significant ($p = .000$) for both subscale analyses. Therefore post-hoc comparisons using the Games Howell test were used to explore differences between groups.

On the professional subscale, divorced/separated practitioners ($M = 18.15$, $SD = 2.81$) had significantly different and lower mean scores ($p \leq .05$) from those who never married ($M = 23.39$, $SD = 4.15$), those who were widowed ($M = 20.33$, $SD = 1.30$), those who were partnered ($M = 24.5$, $SD = 1.92$), and those who were married ($M = 23.15$, $SD = 4.75$). Widowed practitioners ($M = 20.33$, $SD = 1.30$) have significantly different and lower mean scores ($p \leq .05$) from those who were married ($M = 23.15$, $SD = 4.75$), partnered ($M = 24.5$, $SD = 1.92$), or never married ($M = 23.39$, $SD = 4.15$).

On the personal subscale, divorced/separated practitioners ($M = 19.46$, $SD = 3.97$) had significantly different and lower mean scores ($p \leq .05$) from those who never married ($M = 22.59$, $SD = 5.28$), those who were partnered ($M = 23.45$, $SD = 2.56$), and those who were married ($M = 24.93$, $SD = 4.02$). Those who were never married ($M = 22.59$, $SD = 5.28$) had significantly different and lower mean scores ($p \leq .05$) from those who were married ($M = 24.93$, $SD = 4.02$).

Current financial situation. Between groups mean scores for both the professional and personal self-care sub scales were examined within current financial situation. There was a violation of the assumption of homogeneity of variance, leading to the use of the Welch and Brown Forsythe tests instead of the ANOVA. The tests were examined for significant differences in scores between the groups. The Welch and Brown Forsythe tests were significant ($p = .000$) for both subscale analyses. Therefore post-hoc comparisons using the Games Howell test were used to explore differences between groups.

In terms of professional self-care, those who reported “I cannot make ends meet” ($M = 17.83$, $SD = 2.12$) had significantly lower self-care practices than those who reported “I have just enough money” ($M = 21.83$, $SD = 3.95$), “I have enough with little left over” ($M = 22.10$, $SD = 4.54$), and “I always have money left over” ($M = 26.21$, $SD = 3.76$), respectively. Those who indicated “I have just enough money” ($M = 21.83$, $SD = 3.95$) reported engaging in significantly fewer self-care practices than those who contended “I always have money left over” ($M = 26.21$, $SD = 3.76$). Lastly, participants who reported “I have enough with a little left over” ($M = 22.10$, $SD = 4.54$) had significantly lower self-care scores than those indicating “I always have money left over” ($M = 26.21$, $SD = 3.76$).

Analyses for personal self-care yielded a similar pattern. Respondents reporting “I cannot make ends meet” ($M = 20.00$, $SD = .84$) had significantly lower personal self-care scores than participants indicating “I have just enough money” ($M = 22.71$, $SD = 5.40$), “I have enough with a little left over” ($M = 23.25$, $SD = 4.45$), and “I always have money left over” ($M = 26.51$, $SD = 4.50$). Individuals who indicated “I have enough with a little left over” ($M = 23.25$, $SD = 4.45$) engaged in significantly less personal self-care than did those reporting “I always have money left over” ($M = 26.51$, $SD = 4.50$). Finally, social workers who conveyed “I always have money left over” ($M = 26.51$, $SD = 4.50$) rated significantly lower than did those who specified “I have just enough money to make ends meet” ($M = 22.71$, $SD = 5.40$).

Group Differences: Professional Attributes

Independent sample t-tests were used to compare personal and professional, and summative self-care scores and the dichotomous categorical professional variables of employment type (public or private and for profit or nonprofit). When comparing mean self-care scores among those who work for non-profit and for-profit institutions, there are significant findings as indicated by results in Table 4. On each of the subscales, and the summative scale, those who work primarily in for-profit intuitions have significantly higher self-care scores than those who work in non-profit institutions.

Table 4

Comparing Self-Care Scores between For-Profit and Non-Profit Sector Social Workers

	Non-Profit Sector (n =233)		For-Profit Sector (n = 114)		<i>t</i>
	Mean	SD	Mean	SD	
Personal Self Care	22.89	4.49	24.54	5.42	-2.98*
Professional Self Care	21.87	4.69	23.50	4.09	-3.17*
Summative Self Care	44.81	7.98	48.04	8.66	-3.42*

* $p \leq .003$, $N = 348$

SD = Standard Deviation

Mean scores of both the personal and professional self-care scores were compared to professional primary practice level and primary practice area. In each of the analyses, there was a violation of the assumption of homogeneity of variance, leading to the use of the thus the Welch and Brown Forsythe tests instead of the ANOVA. The tests were examined for significant differences in scores between the groups. On each of the four analyses (personal self-care and primary practice level, professional self-care and primary practice level, personal self-care and primary practice area, professional self-care and primary practice area) the Welch and Brown Forsythe tests were significant ($p = .000$). Therefore, post-hoc comparisons using the Games Howell test were used to explore differences between groups. Each is reported below.

Primary practice level and work focus. The mean professional self-care score for those who primarily work in macro practice ($M = 18.56$, $SD = 4.03$) was significantly lower than those who work in primarily micro practice ($M = 24.06$, $SD = 4.09$). Further, those who identified their work as spread out equally across more than one practice area had significantly different mean

scores ($M = 20.79$, $SD = 3.54$) than those who work primarily in micro practice ($M = 24.06$, $SD = 4.09$) and those who worked mostly at the mezzo level ($M = 22.94$, $SD = 6.00$) also had significantly different scores than those whose work is mostly macro ($M = 18.56$, $SD = 4.03$).

Personal self-care was also compared based on work focus. Results were similar to those of professional self-care scores. The mean personal self-care score for those who identify as macro practitioners ($M = 18.06$, $SD = 1.83$) was significantly different from those who work primarily in micro practice ($M = 25.07$, $SD = 4.12$), those who work primarily in mezzo level work ($M = 24.22$, $SD = 5.98$), and those who work equally across different areas of practice ($M = 21.86$, $SD = 4.48$). Those whose work is spread out among more than one practice area also varied significantly from those who mostly work at the micro level and those who mostly work at the mezzo level.

Discussion and Implications

This study is the first known to the researchers to explicitly examine personal and professional self-care practices among rural social work practitioners. Findings from the current study indicate that participants only “sometimes” engage in personal and professional self-care, though professional self-care scores were slightly lower (see Table 3).

There may be several plausible reasons for this particular finding. Indeed, engaging in adept self-care practices can be challenging (Grise-Owens et al., 2016). Many of these challenges may be linked to limited conceptions of self-care. For instance, self-care is often conceptualized as action “separate” from work that may take time and resources (e.g., financial). In contrast, several authors have suggested that self-care is an aspect that should be integrated into personal/professional lives (Grise-Owens et al., 2016). Additionally, helping professionals don’t often view self-care as a valuable, integral part of professional practice (Coleman et al., 2016; Kanter & Sherman, 2017). Other challenges include divergent wellness terminology (Cleantis, 2017) and the individual nature of self-care (Bush, 2015) can make intentionally engaging in personal and professional self-care activities difficult.

Access to self-care opportunities may be limited for rural practitioners. Practically speaking, rural practitioners do not have access to the variety of amenities that facilitate what may be conceptualized as personal self-care often found in urban areas (e.g. access to health and wellness resources). Additionally, a rural social worker’s embeddedness within his/her/their community (Mason, 2011) might mean that social work professionals may not have the ability to disconnect from clients and work to engage in some self-care practices. Croxton, Jayaratne, and Mattison (2002) echoed this – suggesting that the blur between personal and professional boundaries experienced by rural social workers is distinctly rural. Thus, one could posit that rural social work professionals may not have the anonymity that may be needed to engage in some aspects self-care (even those as simple as connecting with a colleague) within their communities of practice. These factors, both uniquely or in combination, may impede practitioner self-care and as such, have impacted participants in the current study.

Promulgating skills and values related to self-care may be achieved in several ways. At a foundational level, social work education programs should look to develop self-care curricula to

assist students in garnering skills related to self-care. Boellinghaus, Jones, and Hutton (2013) spoke of the importance of addressing issues of self-care during educational pursuits. This importance has also been addressed in other professional disciplines, such as nursing (e.g., Chow & Kalischuk, 2008). Though the literature related to self-care and social work education is nominal, Grise-Owens, Miller, Escobar-Ratliff, and George (2018) and Greene, Mullins, Baggett, and Cherry (2017) put forth frameworks for integrating self-care into teaching activities. In addition, continuing education and training opportunities related to self-care as a professional skill are warranted. Collaborations between community agencies and educational programs may be ideal for these endeavors.

Personal Characteristics and Self-Care

Several personal characteristics yielded group differences in self-care scores. For example, analyses indicated that men engaged in fewer professional self-care practices than did women and practitioners who identified as “White” had significantly higher self-care scores than Non-White practitioners. In terms of gender, this finding seems to be somewhat counterintuitive. Several authors have previously asserted that women tend to engage in lower amounts of self-care (Ayala et al., 2017). Data from the current study indicates just the opposite. That minority social workers reported lower self-care scores than white social workers is problematic and merits further study and discussion. Past research on job strain, though not specific to the social work profession, indicates that race and ethnicity are related to job strain (Bennett et al., 2006). Yarborough (2017) provides social-work specific insight to this job strain in her recent work that details the complexity of being a racial minority and a social work practitioner. Complexities of institutional racism and structural inequality cannot be ignored in understanding the experiences of minority social workers and self-care practice. Assuredly, these competing sentiments warrant further explorations, particularly as it relates to rural social work practitioners.

Data also indicated significant differences by relationship status. In summary, those who reported being married tended to engage in higher personal and professional self-care practices when compared to those in other relationship categories. This find may be attributed to several dynamics. For example, several authors have discussed the importance of social and personal supports as they relate to self-care (Grise-Owens et al., 2016; Cleantis, 2017). Ideally, being in a healthy relationship, romantic or otherwise, may provide such support. As an aside, it is possible that relationship status may be a proxy for other variables that impact self-care, such as financial status (see discussion below).

These data may suggest the need to ensure that rural social work practitioners are connected to wider professional networks. Though not variable of consideration for this study, previous research has indicated that membership in professional social work organizations, such as the National Association of Social Workers, the National Association of Black Social Workers, etc. may improve self-care practices. For rural practitioners, participation in these types of ongoing networks may be best facilitated via virtual platforms. Based on the existing literature about supportive professional networks, it is likely, if not probable, that fostering a strong support network could improve practitioner self-care.

Financial situation also appeared to impact self-care practices for this sample. Collectively, data suggest that the more financially stable one was, the higher their professional and personal self-care score. These findings are congruent with previous studies that have examined self-care practices. For example, in a study that examined the self-care practices of healthcare social workers, Miller, Lianekhammy, Pope, Lee, and Grise-Owens (2017) asserted that financial stability may be a predictor of self-care among practitioners.

Interestingly, these findings may suggest the need for a reframe as it related to self-care. Several authors have asserted that self-care is often, and perhaps speciously, viewed as an indulgent act that entails high costs (e.g., Cleantis, 2017). However, others (Grise-Owens et al., 2018) have discussed the need to view self-care not as a luxury associated with costs, but as a necessity that should be integrated into practice.

Professional Characteristics and Self-Care

This study sheds light on a number of seldom-examined professional factors that may impact self-care. Notably, self-care practices differed by practice setting. Results indicated that self-care practices were higher among those employed in for-profit settings across all self-care domains. This finding is particularly intriguing given that most social workers tend to be employed in non-profit settings.

Certainly, organizations have a roll to play in ensuring the wellness of their workforce, in general, and the self-care of individuals, specifically (e.g., Miller et al., 2016). Pragmatically, those employed in non-profit settings may be disproportionately impacted by reduced/restricted community resources, etc. Additionally, in terms of overall culture, non-profit agencies/organizations tend to be steeped in the notion that agency mission takes priority over individual and organizational self-care (Kanter & Sherman, 2017). These underlying tenets may be influencing findings related to employment setting from the current study.

Interestingly, work focus appeared to impact personal and professional self-care. Taken together, data generally indicates that among those in the sample, social workers who work primarily in macro practice and those whose work is spread across practice domains (which may include macro) are engaging in less professional and personal self-care. There may be several plausible explanations for this finding. Aspects of macro social work may be less defined in rural settings, in comparison to other settings. This may lead practitioners to engage in a whole host of divergent activities classified as macro work. Role ambiguity or a lack of clarity around job duties and responsibilities can certainly be stressful. While this fact necessitates the need to engage in more self-care practices, it can also be a hindrance to doing so.

Limitations and Future Research Considerations

As with any research, this study is not without limitations. Certainly, that this pilot data comes from one southeastern state limits its applicability across different geographies. Rurality looks decidedly different in different places – with regard to industry, economy, etc. Thus, future work should include rural practitioners from across a broader geographical cache. Further, because a sample of convenience was used these results are not generalizable. However, as pilot

data goes, this sample was large and does provide a starting point for future work related to the self-care of rural social work practitioners.

Given the findings discussed above, future work related to rural social workers and self-care should further examine the role that gender plays in self-care – as findings here are contradictory to what has previously been reported. Additionally, rurality and self-care related to race and ethnicity should be further explored. Future work should also delve into the distinct self-care practices and barriers to self-care that are experienced by rural practitioners – both personal and professional. Finally, because rural social work is distinct from social work when practiced in more urban areas, research should continue to develop an understanding of the unique challenges faced by rural social workers. Social workers are integral to the health and wellbeing of the rural communities in which they work.

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