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Digital Object Identifier (DOI)

<https://doi.org/10.18060/22320>

Notes/Citation Information

Published in *Advances in Social Work*, v. 18, no. 4.

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Examining Self-Care Among Individuals Employed in Social Work Capacities: Implications for the Profession

J. Jay Miller
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Abstract: *Increasingly, the social work profession recognizes the need for more attention to self-care. Concomitantly, this growing awareness and ethical commitment is fostering a burgeoning self-care movement. However, despite recognition about the importance of self-care, there is a paucity of research that explicitly examines self-care practices among social workers. This cross-sectional study examined the self-care practices of individuals employed in social work capacities (n=1,011) in one southeastern state in the United States. Findings suggest that participants in the sample engaged in personal and professional self-care practices only moderately. Further, data suggest significant group differences in the practice of self-care, by relationship status, educational attainment, health status, and current financial situation, respectively. Overall, results indicate self-care as a potential area of improvement for participants in this study, in general, and perhaps for individuals employed in social work contexts, more generally.*

Keywords: *Self-Care; Social work; Wellness*

The profession of social work plays a crucial role in the betterment of society and human well-being (National Association of Social Workers [NASW], 2008). This demanding role leads to particular challenges for social workers. Research suggests that social workers may be at increased risk for a plethora of “conditions of professional depletion” (Greville, 2015, p. 14). These conditions include compassion fatigue, vicarious traumatization, secondary traumatic stress, and burnout, among other problematic phenomena (e.g., Adams, Boscarino, & Figley, 2006; Dunkely & Whelan, 2006; Grise-Owens, Miller, & Eaves, 2016; Lee & Miller, 2013). Moreover, social workers, and others employed in social service settings, may be disproportionately affected by cumbersome bureaucratic processes, funding cuts and restrictions, and changing political climates, when compared to individuals in other professions (e.g., Whitaker, Weismiller, & Clark, 2006). Systemically, these factors can impact adroit and effective service delivery.

Against this backdrop, increasingly, the social work profession recognizes the need for more attention to self-care. The National Association of Social Workers (2008) issued a clarion call for self-care as “an essential underpinning to best practice” (p. 268). Likewise, the International Federation of Social Workers (2004) includes self-care as a core aspect of ethical practice. This growing awareness and ethical commitment is fostering a burgeoning self-care movement. However, despite recognition about the importance of self-care, there is a paucity of research that explicitly examines self-care practices among

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social workers. This study contributes to addressing this limitation in the current research and practice landscape.

From the outset of this paper, it is pertinent to make a clear distinction. While all individuals taking the survey identified as a “social workers,” per definition, this may not be the case. This study occurred in a state with title and practice protection statutes. However, like many places, this state does have exemptions related to these laws. Thus, some individuals who do not have a social work degree may engage in social work practice, and as such, refer to themselves as “social workers.” So as to acknowledge the uniqueness of the profession, we refer to participants in this study as individuals employed in social work capacities.

Conceptualizing Self-Care

Historically, self-care has been viewed through a medical prism, whereby, patients were encouraged to engage in self-care to assuage the negative outcomes with medical ailments. Since gaining prominence in the literature in the 1960s (e.g., Norris, 1979; Valentine, 1970) this framework has shaped the paradigm of self-care. In 1983, this “medical” view manifested via a report in which the World Health Organization (WHO) defined self-care as “the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health” (p. 2). This definition is focused on self-care as a means to improve medical outcomes for those being helped by medical interventions (i.e., patients).

Evolving Framework and Definitions

More recently, the conceptualization of self-care is shifting to embrace a holistic perspective of the self. Concomitantly, the conceptualization is acknowledging the humanity of all persons, both those being helped and the helpers, themselves. Like the adage, “physician, heal thyself,” this shift is predicated on the notion that whilst self-care can be an effective tool to help patients deal with medical issues, it can also assist in professional practitioner well-being. This shift is necessitated by some of the aforementioned deleterious effects on practitioners, such as burnout, which then impacts quality of service (Cox & Steiner, 2013). With an understanding of systemic effects and parallel processes, the profession is recognizing the interactive effects of practitioner well-being on the quality of services, and, indeed, the viability of the profession.

Amidst this evolving conceptualization, defining *self-care* can be challenging. This challenge, in part, stems from the varied and subjective forms that self-care may take (Lee & Miller, 2013; Smullens, 2015). For instance, Dorociak, Rupert, Bryant, and Zahniser (2017) defined self-care as a “multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being” (p. 326). Others have asserted that these domains include physical, spiritual, social, and psychological aspects of self-care (e.g., Grise-Owens et al., 2016). Lee and Miller (2013) denoted two domains of self-care: *personal* and *professional*. These authors described personal self-care as “a process of purposeful engagement in practices that promote holistic health and well-being of the self;” 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” (p. 98).

Despite the subjective nature of self-care, several authors have proposed universal concepts related to self-care (Smullens, 2015). Cox and Steiner (2013) suggested two universal categories as “lifestyle choices and workplace adaptations” (p. 33). In fact, many concepts related to the practices of self-care can be universal (Grise-Owens et al., 2016). Grise-Owens and colleagues articulated that each practitioner needs to construct a specific self-care plan. This plan must be designed to fit the individual’s life circumstances and personal interests. At the same time, the self-care plan needs to encompass a range of universal considerations, such as relationships, physical health, and professional development. Undoubtedly, the evolving definition of self-care needs to be grounded in both practice wisdom and formal research. This grounded understanding can inform the attention needed to promote holistic self-care as an ethical imperative in professional practice.

Importance of Self-Care

Research suggests that individuals employed in social service contexts are at an increased risk for vicarious traumatization, secondary traumatic stress, compassion fatigue as trauma-related stress, and professional burnout (e.g., Adams et al., 2006; Dunkely & Whelan, 2006; Newell & MacNeil, 2010). As well, social service workers are likely to be more sensitive to shifting political landscapes, funding cuts, and so on, when compared to individuals employed in other social contexts (e.g., Lee & Miller, 2013; Whitaker et al., 2006).

Several authors have suggested that engaging in adept self-care practices may be one way to assuage some of these problematic circumstances (Greville, 2015; Grise-Owens et al., 2016; Weinberg, 2014). For example, Salloum, Kondrat, Johnco, and Olson (2015) suggested that engaging in self-care could help mitigate issues associated with professional burnout. Pope, Giger, Lee, and Ely (2017) and Cohen and Gagin (2005) made similar assertions. Asuero et al. (2014) suggested that engaging in self-care may positively impact professional self-efficacy and professionalism and Bush (2015) explained that self-care can improve services offered to clients.

Social Work Research about Self-Care

Literature, in general, and social work literature, specifically, is in the nascent stages of explicitly examining self-care as a professional practice among social workers. Indeed, a leitmotif clear in the current literature is the need for *more* literature. For instance, NASW (2008) proclaimed that self-care, as a construct, had not been fully examined within the social work profession. Bloomquist, Wood, Friedmeyer-Trainor, and Kim (2015) asserted that “a paucity of research exists with regard to social workers’ perceptions of self-care” (p. 294). Miller, Lianekhammy, Pope, Lee, and Grise-Owens (2017) reported that there are not as many research studies on self-care as one might expect. Others have made similar

assertions (Cox & Steiner, 2013; Grise-Owens, Miller, Escobar-Ratliff, & George, 2017; Lee & Miller, 2013).

Limitations notwithstanding, some researchers have examined self-care among social workers. For example, Bloomquist and colleagues (2015) explored the relationship between self-care practices and professional quality of life. These authors found that while social workers valued self-care, they only engaged in self-care sparingly. Miller et al. (2017) examined the self-care practices of social workers employed in healthcare settings. Similar to Bloomquist et al., these authors concluded that social workers in their sample only engaged in self-care at a moderate level.

The implications derived from the literature are clear. Recognition of the importance of self-care and the role it can play in moderating the challenges associated with professional social work practice is growing (e.g., Cox & Steiner, 2013; Miller et al., 2016; Smullens, 2015). However, few studies have explicitly examined the concept. If social workers are to provide adroit social work services, research must examine the self-care practices of these practitioners, and pursue strategies aimed at improving these practices. This paper seeks to achieve this important aim, and in so doing, address limitations in the current literature.

Study Aim and Research Questions

The overarching aim of this study was to explore the personal and professional self-care practices of individuals employed in social work capacities in one southeastern state. Specifically, this study was rooted in answering three distinct research queries (RQ): RQ1: How often do individuals employed in social work capacities engage in self-care practices?; RQ2: Are there group differences in self-care practices by demographic/professional characteristics?; and, RQ3: What variables predict self-care practices?

Method

Research Design, Protocol, and Sampling Approach

This study employed a cross-sectional survey design. An electronic survey was used to collect primary data from individuals who self-identified as individuals employed in a social work capacity in one southeastern state. The survey was sent to various agencies/organizations known to be associated with individuals employed in social work capacities. Individuals were asked to forward the survey. Survey data were collected and managed via an online survey system. All participants were offered the chance to enter their email address for a \$500 cash card drawing. The incentive survey link was disconnected from the larger survey, thus, participants responses were anonymous. All data were collected during Winter 2017. The protocol utilized for this study was approved by an university Institutional Review Board (IRB).

Instrumentation

The instrument used to collect data for this effort was divided into two sections: (1) general demographic and professional information; and, (2) self-care practices. First, participants were asked to provide general demographic (e.g., age, race, education level, etc.) and professional (e.g., time in the profession, current practice setting, etc.) data.

Second, participants completed the *Self-Care Practices Scale* (SCPS; Lee, Bride, & Miller, 2016) to measure self-care practices. SCPS is an 18-item instrument designed to measure the frequency of personal and professional self-care (i.e., nine items for personal self-care and nine items for professional self-care). 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). Exemplars of items from this part of the scale include “I take small breaks throughout the workday” and “I seek out professional development opportunities.”

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). Exemplars of items for this part of the scale include “When I am not feeling well, I take action to get better” and “I employ strategies to manage stress in my life.”

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 greater frequency in self-care practices. For this study, measures for personal (Cronbach’s Alpha=.80) and professional (Cronbach’s Alpha=.78) care displayed high internal consistency. SCPS has been used in other studies (e.g., Pope et al., 2017, etc.) and has been observed to have acceptable psychometric properties (Lee et al., 2016).

Results

Participants

A total of 1,011 individuals employed in social work capacities participated in this study. The typical participant identified as female (88.3%), Caucasian/White (85.8%), heterosexual (90.8%), and aged 40.1 years ($SD=11.96$). Respondents worked an average of 40.6 hours per week ($SD=10.03$) with approximately 12.8 years ($SD=9.86$) of experience practicing social work. Descriptive data for other demographic and personal/professional characteristics of the sample are presented in Table 1.

Table 1. *Demographic and Professional Characteristics*

	n (%)		n (%)
Gender (n=1009)		Degree Type	
Male	108 (10.7%)	BASW/BSW	231 (24.4%)
Female	891 (88.3%)	MSW	713 (75.6%)
Other (ex. Gender-Expansive, Gender fluid, etc.)	10 (1%)	Employer Type (n=955)	
Race/Ethnic Background (n=1005)		Non-Profit Setting	656 (68.7%)
White non-Hispanic	862 (85.8%)	For Profit Setting	299 (31.3%)
Black non-Hispanic	107 (10.6%)	Employer Sector (n=956)	
American Indian or Alaskan Native	4 (0.4%)	Public (e.g., Governmental)	543 (56.8%)
Asian or Pacific Islander	5 (0.5%)	Private (including private practice)	413 (43.2%)
Hispanic	10 (1.0%)	Level of Work (n=953)	
Biracial/multiracial	9 (0.9%)	Mostly micro-level work (e.g., clinical, individual therapy treatment, etc.)	484 (50.8%)
Other (ex. Jamaican, Ashkenazi, etc.)	8 (0.8%)	Mostly mezzo-level work (e.g., work with families, small groups, etc.)	181 (19%)
Current Relationship Status (n=1009)		Mostly macro-level work (e.g., policy advocacy, community organizing, etc.)	66 (6.9%)
Married	621 (61.5%)	My work is spread out equally across more than one area.	222 (23.3%)
Partnered	68 (6.7%)	Health Status (n=1010)	
Divorced, separated, or widowed	118 (11.7%)	Excellent	130 (12.9%)
Never married	202 (20.0%)	Very Good	439 (43.5%)
Sexual Orientation (n=1007)		Good	336 (33.3%)
Heterosexual or straight	914 (90.8%)	Fair	100 (9.9%)
Gay, lesbian, or bisexual	85 (8.5%)	Poor	5 (0.5%)
Other (ex. Asexual, Pansexual, etc.)	8 (0.8%)	Current financial situation (n=1008)	
Highest Academic Degree (n=1010)		I cannot make ends meet.	52 (5.2%)
High School Diploma/GED	19 (1.9%)	I have just enough money to make ends meet.	305 (30.3%)
Associate's	4 (0.4%)	I have enough money, with a little left over.	482 (47.8%)
Bachelor's	123 (12.2%)	I always have money left over.	169 (16.8%)
Master's	836 (82.8%)		
Doctorate	23 (2.3%)		
First Professional (i.e., law, medicine, or dentistry)	5 (0.5%)		
Social Work Degree (n=1011)			
Yes	944 (93.4%)		
No	67 (6.6%)		

Self-Care Scores

As discussed, self-care was measured via the SCPS. On a scale of zero to 36, the sample had an average score of 24.2 (*SD*=5.32) on the personal self-care domain and 23.5 (*SD*=4.78) on the professional self-care domain. The mean overall self-care score for all participants was 47.7 (*SD*=9.00; out of a possible score range from 0 to 72). Both of these

scores indicate that participants engage in neither high, nor low amounts of personal and professional self-care.

Bivariate Analyses

An independent samples t-test was conducted for variables with two levels, namely employer type (*for-profit/non-profit*) and employer sector (*public/private*). Results showed no significant differences in mean personal or professional self-care for employment type or sector. Group comparisons for variables with three or more levels were assessed using one-way ANOVAs, except when assessing gender and race. No statistical differences in personal self-care practices were found for gender, race, or sexual orientation. Further, no statistical group differences were found in professional self-care practices among these variables: gender, race, sexual orientation, and level of work.

Results yielded significant findings for relationship status, educational attainment, health status, and current financial situation. Refer to Table 2 for means, standard deviations, and confidence intervals for significant variables. Four levels of relationship status (*married, partnered, never married, and divorced, separated, or widowed*) were examined to investigate differences in self-care practices. Results indicated a significant difference in personal self-care, $F(3, 1007)=4.931, p<.01$, and professional self-care, $F(3, 990)=6.189, p<.001$, among those with different relationship statuses. Tukey's post-hoc analysis revealed participants who *never married* reported less personal self-care practices compared to those who were *married*. For professional self-care, those *never married* had fewer reported practices on average compared to those who were *married* or those who were *divorced, separated, or widowed*. Mean score differences for *partnered* respondents in personal and professional did not yield significant differences with any other level of relationship status possibly due to power issues as a result in sample size ($n=68$ vs. $n=120+$). Further research is warranted to determine whether self-care practices of those in partnered relationships truly differ from those in other types of relationships statuses.

Mean differences in educational attainment (*High School/GED, Associates or Bachelor's, Master's, or Doctoral/Professional degrees*) were significantly different for personal $F(3, 1006)=3.213, p<.05$, and professional, $F(3, 992)=3.685, p<.05$, self-care scores. Post-hoc analysis examining pairwise comparisons between education levels did not yield significant differences in personal self-care scores. This discrepancy in results could be due to Type I error with the ANOVA or a lack of power to detect differences between comparisons in more conservative post-hoc analyses. However, significant differences were found in professional self-care between those holding a *Ph.D. or professional degree* and an *Associate's or Bachelor's degree*, with those with a doctorates or professional degree reporting greater professional self-care.

There were significant differences between varying levels of health (i.e., *Excellent, Very Good, Good, Fair, and Poor*) and self-care in both personal, $F(4, 1005)=57.187, p<.001$, and professional, $F(4, 998)=21.210, p<.001$, practices. Follow-up analyses showed group differences in personal self-care was significant for all paired comparisons. All paired comparisons had significantly different mean professional self-care scores, except for *Fair vs. Good* and *Poor vs. Fair* pairings. Mean scores for personal and professional

self-care held similar patterns in that as health of the respondent decreased, the number of self-reported practices decreased.

Group comparisons for current financial situation (*I cannot make ends meet, I have just enough money to make ends meet, I have enough money with a little leftover, and I always have money left over*) revealed significant differences in personal, $F(3, 1004)=34.852$, $p<.001$, and professional, $F(3, 987)=21.120$, $p<.001$, self-care. Post-hoc pairwise comparisons showed significant differences in average personal self-care scores for all pairings, except between *I cannot make ends meet* and *I have just enough money to make ends meet*. All pairings revealed significant differences in average professional self-care scores.

Table 2. *Self-care Means and Standard Deviations for Significant Independent Variables¹*

	Personal			Professional		
	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>
Relationship Status						
Married	621	24.53	5.29	612	23.79	4.62
Never married	202	22.91	4.95	197	22.31	4.85
Divorced, separated, or widowed	120	24.44	5.94	119	24.23	4.93
Educational Attainment						
Associate's or Bachelor's	127	23.21	6.06	123	22.57	5.27
Doctorate/Professional	28	25.82	5.65	28	25.43	4.83
Health Status						
Excellent	130	27.47	4.63	130	26.02	4.23
Very Good	439	25.50	4.69	432	23.91	4.54
Good	336	22.37	5.06	328	22.62	4.75
Fair	100	20.57	4.75	98	21.51	4.82
Poor	5	12.20	3.96	5	16.40	1.95
Financial Situation						
I cannot make ends meet	52	20.88	6.74	50	20.50	7.17
I have just enough money to make ends meet	305	22.60	5.10	300	22.56	4.37
I have enough money, with a little left over	482	24.49	4.82	475	23.70	4.42
I always have money left over	169	26.96	5.10	166	25.45	4.82

Note: ¹ $p<.05$

Multivariate Analysis

A multiple linear regression analysis was conducted to assess the relationship between total self-care scores using explanatory variables for demographic and other personal/professional type characteristics. Continuous variables (age and average hours worked per week) were added to the model. Categorical variables (race, gender, relationship status, current financial situation, sources of income, employer type, and employer sector) were converted into dummy variables and included in the model, with the exception of the levels used as the reference group for comparison (identified in Table 3). The regression results are summarized in Table 3. The model was statistically significant, $F(21, 652)=11.55$, $p<.001$, $R^2_{adj}=.25$.

Table 3. *Regression Analysis Summary*

Model	B	SEB	B	p
Years in practice	0.05	0.05	0.05	0.35
Age (Year)	0.12	0.04	0.16	<0.001***
Average Weekly Work Hours	-0.15	0.03	-0.17	<0.001***
Health status	-3.12	0.36	-0.30	<0.001***
Relationship Status	Reference			
Partnered	0.86	1.41	0.02	0.54
Never married	-0.24	1.16	-0.01	0.84
Divorced, separated, or widowed	1.07	1.33	0.04	0.42
Married	Reference			
Current Financial Situation				
I cannot make ends meet	-5.57	1.61	-0.14	<0.001***
I have just enough money to make ends meet	-4.32	0.95	-0.23	<0.001***
I have enough money, with a little left over	-2.56	0.84	-0.15	<0.001***
I always have enough money	Reference			
Income Source				
Single Income/More Than One Source	-0.41	1.27	-0.01	0.75
Two Incomes	0.70	1.06	0.04	0.51
More Than Two Incomes	2.87	1.76	0.07	0.11
Single Income/One Source	Reference			
Race				
Other Race/Ethnicity	-2.05	1.78	-0.04	0.25
Black	3.26	1.03	0.11	<0.001***
White	Reference			
Gender				
All other types	0.92	3.84	0.01	0.81
Male	-0.04	0.97	0.00	0.97
Female	Reference			
Organization Type				
For-profit setting	-0.35	0.68	-0.02	0.60
Non-profit setting	Reference			
Employer Sector				
Public (e.g., Government)	1.51	0.65	0.09	0.02*
Private	Reference			

Note: $R^2=.27$, $R^2 adj=.25$ ($n=674$, $p<.001$)

Six explanatory variables were significantly related to differences in total self-care practices: age, average hours worked per week, health, current financial situation, race, and employer sector, even after controlling for all other variables in the model. For every 4-year increase in age, total self-care score increased by .5 points. Every 10-hour increase in work per week equated to a 1.5-point decrease in total self-care score. Health was rated by respondents on a scale of 1 (*Excellent*) to 5 (*Poor*). Each unit increase represented a decline in health status, which led to a decrease in total self-care score by 3.12 points. For current financial situation, those who “cannot make ends meet,” “have just enough to make ends meet,” and “have enough, with a little left over” showed lower total self-care scores by 2.5 - 5.5 points compared to respondents who “always have enough money.” Race was a

significant predictor of total self-care score. The adjusted mean difference in total self-care score for black participants compared to white participants was 3.26 points with black participants reporting higher levels of self-care. Lastly, participants working for employers in the public sector had higher total self-care scores (1.51 points) compared to those working for employers in the private sector.

Discussion

This exploratory study examined the self-care practices of individuals employed in social work capacities in one southeastern state. For clarity, this section is presented in a format that explicitly mirrors the above posited research questions.

RQ1: How often do participants engage in self-care practices?

Overall, data from this study suggest that social workers in this sample engage only moderately in professional and personal self-care. Mean scores for personal and professional self-care were 24.2 (range of 0 - 36) and 23.5 (range of 0 - 36), respectively. These data indicate that, overall, social workers in this study reported engaging in self-care “sometimes.”

Given existing, albeit limited, research in this area, perhaps these findings are not surprising. Both Bloomquist et al. (2015) and Miller et al. (2017) concluded that social workers in their study engaged in self-care moderately. The lack of self-care practices may be associated with contextual factors. For instance, agency culture and organizational functioning definitely impact staff morale and effectiveness (Kanter & Sherman, 2017). As such, effective self-care can be a key strategy for offsetting deleterious effects of problematic organizational dynamics. However, self-care is misunderstood and underutilized; in part, this underutilization is due to the lack of skill development as part of professional preparation and development (Smullens, 2015). Social workers and individuals employed in social work positions receive very little, if any, explicit education or training associated with self-care (Grise-Owens et al., 2017). This training can help social workers develop tools and skills to better navigate the organizational contexts and professional stressors. This training can also help practitioners impact the organizational cultures in which they work.

There are other plausible reasons as to why individuals reported engaging only moderately in self-care. For instance, participants in this study may not view self-care as important. Said another way, they may not value self-care. Or, they may not view self-care as connected to their professional practice. No matter the reason, these data lend credence to the notion that self-care is an area of growth for participants in this study, specifically, and perhaps for individuals employed in social work contexts, more generally.

RQ2: Are there group differences in self-care practices by demographic/professional characteristics?

Analyses revealed several group differences related to self-care practices. For instance, current relationship status does appear to impact self-care practices. Participants who *never married* engaged in personal self-care significantly less frequently than did individuals who

were *married*. In terms of professional self-care, individuals who *never married* reported significantly fewer self-care practices than participants who were *married, divorced, separated, or widowed*, respectively. This finding merits further exploration and generates further critical questions. For example, relationship status could be related to income; married or partnered respondents would be more likely to have dual-incomes. More broadly, this finding generates questions about the impact of emotional supports on attention to self-care.

There was also a difference between individuals at varied educational levels. Specifically, those holding a Ph.D. or first-professional degree indicated higher professional self-care practices when compared to those with an Associates or Bachelor's degree. This finding may be linked with the related function of income (see below). Also, presumably, increased educational attainment typically results in higher ranking positions, which often allow for greater control in job functions and greater rewards/recognition. These aspects contribute to greater job satisfaction, which contributes to self-care practices (Cox & Steiner, 2013; Maclean, 2011). Similarly, greater training and professional preparation can contribute to increased awareness about the importance of self-care or increased self-efficacy. Cox and Steiner summarized several studies that found self-efficacy mitigates high-stress working conditions. In a related factor, higher education attainment might indicate more opportunities for sustained supervision and/or mentoring. Supervision and professional development are key aspects of professional self-care.

Interestingly, perceived health status and current financial situation both seemed to impact self-care practices for individuals in this sample. Participants at each "level" of perceived health (i.e., *Excellent, Very Good, Good, Fair, and Poor*) indicated significantly higher self-care practices than the preceding level, with the exception of professional self-care scores for those indicating *Fair* vs. *Good* and *Poor* vs. *Fair* health statuses. Stated plainly, the poorer the reported health status of the participant, the less frequently the participant engaged in self-care practices. On the surface, this finding seems self-explanatory and appears to be the proverbial "chicken and egg" cycle, in which of lack of self-care creates health issues, which lead to decreased self-care, and so forth. However, a more nuanced consideration is needed. Traditionally, self-care has been framed primarily as physical activities completed after work hours, such as "going to the gym." As noted in the introduction of this article, the definition of self-care is expanding beyond the traditional medical model and limited frame of physical health. This finding indicates the need to build a more expansive understanding of self-care that encompasses a holistic approach—beyond the parameters of the medical model.

Differences in self-care practices were also detected based on current financial situation (e.g., *I cannot make ends meet, I have just enough money to make ends meet, I have enough money with a little leftover, and I always have money left over*). Typically, individuals in more stable financial situations engaged in significantly more professional and personal self-care practices (except for personal self-care scores between those who responded *I cannot make ends meet* and *I have just enough money to makes ends meet*).

Intuitively, these findings may be expected. Certainly, finances are a significant life stressor. This finding points to the clear need to advocate for fair and just salaries in the

profession of social work and within organizations. At the same time, similar to the discussion above related to health, this finding may indicate the need for a more holistic approach to self-care. Traditionally, self-care has been conceptualized as activities that involve cost, such as “going to the spa,” and so forth. A multi-faceted approach to self-care engages these traditional activities; however, this holistic approach expands self-care to a much more comprehensive practice.

Similarly, this finding needs to be examined more specifically. The survey did not ask for income, but rather the respondent’s assessment of their financial status. As such, this response may not relate as much to income-level as it does to financial satisfaction—or some combination of both. Rath and Harter (2010) reported on a Gallup study examining financial well-being. The study found that people with the *same* levels of income differ in their assessments of whether that income is adequate. Furthermore, Rath and Harter reported that the differences in perception are largely dependent on the respondent’s level of engagement in their work. Higher scores of engagement correlated with higher scores of satisfaction with income. Rath and Harter (2010) concluded, “Money is easily counted, but it is still a highly subjective variable” (p. 59). Particularly given these interesting considerations, the current study’s finding points to the need for including financial well-being as part of self-care.

RQ3: What variables predict self-care practices?

The exploratory model yielded a total of six variables that were significantly related to self-care practices. As indicated above, these variables are: age, race, health, current financial situation, average hours worked per week, and employer sector.

For every 4-year increase in age, total self-care score increased by .5 points. This finding is congruent with previous studies that found a correlation between age and burnout, with younger workers reporting higher levels of stress (Maslach, 2005). Age may also interact with the variables of finances and level of education as mitigating factors—as discussed earlier. This finding may relate to the particulars of life stage; for example, parenting responsibilities can bring particular stressors for professionals. The interaction of life stage and self-care merits more critical exploration.

Race was the only other demographic category that was a significant predictor of total self-care score. The adjusted mean difference in total self-care score for black practitioners compared to white practitioners was 3.26 points. This finding is particularly intriguing. Certainly, organizational and interactional discrimination contribute to individual workplace stress-levels (Cox & Steiner, 2013). Members of marginalized groups have been found to experience stress that is additive to general stressors (Cox & Steiner, 2013; Meyer, 2003). These findings about demographic differences merit ongoing critical exploration.

As discussed above, health and finances correlated with self-care practices. For health, each unit increase represented a decline in health status, which led to a decrease in total self-care score by 3.12 points. For current financial situation, those who “*cannot make ends meet*,” “*have just enough to make ends meet*,” and “*have enough, with a little left over*” showed lower total self-care scores by 2.5 - 5.5 points compared to respondents who

“*always have enough money.*” As discussed above, these findings merit further examination and point to the need for a more holistic approach to self-care.

In a similar vein, the number of hours worked correlated with self-care. For every 10-hour increase in work per week equated to a 1.5-point decrease in total self-care score. This finding underscores the traditional admonition for “work-life balance” as part of a self-care approach. However, using the holistic approach, this finding points to the need to more broadly conceptualize self-care. Rather than limiting self-care to what employees do *after* work, an expansive framework would include *how* employees work. That is, self-care is not just about taking care of oneself in non-work hours, but, also how one practices self-care in the workplace. This approach sees self-care as an ongoing lifestyle, rather than an emergency response to stress (Grise-Owens et al., 2016; Lee & Miller, 2013).

Limitations

As with any research endeavor, this study is certainly not without limitations. All participants identified as an individual employed in a social work capacity in one southeastern state. Each individual self-selected into the study, and respondents were overwhelmingly female and white. Though these demographics may be reflective of the larger profession, a more heterogeneous sample may have yielded different results. Certainly, future research may look to recruit a more diverse sample. Further, as noted, differential groups sizes may have impacted the analyses (e.g., statistical power), specifically as it related to detecting group differences. And, the scale does not include secondary anchors that denote contextual data for ranking categories (e.g., frequency of “sometimes”). Future studies should collect additional data related to significant findings (e.g., income) and look to control for those, and other, mediating/moderating variables that may impact self-care practices.

Implications

Adept and ethical social work practice requires that practitioners engage in self-care. Thus, studies that examine self-care must also explicate pragmatic implications related to social work practice. In a key, overarching finding, data indicate that participants struggle to engage in apt self-care practices. Also, certain factors are predictive of level of self-care. These findings have particular implications for administrators and supervisors. For example, administrators can advocate for just and fair wages and work hours. Likewise, given that financial insecurity/dissatisfaction is a key predictor of low self-care, the organization could provide accessible resources for employees to learn personal financial management strategies. Similarly, given the finding pertaining to age, supervisors can proactively support younger employees (in particular) in attention to self-care. Since professional development and supervision are core aspects of professional self-care care, supervisors can promote self-care accountability processes as part of the supervision process and team culture. Likewise, administrators can include attention to self-care as part of professional development plans and evaluation processes.

Awareness about the need for attention to practitioner well-being leads to the realization that both individual and organizational responses are necessary. As such,

agencies should engage in strategic initiatives aimed at improving self-care practices. These initiatives may take several forms. Kanter and Sherman (2017) advocated that organizations should take a “WE-Care” approach. These authors contended that traditional “wellness programs,” while helpful, are not sufficient for human services. These authors delineate facets of the WE-Care approach to organizational wellness. Similarly, Miller et al. (2016) provided a description of a comprehensive wellness initiative in a multi-state non-profit organization. More models of organizational wellness initiatives are needed. These models need to incorporate attention to professional development trainings for employees on how to engage in effective self-care. Like any aspect of professional practice, adeptness in self-care needs to be taught and reinforced. Professional development trainings can provide staff with the knowledge, skills, and values necessary for competence in practicing self-care.

The development of self-care as part of professional practice should be integrated in social work curricula (Grise-Owens et al., 2017; NASW, 2008). The current study found that younger professionals tended to report lower self-care scores. This finding supports the need for preparation of professionals to ensure that graduates enter the field prepared to practice self-care. Social Work education inculcates core values and ensures core competencies of the profession; the Council on Social Work Education (CSWE, 2015) delineates these competencies for accreditation purposes. Progressively, self-care is being identified as a core competency (Jackson, 2014).

However, to date, CSWE has not included self-care in its accreditation standards. A self-care competency framework should be developed to ensure best practices. Likewise, models for integrating self-care into social work curricula are needed.

Finally, the profession of social work, as a whole, needs to promote self-care as a valid and essential aspect of professional practice. The NASW (2008) Policy Statement on Self-Care is an excellent example of this promotion. More such statements are needed. Building on these statements, pragmatic resources must be developed. For instance, professional organizations can support the development of materials and practice models for individuals and organizations. Similarly, licensing/credentialing boards can support professional development of self-care practice. For example, all licensed professionals are required to complete ongoing continuing education trainings. Professional boards can include trainings in self-care as one of these requirements.

The crucial mission of the social work profession is laudable and essential. As such, the rewards of practicing in the profession are significant. At the same time, the need to address the costs borne by practitioners fulfilling the profession’s purpose is increasingly apparent. Fulfilling the mission of the profession means sustaining the practitioners activating that mission. Therefore, the profession of social work is compelled to support practitioner well-being, as an integral aspect of professional identity and purpose.

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