Compassion Fatigue

in Funeral Directors:

The Roles of Social Support, 

Training and Self-Care

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Abstract

Human service workers are susceptible to negative phenomena such as compassion fatigue through their work with people experiencing trauma and extreme emotions. The aim of the study was to examine compassion fatigue in Irish funeral directors, and the role of possible protective factors. Measures included; the Professional Quality of Life Scale (Stamm, 2009) which examines compassion satisfaction and compassion fatigue (burnout and secondary traumatic stress), the Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988), 2 self-constructed items examining training; and a purpose designed item exploring self-care. Employing a questionnaire based correlational design; purposive sampling acquired a sample (N=60) of 48 males and 12 females. Findings indicate that funeral directors do not possess high levels of compassion fatigue, although their high levels of compassion satisfaction may reduce the possibility of burnout. Perceived social support from friends was negatively correlated with length of service. Discussion, suggestions and limitations of the study are addressed.
Chapter 1: Introduction

1.1 General Introduction

“The funeral director operates in a market with a seemingly endless source of supply – death will always occur and this service will always be required” (Parsons, 2003, p. 70).

One of the primary caregivers to the newly bereaved is the funeral director (Parsons, 2003). In their work with the bereaved and through body handling, they are among a group of occupations that witness death on a regular basis (Harrawood, White, & Benshoff, 2008). It is estimated that there are 600 funeral service providers in Ireland (Irish Hospice Foundation, 2011), who are responsible for the burial or cremation of up to 30,000 people a year. An examination of the available literature highlights scant research on funeral directors, especially so in Ireland. Additionally, no published literature of any kind has been found that examined compassion fatigue or burnout in funeral directors. The current study is the first to investigate these phenomena in a national sample of Irish funeral directors. As such, this paper will incorporate findings from other human service professionals that are similarly exposed to suffering, trauma, or death through their work duties.

The literature below describes Professional Quality of Life (ProQOL), which comprises of compassion satisfaction (CS), and compassion fatigue (CF) (burnout and secondary traumatic stress). Relationships between CF and: age, gender, length of service, and training are outlined; as well as the role of social support as a buffer against CF. Lastly, research on self-care practices is also discussed.
1.2 Professional Quality of Life

Professional Quality of Life (ProQOL) is the quality a worker feels in relation to their job as a helper (Stamm, 2010, p. 8). Highlighted in the diagram below from Stamm (2010), ProQOL is composed of two aspects; compassion satisfaction (CS) and compassion fatigue (CF).

Compassion satisfaction is regarded as the positive aspects of helping, while CF relates to the negative aspects (Stamm, 2012). The negative aspect (CF) breaks into two parts; burnout and secondary traumatic stress (STS). The most widely used instrument for examining the positive and negative effects of working with people who have experienced extremely stressful events is The Professional Quality of Life Scale (Stamm, 2009). The instrument is utilised in the present study and its component parts are discussed below.
1.3 Compassion Satisfaction

In helping others, human service professionals will empathize with clients and use compassion as an altruistic desire to improve people’s conditions (Radey & Figley, 2007). Compassion is a “sympathetic consciousness of others’ distress together with a desire to alleviate it” (Merriam-Webster Online Dictionary, n.d). Funeral directors are expected to perform their jobs with a display of sympathy and understanding for their clients’ loss (Smith, Dorsey, & Mosley, 2009). Their work requires clear demonstrations of compassion to effectively perform their duties (Bailey, 2010).

The pleasure in helping others through one’s work, positivity about one’s contributions to a helping organisation, and feelings of satisfaction in one’s ability to be an effective caregiver; are all elements of compassion satisfaction (CS) (Stamm, 2012). The sparse literature on funeral directors makes it unclear as to the levels of CS reported in this occupation. However, research in other human services shows how CS can play an important protective role against compassion fatigue. Sprang and colleagues (2007) note that CS can have a positive effect on a workers self-efficacy and can be an energy-enhancing experience. Yoder (2010) discovered that nurses with high CS scores were better able to deal with negative occupational feelings such as “feeling trapped”, “exhausted”, or “bogged down”. Further, CS mitigated negative feelings and stress that arose in this form of people work (Yoder, 2010). In his work with clinicians, Killian (2008) found that CS was associated with having more control or efficacy in the person’s workplace. On the other hand, CS was reduced when clinicians worked a higher number of hours per week with traumatised patients (Killian, 2008, p. 39). Although CS can act as a buffer against compassion fatigue, Eastwood and Ecklund (2008) point out that its major ameliorative influence is more likely to be protective against burnout.
Working around the deceased and the bereaved is for some the ultimate caring profession (Kiernan, 2014). Whether it is a desire or a vocation, it is realistic to suggest that funeral directors will operate with a sense of compassion towards the bereaved they encounter. Nevertheless, CS is not always easily achieved (Radey & Figley, 2007). But for workers who do possess high levels of CS, the research above shows that it can be a safeguard against CF. However, as a worker’s heart goes out to their client through continued displays of compassion, their hearts can give out from fatigue (Radey & Figley, 2007, p. 207).

1.4 Compassion Fatigue

On the other end of the compassion spectrum are the adverse reactions to helping others. If CS is deemed the “good stuff”, then the negative aspects of helping, the “bad stuff”, are known as compassion fatigue (CF) (Stamm, 2012, p. 1). It is acknowledged that being indirectly exposed to trauma can increase the risk of emotional problems for the helper (Bride, 2004; Bride, Radey, & Figley, 2007; Kadambi & Truscott, 2003; Simpson & Starkey, 2006; Sprang et al., 2007). This occupational stress phenomenon is often referred to in the literature by various terms such as vicarious traumatisation (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), compassion fatigue (Figley, 1995), and secondary traumatic stress (Stamm, 2009, 2010, 2012). Stamm (2010) remarks that the terminology continues to be a “taxonomical conundrum” (p. 9), and while there is much overlap between the terms; a common theme is working closely around traumatised populations (Sexton, 1999).

Compassion fatigue can have a sudden onset (Eastwood & Ecklund, 2008). The term stems from the work of Joinson (1992). The author identified how nurses working with severely ill patients can develop feelings of irritability, loss of interest in work, and
helplessness towards the sufferers, and thereby exposing them to a higher risk of CF. A myriad of supporting roles are at risk of developing CF. For some it can arise from experiencing traumatic events such as abuse, terminal illness, or accidents (Yoder, 2010). Large scale disasters such as Hurricane Katrina, the 9/11 terrorist attacks, school shootings and war can also have a profound effect on those responders or witnesses to trauma (Yoder, 2010). The symptoms of secondary traumatic stress (STS) can include; being afraid, having difficulty sleeping, the return of images from an upsetting event, or avoiding things that remind one of the event (Stamm, 2010, p. 17). It is essentially characterised by a preoccupation of thoughts about people one has helped (Stamm, 2010).

Religious roles can develop CF through the support they offer to mourners (Roberts et al., 2003). Likewise, funeral directors regularly work face-to-face with the bereaved, who seek consolation and comfort in a time of personal crisis (Hyland & Morse, 1995). Interestingly, secularisation in modern times can lead to clergy being less involved with end-of-life ceremonies, and therefore the funeral director becomes the sole point of contact for a mourner wishing to receive grief support (Emke, 2002). Accordingly, the alternative title of “funeral counsellor” could be a more fitting work description (Bremborg, 2006). Nevertheless, it is relevant to suggest that if clergy are at risk of experiencing CF due to their interactions with the bereaved; funeral directors, by the same token, may also be at risk.

The main risk factor for developing STS, or what Figley (1995) calls compassion fatigue, is from exposure to traumatic events as a result of working with the traumatised (Bride, 2004). Mental health workers can be profoundly affected by listening to accounts of graphic descriptions about traumatic events from their clients (Buchanan et al., 2006). This can diminish the caregiver’s capacity to help others (Pross & Schweitzer, 2010). In addition, re-experiencing the trauma of others can have a lasting effect that creates traumatic memories (Figley & Figley, 2009). Violent deaths resulting in damaged or unrecognisable bodies can
cause sensory overload, and even for the most experienced professionals like pathologists or funeral directors, these experiences can still be highly shocking (McCarroll et al., 1993).

Some undertaking for the funeral director may be simply about guiding a family through proceedings and ensuring everything runs smoothly (Holloway et al., 2013), however more difficult situations may also present. Individuals who are bereaved by homicide can experience overwhelming emotions and intense suffering beyond the imagination of some (Malone, 2007). In organising funeral arrangements for these mourners, what is presented to the funeral director is most certainly a negotiation with a traumatised population. As Ireland has one of the highest rates of homicide in Europe (O’Keefe, 2014), and with 83 recorded cases in 2013 alone (Central Statistics Office, 2014), it is reasonable to suggest that some funeral directors are operating in an environment at risk of STS.

Secondary traumatic stress is not an inevitable consequence of working with traumatised populations; some human service workers may show no such symptoms (Pross & Schweitzer, 2010). However, the second component of CF (burnout) can be experienced alongside STS, or just solely on its own (Stamm, 2010).

1.5 Burnout

For those working in human service institutions, work can entail spending large amounts of intense involvement with other people (Maslach & Jackson, 1981). These interactions often involve dealing with people’s difficulties; consequently, feelings of anger, embarrassment, and despair are common. As a result of these working conditions, the helper can endure chronic stress which is emotionally draining and can pose the risk of burnout (Maslach & Jackson, 1981).
Burnout was first discussed in an article by Freudenberger (1974). He regarded it as an occupational hazard for the “dedicated and the committed” (Freudenberger, 1974, p. 161). Young social workers were found to work long hours in intense environments (Freudenberger, 1974). Initially burnout was difficult to describe, as many people used it to explain a multitude of work-related responses (Maslach & Goldberg, 1998). The most commonly accepted description is from the work of Maslach (2001), an eminent author in the research of burnout. Burnout encompasses three areas; feelings of emotional and physical exhaustion, cynicism or a detached response to one’s job, and a low sense of personal accomplishment or ineffectiveness (Maslach, Schaufeli & Leiter, 2001).

As stated above, burnout and STS are the two components of CF (Stamm, 2012). A distinction between the components is that STS has a rapid onset, while burnout has typically a gradual onset (Stamm, 2012). Human service workers who enter the field with an enthusiastic outlook, will often put the needs of others before their own (Maslach & Goldberg, 1998), or they will strive for further meaning in their own lives by acting as a saviour in their field (Perkins & Sprang, 2013). Often in the pursuit of career goals, highly dedicated workers can take on too much resulting in exhaustion (Maslach et al., 2001). The risks for burnout tend to increase for people with high caseloads; this is compounded if it persists over prolonged periods with an inadequate sense of capacity to manage it (Spickard, Gabbe & Christensen, 2002).

Burnout can also be seen in areas such as the military (Linnerooth, Mrdjenovich, & Moore, 2011). Similar to the occupational theme of the funeral director; death is a common experience. Military psychologists spend their time working with emotional stressors that surround combat related trauma (Linnerooth et al., 2001). The deaths of fellow service members can impact heavily on soldiers. In areas of combat with frequent casualties, high
caseloads may increase the risks for burnout in this subgroup of psychologists (Linnerooth et al., 2001).

1.6 Relationships with Age

A demographic variable that is regularly related to professional burnout is age (Maslach et al., 2001). High levels of burnout are regularly experienced by younger human service professionals between the ages of 30 and 40 (Tomic, Tomic & Evers, 2004; Schaufeli & Enzmann, 1998, cited in Tomic et al., 2004). Younger workers may be more vulnerable to work pressures than those in higher age categories (Tomic et al., 2004), and often make light of the risk burnout can have in their chosen careers (Maslach & Goldberg, 1998). In a study of physicians, age was discovered to be negatively correlated with emotional exhaustion (Bruce, Conaglen & Conaglen, 2005). Also, after the September 11th terrorist attacks, age was found to be inversely related to burnout in a sample of New York clergy (Roberts et al., 2003).

Although burnout is more likely to appear in the early stages of one’s career (Maslach et al., 2001), contradictory findings also exist. A counter argument is that levels of burnout tend to be relatively stable over time, and can instead be a prolonged response to chronic job stressors (Maslach et al., 2001). In the human services field of oncology nursing, no correlations were discovered between age and criterion variables such as CF or burnout (Potter et al., 2010). Similarly, no correlations existed between age of hospice nurses and their CF scores in a study by Abendroth and Flannery (2006). Bride (2004) adds that instead of age being the factor in the development of CF, it could be more likely due to older human service workers having better coping abilities that younger staff are yet to learn.
The research on age portrays mixed results for its relationship to CF or solely that of burnout. However, there does seem to be a protective factor with age, which suggests younger workers (e.g. funeral directors) may be more vulnerable to the risks of burnout than older counterparts. In addition to the study of age as a predictor of CF and burnout, the role of gender is also acknowledged.

1.7 Gender differences

A review of the existing literature on funeral directors in Ireland revealed only one article based on a survey of health and safety (Kelly & Reid, 2011). The gender composition of males and females in this study sample (N=129), were 112 and 17 respectively (Kelly & Reid, 2011, p. 572). These findings indicate that the Irish funeral industry seems to be predominantly occupied by males. A few decades ago in the United States, funeral directors were predominantly all males (Cathles, Harrington & Krynski, 2010; Harrawood, White, & Benshoff, 2008). Women were usually responsible for laying out the body of the deceased (Kearl, 1997), and there was a belief that women could not handle the distressing sights that their male counterparts witnessed (Cathles et al., 2010). However this occupational trend has changed in recent times with many more women enrolling in mortuary science (Cathles et al., 2010; Harrawood et al., 2008). In the present study, it was anticipated that some responses would be from female funeral directors and therefore gender differences in CF should be investigated.

An examination of the research on CF and its relationship to gender highlighted some notable findings in other human services. Abendroth and Flannery (2006) discovered that female hospice workers were more at risk for moderate levels of CF. Female trauma therapists have been found to have a higher predisposition to exhibiting trauma symptoms
than males (Brady et al., 1999). Female nurses, another profession working with trauma clients, may be more vulnerable to developing burnout as per their family role that can involve raising children as well as working (Cohen-Katz et al., 2005; Killian, 2008). Similar results in a study with mental health providers by Sprang and colleagues (2007), found that female gender increased the risk of suffering from CF and burnout (p. 266). Conversely, in a study examining frontline mental health professionals, no differences existed between gender and CF (Ray et al., 2013). Further, male and female physicians studied by Bruce et al. (2005) showed that those scoring in high ranges of burnout were the male practitioners.

Other research argues that gender is not a major factor in the development of burnout (Maslach & Jackson, 1985), and if any differences exist; they are usually quite small, if present at all (Maslach & Jackson, 1981, 1985). Maslach (2001) adds, that often gender differences exist because of the population being examined, such as the over representation of males in the police or females in the nursing sector. Like age, the research on the relationship gender has with CF is mixed, and caution with interpreting gender differences in burnout have been highlighted (Maslach, 2001). Nonetheless, the research does suggest that females involved in work with traumatised populations may be more prone to developing CF.

1.8 Length of Service in Profession

The relationship between the length of occupational service and levels of CF and burnout are also highlighted. For example, Potter and colleagues (2010) acknowledge the demands and difficulties faced by oncology nurses. This occupation group is vulnerable to developing CF due to workplace exposure of patients suffering the effects of trauma, such as side effects of treatment and the end stages of cancer (Potter et al., 2010). Further, oncology staff may feel a personal sense of failure or futility as a result of empathising with patients’
losses (Potter et al., 2010). Using a version of the current study’s measurement for CF and burnout, Potter et al. (2010) looked at relationships to job experience. While significant relationships were not present, staff with 11-20 years of experience had the highest percentage of high-risk CF scores, followed by 6-10 years, and then those in the 1-5 category (Potter et al., 2010, p. 58). These results show an incremental trend between experience as a professional and risk of CF. The findings suggest that staff in human services exposed to the suffering of others, may be more at risk for CF the longer they are in the field.

1.9 Social Support

Simpson and Starkey (2006) note that differences in coping techniques to handle stressors can play an important role in CF. Social support has received much attention as a powerful coping resource since the mid-1970’s (Zimet et al., 1988). It essentially involves the relationships between people (Kim, Sherman & Taylor, 2008). Sarason and colleagues (1983) describe social support “as the existence or availability of people on whom we can rely, people who let us know that they care about, value, and love us” (p. 127). This description points towards a connection felt by the person to those around them. This connection between a person and their social support networks has a benefit of being a buffer against the effects of stressors; improving psychological well-being (Cohen & Wills, 1985).

Paramedics working with the suffering of those they help have described how personal support networks are paramount in helping them deal with traumatic occupational experiences (Regehr, Goldberg & Hughes, 2002). The majority of emergency workers in this study reported that support from their spouse was vital in helping them deal with the grief of others and trauma experienced in their work (Regehr et al., 2002). While the findings for perceived support from friends and family were mixed, the participants highlighted a comfort
in being able to share difficult experiences with a spouse in a safe environment away from incidents such as multiple casualties, violence and infant death; encounters outside the everyday experiences of an average person (Regehr et al., 2002). The research suggests a considerable importance for these human service workers, in being able to use a close relationship as a form of coping. Similar to the work of paramedics, funeral directors are systematically exposed to death (Linley & Joseph, 2005), therefore, it can be suggested that high levels of perceived social support will be a necessary coping mechanism for those working in the funeral services.

Further research on social support reveals a problem that may be encountered by human service workers. The issue centres on how confidentiality might act as a barrier to workers seeking to utilise support networks (Løvseth & Aasland, 2010). In a Norwegian study comprising of funeral directors, nurses, chaplains, police officers, and rescue workers; Løvseth and Aasland (2010) examined how the privacy of clients and professional reputation may come before the well-being of the helper. Ethical obligations for confidentiality revealed that most participants only disclosed their occupational difficulties to fellow workers. Research with hospice and palliative medicine staff has also reported a similar reliance on work colleagues for support, over family and friends (Swetz et al., 2009). However, in the Løvseth and Aasland study (2010); compared to the nurses, chaplains, and police officers; funeral directors were more inclined to disclose their difficulties with family and friends.

A recent study (Ariapooran, 2014) shows the possible benefits of social support for protection against CF and burnout. As another caring profession, nurses deliver support to those struggling with trauma, disease, and imminent death (Ariapooran, 2014). This type of work leaves nurses open to the risks of CF and burnout. Similar to the present study, the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) was incorporated to measure social support against nurses’ levels of CF and burnout. Findings revealed a negative
correlation between CF and social support from family (Ariapooran, 2014, p. 282). It is unclear why CF did not have a negative correlation with support from friends (Ariapooran, 2014), however one explanation may be that social support from these sources are perceived differently (Bolger & Amarel, 2007). People may not interpret subtle or undetected support from friends as it can take place “between the lines” as unnoticed support (Bolger & Amarel, 2007). This may be why nurses in Ariapooran’s study (2014) showed family support to be a more important buffer against CF.

How social support is sought can relate to the type of relationship between the person looking for support and those who provide it (Kim et al., 2008). Many funeral professionals spend their time working as part of a family run business (Funeral Director, 2010; Parsons, 1999), so social support from familial sources may be more accessible as a buffer against CF and burnout. Furthermore, funeral directors can be conscious of their profession (Kephart, 1950), and with a stigma of body handling the dead (Parsons, 2003) evoking a creepy or morbid image in some people (Van Beck, 2013), it may hinder their ability to seek social support through friends.

1.10 Training

As a result of strong emotional investments to one’s work, psychological difficulties such as CF can develop (Stamm, 2012). Simpson and Starkey (2006) highlight that educational programs that involve training around topics such as CF or coping with workplace stressors may help minimise negative experiences. For example, counselling is regarded as another emotionally demanding career in the human services, where the practitioner works with clients experiencing suffering and trauma (Simpson & Starkey, 2006). The authors argue that if counsellors are informed of the possibility of experiencing
naturally occurring phenomena like CF, they can be better prepared to halt its progress should it develop. Consequently, counsellors are less likely to leave their job due to the difficult nature of the work. This is in contrast to turnover in new therapists who may be unable to process traumatic material due to lack of specific training or awareness of CF (Simpson & Starkey, 2006).

According to Smith and Hough (2011), specific training should be provided to workers in settings where death occurs regularly. The authors examined medicine interns who worked in an end-of-life care-setting. Their research showed that interns cited perceived deficiencies in death-specific education and thus were not able to manage their own feelings around patient death. However, supplementing the worker’s qualifications with further death-specific training could help mitigate feelings such as stress, depression, and burnout (Smith & Hough, 2011). Similarly, educational interventions are also highlighted as important for junior doctors exposed to dying (Linklater, 2010). The benefits can be a better understanding of their own emotional distress surrounding patient death, along with further enhancing the ability to practice effectively (Linklater, 2010).

Other researchers such as Meadors and Lamson (2008) examined training specifically around CF. In their sample of paediatric intensive-care workers, an experimental group who attended further education around CF showed significant increases in their knowledge of CF. While this may come as no surprise, significance lies in that their awareness of CF had increased. As CF is highly treatable once professionals are able to spot the symptoms and therefore adopt interventions (Figley, 2002); training or additional workshops offered to workers may help reduce its negative effects.
11 Self-Care

A characteristic of CF is an inability to separate one’s private life from the worker’s professional role (Stamm, 2010). The deceased presented to funeral directors can vary from natural occurrences, to more mentally difficult circumstances like road accident victims, child death, or suicide. Considering the emotionally-taxing work of funeral directors, those in human service careers involved with end-of-life issues need to address protective factors against phenomena like CF (Holland & Neimeyer, 2005). Figley (2002) remarks that the cost of caring for others can have negative consequences and where CF is experienced, there is often a chronic lack of self-care. For human service workers, self-care can include being aware of indicators that work is taking a toll, or that heightened stress is becoming too intense (Figley, Figley & Norman, 2002). The literature around self-care strategies that can help protect against CF highlights a variety of suggestions.

Staff working in hospice and palliative medicine are frequently subjected to suffering and death. Swetz and colleagues (2009) addressed self-care in this occupation group due to the challenges encountered and the potential for burnout. The study explored what strategies were employed to help maintain a work-life balance. Responses included: exercise, cooking, travel, humour, literature, and religion amongst others (Swetz et al, 2009). Workers cited physical well-being (exercise, nutrition) as most useful for protection against burnout (60%), professional relationships closely followed (57%), while hobbies (40%), “time away” (27%), and humour (13%) were also deemed beneficial (Swetz et al., 2009, p. 776).

Killian (2008) examined self-care strategies among therapists who cited a number of favourable techniques. Increased leisure time and spirituality were reported as vital, and exercise was felt to play a major role for enhancing well-being. Although reducing work load was associated with lower levels of occupational stress, the individual coping strategies did
not influence therapist’s levels of STS (Killian, 2008). The author notes that therapists may need to be pro-active in their efforts to maintain positive self-care strategies, as none of the therapists had received specific training or workshops around professional self-care (Killian, 2008). Research on spirituality has revealed a protective role against challenging work circumstances (Holland and Neimeyer, 2005), and these palliative care workers who regularly utilised spiritual practices reported lower burnout levels.

Portnoy (2011) states that those in helping professions need to maintain self-care as it increases their capacity to provide a better service to the client. This author suggests a number of ways to offset the development of burnout and CF. Sensible eating habits and adequate rest should be encouraged, specific self-care training should be offered to help minimise workplace stress, and there should be a delegation of the caseload; especially for more challenging situations (Portnoy, 2011). The suggestion on caseload sharing may have a special potency for funeral directors, as per burials of a psychologically challenging nature.

Cohen-Katz et al. (2005) highlighted that nurses believed healthy eating and exercise to be important personal coping techniques for managing self-care. Other studies highlight how humour and hobbies might help those working in occupations that revolve around death, with these methods possibly helping to buffer against CF (Benson & Magraith, 2005). McCarroll and colleagues (1993) note how humour can act as a beneficial tension reducer. In this study, disaster workers handling bodies after violent deaths reported that “gallows humour” was often employed in time spent with other professionals. Although some found it to reduce tension, others felt that humour was ineffective and using it portrayed a person who had become immune to trauma (McCarroll et al., 1993).

Similarities can be drawn between the work theme of funeral directors and other human service roles (i.e. death and suffering), and accepting that your work requires a need
for added self-care attention should be a priority to avoiding future unhappiness (Ruth, 2014). However, Radey and Figley (2007) note that although there is a belief that lessons in self-care will promote a more resilient worker; the research does not fully support this notion. Eastwood and Ecklund (2008) add that while self-care practices can act as a buffer against burnout, they do not directly lessen the risk for CF. Nonetheless, the various self-care strategies above elucidate some positive signs for those involved in stressful people work; and how education on self-care and an acknowledgment of its importance (although subjective), may benefit the resilience of human service providers.

The research on funeral directors in Ireland is extremely limited. The above literature review does indeed utilise research from other human service professions that may not directly match the unique duties of the funeral director. However, the American Board of Funeral Service Education, does regard the funeral director to be a human service profession, as little time is spent actually working on the deceased; with the majority of time spent working directly with the bereaved (Funeral Director, 2010).

1.12 Rationale of the present study

Funerals provide mourners an outlet for grief (Schafer, 2012); and amidst this emotion the funeral director must work. As human service workers are highly susceptible to CF (Bride, 2004; Buchanan et al., 2006; Figley, 1995, 2002; Stamm, 2012), funeral workers should be similarly at risk due to the helping nature of their profession. Research on CF highlights negative correlations between burnout and age (Bruce et al., 2005; Maslach et al., 2001; Tomic et al., 2004), and links between CF and length of service (Potter et al., 2010). Additionally, female gender may be a risk factor for developing CF (Abendroth & Flannery, 2006; Brady et al., 1999; Cohen-Katz et al., 2005; Sprang et al., 2007). However, high levels
of CS (Eastwood & Ecklund, 2008; Yoder, 2010) and perceived social support (Ariapooran, 2014; Cohen & Wills, 1985; Zimet et al., 1988) can function as buffers or coping mechanisms against CF for other human services. As funeral directors spend most of their professional lives working alongside family (Funeral Director, 2010; Parsons, 1999); this may hinder support from friends. Training on death-specific education shows promise for mitigating occupational phenomenon like CF (Linklater, 2010; Smith & Hough, 2011), and self-care training should also be of benefit (Portnoy, 2011). Human service professionals often cite various self-care strategies that they incorporate in their efforts to address occupational challenges (Benson & Magraith, 2005; Cohen-Katz et al., 2005; Holland & Neimeyer, 2005; Killian, 2008; McCarrall et al., 1993; Swetz et al., 2009). Although self-care practices have been criticised for their efficacy (Eastwood & Ecklund, 2008; Radey & Figley, 2007), it is anticipated that the present study’s examination of self-care practices can contribute to a sector that is largely unexamined (i.e. funeral directors), and will hopefully elucidate strategies that this population perceive as useful for separating their work from their personal lives.

1.13 Hypotheses

Based on the literature review and the aforementioned rationale, the proposed hypotheses are as follows;

**H1**: Compassion fatigue

Funeral directors will report high levels of compassion fatigue (for both components) (i) burnout and (ii) secondary traumatic stress, (compared to another population sample).
H2: Gender

Female funeral directors will have significantly higher levels of compassion fatigue (both burnout and secondary traumatic stress) compared to males.

H3 (i): Compassion satisfaction and burnout

There will be a significant negative correlation between compassion satisfaction and burnout.

H3 (ii): Compassion satisfaction and secondary traumatic stress

There will be a significant negative correlation between compassion satisfaction and secondary traumatic stress.

H4: Age

There will be a significant negative correlation between burnout and age.

H5: Length of service as a funeral director

There will be a significant positive correlation between compassion fatigue (both burnout and secondary traumatic stress) and the number of years working as a funeral director.

H6: Social support and compassion fatigue

There will be a significant negative correlation between compassion fatigue (both burnout and secondary traumatic stress) and levels of perceived social support.

H7: Social support from friends and length of service

There will be a significant negative correlation between length of service and perceived social support from friends.

H8 (i): Training

There will be a significant negative correlation between compassion fatigue (both burnout and secondary traumatic stress) and attendance at death-specific/grief workshops/training.
H8 (ii): Training

There will be a significant negative correlation between compassion fatigue (both burnout and secondary traumatic stress) and attendance at self-care workshops/training.

Self-Care Strategies

A purpose designed question on self-care (see Method section 2.3.4) examined the perceived usefulness of 8 different self-care strategies (Exercise, Reading, Religious or Spiritual Activity, Humour, Watching Television, Travel/Vacations, Socialising, and Nutrition/Healthy Eating). Inferential statistics were not deemed appropriate and therefore the results will be descriptive and exploratory in nature. Additional responses that funeral directors also stated to help separate their work from their personal life will also be addressed.
Chapter 2: Methodology

2.1 Participants

The present study specifically examined funeral directors and therefore non-probability purposive sampling was employed. Using posted and online-surveys, the sample (N=60) were recruited using emails from directory listings of funeral directors on rip.ie and iafd.ie. An additional 25 questionnaires were posted to funeral directors without an available email address (full procedure outlined below).

Participants (N=60) ranged in age from 25 to 73, with a mean 51 (SD=10.78). Of the respondents, 48 were male (80%) and 12 were female (20%). In the sample (N=60), the average number of years working as a funeral director was 22 (SD=12.59). The funeral directors were from both the Republic of Ireland and Northern Ireland. As responses were anonymous, the demographic breakdown for Republic of Ireland and Northern Ireland respondents is unknown. Inclusion criteria for participation required respondents to be over 18 years old and working as a funeral director. Participation was voluntary and no monetary incentives were used. Individuals who wished to participate were offered a summary of the results.

2.2 Design

This was a questionnaire-based study. A correlational design was employed to investigate relationships between variables. The study was both quantitative and qualitative in description. All participants, recruited through non-probability purposive sampling, completed the same questionnaire pack (Appendices B-F).
The predictor variables were; social support, training in self-care, training in grief-specific/bereavement training, length of service, age, and gender. The criterion variable was scores on the Professional Quality of Life Scale (ProQOL-V) (Stamm, 2009). This scale measures compassion satisfaction (CS) and compassion fatigue (CF). CF consists of two parts; (1) Burnout, and (2) Secondary Traumatic Stress (STS). Therefore the criterion variable has three subscales; CS, burnout, and STS.

2.3 Materials

To encourage more consideration to each item and to prevent disinterest, the researcher limited the total items so that completion of the survey would take around eight minutes. The questionnaire (Appendix B-F) contained five sections, giving a total of 56 items.

2.3.1 Demographics.

Section one contained a short demographic questionnaire (Appendix B) which sought the following data; age, gender, and the length of service.

2.3.2 ProQOL & MSPSS.

Sections two and three incorporated two published questionnaires; the Professional Quality of Life Scale (Stamm, 2009) (Appendix C), and the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988) (Appendix D).
**Professional Quality of Life Scale (ProQOL) – Version 5 (Stamm, 2009)**

The Professional Quality of Life Scale (ProQOL) is a revised version of Figley’s (1995) Compassion Fatigue Self-Test that was adopted, renamed and developed by Stamm (2009). It is the most commonly used measurement to assess the positive and negative effects of working with people who have experienced extremely stressful events (Stamm, 2010, p. 12). Professional quality of life incorporates two aspects; CS and CF, which consists of two parts; burnout and STS. CS is the pleasure and positive aspects derived from helping, burnout is associated with hopelessness and difficulties doing your job effectively, and STS relates to secondary exposure to extremely stressful or traumatic events.

The current ProQOL-V (see Appendix C), is a simple to administer non-diagnostic self-report measure. It has 30 items designed to measure respondents on the three discreet scales (CS, Burnout, STS). Participants select responses on a 1 (never) to 5 (very often) Likert scale. Scores on each scale are determined by summing the item answers. Low level scores on all scales are 22 or less, average levels are between 23 and 41, and high levels are 42 or more. Scores that may highlight a problem are CS less than 40, and scores greater than 57 for burnout and STS. Some items on the burnout subscale are reverse scored. The results of the scales cannot be combined to give a single meaningful score.

Examples of questions include; “I feel trapped by my job as a [helper]”, “I feel as though I am experiencing the trauma of someone I have [helped]”, and “I feel invigorated after working with those I [help]”. Stamm (2009) permits editing the words in parentheses to fit the research sample. For instance, the present study used ‘funeral director’ instead of ‘helper’. Additionally, in the instrument instructions it asks to “Select the number that honestly reflects how frequently you experienced these things in the [last 30 days]; this was replaced with; “last year”.
Stamm (2010) notes that this new ProQOL version is more psychometrically sound, and as it is shorter it reduces the burden on the participant. The reliability of the instrument scales are reported by Stamm (2010, p. 28) as; CS ($\alpha = .88$), Burnout ($\alpha = .75$), and STS ($\alpha = .81$). Additionally, there is good construct validity with strong support from over 200 published papers (Stamm, 2010).

*Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988)*

The Multidimensional Scale of Perceived Social Support (MSPSS) (see Appendix D) is a 12 item self-report measure designed by Zimet and colleagues (1988). This short and simple to use instrument (Dahlem, Zimet & Walker, 1991) measures a participant’s subjective levels of perceived social support. It contains three subscales that can be used to assess sources of perceived social support from significant other (items 1, 2, 5, 10), family (items 3, 4, 8, 11), and friends (items 6, 7, 9, 12). Additionally, the measure gives a total subjective score of perceived social support. Participants rate each item on a Likert scale from 1 – 7; where 1 = “*very strongly disagree*” and 7 = “*very strongly agree*”. A participant’s total score of perceived social support is determined by the sum of all 12 items. Total scores range from 12 – 84 (12 – 48 = Low Acuity; 49 – 68 = Moderate Acuity; 69 – 84 = High Acuity). Scores for perceived social support from significant other (SO), family (FAM), and friends (FRI) can be assessed by summing the scores of a subscale’s items (above). Subscale means range from 1 - 7 (1 – 2.9 = low support; 3 – 5 = moderate support; 5.1 – 7 = high support). Examples of questions include; “There is a special person who is around when I am in need” (SO), and “My friends really try to help me” (FRI). According to Zimet and colleagues (1988), the MSPSS has good internal consistency, with a Cronbach’s coefficient alpha of .88 for the total scale. Similarly, good internal reliability was also found for the three subscales; SO ($\alpha = .91$), FAM ($\alpha = .87$), and FRI ($\alpha = .85$) (Zimet et al., 1988, p. 36). Lastly, the developers of the measure demonstrated adequate test-retest reliability for the scale,
reporting a Cronbach’s coefficient alpha of .85 (Zimet et al., 1988, p. 36), indicating that the MSPSS is a psychometrically sound instrument.

2.3.3 Training Measures.

Section four contained two purpose-designed questions (see APPENDIX E) seeking information on training in self-care, and training in death-specific/bereavement education. Participants were asked two questions:

1. “Please indicate if you have ever completed any form of further training / continuing professional development / workshops etc. around the topic of self-care. [Examples could include: Stress reduction techniques, Mindfulness, Compassion Fatigue awareness].”

2. “Please indicate if you have ever completed any bereavement / grief-specific training”.

Participants answered both questions by selecting from the following options:

None attended, 1 attended, 2 attended, 3 attended, 4 attended, 5 or more attended.

2.3.4 Self-Care Measure.

Section five (also a purpose-designed measure) investigated the perceived usefulness of specific self-care practices. The measure (Appendix F) consisted of eight self-care strategies, and asked participants to rate each one for its benefit in helping them separate their work from their professional life. The self-care strategies listed were: Exercise, Reading, Religious/Spiritual Activity, Humour, Watching Television, Travel/Vacations, Socialising, and Nutrition/Healthy Eating. Rating was based on a 5-point Likert-scale system (1 = never useful, 2 = rarely useful, 3 = sometimes useful, 4 = often useful, and 5 = very often useful).
This section concluded with an optional question asking; “If there is anything else that you find personally useful in helping you separate your work from your personal life, please state below”. Participants could place their answer below the question in a box provided (Appendix F). Of the sample (N=60), 28 participants answered this question.

2.4 Procedure

To acquire the sample (N=60), surveys were posted and emailed to participants. A total of 400 questionnaires were distributed. Funeral directors with listed emails on two websites; rip.ie and iafd.ie, were used for the online-surveys. Rip.ie is an up-to-date website displaying death notices and directory listings for funeral directors. Iafd.ie is a website for members of the Irish Association of Funeral Directors (IAFD). It must be noted that some funeral directors listed on rip.ie are not members of the IAFD; therefore this study had a sample of both IAFD members and non-members.

The online-survey was created using Google Docs, which provided a link for online purposes. Twenty-five questionnaires were posted out to funeral directors where no email address was found. This included a stamped-addressed envelope for return purposes. Questionnaires were identical to the online-version and were created on Microsoft Word. Of the 400 questionnaires distributed, a total of 54 online-surveys were completed and 6 postal surveys were returned; giving a total response rate of 15%.

All participants completed the same questionnaire pack (Appendices B-F). An information sheet (Appendix A) outlining the nature and purpose of the study preceded the questionnaire. This also noted the time taken to complete the survey, and that participation was voluntary and anonymous. Consent was obtained by asking participants to tick a box
prior to beginning the survey. The information sheet also informed participants that by completing the questionnaire, they were consenting for their results to be presented at a later date.

To acquire additional responses, a single reminder email was sent six weeks after the initial emailed surveys. Data collection took place from December 2014 to February 2015. Once all online and posted survey responses were returned; they were combined into a Google spreadsheet and exported to IBM SPSS Statistics (Version 22) for analysis.

2.5 Ethical Considerations

Formal ethical approval for the study was granted by the Psychology Filter Committee at Dublin Business School. For queries relating to the study, the researcher provided the supervisor’s email as well as their own in the information sheet. Additionally, to address any possible feelings or concerns arising from the questionnaire; appropriate contacts were provided in a debrief page at the end of both the online and postal survey (Appendix G).

2.6 Proposed Data Analysis

The analysis of data will employ both descriptive and inferential statistics. Descriptive statistics such as mean scores and standard deviations for demographic variables will examine the raw data and highlight major trends. Similarly, descriptive statistics will be employed with the criterion and predictor variables for initial examination. The criterion variable is scores on the ProQOL-V scale, that is, CS, and CF’s two components; burnout and STS. The predictor variables are gender, age, length of service, perceived social support, death-specific/bereavement training and self-care training. Descriptive statistics will also
examine the perceived usefulness of self-care strategies, while the additional qualitative responses will also be addressed for any recurring themes.

If the data are normally distributed, inferential statistics will include; two one-sample t-tests to examine funeral directors’ levels of CF (burnout and STS), against a comparison research study; an independent samples t-test will examine significant gender differences in CF; lastly, a series of Pearson’s correlations will test hypotheses for the relationships between the predictors and criterion variable.
Chapter 3: Results

3.1 Descriptive Statistics

Demographic descriptives

Table 1 below shows that the sample (N=60) consisted of 48 male funeral directors (80%) and 12 female (20%). The mean age was 51.43 years (SD=10.78). The youngest funeral director was 25 and the oldest 73. The majority of funeral directors (71.7%) were over the age of 46; with only 28.3% under this age. Further, only 2 participants were between the ages of 18 to 30 years. Regarding length of service; the mean was 22.23 years (SD=12.59), with a range of 2 to 40 years. Most funeral directors had worked for 31 years or more (30%); however the length of service had a relatively even dispersion in this sample (see Table 1).

Table 1: Demographic variable descriptives

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>48</td>
<td>80</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>20</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Total</td>
<td>60</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>2</td>
<td>3.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>31-45</td>
<td>15</td>
<td>25.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>46-60</td>
<td>34</td>
<td>56.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>61+</td>
<td>9</td>
<td>15.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Length of service (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10</td>
<td>16</td>
<td>26.7</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11-20</td>
<td>15</td>
<td>25.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21-30</td>
<td>11</td>
<td>18.3</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>31+</td>
<td>18</td>
<td>30.0</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
**Predictor descriptives**

Participant scores (N=60) for all predictor variables are displayed in Table 2 below. On the MSPSS (Zimet et al., 1988), participants had a mean score of 67.47 (SD=13.58), indicating that this sample of funeral directors perceive moderate levels of social support in their lives. Mean scores on the MSPSS reveal that the sample perceived high support from all three subscales sources; with highest perceived support from family (mean=5.85, SD=1.28); followed by significant others (mean=5.79, SD=1.41); and friend support perceived as the lowest of the subscales (mean=5.22, SD=1.35). Possible scores on this measure are between 12 and 84; the range for the present study was 17 to 84.

As can be seen in Table 2, training on death-specific/bereavement education had a mean score of 0.95 days attended (SD=1.35), while the number of days attended at training on self-care was slightly higher with a mean score of 1.12 (SD=1.47). Days attended for both ranged from 0 - 5. Further SPSS analysis revealed that 34 participants (57%) never attended death-specific/bereavement training; 9 participants with at least one day attended; and only 2 participants attending five or more. For self-care training, 30 participants (50%) had never attended a workshop; 13 had attended one day; and only 3 participants had attended five or more.
Criterion variable descriptives

The participant’s total mean scores on the ProQOL-V, (Stamm, 2009), are displayed in Table 3 below. Analyses revealed that funeral directors’ mean total score for CS was 43.37 (SD=4.83), indicating that this sample scored in the high level for CS. The minimum score was 30 (average level) and the maximum score was 50. Scores for CF’s two components; burnout and STS are also outlined in Table 3. Funeral directors’ total mean score for burnout was 20.57 (SD=5.03), indicating low levels of burnout in the sample. Similarly, low levels of STS were also reported, with a total mean score of 21.07 (SD=5.77). Maximum scores for burnout and STS were 32; indicating that average levels of these components was experienced by some funeral directors.

Table 2: Descriptive statistics for predictor variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSS Total</td>
<td>67.47</td>
<td>13.58</td>
<td>17</td>
<td>84</td>
</tr>
<tr>
<td>PSS from significant other</td>
<td>5.79</td>
<td>1.41</td>
<td>1.75</td>
<td>7</td>
</tr>
<tr>
<td>PSS from family</td>
<td>5.85</td>
<td>1.28</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>PSS from friends</td>
<td>5.22</td>
<td>1.35</td>
<td>1.5</td>
<td>7</td>
</tr>
<tr>
<td>Death-specific/bereavement training days attended</td>
<td>0.95</td>
<td>1.35</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Self-care training days attended</td>
<td>1.12</td>
<td>1.47</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Length of service (years)</td>
<td>22.23</td>
<td>12.59</td>
<td>2</td>
<td>40</td>
</tr>
</tbody>
</table>

Note. PSS = Perceived Social Support
Table 3: Criterion variable descriptives (ProQOL-V measure)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion Satisfaction</td>
<td>43.37</td>
<td>4.83</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Burnout</td>
<td>20.57</td>
<td>5.03</td>
<td>10</td>
<td>32</td>
</tr>
<tr>
<td>Secondary Traumatic Stress</td>
<td>21.07</td>
<td>5.77</td>
<td>12</td>
<td>32</td>
</tr>
</tbody>
</table>

Self-care descriptives

The measure examining the self-care strategies (Exercise, Reading, Religious/Spiritual Activity, Humour, Watching Television, Travel/Vacations, Socialising, and Nutrition/Healthy Eating) for their usefulness in separating work from their personal life was rated by participants from 1-5 (“never useful” to “very often useful”). No relationships were found between the self-care strategies and CF. Furthermore, as this item was a self-created measure, it was deemed inappropriate to compute a total score for analyses of these self-care strategies. Therefore, the scores for each were calculated into mean values, and the results are outlined in a descriptive nature below.

Table 4 below shows a breakdown of how funeral directors rated each self-care strategy. It was found that humour was rated as most useful, with 53 subjects (88%) stating it was either “often useful” or “very often useful”. Socialising, travel/vacations, and watching TV were rated as second, third, and fourth most useful respectively. No participants rated humour or socialising as “never useful”. Interestingly, religious/spiritual activity was deemed
the least useful for helping funeral directors separate their work from their personal life; with 22 participants (37%) stating that it was either “never useful” or “rarely useful”.

Table 4: Descriptives showing perceived usefulness of selected self-care strategies (rank ordered by mean scores) (N=60)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Min</th>
<th>Max</th>
<th>Never useful</th>
<th>Rarely useful</th>
<th>Sometimes useful</th>
<th>Often useful</th>
<th>Very often useful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Humour</td>
<td>4.33</td>
<td>2</td>
<td>5</td>
<td>0 (0)</td>
<td>2 (3)</td>
<td>5 (8)</td>
<td>24 (40)</td>
<td>29 (48)</td>
</tr>
<tr>
<td>Socialising</td>
<td>4.07</td>
<td>2</td>
<td>5</td>
<td>0 (0)</td>
<td>6 (10)</td>
<td>6 (10)</td>
<td>26 (43)</td>
<td>22 (36)</td>
</tr>
<tr>
<td>Travel/Vacations</td>
<td>3.97</td>
<td>1</td>
<td>5</td>
<td>3 (5)</td>
<td>8 (13)</td>
<td>6 (10)</td>
<td>14 (23)</td>
<td>29 (48)</td>
</tr>
<tr>
<td>Watching TV</td>
<td>3.92</td>
<td>1</td>
<td>5</td>
<td>2 (3)</td>
<td>2 (3)</td>
<td>12 (20)</td>
<td>27 (45)</td>
<td>17 (28)</td>
</tr>
<tr>
<td>Exercise</td>
<td>3.83</td>
<td>1</td>
<td>5</td>
<td>1 (2)</td>
<td>4 (6)</td>
<td>18 (30)</td>
<td>18 (30)</td>
<td>19 (31)</td>
</tr>
<tr>
<td>Nutrition/healthy eating</td>
<td>3.68</td>
<td>1</td>
<td>5</td>
<td>1 (2)</td>
<td>7 (11)</td>
<td>16 (26)</td>
<td>22 (36)</td>
<td>14 (23)</td>
</tr>
<tr>
<td>Reading</td>
<td>3.42</td>
<td>1</td>
<td>5</td>
<td>4 (7)</td>
<td>9 (15)</td>
<td>17 (28)</td>
<td>18 (30)</td>
<td>12 (20)</td>
</tr>
<tr>
<td>Religious/spiritual activity</td>
<td>3.00</td>
<td>1</td>
<td>5</td>
<td>7 (12)</td>
<td>15 (25)</td>
<td>16 (26)</td>
<td>15 (25)</td>
<td>7 (11)</td>
</tr>
</tbody>
</table>

Note. Because of rounding, some percentages do not total 100.
Qualitative question on self-care

The questionnaire item examining self-care strategies finished with an optional question asking participants to state anything else they perceived to help them in terms of personal self-care strategies. Of the sample (N=60), 28 participants chose to answer this question. Responses included: suppression of feelings, fishing, meditation, gardening, and music. Other novel responses were: keeping a journal for reflecting on previous funerals, farming, and using a previous qualification in psychotherapy for help with funeral care. Some funeral directors remarked how child deaths and suicides were more difficult to work with, and how the hours of a funeral director can be long (see Appendix H for full list of responses).

3.2 Inferential Statistics

Prior to running inferential statistics, data normality was confirmed by checking for the assumptions.

H1 Compassion fatigue compared to population sample

The comparison study to compare funeral directors’ CF levels against is a paper from Thieleman and Cacciatore (2014). The researchers used the same measure to examine CF (burnout and STS) in a sample of 41 traumatic bereavement volunteers and professionals.

(i) Burnout

The current study had a mean for burnout of 20.57 (SD=5.03) which was higher than the comparison research mean of 19.63. The 95% confidence
limits shows that the population mean difference of the variables lies somewhere between -.36 and 2.24. A one sample t-test found no significant difference between the two means (t (59) = 1.44, p = .154). Therefore we can not reject the null.

(ii) Secondary traumatic stress

The current study had a mean for STS of 21.07 (SD=5.77) which was higher than the research mean of 20.66. The 95% confidence limits shows that the population mean difference of the variables lies somewhere between -1.08 and 1.90. A one sample t-test found that there was no significant difference between the two means (t (59) = 0.55, p = .587). Therefore we can not reject the null.

H2 Gender

An independent samples t-test was conducted to examine gender differences in funeral directors’ levels of CF (burnout and STS).

Females (mean = 20.67, SD = 6.50) were found to have higher levels of burnout compared to males (mean = 20.54, SD = 4.67). The 95% confidence limits show that the population mean difference of the variables lies somewhere between -3.40 and 3.15. However, the independent samples t-test found no significant differences in burnout between males and females (t (58) = -.07, p = .939). Therefore the null can not be rejected.

Similarly, females (mean = 22.08, SD = 5.52) were found to have higher levels of STS compared to males (mean = 20.81, SD = 5.86). The 95% confidence limits show that the
population mean difference of the variables lies somewhere between -5.02 and 2.48. However, the independent samples t-test found no significant differences in STS between males and females (t (58) = -.68, p = .500). Again, the null can not be rejected.

H3 (i) Compassion satisfaction and burnout

The mean scores for CS was 43.37 (SD=4.83) and for burnout was 20.57 (SD=5.03). A Pearson correlation coefficient found that there was a moderate negative significant relationship between CS and burnout (r (60) = -.484, p < .001). Therefore the null is rejected.

H3 (ii) Compassion satisfaction and secondary traumatic stress

The mean scores for CS was 43.37 (SD=4.83) and for STS was 21.07 (SD=5.77). A Pearson correlation coefficient found no significant relationship between CS and STS (r (60) = -.073, p = .578. Therefore, the null can not be rejected.

H4 Age

Pearson’s correlation coefficients found no significant relationships between burnout and the age of funeral directors (see Table 5 below).

H5 Length of service

Pearson’s correlation coefficients found no significant relationships between CF (burnout or STS) and the number of years working as a funeral director. Although not
significant; length of service and the STS component of CF may have been approaching significance \((p = .054)\).

**H6 Social support**

Pearson’s correlation coefficients found no significant relationships between CF (burnout or STS) and perceived social support. Although not significant, a negative relationship between burnout and perceived social support from friends was approaching significance (see Table 5 below).

**H7 Social support from friends and length of service**

The mean scores for perceived social support from friends was 5.22 (SD=1.35) and for length of service was 22.23 (SD=12.59). A Pearson correlation coefficient found a weak negative significant relationship between perceived social support from friends and length of service \((r (60) = -.297, p = .021)\). Therefore the null is rejected.

**H8 (i) and H8 (ii) Training**

No significant correlations were found between CF (burnout and STS) and (i) training in death-specific/bereavement education or (ii) training in self-care (see Table 5 below).
Table 5: Pearson’s r correlations showing criterion and predictor relationships.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Compassion satisfaction</th>
<th>Burnout</th>
<th>Secondary traumatic stress</th>
<th>Age</th>
<th>Length of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compassion satisfaction</td>
<td>---</td>
<td>---</td>
<td></td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Burnout</td>
<td>-.000**</td>
<td>---</td>
<td></td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Secondary traumatic stress</td>
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<td>---</td>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>Age</td>
<td>.241</td>
<td>-.384</td>
<td>.327</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Length of service</td>
<td>.520</td>
<td>.305</td>
<td>.054</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Death-specific/bereavement training attended</td>
<td>-.140</td>
<td>-.658</td>
<td>-.105</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Self-care training attended</td>
<td>-.581</td>
<td>.590</td>
<td>-.530</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>PSS total</td>
<td>.206</td>
<td>-.154</td>
<td>-.749</td>
<td>.230</td>
<td>-.217</td>
</tr>
<tr>
<td>PSS from significant other</td>
<td>.178</td>
<td>-.242</td>
<td>-.954</td>
<td>.156</td>
<td>-.583</td>
</tr>
<tr>
<td>PSS from family</td>
<td>.310</td>
<td>-.518</td>
<td>.574</td>
<td>.080</td>
<td>-.781</td>
</tr>
<tr>
<td>PSS from friends</td>
<td>.419</td>
<td>-.080</td>
<td>-.198</td>
<td>-.912</td>
<td>-.021*</td>
</tr>
</tbody>
</table>

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Note. PSS = Perceived Social Support
Chapter 4: Discussion

4.1 Key findings

The goal of this study was to add to the literature gaps by determining if funeral directors are at risk of suffering from CF; and whether perceived social support, training, age, and length of service could have buffering effects against it. The study also explored self-care strategies employed by these workers. The results of the preceding analysis have shown that funeral directors in this sample are not at risk of suffering from CF. Positively, they obtained low scores in both the burnout and STS components. This is in contrast to literature that shows those in the human services are highly susceptible to these work phenomena through dealing with traumatised populations (Bride, 2004; Bride et al., 2007; Buchanan et al., 2006; Figley, 1995; Figley & Figley, 2009; Freudenberger, 1974; Joinson, 1992; Kadambi & Truscott, 2003; Maslach, 2001; Maslach & Jackson, 1981; Maslach et al., 2001; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Roberts et al., 2003; Simpson & Starkey, 2006; Sprang et al., 2007; Stamm, 2009, 2010, 2012; Yoder, 2008).

Funeral directors had no significant differences in burnout and STS when compared to another population norm (Hypothesis 1). One interpretation for this finding is that the population comparison (traumatic bereavement volunteers and professionals) spend far more time with the traumatised population compared to funeral directors. Contact between the funeral director and the bereaved may only last a few days (Parsons, 2003), and as such, CF’s development may be inhibited by the cessation of dealing with the bereaved once the funeral has finished.
Hypothesis 2 did not show support for gender being a risk factor for CF. Despite females having a marginally higher mean score for burnout and STS; differences were not significant. This supports research that states; if gender differences exist, they are relatively low, if present at all (Maslach & Jackson, 1981, 1985). The unequal distribution of males and females made it difficult to detect any genuine differences in CF; however, this is in contrast to gender differences being discovered in occupations where there is an over-representation of a certain gender (Maslach, 2001); in this case males. A surprising finding was the higher than expected female responses to this study (20%). Although the funeral director population in Ireland is predominantly male occupied, almost a quarter of respondents were female; which dispels any notion that females are not capable of dealing with such traumatic work (Cathles et al., 2010).

Support for Hypothesis 3 was found for CS being a buffer against CF (Eastwood & Ecklund, 2008), if only for the burnout component. Results showed the presence of a significant moderate negative relationship ($p < .001$). It is unclear why CS was only correlated to burnout (Hypothesis 3 - i), and not with STS (Hypothesis 3 – ii). One interpretation is that a high satisfaction for doing one’s work may offset the chances of developing burnout; which is related more to exhaustion and temporal elements (Freudengerber, 1974; Maslach et al., 2001), in contrast to STS which centres around more immediate experiences of witnessing trauma (Stamm, 2010). Accordingly, as CS entails a feeling of satisfaction in one’s ability to be an effective caregiver (Stamm, 2012) and thus not avoid a distressing issue; these funeral director’s high levels of CS may supersede burnout’s gradual development, but not lessen unexpected and more immediate STS.

The results did not report a significant negative correlation between burnout and age (Hypothesis 4), suggesting that age is not a risk factor for burnout in this sample. This is contradictory to previous literature that argues that younger workers are at a higher risk for
burnout (Tomic et al., 2004). Only two participants were between the ages of 18-30, which may have made it more difficult to detect significant results. Although Roberts et al. (2003) found age to be negatively correlated with burnout in a sample of clergy; their research was conducted after the 9-11 terrorist attacks which may have involved clergy facing a lot more human contact in the aftermath of the disaster, than compared to the intermittent work schedule of these funeral directors. Further, as funeral directors often work in family run businesses (Funeral Director, 2010; Parsons, 1999), younger funeral directors may feel more supported by parent colleagues in sharing the caseload.

Results showed a relatively even distribution for length of service in this sample. Potter et al. (2010) highlighted a trend that the risk for CF may increase with length of service; however no significant negative correlations were discovered in the present study (Hypothesis 5). One implication of this is that as many go on to inherit family establishments (Funeral Director, 2010; Parsons, 1999); length of service should not pose a concern. The finding (Hypothesis 5) suggests that those funeral directors serving the longest time in the profession are no more at risk for CF than those new to the occupation. An alternative explanation is that considering CF can result in turnover in certain professions (Simpson & Starkey, 2006); newer workers who developed CF may not be present in the research sample (Maslach et al., 2001). Again, this can only be speculated.

Hypothesis 6 did not find any significant negative correlations between CF and total perceived social support or subscale scores. This finding does not support previous research that perceived social support from family may minimize the effects of CF (Ariapooran, 2014). However, this sample of funeral directors reported high total mean levels of perceived social support, as well as high levels from significant others, family, and friends. Positively, this highlights that funeral directors nonetheless feel supported in their lives. One possible reason for no significant results here is the previously referred to point regarding how
confidentiality may function as a barrier to social support (Løvseth & Aasland, 2010). Ethical obligations on behalf of some funeral directors may have influenced how they self-reported. Although this study was anonymous, it can not be certain how honestly participants answered each item. The point on confidentiality as a barrier is further underlined by the low response rate (15%).

Support was found for Hypothesis 7; which looked for a significant negative correlation between length of service and perceived social support from friends. Although this correlation was weak, it does suggest that funeral workers who are in the profession for longer, will perceive less support from friends. As stated previously, family run funeral establishments are common (Funeral Director, 2010; Parsons, 1999), and with the passage of years; close bonds may be forged with fellow family members. This may lead the friends of funeral directors becoming distant or surplus to the support already received from family. Alternatively, Van Beck’s (2013) theory that the work of a funeral director may evoke a creepy or morbid image in some people; may be another explanation why friend support is not as accessible to the funeral director.

Attendance at death-specific/bereavement training (Hypothesis 8 – i) or self-care training (Hypothesis 8 – ii) did not have any significant negative correlations with CF. Although these measures were self-constructed, they do not support the view that educational programmes can minimise occupational problems such as perceived death-specific inadequacies (Linklater, 2010; Smith & Hough, 2011), self-care neglect (Figley, 2002), or CF (Meadors & Lamson, 2008; Simpson & Starkey, 2006). Furthermore, the sample in this study was made up from IAFD members and non-members. The IAFD code of practice says that vocational training will be provided to members; to enhance the service they provide (Irish Association of Funeral Directors, n.d.). Training around occupational health hazards such as infectious diseases are addressed with IAFD members (Kelly & Reid, 2011), but it is unclear
what training is offered to funeral directors for the mental health hazards of this profession. It is therefore unclear in the present study whom the results apply to. Perhaps IAFD members are offered more training in death-specific/bereavement and self-care education, but this is uncertain. Future studies could undertake an independent groups design examining members and non-members for a more detailed insight into the effects of specific training on CF. As CF can lead to a deterioration of a worker’s ability to practice their profession, providing a comprehensive overview for educational purposes would be paramount (Figley, 2002, p. 1438).

Final attention is drawn to the current study’s findings on self-care strategies. As stated above, the measure on self-care was self-constructed and later omitted from being utilised in any data analysis; based on the validity of the measure. Descriptive results highlighted how funeral directors believed humour to be most useful in helping them “switch off” or as a form of self-care. This was a similar strategy reported by disaster workers handling bodies after violent deaths (McCarroll et al., 1993). Below humour; socialising, travel/vacations, and watching TV were second, third, and fourth most useful. Exercise and nutrition/healthy eating were perceived as “very often useful” by 31% and 23% respectively. Nurses similarly reported these strategies as important coping techniques (Cohen-Katz et al., 2005). As many funerals are involved with the church (Parsons, 2003), it was surprising how religious/spiritual activities were deemed the least useful. It could be suggested that as funeral directors spend much time in this setting through their work, it is an area they distance themselves from in their personal lives. Just above religion was reading as the second least useful form of self-care.

Of the study sample (N = 60), 28 replies were received for the optional item on self-care practices. Responses included exercise and hobby orientated strategies such as walking, playing golf, fishing, music, arts, and gardening; as well as practical techniques such as
journal writing, meditation and “no phone contact”. This rich data also provided an insight into two recurring themes. The first was how suicides and the deaths of children were more difficult; stressing the need for self-care maintenance in this occupation. Secondly, many stated how busy the job is in general. This could be further compounded by other roles in life, with farming and child minding also being reported (see Appendix H for all responses). Eastwood and Ecklund (2008) stated how self-care practices may function as a buffer against burnout, but not against STS. However, with such low levels reported for both in this sample, it could be argued that funeral directors’ wide variety of employed self-care strategies do indeed function to lessen the effects of both in this unique field of work.

4.2 Limitations and suggestions for future research

A number of shortcomings in the present study must also be addressed. Firstly, the low sample size makes it difficult to infer the effect the predictor variables had on reported levels of CF. This study did not report significant correlations between several study variables, including burnout with support from friends, and STS with length of service; however, correlation values suggest they may have been approaching significance. It would be interesting to examine if these results would have any significance in a larger sample size, and whether the number of subjects in this study hindered this outcome. However, this study acquired 60 participants which equates to ten percent of the reported 600 funeral directors working in Ireland (Irish Hospice Foundation, 2011). A study investigating ten percent of Irish students for example could certainly be argued to give a noteworthy result of what the research was examining. Therefore, the present study’s sample could be fairly representative, as per the small numbers working as funeral directors. Although it must be noted that while
some correlations may have been approaching significance, there would be no guarantee of further findings if a larger sample was obtained.

In acquiring the sample, 375 emails and 25 postal questionnaires were distributed. Financial considerations dictated the study to rely more heavily on the email responses. Some funeral directors only post a telephone number for enquiries and do not list emails. A problem arises here in respect to certain individuals becoming “out of reach” for participation in the study. In the self-care qualitative item, it was noted by one funeral director that they were not competent with the internet aspect of business dealings, and that their sons were better in this domain (see Appendix H). It could be possible that the present study missed out on an older generation of funeral director, who in turn could have reported entirely different experiences of CF. Future research could employ telephone surveys to these possible individuals, however with 56 items in the present study; it would be difficult to find participants willing to endure a lengthy telephone survey. It is recommended that any survey being carried out would be of minimal inconvenience to participants.

Although this study’s self-constructed measure of self-care practices has illuminated some strategies employed by this occupation sample, a quantitative measure may have been more appropriate. Future studies should incorporate a valid measure to assess self-care. Reviewing this limitation, post-analyses, the author suggests an instrument such as the Exercise of Self-Care Agency Scale (Kearney & Fleischer, 1979), which examines aspects such as motivation to engage in self-care. This could offer additional analyses on how self-care may mitigate CF.

A strength of this study is the use of the ProQOL-V (Stamm, 2009) for measuring CF. It provides a measure of the burnout component and the scale is considered psychometrically sound (Stamm, 2010). Nonetheless, as the ProQOL-V does not focus solely on burnout, an
alternative measure that does may have resulted in more accurate levels of burnout reported. Burnout is regularly associated with the work of Maslach (2001), who originally devised the *Maslach Burnout Inventory* (1981); the most widely used research measure of burnout. Future research investigating solely the burnout component of CF, may wish to consider such a measure.

Lastly, the *MSPSS* (Zimet et al., 1988) used in this study examines perceived support from significant others, family, and friends. It does not include a measure for support from occupational sources. As funeral directors sometimes rely on fellow workers for support (Løvseth & Aasland, 2010), research examining compassion fatigue and the perceived benefits of support from this source would be highly beneficial.

### 4.3 Conclusion

This study examined CF in a sample of funeral directors from the Republic of Ireland and Northern Ireland. Although CF’s components, burnout and STS, can be the negative sequelae of working in the human services; this sample of funeral directors do not seem to be at risk. These workers scored high in CS suggesting that they derive a great deal of pleasure from their profession. The high levels of CS may be why this cohort is not at risk for developing CF. Although CS had no significant correlation with STS; the study suggests it can serve as a buffer against burnout. Gender, age, and length of service do not seem to be factors related to the development of CF in these funeral directors.

Despite the findings that funeral directors have a strongly perceived social support network from significant others, family *and* friends; the present study indicates that perceived support from friends may decline the longer the individual stays in this profession. This paper
did not show any benefits of attending training in grief-specific/bereavement education or self-care training to lessen the risks of experiencing CF. However, funeral directors do seem to employ a wide range of personal self-care strategies. Consequently, this may ultimately lessen their need for guidance in how to adequately separate the difficult occupational challenges from their personal lives.
References


Appendix A: Information Sheet

Hello,

My name is Ger McCormack and I am a final year undergraduate student in Dublin Business School. I am undertaking a research study as part of a Bachelor of Psychology, which will be submitted for examination this year. The research is being carried out under the supervision of Dr Chris Gibbons.

My interest and purpose of this study is to investigate compassion fatigue, burnout, and compassion satisfaction in funeral directors. The study will also look at social support and training. Compassion fatigue and compassion satisfaction are the negative and positive aspects, respectively, that people can feel in relation to their work as a helper. Burnout is one of the elements of Compassion Fatigue and is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively.

Most of the studies on compassion fatigue and burnout have focused on individuals traditionally thought of as being in helping professions, such as therapists, social workers, nurses, doctors, and fire fighters. Very limited published research, however, has been conducted into examining these phenomena among funeral directors, especially so in Ireland. The overall results obtained will supplement any research literature and should enhance understanding in respect of these issues.

Participation in this study is entirely voluntary. The specific information that you provide will be strictly confidential. Your name or business is not required, and all responses will be completely anonymous, as only basic demographic information is required. No individual can be identified in any publication of the results. All information will be stored on a secure password protected account, and only the researcher and supervisor will have access to it. The data will be destroyed within a year after the submission date (March 2015). Summaries of the information that you and other funeral directors participating in the study provide, may appear in a research seminar scheduled at a later date in 2015.

The survey to follow should take approximately 8 minutes to complete.

The ethical aspects of this study have been approved by the Ethics Committee for the School of Psychology in Dublin Business School.

Contact information: If you have any questions or concerns regarding this project, please feel free to contact me by e-mail: xxxxxx@gmail.com or my Supervisor Chris Gibbons; Additionally, if you are interested in this study and would like to receive a copy of the results in the future, please contact myself and I would be most welcome in sharing them.

Thank you very much for your participation.
Appendix B: Consent and Demographical Information

If you are over the age of 18, currently working as a funeral director, and consent to be part of this study; please tick the box below

☐

Please select your gender

☐ Male

☐ Female

Please indicate your age below

☐

Please estimate the number of years you have been working as a Funeral Director

☐
Appendix C: Professional Quality of Life Scale (ProQOL): Compassion Satisfaction and Compassion Fatigue [Version 5] (Stamm, 2009).

When you [help] people you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the [last 30 days].

1=Never  2=Rarely  3=Sometimes  4=Often  5=Very Often

___ 1. I am happy.
___ 2. I am preoccupied with more than one person I [help].
___ 3. I get satisfaction from being able to [help] people.
___ 4. I feel connected to others.
___ 5. I jump or am startled by unexpected sounds.
___ 6. I feel invigorated after working with those I [help].
___ 7. I find it difficult to separate my personal life from my life as a [helper].
___ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
___ 9. I think that I might have been affected by the traumatic stress of those I [help].
___ 10. I feel trapped by my job as a [helper].
___ 11. Because of my [helping], I have felt "on edge" about various things.
___ 12. I like my work as a [helper].
___ 13. I feel depressed because of the traumatic experiences of the people I [help].
___ 14. I feel as though I am experiencing the trauma of someone I have [helped].
___ 15. I have beliefs that sustain me.
___ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
___ 17. I am the person I always wanted to be.
___ 18. My work makes me feel satisfied.
___ 19. I feel worn out because of my work as a [helper].
___ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
___ 21. I feel overwhelmed because my case [work] load seems endless.
___ 22. I believe I can make a difference through my work.
___ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
___ 24. I am proud of what I can do to [help].
___ 25. As a result of my [helping], I have intrusive, frightening thoughts.
___ 26. I feel "bogged down" by the system.
___ 27. I have thoughts that I am a "success" as a [helper].
___ 28. I can't recall important parts of my work with trauma victims.
___ 29. I am a very caring person.
___ 30. I am happy that I chose to do this work.
Appendix D: Multidimensional Scale of Perceived Social Support (Zimet et al., 1988)

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the “1” if you Very Strongly Disagree
Circle the “2” if you Strongly Disagree
Circle the “3” if you Mildly Disagree
Circle the “4” if you are Neutral
Circle the “5” if you Mildly Agree
Circle the “6” if you Strongly Agree
Circle the “7” if you Very Strongly Agree

1. There is a special person who is around when I am in need. 1  2  3  4  5  6  7
2. There is a special person with whom I can share my joys and sorrows. 1  2  3  4  5  6  7
3. My family really tries to help me. 1  2  3  4  5  6  7
4. I get the emotional help and support I need from my family. 1  2  3  4  5  6  7
5. I have a special person who is a real source of comfort to me. 1  2  3  4  5  6  7
6. My friends really try to help me. 1  2  3  4  5  6  7
7. I can count on my friends when things go wrong. 1  2  3  4  5  6  7
8. I can talk about my problems with my family. 1  2  3  4  5  6  7
9. I have friends with whom I can share my joys and sorrows. 1  2  3  4  5  6  7
10. There is a special person in my life who cares about my feelings. 1  2  3  4  5  6  7
11. My family is willing to help me make decisions. 1  2  3  4  5  6  7
12. I can talk about my problems with my friends. 1  2  3  4  5  6  7
Appendix E: Training Measurement

Please indicate if you have ever completed any form of further Training / Continuing Professional Development / Workshops etc. around the topic of Self-Care.

[Examples could include: Stress reduction techniques, Mindfulness, Compassion Fatigue awareness etc.]

None attended
1 attended
2 attended
3 attended
4 attended
5 or more attended

Additionally, please indicate if you have ever completed any death-specific / bereavement training.

None attended
1 attended
2 attended
3 attended
4 attended
5 or more attended
Appendix F: Self-care and qualitative measure

Lastly, I am interested to know if there is anything that you like to do, engage in, that helps you ‘switch off’, or that you regard as beneficial to you as a form of self-care?

(Please rate the following for their usefulness in this regard, by ticking the appropriate boxes below)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never Useful</th>
<th>Rarely Useful</th>
<th>Sometimes Useful</th>
<th>Often Useful</th>
<th>Very Often Useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td></td>
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<tr>
<td>Reading</td>
<td></td>
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<td>Religious or Spiritual Activity</td>
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<td>Humour</td>
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<td>Watching Television</td>
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<td>Travel/Vacations</td>
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<tr>
<td>Socialising</td>
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<td></td>
<td></td>
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<tr>
<td>Nutrition / Healthy Eating</td>
<td></td>
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</tbody>
</table>

If there is anything else that you find personally useful in helping you separate your work from your personal life, please state below.
Appendix G: Debrief Information

Debrief and Support Contacts

Thank you for your participation in this study. The time you have given is most appreciated. Again, I would like to remind you that all information given will remain strictly confidential.

If you have any questions, concerns or feelings arising from this study, the following organisations provide support;

The Samaritans: is a confidential 24 hour support service that can be contacted by telephone in Ireland at: 116 123
Northern Ireland: 08457 60 90 90
Via email: jo@samaritans.org
Or online at: www.samaritans.org

www.counsellingdirectory.ie is Ireland’s largest independent directory of accredited counsellors and psychotherapists with over 1200 listings. For counsellors and psychotherapists in Northern Ireland, please visit www.counselling-directory.org.uk
Appendix H: Qualitative responses.

The following list contains the qualitative responses received. Certain parts were deleted (marked [EDITED] in text) for purpose of participant anonymity.

“Once the family are happy, I am happy. Usually praised and complemented on a job well done. Every situation different; suicide or child harder”

“Take regular breaks off duty i.e. no phone contact”

“There are a lot of traumatic events that I come across that I cannot discuss with anybody for professional reasons”

“Playing Golf”

“As a self-employed [EDITED] Funeral Director; it is impossible to separate your work from your personal life. I am available 24 hours a day and have to sacrifice family events due my work. As I was born into this business I have seen it from both sides”

“Taking time out if possible; to meet with local groups, committees etc. ”

“Gardening”

“Arts and Craft. Sometimes to do the aforementioned activities in-between work and going home; but the funeral directors’ hours are very long”

“Young family & music”

“I never bring my work home with me. I am [EDITED] young family and even after the funerals of young children; I still leave my work at work before I go home. I would say leave your work at work; and enjoy life with your family and friends”

“Farming”

“Understanding that it is not my fault the person has died. My job is to help the family create a personal funeral tribute, simple as that. It is not the FD’s role to be a bereavement/grief counselor”
“The commitment of small town Irish Funeral directors, who are on call 24/7 365 days a year, is seldom appreciated. The profession is a vocation with limited opportunity for switch off... from any moment being needed; 3am or 3pm are the same in the life of a Funeral Director”

“Involved with sports clubs, and early morning walk”

“I'm a trained psychotherapist; which has helped me to work very well in the area of funeral direction”

“Taking time for myself”

“Christian meditation, De Mello style I find superb to switch off”

“I am a very busy mum [EDITED] and have a very supportive husband. I'm very often too busy with my time off work, as I give all my attention to my family; which helps me focus on positive things. Having a positive outlook is very important, and being grateful for everyday”

“[EDITED] I work in the Funeral Trade [EDITED]; doing approximately 50 funerals a year. We are [EDITED]. I would do most [EDITED] and my wife deals with the funeral business. We all help out with different aspects of the funerals. I normally do all the organising; [EDITED] son [EDITED]. My wife handles the hardest part of the job which is dealing with grieving and emotional people. She is excellent at it and people seem to cope better after dealing with her. She probably gives too much of herself and this can take its toll emotionally”

“To have other interests outside of work”

“I’m [EDITED] & have been in the business/trade with [EDITED]...the business has changed a lot and my sons [EDITED] are better with internet/web-site side of things/business...and have more energy for the long funeral hours. Day of Viewing can be 5-8, so 4pm to 8-30 our time for the viewing...day of burial can be 10-2....so business is very time consuming...and sons have more energy...Some of the old traditions like the wake are also becoming very popular again...so it now means that a funeral is almost a 3 day duration now”

“I operate a 24 hour service; so I grab quality time when i can”

“Going fishing”
"Generally I can switch off and detach myself once various sections of funerals are completed. Children’s deaths are upsetting and traumatic, but families rely on us to support them in a professional manner, therefore it is necessary to suppress your own feelings during this time. This would really be the only time I would have a problem, but I do not carry this feeling over after the event"

“Playing golf”

“Being with family and close friends”

“I write down comments and observations about every funeral I arrange and find it very useful to look back over them from time to time”

“The only thing I can add is that I didn’t choose the job, it chose me. As part of a family business it was a gradual transition; one I was very firmly not going to enter into, or so I thought. It is a very rewarding job, but you have to leave it at the door where tragedies are concerned. I think it takes a certain personality to be able to do this work. At least that is what I am told by countless people, "How do you do it?" I genuinely can’t answer that”