LIBERTY UNIVERSITY SCHOOL OF DIVINITY

THE CHALLENGES AND BIBLICAL ‘SELF-CARE’ STRATEGIES FOR ‘DIRECT-CARE’ STAFF IN RESIDENTIAL TREATMENT FACILITIES

A Thesis Project Submitted to
The Faculty of Liberty University School Of Divinity
In Candidacy for the Degree of
Doctor of Ministry

By
MICHAEL PATRICK JONES

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THESIS PROJECT APPROVAL SHEET

DR. CHARLIE DAVIDSON, DMIN.
Director, Doctorate of Ministry

DR. DAVID W. HIRSCHMAN
Associate Professor of Religion
ABSTRACT

MINISTERING TO THOSE IN "DIRECT-CARE" MINISTRIES
Michael Patrick Jones
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Mentor: Dr. Charlie Davidson, DMin.

Ministry means more than just pastoral duties within the context of the church. Those in ministry, and particularly those in ‘direct-care’ positions working in residential treatment facilities in childcare face a plethora of issues that can be mentally, emotionally, physically, relationally, and spiritually taxing. This project will provide biblically based engaging, edifying, encouraging, and equipping ministries the necessary skills to enable those who are in ‘Direct-Care’ positions to develop ‘self-care’ practices to address these issues.

This thesis will investigate the causes and effects that impact those in ‘direct-care’ ministry to experience disillusionment, discouragement, depression, despair, defeat, and/or departure from ministry. In addition, the thesis will identify the ‘self-care’ practices that those in ‘direct-care’ ministries and their families can employ to remain successful in their ministries. This thesis will be developed using existing research on the causes and effects, the steps to avoid ministry failure, online surveys with those in ‘direct-care’ ministry and non-recorded interviews with professionals, and related sources and current data.
DEDICATION

To Gwendolyn, my precious wife, best friend, partner in life, and the mother of our incredibly wonderful and gifted children, aside from my salvation in Christ, you are my most cherished blessing and gift from God. You are a source of godly wisdom, inspiration, strength, and encouragement. Thank you for believing in me enough to put your own dreams, goals, and desires on hold so that I can achieve such goals as this. And to all of our children: Amber, Ian, Taylor, Christina, Ashley, and Stephen—thank you all for being such wonderful blessings and enriching my life as each of you do. And to my faith-filled friends, colleagues, and professors, thank you all for your willingness to be used by God to help guide me to become the man of God I so desire to be. I am truly blessed to have been surrounded with such a great cloud of witnesses: my family, friends, colleagues, and professors. You have all been used by God to challenge, instruct, encourage, and equip me, for my purpose, and God’s plan, and I am forever grateful. I thank my God for each of you, and I pray that He will bless each of you, as you have been a blessing to me.
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>CF</td>
<td>Compassion Fatigue</td>
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<tr>
<td>CPS</td>
<td>Child Protective Services</td>
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<tr>
<td>DC</td>
<td>Direct-Care</td>
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<tr>
<td>DMIN</td>
<td>Doctorate of Ministry</td>
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<tr>
<td>DSM-V</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 5th Edition</td>
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<tr>
<td>DSS</td>
<td>Department of Social Services</td>
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<tr>
<td>EMT’s</td>
<td>Emergency Medical Technicians</td>
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<tr>
<td>GAL</td>
<td>Guardian Ad Litem</td>
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<tr>
<td>KJV</td>
<td>King James Version</td>
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<tr>
<td>LBTS</td>
<td>Liberty University Baptist Theological Seminary</td>
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<tr>
<td>NIV</td>
<td>New International Version</td>
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<tr>
<td>NLT</td>
<td>New Living Translation</td>
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<tr>
<td>PO</td>
<td>Parole Officer / Probation Officer</td>
</tr>
<tr>
<td>RCW</td>
<td>Residential Child Care Worker</td>
</tr>
<tr>
<td>RGH</td>
<td>Residential Group Home</td>
</tr>
<tr>
<td>RTC/F</td>
<td>Residential Treatment Centers/Facilities</td>
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<tr>
<td>RTF</td>
<td>Residential Treatment Facility</td>
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<tr>
<td>PRTF</td>
<td>Psychiatric Residential Treatment Facility</td>
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<tr>
<td>STS</td>
<td>Secondary Traumatic Stress</td>
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<td>TFC</td>
<td>Therapeutic Foster-Care</td>
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<td>VT</td>
<td>Vicarious Trauma</td>
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INTRODUCTION

What is ministry? Ministry has been defined by many within the context of governmental agencies, para-church organizations, and religious institutions, and most specifically within the context of the office, duties, or work of a religious minister. However, ministry, even within the context of an Evangelical Christian understanding, encompasses so much more than just the office, duties, or work of a religious minister, that is, one who is a pastor, preacher, teacher, or evangelist. Yet, the English word “ministry” is defined in the Merriam-Webster dictionary as:

“min·is·try articulated as the noun “ˈmi-nə-strē”: the ministry: “ministry” includes those who perform the work of ministry both within the context of church/chaplaincy/para-church ministry vocations; and those working in “helping” fields ministering to others in various vocations in direct-care “helping” positions. ¹

There are many examples of such “helping positions.” “Helping positions” and/or “helping fields” are those vocations that are human service-oriented fields that work directly with people. Vocations in “helping fields” implies people working directly with people, and means interacting with people in such a way that the individual invests something of himself/herself to provide for another in the mental, emotional, physical, relational, social, and spiritual aspects of their lives. Vocations in “helping fields” with reported high levels of stress are as varied as the causes of the stressors resulting in burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF), these include the following: social workers, licensed clinical social workers, therapists, recreation-therapists, counselors, psychologists, psychiatrists, psychiatric aides (nurses), pastors, chaplains, teachers, nurses, nursing assistants, home health-aides,

emergency medical technicians (EMT’s), police officers, crime scene investigators, lawyers, hospice workers, and ‘Direct-Care’ staff; these professionals working in residential treatment centers/facilities (RTC/F’s) with children and/or youth in childcare.  

This research project and thesis paper explores the latter: ‘Direct-Care’ ministry staff working in (RTC/F’s) working with children and/or youth in childcare.

The reasons why people choose to pursue a “helping field” vocation or ministry work are as diverse as the types of ministry in a contemporary context. Many people enter full-time vocational ministry in various religious and faith-based organizations for a variety of reasons, such as faith-based, familial, and personal. For those who enter the ministry in the Evangelical Christian faith, it is typically because they believe they are “called” by God—set apart and ordained for a particular ministry. For many, they enter the Evangelical Christian ministry with the specific intent on ministering to others, or either those who have already become adherents of the Christian faith—pastors, preachers, teachers, etc. Others pursuing a “helping field” vocation or ministry within the context of a faith-based ministry include evangelistic outreach efforts, apologetics and/or missionary work of an individual, agency, or para-church organization; these people are evangelists, apologists, and missionaries. Most would agree that their ministry is intended to reflect God’s love, mercy, and grace in a manner that demonstrates in word and deed the teachings of the Bible, the Judeo-Christian faith, while also encompassing the life, ministry, and examples of the Lord Jesus Christ. Few would counter their position.

In addition, there are those whose work in full-time ministry is of a more practical, pragmatic “hands-on” demonstration of their Christian faith and beliefs. Their ministry is lived out daily amongst those they minister to in word and deed. They do the work of ministry in

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‘Direct-Care’ (DC) ministries staff positions in (RTC/F’s) in childcare working with ‘at-risk’ children and/or youth, or in homes for the developmentally disabled, in hospitals, assisted living centers, retirement homes, and hospices. Others do the work of ministry as chaplains in hospitals, corporations, the military, with police and fire departments. Thus, ministry takes on a much broader and perhaps less widely accepted understanding that more fully encompasses a more biblically accurate and appreciated definition.

Some enter the world of full-time vocational ministry out of a sense of idealism with a desire to help others. This sense of idealism motivates some to do something more with their lives then earn a paycheck. “Idealism” is central to their purpose for working in a “helping field” vocation.³ They identify a need, and as these individuals are compassionate and caring, people-centered, service-oriented individuals, they look for positive ways to affect the lives of others in meaningful ways to fill that need. Interestingly enough, individuals from all camps (can and will likely) find themselves struggling with the same realities of the work of ministry. These realities often take their toll on the individual and their families.

Most people begin a career in full-time vocational ministry with an idealism rife with expectations that their career in a “helping field” will allow them to utilize their natural abilities, talents, education, experience, spiritual gifting, to fulfill their God-given callings. This idealism, however, soon gives way to reality when the issues related to ministry work, the demands of the office, and the expectations of others, (combined with those stressors that are self-imposed, the duties of the position, and the workload of ministry) begin to take their toll on them and their families. Simply stated, those in ministry and their families often feel as though they are always on demand, always on duty, and always on display. The toll of these stressors often manifests

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with deleterious effects on the mental, emotional, physical, relational, and spiritual aspects of their lives and that of their families. While these stressors are a part of ministry, these stressors, as well as burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF), and the toxic spillover often, accompany the work of (DC) ministries. Then there are demands specific to the work associated with ‘Direct-Care’ ministries, and the expectations placed upon those in (DC) ministries staff by the organizations that employ them, such as insufficient training to meet the mental, emotional, and physical demands of the types of children and/or youth in care, inadequate staffing, undesirable work schedules or excessively long work shifts, low salaries, poor benefits, poor job conditions, ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high (DC) ministries staff turnover. The issues, demands, and expectations combined create an environment ripe for (DC) ministries staff to struggle with the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) associated with this type of ministry work. These stressors must be addressed for the overall personal and professional fulfillment and well-being of the (DC) ministries staff, as well as their families, and for their continued ministry success at their given placement of service.

The goal of this thesis project: *The Challenges And Biblical ‘Self-Care’ Strategies For ‘Direct-Care’ Staff In Residential Treatment Facilities*, is to develop a greater understanding and awareness of how the issues, demand and expectations associated with the work of (DC) ministries in (RTC/F’s) in childcare; and how the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) impacts the mental, emotional, physical, relational and spiritual aspects of the professional and personal lives for those in (DC)
ministries positions, and the toll it takes on their families, and the organizations with which they are affiliated, as well as the children and/or youth in care.

The potential value of this project can be appreciated on multiple levels. First, it will provide ‘self-care’ awareness training on the impact of the mental, emotional, physical, relational, and spiritual issues that impact the professional and personal lives of (DC) ministries staff. Second, the research, survey results, and subsequent ‘self-care’ awareness training will become the basis to provide ‘self-care’ coaching of (DC) ministries staff on how to develop better coping skills for dealing with these issues, demands, and expectations and the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) while working in (RTC/F’s) in childcare. Third, it will present bibliically-based ‘self-care’ recommendations for both the (DC) ministries staff and their families that aim to equip, encourage, and empower them to employ strategies to combat the toxic spillover of these stressors. If employed regularly, these benefits, combined with organizational employee-engagement practices, could help them be successful in coping with the mental, emotional, physical, relational, and spiritual tolls that (DC) ministries staff and their families will experience. Thus, they might enjoy a greater quality of life with personal and professional fulfillment and success. Fourth, it will provide opportunities for additional services of coaching, pastoral counseling, and/or referrals for professional counseling. Fifth, it will provide mediation, liaison and consulting services for the organizations that employ (DC) ministries staff with the necessary information needed to address the issues, demands, and expectations that impact (DC) ministries staff, while also providing the ‘self-care’ awareness training, morale building, and employee engagement resources to better address organizational (DC) ministries staff recruiting, retention, and release issues.
STATEMENT OF PROBLEM

The work of ministry is challenging on multiple levels for a plethora of reasons. The work of ministry has issues, demands and expectations that few vocations include. The prevalence of these issues, demands, and expectations on the individual minister and their families cannot be understated. These issues, demands, and expectations on those in the ministry, combined with the demands specific to serving in (DC) ministries staff have often had an even greater deleterious effect, as these issues and demands are all too often exacerbated by the presence of additional expectations placed upon these staff by the organizations that employ them.

On a daily basis, those in (DC) ministries working in (RTC/F’s) in childcare with “at-risk” and/or behaviorally challenged children and/or youth face the issues, demands, and expectations of working with children and/or youth from abusive and neglected backgrounds. These children and/or youth often struggle with the mental, emotional, physical, relational, and behavioral consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes. Providing (DC) ministries for these children and/or youth exposes those in (DC) ministries to the toll these stressors that often manifest upon them with deleterious effects in the mental, emotional, physical, relational, and spiritual aspects of their lives and that of their

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families. While there are stressors that are a part of any ministry role, these stressors, as well as those stressors of burnout, (STS), (VT), and (CF), and the toxic spill-over often accompany the expectations placed upon (DC) ministries staff by their organizations. These combined stressors should be addressed with ‘self-care’ awareness training for the overall personal and professional fulfillment and well-being of the (DC) ministries staff, as well as their families, and for their continued ministry success with the organizations that employ them.

This ‘self-care’ awareness training for (DC) ministries staff could best be provided by someone who has also had experience working as a (DC) ministries staff member in (RTC/F’s) in childcare. This training should be ideally carried out by someone who has experienced the same vocational stressors of ministry, as well as the mental, emotional, physical, relational and spiritual stressors that are uniquely a part of (DC) ministries. In addition, this person should also have already experienced the combined issues and demands of ministry and (DC) ministries work, as well as the expectations and stressors placed upon them by the organizations that employ (DC) ministries staff. Furthermore, this person should be able to 1.) attest to how these issues, demands, and expectations can take a significant and negative toll upon the individual’s professional life. And 2.), how the toll of these stressors often manifests with deleterious effects on the mental, emotional, physical, relational, and spiritual aspects of their personal lives and that of their families. They should understand that while these stressors are a part of ministry,


these stressors as well as those stressors of burnout, (STS), (VT), and (CF), and the toxic spillover that often accompanies the work of (DC) ministries can be overwhelming. Moreover, they should not only have a heart for God, but also a heart for ministry to others. In possessing a heart for ministering to those who serve in (DC) ministries, they may be successful where God has placed them to serve—in spite of these issues, demands, and expectations. In fact, they may thrive in the wisdom, strength, and courage of the Lord. Ideally, the successful ‘self-care’ awareness trainer will encourage, edify, and equip the trainees with more than just the data, statistics, facts, and figures found in the realms of textbooks, scholarly articles, professional journals, or the psychology and counseling works by the noted experts. These resources should be accompanied by the Word of God, the leading of God’s Holy Spirit, the godly counsel of others, a God-given common sense, and an understanding of how the circumstances of life can be used by God to speak truth into brokenness.

With this in mind, the biblical premise for this ministry to (DC) ministries staff comes from Romans 1:8-12 (NIV):

“First, I thank my God through Jesus Christ for all of you, because your faith is being reported all over the world. God, whom I serve in my spirit in preaching the gospel of his Son, is my witness to how constantly I remember you in my prayers at all times; and I pray that now at last by God’s will the way may be opened for me to come to you. I long to see you so that I may impart to you some spiritual gift to make you strong—that is, that you and I may be mutually encouraged by each other’s faith.”

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Statement of Limitation

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The project does not presume to have all of the answers to assist organizations to fully address all of the issues, expectations and demands placed upon those in (DC) ministries. While the project recognizes that these issues, expectations, and demands can and should be addressed; it reveals how these issues, expectations, and demands and the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) affect the mental, emotional, physical, relational, and spiritual aspects of (DC) ministries staff and their families, could be addressed through ‘self-care’ awareness training.

This ‘self-care’ awareness training could provide coaching on how to develop stress coping skills and practices to combat the stressors that these issues, demands, and expectations often bring. This ‘self-care’ awareness training could provide a biblically-based, hope-filled approach for both the (DC) ministries staff and their families that equips, encourages, and empowers, and if employed consistently, can also help them be successful in coping with the mental, emotional, physical, relational, and spiritual tolls that (DC) ministries could have on them and their families. The result would be that the (DC) ministries staff might enjoy a greater personal and professional fulfillment and success; thus, their families might enjoy a greater quality of life.

In addition, this ‘self-care’ awareness training could provide opportunities for additionally pastoral services of coaching, pastoral and/or referrals for professional counseling. Finally, it could provide the organizations that employ (DC) ministries staff with the necessary information needed to better address (DC) ministries staff training, morale, supervision, recruiting, retention and release issues. However, there is no guarantee that this project, if employed, would be successful in every organization, or with every (DC) ministries staff, and/or with every (DC) family.
Theoretical Basis for Project

Ministers are qualified by God, and called of God. He alone knows their hearts, and He chooses the men and women. He ordains them for the service to which He has called them. He knows how they will serve and where they will serve, and He knows the challenges they will each face while serving in the ministry. He knows how and when they may well become overwhelmed doing His work. He knows whether they will either turn from it or turn to Him in it and seek His wisdom, guidance, courage, strength, peace, and grace to endure. God knows whether they will serve only for a season, or continue serving as a chosen vocation. This knowledge, the existing research, and phenomenological experience reveals that those in (DC) ministries face daily the issues, demands, and expectation, as well as stressors that tax them mental, emotional, physical, relational, and spiritually. These challenges can take a deleterious toll on them as (DC) ministries staff, and their families.

The overall effect on these (DC) ministries staff and their families also takes a toll on the organizations that employ the (DC) ministries staff, concerning the recruiting, retention and releasing of (DC) ministries staff. Many organizations struggle to meet the staffing demands for (DC) ministries staff positions. Those who do fill those positions typically struggle with high turnover rates from 30% to 40% of (DC) ministries staff. The average number of years of time in service for (DC) ministries staff working in (RTC/F’s) is less than two years.9 This creates a recruiting, retention, and release cycle that can quickly overwhelm and/or exhaust the organization’s human resources, and training personnel, as well as pastoral counseling, management, and administrative support staff.

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Of equal concern is the tragic impact of this high turnover rate of (DC) ministries staff upon the children and/or youth in the care of organizations. The high turnover rate of organizations’ (DC) ministries staff often hinders the ability of these children and/or youth to establish the therapeutic relationships with (DC) ministries staff that is the very conduit for growth and change for children and/or youth in care. Many of the children and/or youth’s placement at an (RTC/F) often exceeds that of their (DC) ministries staff. There is a significantly tragic toll on the (DC) ministries staff, their families, the organizations, and the children and/or youth in care.

(DC) ministries staff are the front-line staff doing the day-to-day, round-the-clock work of ministering to those in the organizations’ care. Their role in providing (DC) ministries is crucial to an organization’s success, yet they are all too often under-rated and under-appreciated. Far too many organizations overlook the demands, expectations, and stressors associated with (DC) ministries, even though their ministry role can significantly affect the organization’s operational success or lack thereof.

It is generally accepted that the work of ministry is challenging on multiple levels for a plethora of reasons. In addition, it is accepted that the work of (DC) ministries in (RTC/F’s) working with children and/or youth in childcare has issues, demands, and expectations that few other “helping field” vocations include.\(^{10}\) The prevalence of these demands on the individual (DC) ministries staff and their families cannot be understated. These demands specific to those in ministry, combined with the demands of those serving in (DC) ministries have often had an even greater deleterious effect, as these demands are all too often exacerbated by the “levels of

care” required by the children and/or youth in care, as well as the expectations placed upon them by the organizations that employ them, and the various stakeholders involved. These same vocational stressors are present, as well as the mental, emotional, physical, relational, and spiritual aspects that are uniquely a part of (DC) ministries; thus, when combined they can have a significant impact upon the individual (DC) ministries staff personal and professional life.\textsuperscript{11} The toll of these stressors often manifests with deleterious effects on the mental, emotional, physical, relational, and spiritual aspects of their lives and that of their families.\textsuperscript{12} While these stressors are a part of ministry, these stressors specific to working in (DC) ministries in (RTC/F’s) in childcare add to those stressors those of burnout,\textsuperscript{13}, (STS),\textsuperscript{14} (VT), and (CF),\textsuperscript{15} and the toxic spill-over that often accompanies the work of (DC) ministries. These stressors should be addressed for the overall professional and personal fulfillment, and overall well-being of the (DC) ministries staff, as well as their families, and for their continued ministry success at their given placement of service.

It is also essential for the overall benefit of the organizations that employ (DC) ministries staff, the individual (DC) ministries staff, and their families that adequate resources to help


address these issues, demands, and expectations be made available before their deleterious toll is taken upon those in (DC) ministries, their families, and the organizations that employ them.

This approach seeks to combine “self-care” awareness training, coaching, biblically-based pastoral counseling, pastoral care/chaplaincy services, and pastoral counseling as well as working with the organizations to develop and implement employee engagement protocols to better minister to those in (DC) ministries and their families, as well as provide for the organization as a whole that employs (DC) ministries staff.

When these issues, demands, and expectations are addressed with ‘self-care’ awareness training, everyone wins. The individual (DC) ministries’ staff learns better ways to cope with the stressors that accompany these issues, demands, and expectations. Also, their families enjoy less of the toxic-spillover and reap the benefits of a healthier professional and personal work to life balance. The organization gains a better prepared, better equipped, and most likely more mentally, emotionally, physically, relationally, and spiritually stable (DC) ministries staff that can better cope with the issues, demands, and expectations, and stressors associated with the work. In addition, the organization can enjoy the benefits of better employee engagement, better management practices, and an overall better quality of work place environment. These combined efforts lead to the overall personal and professional fulfillment and well-being of the (DC) ministries staff, improved quality of life for him/her and his/her family, and also for his/her continued ministry success at their given placement of service; and a better overall quality of services provided for those in care. This leads to a higher retention of (DC) ministries staff and improved recruiting of quality candidates. Ultimately, the benefit is the consistency of services, and the quality of services provided for the children and/or youth in care. Thus, they gain a
better-prepared and better equipped, and better-balanced (DC) ministries staff who can provide a better quality of care.

Statement of Methodology

This thesis project and research study design employs a multi-step process. First, the author established a workable 500 mile geographic area of research for the study from the author’s current work/study location near Wilmington, NC. This roughly covers the areas of North Carolina, South Carolina, Virginia, Maryland, District of Columbia, Tennessee, Georgia, and parts of Alabama, Kentucky, and West Virginia. Then, the author identified those organizations within a 500 mile geographical area (of the author’s current work/study location), that provided (DC) ministries in a residential treatment center/facility or residential group home environment to children, youth, and young adults with ‘at-risk’ youth and/or behavioral and/or developmental disabilities; those (RTC/F’s) for childcare whose residential clientele has a minimum of 40 persons, and whose (DC) ministries staff is at a minimum of 15 persons. Then, the author reviewed a listing of organizations within that geographical radius to determine the 158 organizations that fit the stated criteria and were thus identified as potential candidates for contact to request their organization (DC) ministries staff’s participation in the research study. That number then became the initial pool of target organizations. That pool of target organization candidates was then further reviewed for how these organizations would meet the greater refined stated criteria and of the initial 158 total organizations; in total, only 35 total organizations were selected as potential target organizations. This became the final pool of target organizations to approach for participation in the online research survey and study.
Second, having identified those target organizations, the author will contact the CEO/President and/or Chief Operating Officer via certified mail, with a letter of introduction. The letter of introduction included: a.) the reason for contacting their organization, b.) the desire to utilize that organizations (DC) ministries staff’s participation in research, c.) the potential benefits of the summary of survey data to the organization, d.) a sample of the survey, e.) the researcher’s contact information, f.) a web-link to the online survey, and g.) an assurance of anonymity for all survey participants.

Third, the online survey portal will be monitored for 30 days following the mailing of the initial letter of introduction to see which organizations (DC) ministries staff have completed the online survey.

Fourth, if there is no online activity noted by a target organization within 30 days after the initial mailing, I plan to mail out a second or follow-up letter and make a telephone call to the leadership of those target organizations, requesting again that the organization's leadership reconsider the benefits of (DC) ministries staff’s participation in the online research survey. The intent would be to gain the participation of as many of the target organizations in the research study and online survey.

Fifth, the online survey portal will be again monitored for 30 days following the mailing of the second or follow-up letter to see which organizations (DC) ministries staff have completed the online survey.

Sixth, if after the second or follow-up mailing there is no activity by an organization, there will be no further attempts to contact that organization's leadership for their organization's
participation in the online research survey and study. The intent would be to gain the organizations’ participation in the research study and online survey. Those organizations that have not responded would have their organizational information removed from the online survey portal. The research study and online survey would then be closed except to those organizations that have already begun participation in the research study and online survey. The intent here would be to develop a research window that would allow for a timely completion of the research project. It is expected that only 10% of the 35 target organizations will respond, or (3) (RTC/F’s), and of those only approximately 50% of their (DC) ministries staff will voluntarily participate in the research study and online survey, or out of approximately (60) eligible (DC) ministries staff, only a total of (30) are expected to participate. Thus, the overall goal for the research study and online survey was adjusted to a minimum of (3) organizations; and/or (30) (DC) ministries staff.

Seventh, when the organization has agreed / given their authorization to have their (DC) ministries staff participate in the research study and online survey, they will then provide their organization’s (DC) ministries staff with the web-link to the online survey to participate in the online survey.

Eighth, the (DC) staff would then follow the web-link provided to the “Introduction” page, from where they will select from the “Drop-Down” the name of their organization. They will then be redirected to the “Informed Consent Information” pages, and then to a “Statement of Consent” page where they will be provided the option to “Take the Survey” or “Disagree” for their “Informed Consent Information” document completion. The (DC) ministries staff survey participant then follows the prompts to complete the online survey’s forty questions, which
should take no more than fifteen minutes to complete. The (DC) ministries staff survey participant, upon completing the online survey’s questions, will be directed to a survey completion page, which ends with a “Done” option. Once the “Done” option is selected, the (DC) ministries staff survey participant will be automatically logged off, and that individual’s survey is then finalized.

Ninth, to achieve anonymity for the survey participants, all (DC) staff participants of the organization who participate in the survey will be identified only by a sub-numerical identifier associated with the organization’s numerical identifier, thus creating and maintaining an anonymous survey portal for their staff’s participation in the survey. The sub-numerical identifier for these direct-care staff participants is identifiable only as attached to that of the organizational numerical identifier. No other identifier will be captured. The entire numerical identifier "string" would follow a type pattern, as the following example illustrates:

Organization: ABC, Inc.: ABC, Inc. (Organizational Identifier)
Staff: ‘Direct-Care’ (DC) Staff Participant: 001 (Individual Identifier)
Date of Survey: (April 1, 2015): 04012015 (Date Identifier)

The combined numerical identifier string would then be read as: ABC, Inc. 001-0401-2015.

All of the data retrieved from that numerical identifier would then be specific to that organization.

Tenth, all the data retrieved from that numerical identifier would then be specific to that organization. Yet, it could also enhance the findings for the overall research project. Further, the summary of data captured from the survey could be provided for the organization's leadership
contact (president, chief executive office, chief operating officer, vice-president of residential services, residential director, etc.) in an effort to generate further interest in services which could be provided to the organization that are intended to address these areas of concern as reported by the organization's (DC) ministries staff.

This thesis project and research study will keep the hard copies of the research study materials and online survey information, including the authorized “Informed Consent Information” forms (pages) and completed survey data received in a locked drawer and/or locked filing cabinet and the digital records of the data from the authorized “Informed Consent Information” and online surveys in a password protected computer file. Once the thesis project and research study is completed, these documents on file will be kept on file for three years and will then be destroyed.

The following overview examines how this thesis project and research study will be approached in each chapter:

Chapter One: The History Of ‘Direct-Care’ Ministries In Residential Treatment Facilities (RTF’s) In Childcare In The United States

This chapter outlines the historical nature of the work of (DC) ministries in the United States of America, from before 1800 to the present. It discusses its evolution, from orphanage to academies, schools, to (RGH’s) and/or (RTC/F’s). It also explores how in the early period of this country’s formation, the needs of dependent children, youth and adults were generally met through indenture, almshouses, or charity of neighbors. Smith, Eve P. “Orphanages.” Encyclopedia of New York State. Ed. Peter R. Eisenstadt and Laura-Eve Moss. Syracuse University Press, 2005. 1161+. Academic OneFile. Web. 24 Oct. 2015.
community to maintain families in their own homes; 2.) Farming-out, a system whereby individuals or group of paupers were auctioned off to citizens who agreed to maintain the paupers in their homes for a contracted fee; 3.) Almshouses or poorhouses, institutions established and administered by public authorities in large urban areas for the care of destitute children and adults; and 4.) Indenture, a plan for apprenticing children to households where they would be cared for and taught a trade, in return for which they owed loyalty, obedience, and labor until the costs of their rearing had been worked off. 17 Most of the orphanages in the United States were established by religious organizations during the eighteenth and nineteenth centuries.18 Later, following World War II, most orphanages in the United States were closing, leaving only a handful of orphanages remaining. However, during the Civil Rights movement, orphanages became associated with the substandard care of the children and youth in care, poor food and accommodations, and a lack of support services due to insufficient funding. A shift from the orphanage “congregate” style of dorm living to a more home/family “cottage” style living became the preferred approach toward residential childcare living. It was during the 1950s and 1960s, a period of intense scrutiny and criticism of residential childcare forced significant changes to occur. By the mid 1970’s, many of these orphanages had changed to become organizations that operate as (RGH’s), or (RTC/F’s). These organizations now provide residential care for many youth that in times past would have found a home in an orphanage.19 Today, the primary difference between (RGH’s) and (RTC/F’s) is the “levels of care” or


“continuum of care” provided for the clinical continuum of services, referred to as “milieu of services” for the children and/or youth in residential care. These levels of care followed along with many of the other changes that began after WWII. These changes in residential childcare led most orphanages in the United States to evolve into (RGH)’s and/or (RTC/F’s) that operate under a “level of care” model “continuum of care.” However, these changes required changes too of the staff working at these RTC/F’s), new training requirements began to evolve. Finally, this chapter also reveals the type of challenges faced by (DC) ministries staff as part of their work with children and/or youth in (RTC/F’s) in childcare today, that further exacerbate the issues, demands, and expectations that lead to high turnover rates. Those providing (DC) ministries in (RTC/F’s) in childcare servicing children and youth ages 1 to 21 often work with children and youth from widely diverse backgrounds of abuse and neglect. The children and youth also often struggle with the mental, emotional, physical, relational, and behavioral consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. These same children and youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’ requiring psychotropic medication use, as well as regular counseling and therapy. Revisions in the required training came as a result of the type of children and/or youth coming into (RTC/F’s) childcare. The mental, emotional,

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physical, relational, and academic and spiritual needs of children and youth in (RTC/F’s) today require far more demanding care. The issues, demands, and expectations on those working in (RTC/F’s) in childcare in (DC) ministries is equally demanding.

Chapter Two: The Challenges Associated With The Work Of ‘Direct-Care’ Ministry In Residential Treatment Facilities

This chapter examines the challenges faced by (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare. More specifically, this chapter reviews the issues related to the work of ministry, the demands specific to the work of (DC) ministries in (RTC/F’s) in childcare; and also the expectations placed upon these (DC) ministries staff by the organizations that employ them. This thesis, research study, and online survey seek to reveal how providing (DC) ministries in (RTC/F’s) in childcare working with children and/or youth exposes those working in (DC) ministries to the issues related to ministry work—always being on demand, always being on display, and always on-duty. Then there are those demands specific to (DC) ministries: Those providing (DC) ministries in (RTC/F’s) in childcare servicing children and youth ages 1 to 21 that often work with children and youth from widely diverse socio-economic backgrounds, ages, ethnicities, and genders who have experienced abuse and/or neglect. Too, these children and/or youth often struggle with the mental and emotional disorders, as well as physical, relational, and behavioral challenges resulting from their having witnessed and/or experienced violence, verbal, mental, emotional, physical and/or sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. These same children and/or youth often have histories of

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substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy. The children and/or youth who are able to operate with minimal supervision, as one would expect in a typical residential environment of a single-family home are considered “Level I.” Typically, these children and/or youth do not have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy, Level I children and/or youth do not typically enter into a (RTC/F’s) environment. The residential care needs of these children and/or youth are best met at a Level I “level of care”, which is often a foster-home setting. The primary difference between a foster-home setting and a therapeutic foster-home setting is that the latter operates at higher strata within the “continuum of care” and is considered the entry point for children and/or youth into residential treatment services.25

There are the four different strata within the continuum of care of residential treatment for children and/or youth: treatment foster-care (TFC), (RGH’s), (RTC/F’s), and Impatient Psychiatric Residential Treatment Facilities (PRTF’s). These strata are also referred to as the “levels of care” outlining the clinical “continuum of care” and “milieu of services” for the children and/or youth in residential care; these “levels of care” are at times referred to as Level

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25 Ibid.
II, III, IV, and (PRTF).\textsuperscript{26} The staffing structures may include family and program type settings or higher levels of care requiring greater levels of supervision and/or clinical care. The “levels of care” greatly depend on what is available at the time placement is needed, and what “level of care” would be most appropriate for the children and/or youth based on their demonstrated behaviors, DSM-V diagnosis, mental and emotional disorders, and their physical and/or educational needs.\textsuperscript{27} As many of these children have suffered abuse/neglect within their own families and, as a result, have a great deal of trouble adjusting to a family setting. These “levels of care”—“continuum of care,” “milieu of services” are meant to provide the appropriate “level of care” and services for the child and/or youth receiving services. Each “level of care” in (RTC/F’s) in childcare provide a “milieu of services” at various levels of supervision ranging from minimal to constant—‘sight and sound’ to clinical care with round the clock staffing care.\textsuperscript{28} In addition, the levels of care are equally dictated by the levels of cooperation by the children and/or youth in care. These levels of care range from the Level I (Low), which provides a structured and supervised “continuum of care” in a family or foster-care home setting.\textsuperscript{29} Level II (Moderate) provides a structured and supervised “continuum of care” where there are no locks, but the child needs a higher level of constant supervision to be maintained in the community.


where the children and/or youth in care are accepting of the treatment.\textsuperscript{30} Level III (High) provides a highly structured and supervised “continuum of care” where locks may be employed for added security. The children and/or youth in care need a higher level of constant supervision, and the children and/or youth in care are only minimally accepting of treatment.\textsuperscript{31} In addition, Level IV (Secure) provides a secure structured and maximum level of supervised “continuum of care” where there are locks and the children and/or youth in care need a higher level of constant supervision to be maintained in the community where the children and/or youth in care are not accepting of the treatment. In this setting, there is constant supervision by staff who are awake during times when the child is sleeping in order to maintain the child. Typically, Level III and IV “levels of care” in (RTC/F’s) are physically secure—locked down facilities. There are locks and the child needs a higher or maximum level of constant supervision to be maintained within the treatment facility/center with a higher level of clinical intervention than in a Level II facility. The children and/or youth in care at Level IV (RTC/F’s) and (PRTF) are not accepting of the treatment. Many of the children and/or youth in care at these “levels of care”, have manifested severe DSM-V diagnosed behaviors stemming from significant trauma related backgrounds, as well as backgrounds that include mental, emotional, physical, verbal, and sexual abuse and neglect.\textsuperscript{32} In addition, many of the children and/or youth coming into residential care have


\textsuperscript{31} Ibid.

\textsuperscript{32} Ibid.
stunted academic backgrounds due to frequent relocations, parental neglect, and/or truancy issues related to inadequate adult supervision and care.\textsuperscript{33}

As many of the children and/or youth in Levels II, III, IV, and (PRTF) “levels of care” are not always accepting of the treatment process a higher level of supervision is required, and often such security includes a “sight and sound” approach to begin the treatment process. In these ‘levels of care’: II, III, IV, and (PRTF), the children and/or youth may have histories of elopement from treatment facilities. As a result, the continuum of care and services provided for the children and/or youth in care: mental, emotional, physical, educational, and spiritual care must also be met in a secure setting provided by the residential provider.\textsuperscript{34} Typically, the treatment (therapeutic, psychiatric, psychological, medical, vocational, recreational, and educational) needs of children and/or youth in care at this level are so extreme that these activities can only be undertaken in a therapeutic context.\textsuperscript{35} These services are conducted in a manner that is fully integrated into ongoing treatment.

Chapter Three: The Stressors Associated With The Work Of ‘Direct-Care’ Ministry In Residential Treatment Facilities

This chapter builds on the previous chapter, while there are challenges unique to the work of (DC) ministries there are also expectations and stressors associated with the work of (DC) ministries in (RTC/F’s) in childcare can take a deleterious toll on the mental, emotional,


\textsuperscript{35} Ibid.
physical, relational, and spiritual well-being of the (DC) ministries staff and their families. These common stressors in “helping fields” vocations include burnout, (STS), (VT), and (CF).

In a level II, III, and IV (RTC/F’s) as well as (PRTF), (DC) ministries staff daily encounter behaviors from children and/or youth who have significant psychological, behavioral, and emotional disorders, as well as behavioral issues that bring them into care. (DC) ministries staff deal with behaviors ranging from the inability to follow directions, and/or conform to structure of school, home or community, violent arguments, self-injurious behavior, risk taking, sexual promiscuity, self-harm and suicidal actions, physical altercations, verbally aggressive and provocative and/or profane language and severe property damage incidents. The expectations placed upon (DC) ministries staff by the (RTC/F’s) that employ them are diverse. Often times (DC) ministries staff must also interact with Department of Social Services (DSS); and court appointed personnel such as Guardian Ad Litem’s (GAL’s), Probation and/or Parole Officers (PO’s); and engage with school officials and teachers over frequent school related issues; as well as family and/or legal guardians. In their role as a surrogate-parent, (DC) ministries staff have a number of duties in providing care and supervision of these children and/or youth. In addition to providing for the children and/or youths care, (DC) ministries staff must also remain vigilant for a moderate to high risk for children and/or youth abusing medications, acting in self-harm, sexually victimizing others, and eloping. Finally, as there is also an increasing likelihood that children and/or youth coming into care will struggle with DSM-V diagnosed behavior issues, which are usually in the form of mental or emotional disorders related to their trauma related

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experiences, and moderate to severe behavioral challenges, they may also suffer from severe affective, cognitive or developmental delays/disabilities. These all require (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare to maintain a constant awareness of the status of the children and/or youth in care, and keep those in care in constant ‘sight and sound’ supervision. The work of (DC) ministries staff in (RTC/F’s) in childcare have expectations placed upon them by the organizations that employ them. Those that work as (DC) ministries staff in residential childcare facilities have what is considered to be one of the most difficult and emotionally exhausting positions in the “helping fields” careers. These expectations often include working with insufficient training to meet the demands of the types of children and/or youth in care, inadequate staffing, undesirable work schedules or excessively long work shifts, low salaries, poor benefits, poor job conditions, ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high (DC) ministries staff turnover. The issues, demands, and expectations combined create an environment ripe for (DC) ministries staff to struggle with the stressors associated with this type of ministry work. Existing research demonstrates that the stressors associated with the (DC) ministries work in (RTC/F’s) in childcare include burnout, (STS), (VT), and (CF), and the toxic spillover that often accompanies the work of (DC) ministries. In addition, how these issues and demands, combined with those


expectations placed upon them by the organizations with which they are affiliated, can create an environment that is detrimental to the individual (DC) ministries staff, and their families.\textsuperscript{40}

Many studies have been conducted on the negative impact that workplace expectations have on those working in (DC) positions in (RTC’s) and/or (RTF’s) in childcare. These studies reveal that these additional expectations and subsequent stressors include insufficient training to meet the demands of the types of youth in care, inadequate staffing, undesirable work schedules or work shifts, low salaries, poor benefits, poor job conditions, undefined job responsibilities, a lack of appropriate supervision, poor communication, insufficient resources, and high (DC) ministries staff turnover.

In addition, there are the stressors placed upon (DC) ministries staff of unrealistic expectations and demands placed upon them by the organization’s mid-level management and senior administrative staff, the courts, social workers, guardian ad litems, school officials, and even parents.\textsuperscript{41} This often exacerbates the already overwhelmed (DC) ministries staff with thoughts and feelings of being mentally, emotionally, physically, relationally, and spiritually exhausted; thus, they can become ideal candidates for burn-out, boil-over, and burn-up. Combined, these expectations alone would be enough to discourage even the most hardy and well-intentioned individual to reconsider their level of commitment to an organization. Added to the issues associated with the work of ministry, in addition to the demands specific to (DC) ministries work, these issues, demands, and expectations create an environment that is


\textsuperscript{41} Ibid.
detrimental to the professional and personal success of (DC) ministries staff, their families, and the overall success of the organizations that employ them. These stressors can be addressed with “self-care” awareness training for (DC) ministries staff for their overall personal and professional fulfillment and well-being, as well as their families, and also for their continued ministry success at their given placement of service, as well as the continued success of the organization’s mission of working with the children and/or youth in care. Additionally, organizations that operate residential childcare centers must also reconsider the importance of employee-engagement policies, and work to recruit and retain quality staff.

Chapter Four: The Current Research, Phenomenological Research, And The Online Survey Research Data And Analysis

This chapter supports the preceding chapter’s historical research to date, the phenomenological research, and the online survey research data and analysis for this thesis. Through the combined research of the current (existing research) and the phenomenological research, statistical data was developed from this research study, and the results of the online survey of (DC) ministries staff working in (RTC/F’s) in childcare were used to support this thesis. The statistical data developed from the research study and the results of the online survey revealed the prevalence of the issues associated with the work of ministry, the specific demands of working in residential treatment facilities in childcare, and the expectations placed upon (DC) ministries staff by the organization’s that employ them. It is these issues, demands, and expectations that foster an environment rife with the stressors of burnout, (STS), (VT), and (CF), which are detrimental to the (DC) ministries staff’s personal and professional well-being. While the prevalence of these issues, demands, and expectations may vary from organization to organization, this research study and its results from the online survey reveal that the responses
follow a well-established norm. The issues, demands, and expectations create an environment that, if left unaddressed, contributes significantly to the stressors of burnout, (STS), (VT), (CF), and can ultimately lead to the departure of (DC) ministries staff from their chosen field of ministry and/or organization.

Chapter Five: The Recommended Biblical ‘Self-Care’ Training And Practices, And Pastoral Counseling Interventions For ‘Direct-Care’ Ministries Staff

This chapter brings the proposed recommendations for directed ‘self-care’ awareness training and recommended ‘self-care’ practices. It also addresses the need for regular ‘self-care’ coaching and pastoral counseling interventions. When combined, these work together to provide (DC) ministries staff with the resources needed to better deal with the mental, emotional, physical, relational, and spiritual issues associated with the work of ministry, the specific demands of working in residential treatment facilities in childcare, and the expectations placed upon (DC) ministries staff by the organizations that employ them.

(DC) ministries in (RTC/F’s) in childcare have gone through many changes since its beginnings in the United States nearly three hundred years ago. The constants in (RTC/F’s) in childcare have been its (DC) ministries staff, and also its purpose, i.e., to care for children and youth who otherwise would have few other alternatives.

Chapter Six: Conclusion

This final chapter summarizes the proposed recommendations for directed ‘self-care’ awareness training and recommended biblical ‘self-care’ practices, and also provides for the importance of a combined approach of ‘self-care’ awareness training, the practice of these ‘self-care’ techniques, and organizational employee-engagement efforts. The preponderance of evidence from prior research demonstrates, as does this research study that individual ‘self-care’
training and practices alone are insufficient to address the needs of those providing (DC) ministries that are encountering the deleterious effects of burnout, (STS), (VT), and (CF) as a result of their workplace stressors. The overall impact of these issues, demands, and expectations placed on (DC) ministries staff is that there is a toxic spillover, which in turn has a deleterious effect on the spouses, and/or families creates an environment for both professional and personal failure. Research reveals that burnout, (STS), (VT), and (CF), while it cannot be avoided entirely for those working in “helping fields”, it can be mitigated, and even alleviated to some degree with proper ‘self-care’ practices and organizational employee-engagement practices, with modifications to recruiting, training, and supervision practices. These practices result in longer (DC) ministries staff retention, with staff enjoying an overall better quality of life both professionally and personally for the individual, their spouses, and their families. It also provides for a better overall workforce environment, and the results provide a better quality of services to the children and/or youth in care.

A combined approach also addresses the need for regular ‘self-care’ awareness training, mentoring and team coaching, pastoral counseling interventions, and/or referrals for clinical care. This combined approach works together to provide (DC) ministries staff with the resources needed to better deal with the mental, emotional, physical, relational, and spiritual issues associated with the work of ministry, the specific demands of working in residential treatment facilities in childcare, and the expectations placed upon (DC) ministries staff by the organizations that employ them.

**Review of Literature**

The English word “ministry” is defined in the Merriam-Webster dictionary as:
“min·is·try articulated as the noun “ˈmi-nə-strē”: the ministry: “ministry” includes those who perform the work of ministry both within the context of church/chaplaincy/para-church ministry vocations; and those working in “helping” fields ministering to others in various vocations in direct-care “helping” positions. ⁴²

Romans 1:8-12 (NIV) is the premise for this thesis, research study and online survey, which could then become the basis for a directed ‘self-care’ training and pastoral care ministry to those working in (DC) ministries staff positions in (RTC/F’s) in childcare. This directed ‘self-care’ training would focus on providing ‘self-care’ training in five aspects of the whole person: Mentally, Emotionally, Physically, Relationally, and Spiritually.

The intent of this directed “self-care” training for (DC) ministries staff working in (RGH’s), (RTC/F’s) is two-fold. First, it would provide “self-care” strategies for (DC) ministries staff to address the stressors of burnout ([STS], [VT], and [CF]) that are often associated with the issues, demands, and expectations common to the work of (DC) ministries working with children and/or youth in residential care. Secondly, it would provide the organizations that employ (DC) ministries staff working with children and/or youth in residential care with the information and tools to address the stressors associated with the issues, demands, and expectations associated with the work of (DC) ministries in residential childcare. From a pastoral counseling perspective, and with the intent on providing a helping ministry to those in this “helping field,” this directed “self-care” training would promote the importance of living a balanced life in terms of the mental, emotional, physical, relational, and spiritual factors, in addition to being healthy and also in harmony with the Word of God. It is understood and appreciated that not everyone working as (DC) ministries staff working with children and/or youth in residential care are

adherents to the Judeo-Christian faith, believers in Jesus Christ, or the teachings of the Bible. The strategies of this directed “self-care” training would of a benefit to any (DC) ministries staff as they seek to maintain a healthy and balanced personal and professional life, and to the organizations that employ them to address (DC) ministries staff recruiting and retention issues.

The Bible provides an aim, which is to grow in love with a pure heart, a clear conscience, and a genuine faith—a Christlikeness; as found in 1 Timothy 1:5 (NLT). 43 Such a balanced and healthy life led by the Holy Spirit of God produces the fruit of the Spirit of God in a believer’s life: love, joy, peace, patience, kindness, goodness, faithfulness, gentleness and self-control (Galatians 5:22-23 (NLT)). 44 This balanced and healthy life, however, requires daily ‘self-care’ practices and healthy boundaries. Proverbs 25:28 (KJV) addresses a life without such as a city that is broken down, and without walls. 45 ‘Self-care’ is modeled in the life of Christ. Mark 6:31 (NLT) is one such example, where Christ observed ‘self-care’ practices and established boundaries. 46 In addition, boundaries are recorded for believers in Exodus 20:10-11 (NLT). Here, the Bible reveals God’s intention for man to establish “self-care” practices and boundaries to maintain wellness. 47 ‘Self-care’ extends to the total person—mentally, emotionally, physically, relationally, and spiritually.

Coming from a ‘mental’ perspective, in addressing the mental ‘self-care’ aspects of a person’s life, the Bible reveals insights that what a person thinks on, and how believers think


44 Ibid. 1505.


47 Ibid. 102.
about themselves, and others is key. Romans 12: 1-3 (NIV) is a key text for believer’s to be transformed by the renewing of a believer’s mind; and to be able to test and approve what God’s will is. This type of biblically sound and sober thinking provides for a realistic self-assessment, which is neither self-denigrating, nor self-diluting. It provides for a proper biblical understanding of who and what a person is in God’s perspective—sinners, in need of a Savior and how God is a witness in a believer’s life. Acts 23:1 (ESV)

Emotionally speaking, ‘self-care’ includes how a person responds to what they think, feel, and act on their experiences. Scripture teaches this in Philippians 4:6-9 (NIV). Too, Scripture teaches that believers are to be filled with and led by the Holy Spirit of God, rather than to be led by mere emotion, but to be humble, sober-minded, and resisting the urges to succumb to their anxieties, doubts, and fears. The Bible reveals this in 1 Peter 5:6-11 (NIV).

Concerning physicality, how we think and feel affects a person’s behavior. Scripture teaches this in Matthew 12:33-37 (NIV). ‘Self-care’ also includes being mindful in all that person does, mindfulness in everything, as though it is done for Christ in 1 Corinthians 10:31 (NIV).

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51 Ibid. 1011.

52 Ibid. 813-814.

53 Ibid. 955.
Relationally speaking, in how a believer responds to others, even those who make their lives difficult. Matthew 5:44 (NIV) teaches believers to love their enemies, and pray for them.\(^{54}\) Love is the truest revelation of the transformation initiated by God in the human heart. How a believers respond to others in love is the hallmark of genuine Christ-likeness, as modeled in Luke 6:27-31 (NIV).\(^{55}\) Godly love is demonstrated in the genuine compassion, mercy, and grace believers afford others, as they themselves have received from God. Christ’s teachings reveal that believers should love their enemies, do good to them, and lend to them with no expectations; also, it is important to be merciful, and not to judge or condemn, but rather to be forgiving, gracious, and generous in their actions towards others, as found in Luke 6: 35-38 (NIV)\(^{56}\) This love for others is the second of the two great commandments of God. Believers are to love God, and love others, as commanded in Matthew 22:36-40 (NIV)\(^{57}\) This love for others would become the identifying characteristic of all true believers, as Jesus revealed in John 13:34-35 (NIV)\(^{58}\) However, love must be genuine, not insincere, or self-serving. Believers are to love good, and hate evil. To be so genuinely concerned for others, this love compels a believer to act on behalf of others well-being, putting others needs before their own. When believers love this way, they never lack their initial zeal for the Lord, and recognize that when they serve others, they are serving Christ. This enables believers to maintain their spiritual fervor, their joyful hope, their patience in affliction, and faithfulness in prayer. This empowers believers to share


\(^{55}\textit{Ibid. 859-860.}\)

\(^{56}\textit{Ibid. 860.}\)

\(^{57}\textit{Ibid. 824.}\)

\(^{58}\textit{Ibid. 899.}\)
with the Lord’s people who are in need, and to practice hospitality. This empowers God’s people to bless those who persecute them. Rejoice with those who rejoice; and mourn with those who mourn. Also, living in harmony with one another breaks down the barriers of pride and makes believers willing to associate with people of all socio-economic strata. God’s Word commands believers not to be conceited or haughty towards others. It teaches believers to not repay anyone for the harm they have done with like treatment. God’s Word teaches us to be careful to do what is right in the eyes of everyone, and as far as it is possible, as far as it depends on you, live at peace with everyone, as revealed in Romans 12: 9-18 (NIV) 59

   Spiritually, in how a believer responds to God…. Believers are to worship God with their total being, heart, soul, mind, and strength. This biblical teaching is the first and greatest commandment. And the second greatest command is to love others as they love themselves, as revealed in Matthew 22:36-40 (NIV) 60 Believers demonstrate the genuineness of their love for God, and Christ’s Lordship in their lives by their obedience to His commands in John 14:15, 21, 23-24 (NIV). 61

   Those in (DC) ministries in (RTC’s) and/or (RTF’s) in childcare provide an invaluable service on multiple levels of for society. They provide residential treatment care for children and/or youth that are viewed as a burden on their families, friends, communities, and society as a whole. They give of their time, talent, and treasure to society; the reliance upon those who do the work of ministry is great, societies care for them should be as well, caring for them as if for


60 Ibid. 824.

61 Ibid. 900.
Christ mentally, emotionally, physically, relationally, and spiritually; as Scripture teaches in Matthew 25:40 (NIV)  

Books


This source is a good resource for exploring the history of (RTC/F’s) in childcare in the United States from its inception to the present day. It establishes a historical connection between orphanages and (RTC/F’s).


This book provides the pastoral counselor and/or Christian counselor with the means to integrate a Christ-centered approach with contemporary psychology and 21st century therapeutic approaches.


The author provides supportive and insightful information on dealing with burnout, and how internal and external factors may contribute to increased risk for burnout. The author also addresses how active coping is as important as interventions, which may be individual or organizational related, or a combination and an interaction of the two.


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This source provided additional information about residential care of children and/or youth. Specifically providing information on the average length of stay for children and/or youth in residential care facilities, the degree of disturbance and types of mental and emotional disorders and/or behavioral challenges and patterns of resident’s behavior faced by (DC) ministries staff.


This source provides additional supportive information about the daily issues, demands, and expectations on (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare.


This book provides additional insight into the “helping fields” vocations and how those working in these vocations are particularly susceptible to burnout, (STS), (VT), and (CF) because of a loss of idealism.


This work is an excellent resource for those seeking to provide Christian counseling to those seeking counseling and care that is both biblically based and provides theoretical approaches that are based in research, theory, and the successful practice of Christian counselors. It provides counseling advice and recommendations for approaches that are specifically driven to assist the pastoral counselor and/or Christian counselor with the means to provide adequate ‘soul-care’ for those in need.

This source is a great resource for those seeking to provide pastoral counseling and/or Christian counseling. As a biblically based comprehensive integrated resource, this book provides insights in helping those seeking care with personal, emotional, grief, loss, and trauma issues.


This book is an excellent resource for pastoral counselors and/or Christian counselors seeking to help those seeking care for all manner of issues. In addition, the book provides the foundations for Christian counseling, as well as the various modes and applications of Christian counseling.


This work is a great resource for those who seek to provide pastoral care and counseling to those who suffer from issues that may result in an inaccurate manner of thinking, feeling, and responding to God, His Word, and the Holy Spirit’s leading, as a result of an attachment injury formed in their early childhood. The book provides a strong spiritual argument for how individuals develop their attachment/relationship styles toward God based on the well-established “Attachment Theory” proposed originally by John Bowlby and championed by Ainsworth, Main and Solomon, Johnson and Wiffen, and others. The book follows a logical progression, provides an end of chapter reflection, Scriptural support, research, and a plethora of related quotes from a variety of sources.

This classic work is also a great resource as it aids the counseling pastor and Lay people in understanding the importance of establishing appropriate biblically based boundaries in life. How establishing boundaries both protects that which should be valued, and learning in order to grasp how violating those boundaries or failing to establish appropriate boundaries can have a deleterious effect on one’s life and those around them.


This author writes a resource for those seeking to provide pastoral care and counseling to those who suffer from relationship issues, helping them to learn how to rebuild healthy relationships. This is accomplished whereby the pastoral counselor facilitates the releasing of the power of God through their lives into the hearts and souls of those in care, in such a way that they understand enter into a kind of relating that only the gospel makes possible; a kind of relating that Crabb calls connecting. The book contends that this kind of relating depends entirely on deepening fellowship with Christ, which then spills over onto others with the power to heal their relationships, and change their lives. The book outlines the need for an increasing dependence upon Jesus Christ, and the leading of the Holy Spirit into experiences in the desert, impenetrable darkness, unexplained difficulties, and facing the damage that selfishness has caused others; this helps us identify those bad urges that impede connection with God and others.


The author provides supportive information on the history of residential childcare in America from its early colonial times to the present day. It outlines the decline of the “congregate plan” of the orphanages and institutional care in the early 1900s for the more home-like “cottage plan” of residential care.

This book provides insights into the work of a (RCW), including the types of group care, the demands and daily routines, types of children and/or youth in care, their mental and emotional disorders, and behavioral challenges, and the demands specific to the work of (DC) ministries staff working in residential care.


This source provided additional supportive information on residential childcare staff burnout, and recommendations to prevent staff burnout.


This resource provides insights that define and clarify the immediate and long-term consequences of highly stressful events, while it also provided insights into the historical, theoretical, and empirical grounding for the treatment of (CF), (STS), and (VT).


This author provided additional historical information on residential childcare in America from orphanages in an institutional model of care, to its evolution to residential care with its array of services and strategies of care.

This work is a great resource for the pastoral counselor seeking to help others rediscover the spiritual disciplines that lead others into a greater intimacy of relationship with God and provide for a return to a vibrant and maturing spiritual life ‘in Christ.’


This resource provides historical information on the institutional care of children and youth in America from its colonial period to the Great Depression; in reviewing both, the book states the causes that led to their being placed into care and the types of care provided. This book provided additional information on the history of residential childcare facilities in the United States and the evolution of orphanages into (RGH’s) and (RTC/F’s) and the societal and governmental changes that were the catalyst for this change.


Author Tim Hacsi wrote the chapter in *A Brief History of Child Welfare* that provides additional information on the topic of the history of the child welfare system in the United States. The editors, Eve P. Smith and Lisa A Merkel-Holquim, combine the writings of several authors to provide the reader with the history, examples and practices of the child welfare system in the United States from the Revolutionary War to its writing in 1996.


This resource provided information about the importance of organizations recruiting and then retaining, and providing support for residential childcare staff.

The authors offer a great overall quick reference guide to assist those providing pastoral counseling and care to people suffering with a plethora of personal issues. This book provides not only a guide of what the counseling may present, but it also offers those seeking to provide appropriate pastoral care and counseling with the recommendations for potential therapeutic approaches.


This resource provided additional historical information on residential childcare in America and the development of the children’s home.


This seminal work by Christina Maslach, a renowned researcher, author, and expert on the topic of burnout, reveals how to recognize, prevent, and cure burnout syndrome for those in “helping” professions.


These authors continue to build on their seminal research and work on burnout. In this work, the authors have expanded published material to include their primary research tool and the widely used Maslach Burnout Inventory, which is a tool that individuals can utilize to determine their levels of exposure to the stressors that lead to and contribute to burnout.


The authors provide an intelligent argument against a commonly held position that employees are solely responsible for their mental, emotional, physical, and relational behaviors that
contribute to their burnout. This insightful work by Maslach and Leiter identifies organizations as the chief source of job related stressors, and where the accountability for job burnout should rest.


The author outlines the historical nature of the work of (DC) ministries in the United States of America, from before 1800 to the present, and its evolution from orphanage to residential treatment facility. It reveals how in the early period of this country’s formation, dependent adults, youth, and children were treated alike and were generally handled in one of four ways: 1) Outdoor relief; 2) Farming-out; 3) Almshouses or poorhouses; and 4) Indenture.


This work is a dynamic resource for pastoral counselors and counselors who seek to provide those who come to them for biblically based counseling that is thoroughly comfortable within the interwoven complexity of the psychological, theological and spiritual context of working with the whole of the person to provide appropriate pastoral counseling and/or Christian therapeutic care and counseling.


This resource provided a dictionary reference for the words “minister”, and “ministry” and was an excellent tool for capturing word definitions, synonyms, and antonyms for greater word appreciation, accuracy, and vocabulary increase and usage.

This author provides historical information on residential childcare in America from its early colonial times to present. This covers the period prior to the rise of the “congregate plan” of the orphanage as the primary institution for residential child care, to the “cottage plan” of residential care with a more homelike setting of (RGH’s), and (RTC/F’s).


This book provided additional information on the history of residential childcare facilities in the United States and the evolution of orphanages into (RGH’s), (RTC/F’s)


The author examines the root cause of spiritually unhealthy people, which largely stems from what lies beneath the surface of their emotionally unhealthy lives. It addresses how for all the emphasis today on spiritual formation, church leaders rarely address what spiritual maturity looks like as it relates to emotional health, and how for this reason many people remain emotionally unaware and socially immature. While not discarding the importance of professionally trained Christian counselors, it argues that the church should be the primary vehicle for spiritual growth and emotional maturity. The book also examines how ‘emotional’ issues have been referred to the therapist’s office, and how only those ‘spiritual’ problems are counseled in the church. Yet, the two are inseparably linked and critical to a fully mature and biblical discipleship. The book illustrates that the key to achieving biblical discipleship lies in developing a new paradigm on how to view how God speaks through emotions just as much as
he speaks from Scripture, prayer, sermons, godly counsel, music and circumstances to develop our spirituality.


This writer provides those in “helping-fields” with clear explanations of the causes of practitioner stress and provides self-care strategies to mitigate and/or remedy work related stressors.


These authors provided information about the continuum of care; specifically, what is “milieu” and how “milieu” is involved in providing a continuum of care for children and/or youth in residential childcare facilities.


This work combines Swenson’s experience as both a physician and a believer in Jesus Christ. The book provides the reader with an easy to read work that helps the reader identify the causes of overload—the lack of margin in these areas, and equally importantly, how to remedy the lack of margin and regain an appropriate balance of margin in one´s lives. Swenson asserts that marginless living is a deficit of margin in emotional, physical, financial, and time reserves.

These authors provided additional supporting information about the work of the (RCW) working with emotionally disturbed children and/or youth in residential childcare in therapeutic milieu.


This sacred book—God’s Word, _The Holy Bible_, in its various translations, is the source for all godly living. It is the definitive source for teaching, for reproof, for correction, and for training in righteousness, in that every person who places himself or herself under its authority may be complete, lacking nothing, and equipped for every good work that God has called them to for His glory, and the good of others.


This author provides additional information on recommended ‘self-care’ strategies and practices. These ‘self-care’ strategies cover the many facets of a person’s life; however, the strategies are divided into external (outer) environments and internal (inner) environments to reduce stress.


This resource provided additional information about the challenges and complexities of the daily work life of (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare.

This source provided additional supporting information on the variety of “continuum of care” or “levels of care” in long-term residential treatment for children and/or youth with mental, emotional and/or severe behavioral issues requiring out-of-home residential treatment and care.


This work combines the expertise and experience of a seasoned ministry professional, and it also provides those who seek to learn how to navigate the issues associated with the work of ministry and avoid ministry failure. The lessons available in this book are a great resource for those seeking to provide pastoral counseling to those who are also in ministry.

**Journals**


Anderson’s dissertation on pastoral burnout and marital satisfaction was a great asset. The dissertation provides insight into the issues faced by those in the ministry. Unlike other ‘helping field’ professions, the work of ministry has its unique issues. This book provides those who minister to others in ministry with insights that help them understand that this issues are a common experience in ministry.


This journal article outlines the type of children and/or youth encountered in (RTC/F’s) in childcare by (DC) ministries staff today, particularly regarding how those providing (DC)
ministries in (RTC/F’s) in childcare servicing children and youth ages 1 to 21 often work with children and youth from widely diverse backgrounds from abuse and neglect. The article also discusses how these children and/or youth often struggle with the mental, emotional, physical, relational, and behavioral consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. Also, the article looks at how these children and/or youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy. This article reveals some of the demands placed upon those in (DC) ministries.


These authors provide additional support for how burnout has been linked to (DC) ministries staff turnover, absenteeism, and reduction in the quality of services, as well as numerous physical and psychological disorders, and the disruption of interpersonal relationships.


Chandler’s journal article outlines some of the research, which indicates that the stresses of ministry can be severe. The toll on the mental, emotional, physical, relational, and spiritual faculties of those in ministry and their families can be significant. Citing other professionals, this article reveals the stressors on those in ministry. Particularly: (a) inordinate time demands; (b) unrealistic expectations, (c) isolation; and (d) loneliness. This article concludes by stating that because of these stressors, pastors ‘personal lives may become severely imbalanced, and
their spiritual lives ironically dry. These four concerns are well-established risk factors linked to pastoral work and have generated questions about practices that might mitigate pastoral burnout.


This article provided additional support for factors that contribute to the turnover of (DC) ministries staff working in (RTC/F’s) working with children and/or youth in childcare.


This article provides insights into (DC) ministries’ staff retention and turnover in residential treatment centers, including average annual turnover rates, the nature of (DC) work, and its challenges working with children and youth. The article reviews the characteristics of staff that are prone to burnout, (STS), (CF), and/or (VT), and those that are less prone. In addition, it covers how organizations can retain (DC) ministries’ staff, and the characteristics of (DC) staff that organizations should seek to recruit and retain.


These authors provide additional information on the risk of compassion fatigue among (RCW’s) in residential childcare, and the self-care practices employed to offset the effects of burnout, and compassion fatigue (CF).

This seminal work by the author coined the term “burn-out” and established the initial research on the topic of burnout, its causes, and its impact on the mental, emotional, and physical aspects of the individual.


This journal article provides support for how institutional factors contribute to burnout. While there are a wide range of institutional factors believed to contribute to burnout, it is believed that there are some key issues, such as autocratic administrative style, limited opportunities for promotion, lack of autonomy, lack of appreciation or rewards (salary, vacation time, etc.) may lower self-esteem over time. Also, cost-effectiveness measures that lead to understaffing and/or high caseloads may undercut one’s ability to properly perform one’s functions, thus lowering ones’ sense of self-efficacy. This journal article examines how burnout tends to build-up relatively slowly across time; with some studies indicating it may take years to develop, yet how many studies have used time measures without looking at the actual factors that contribute to burnout. This journal article argues that two of the most commonly used time measures in research on burnout are years in the same position and years in the same profession.


Jackson’s and Maslach’s journal article provides additional insights in how work-related stress can spillover from ones professional life into their personal life and have a detrimental effect of their relationships with family members.

These authors provided insight into the various “levels of care” for children and/or youth with from and entry-level foster-care setting to (RGH), to (RTC/F’s) to (PRTF’s).


This journal article provides additional information on the importance of developing coping mechanisms to better deal with the stressors associated with the work of ministry.


This journal article provides survey results from and international research study of child and youth care workers revealing insights into (DC) ministries staff worker profiles, working conditions, and practices.


These authors provide the investigated factors that affect (DC) ministries staff coping strategies when working with high demands clients that often lead to burnout. Their work demonstrated the levels of emotional exhaustion (EE), depersonalization (DP), and personal achievement (PA) in (DC) ministries staff surveyed.

These authors provide insight into the continuum of care in residential care for children and/or youth. They cover costs of care, assessments, and placement based on Children’s mental health needs using the Child Severity of Psychiatric Illness (CSPI) and/or DSMN-IV tools to measure and assess psychiatric symptoms, risk factors, and functioning level of pathology, and whether the behavior was recent, and acuity of risk behavior.


This additional journal article provided by one of the pioneers in the research of burnout discussed the impact of its three dimensions: emotional exhaustion, cynicism, and a sense of inefficacy on the individual, their families, and organizations. Further, the authors provide additional insights and support for continued research and early intervention strategies in the treatment for burnout among those working in human service fields.


The authors provide additional insights into the stressors of workplace related burnout of professionals working in “people-work” also known as “helping fields.” This resource provides additional supporting information on how the toxic spillover from these stressors culminates in Burnout, which is a syndrome of the combined effects of emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA), which affects the individual, the organizations that employ them, and ultimately those in care.

In this journal article, the authors review the past twenty-five years of international research on the topic of burnout, the new conceptual models for treatment, the current focus on engagement, the positive antithesis of burnout, and the emerging interventions to alleviate burnout.


Pazaratz’s journal article provides supportive information on the job description for (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare.


Pector’s journal article provides statistics and research data from a 2002 study on ministerial health and wellness. The study revealed that a significant number of clergy struggle with personal issues ranging from health related issues to relationship issues resulting in divorce, to mental and emotional issues resulting in burnout. How the three dimensions of burnout experienced regularly by those in ministry often lead to: emotional exhaustion (EE), depersonalization (DP), and reduced personal accomplishment (PA) which leads to disillusionment, conflict, loneliness and depression. Many subsequently leave the ministry because of poor denominational support, poor health and inadequate support from their families.


This author provided additional information about the taxing nature of the (DC) ministries staff role in residential care work, and the organizational practices that contribute to low staff retention and staff turnover.

These authors provided supportive information into the stressors associated with (DC) work in residential childcare, and the coping strategies utilized by individual staff, co-workers, and the organizations that employ them.


This resource provided information into the “levels of care” within the “continuum of care” of residential child care from the least restrictive forms of care in foster-care, to the highest “level of care” and most restrictive form of care in a (PRTF). This resource also provided the high cost of treatment for children and/or youth in (RTC/F’s) identified it as the highest cost of the four “levels of care” within the continuum of care in the residential childcare milieu of services.


This journal article provides a brief outline for the formation of long-term residential care for children and youth in America, from the establishment of orphanages to (RGH’s), (RTC/F’s).


These authors provided supporting information on the causes of burnout, (CF), (VT), for Child Welfare Workers.

This article provides supporting information into the detrimental effects of burnout, (STS), (VT) and/or (CF) on (DC) ministries staff on their spouses, and families—their social support systems, as well as their co-workers, and the organizations that employ (DC) ministries staff.

Electronic Sources

“Compassion Fatigue” Accessed April 14, 2015 at the Compassion Fatigue.org website at:
http://www.compassionfatigue.org/pages/healthprogress.pdf

“Levels of Residential Care.” Accessed March 2, 2015 at the Alliance Behavioral Healthcare / Durham SOC Care Review website:

“Perspectives on Residential and Community-Based Treatment for Youth and Families.” Accessed May 29, 2015 at the Magellan Health Services / Magellan Health Services Children’s Services Task Force website:

“Secondary Traumatic Stress” Accessed April 13, 2015 at The National Child Traumatic Stress Network website at:
http://www.nctsn.org/resources/topics/secondary-traumatic-stress

“U.S. Department of Labor: Direct-Care Workers In Residential Childcare Statistics.” Accessed July 24, 2015 at the U.S. Department of Labor website at:
CHAPTER 1
RESIDENTIAL ‘DIRECT-CARE’ MINISTRIES IN CHILDCARE IN AMERICA—A BRIEF REVIEW: FROM ORPHANAGES TO RESIDENTIAL TREATMENT FACILITIES

The History Of Residential Childcare In America

‘Direct-Care’ (DC) ministries have had a long and varied association with residential treatment centers/facilities (RTC/F’s) in childcare. The historical nature of the work of (DC) ministries in the United States of America, from before 1800 to the present, and its evolution, from orphanage to residential group homes (RGH’s), or (RTC/F’s) is fascinating and varied. In the early period of this country’s formation, the needs of dependent children, youth, and adults were generally met through indenture, almshouses, or charity of neighbors.¹

In the early period of this country’s formation, dependent adults, youth, and children were treated alike and generally handled in one of four ways: 1.) Outdoor relief: a public assistance program for poor families and children consisting of a meager dole paid by the community to maintain families in their own homes. 2.) Farming-out: a system whereby individuals or group of paupers were auctioned off to citizens who agreed to maintain the paupers in their homes for a contracted fee. 3.) Almshouses or poorhouses: institutions established and administered by public authorities in large urban areas for the care of destitute children and adults. 4.) Indenture: a plan for apprenticing children to households where they would be cared for and taught a trade, in return for which they owed loyalty, obedience, and

labor until costs of their rearing had been worked off. Additionally, dependent children and youth were provided for by relatives, neighbors, and churches officials. In addition, there were a few private organizations established at this early time. However, the most often used avenue of care for orphaned children until the ages of eight or nine were the almshouses, and thereafter they were placed into indentured care until they reached maturity. After this, the use of foster parents by governmental agencies to provide long-term residential housing for these impoverished children and/or youth became an increasingly attractive approach. Most of the orphanages in the United States were established by religious organizations during the eighteenth and nineteenth centuries. The provisions of care in most orphanages were meager, and maintained at the least expense possible on the community so as to not to reward abuse of the limited services available.

Around the middle of the nineteenth century, the number of orphaned children and/or youth had increased, largely as a result of the Civil War. By 1900 there were an estimated one hundred thousand children and/or youth housed in orphanages across the United States. These

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8 Ibid.
children and/or youth had histories of neglect, abuse, or abandonment. Children and/or youth were typically segregated by gender and age, though at times siblings were removed from their homes as a result of parental inability to provide adequate care, and the orphanage was deemed a better alternative. While most of these orphanages were established by charitable organizations that were chiefly funded through religious institutions, i.e., churches and parachurch organizations, there was an emphasis saving youth from physical and moral degradation. This emphasis included education and/or vocational apprenticeships in a highly structured denominationally doctrine bound environments, whose funding was also provided through the both private and public sectors.

This preference changed with the “Progressive Movement” in 1909, when the then President Theodore Roosevelt at the White House Conference on the Care of Dependent Children began to deinstitutionalize orphanages throughout the United States. This effectively spelled the end of the “congregate plan” of orphanages in favor of the more homelike “cottage plan” for child residential care. Roosevelt initiated the “ Mothers’ Pension” what later become known as the ‘Welfare Act.’, which was a policy whereby funds were provided directly to the mothers of children and/or youth, who although not actual orphans, may have come from destitute families, broken homes, and single parent house-holds, or because of temporary

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11 Ibid.


13 Ibid.
misfortune were unable to maintain suitable homes for rearing their children. This significantly affected and undermined the efforts of the charitable organizations that had been providing childcare for abused, neglected, and orphaned children and/or youth to that time. As more public funding began to be channeled into the ‘Welfare’ programs, more government oversight was required. This “Progressive Movement” continued and became the catalyst for new governmental agencies to manage these funds, and programs. As a result of decreased funding and increased governmental oversight, many orphanages began to reorganize into reform schools, academies, group homes. The children and/or youth in care typically lived with a group home mother. Though education and vocational apprenticeships remained the emphasis, additional activities allowed for a more balanced approach to residential childcare. These smaller facilities eventually became what is known today as group homes and boarding schools for at-risk youth.14 “Orphanages and children’s homes also sheltered children of unwed mothers, of incarcerated or institutionalized parents, and of abusive families during their growing up years [Maguire 1985]. The institution provided its own subculture and social linkages. Institutions shifted during the second quarter of this century from the large congregate dormitory models to cottage campuses in order to replicate a life situation as close to family living as possible.”15

It was in the 1920s and 1930s that the most extensive reforms were initiated in ‘out-of-home’ care of children. It was then that foster-homes became the preferred option of childcare, and the decentralization of placement of children and/or youth in large congregate institutions to


smaller, more specialized group care agencies for children and/or youth not suited for foster-home placement.\textsuperscript{16}

The central criticism for orphan care in the United States was that orphanage type care was detrimental to the individuality of the child and/or youth in care. The quality of care for children and/or youth in care was questioned in light of the images portrayed in the writings of Charles Dickens of the British orphanage system. This reflection impacted negatively on the orphanage systems in the United States. “Closely related to the rejection of the orphanage was the belief that public policy and private charity could reconstruct the country’s social arrangements so as to make American democracy safe for its children. Proposals to deinstitutionalize children were therefor linked to an extensive catalog of reforms designed to create a child-friendly society in which stable and wholesome families would see habits, values, and characters, of future citizens.”\textsuperscript{17} Following this, Charles Loring Brace, an American social reformer and founder of the Children’s Aid Society initiated the Orphan Train Movement. The movement aimed to place homeless and orphaned children and/or youth from the eastern cities into families in the rural Midwest. This movement was an early model of the modern foster care system in America. It was during this period that residential care shifted from large congregate institutional dormitory models to smaller cottage campuses in an effort to provide a family living style models of care.\textsuperscript{18} However, for many years to come, the orphanage was still the


\textsuperscript{17} Crenson, Matthew A. \textit{Building the Invisible Orphanage: A Prehistory of the American Welfare System}. (Harvard University Press, 2009) 19.

predominantly preferred model of care for abused, neglected and/or orphaned children and/or youth. 19

Following World War II, most orphanages in the United States were closing, leaving only a handful of orphanages remaining. In the 1950s and 1960s, echoes of the “Progressive Movement”, new liberalism, and protest movements ushered in additional social reforms and criticisms of the orphanage institutional system of care for children and/or youth began anew.20 “The late 1950s and 1960s were a time when some of the more venturesome institutions throughout the country began to take a hard look at whom they were serving and what their resources were to do the job. Some institutions closed their doors to custodial care and became residential treatment centers/facilities, a change that required different organizational structures, program design, staffing, and admission requirements.”21 A period of significant change began following the Civil Rights movement of the 1960s and 1970s when many orphanages became associated with substandard care of the children and youth in care, poor food and accommodations, and a lack of support services due to insufficient funding.22 During this same period, these changes forced the orphanages that remained in operation to change and become


organizations that operate as (RGH’s), or (RTC/F’s). These organizations now provide residential care for many youth that in times past would have found a home in an orphanage. Between the 1980s and the early 2000s, there came a wave of greater governmental oversight at the state and federal levels with the establishment of public child welfare agencies and separate divisions within state agencies. The impact of these agencies: Department of Social Services (DSS), Child Protective Services (CPS), Guardian Ad Litem (GAL) services within the family and juvenile courts assumed greater responsibility for child welfare at the state and county levels. This new oversight brought changes in the setting of standards, licensing, and regulation of public and voluntary childcare facilities. In addition, these changes affected the funding sources for residential childcare organizations. The coordinated resources, both bureaucratic and financial, from the federal, state, and county levels brought programs that came under greater scrutiny, and financial support for residential childcare facilities was significantly adversely impacted, if not eliminated altogether. These societal and governmental changes forced these orphanages turned residential childcare facilities to again recreate themselves and modify their approaches to provide a “milieu of services” within the “continuum of care” in residential services to children and youth and their families.


25 Ibid.

26 Ibid.
Many of these former orphanages attempted to recreate themselves turning to newer models of care, i.e., “homes”, “schools” or “academies”, and “villages;” while other organizations departed altogether from their historical roots in residential care to a community-based format. The emphasis shifted to providing a milieu of services for children and/or youth and their families from a “community-based” service approach with foster-care, therapeutic foster-care, adoption, and an array of therapeutic services that often include: therapeutic counseling, intensive in-home services, early childhood / child abuse/neglect prevention, teen-mother and infant programs, childcare programs, and mediation services.

Not all of these organizations could make the changes necessary due to a lack of funding resources. As a result, some of these residential childcare organizations ceased operation. Others began to operate as either (RGH’s), (RTC/F’s), or closed their residential programming and chose to operate solely as “community-based” service providers offering a milieu of services for children and/or youth and their families.

“These three stages through which residential childcare facilities have passed can be referred to as: 1) the institutionally oriented or orphanage and/or congregate living phase. 2) the child-centered individualization or move toward “cottage” family-style phase, and 3) the family-oriented or co-planning or community-based services phase.”27

Several organizations within the continental United States that began as an orphanage now operate as (RGH’s), (RTC/F’s), or Children’s Homes and Schools. Many of the older organizations that initially began as orphanages that still exist today began following the Civil War. It was during this period that the migration to larger industrialized and urban areas began.

The urban poor experienced deplorable living conditions, long work hours in the factories, and inadequate childcare.\textsuperscript{28} These organizations continue to operate, evolving in response to the changing needs of the children and youth brought into care, and serve in the midst of the continuing changes in the culture beliefs, socially accepted norms, economic growth and restrictions, and governmental regulations.\textsuperscript{29} Many of these organizations have continued to evolve to meet the needs of the children and/or youth before them today. Many have continued to adjust their models of care adopting behavioral modification programs, or “point and level systems” as an organizational framework for resident behavior management.

Many of these organizations have evolved from orphanages to (RGH’s), Academies, and Schools, while others have evolved into (RTC/F’s). While these organizations are similar in nature, in that each provides long-term residential childcare for children and/or youth, and employ residential (DC) ministries staff, there are significant differences between (RGH’s) and (RTC/F’s). Today, the primary difference between (RGH’s) and (RTC/F’s) are the “levels of care” and the “continuum of care” and the milieu of services provided for the children and/or youth in residential care.\textsuperscript{30} These differences in the “levels of care” and “continuum of care” are chiefly noted in the milieu of services provided at each “level of care.” “The milieu is the environment in which the child lives. This includes the general structure, supervision, and reinforcement used by the agency to change behaviors and teach social skills. This will include


consequences, counseling, teaching, reinforcement, and staff relationships.” 31 The milieu of services can be varied at each “level of care” and are often designed around a “person-centered” plan of approach to meet the specific needs of the children and/or youth in care.

Balcerzak writes, “In addition to shifts over time in the distribution of children by type and auspices of facilities, and the proliferation of newer, smaller facilities, a third major change in the field was a reduction in average length of stay of the children in residential group care.” 32 Balcerzak’s research revealed that in the 1960s, nearly three-quarters of the children and/or youth in residential care had an average length of stay of two years or longer. By the 1980s, approximately one-third of the children and/or youth in residential care averaged a two years or longer length of stay in residential care. The phenomenological research reveals the average length of stay for children and/or youth in residential care is between nine and thirteen months.

The ‘Levels of Care’ in Residential Childcare Treatment

   Foster care is considered the entry level into residential care for children and/or youth. It is the least restrictive treatment based care for children and/or youth with emotional and behavioral disorders. 33 Beyond a non-therapeutic foster-care home, there are four primary levels of residential care within the continuum of care for children and/or youth with emotional and behavioral disorders in residential treatment: treatment foster care (TFC), residential group care, small group care, and cottage care.


homes (RGH’s), residential treatment centers/facilities (RTC/F), and impatient psychiatric care facilities (PRTF). The children and/or youth at a therapeutic foster-care home are considered to be in “the least restrictive treatment based residential options available for children and/or youth with emotional and behavioral disorders (Curtis, Alexander, & Lunghofer 2001; Farmer et al. 2004) [and have] emerged as a preferred alternative to more restrictive settings for children and adolescents with severe emotional and behavioral disorders (James & Meezan 2002).” [A therapeutic foster-home] combines a structured therapeutic approach with the benefits of a more normative family-based milieu, utilizing “specially trained treatment parents as the primary implementers of therapeutic plans” (Breland-Noble, Farmer, Dubs, Potter, & Bums 2005, p. 168).” In a therapeutic foster-care setting, children and/or youth are able to operate with a therapeutically trained “parent” as a “foster-parent” as one would expect in a typical residential environment of a single-family home.

The second “level of care” within the residential continuum of care is the Level I “level of care” in a (RGH) setting. A (RGH) setting typically is a group home for unrelated children and/or youth. While there are a number of similarities between (RGH’s) and (RTC/F’s), in that, both provide residential childcare to children and/or youth in need, there are also significant

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35 Ibid.


37 Ibid.

differences that set the two apart. Most (RGH’s) generally operate as Level I type facilities providing residential care for children and/or youth minimal emotional and/or behavioral issues, and typically provide for any therapeutic needs through outsourcing these services.  

The (RGH) is considered the second of the four “levels of care” within the “continuum of care” for children and/or youth. Most of these children and/or youth do not have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, or psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy. Level I children and/or youth do not typically enter into the next “level of care” residential setting, which is a (RTC/F’s) environment. Largely, because the residential care needs of these children and/or youth are best met at a Level I “level of care”; this distinction is the primary difference between a (RGH) environment and (RTC/F’s) that typically operates at higher strata of “levels of care.”

The primary difference between (RGH’s) and (RTC/F’s) are the “levels of care” provided and the “continuum of care” “milieu of services” for the children and/or youth in residential care. (RGH’s) generally focus on providing residential support and care and often do not adhere to a particular model of care for the children and/or youth in care for behavior modification. Generally, the children and/or youth in care at a (RGH) do not receive onsite academic instruction, but rather the youth attend local public schools during placement and (DC) ministries staff function in a ‘House Parent’ role with limited training in how to work with mentally, emotionally, and behaviorally challenged children and/or youth.  


40 Ibid.
Residential Treatment Centers/Facilities (RTC/F’s) also provide residential support and care, yet most operate under some form of behavioral modification approach, or model of care, which is generally referred to as a point and/or level system. Generally, the children and/or youth in care at (RTC/F’s) receive onsite academic instruction, due to extreme behavioral challenges, and the children and/or youth usually attend an onsite school during placement. These organizations employ (DC) ministry staff who function in a similar role, yet may have a different job title: ‘Residential Counselor’, ‘Teaching-Parent’, ‘Family Teacher’, ‘House Parent’, ‘Youth Counselor’, or ‘Residential Advisor role. Due to the “level of care” setting in a Level II or III facility with children and/or youth with diagnosed DSM-V mental and emotional disorders and behavioral challenges, these roles generally require considerable pre-service training by the organizations that employ them. (DC) ministries staff generally operate on a campus, or within a unit, cottage, house, or home. (DC) ministries staff typically work as part of a multi-staff team, often including ‘awake-night’ or ‘overnight’ staff providing 24/7 supervision of the children and/or youth in care.  

(RTC/F’s) provide a higher “level of care” albeit at one of “the costliest and most restrictive forms of care for children and/or youth with emotional and behavioral disorders outside of impatient psychiatric care.”

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extended stays. This can result in annual costs between $50,000 and $75,000 per child.'"

Residential childcare settings constitute the most expensive of the placement settings. The monthly costs for placement of children and/or youth are estimated to be 6 to 10 times higher than foster care, and treatment foster care involves about 3 times the cost of regular nonrelative foster care (Barth 2002).

(RTC/F’s) provide a continuum of care within the framework of the “levels of care” Levels II, III, IV, and PRTF to children and/or youth requiring higher levels of supervision, care, and/or emotional and/or behavioral therapeutic treatment. Like the (RGH), the (RTC/F’s) provide a “continuum of care” that includes providing care that seeks to minister to the mental, emotional, physical, academic, and spiritual needs of the children and/or youth in care. (RTC/F’s) provide for specialized mental health treatments and the individual therapeutic needs of the children and/or youth in care through a milieu of services both in-house and outsourced in a non-hospital setting.

The last of the four “levels of care” within the residential “continuum of care” spectrum is the (PRTF). The (PRTF) is an impatient hospitalization, and is the most restrictive form of residential care for children and/or youth in a residential treatment setting. This “level of care” within the overall “continuum of care” for children and/or youth with severe mental, emotional and/or behavioral disorders consumes the largest part of a state’s child mental health resources and, according to Burns et al (1999), has the weakest evidence base for efficacy. Typically, a

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46 Ibid.
patient’s treatment at impatient psychiatric care facilities is brief due to the changes in health-care management. As a result, the rates of recidivism are high.47

While these distinctions in “levels of care”, or “continuum of care” still exist across the United States, many states have moved away from these “leveling systems” as a means to identify the “continuum of care” provided by long-term residential childcare facilities in an effort to eliminate a further stigmatizing of the children and/or youth in residential care.

The “levels of care” or “continuum of care” of the facilities within the scope of this research study included (DC) ministries staff working with children and/or youth in (RGH’s) (RTC/F’s) in childcare. No (PRTF’s) participated in this research study. The following types of facilities described opted to participate in the research study and online survey:

(RGH’s): The staffing structure at this “level of care” facility may include family and program type setting, albeit in a foster placement setting. The children and/or youth who would be appropriate for this “level of care” have displayed difficulty in a typical biological family setting, in that continued placement with the family would not be appropriate and effective. Typically, children and/or youth receiving placement in this setting have been removed not because of their mental, emotional, or behavioral issues, but rather because of a family dysfunction issue that necessitated their removal from the family home.48

(RTC/F’s): The staffing structure at this level of care may also include family and program type settings. The children and/or youth who would be appropriate for this “level of care” have
displayed difficulty in a typical biological family setting, in that continued placement with the family would not be appropriate and effective. Typically, children and/or youth receiving placement in this setting have been removed not because of their mental, emotional, or behavioral issues, but rather because of a family dysfunction issue that necessitated their removal from the family home.48


“levels of care” have displayed difficulty in a typical family setting, in that continued placement with the family or a foster-family would not be inappropriate and ineffective. Therapeutic foster care may provide a more effective milieu of services within the continuum of care that might not otherwise be readily available, or meet the mental, emotional, or behavioral needs of the children and/or youth in care. Many of these children have suffered abuse/neglect within their own families and as a result have a great deal of trouble adjusting to a family setting. This “level of care” seeks to provide a “continuum of care” and services that are responsive to the children and/or youth’s needs for intensive, interactive, therapeutic interventions. While there are (DC) ministries staff providing care 24/7 at this “level of care” while also providing supervision, it is not a secure treatment facility. 49

These “levels of care” within the residential “continuum of care” demonstrate a broad spectrum of care and “milieu of services.” These variations in residential care for children and/or youth came into existence because of the governmental and societal changes noted above, as well as the demands for change mandated because of the types of children and/or youth coming into care in residential childcare. With these changes, orphanages gave way to (RTC/F’s), and many of the organizations that operated under a Level II, III, or IV “level of care” model also began to utilize a behavioral modification system or ‘point and leveling’ systems within their continuum of care. 50 However, these changes also required changes in the type of training for (DC) staff working at these (RTC/F’s) with children and/or youth in


residential care. These changes mandated new training requirements for (DC) ministries staff, and preservice and annual training began to be implemented, albeit with varying degrees of adequacy, consistency, and availability.

**The ‘Direct-Care’ Ministry Staff In Residential Treatment Facilities Today**

Most (DC) ministries staff today working in (RTC/F’s) enter the field with a minimum of a bachelor’s degree in a human services field, while some hold a master’s degree in social services, psychology, or an advanced ministry degree. To this highly educated staff person, the organizations add training of (DC) ministries staff that often exceed forty hours of annual training, which includes therapeutic approaches for working with mentally and emotionally unstable persons, and therapeutic crisis intervention strategies for when those in care become a harm to themselves and/or others. The training includes therapeutic crisis intervention strategies, behavioral support techniques, conflict resolution, and how to provide immediate emotional support and care. Then, there is the First- Aid, CPR, and AED training, and Blood-borne pathogens training, vehicle operation, household (unit) cleaning procedures, incident reporting and report writing. Additionally, they are required to have Medication Administration and Records (M.A.R.s), documentation training, and model of care training. Also, there is staff and client boundaries training, diversity in the workplace, sexual harassment, client’s rights and confidentiality training, records management training, vehicle training, house-keeping skills, recognizing and reporting child abuse training, as well as organizational policies and procedures training. The combined education and organizational training seeks to prepare these (DC) ministries staff for the issues, demands, and expectations they will face daily while working in (RTC/F’s) in childcare. Yet, for all of this preparation, there are few organizations that provide
directed ‘self-care’ training opportunities for (DC) staff to address the mental, emotional, physical, relational, and spiritual tolls that are taken on them, and the toxic spillover that affects their families and the organization that employs them.

As noted above, those providing (DC) ministries in (RTC/F’s) in childcare servicing children and youth ages 1 to 21 often work with children and youth from widely diverse backgrounds from abuse and neglect. The children and youth also often struggle with the mental, emotional, physical, relational, and behavioral consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. These same children and youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy.\footnote{Baker, A. J. L., Kurland, D., Curtis, P., Alexander, G., & Papa-Lentini, C. “Mental Health and Behavioral Problems of Youth in the Child Welfare Systems: Residential Treatment Centers compared to Therapeutic Foster Care in the Odyssey Project Population.” \textit{Child Welfare}, 86, (2007): 97–123.}

Much of today’s training requirements for (DC) staff are a result of the type of children and/or youth coming into (RTC/F’s) care. The mental, emotional, physical, relational, and academic needs of children and youth in (RTC/F’s) today require care that is far more demanding. The issues, demands, and expectations on those working in (RTC/F’s) in childcare in (DC) ministries are equally demanding. The issues, demands, and expectations of the work of (DC) ministries working with children and/or youth in residential childcare are further complicated by the requirements of care within the “level of care” within the “continuum of
care” provided by the organization. This is most often referred to as the “milieu” or range of services provided to meet the individual needs of the children and/or youth in care. To better understand “milieu” in the context of residential childcare, Trieschman writes, “The daily events in a group-living situation may be viewed as foreground or background. The events and interactions of the day may be thought of merely as time-fillers between psychotherapy sessions, or only as providers of life necessities such as eating, sleeping, and recreation. Or—and this is our preference—the milieu can be thought of as the major impact that the institution has on the child. Whether as a time-filler or as a major therapeutic tool, a milieu exists in every group living situation. In recent years, every children’s institution has claimed that they have a “therapeutic milieu,” implying that they paid special attention to the therapeutic use of daily events.”

Nevertheless, in light of the issues of ministry and the demands of working in (DC) ministries in (RTC/F’s) in childcare, combined with the expectations placed upon these (DC) ministries staff by the organizations that employ them, many studies have been conducted on the negative impact that workplace expectations have on those working in (DC) ministries staff positions in (RTC/F’s) in childcare. These studies reveal that these additional expectations and subsequent stressors include insufficient training to meet the demands of the types of youth in care; inadequate staffing; undesirable work schedules, or work shifts; low salaries; poor benefits; poor job conditions; undefined job responsibilities; a lack of appropriate supervision; poor communication; insufficient resources; and high (DC) ministries staff turnover. In addition,

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there are the expectations placed upon (DC) ministries staff that are often perceived to be unrealistic expectations. The organizations’ mid-level management and senior administrative staff have placed these issues, demands, and expectations upon them. It is further exacerbated by the demands of the clients, courts, social workers, guardian ad litem’s, school officials, parents and community that often exacerbate the already overwhelmed (DC) ministries staff with the stressors of burnout, (STS), (VT),⁵⁴ and (CF)⁵⁵ that lead to thoughts and feelings of being mentally, emotionally, physically, relationally, and spiritually exhausted.⁵⁶

Combined, these expectations alone would be enough to discourage even the most hardy and well-intentioned individual to reconsider their level of commitment to an organization. Added to the issues associated with the work of ministry, the demands specific to (DC) ministries work, and the expectations of the organization that employs them, these issues, demands, and expectations foster an environment that is rife with the stressors of burnout, (STS), (VT), and (CF). These are detrimental to the professional, and personal well-being and success of (DC) ministries staff, their families, and the overall success of the (RTC/F’s), and the organizations that employ them.

The following chapter builds on the preceding chapter with the issues, demands, and expectations of (DC) ministry, as well as the stressors on (DC) ministries staff and the toxic

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spillover of these stressors in their professional lives into the personal lives, which can have a deleterious effect on their marriages and families, friends, and social support systems.
(DC) ministries staff face a number of issues, demands, and expectations while working in (RTC/F’s) in childcare. These issues, demands, and expectations often manifest themselves in stressors that can have a deleterious effect on their mental, emotional, physical, relational, and spiritual aspects of the professional and personal lives.\(^1\) The issues are associated with the work of ministry, while the demands specifically associated with working in (DC) ministries in (RTC/F’s) in childcare. In addition, the expectations are placed upon these (DC) ministries staff by the organizations that employ them. Also, these issues, demands, and expectations can take a significant negative toll on the professional and personal lives of the individual (DC) ministries’ staff, their families, and the organizations that employ them.\(^2\) These issues, demands, and expectations can manifest themselves in the mental, emotional, physical, relational, and spiritual aspects of the (DC) ministries’ staff professional and personal lives in a variety of areas: burnout, (STS), (VT),\(^3\) and (CF).\(^4\) These are the stressors often associated with the ‘helping field’ work of

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\(^1\) Wilson, Michael Todd and Brad Hoffman. *Preventing Ministry Failure: A ShepherdCare Guide for Pastors, Ministers and Other Caregivers.* (Downers Grove: InterVarsity Press, 2007)


(DC) ministry in (RTC/F’s) working with children and/or youth in childcare that lead to a premature departure from this field of ministry.

The Issues Associated With The Work Of Ministry

The issues related to ministry work are in themselves taxing. The issues related to ministry work—always being on demand, always being on display, and always being on-duty, are issues that can challenge even the most dedicated and devoted in spirit. Those in ministry are often called upon to provide care for others when they are in the midst of a crisis. In fact, those in ministry are among the first individuals that others turn to when they are in need of assistance. Those in ‘helping fields’ ministries work to meet others needs mentally, emotionally, physically, relationally, or spiritually. This work in human services takes its toll, typically in the areas of Emotional Exhaustion (EE), Depersonalization (DP) and Personal Achievement (PA), which are the symptoms prevalent in a work related stress response, known as “Burnout.” Christina Maslach, a pioneer in the research on burnout, and working with Susan E. Jackson, writes in their “The Measurement of Experienced Burnout” article,

“A key aspect of burnout of the burnout syndrome is increased feelings of emotional exhaustion. As their emotional resources are depleted, workers feel they are no longer able to give of themselves at a psychological level. Another aspect is the development negative, cynical attitudes and feelings about one’s clients. Such negative reactions to clients may be linked to the experience of emotional exhaustion, i.e., these two aspects of burnout appear to be somewhat related. This callous or even dehumanized perception of others can lead staff to view their clients as somehow deserving of their troubles (Ryan 1971), and the prevalence among human service professionals of this negative attitude toward clients has been well documented (Wills 1978). A third aspect of the burnout is the tendency to evaluate oneself negatively, particularly with regard to one’s work

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with clients. Workers feel unhappy about themselves and dissatisfied with their accomplishments on the job.”

Always being on demand, and always being on duty takes its toll. Those in ministry learn early on that the work of ministry is not an 8 to 5 job. Neither life nor ministry happens on a regular schedule. As such, being on demand means being available 24/7. These two aspects of the work of ministry are further complicated by always being on display, and always being on-duty; thus, the individual whose vocation is ministry, as well as their spouses, and their families often lament that their lives are lived out before others. No aspect of the personal, marital, or familial lives, good or bad, is left private. Those in ministry learn early on that ministry is taxing mentally, emotionally, physically, relationally, and spiritually. These are significant issues of the work of ministry that can challenge even the most dedicated and devoted in spirit.

Though these issues are well known to those in ministry, they are often overlooked or ignored by those seeking to enter vocational ministry. Chiefly because most people begin a career in full-time vocational ministry with an idealism rife with expectations that their career in a ‘helping field’, will allow them to utilize their natural abilities, talents, education, experience, and spiritual gifting, to fulfill their God-given callings. This idealism however soon gives way to reality. When the issues associated with the work of ministry, the demands of the office, and the expectations of others, combined with those stressors that are self-imposed, the duties of the position, and the workload of ministry begin to take their toll on them and their families. 7

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Simply stated, those in ministry and their families often feel overwhelmed, as though they are always being deluged with drama, always being on demand, always being on display, and always being on-duty. The toll of these stressors often manifests with deleterious effects on the mental, emotional, physical, relational, and spiritual aspects of the lives of the individual minister, and that of their families. Typically, these stressors manifest themselves in the areas of Emotional Exhaustion (EE), Depersonalization (DP) and Personal Achievement (PA), the symptoms prevalent in a work related stress response, known as “burnout.”

While issues associated with the work of ministry are well known, the stressors associated with the work of ministry are not. These stressors, which lead to burnout, as well as those stressors of (STS), (VT), and (CF), and the toxic spillover that often accompanies the work of ministry, makes the ministry work of a (RCW) “one of the most difficult and emotionally exhausting careers in the human services industry (Krueger 2002). These stressors must be addressed for the overall personal and professional fulfillment and well-being of the (DC) minister, as well as their families, and for their continued ministry success at their given placement of service.

The Demands Associated With The Work Of ‘Direct-Care’ Ministries

There are demands specific to (DC) ministry. Those providing (DC) ministries in (RTC/F’s) in childcare servicing children and youth ages 1 to 21 often work with children and

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youth from widely diverse backgrounds from abuse and neglect. The children and youth also often struggle with the mental, emotional, physical, relational, and behavioral consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. These same children and youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis’, requiring psychotropic medication use, as well as regular counseling and therapy (Baker, Kurland, Alexander & Papa-Lentini 2007). Surveys of residential treatment facilities in the United Kingdom reveal that nearly three-quarters (72%) of children and/or youth in residential care have mental disorders, others (60%) have conduct disorders, and another 18% had emotional disorders (Office of National Statistics 2003). The children and/or youth in residential care “experience disproportionally high levels of social disadvantage and abuse…prior to placement (Brodie 2005, p. 1). Children in residential care often display poor social skills and low self-esteem, and the [‘Direct-Care’] workers who care for them are faced with a particularly difficult task (Berridge & Brodie 1998), frequently encountering chaotic, destructive behavior, a fear of going to school, persistent offending, inappropriate sexual behavior and difficult relations with parents (Whitaker et al. 1998). As Conner, et al state,


13 Ibid.
“Increasingly, children and adolescents admitted to Residential Treatment Centers [(RTC’s)] have high rates of serious of serious emotional disturbances. These may include complex neuropsychiatric diagnoses, multiple attachment disruptions, chronic traumatic experiences, multiple changes of caregivers, and multiple placements. Many referred youths are suspicious and defensive about the therapeutic encounter, and a long time in a stable environment with consistent staff is often necessary to establish a working therapeutic alliance. Changes in the environment and among mental health workers and teachers in residential treatment are often difficult for these youths. Staff transitions may rekindle past attachment losses, grief reactions, uncertainties over safety or stability of the therapeutic environment, remind them of previous traumas, increase their anxiety, and possibly increase their vulnerability to anti-therapeutic dangerous behaviors (Braxton 1995). A high rate of turnover, especially among direct care staff and teachers, undermines the educational and therapeutic mission of residential treatment centers (West 1998).”

It is these issues and demands that begin to create an environment that is ripe with stressors that bring about burnout, (STS), (VT), and (CF). It is also these stressors that are exacerbated, as they are a part of the daily living experience working as (DC) ministry staff. The issues associated with the work of ministry, combined with the demands that are associated with the work of (DC) are referred to as (RCW). Those working in a (DC) ministry role, also referred to as a (RCW) profession, are similar to other social service and mental health professions, such as child welfare workers and therapists… (RCW) are professionally distinct; however, as they often cope with children’s issues as they are erupting in the present. These issues are enacted behaviorally, in the present, and workers are charged with the management of the child and the milieu in that moment (Savicki 2002). These professionals experience “High levels of


15 Ibid.

continuous contact with the same group of clients within their daily living space [which] clearly mark[s] child and youth care practice as unique from other helping professions” (Savicki, p. 19; Bertolino & Thompson 1999). “Writers on staff burnout have suggested that human service work imposes special stressors because of clients’ emotional demands (Maslach 1978), a ‘professional mystique’ that creates unrealistic expectations of and for workers (Cherniss 1980), and the requirement that workers use themselves as the ‘technology’ for meeting clients’ needs (Berkeley Planning Associates (1997, p. B16).”

These issues, demands, and expectations on (DC) staff working in (RTC/F’s) with children and/or youth in residential care are only exacerbated as they work with children and/or youth at each increasingly higher “level of care” within the residential child care continuum of care strata. There are different strata of (RTC/F’s) typically referred to as the “levels of care” and/or “continuum of care” “intensive or restrictive settings” provided within the clinical continuum and milieu of services for the children and/or youth in residential care. With each increasing step within the “levels of care” within the residential “continuum of care”, so too does the severity of mental and emotional disorders, and conduct disorders, and behavioral challenges increase. These increases in “levels of care” also exacerbate the stressors on (DC) ministries staff.

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These “levels of care” are therapeutic foster-care homes, (RGH’s), (RTC/F’s) and impatient psychiatric care, are referred to as (PRTF’s). The first of these “levels of care” within the “continuum of care: in residential services is therapeutic foster-care. In this setting, the staffing structures may include family and program type settings. Typically, the child has displayed difficulty in a family setting as such that placement with a family would not be indicated. Many of these children have suffered abuse/neglect within their own families and as a result have a great deal of trouble adjusting to a family setting. The entry “level of care” within the “continuum of care” in residential care is treatment foster care, or foster-care as it is generally referred to. This “level of care” is the least restrictive residential treatment option.

A next higher level of supervision and structure that can be provided beyond a foster-care home is the (RGH). At this “level of care,” supervision is provided by (DC) staff during waking hours, and also during times when the child is sleeping in order to maintain the child. “This is referred to as a facility that is “staff secure.” There are no locks, but the child needs a


20 Ibid.


23 Ibid.

slightly higher level of constant supervision to be maintained in the community. In this setting the children and/or youth are generally accepting of treatment. The milieu of services are again responsive, albeit typically not onsite, but rather as out-sourced to meet the needs for intensive, active, therapeutic intervention for the children and/or youth in care. This setting has a slightly higher level of consultative and direct service from psychiatrists, psychologists, therapists, medical professionals, etc.”

The next higher level of supervision and structure that can be provided are (RTC/F’s). In this setting, there is constant supervision by (DC) staff during regular hours and possibly after hours with awake-night and/or on-call emergency staff providing supervision during times when a child is sleeping. This “level of care” is often considered a “step-down” facility, as it is often utilized as a reentry point into a less restrictive setting than that of a (PRTF) or a juvenile detention center. However, because of the type of children and/or youth in care at this level, “this type of facility may or may not be “staff secure” and a physically secure location, in which there are locks and other security measures taken, as children need a high level of care and constant supervision in order to be maintained within the treatment facility.” Here, there is a higher level of clinical intervention than in a (RGH) facility. The children and/or youth at this


28 Ibid.
type of facility usually have a history of elopement from lower “level of care”; as such, their educational needs must also be met in a secure setting provided by the residential provider.29

Lastly, within the residential “continuum of care: “levels of care” is the inpatient psychiatric care facility, also referred to as a (PRTF).30 Because of the type of children and/or youth in care at this level, “this type of facility may be a “staff secure” and physically secure location, where there are locks and other security measures taken, as children need a high “level of care” and constant supervision to be maintained within the treatment facility. Here there is a higher level of clinical intervention than in a (RGH) facility. The children and/or youth at this type of facility usually have a history of elopement from lower “levels of care” facilities. The children and/or youth’s educational needs are met in a secure setting provided by the residential provider. In this type of facility a time out room is provided for when the children and/or youth in care are unmanageable or they require ‘time and space’ to alleviate behavioral issues.31 In this “level of care,” there is also the possible use of seclusion and/or restraint to control aggressive or self-injurious behaviors.32 In this setting, the child and/or youth is not at all accepting of the treatment process and requires the security of a locked facility to begin the treatment process.

Typically, the treatment (psychiatric, psychological, medical, vocational, recreational,


32 Ibid.
educational) needs of consumers at this level are so extreme that these activities can only be undertaken in a therapeutic context. These services are conducted in a manner that is fully integrated into ongoing treatment.  

(DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare daily encounter behaviors from children and/or youth in care who have the inability to follow directions, and/or conform to structure of school, home, or community. These children and/or youth have constant and sometimes violent arguments with caretakers, peers, siblings and/or teachers. The (DC) staff must remain hyper-vigilant for behaviors from the children and/or youth and they strive to moderate levels of self-injurious behavior, risk taking, and sexual promiscuity.

In addition, (DC) ministries staff are constantly monitoring for suicidal actions of the children and/or youth in care, and make themselves aware of their histories of self-harm and serious suicidal actions. Then, (DC) ministries staff must always be prepared to intervene as trained for the almost daily physical altercations in school, home or community. These ‘therapeutic’ interventions known as ‘takedowns’ occur with such frequency that staff must often dress accordingly. Many (DC) ministries staff have been injured as a result, even though their training strives to minimize the possibilities for staff, and the children and/or youth in care. (DC) ministries staff also endure near constant verbally aggressive and provocative and/or profane language. Though great effort is taken to provide the children and/or youth in care with a clean,
orderly, and well-maintained environment, and (DC) ministries staff work hard to keep it so, there are frequent and severe property damage incidents. Often the children and/or youth in care take out their frustrations on their environments.

As these children and/or youth in care are often in the care of the (DSS), and/or courts, (DC) ministries staff must regularly interact with (DSS) and court appointed (GAL), (PO) personnel, working with the children and/or youth in care to navigate their legal system involvement. (DC) ministries staff must also regularly engage with school officials over frequent school related issues: Individual education plans for children and/or youth who are frequently behind in their academic growth, disciplinary issues, suspensions, and expulsions. At these levels, there is also a moderate to high risk for children and/or youth sexually victimizing others. There is also an increasing likelihood that children and/or youth coming into care will struggle with DSM-IV diagnosed behavior issues mental and emotional trauma related to their experiences, and/or have the presence of severe affective, cognitive or developmental delays/disabilities. 34 As Lyons et al. assert,

“…the children and/or youth’s mental health needs are assessed using the Child Severity of Psychiatric Illness (CSPI, Lyons 1998), a measure that assesses psychiatric symptoms, risk behaviors, and functioning (school, home, and peer) as well as factors that influence level of pathology in these areas (Lyons et al. 1997) …The Risk Factors dimension takes into account the recency and acuity of each risk behavior, with higher ratings assigned to more recent and acute risk…The Risk Factors dimension of the CSPI consists of ratings of suicide risk, danger to others, elopement risk, crime delinquency, and sexual aggression…The anchor points [in one study] of the Symptoms dimension of the CSPI correspond to five broad diagnostic categories: emotional disturbance, conduct disruptive, neuropsychiatric disturbance, oppositional behavior, and impulsivity. A rating of 2 or greater in any area corresponds to a level of symptomology great enough to warrant a specific Diagnostic and Statistical Manual of Mental Disorders (4th ed.;

DSM-IV; American Psychiatric Association 1994) diagnosis within these broader categories… Most psychopathology was seen in the following three areas: emotional, conduct, and oppositional.”

The needs of the children and/or youth in residential care require (DC) ministries staff working in (RTC/F’s) in childcare to maintain a constant awareness of the status of the children and/or youth in care, and also keep those in care in what some organizations refer to as constant ‘sight and sound’ supervision.

**The Expectations Placed upon Staff by the Organizations That Employ Them**

The complexity of these issues and demands associated with the work of (DC) ministries staff working in (RTC/F’s) is further complicated by the expectations placed upon them by the organizations that employ them. The expectations placed upon them by the organizations that employ them often include experiencing a poor quality of life with living and working in often isolated and remote, or rural areas. (DC) ministries staff “typically receive low wages, and few benefits, and work under high levels of physical and emotional stress.”

They often have to work in different types of work environments: (RGH’s), (RTC/F’s), (PRTF’s), therapeutic foster homes, and step-down units; working short shifts, long shifts, days and nights, or awake-night shifts. Sometimes working alone because of staff shortages is often a regular expectation placed

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upon (DC) ministries staff while working with children and/or youth in (RTC/F’s) in childcare (Bertolino & Thompson 1999; Hyde 2001).  

Working in (RTC/F’s) in childcare with these children and/or youth require the (DC) ministries staff to have a sufficient education, which is often a minimum of a bachelor’s degree, and with some experience preferred, and moreover, the work requires considerable onsite specialized training. Much of today’s training requirements for (DC) ministries staff are a result of the type of children and/or youth coming into (RTC/F’s) care would require. The mental, emotional, physical, relational, and academic needs of children and youth in (RTC/F’s) today require care that is far more demanding. The issues, demands, and expectations on those working in (RTC/F’s) in childcare in (DC) ministries are quite overwhelming, and can have a negative impact on these individual staff, their spouses, and their families, as well as their co-workers, the organizations that employ them, and ultimately the children and/or youth in care.

Many studies have been conducted on the negative impact that workplace expectations have on those working in (DC) ministries staff positions in (RTC/F’s) in childcare. These studies reveal that these additional expectations and subsequent stressors include: insufficient training to meet the demands of the types of youth in care, inadequate staffing, undesirable work schedules, long work shifts, heavy workloads, low salaries, poor benefits, poor job conditions,

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37 Bertolino, B. & Thompson, K. *The Residential Youth Care Worker In Action: A Collaborative, Competency Based Approach.* (New York: Haworth Mental Health Press, 1999.)

undefined job responsibilities, a lack of appropriate supervision, poor communication, insufficient resources, and a debilitating high (DC) ministries staff turnover.\(^{39}\)

In addition, there are the stressors placed upon (DC) ministries staff of unrealistic expectations and demands placed upon them by an organization’s mid-level management, senior administrative staff, and consumers: the courts, (DSS), (GAL’s), school officials, and even parents. This often further exacerbates the already overwhelmed (DC) ministries staff with thoughts and feelings of being mentally, emotionally, physically, relationally, and spiritually exhausted, thus making them ideal candidates for burnout, (STS), (VT), and (CF). Combined, these expectations alone would be enough to discourage even the most hardy and well-intentioned individual to reconsider their level of commitment to an organization. Added to the issues associated with the work of ministry, and the demands specific to (DC) ministries work, these issues, demands, and expectations create an environment that is detrimental to the professional and personal success of (DC) ministries staff, their families, and the overall success of the organizations that employ them.

Again, as noted above, these issues, demands, and expectations create an environment rife with stressors. The stressors of burnout, (STS), (VT), and (CF) can affect the professional lives of (DC) ministries staff. The effects on the mental, emotional, physical, relational and spiritual aspects of their lives can be equally detrimental to the individual’s personal lives, and the toxic spillover that often accompanies such deleterious effects on the individual (DC) staff

person’s professional and personal lives can also take its toll on their spouses, families, friends, co-workers, and their spiritual relationship with God.

The following chapter three will examine the stressors of burnout, (STS), (VT), and (CF) that so often have such a negative impact on those that work as (DC) ministries staff in (RTC’s) and/or (RTF’s) working with children and/or youth in childcare. This work requires that staff place themselves in significantly taxing positions that expose them regularly to the stressors so often associated with working in human services, particularly those in ‘helping fields.” Exposure to these stressors often manifests as (DC) ministries staff struggle with the issues, demands, and expectations associated with the work of (DC) ministries staff with children and/or youth in residential care. The effects of which can have a deleterious effect on them mentally, emotionally, physically, relationally, and spiritually. It can affect their spouses, their families, their co-workers, as well as the organizations that employ them. Ultimately having an adverse effect on the quality of care and services provided to the children and/or youth in care.
CHAPTER 3
THE STRESSORS ASSOCIATED WITH THE WORK OF ‘DIRECT-CARE’ MINISTRY IN RESIDENTIAL TREATMENT FACILITIES

The stressors associated with the work of (DC) ministries in (RTC/F’s) in childcare can take a deleterious toll on the mental, emotional, physical, relational, and spiritual well-being of the (DC) ministries staff and their families. These stressors include burnout, (STS), (VT), and (CF).

The Burnout

The phrase ‘burnout’ as a psychological and/or psychiatric term was originally coined by H. J. Freudenberger in his article ‘Staff Burnout” (Freudenberger 1974).\(^1\) Freudenberger observed that ‘burn-out’ manifested differently in symptoms and degree from person to person, though the symptoms occurred for most within a year after beginning work for an organization. It was approximately at that time that disappointment, disillusionment, discouragement began to set in, and burnout began to manifest.\(^2\)

Maslach writes, “Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do ‘people-work’ of some kind. It is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems…”\(^3\) Although it has some

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\(^2\) Ibid.

of the same deleterious effects as other stress responses, what is unique about burnout is that the stress arises from social interaction between helper and recipient.”

Research over the last twenty-five years reveals that burnout develops as a factor of working condition (LeCroy & Rank 1987) over and extended period (Johnson & Stone 1987). Some (DC) ministries staff workers experience ‘emotional exhaustion’ (Dickinson & Perry 2002) in an attempt to deal with challenging behavior, and concerns for their physical safety. “Many of the children and/or youth lack positive support systems from family members and friends and may feel isolated, afraid, and resentful (Frensch and Cameron 2002). These children and youth often have significant psychological, behavioral, and emotional problems, it is the job of the child, and youth care worker to guide these children and youth through their daily routines. Children and youth may become verbally and physically aggressive, engage in self-harming behaviors, act-out sexually, and may resist treatment from counselors and youth care workers (Ryan et al. 2008). Providing care to high-risk children and youth in residential care is stressful and challenging, and yet little research has gone into better understanding the difficulties these workers face.”

It is no wonder that (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare often suffer from burnout, (STS), (VT), and (CF). Research reveals that the three key dimensions of this stress response are overwhelming exhaustion, feelings of cynicism and detachment from the job, and a sense of ineffectiveness and lack of accomplishment.”

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related is indicated in Maslach’s comments, “Job burnout is a psychological syndrome that involves a prolonged response to stressors in the workplace. Specifically, it involves the chronic strain that results from an incongruence, or misfit, between the worker and the job.”

Following the last twenty-five years of research by Maslach and many others, “burnout was viewed as a form of job stress, with links to such concepts as job satisfaction, organizational commitment, and turnover.”

Maslach continues,

“The three dimensions of burnout are related to workplace variables in different ways. In general, exhaustion and cynicism tend to emerge from the presence of work overload and social conflict, whereas a sense of inefficacy arises more clearly from a lack of resources to get the job done (e.g., lack of critical information, lack of necessary tools, or insufficient time.) The combinations of variations on these three dimensions can result in different patterns of work experience and risk of burnout.”

While Freudenberger and Maslach among others pioneered the research on the topic of burnout, Eastwood and Ecklund note that,

“McCann and Pearlman (1990) then introduced the phenomena of vicarious trauma to explain the cognitive shifts and reactions of therapists working with trauma victims. Focusing on the development of trauma symptoms, Figley (1995a) introduced the concept of secondary trauma stress, which was later renamed compassion fatigue, to describe the development of posttraumatic stress symptoms among those who have been exposed to traumatic material through providing help to victims (Figley 1995b, 1998b, 1999, 2002a, & 2002b). Figley defines compassion fatigue as “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing

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of reminders, [and] persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others” (Figley 2002b, p. 1435). Unlike burnout, which emerges gradually because of emotional exhaustion, compassion fatigue can emerge suddenly. Compassion fatigue (CF) includes a sense of helplessness, isolation and confusion, which may be disconnected from specific triggers. Pearlman and Saakvitne (1995) emphasize that compassion fatigue involves the symptomatic presentation of the caregiver of traumatized/distressed clients as a result of exposure to the client’s trauma. Compassion fatigue as a phenomenon very much resembles the symptomatic presentation of posttraumatic stress disorder (PTSD: American Psychiatric Association 2000). Most of the studies on burnout, vicarious trauma, and compassion fatigue have focused on individuals traditionally thought of as being in ‘helping professions,’ such as therapists, social workers, nurses, doctors, fire fighters, and police officers. Very limited published research, however, has been conducted into examining these phenomena among professionals that work with the traumatized and emotionally disturbed children.”

The issues, demands, and expectations on (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare regularly function under such work conditions with far more taxing stressors. Barford and Whelton are correct as they note, “The profession of Child and Youth Care is considered one of the most difficult and emotionally exhausting careers in the human service industry (Krueger 2002).” These issues, demands, and expectations combine to create an environment ripe with the stressors of burnout, (STS), (VT), and (CF) that often lead to high turnover of (DC) ministries staff because of the accompanying discouragement, demoralization, and job dissatisfaction, which impacts their professional and personal lives, the effects of which impact the individual (DC) ministries staff person, their spouses, their families, the organizations that employ them, and the children and/or youth in care. Maslach notes,

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“The consequences of burnout are potentially very serious for the staff, the clients, and the larger institutions in which they interact...initial research on this syndrome (Maslach 1976, 1978a, 1978b, 1979; Maslach and Jackson, 1978, 1979 in press; Jackson and Maslach (1980), Maslach and Pines (1977), Pines and Maslach (1978, 1980), along with the work of Freudenberger (1974, 1975) suggest that burnout can lead to deterioration in the quality of care or service that is provided by the staff. It appears to be a factor in job turnover, absenteeism, and low morale. Furthermore, burnout seems to be correlated with various self-reported indices of personal distress, including physical exhaustion, insomnia, increased use of alcohol and drugs, and marital and family problems.”

Exhaustion—physical exhaustion is the first visible manifestation. Exhaustion is then joined with anger, irritation and frustration. Their mental state becomes impaired; then, suspicion and paranoia form, and thoughts of betrayal by fellow staff and management staff begin. When burn-out’ takes over, [Mentally] a person’s thinking becomes excessively rigid, stubborn, and inflexible; there are resistant to growth and constructive change. [Emotionally] Emotional regulation becomes erratic and unstable, and their negative attitudes become caustic speech verbalized before the entire organization. [Physically] Physically, the person’s appearance begins to take the toll of mental, emotional, and physical exhaustion. However, oddly enough, the person struggles to maintain at work, and productivity continues to decline. [Relationally] Relationally, this person too struggles to maintain interpersonal relationships with others both professionally and personally, and thus begins to feel the toll of burnout in their professional and personal lives (Freudenberger 1974).
Scalise (2012) asserts that, “Burnout is a defense mechanism characterized by disengagement. Stress is characterized by over-engagement. In burnout, the emotional damage is primary. In stress, the physical damage is primary. The exhaustion of burnout affects motivation and drive. The exhaustion of stress affects physical energy. Burnout produces demoralization. Stress produces disintegration. Burnout can best be understood as a loss of ideals and hope. Stress can best be understood as a loss of fuel and energy. Burnout produces a sense of helplessness and hopelessness. Stress produces a sense of urgency and hyperactivity. Burnout produces paranoia, depersonalization, and detachment. Stress produces panic, phobia, and anxiety” (Scalise 2012).  

Scalise (2012) indicates that burnout can have a negative impact on an individual’s sense of helplessness and hopelessness. This speaks to the individual’s sense of spiritual well-being, their sense of having a purpose for being, and a sense of having a hope and a future. It also speaks to the individual having a sense of connectedness with the self, with others, and also having a sense of connectedness with God. The individual feels alone, isolated, and detached on every level—mentally, emotionally, physically, relationally, and spiritually.

Current research indicates that the stresses of ministry can be severe. The toll of the stressors associated with the work of ministry on the mental, emotional, physical, relational, and spiritual faculties of those in (DC) ministry in (RTC/F’s) in childcare and their families can be significant. “According to Barna (1993), London and Wiseman (2003), and Sanford (1982), pastors comprise one group of helping professionals who are especially prone to burnout. Issues that pastors face include (a) inordinate time demands (Jinkins and Wulff 2002); (b) unrealistic expectations (London and Wisemen 2003); (c) isolation (Sanford 1982); and (d) loneliness.

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(Spaine 1999). As a result, pastors’ personal lives may become severely imbalanced (Oswald 1991a), and their spiritual lives ironically dry (Hall 1997).

These four concerns are well-established risk factors linked to pastoral work and have generated questions about practices that might mitigate pastoral burnout.\(^\text{17}\) The deleterious effects of burn-out for those in ‘helping fields’ such as those in the ministry, and/or (DC) ministries is corroborated by emerging research that reveals that those in ministry report a variety of specific stressors which contributed to their burnout.\(^\text{18}\) Anderson notes, “This research indicates that these stressors fall into three categories: (a) demands of the ministry, (b) impact on family life, and (c) impact on personal life.”\(^\text{19}\)

Research has revealed that in the first category: the demands of ministry demonstrate how those in ministry struggle with the issues associated with ministry: expectations of congregations (Blanton 1992; Lee 1999; Rayburn 1991; Richmond, Rayburn, & Rogers 1985); expectations to accomplish a broad range of activities (Gleason 1977; Tomic, Tomic, & Evers 2004); expectations to operate within limited time constraints (Hill, Darling, & Raimondi 2003; Morris & Blanton 1994; Richmond et al. 1985); and always being on demand, when coupled with low levels of financial compensation (Blanton 1992) contribute to feeling overworked and underpaid (Morris & Blanton 1994; Rayburn 1991). In addition, within the category of demands of the job, ministers struggle with the requisite frequency of moves, the incidence of unwelcome


surprises, the lack of visible results, and the pathology of parishioners (Blanton 1992; Gleason 1977).  

In the second category, the impact on family life, research suggests that having ambiguous boundaries, or a failing to establish adequate boundaries between professional and personal life can be a contributor to the stressors of ministry (Blanton 1992; Gleason 1977; Hill et al. 2003; Lee 1999; Morris & Blanton 1994, 1998). The expectations placed upon those in ministry to always be on demand, always be on display, and always be on duty can place unrealistic expectations on the individual minister, their spouse, and their family (Morris & Blanton 1994; Rayburn 1991). Researchers suggest that boundary ambiguity contributes to assumptions that those in ministry and their families are a package, this often leads spouses and families feeling unappreciated and under-valued (Morris & Blanton 1994; Rayburn 1991). Ministers also reported problems in their marriages (Blanton 1992; Noller 1984; Richmond et al. 1985) and difficulties in parent-child relationships (Blanton 1992) due to unrealistic expectations placed upon them and their families.

The research also reveals that the third category of stressors, the impact of ministry on the individual minister’s personal life, is equally profound. Those in ministry often struggle with how their lives are always on display, and that they feel pressure to perform adequately (Morris & Blanton 1994; Rayburn 1991). Constant observation, evaluation and criticism often lead those in ministry to perfectionism, work addiction, diminished self-esteem, and increased stress.

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21 Ibid.

22 Ibid.
The effects of which can have deleterious impact on the lives of those in ministry (Blanton 1992; Gleason 1977). Additionally, there are the other related issues associated with the work of ministry: frequent relocations, low salaries, poor benefits, inadequate housing, and a substandard quality of life compared with their own congregants, and/or others in ministry, undefined roles, and the under-valued belief that accompanies these expectations (Blanton 1992; Gleason 1977). In addition, those in ministry report a sense of isolation, with little to no social support systems (Blanton 1992; Krause, Ellison, & Wulff 1998; Tomic et al. 2004). This can be exacerbated by poor pastor-to-congregation compatibility (Hill et al. 2003; Ostrander, Henry, & Fournier 1994). It may result from the frequently reported and inevitable isolation of leaders at any senior level, either corporate or ministerial (Hill et al. 2003). These factors combined work together as the issues associated with the work of ministry to create an environment ripe for burnout.

According to Maslach (1982), burnout in one's profession may occur when the demands placed on an individual exceed the benefits he or she reaps from the work. Maslach (2003) identified those in ‘helping field’ professions such as ministry, healthcare, and teaching positions as being particularly susceptible to burnout; these are positions with high demands and little return.

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24 Ibid.

Burnout, Maslach (2003) explained, is characterized by emotional exhaustion [EE], depersonalization [DP], and reduced personal accomplishment [PA].

Emotional exhaustion (EE) occurs when one is over-invested and involved in the problems of others. In time, this over-involvement could lead to feelings of emptiness, being drained, and having nothing left to give. Depersonalization (DP), or a sense of indifference towards the needs of others, occurs subsequent to emotional exhaustion as a form of detachment in order to protect one from being depleted. Detachment can lead to the third element of burnout, specifically feelings of guilt, referred to as reduced personal accomplishment (PA). These feelings arise as one comes to recognize his or her symptoms of depersonalization as characterological rather than situational, concluding that he or she is a bad person for not giving or caring more. As it logically flows from the downward spiral of burnout, high levels of pastoral burnout have resulted in equally high levels of attrition.

Anderson writes, “It has been estimated that at the end of every month an additional 1,500 pastors have vacated their positions. Research has indicated that 7 to 13% of pastors have left ministry prematurely due to burnout (Memming 1998; Zikmund, Lummis, & Chang 1998). The pastorate has proven a difficult position; burnout and attrition rates have indicated the enormous stress encountered by those in the profession.”

(DC) ministries staff also report struggling with these same burnout characterizations: Emotional exhaustion (EE), which occurs when one is over-invested and involved in the problems of others. (DC) staff often over-invest in the lives of the children and/or youth in care.

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27 Ibid.

seeking the best for those in their care, and are equally involved in the problems of the children and/or youth in care. In addition, it is often reported that this over-involvement leads to feelings of disappointment, discouragement and emptiness, being drained, and having nothing left to give. (DC) ministries staff report experiencing depersonalization (DP), or a sense of indifference towards the needs of others, stemming from their work with particularly challenging children and/or youth, whose behaviors are viewed as excessively taxing.\(^{29}\) This is usually followed by (DC) ministries staff seeking to distance themselves from the youth either physically or emotionally. Often they seek removal of such challenging youth from the (RTC/F’s) programming for failing to make significant progress, and requiring higher “levels of care.” This often occurs subsequent to emotional exhaustion as a form of detachment in order to protect one from being further depleted. This detachment often leads to the third element of burnout, specifically feelings of guilt, referred to as reduced personal accomplishment (PA). These emotions are often exacerbated by supervisors and administrative management who challenge (DC) ministries staff to remember that these are the type of children and/or youth coming into (RTC/F’s) today. This response from supervisors and administrative management personnel only further reinforce a growing awareness of (DC) ministries staff that these feelings arise as one comes to recognize his or her symptoms of depersonalization as characterological rather than situational, concluding that he or she is a bad person for not giving or caring more. This then reinforces a growing paranoia and negative attitude toward the organization and its leadership, which is another hallmark of burnout, as identified by Freudenberger (Freudenberger 1974).\(^{30}\)


Phenomenological research has been noted that if the individual (DC) ministries staff were to perform a self-check of their potential for burnout, they would likely see it from a four-stage checklist. Gorkin suggested that this view was more process oriented, that there were four stages of burnout, which include: “1.) [Physical], mental, and emotional exhaustion—feeling worn out after hard work, 2.) [Spiritual], shame and doubt—experiencing a deep sense of loss and change perceived as uncontrollable, 3.) [Relational], with cynicism and callousness—chronic uncertainty and vulnerability turn into irritability and ironic responses to others, 4.) [Mental and Emotional], a sense of failure, helplessness and crisis—coping seems to be unraveling, vulnerable, not just moody, but rather leading to clinical depression. It may be time for some medical and/or professional counseling.”31

Particular to the ‘helping fields’ of ministry, social service work, and or (DC) ministries which spans both the work of vocational ministry and that of social services, “job burnout was first recognized as a psychological problem among healthcare and social service professionals in the 1970s (Pines & Maslach 1978).32 Maslach and Pines extensive interviews with healthcare and social service professionals revealed they often experienced emotional exhaustion. Accompanying this was a loss of motivation resulting from the prolonged mental and emotional stress encountered in their jobs. Subsequent research identified the three distinct features now recognized as comprising burnout: emotional exhaustion (EE), depersonalization (DP) (a defense mechanism by which caregivers and service providers experience emotional distance from their


clients), and feelings of ineffectiveness or lack of personal accomplishment (PA) (Maslach 2003; Maslach et al. 2001).“33 34

These three factors characteristic of burnout are frequently reported by (DC) ministries staff working in (RTC/F’s) in childcare. Though burnout was originally conceptualized as a response to job stress produced by the demands of helping needy clients (Maslach 1982),35 it was quickly realized that institutional/organizational factors contribute to burnout (Maslach and Florian 1988; Maslach and Leiter 1996).36 37 This research has been supported by reports from (DC) ministries staff working in (RTC/F’s) in childcare.

The Secondary Traumatic Stress / Vicarious Trauma / Compassion Fatigue

As was the case with burnout, research on (STS) also known as (VT) or (CF) emerged from the clinical observations of the psychological problems observed in (DC) providers (Figley 1995; Kadambi and Ennis 2004).38

(STS) refers to re-experiencing in a direct and/or indirect exposure to traumatic material (Figley 1995). Figley also coined the term (CF) to describe the effects of (STS) on the individual


in a less stigmatizing manner. (STS), (VT), and (CF) have become interchangeable terms. Their relationship to burnout is that (STS), (VT), and (CF) share symptoms with burnout, yet differ in that burnout results from non-traumatic work related stress, with long hours and an overwhelming work load and is typified by symptoms of emotional exhaustion (EE), depersonalization (DP), and reduced feelings of personal accomplishment (PA) (Kahill 1998).³⁹

As with burnout, (STS) was thought to be a response to the prolonged exposure to the stress of interpersonal interactions between those in ‘helping field’ vocations and their traumatized clients. This has been supported by the research and writings of Jenkins and Baird (2002) who stated that burnout and (STS) “are similar in that they result from exposure to emotionally engaging clients via interpersonally demanding jobs, and represent debilitation that can obstruct providers’ services” (p. 423). Unlike burnout, (STS) is viewed mainly as a response to prolonged exposure to people who have been traumatized.⁴⁰ Figley (1995), who coined the term “compassion fatigue” in reference to (STS) among mental health professionals, described (STS) as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other” (p. 7).⁴¹ Thomas and Wilson (2004) view (STS) as part of a group of related occupational stress syndromes, including (VT) and (CF).

These syndromes have five basic components:

1. Frequent intense encounters with clients;
2. Physical and mental fatigue states;
3. Challenges to values, beliefs and worldview;
4. Exposure to traumatized clients;
5. Expectable stress responses. Some of these components are elements of burnout, along with feelings of disillusionment, isolation, and emotional distancing that also occur in both STS and burnout (Figley 1995). However, Secondary Traumatic Stress (STS) has a more clear

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⁴⁰ Ibid.

⁴¹ Ibid.
operational definition than Vicarious Traumatization (VT) (Kadambi and Ennis 2004) and is distinguished from burnout in that its core symptoms are similar to the symptoms of post-traumatic stress disorder (PTSD), including flashbacks, nightmares, and intrusive thoughts (Figley 1995)."^{42}

The phenomenological research of this research study reveals that (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare experience these five basic components of (STS) on a regular basis. (1) There are the frequent intense encounters with children and/or youth in care; (2) They experience both physical and mental fatigue states while on shift; (3) They experience constantly challenges to their personal values, beliefs and worldview; (4) They are continuously exposed to traumatized children and/or youth; and (5) they report frequent expectable stress responses identified by researchers—experiencing the mental, emotional, physical, relational, and spiritual effects of burnout, secondary traumatic stress, and compassion fatigue: social withdrawal, depersonalization, cynicism, exhaustion, irritability, low energy, feeling underappreciated and overworked; numb, disillusioned, hardened, jaded, and overwhelmed.

Other research reveals that (DC) ministries staff report being unable to disengage with their work, and frequently report (PTSD) post-traumatic stress disorder-like symptoms, including flashbacks, nightmares, and intrusive thoughts, and find themselves thinking about, and talking about their work even when they are off-duty.\^{43} The phenomenological research of this research study further supports this evidence. Sprang, Craig and Clark (2011) contend that (STS) has been revealed to be a common occupational hazard for those working in the (RTC/F’s)


\^{43} Ibid.
in childcare field. Emerging research reveals the detrimental consequences to a childcare worker’s overall personal well-being and professional effectiveness due to prolonged exposure to (STS) (Conrad & Kellar-Guenther 2006; Hopkins, Cohen-Callow, Kim, & Hwang 2010; Van Hook & Rothenburg 2009).

Additional research studies show that anywhere from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of (STS) or related conditions of PTSD and (VT). While this research focuses on therapists and child welfare workers, it is universally recognized that any child-care professional who works directly with traumatized children and/or youth, and is in a position to hear these children and/or youth recount their traumatic experiences are at a significantly higher risk of developing (STS).

Workers involved in direct patient care in ‘helping fields’ such as (DC) ministries staff are often exposed to the traumatic aftermath of suffering and negativity of those in their care on a daily basis. Professionally speaking, they face increasingly the issues, demands, and expectations placed upon them in the workplace, while on a personal level, they struggle to meet the issues, demands, and expectations of family life. As this struggle continues, the balance continues to elude these ‘helping field’ professionals, and soon the (DC) ministries staff succumbs to a numbness that begins to take over, thereby insulating them from the cares and


45 Ibid.

concerns of others. This numbness is known as (CF). As (CF) is another term used for (STS), and (VT) is characterized as a gradual lessening of compassion over time, it is often accompanied by disappointment, disillusionment, and discouragement the precursors of burnout. These are typically followed by a growing sense of dissatisfaction and an increasingly vocal negative perspective of the work and organization. Those who have suffered from (CF) have endured exposure to traumatic material (events, reenactments, stories, etc.) through providing help to traumatized persons. Individuals suffering with burnout, (STS), (VT), and/or (CF) report a diminished trust in humanity, and a heightened sense of vulnerability, a sense of emotional numbing, followed by a sense of hopelessness and fatalism. Research indicates that though (CF) is a type of burnout, it is distinctly different; a person can suffer from both burnout and (CF). They share some symptoms, and both take a toll on a person’s health and their relationships with others. Burnout, (STS), (VT) and (CF) effect the (DC) ministries staff, their families, and the organizations that employ (DC) ministries staff with increased low morale, absenteeism, decreased motivation and productivity, and overall apathy for organizational mission accomplishment.

(CF) is caused by empathy—caring for and about others. (CF) develops as the consequence of the stress resulting from caring for and helping traumatized people. (CF) develops with exposure to traumatic material shared by another that develops into a preoccupation with the other’s trauma. (DC) ministries staff experience (STS), (VT) and (CF) on a daily basis in their work in (RTC/F’s) in childcare require them to provide care for

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48 Ibid.
traumatized children and/or youth in their care. This constant exposure to the trauma narratives and trauma reenactments of the children and/or youth in care often result in the stressors of burnout, (STS), (VT) and (CF) for (DC) ministries staff.

The long-term effects of compassion fatigue include reduced empathy, a diminished sense of personal safety, reduced sense of control, increased hopelessness, and increased involvement in escape mentality, fantasy thinking, and participation in activities that can have a detrimental effect on the individual, and their families. These behaviors range from chronic overeating to substance or alcohol abuse and binge behaviors.

The deleterious effects of burnout, (STS), (VT), and (CF) on (DC) ministries staff are often combined with the cumulative stressors of the issues associated with the work of ministry, the demands associated with the work of (DC) ministries in (RTC/F’s) in childcare, and the expectations placed upon them by the organizations that employ them. The resulting impact of these stressors can take a deleterious toll on the individual (DC) ministries staff mentally, emotionally, physically, relationally, and spiritually. These combined stressors can be toxic to (DC) ministries staff—professionally and personally, and take its toll on the (DC) ministries staff families as well.

Dennis Portnoy, M.F.T. (2015), identifies five symptoms of burnout, (STS), (VT), and (CF), for staff and employers to be aware of that include:

Mentally: Cognitively the individual manifests lowered concentration, apathy, rigid thinking, disorientation, minimization, paranoia, and preoccupation with trauma.

Emotionally: Powerlessness, anxiety, guilt, anger, numbness, fear, helplessness, sadness, depression, depleted, shock, blunted or enhanced affect. Experiencing troubling dreams similar to a patient’s dream. Suddenly and involuntarily recalling a frightening experience while working with a patient or family
Physically: Somatic: (…of or relating to the body, especially as distinct from the mind.) Sweating, rapid heartbeat, breathing difficulty, aches and pains, dizziness, impaired immune system, headaches, difficulty falling or staying asleep.

Behavioral: Irritable, withdrawn, moody, poor sleep, nightmares, appetite change, hyper-vigilance, isolating.

Spiritually: Questioning life’s meaning, pervasive hopelessness, loss of purpose, questioning of religious beliefs, loss of faith/skepticism.

Like the research of Maslach and Jackson noted above, the research of Galek, Flannelly, Greene and Kudler (2011) confirm,

“A wide range of institutional factors is believed to contribute to burnout. Issues such as an autocratic administrative style, limited opportunities for promotion, lack of autonomy, lack of appreciation or rewards (salary, vacation time, etc.) may lower self-esteem over time (Maslach et al. 2001; Weiner 1989). On the other hand, cost-effectiveness measures that lead to understaffing and/or high caseloads may undercut one’s ability to perform one’s functions properly, lowering ones’ sense of self-efficacy (Lewandowski 2003). Whatever the case may be, burnout tends to build-up relatively slowly across time, with some studies indicating it may take years to develop (Maslach and Florian 1988; Maslach et al. 2001). Hence, many studies have used time measures without looking at the actual factors that contribute to burnout. Two of the most commonly used time measures in research on burnout are years in the same position and years in the same profession.”

There is a paucity of research on these stressors specific to the work of (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare. Also, there are few demographic studies revealing the age, gender, education level, personality type, or marital status for those most susceptible to these stressors. What research is available reveals that “the demographic factors that have been shown to be most predictive of burnout levels are age of the

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employee, marital status, and perceived levels of social support (Cordes and Dougherty 1993; Lau et al. 2005; Maslach et al. 2001).”

Another study reveals that women are at greater risk, and also those who are more naturally empathetic or those who have unresolved personal trauma. In addition, those workers who have a demanding case load, or whose work causes them to be socially and organizationally isolated or feel professionally compromised due to inadequate training. Emerging research reveals that organizational factors play a key role, and it is these organizational factors that contribute most to the onset of (STS), (VT), and (CF).

Barford and Whelton (2010) write,

“Workload has also been shown to contribute to burnout (e.g., Farber and Heifetz 1982; Maslach and Florian 1988). More demanding workloads impinge on helpers’ ability to perform their duties effectively, thereby lowering their sense of self-efficacy. Since over-functioning is a common characteristic of helpers, they may not recognize that their workload is the problem and may instead internalize the cause. The number of hours per week of direct client contact is the most commonly used measure of workload in studies of therapists, counselors, social workers, and chaplains (e.g., Ackerley et al. 1988; Coady et al. 1990; Flannelly et al. 2005a, b; Ross et al. 1989; Vredenburgh et al. 1999). All of the studies just cited reported that one or more measures of burnout increased with hours of patient contact.”

Clearly, the resulting impact of work related stressors of burnout, (STS), (VT), and (CF) can take a deleterious toll on the individual (DC) ministries staff: mentally, emotionally, physically,

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52 Ibid.


relationally, and spiritually. However, there are additional consequences to these deleterious effects.

The Toxic Spillover

Often the issues, demands, and expectations placed upon the individual that result in stressors, which contributed to their burnout from the three previous mentioned categories: (a) demands of the job, (b) impact on family life, and (c) impact on personal life spill over into other areas of life. “Spillover, or transfer of affect from one domain of life to another, has recently been acknowledged to impact functioning in various domains of life.”\(^{55}\) This “spillover” will often have a deleterious effect on the mental, emotional, physical, relational, and spiritual aspects of those in ministry and their families. With its negative effect, it is referred to here as “toxic spillover.”

The issues associated with the work of ministry, the demands specific to (DC) ministries work, and the expectations placed upon them by the organizations that employ them take its toll on the spouses and families of those in (DC) ministries. The ministry of (DC) as noted above shares many of these same issues associated with the work of ministry. Anderson (2010) has determined that,

“Isolation has been a problem for both pastors and their spouses (Hill et al. 2003). Within the congregation, pastoral couples hold a unique position, and as such, often feel isolated from their communities. Seventy percent of pastors in one study indicated they did not have a close friend (London & Wiseman 1993). Many clergy have experienced a reduced quality of life as compared to parishioners (Warner & Carter 1984), and they have reported being lonely and vulnerable despite having been surrounded by their congregants (Hill et al. 2003). The spouses of clergy indicated that they have been treated differently because of

their title as the pastor's spouse, and this phenomenon was experienced within both the church and the geographical community.”

The phenomenological research of this research study reveals that the spouses and families of (DC) ministries staff share these experiences. The research of Pector (2005) further confirms and reveals, “Clergy families are stressed by frequent relocation, and spouses often work outside the home. Marital satisfaction is lower for clergy couples than for lay couples. Pastors often feel they have too little time with children, and some clergy families feel they live in a fishbowl, with onlookers expecting perfection.”

The issues associated with the work of ministry, such as always being on demand, always being on display, and always being on duty, are however only those most stated concerns. In addition, there are those issues that are often not spoken about.


“…pastors and their spouses rarely turned to support systems outside their family. Thus, spousal support has been integral for the sustenance of pastors, in fact, many pastors have explained that it has been their only intimate relationship. However, McMinn and colleagues provided one caveat to the support available through the marriage relationship - it is a source of support only for those couples that have been able to maintain healthy relationships. Many clergy marriages have not been able to thrive due to limited time allotments devoted to the relationship or a scarcity of resources for pastors when problems have been encountered (McMinn et al. 2005).”

Anderson continues,

“…evidence of clergy marital unhappiness has been found in the soaring divorce rates of clergy (Morris & Blanton 1994). Ministers have had the third highest rate of divorce among professional groups (Richmond et al. 1985). Similar results have been found by other studies (Mace & Mace 1980; Noller 1984; Warner & Carter 1984). Pastors, as well as congregants, encounter difficulties in life;

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however, pastors have not had a pastor of their own to depend on for support. Despite the frequency of marital difficulties and the lack of supportive resources (Hill et al. 2003; Noller 1984), clergy have been continually sought for marriage advice and marriage counseling (Meek et al. 2003; Morris & Blanton 1994; Richmond et al. 1985; Ripley 2003). Richmond and colleagues explained that clergy have been a major source of marriage counseling, having provided over half of the marital counseling services in the United States. Pastors have worked hard to support the marriages of others; however, they are in a demanding, self-sacrificial profession with high burnout rates, and many pastors have concurrently endured difficulties in their own marriage relationships.”

In addition, research reveals that associated with the issues of the work of ministry, “a spiritual dryness emerges as the primary predictor of emotional exhaustion, the stress dimension of burnout. Rather than any specific spiritual, rest-taking, or support system practice (i.e., praying, fasting, taking retreats, or meeting with a close friend), this finding reinforces the premise that pastors, by virtue of their calling, there is a need to nurture an ongoing and renewal relationship with God to maintain life balance, reduce stress, and avoid burnout.”

Then, there are the demands associated with the work of (DC) ministries in (RTC/F’s) in childcare on (DC) ministries staff’s spouses, and families is equally detrimental. Burnout, (STS), (VT), and (CF) can have a deleterious effect not only on the (DC) ministries staff individual, but it also effects their families equally. The spouses and family members of these (DC) staff also struggle with the effects of the issues associated with the work of ministry the demands associated with the work of (DC) ministries in (RTC/F’s) in childcare and the expectations placed upon the (DC) staff by the organizations that employ them. Spouses and


60 Ibid.

family members also struggle with the tolls that burnout, (STS), (VT), and (CF) take upon them.

The research of Galek, Flannelly, Greene and Kudler (2011) reveal that,

“…although burnout and STS may be similar to some degree, STS is specifically thought to be the result of indirect exposure to another person’s traumatic experiences, such that a helper acquires symptoms that are much like those of the traumatized person he/she is trying to help (Figley 1995; McCann and Pearlman 1990; Thomas and Wilson 2004). Hence, whereas burnout develops from prolonged occupational exposure to demanding interpersonal situations and institutional factors, STS develops over consecutive interactions with traumatized individuals. STS has a relatively fast onset, according to Figley (1995), and it may even arise from a specific event…Given its rapid development, however, STS may be more closely related to helpers’ reduced sense of safety and self-control in a world where horrific events can apparently happen to anyone (McCann and Pearlman 1990; Rosenbloom et al. 1999).” 62

Without adequate pre-hire screening, pre-service and in-service training that includes and awareness of these stressors, and the ‘self-care’ training that should also be made available in an effort to mitigate, and/or alleviate the deleterious effects of these stressors. This ‘self-care’ training should be accompanied by organizational efforts in employee engagement avenues to further address these issues, demands, and expectations. As a result, these stressors will likely spillover from the (DC) ministries staff’s professional lives into their personal lives with additional deleterious effect when they take work home.

It is therefore likely that this same toxic spillover from the experiences of the (DC) staff individual who then shares their work related experiences, trauma narratives, and trauma reenactments of the children and/or youth in care then inadvertently become a catalyst for burnout, (STS), (VT), and (CF) that also effects their spouse and family.

Finally, the expectations placed upon (DC) ministries staff by the organizations that employ them, also have and deleterious effect on the spouses, and families of staff, as well as co-

workers, and those in care. These expectations often include: working with insufficient training to meet the demands of the types of youth in care; inadequate staffing; undesirable work schedules, or excessively long work shifts; low salaries; poor benefits; isolated living conditions, ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high (DC) ministries staff turnover.

As these studies reveal, those in full-time ministry, particularly those in (DC) “helping” ministries are prone to suffer burnout, secondary traumatic stress, stressors, and toxic spillover. Pector’s (2005) perspective on these stressors provides additional insights,

“Burnout is an adaptation to exhaustion that involves withdrawing from others and limiting empathy. Conversely, caregivers with compassion fatigue fully extend themselves despite physical, mental, and spiritual depletion. Fight or flight responses help in acute stress, but hurt in chronic stress. Physiologically, caregiver stress creates depression, anger, anxiety, and higher awareness of mortality. A critically overstressed caregiver may feel suicidal or numb, reverse roles to seek solace from clients, make frequent errors, or become chemically dependent.”

These same stressors often have the same deleterious toxic-spillover effect on those whose lives come into contact with (DC) staff suffering from these stressors.

Numerous studies have examined the effects of these stressors and have also provided recommendations to mitigate and/or alleviate the impact on the individual. Those in (DC) ministries in (RTC/F’s) in childcare provide an invaluable service to society. In ministering to the children and/or youth in care, they place themselves and their families at risk, and often struggle in silence. As a direct result of their work in (RTC/F’s) in childcare, (DC) staff are mentally taxed, emotionally depleted, physically exhausted, relationally broken, and spiritually

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Dry. (DC) ministries staff pour themselves out and have not always the means to replenish themselves or their families. Clearly, the issues, demands and expectations on those in (DC) ministry, and their families are great. These staff and their families often struggle in silence for fear that to be transparent would mean that the issues, demands, and expectations of others would go unmet, and worsen the needs of others would go unfulfilled. In short, those in (DC) ministries in (RTC/F’s) in childcare minister to the children and/or youth in care, and take their ministries to heart. They do what they do for the children and/or youth in care. “It is all for the kids.” So they suffer, their own needs go unrecognized, until they are unable to continue. This thesis topic was pursued in an effort to determine whether or not the phenomenological research experiences while working as (DC) ministries staff, and the observations made as a Director of Pastoral Care/ Chaplain and Campus Pastor at a residential treatment facility in childcare ministering also to (DC) ministries staff could be verified.

A research study was conducted and an online survey was created to determine whether these issues, demands, and expectations associated with the work of (DC) in (RTC/F’s) in childcare were common experiences. The online survey questions were intended to determine if these (DC) ministries staff were experiencing the same measure of impact on the mental, emotional, physical, relational, and spiritual aspects of their lives with the same deleterious effects on their professional and personal lives, and those of their families.

The following chapter, Chapter 4, seeks to support the preceding chapter’s historical research to date, alongside the phenomenological research. It will also seek to support the thesis through the statistical data developed from this research study and the summary results of the online survey of (DC) ministries staff working in (RGH’s), (RTC/F’s) in childcare. The statistical data developed from the research study and the summary results of the online survey
reveals the prevalence of the issues associated with the work of ministry, the specific demands of working in (RTC/F’s) in childcare, and the expectations placed upon (DC) ministries staff by the organizations that employ them. While the prevalence of these issues may vary from organization to organization, the issues, demands, and expectations on (DC) ministries staff do differ, largely due to the mental and emotional issues and the behavioral challenges of the children and/or youth in care; the research study and results from the online survey reveal that the trends follow well-established norms.
CHAPTER 4
THE CURRENT RESEARCH, THE PHENOMENOLOGICAL RESEARCH,
AND THE
ONLINE SURVEY RESEARCH DATA ANALYSIS

The Current Research

As noted prior, research studies spanning several years universally reveal that those working in human services, particularly those working in “helping fields” are prone to the deleterious effects of burnout, (STS), (VT), and (CF).

Many of these studies have addressed these stressors and the deleterious impact they have had on the individual. While some of these studies have focused their research on those working as (DC) ministries staff in (RTC/F’s) in childcare servicing children and/or youth few of these studies have directed their research into the impact of the issues, demands, and expectations specific to this ministry, and the stressors of burnout, (STS), (VT), and (CF) that are associated with working with higher levels of “at-risk” and/or behavioral children and/or youth in (RTC/F’s) in childcare. The work of (DC) ministries in (RTC/F’s) with children and/or youth in childcare is among the most challenging of the “helping fields” professions.

While there are challenges present in working in any of the human services fields, each with its own issues, demands, and expectations and each with its own stressors, none are as uniquely challenging as working in (DC) in (RTC/F’s) with children and/or youth in childcare. This is largely due to the levels of care required for the clinical continuum of services for the children and/or youth in residential care. There are even significant differences to the issues, demands, and expectations placed upon those who provide (DC) ministries in (RTC/F’s) versus
those that provide (DC) ministries in (RGH’s) in childcare servicing children and/or youth.

Again, the primary difference between (RGH’s) and (RTC/F’s) are the “levels of care” provided for the clinical “continuum of services,” or milieu of service for the children and/or youth in residential care.

While there are a number of similarities between (RGH’s), and (RTC/F’s), in that, both provide residential childcare to children and/or youth in need, there are also significant differences that set the two apart. (RGH’s) are generally considered to operate as Level I type facilities providing residential care for children and/or youth minimal emotional and/or behavioral issues, and also typically provide for any therapeutic needs through outsourcing these services. (RTC/F’s) provide a “continuum of care” to children and/or youth on level two, three, and four status that require higher levels of supervision, care, and/or emotional and/or behavioral therapeutic treatment. These distinctions exist across the United States, however many states have moved away from leveling systems, which are a means to identify the continuum of care provided by a residential childcare facility. As a result, many organizations providing residential care for children and/or youth operate with multiple “levels of care” under one model or a continuum of care—often referred to as a “person-centered plan” approach—a unique, individually-focused approach to planning and providing for children and/or youth in need of services and support.

In short, (RTC/F’s) can provide residential care, and a “continuum of care,” or milieu of services for children and/or youth of a level two, and/or level three status. Furthermore, under certain conditions, also children and/or youth on step-down from level four facilities, and in some cases step-downs from level five facilities, all at the same (RTC/F’s).
As a result, the issues, demands, and expectations as well as the stressors associated with the work of (DC) ministries in (RTC/F’s) with children and/or youth in childcare often result in burnout, (STS), (VT), and (CF). This research project sought to reveal the impact of the issues, demands, and expectations, and the stressors associated specifically with (DC) work in (RTC/F’s) working with children and/or youth in childcare on the mental, emotional, physical, relational, and spiritual aspects of (DC) ministries staff professional and personal lives.

The Phenomenological Research

The phenomenological research resulted from both the several years this author spent working as a (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare, and from my current work as a Director of Pastoral Care/Chaplain and Campus Pastor providing ministry to residents and staff at (RTC/F’s). During these last few years, there have been sufficient opportunities from my own personal experience and the input and insights of current (DC) ministries staff from which to establish the phenomenological research.

As with any phenomenological research, this project is a study that attempts to gain insight into the perceptions, perspectives and experiences of their particular situations. This research project too sought to understand (DC) ministries staff’s perceptions, perspectives, and experiences of their particular situations. This phenomenological research was central to this thesis project in understanding how the issues, demands, and expectations specific to working as (DC) ministries staff in (RTC/F’s) with children and/or youth in childcare impacts the individual (DC) worker in the mental, emotional, physical, relational, and spiritual aspects professionally and personally. This experience includes having had opportunities to work at four different residential care facilities with children and/or youth in childcare working with level two children and/or youth at a group home facility. This phenomenological research included working with
level two, and level three children and/or youth in (RTC/F’s), and working with level four children and/or youth in step down program facilities (RTC/F’s). These four varied placements afforded multiple opportunities to engage with other (DC) ministry staff to glean from the shared experiences.

The phenomenological research gained from working in this field of ministry, and from these encounters with other (DC) ministries staff became the genesis for this thesis project, research study and online survey. It was as a direct result of this phenomenological research—my own experience working in (DC) ministries, and the informal research gained from working with other (DC) ministries staff in (RTC/F’s) with children and/or youth in childcare, that revealed significant concerns over the issues, demands, and expectations, and the stressors associated with this type of ministry that contribute to the premature departure from this type of ministry. A review of the current research of the issues, demands, and expectations and the subsequent stressors associated with working as (DC) ministries staff in (RTC/F’s) with children and/or youth in childcare reveals the prominence of burnout, (STS), (VT) and (CF) as a common occurrence in (DC) ministries in residential care working with children and/or youth as with many “helping fields.”

The current research and the phenomenological research reveal that these stressors can negatively affect the lives of (DC) ministries staff, and the quality of their professional and personal lives. Of equal importance was how the issues, demands, and expectations and the associated stressors of burnout, (STS), (VT), and (CF) that often accompany the work of (DC) ministries in (RTC/F’s) working with children and/or youth in childcare can have not only a deleterious effect upon them, but also on their families, the organizations that employ them, and ultimately to the children and/or youth in care.
The Online Survey And Research Data And Analysis

This thesis project: The Challenges And Biblical ‘Self-Care’ Practices For ‘Direct-Care’ Staff In Residential Treatment Facilities sought to examine the current research. Following this, the project aimed to conduct a review of the current research against the phenomenological research for comparison, and then conduct the online survey with multiple organizations with multiple (DC) ministries staff in an effort to verify the existing current research; the phenomenological research. In addition, it attempted to gain a greater understanding and awareness of how the issues, demands, and expectations specific to the work of (DC) ministries in (RTC/F’s) and the subsequent stressors placed upon those in (DC) ministry working in (RTC/F’s) with children and/or youth in childcare adversely impact the mental, emotional, physical, relational, and spiritual aspects of the staff, their families, and the organizations that employ them. Additionally, how the impact of these stressors upon those in (DC) ministries working in (RTC/F’s) with children and/or youth in childcare takes its toll on their families, and the organizations they are affiliated with.

There have been numerous studies on the effects of burnout, (STS), (VT), and (CF) on those working in human services fields, particularly those in “helping fields.” Few of these studies, however, limited their research to the deleterious effects, and subsequent impact of these stressors on the mental, emotional, physical, relational, and spiritual aspects on (DC) ministries staff working in (RTC/F’s) with children and/or youth in childcare as does this research project.

Methods

Subjects:
First, this author established a workable 500 mile geographic area of research for the study from my current work/study location near Wilmington, NC. This roughly covers the areas of North Carolina, South Carolina, Virginia, Maryland, District of Columbia, Tennessee, Georgia, and parts of Alabama, Kentucky, and West Virginia. Then, the author identified those organizations within a 500 mile geographical area (of my current work/study location), that provide (DC) ministry in a residential treatment center/ facility and/or group home environment to children, youth, and young adults with ‘at-risk’ youth and/or behavioral and/or developmental disabilities; those (RTC/F’s) for childcare whose residential clientele has a minimum of 40 persons, and whose (DC) ministries staff is at a minimum of 15 persons. Then, a review was conducted on a list of organizations within that geographical radius in order to determine the 158 organizations that fit the stated criteria, and were thus identified as potential candidates for contact to request their organization (DC) ministries staff’s participation in the research study. That number then became the initial pool of target organizations. That pool of target organization candidates was then further reviewed for how these organizations would meet the greater refined stated criteria; of the initial 158 total organizations, only 35 total organizations were selected as potential target organizations. This became the final pool of target organizations to approach for participation in the online research survey and study.

Having identified those target organizations, and contacted the CEO/President and/or Chief Operating Officer via certified mail, with a letter of introduction, the letter of introduction included: a.) the reason for contacting their organization, b.) the desire to utilize that organizations (DC) ministries staff's participation in research, c.) the potential benefits of the summary of survey data to the organization, d.) a sample of the survey, e.) the researchers
contact information, f.) a web-link to the online survey, and g.) an assurance of anonymity for all survey participants.

The online survey portal was monitored for 30 days following the mailing of the initial letter of introduction to see which organizations (DC) ministries staff have completed the online survey.

If there is no online activity noted by a target organization within 30 days after the initial mailing, I plan to mail out a second or follow-up the letter and make a telephone call to the leadership of those target organizations, requesting again that the organization's leadership reconsider the benefits of (DC) staff's participation in the online research survey. The intent would be to gain the participation of as many of the target organizations in the research study and online survey.

The online survey portal will be again monitored for 30 days following the mailing of the second or follow-up letter to see which organizations (DC) ministries staff have completed the online survey.

If after the second or follow-up mailing, there is no activity by an organization, there will be no further attempts to contact that organization's leadership for their organization's participation in the online research survey and study. The intent would be to gain the organizations participation in the research study and online survey. Those organizations that have not responded would have their organizational information removed from the online survey portal. The research study and online survey would then be closed except to those organizations that have already begun participation in the research study and online survey. The intent here would be to develop a research window that would allow for a timely completion of the research project. It is expected that only 10% of the 35 target organizations will respond, or (3)
(RTC/F’s); and of those only approximately 50% of their (DC) ministries staff will voluntarily participate in the research study and online survey. Or out of approximately (60) eligible (DC) ministries staff, only a total of (30) are expected to participate. Thus, the overall goal for the research study and online survey was adjusted to a minimum of (3) organizations; and/or (30) (DC) ministries staff.

When the organization has agreed / given their authorization to have their (DC) ministries staff participate in the research study and online survey, they will then provide their organization’s (DC) ministries staff with the web-link to the online survey that they may participate in the online survey.

The (DC) ministries staff would then follow the web-link provided to the “Introduction” page, where they will select from the “Drop-Down” the name of their organization. They will then be redirected to the “Informed Consent Information” pages, and then to a “Statement of Consent” page where they will be provided the option to “Take the Survey” or “Disagree” for their “Informed Consent Information” document completion. The (DC) ministries staff survey participant then follows the prompts to complete the online survey’s forty questions, which should take no more than 15 minutes to complete. The (DC) ministries staff survey the participants upon completing the online survey’s questions, who will then be directed to a survey completion page, which ends with a “Done” option. Once the “Done” option is selected the (DC) ministries staff survey participant will be automatically logged off, and that individual’s survey is then finalized.

To achieve anonymity for the survey participants, (DC) ministries staff participants of the organization who participate in the survey will only be identified by a sub-numerical identifier associated with the organizations numerical identifier, thus creating and maintaining an
anonymous survey portal for their staff’s participation in the survey. The sub-numerical identifier for these direct-care staff participants is identifiable only as attached to that of the organizational numerical identifier. No other identifier will be captured. The entire numerical identifier "string" would follow a type pattern as the following example illustrates:

Organization: ABC, Inc.: ABC, Inc.  (Organizational Identifier)
Staff: ‘Direct-Care’ Staff Participant: 001  (Individual Identifier)
Date of Survey: (April 1, 2015): 04012015  (Date Identifier)

The combined numerical identifier string would then be read as: ABC, Inc. 001-0401-2015.

All of the data retrieved from that numerical identifier would then be specific to that organization.

All the data retrieved from that numerical identifier would then be specific to that organization. This could also enhance the findings for the overall research project. Further, the summary of data captured from the survey could be provided for the organization's leadership contact (President, Chief Executive Office, Chief Operating Officer, Vice-President of Residential Services, Residential Director, etc.) in an effort to generate further interest in services which could be provided to the organization that are intended to address these areas of concern as reported by the organization's (DC) ministries staff.

This thesis project and research study will keep the hard copies of research study materials and online survey information including the authorized “Informed Consent Information” forms (pages) and completed survey's data received in a locked drawer and/or locked filing cabinet, and the digital records of the data from the authorized “Informed Consent
Information” and online surveys in a password protected computer file. Once the thesis project and research study is completed, these documents on file will be kept on file for 3 years and will then be destroyed.

Instruments:

A forty-two question online survey was created to: (1) identify the organization’s participating in the research study and online survey, (1) appropriate and voluntary participation in the online survey, and (5) “Mental” aspects of (DC) work, (5) “Emotional” aspects of (DC) work, (5) “Physical” aspects of (DC) work, (5) “Relational” aspects of (DC) work, (5) “Spiritual” aspects of (DC) work, and, (15) “Morale” aspects of (DC) work. Similar to the Maslach Burnout Inventory (MBI) (Maslach & Jackson 1981), a twenty-five question survey was created to measure hypothesized levels of burnout, (STS), (VT), and (CF) of the (DC) ministries staff survey participant’s mental, emotional, physical, relational, and spiritual aspects. Like the Maslach Burnout Inventory (MBI), this instrument sought to measure the frequency and intensity with which these respondents dealt with the issues, demands, and expectations associated with their work that resulted in burnout, (STS), (VT), and (CF). As with the Maslach Burnout Inventory (MBI), this instrument sought to measure levels of emotional exhaustion (EE): feeling emotionally worn down and exhausted by the work, Personal Accomplishment (PA): feelings of competence and accomplishment in work. Depersonalization (DP): and increasing awareness of personal detachment, and feelings of impersonal response, increased attitudes of uncaring and unfeeling toward the needs of others.¹

Additionally, similar to the Work Environment Scale (WES) (Moos 1981), the online survey sought to measure the workplace environment and morale in the workplace using a ten-question portion in the survey. Here, like the Work Environment Scale, the survey respondents measured on: (1) Involvement—the extents to which workers are concerned about and/or are committed to their jobs. (2) Peer cohesion—level of friendliness and support in co-workers. (3) Supervisor support—perceived support from management. (4) Autonomy—the degree to which workers are encouraged to be self-sufficient and to make their own decisions. (5) Task orientation—the extent to which the workplace environment is efficient and effective. (6) Work pressure—the extent to which the issues, demands, and expectations, the press of work dominates the job experience. (7) Clarity—the extent to which workers know what the rules are, in addition to the policies, model of care, and requirements of the job, and also whether the workers feel those have been and are being communicated both from management and to and from peer workers. (8) Control—the extent to which management and immediate supervisors use rules, policies, and expectations (implied or stated) to maintain control over staff. (9) Physical comfort—whether workers feel physically safe in the workplace, and the pleasantness of the physical surroundings.²

The survey also included aspects of the Attributions of Therapeutic Outcome measure (ATO) (Cooley & Savicki 1983), which is a twenty-five question tool to measure the types of attributions therapists make about outcomes in their clients. Similar to the ATO, this survey sought to determine whether the (DC) staff were concerned whether their work with the children and/or youth in care was effective and instrumental in creating positive and lasting change.

Lastly, under the morale heading, the survey itself was designed in a Likert-type scale design. The online survey was used to provide a rating scale to capture the correlation of the variables of work force contentment and satisfaction, or the adverse for the (DC) ministries staff measuring overall job satisfaction, with salary, job challenge, job characteristics, job promotion and career growth potential, peer support, supervisor support, trust, and expectations, and effectiveness. Also queried were the following: employee benefits, perception of organizational concern about employee well-being, and employee engagement, employee satisfaction with organization, employee morale, and the likelihood that (DC) ministries staff surveyed would pursue employment elsewhere within the coming year. (See Tables 1 and 2).

**Table 1.1 ‘Direct-Care’ Ministries Staff Research Study/Online Survey Information**

<table>
<thead>
<tr>
<th>Sample Size:</th>
<th>N = 128</th>
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<tr>
<td>Gender:</td>
<td>Male and Female</td>
</tr>
<tr>
<td>Marital Status:</td>
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</tr>
<tr>
<td>Education Status:</td>
<td>All (GED/High School Diploma/College/Masters)</td>
</tr>
<tr>
<td>Employment Status:</td>
<td>Full time / Part time</td>
</tr>
<tr>
<td>Employment Position:</td>
<td>(DC) ministries staff at an (RTC) and/or (RTF)</td>
</tr>
<tr>
<td>Range For Field of Study:</td>
<td>500 Geographical Square Miles From Wilmington, North Carolina</td>
</tr>
<tr>
<td>Number of Organizations Surveyed:</td>
<td>10</td>
</tr>
<tr>
<td>Number of ‘Direct-Care’ Staff Surveyed:</td>
<td>128</td>
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</table>
Table 1.2 Direct-Care Staff Sampling Research Study and Online Survey Statistical Analysis:

Research Study And Online Survey Of 'Direct-Care' Ministries Staff Working In Residential Treatment Facilities in Childcare With 'At-Risk', and/or Behaviorally Challenged Children, and Youth.

Q1 Please identify what organization you work for.

Answered: 128   Skipped: 0
Basic Statistics

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<thead>
<tr>
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<th>Maximum</th>
<th>Median</th>
<th>Mean</th>
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<tr>
<td>Girls</td>
<td></td>
<td></td>
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<td>Responses</td>
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<td>-------------------------------------------------------</td>
<td>-----------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama Baptist Children's Homes (1)</td>
<td>0.78%</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Appalachian Children’s Home (2)</td>
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<tr>
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<td>Bethany Children’s Home (4)</td>
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<tr>
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<td>Boys and Girls Homes of North Carolina, Inc. (6)</td>
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<tr>
<td>Organization Name</td>
<td>Percentage</td>
<td>Number</td>
<td></td>
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<tr>
<td>--------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
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<tr>
<td>Christ’s Home For Children (10)</td>
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<td></td>
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<td>Florida Baptist Children’s Home (15)</td>
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<tr>
<td>Florida Sheriff’s Youth Ranch (16)</td>
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<td>Legacy Treatment Services (Formerly The Children’s Home) (21)</td>
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<td>Stepping Stones, Inc. (Stepping Stones Boy’s Home) (25)</td>
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Q2 Statement of Consent: I have read and understood the above information. I am 18 years of age or older. I am currently employed as a 'Direct-Care' ministries staff in a residential treatment facility in childcare. I have no questions; or have asked questions and have received answers. I understand that I will not receive, nor do I expect any compensation for my participation in the research study and online survey. I consent to participate in the research study and online survey.

Answered: 105   Skipped: 23

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<td>Disagree (2)</td>
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Q3 I am mentally prepared for the job that I do.

Answered: 101   Skipped: 27

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Q4 I am well trained by my organization for the job I do.

Answered: 101  Skipped: 27

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<th>Disagree</th>
<th>Neutral</th>
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<td>11.88%</td>
<td>44.55%</td>
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Q5 I find my job fulfilling.

Answered: 101    Skipped: 27

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<td>0.99%</td>
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<td>Median: 5.00</td>
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<tr>
<td>Mean: 4.46</td>
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<td>Standard Deviation: 0.78</td>
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Q6 I am often mentally overwhelmed at work.

Answered: 100    Skipped: 28

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<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
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<th>Weighted Average</th>
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<tbody>
<tr>
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<td>34.00%</td>
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<td>25.00%</td>
<td>9.00%</td>
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<tr>
<td></td>
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<td>34</td>
<td>27</td>
<td>25</td>
<td>9</td>
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<td>1.07</td>
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Q7 I often seek to relieve the stress of my work.

Answered: 101    Skipped: 27

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<th>Strongly Agree (5)</th>
<th>Total</th>
<th>Weighted Average</th>
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<tr>
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<td>15.84%</td>
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Q8 I feel as though I make a positive impact at work.

Answered: 100    Skipped: 28

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<th>Agree (4)</th>
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<td>38.00%</td>
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**Basic Statistics**

- Minimum: 1.00
- Maximum: 5.00
- Median: 4.00
- Mean: 4.24
- Standard Deviation: 0.76
Q9 I feel emotionally supported by my organization.

Answered: 100    Skipped: 28

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<th>Weighted Average</th>
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Basic Statistics

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<th>Standard Deviation</th>
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<td>4.00</td>
<td>3.94</td>
<td>1.01</td>
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Q10 I feel valued at my organization.

Answered: 100    Skipped: 28

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<td>8.00%</td>
<td>17.00%</td>
<td>44.00%</td>
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Q11 I often feel emotionally stressed at work.

Answered: 100    Skipped: 28

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Q12 I feel as though my job has negatively impacted my life.

Answered: 100   Skipped: 28

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Q13 I often feel physically exhausted after my work shift.

Answered: 100    Skipped: 28

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Q14 I often feel the need to relieve the stress of my job.

Answered: 100  Skipped: 28

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Q15 I often feel overly tired while at work.

Answered: 100   Skipped: 28

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Q16 I have called in sick to work when I was not sick.

Answered: 100    Skipped: 28

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Q17 I feel as though my job has taken a physical toll on me.

Answered: 100    Skipped: 28

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Q18 I feel relationally isolated at work.

Answered: 100    Skipped: 28

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**Basic Statistics**

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Q19 I feel as though my job has had a negative impact on my relationships outside of work.

Answered: 100   Skipped: 28

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Q20 I get along well with my co-workers.

Answered: 100   Skipped: 28

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Q21 I feel as though my opinions about work matter to my co-workers.

Answered: 100  Skipped: 28

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<td>RELATIONAL</td>
<td>3.00%</td>
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Q22 I feel as though I am an important part of the organization.

Answered: 100   Skipped: 28

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Q23 I feel as though the organization cares about my spiritual well-being.

Answered: 99  Skipped: 29

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Q24 I feel my spiritual beliefs are challenged by my job.

Answered: 100  Skipped: 28

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Q25 I have opportunities for personal spiritual renewal.

Answered: 100    Skipped: 28
Q26 I have sufficient opportunities for personal spiritual development.

Answered: 100  Skipped: 28

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Q27 I feel it is important to find harmony in my life with my work and my spiritual life.

Answered: 100  Skipped: 28

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Q28 I feel as though I am well paid for the work I do.

Answered: 98    Skipped: 30

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<td>8</td>
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<td>30.61%</td>
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<td>2.93</td>
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Q29 I feel as though my job is challenging.

Answered: 99   Skipped: 29

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Q30 I often feel like the tasks assigned to me by my supervisor help me grow professionally.

Answered: 100    Skipped: 28

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Q31 I feel as though there are opportunities to get promoted where I work.

Answered: 98    Skipped: 30

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Q32 I feel as though I am supervised effectively at work.

Answered: 99    Skipped: 29

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<td>4.00</td>
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Q33 I am satisfied with my employee benefits.

Answered: 100    Skipped: 28

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<th>Disagree (5)</th>
<th>Neutral (16)</th>
<th>Agree (48)</th>
<th>Strongly Agree (29)</th>
<th>Total</th>
<th>Weighted Average</th>
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<td>3.97</td>
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<td>0.91</td>
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Q34 I am satisfied with my job.

Answered: 100    Skipped: 28

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Q35 I trust my supervisor.

Answered: 100  Skipped: 28

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<td>4.00</td>
<td>4.08</td>
<td>1.06</td>
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Q36 I feel as though my organization cares about its employees.

Answered: 98    Skipped: 30

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<th>Disagree (2)</th>
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Q37 I feel as though my opinions about my work matter to my supervisor.

Answered: 99  Skipped: 29

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|                  | 3                      | 7             | 14          | 34        | 41                 |       |                  |

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<td>1.05</td>
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Q38 I feel as though my supervisor has realistic expectations of me.

Answered: 100  Skipped: 28

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<th>Disagree (2)</th>
<th>Neutral (3)</th>
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<tr>
<td>0.00%</td>
<td>10.00%</td>
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<td>5.00</td>
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Q39  I like working for my organization.

Answered: 100    Skipped: 28

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<td>Agree</td>
<td>38</td>
<td>38.00%</td>
</tr>
<tr>
<td>Neutral</td>
<td>11</td>
<td>11.00%</td>
</tr>
<tr>
<td>Disagree</td>
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<td>1.00%</td>
</tr>
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<td>Strongly Disagree</td>
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**Basic Statistics**

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<td>Median</td>
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<tr>
<td>Mean</td>
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<td>Standard Deviation</td>
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Q40 I look forward to coming to work.

Answered: 98    Skipped: 30

### Basic Statistics

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<td>5.00</td>
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Q41 I am likely to look for another job outside the organization within the next year.

Answered: 98  Skipped: 30

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<td>48.98%</td>
<td>23.47%</td>
<td>18.37%</td>
<td>7.14%</td>
<td>2.04%</td>
<td>98</td>
<td>1.90</td>
</tr>
<tr>
<td></td>
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<td>23</td>
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<td>5.00</td>
<td>2.00</td>
<td>1.90</td>
<td>1.06</td>
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Strongly Agree 2.04% (2)
Agree 7.14% (7)
Neutral 18.37% (18)
Disagree 23.47% (23)
Strongly Disagree 48.98% (48)
Q42 I feel that I have career growth and development potential with my organization.

Answered: 99    Skipped: 29

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<td>12.12%</td>
<td>20.20%</td>
<td>46.46%</td>
<td>14.14%</td>
<td>99</td>
<td>3.48</td>
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<td>5.00</td>
<td>4.00</td>
<td>3.48</td>
<td>1.10</td>
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Discussion:

The online survey results clearly identify that (DC) ministry staff working in (RTC/F’s) with children and/or youth in childcare face issues, demands, and expectations associated with the work of (DC) ministries that fosters the stressors of burnout, (STS), (VT), and (CF). In the five aspects surveyed: mental, emotional, physical, relational, spiritual, and the aspect of morale the overall combined survey results indicate:

<table>
<thead>
<tr>
<th>Category</th>
<th>Survey Question</th>
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<th>Max</th>
<th>Mean</th>
<th>SD</th>
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<tbody>
<tr>
<td>MENTAL:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Q3</td>
<td>“I am mentally prepared for the job that I do.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.49</td>
<td>0.68</td>
</tr>
<tr>
<td>Q4</td>
<td>“I am well trained by my organization for the job I do.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.16</td>
<td>0.85</td>
</tr>
<tr>
<td>Q5</td>
<td>“I find my job fulfilling.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.46</td>
<td>0.78</td>
</tr>
<tr>
<td>Q6</td>
<td>“I am often mentally overwhelmed at work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>2.99</td>
<td>1.07</td>
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<tr>
<td>Q7</td>
<td>“I often seek to relieve the stress of my work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>3.38</td>
<td>0.96</td>
</tr>
<tr>
<td>TOTAL WEIGHTED AVERAGE</td>
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<td>25.00</td>
<td>19.48</td>
<td>4.34</td>
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</table>

This statistical data reveals that although respondents feel they are mentally prepared and trained to do the job, nearly three-quarters of the respondents feel they are mentally overwhelmed while at work, and often seek to alleviate the mental stress of the work through some ‘self-care’ practice.

Clearly, (DC) ministries staff responded that they are mentally taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

EMOTIONAL:

<table>
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<th>Max</th>
<th>Mean</th>
<th>SD</th>
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<tbody>
<tr>
<td>Q8</td>
<td>“I feel as though I make a positive impact at work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.24</td>
<td>0.76</td>
</tr>
<tr>
<td>Q9</td>
<td>“I feel emotionally supported by my organization.”</td>
<td>1.00</td>
<td>5.00</td>
<td>3.94</td>
<td>1.01</td>
</tr>
<tr>
<td>Q10</td>
<td>“I feel valued by my organization.”</td>
<td>1.00</td>
<td>5.00</td>
<td>3.90</td>
<td>0.97</td>
</tr>
<tr>
<td>Q11</td>
<td>“I often feel emotionally stressed at work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>3.02</td>
<td>1.16</td>
</tr>
<tr>
<td>Q12</td>
<td>“I feel as though my job has negatively impacted my life.”</td>
<td>1.00</td>
<td>5.00</td>
<td>1.88</td>
<td>0.93</td>
</tr>
<tr>
<td>TOTAL WEIGHTED AVERAGE</td>
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<td>25.00</td>
<td>16.98</td>
<td>4.83</td>
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</table>
This statistical data reveals that although respondents feel they are emotionally making a positive difference at work, and feel supported by their organizations, more than half of the respondents feel they are emotionally overwhelmed at work, and seek to alleviate the emotional stress of the work through some ‘self-care’ practice. Clearly, (DC) ministries staff responded that they are emotionally taxed because of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

PHYSICAL:

Q13 “I often feel physically exhausted after my work shift.” 1.00 5.00 3.36 1.02
Q14 “I often feel the need to relieve the stress of my job.” 1.00 5.00 3.33 1.00
Q15 “I often feel overly tired while at work.” 1.00 5.00 2.81 1.00
Q16 “I have called in sick to work when I was not sick.” 1.00 5.00 1.23 0.61
Q17 “I feel as though my job has taken a physical toll on me.” 1.00 5.00 2.41 1.16
TOTAL WEIGHTED AVERAGE……………………………………5.00…..25.00…13.14…...4.81

This data reveals that although respondents feel they are physically exhausted after a work shift; and often feel tired while at work; and that more than half of the respondents feel the need to relieve the physical stress of the work through some ‘self-care practice; most reported they would not abuse sick leave, when they were not actually sick as part of the ‘self-care’ practice. Clearly, (DC) ministries staff responded that they are physically taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare

RELATIONAL:

Q18 “I feel relationally isolated at work.” 1.00 5.00 2.19 1.11
Q19 “I feel as though my job has had a negative impact on my relationships outside my work.” 1.00 5.00 2.20 1.19
Q20 “I get along well with my co-workers.” 1.00 5.00 4.26 0.77
Q21 “I feel as though my opinions about work matter to my co-workers.” 1.00 5.00 3.93 0.92
Q22 “I feel as though I am an important part of the organization.” 1.00 5.00 3.97 0.89
TOTAL WEIGHTED AVERAGE……………………………………5.00…25.00…16.55…...4.88
This data reveals that just under half of the respondents feel they are relationally isolated at work, and also feel that their job has had a negative impact on their relationships outside of their work. Most get along well with their co-workers and feel their opinions about work matter to their co-workers, and also that they feel valued by their organizations. Clearly, (DC) ministries staff responded that they are relationally taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

SPIRITUAL:

Q23 “I feel as though the organization cares about my spiritual well-being.” 1.00 5.00 3.92 1.01
Q24 “I feel my spiritual beliefs are challenged by my job.” 1.00 5.00 2.49 1.28
Q25 “I have opportunities for personal spiritual renewal.” 1.00 5.00 3.72 0.95
Q26 “I have sufficient opportunities for personal spiritual development.” 1.00 5.00 3.60 1.03
Q27 “I feel it is important to find harmony in my life with my work and my spiritual life.” 1.00 5.00 4.28 0.72

TOTAL WEIGHTED AVERAGE……………………………….5.00…..25.00….18.01…..4.99

This data reveals that although respondents feel it is important to find harmony in their lives with their work and spiritual beliefs, that they believe that the organization cares about their spiritual well-being, and have opportunities for spiritual renewal and spiritual development, half of the respondents feel their spiritual beliefs are challenged by their job. Clearly, (DC) ministries staff responded that they are spiritually taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

MORALE:

Q28 “I feel as though I am well paid for the work I do.” 1.00 5.00 2.93 0.98
Q29 “I feel as though my job is challenging.” 1.00 5.00 4.15 0.77
Q30 “I often feel like the tasks assigned to me by my supervisor help me grow professionally.” 1.00 5.00 3.79 0.92
Q31 “I feel as though there are opportunities to get promoted Where I work.” 1.00 5.00 2.95 1.08
Q32 “I feel as though I am supervised effectively at work.” 1.00 5.00 3.87 1.06
Q33 “I am satisfied with my employee benefits.” 1.00 5.00 3.97 0.91
Q34  “I am satisfied with my job.”  1.00  5.00  4.12  0.84
Q35  “I trust my supervisor.”  1.00  5.00  4.08  1.06
Q36  “I feel as though my organization cares about its employees.”  1.00  5.00  3.98  0.98
Q37  “I feel as though my opinions about my work matter to my supervisor.”  1.00  5.00  4.04  1.05
Q38  “I feel as though my supervisor has realistic expectations of me.”  1.00  5.00  4.04  0.90
Q39  “I like working for my organization.”  1.00  5.00  4.37  0.72
Q40  “I look forward to coming to work.”  1.00  5.00  4.16  0.82
Q41  “I am likely to look for another job outside the organization within the next year.”  1.00  5.00  1.90  1.06
Q42  “I feel I have career growth and development potential with my organization.”  1.00  5.00  3.48  1.10

TOTAL WEIGHTED AVERAGE........................................15.00.....75.00…55.83…14.25

This data reveals that although respondents feel that they like the organizations that they are employed with, like the job they do, feel that they are challenged and compensated appropriately, like their supervisors, feel valued by the organization and their supervisor, and also trust their supervisor. Still, nearly one-third of the respondents reported they would most likely seek employment with another organization within the next year. Clearly, there is a disconnection with the organization at some level.

The current research, the phenomenological research, and the online survey research and data analysis reveal that these additional expectations and subsequent stressors include insufficient training to meet the demands of the types of youth in care; inadequate staffing; undesirable work schedules, or work shifts; low salaries; poor benefits; poor job conditions, undefined job responsibilities, a lack of appropriate supervision, poor communication, insufficient resources, and high (DC) ministries staff turnover. In addition, there are the stressors placed upon (DC) ministries staff of unrealistic expectations and demands placed upon them by the organizations mid-level management and senior administrative staff, the courts, social workers, guardian ad litem’s, school officials, and even parents. This often exacerbates the already overwhelmed, (DC) ministries staff with thoughts and feelings of
being mentally, emotionally, physically, relationally, and spiritually exhausted and ideal candidates for burn-out, boil-over, and burn-up.

Combined, these expectations alone would be enough to discourage even the most hardy and well-intentioned individual to reconsider their level of commitment to and organization. Added to the issues associated with the work of ministry and the demands specific to (DC) ministries work, these issues, demands, and expectations create an environment that is detrimental to the professional, and personal well-being and success of (DC) ministries staff, their families, and the overall success of the organizations that employ them.

This thesis asserts that it is the issues, demands, and expectations specifically associated with the work of (DC) ministries work in (RTC/F’s) with children and/or youth in childcare that lead to an increasing prevalence of the stressors of burnout, (STS), (VT), and (CF) among (DC) ministry staff. Moreover, these issues, demands, and expectations and their associated stressors can and often do lead to premature departure from this “helping field” of ministry.

This thesis further asserts that the deleterious effects of these stressors that can so adversely impact the (DC) ministry staff, their families, the organizations that employ them, and ultimately the children and/or youth in care, that (DC) ministries staff and the organizations that employ them can and should be addressed with a combination of appropriate ‘self-care’ training; and the daily employment of these ‘self-care’ practices by (DC) ministries staff and organizational employee engagement practices to aid them in greater professional and personal fulfillment, which will also provide the organizations with resources to address (DC) ministries staff recruiting and retention issues.

The purpose of this thesis, research study, and online survey was two-fold: 1.) Identify the impact of the stressors of burnout, (STS), (VT), and (CT) on (DC) ministries
staff working in (RTC’s) and/or (RTF’s) working with children and/or youth in childcare, and its deleterious impact as toxic spillover on their spouses, families, co-workers, and the organizations that employ them, and ultimately the children and/or youth in care. 2.) Provide biblically sound ‘self-care’ practices to alleviate and/or mitigate the stressors associated with this “helping field” vocation.

The following chapter, Chapter five, seeks to summarize the preceding chapter’s historical research, the phenomenological research, and the statistical data developed from this research study, and the results of the online survey. The statistical data developed from current research, the phenomenological research, and the research study and the summary results of the online survey reveals the prevalence of the mental, emotional, physical, relational, and spiritual issues, as well as morale issues associated with the work of ministry; the specific demands of working in (RTC/F’s) in childcare; and the expectations placed upon (DC) ministries staff by the organizations that employ them.

While the prevalence of these issues may vary from organization to organization, the issues, demands, and expectations on (DC) ministries staff do differ. This is largely due to the mental and/or emotional issues and the behavioral challenges of the children and/or youth in care; the research study and results from the online survey reveal that the trends do follow well-established norms. Clearly, there is a need for ‘self-care’ training for (DC) ministries staff as there are significant stressors associated with the “helping field” ministry of (DC) ministries working in (RTC/F’s) with children and/or youth in childcare. The individual (DC) ministries staff and the organizations that employ them can and should address this with appropriate ‘self-care’ training, supervision, and the daily employment of such ‘self-care’ practices to ensure the professional and personal success of (DC) ministries staff working in (RTC/F’s) in childcare.
CHAPTER 5

THE BIBLICAL ‘SELF-CARE’ STRATEGIES, AND PASTORAL COUNSELING INTERVENTIONS FOR ‘DIRECT-CARE’ MINISTRIES STAFF

The ‘Self-Care’ Training And Organizational Employee Engagement Strategies For Improved Recruiting, Retention, And Release Issues Of ‘Direct-Care’ Staff

A plethora of existing research, as well as this writer's research, reveals that the issues, demands, and expectations associated with the work of (DC) ministries in (RTC/F’s) in childcare are among the most stressful of all the “helping field” vocations. Adding the stressors of burnout, (STS), (VT), and (CF) can have a deleterious effect on the individual staff, as well as their families. The effects of these stressors on (DC) ministries staff and on their families often manifest themselves in the mental, emotional, physical, relational, and spiritual aspects of their professional and personal lives. In addition, these effects often begin with either the individual (DC) ministries staff person, or their families grasping the dynamic impact of, or cause of such stress. Often misperceiving the true causes of these stressors, (DC) ministries staff often attribute the effects of these stressors to personal weaknesses, failings, or personality flaws. On this, Maslach writes,

“First of all, the burnout syndrome appears to be a response to chronic, everyday stress (rather than the occasional crises). The emotional pressure of working closely with people is a constant part of the daily job routine. What changes over time is one’s tolerance for this continual stress, a tolerance that gradually wears away under the never-ending onslaught of emotional tensions. As a result, when a caregiver begins to have problems in dealing with people, he or she has difficulty in identifying their situational cause. There is no immediate change in the work environment that corresponds with the noticeable change in the work environment that corresponds with the noticeable change in his or her behavior…in fact; the stress of the job is the cause. However, since the job is a constant factor, the person is unable to see a situational cause that coincides with the effect. Therefore, the obvious choice is between two possible causes, both person-centered: “The problems are caused either by me or by them.”

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“Burnout is often experienced by those in the helping professions, such as clergy, doctors, teachers, police officers, social workers, and others who work extensively with people. It is thought to result from excessive demands that others place on their energy, time, and resources.”

When these stressors and their deleterious effects begin to take their toll, a pastor or pastoral counselor is often the first person that (DC) ministries staff and their families seek out for counsel. It is paramount that the pastor or pastoral counselor grasp that “much counseling has to do with problem management or reduction. To state this positively, much Christian counseling has to do with learning and applying the principles of kingdom living to the chronically recurring sins, fears, failures, and dark areas of our life.”

“The work of preaching and counseling, when blessed by the Holy Spirit, enables men through the gospel and God’s sanctifying Word to become pure in heart, to have peaceful consciences, and to trust God sincerely. Thus, the goal of nouthetic counseling is set forth plainly in the Scriptures: to bring men into loving conformity to the law of God.”

Whether pastors and pastoral counselors practice a solely nouthetic approach, or a nouthetic approach combined with other counseling approaches for a more eclectic approach overall to pastoral counseling, they strive to provide a genuine hope, help, and healing that begins with God’s Word.

Pastors and Pastoral Counselors seek to include God’s Word, the Bible, God’s Holy Spirit, and an approach that incorporates into each counseling session God’s power to bring about growth and healing. “The goal of a helping relationship is to promote growth. More specifically, the goal of the helping relationship in Christian counseling is to help people

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enter into a richer experience with God and others (Crabb 1977).” While not every (DC) ministries staff working with children and/or youth in residential childcare is a Christian, those that come to a pastor or pastoral counselor should expect that the pastor or pastoral counselor will reference God, and the Holy Spirit, will utilize God’s Word—the Bible as the primary resource for hope, help, and healing. Even those that are not Christians can still appreciate the value of the timeless teachings of the Bible. McMinn writes, “Some have suggested using the Bible as a self-help book with religious clients. Even Albert Ellis, a self-proclaimed atheist and outspoken opponent of devout religious faith, had this to say about the Bible in a recent article: “I think that I can safely say that the Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined.” This is equally appropriate for the pastor or pastoral counselor working with (DC) ministries staff and their families struggling with the effects of burnout, (STS), (VT), and (CF). With this in mind, this pastor and pastoral counselor approaches biblically recommended “self-care’ training, and/or pastoral counseling intervention strategies with an eclectic approach that is firmly grounded in a nouthetic approach first and foremost. Clinton, Hart, and Ochsclager assert that,

“Christian counseling and pastoral care is grounded upon the centrality of healing relationships with both vertical and horizontal dimensions. Like all counseling, it is dyadic in its horizontal dimension between two persons. As truly Christian counseling, it becomes uniquely triadic due to God’s presence in the vertical, supernatural dimension. In Christian counseling, the Holy Spirit is the third person in every counseling situation. Since this vertical dimension is unique to Christian counseling, it is essential that we begin healing pursuits with the relational God—with Father, Son, and Holy Spirit.”

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7 Ibid. 15.
They continue,

“Mark McMinn recently called attention to the importance of theology in counseling when he stated: “Effective Christian counselors also consider theological perspectives at the same time that they engage in the various psychological tasks of counseling. Historical and systematic theology, biblical understanding, and Christian tradition are all valued and considered essential components of counseling.” Effective counselors, in McMinn’s view, are those given to “multitasking”—the ability to utilize insights and skills gained from the study of theology, psychology and spirituality simultaneously and appropriate for the benefit of the client.”

Pastors and pastoral counselors are in the business of Christian soul care. Hebrews 13:17 teaches that it is the work of spiritual leaders (pastors), and that they will be held accountable to God for the souls of those placed in their care. Clinton and Ohlschlager write,

“Christian soul care is a journey of healing, sustaining, reconciling, and guiding. It includes both the care and cure of the soul. As such, Christian soul care makes abundantly clear that the care of souls is a Christian activity that expresses the love of God to the needs of the human soul. The term for “soul” in the Greek New Testament—psyche, which translated from the Hebrew word nepesh—was used 101 times and referred to one’s inner life, the self, the living personality. Furthermore, since the Hebrew and the Middle Eastern mind emphasized the essential unity or wholeness of the person, the term is used interchangeably with “spirit” (pneuma, or ruah in Hebrew), “heart” (kardia, or leb in Hebrew), and “mind” (nous in the Greek). The biblical soul is the undifferentiated, immaterial life force that was created by God to be in relationship with him and, if redeemed, will live in eternity with him (Genesis 2:7; Deuteronomy 13:3; 1 Peter 1:22).”

Pastors and pastoral counselors today must minister to the whole of the person. That is to minister to the needs of the individual’s, whether mental, emotional, physical, relational, and/or spiritual well-being. This takes the issue of ‘soul care’ beyond the former limitations assumed by many, back to its historical and biblical roots. Anderson, Zuehlke, and Zuehlke address this writing,

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“Theologians have not come to a complete agreement regarding the basic nature of humanity. Those adopting a trichotomous view believe we are composed of body, soul, and spirit. In this view, the soul includes mind, will, and emotions. Others take a dichotomous perspective and understand the soul and the spirit to be essentially the same. Those who incline toward this approach appeal to the fact that we are essentially material and immaterial, possessing an inner person and an outer person. A growing number of Bible scholars and therapists support a wholistic [sic] approach to the integration of the components of human nature.”

Townsend builds on this writing,

“All counselors, pastoral or not, implicitly or explicitly manage the boundary between personal faith, religious or spiritual knowledge, and psychotherapy. Because of their claim to engage the spiritual and religious lives of clients, pastoral counselors must be particularly complex since pastoral counseling is no longer contained as an extension of Protestant ministry or bound historically, philosophically, theologically, or institutionally to the context and practices of the church...Pastoral counselors must engage an increasingly plural world with a versatile, critically examined theological vocabulary that expresses the discipline’s voice in relation to the following:

- Intra-Christian counseling contexts that cross boundaries between Protestant, Catholic, Orthodox, conservative evangelical, Holiness, and other traditions;
- Conservatives about counseling and human well-being in interreligious contexts;
- Public policy and its effect on physical, psychological, and spiritual life as expressed in community mental health and other social service agencies; and,
- Public policy affecting human physical, psychological, and spiritual welfare as expressed by legislation and social action.

Dialogue in these larger arenas—and work with expanding diversity of client populations—requires pastoral counselors to be clear about how they manage the boundaries between behavioral sciences and theology, or spirituality and psychotherapy.”

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Pastors and Pastoral Counselors seeking to minister from a holistic approach, minister to every aspect of the individual (DC) ministries staff person, regardless of whether their needs are mental, emotional, physical, relational, or spiritual. Pastors and pastoral counselors understand that God’s Word teaches, and research reveals that the one must be in harmony mentally, emotionally, physically, relationally, and spiritually—to achieve that harmony and balance, or all aspects of the person’s life can be adversely effected. To help (DC) ministries staff working in (RTC/F’s) with children and/or youth the organizations that employ them must provide ‘self-care’ awareness training for new staff, and regular on-going ‘self-care’ awareness training for staff currently filling this role. Additionally, organizations must institute appropriate employee engagement practices that seek to address the issues, demands, and expectations that foster such workplace stressors, and mitigate these stressors with ‘self-care’ awareness training, employee engagement practices, and workforce improvement processes. Organizations must accept that there is a plethora of research from the last twenty-five years; much of it by the experts referenced in this paper.

The experts in the fields of burnout, (STS), (VT), and (CF) that have been referenced in this paper demonstrate through their writings and research that these deleterious effects cannot be attributed solely to the individual, but rather to a large degree as a result of the issues, demands, and expectation placed upon them in the workplace by administrators, supervisors, clients, and stakeholders at every level. The organization by extension of its administrators, supervisors, clients, and stakeholders, however, is largely the cause for, and continues to be a perpetuator of many of these stressors, even ignoring and denying their culpability in failing to address the issues, demands, and expectations, as well as the stressors that result. This not only compounds the problems experienced by (DC) ministries staff, but it also fosters an environment that is unhealthy on multiple levels all of which impact, the mental, emotional, physical, relational, and spiritual aspects of the employees, as well as
employee morale, which impacts adversely the overall quality of services provided. Maslach writes,

When people are working with others in the context of an institution, “administrative response” is another unrecognized factor that leads them to misperceive the cause of burnout as coming from themselves. If difficulties arise in the delivery of care or service, administrators and supervisors are programmed to see the problem in terms of subordinates who are not performing their job adequately, rather than of shortcomings in the operational features of the institution itself. Because they assume that many of the hassles result from errors, faulty judgments, or laziness on the part of the employees, a major aspect of the job of administrators is directed toward getting employees to improve their job performance or getting better employees—the old “shape up or ship out” motivational advice. Thus, when employees complain to administrators about the emotional stress of their work, the typical person-oriented response is, “What’s the matter, can’t you take it?” Or, “What seems to be your problem?” In one stroke the administrator takes the institution off the hook and hangs the complainer on it instead…12

Clearly, how the organization responds to the needs of (DC) ministries staff struggling with the deleterious effects of burn-out, (STS), (VT), and (CF) is central to mitigating the impact of the stressors associated with the work of (DC) ministries staff working with children and/or youth in residential childcare. The impact on the individual (DC) ministries staff, and their families. Perhaps this can be achieved through a combination of effective employee engagement practices that strive to allow the staff to feel heard, valued, and included in the day-to-day programming decisions. Where staff are encouraged, empowered, and enabled to share their concerns, comments, and complaints and find a willingness on the part of administrators to work together with (DC) ministries staff to resolve concerns, and mitigate as much as possible those issues, demands, and expectations associated with the work of (DC) ministries working with children and/or youth in residential childcare. Employee engagement practices alone are however insufficient to achieve this end.

For those professionals in ‘helping fields’, like (DC) ministries staff working in (RTC/F’s) in childcare, learning how to develop appropriate ‘self-care’ skills is also necessary. In fact, individual “self-care” is paramount. Following adequate ‘self-care’ training, there must also be the daily employment of ‘self-care’ practices. Finally, these skills, when combined with appropriate coaching and pastoral counseling can work together to assist (DC) ministries staff in effectively combating these stressors, and their toxic spillover can have a deleterious effect on their professional and personal lives. This proactive five step strategic approach could reap both short and long-term dividends for the individual (DC) ministries staff, their families, and the organizations that employ them.

First, there must be an acknowledgement and willingness to address these issues, demands, and expectations that contribute to these stressors in the lives of (DC) ministries staff by the organizations that employ them. There must be an intention from these organizations to develop a ‘self-care’ training program, or provide (DC) ministries staff and supervisors with the opportunities to engage in regularly scheduled out-sourced ‘self-care’ training. Appropriate ‘self-care’ training, coaching and pastoral counseling, and as necessary, referral to other professional therapeutic counseling must be developed to address the specific needs of (DC) ministries staff. To be effective, this ‘self-care’ training must be followed by the daily employment of ‘self-care’ practices that too are designed to specifically combat the issues, demands, and expectations encountered daily by the individual (DC) ministries’ staff. In addition, organizations would do well to provide incentives for those that demonstrate regularly employed ‘self-care’ practices as recommended by the training they have received. It would be of a significant benefit to (DC) ministries staff that they have regular access to coaching and pastoral counseling to help staff who are struggling against the stressor professionally and personally.
Second, (DC) ministries staff must understand that early recognition and employed ‘self-care’ practices both in and out of the workplace are key to creating and maintaining professional and personal wellness. However, for many, ‘self-care’ is not a priority. All too many (DC) ministries staff focus only on others, placing themselves last. Sadly, this often means that these (DC) ministries staff will likely not last—either professionally, or personally. For those in (DC) ministries in (RTC/F’s) in childcare, to be successful both professionally and personally they must develop a regimen of ‘self-care’ practices that provide for their mental, emotional, physical, relational, and spiritual replenishment.

Third, it is paramount for the professional and personal well-being of the (DC) ministries staff working in (RTC/F’s) in childcare that they appreciate their need for ‘self-care’ training and daily employment of ‘self-care’ practices. It is equally important that the organizations that employ (DC) ministries staff in (RTC/F’s) in childcare recognize the issues, demands, and expectations on these staff, and also develop and/or include ‘self-care’ training for (DC) ministries staff.

Fourth, it is important for individuals and their employers to recognize and challenge the spiritual and psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation.

Fifth, central to this approach is and appropriate understanding that ‘self-care’ actually increases a caregiver’s—(DC) ministries staff’s capacity to care for others. Portnoy asserts,

“For those in the helping professions, early recognition and improved self-care both in and out of the workplace are key to creating wellness. Many caregivers focus on others at the expense of their own well-being. It is crucial for them to replenish themselves and commit to having a life outside of work that includes daily nurturing activities. People often understand this concept intellectually, but the knowledge doesn’t necessarily lead to taking better care of themselves. It is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such
as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation. Self-care actually increases a caregiver’s capacity to care for others. Self-care, however, is not just about making healthy lifestyle choices — it is about being present with one’s feelings, sensations and intuitive guidance in order to detect what is best in any given moment.”

This research reveals that those in ‘helping fields’ like (DC) ministries staff report increased compassion satisfaction which strongly negatively correlate with numerous items on the burnout, (STS), (VT), and (CF) subscales. In short, those in ‘helping fields’ who were able to develop coping skills to better enable them to more effectively deal with the stressors associated with their work were better able to perform their work with a greater sense of well-being and experienced greater professional and personal satisfaction. This sense of well-being and professional and personal satisfaction translated into improved attitudes, increased work performance, and better overall quality of care for those they serve.

Portnoy (2011) asserts that those in ‘helping fields’ who “had higher compassion satisfaction scores were more interpersonally “fulfilled,” as defined by scores on “being happy,” “being me,” and “being connected to others.” These professionals in ‘helping fields’ “did not feel as trapped and did not experience difficulty separating personal life and work. They were also less likely to feel exhausted, bogged down or “on the edge.”

The Biblical ‘Self-Care’ Practices and Pastoral Counseling Interventions for ‘Direct-Care’ Ministries Staff

**Recommended ‘Self-Care’ Practices:**

Clearly, the development and daily practice of ‘self-care’ strategies plays a significant role in achieving mental, emotional, physical, relational, and spiritual well-being. Examples

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14 Ibid.

15 Ibid.
of commonly recommended and employed ‘self-care’ practices for mental, emotional, physical, relational, and spiritual well-being, and improved work-to-life balance include:

Mental:

- Develop a habit of journaling to vent, express, and release negative thoughts, attitudes and distressed emotions.  

- Develop a habit of stimulating one’s mind and increasing intellectual excitement by Reading, or continuing one’s professional education

- Develop short-term, mid-range and long-term goals, which one can achieve within three, six, and twelve months or longer.

- Develop a habit of learning to separate mentally ones’ professional life from one’s personal life in order to experience renewal.

- Develop a habit of learning a new skill, or participating in a creative art or pastime. Begin exploring and implementing a hobby or activity that will bring one joy, inner peace, self-confidence, and happiness.

- Develop a habit of daily meditation, and mindfulness-based stress reduction practices.

- Seek out qualified and capable pastoral and as needed professional therapy.

Emotional:

- Develop a habit of listening to how you express your emotions—be honest with


17 Ibid.


yourself and others, identify one’s own needs, put words to one’s emotions and learn to discuss them openly and honestly with trusted others to help ameliorate the stressors.  

-Develop a habit of learning to separate emotionally ones’ professional life from one’s personal life in order to experience renewal.

-Develop a habit of positive ‘self-talk.’ —stop reinforcing negative thoughts, feelings in addition, past actions. Optimism and pessimism can affect one’s overall health and well-being. Positive self-talk that accompanies optimism can ameliorate the toxic effects of stress and plays a central role in effective stress management.

-Develop a habit of daily meditation, and mindfulness-based stress reduction practices.

-Develop healthy relationships with others both in and outside the workplace that provide appropriate social support.

-Develop and attitude of professional detachment (engaged (active) coping strategies) to better, protect from the toxic effects of depersonalization, (DP) and a decrease in personal accomplishment (PA) associated with the stressors of the workplace: Burn-out, Secondary Traumatic Stress, Compassion Fatigue, Vicarious Trauma, and the toxic spillover that results.

-Develop healthy means to express your emotions through healthy and constructive avenues--hobbies developing skills other than verbalizing emotions, such as gardening, drawing, writing, playing and instrument, building something, take up writing poetry, stories, plays, songs, doing some painting, acting, or singing.

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-Seek out qualified and capable pastoral/and as needed professional therapy. \(^{30}\)

Physical:

-Develop a habit of learning to separate physically ones’ professional life from one’s personal life in order to experience renewal. \(^{31}\)

-Develop a habit of eating nutritious meals regularly, maintain a healthy diet—consume good calories, not bad calories and exercise to burn more calories than one takes in. \(^{32}\)

-Develop a habit of daily exercise routines that include at least three times per week cardio exercise, for a minimum of 30 minutes per day (treadmill, elliptical, bicycle, etc., achieving 60-70% of heartrate of 220 minus age equals max heartrate for individual.), and then at least twice per week, Resistance/Strength training and Flexibility for 20-30 minutes each time. Varying the training routines to keep things interesting and enjoyable. Do things to exercise that are enjoyable, things that are more likely to be continued. \(^{33}\)

-Develop a habit of losing weight naturally and healthily with exercise and proper eating. Do not Diet. \(^{34}\)

-Develop a habit of getting a good night’s rest each night. Get nightly sleep rest of at least 6 to 7 1/2 hours of sleep each night. \(^{35}\)

-Develop a habit of enjoying non-sleep related rest and relaxation. Make time for leisure activities that have no purpose yet are enjoyable: funny movies, a walk on the beach, listen to music, read a good book, or spend time with a friend. \(^{36}\)

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\(^{31}\) Ibid.


\(^{35}\) Ibid.

\(^{36}\) Ibid.
Develop a habit of including ten to fifteen minutes in the sunlight each day.  
Seek out healthy outlets for physical exercise that create exciting, interesting and engaging opportunities for recreation and physical exercise. It has been reported that participation in leisure activities provides resources that can assist one in resisting the onset of stress or better cope with stress before it has an impact on one’s health.

Relational:

- Develop a habit of learning to separate relationally ones’ professional life from one’s personal life in order to experience renewal.

- Develop a habit of taking time to “un-plug” from work related activities, and enjoy and engage with spouses, and family members in restful, recreational, rewarding activities.

- Develop a habit of learning to say, ‘No!’ occasionally to others whose demands on you and your time place unreasonable expectations that interfere with your personal and/or family time. This helps to define what is most important in one’s life, and establishes healthy boundaries.

- Develop a habit of defining responsibilities—delegate what you can, to those who can, and what others can do, other than those things that you alone must do. This allows others opportunities for professional and personal growth; and create opportunities for freeing up one’s schedule for greater work-to-life balance.

- Develop a habit of intentionally stepping away from work related activities throughout the day, just to take a fifteen-minute break to pray (talk to God), call your spouse, call your family, talk to a friend, take a walk, or just enjoy the ‘self-care’ moment alone.


- Develop a habit of planning and taking time off away from the workplace and work-related activities. It is important to plan, and take vacations with one’s spouse, and family. It is not the quantity of time—it is the quality of the time that matters most. It is all about creating fond memories and building relationships.

- Develop a habit of taking time to be alone with oneself to think, to dream, to rest.

- Seek out healthy relationships for personal fulfillment that create exciting, interesting and engaging opportunities to meet with and enjoy quality time with family and friends, and to develop healthy relationships with friends and coworkers outside of the workplace.

Spiritual:

- Develop a habit of spending quality time with God in daily personal Bible study/devotions, meditating on God’s Word and allow the Holy Spirit to speak truth into your life circumstances and situations, both professional, and personal.

- Develop a habit of spending quality time with God in daily personal prayer time.

- Develop a habit of regular church fellowship and worship service attendance.

- Develop a habit of maintaining accountability with another trustful maturing believer who will be safe sounding board, and available accountability partner, and godly mentor.

- Develop a habit of spending time in silence before God—just listening, looking and learning to hear from God.

- Develop a habit of fasting and praying on a weekly basis for clarity of thought, answer to prayer, for wisdom, courage to act, and/or strength to endure, and also

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45 Ibid. 73.


48 Ibid. 33.

49 Ibid. 158.


51 Ibid. 15.
spiritual victory over sin, and the forces of darkness that seek to bring confusion, doubt, fear, frustration, disillusionment, and discouragement. Fasting and prayer are practical demonstrations of one’s utter dependence on, and need for God.\footnote{Foster, Richard J. \textit{Celebration Of Discipline: The Path to Spiritual Growth}. (New York: HarperCollins Publishers, 1988) 47.}

Seek out a Bible believing and preaching church to join. Seek out godly relationships and opportunities for personal spiritual growth and spiritual maturing; that create exciting, interesting and engaging opportunities to grow in one’s faith, participate in corporate worship; attend regular discipleship classes with one’s spouse, and family, or friends.

These examples of recommended ‘Self-care’ practices are abound in the contemporary context for the mental, emotional, physical, relational, and spiritual aspects of an individual’s life, in that they might achieve work-to-life balance. In addition, there are also a number of resources available that advocate for the establishment of appropriate boundaries to maintain a work-to-life balance. However, for all of the examples that are available, and for all of the awareness brought for the need to develop and employ ‘self-care’ practices, and establish appropriate boundaries—most people do not heed the counsel available, nor do they take advantage of the benefits that the ‘self-care’ practices and boundaries would reap, for themselves, or for their families.

The Biblical ‘Self-Care’ Practices And Pastoral Counseling Interventions With ‘Direct-Care’ Ministries Staff

\textbf{Practical Pastoral Counseling Intervention Strategies:}

Pastoral counseling can take place in the formal setting of a pastor’s office, or in the informal setting of a parishioner’s home, work place, hospital room, or at any number of public venues. It is well accepted that when people are in crisis they often seek out the counsel of a clergy member for guidance. There are a number of pastoral counseling approaches, whether nouthetic counseling, a form of pastoral counseling that employs only the use of Scripture and a focus on Christ, and the power of the Holy Spirit to facilitate
change and healing. The pastoral counselor may also employ nouthetic counseling and some combination of approaches dependent upon their personal expertise and application appropriateness that merge for an eclectic approach. The aim of pastoral counseling is to admonish, correct, or instruct. The motivations for providing the pastoral counseling may vary and stem from confrontation, concern, or change, the aim is to promote Christ, the truths of God’s Word, the power of the Holy Spirit to facilitate change in the innermost being for Christian maturity and greater growing Christ-likeness. The overall impact of effective pastoral counseling cannot be fully measured; yet, the impact on a life a peace with God, self and others as a result can be greater personal and professional fulfillment.

As a pastoral counselor, it is paramount to ground any pastoral care and counseling provided in the Word of God-The Bible. Whether a pastoral counselor seeks to provide counseling solely from a nouthetic approach or provider an eclectic approach employing any number of counseling approaches, pastoral counseling must begin with and stem forth from the Word of God. Jay E. Adams, author of Competent To Counsel: Introduction to Nouthetic Counseling, writes that the biblical qualification for nouthetic counseling is one preferably who is a pastor, who is properly equipped through seminary training, is full of goodness and knowledge, has the proper information and attitude, and operates with integrity and truth, with a genuine desire to help others makes for an excellent pastoral counselor. Pastoral counseling that employs nouthetic confrontation contains three elements: 1.) To effect personality and behavioral change; 2.) Training by word of mouth, and 3.) Motivated by love and concern such that the counseling seeks to correct by verbal means for their good, and ultimately for the glory of God. Adams continues,

“Preeminently, a nouthetic counselor must be conversant with the Scriptures. This is one reason why properly equipped ministers may make excellent

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counselors. A good seminary education rather than medical school or a degree in clinical psychology, is the most fitting background for a counselor. Real counseling involves the imparting of information. Counseling means, among other things, giving advice. The Holy Spirit uses counselors to right wrongs by the application of God’s Word to human problems. Knowledge of Scripture does not mean merely the memorizing and cataloging of facts. One in whom the “word of Christ dwells richly” (Colossians 3:16), is one who knows the meaning of Scripture for his own life. Because he is capable of solving his own problems scripturally, he is qualified to help others do so. Knowledge and goodness combine for this purpose, since one must have the welfare of the other person at heart to motivate him to spot wrong courses of behavior and endeavor to correct them. Goodness embraces both the involvement and empathetic concern about which something already said. It also comprises an enthusiasm of life in which Christ is apparent, and which thereby communicates hope to the counselee.”  

Understanding the biblical role of a pastor too is paramount for grasping the significance of the role that pastoral counseling takes in ministry. Adams illustrates this most poignantly with the biblical Psalm 23 passage, which provides the Lord’s shepherding of His people. Adams employs this biblical illustration for the pastoral ministry and the use of nouthetic counseling writing,

“All this pictures the responsibility that a pastor carries for his people. The reviving of the soul, rest, peace of heart and mind, are still basic needs of God’s sheep. And pastors, as under-shepherds, cannot shirk their responsibility to provide for these needs. They cannot delegate this responsibility to a psychiatrist. A minister, therefore, must consider nouthetic confrontation as an essential part of his pastoral responsibility. By definition, a pastor (i.e., a shepherd) cares for worn, weary, discouraged sheep. He sees to it that they find rest. The pastor, then, must take up his ministry to men in misery.”

Helping others understand the importance of establishing and maintaining biblical ‘self-care’ practices and boundaries is central to the pastoral care and counseling provided to guide others to mental, emotional, physical, relational, and spiritual well-being.

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55 Ibid.
Maintaining Margin through Boundaries:

Establishing appropriate boundaries is central for those in ministry and (DC) ministries both for themselves and for their families. Wilson and Hoffman (2007) argue that “boundaries define where one thing ends and another begins; differentiate what belongs to us from what belongs to someone else; distinguish our responsibility from someone else’s responsibility; and filter bad things out while either permitting or keeping good things in. In short, boundaries help us prioritize and protect what matters to us. To define boundaries properly, it is necessary to make value judgments. That is, boundaries are only important when they support our values.”

When those in ministry establish appropriate and healthy boundaries, both they and their families, as well as those they minister to reap the benefits. The importance of establishing boundaries is best understood in the context of margins. Swenson, (2004) developed the concept that “margin is the space between our load and our limits. It is the amount allowed beyond that, which is needed. It is something held in reserve for contingencies or unanticipated situations. Margin is the gap between rest and exhaustion, the space between breathing freely and suffocating. According to Swenson (2004), “…margin is the opposite of overload. If we are overloaded we have no margin.”

The key to returning to a healthy margin is establishing boundaries. How that is accomplished creates both challenges and opportunities for personal, family, and corporate growth. It means making some changes. “Boundaries for Christians are designed to protect Christ-like values and help us live a lifestyle consistent with Christian principles.” Wilson & Hoffman, 2007) A fundamental tenet of the Christian faith is discipleship—growing in

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56 Wilson, Michael Todd and Brad Hoffman. Preventing Ministry Failure: A ShepherdCare Guide for Pastors, Ministers and Other Caregivers. (Downers Grove: InterVarsity Press, 2007), 140.


greater and growing Christlikeness, developing Christ-like values helps believers live out Christ-like principles: central to this aim is maintaining appropriate and healthy boundaries. Examples of Christ-like principles and values found in Scripture provide commands, instructions and guidelines on how to live successful Christian lives. Believers in Jesus Christ are to be indwelled, empowered, and equipped by the Holy Spirit of God. God’s Word is replete with God’s commands that believers establish appropriate boundaries to maintain a healthy balance, some of these biblical instructions are meant to protect a person mentally, emotionally, physically, relationally, and spiritually. Examples of biblical texts that address these aspects of the total person are:

Mentally:

In regards to the mental aspect of a person’s life, the Bible reveals how one should establish biblically based mental boundaries and ‘self-care’ practices. The Bible states how those who are believers are to develop a renewed pattern for what they think on, and how they are to think about themselves before God, and others. Believers are urged to not be conformed to the pattern—ways of the world, but rather to be transformed by the renewing of our mind. It is only then that a person will be able to both discern and determine God’s will. Establishing mental ‘self-care’ practices includes establishing boundaries that include how and what a person thinks on.

“Therefore, I urge you, brothers and sisters, in view of God’s mercy, to offer your bodies as a living sacrifice, holy and pleasing to God—this is your true and proper worship. Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is—his good, pleasing and perfect will. For by the grace given me I say to every one of you: Do not think of your-self more highly than you ought, but rather think of yourself with sober judgment, in accordance with the faith God has distributed to each of you.” (Romans 12: 1-3 (NIV) 59

Establishing sound mental ‘self-care’ practices also includes grasping that at times when people may not have all the answers that they seek. People need to learn how to rely on God’s Holy Spirit, and God’s Word to enlightened, and also inform their decisions and course.

Trust in the LORD with all thine heart; and lean not unto thine own understanding.

6 In all thy ways acknowledge him, and he shall direct thy paths. (Proverbs 3:5-6 (KJV))

Developing a mental ‘self-care’ practice that is biblically based includes having and understanding that God’s ways are not our ways. People have only a finite understanding of things, with a limited perspective. God’s Word and Spirit, provides for insight and wisdom that eclipses our own.

“For My thoughts are not your thoughts, Nor are your ways My ways,” says the LORD. 9 “For as the heavens are higher than the earth, So are My ways higher than your ways, And My thoughts than your thoughts.” (Isaiah 55:8-9 (NKJV))

In regards to the mental aspects of a person’s life, God’s Word too provides the basis for establishing mental boundaries and ‘self-care’ practices. While those who profess faith in Christ are urged in God’s Word not to conform to the ‘way’ of this world’s thinking, but to be renewed in their way of thinking, that is, believers are to think differently because the flesh, the world, and the forces of evil no longer hold sway over their thoughts. Instead, their way of thinking is now under the authority of God’s Word, which is God-breathed and useful for teaching, rebuking, correcting, and training in all

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righteousness (2 Timothy 3:16). In addition to the Word of God—the Bible, there is the indwelling Holy Spirit, and the godly council of other believers. Together, they become the foundation for establishing sound mental ‘self-care’ practices and the boundaries that protect a believer’s mental well-being. Believers are to place themselves under the authority of God’s Word, God’s Holy Spirit. They are admonished to seek out the godly council of mature believers. God’s Word, teaches, rebukes, corrects, and trains believers that they may alter their way of thinking to God’s way of thinking. God’s Holy Spirit guides them in all truth (John 16:5-15), He will enable them, and empower them, and equip them for service to God and He will bear the fruit of godliness in and through them (Galatians 5:22-23); these become the hallmarks which identify growing and maturing believers in Jesus Christ. They are also some of the means by which God provides healthy mental ‘self-care’ practices and boundaries a person requires to maintain sound mental health.

Emotionally:

In regards to the emotional aspects of a person’s life, God’s Word too provides the basis for establishing emotional boundaries and ‘self-care’ practices. The Bible also provides for how believers are to maintain and appropriate and biblically based emotionally healthy perspective. The Bible reveals how believers are to respond to what their emotional responses to what they think, feel, and experience. When people are taxed mentally, emotionally, physically, relationally, and spiritually, their emotions can often be unstable and erratic. Research reveals that under such conditions anxiety grows. God’s Word speaks directly to how a believer should address anxiety—with praise, prayer and petition, which yields the peace of God.
Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus. Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things. Whatever you have learned or received or heard from me, or seen in me—put it into practice. And the God of peace will be with you. (Philippians 4:6-9 (NIV))

God’s Word also speaks about how the peace of God will guard our hearts and minds in Jesus Christ. Protecting what a believer exposes their hearts and minds to is central to establishing sound emotional ‘self-care’ practices and the boundaries that protect them. For it is from what good they store up inside them that is the good, they draw from, just as it is from the evil that they store up inside them, that they draw evil out from within us. In short, what a person exposes themselves to, becomes what they take in and it is from what they have taken in that they then draw on especially in times of stress or duress.

Make a tree good and its fruit will be good, or make a tree bad and its fruit will be bad, for a tree is recognized by its fruit. You brood of vipers, how can you who are evil say anything good? For the mouth speaks what the heart is full of. A good man brings good things out of the good stored up in him, and an evil man brings evil things out of the evil stored up in him. But I tell you that everyone will have to give account on the day of judgment for every empty word they have spoken. For by your words you will be acquitted, and by your words you will be condemned. (Matthew 12:33-37 (NIV))

If a person wants to establish mental and emotional ‘self-care’ practices and boundaries, they must guard what they take into their hearts and minds—what they allow to influence their lives.

Physically:

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63 Ibid. 813-814.
In regards to the physical aspects of a person’s life, God’s Word too provides the basis for establishing physical boundaries and ‘self-care’ practices. The Bible provides for how believers are to maintain boundaries for physical health through observing God-given ‘self-care’ practices. The Bible reveals that physical ‘self-care’ is part of God’s plan for establishing and maintaining overall good health.

8 “Physical training is good, but training for godliness is much better, promising benefits in this life and in the life to come.” (1 Timothy 4:8 (NLT)

Sound physical health is important as pertaining to the physical body of a person (somatically), and also pertains to the whole person—mentally, emotionally, physically, relationally, and spiritually. As believers learn that they are indwelt with the Holy Spirit of God, and thus become the temple of the living God, they value physical well-being.

“19 Don’t you realize that your body is the temple of the Holy Spirit, who lives in you and was given to you by God? You do not belong to yourself, 20 for God bought you with a high price. So you must honor God with your body.” (1 Corinthians 6:19-20 (NLT)

In addition, the Bible makes a brief reference that whatever a person does for the physical body; they should do with God’s glory in mind.

“So whether you eat or drink or whatever you do, do it all for the glory of God.” (1 Corinthians 10:31 (NIV)

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65 Ibid. 1462.

Yet, believers are admonished to discipline their bodies—to keep it under control. Here, Paul models what it is to not be consumed by ones appetites of the flesh, but rather to be controlled by the Word of God, and the leading of God’s Holy Spirit.

“27 I discipline my body like an athlete, training it to do what it should. Otherwise, I fear that after preaching to others I myself might be disqualified.”

(1 Corinthians 9:27 (NLT) 67

Relationally:

In regards to the relational aspects of a person’s life—how they respond to, and relate with others, God’s Word also provides the basis for establishing relational boundaries and ‘self-care’ practices. The Bible provides for how believers are to maintain boundaries for healthy relationships through observing God-given ‘self-care’ practices. The Bible reveals that relational ‘self-care’ begins with a right relationship with God. God’s Word reveals a concentrically outward focus that enables healthy relationships with the self, with God, and with others. The Bible reveals how a person develops a proper perspective of the self with God, which enables healthy relationships with others. How a person perceives themselves—not thinking more of themselves that they would look down on others. When they humble ourselves—think soberly about who they are before the Creator God of the universe, their Maker, they find themselves grasping the gift of God’s mercy, love, and grace in Christ. They then understand that they are sinners in need of a Savior, and upon turning to Christ, find peace as they draw near to God, and He draws near to them.

“6 And he gives grace generously. As the Scriptures say,

“God opposes the proud but gives grace to the humble.”

7 So humble yourselves before God. Resist the devil, and he will flee from you.
8 Come close to God, and God will come close to you. Wash your hands, you

sinners; purify your hearts, for your loyalty is divided between God and the world. 9 Let there be tears for what you have done. Let there be sorrow and deep grief. Let there be sadness instead of laughter, and gloom instead of joy.

10 Humble yourselves before the Lord, and he will lift you up in honor.” (James 4:6-10 (NLT) 68

With the grace that is then given those who turn to God in Christ, we are then able to through the faith in Christ, and the power of God’s indwelling Holy Spirit to break the sin of self-centeredness, self-absorption, and selfishness, that our attentions, and interests might first be God’s and then to the plight of others around us.

“3 Because of the privilege and authority[al] God has given me, I give each of you this warning: Don’t think you are better than you really are. Be honest in your evaluation of yourselves, measuring yourselves by the faith God has given us.” (Romans 12:3 (NLT) 69

When a believer grasps the enormity of God’s gracious act in forgiving our sins through the sacrificial atoning death of Christ on Calvary’s Cross. They are then reminded of the need to pray for those who persecute them, and forgive those who have trespassed against them.

“14 “If you forgive those who sin against you, your heavenly Father will forgive you. 15 But if you refuse to forgive others, your Father will not forgive your sins.” (Matthew 6:14-15 (NLT) 70

And,  

“But I tell you, love your enemies and pray for those who persecute you,”  
(Matthew 5:44 (NIV) 71

And,  

“But to you who are listening I say: Love your enemies, do good to those who hate you, bless those who curse you, pray for those who mistreat you. If someone slaps you on one cheek, turn to them the other also. If someone takes your coat, do not withhold your shirt from them. Give to everyone who asks you, and if anyone takes what belongs to you, do not

68 The Holy Bible. (New Living Translation). 1605.

69 Ibid, 1448.

70 Ibid, 1205.

demand it back. Do to others as you would have them do to you.” (Luke 6:27-31 (NIV) 72

And,

“But love your enemies, do good to them, and lend to them without expecting to get anything back. Then your reward will be great, and you will be children of the Most High, because he is kind to the ungrateful and wicked. Be merciful, just as your Father is merciful. “Do not judge, and you will not be judged. Do not condemn, and you will not be condemned. Forgive, and you will be forgiven. Give, and it will be given to you.” (Luke 6: 35-38 (NIV) 73

And also,

“‘Teacher, which is the greatest commandment in the Law?’ Jesus replied: “‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself.’ All the Law and the Prophets hang on these two commandments.” (Matthew 22:36-40 (NIV) 74

And,

“A new command I give you: Love one another. As I have loved you, so you must love one another. By this everyone will know that you are my disciples, if you love one another.” (John 13:34-35 (NIV) 75

And also,

“Love must be sincere. Hate what is evil; cling to what is good. Be devoted to one another in love. Honor one another above yourselves. Never be lacking in zeal, but keep your spiritual fervor, serving the Lord. Be joyful in hope, patient in affliction, faithful in prayer. Share with the Lord's people who are in need. Practice hospitality. Bless those who persecute you; bless and do not curse. Rejoice with those who rejoice; mourn with those who mourn. Live in harmony with one another. Do not be proud, but be willing to associate with people of low position. Do not be conceited. Do not repay anyone evil for evil. Be careful to do what is right in the eyes of everyone. If it is possible, as far as it depends on you, live at peace with everyone.” (Romans 12: 9-18 (NIV) 76


73 Ibid, 860.

74 Ibid, 824.

75 Ibid, 899.

God’s Word, and the tenets of the Christian faith outline the way believers are to relate to self, to God, and to others. Having an appropriate self-awareness leads believers to an appropriate awareness of who they are before a holy and righteous God, Who loved them even while they were His enemies—sinners (Romans 5:8). That His great love for us motivated God to act in our best interest and provide a way for us to be in right relationship with Him, through Jesus Christ His one and only Son, so that whoever would believe in Him would not perish but have eternal life. For God did not send His Son into the world to condemn the world, but in order that the world through Him might be saved. (John 3:16-17).

This love then compels believers to live out this selfless love to a lost and dying world, to continue Christ’s mission—to seek and save the lost (Luke 19:10). Everything they think, say, and do is then motivated by the love of God within us to achieve this end. Every relationship they have with others becomes a vehicle to that end. It requires us to establish ‘self-care’ practices that keep us focused on maintaining healthy perspectives on our relationship with self, with God, and with others. It requires us to establish boundaries to ensure that our relationships are appropriate, healthy, and God honoring.

Spiritually:

Spiritually, in how a believer responds to God. In regards to the spiritual aspects of a person’s life—how they relate to, and affect the human spirit and soul—the ethereal, as in pertaining to our relationship with God. The relationship they have as a believer through faith in His Son—Jesus Christ, as empowered and enabled by His Holy Spirit to live victorious lives “in Christ.” God’s Word too provides the basis for establishing appropriate spiritual ‘self-care’ practices and boundaries that foster a vibrant and maturing spiritual life in Christ. This begins with grasping, the two greatest commandments—love God, love others, as they love themselves.
“‘Teacher, which is the greatest commandment in the Law?’ Jesus replied: ‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself.’ All the Law and the Prophets hang on these two commandments.” (Matthew 22:36-40 (NIV))

And,

“If you love me, keep my commands….Whoever has my commands and keeps them is the one who loves me. The one who loves me will be loved by my Father, and I too will love them and show myself to them.” …Jesus replied, “Anyone who loves me will obey my teaching. My Father will love them, and we will come to them and make our home with them. 24 Anyone who does not love me will not obey my teaching. These words you hear are not my own; they belong to the Father who sent me.” (John 14:15, 21, 23-24 (NIV))

It is clear from God’s Word that the whole of a person, the mental, emotional, physical, relational, and spiritual must achieve balance and harmony for total well-being. To achieve this, balance and harmony requires the person to establish appropriate ‘self-care’ practices and boundaries. Some would refer to such practices and boundaries as limits. Everyone has them, yet few acknowledge them until after these limits have been exceeded at the great detriment of themselves and those around them. Scazzero writes, “While our culture resists the idea of limits, it is critical that we embrace them. They are like a fenced-in yard that protects young children. They are the hands of a friend, keeping us grounded so that we don’t hurt ourselves, others, or God’s work.”

Boundaries are limits. God established limits, boundaries to keep people safe from harm and evil. From the very beginning of human history, He demonstrated that limits, boundaries are important. Simply stated, when a person establishes and respects appropriate


78 Ibid, 900.

79 Scazzero, Peter L. The Emotionally Healthy Church: A Strategy For Discipleship That Actually Changes Lives. (Grand Rapids: Zondervan, 2003), 146.
limits, boundaries they keep things how they are intended to be, and where they are intended to be, and it reminds them why they are intended to be that way.

Maintaining healthy boundaries can be more fully appreciated in the context of understanding how healthy margins are achieved. Swenson (2004) asserts,

“The Formula for margin is straightforward: Power-Load=Margin. Power is made up of factors such as energy, skills, time, training, emotional and physical strength, faith, finances, and social supports. Load is made up of such factors as work, problems, obligations and commitments, expectations (internal and external), debt, deadlines, and interpersonal conflicts. When our load is greater than our power, we enter into negative margin status, that is, we are overloaded. Endured long-term, this is not a healthy state. Severe negative margin for an extended period of time is another name for burnout. When our power is greater than our load, however, we have margin.”

To establish appropriate boundaries is too look beyond the immediate, and grasp the larger picture. It is understanding that to accomplish the greater good of being available for continued effective ministry to those they minister to, those in ministry must consider appropriate boundaries a part of their self-care regiment, and paramount to the mental, emotional, physical, relational, and spiritual well-being of themselves, and their families.

“When grounded in Christian values and principles, boundaries look beyond the perceived ‘needs’ of the moment, seeking God’s greater purpose in the world.”

To build upon the benefits of establishing appropriate and healthy boundaries, Hand and Fehr (1993) identified three practices and behaviors essential for pastoral health: (a) spiritual renewal practices, (b.) rest-taking practices, and (c.) support system practices.

“Despite the stress, some pastors are highly adaptive to the hardships of ministry and

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81 Wilson, Michael Todd and Brad Hoffman. Preventing Ministry Failure: A ShepherdCare Guide for Pastors, Ministers and Other Caregivers. (Downers Grove: InterVarsity Press, 2007), 144.

demonstrate effective coping mechanisms. These pastors utilize strategies for coping with ministry stress including hobbies, spiritual development, sports, and vacations (McMinn, Lish, & Trice 2005; Meek et al. 2003).”

Also, according to Pector (2005),

a “healthy lifestyle, social support, and work/life balance help pastors resist burnout…. Healthy meals, eaten at leisure and accompanied by stimulating conversation, nourish spirit as well as body…. Hobbies and recreation maintain social connectedness. Formal and informal fellowship with other clergy reduces professional isolation. Courses to learn about other faiths and cultures, meditation, counseling, leadership, conflict resolution, and other topics enrich the mind—and ultimately the congregation. Fatigued pastors can recruit lay help with chores and observe a weekly time of reflection.”

Along these similar lines, Swenson argues, “to be healthy we require margin in at least four areas: emotional energy, physical energy, time, and finances. Margin— a buffer of reserves in these areas, is central to maintaining a balanced life.” Swenson continues,

“Margin grants freedom and permits rest. It nourishes both relationship and service. Spiritually, it allows availability for the purposes of God. From a medical point of view, it is health-enhancing. It is a welcome addition to our health formulary: Add a dose of margin and see if life doesn’t come alive once again.”

This then is the goal of developing ‘self-care’ practices, and establishing appropriate boundaries. It is then that the whole of a person, the mental, emotional, physical, relational, and spiritual may achieve balance and harmony for total well-being. It is not possible for a person to avoid the stressors of life. Neither is it likely that the (DC) ministries staff working in (RTC/F’s) in childcare will avoid with any measure of success the issues associated with

83 Anderson, Cara J. Pastoral Burnout and Marital Satisfaction. Fuller Theological Seminary. 2010. 7.


the work of ministry; or the demands specific to the work of (DC) ministries; or the expectations placed upon them by the organizations that employ them.

Such balance and harmony requires the (DC) ministries staff working in (RTC/F’s) in childcare be intentional about learning how to develop and employ on a daily basis appropriate ‘self-care’ practices and boundaries. The benefits for the professional and personal well-being of the individual (DC) ministries staff and for their families depend on it.

**Healthy Spillover:**

Understanding the benefits of a healthy family life and a social support system is key. Just as the stressors from the issues related to the work of ministry, the demands specific to the work of (DC) ministries in (RTC/F’s) in childcare; and the expectations placed upon them by the organizations that employ them tend to have a toxic effect on the (DC) ministries staff individual, and their families. So too, the benefits of ‘self-care’ practices, and the benefits of establishing appropriate ‘self-care’ boundaries can become the catalyst for a healthy spillover.

Spillover describes how the experience of dissatisfaction or satisfaction in one sphere of individual’s life may impact the individuals other various spheres of life in regards to the mental, emotional, physical, relational, and spiritual spheres of the individuals life. Spillover is also the means by which the experiences of one individual have had an impact upon the other spouse or family member. For those in (DC) ministries staff positions, this means that as a spouse their satisfaction experiences have been shown to influence the other spouse and contribute to a mutual affective experience (Demerouti et al. 2005; Kelloway & Barling 1994). The research of Hammer and colleagues (2005) found that the spouses of those with a greater amount of positive family-to-work spillover had lower levels of depression than the spouses of individuals with lower levels of positive family-to-work
spillover. This healthy spillover too had a positive impact on marital satisfaction. According to the research of Grzywacz and Marks (2000), this has been related to higher levels of positive family-to-work spillover.

Emerging research reveals that the high level of marital satisfaction, which has been contributed to increased positive family-to-work spillover, has also been related to lower levels of depression. Research supports the observations that healthy families provided greater support, and a measure of insolation, which serves to lessen the negative and potentially toxic impacts related to workplace stress. The converse of this aspect of spillover is also equally applicable. Just as the positive aspects in the spheres of an individual’s life manifest healthy spillover, so too the negative aspects in the spheres of an individual’s life can manifest toxic spillover onto those around them. This leaves those who are in the most intimate contact with the individual (DC) ministries staff vulnerable and susceptible to the impacts family-to-work spillover. A study by Demerouti et al. (2005) found that negative work-to-family spillover for one spouse contributed to a mutual experience of exhaustion for husband and wife. According to the model of spillover designed by Demerouti et al., increased levels of exhaustion for one spouse, in turn affected the life satisfaction for both spouses.

Other studies (Hammer et al. 2005) have also found negative outcomes for spouses of those with high levels of negative work-to-family spillover. Hammer and colleagues (2005) reported that husbands' negative work-to-family spillover was a significant predictor of wives' depression. The observations and research of Anderson (2010) into the interplay between intimate individuals suggests that the independent experiences encountered by one spouse would directly and indirectly affect the life experience of the other. The affect related to both stressful and positive encounters has been shown capable of spillover between marriage partners, and this spillover may have impacted spouses' successive approaches to
life and ministry.” 87 The benefits of a healthy social support from spouses and families cannot be understated. This healthy spillover is instrumental in lessening the toxic impact of workplace stress on those working in (DC) ministries staff positions in (RTC/F’s) in childcare and their families. The ‘self-care’ practices that include mental, emotional, physical, relational, and spiritual ‘self-care’ practices and the establishment of appropriate boundaries addresses the intentionality of limiting the intrusion of the negative spillover associated with workplace stressors.

According to the research of Hobfoll (2002), who views social support as a process, this is particularly important when the personal resources of an individual in the mental, emotional, physical, relational, and spiritual aspects have been taxed and ‘margin’ is no longer available, social support from spouses and family members may be a key resource in and individuals environment leading to improved mental health and other positive physical outcomes (Cohen et al. 1997; Cohen and Wills 1985). The research of Galek, Flannelly, Greene, and Kudler (2011) also reveal that social support may also be viewed in the context of mental ‘self-care’ practices, in that in that the presence of intimate others in whom an individual can confide in provides an effective means of maintaining self-esteem (Sarason et al. 1987).” 88 Thus, the importance of having a healthy family support system cannot be understated. However, this does not negate the need for healthy workplace relationships and the social support of peers and supervisors. Galek, Flannelly, Greene, and Kudler (2011) reveal in their research that the adverse effects on an individual who has a “lack of social support within an organization puts a strain on personal resources in response to occupational stress, which leads to burnout. In contrast, work-related sources of social support enhance


personal resources in response to stress, ameliorating burnout. From a systems perspective, it is likely that support from work colleagues, other than supervisors, would also be associated with lower burnout, and there is some evidence of this effect (Greenglass et al. 1997; Huebner 1994).”

It is clear from emerging research that developing ‘self-care’ practices that are employed on a daily basis, and establishing appropriate boundaries to limit the impact of workplace stressors are required for the continued professional and personal success of those working in (DC) ministries, and their families. However, it is equally clear that people will not develop ‘self-care’ practices or establish appropriate boundaries until they learn to appreciate what they are, and how they can be of a benefit to them professionally and personally. This requires a concerted and intentional effort on the part of the organizations that employ (DC) ministries staff to provide the necessary ‘self-care’ training for all (DC) ministries staff in an on-going manner. Research demonstrates that “without commensurate renewal, the complex, competing, and stressful tasks of ministry often create conditions of spiritual, mental, physical, and social depletion and fatigue. (London & Wisemen (2003); Sanford (1982). As Diddams et al. (2004) stated, “Practicing rest bolsters psychological resiliency and personal agency” (p. 317), which serves as an essential element in stress management (Carver 1998). Chandler noted in her summary that Diddams’ research suggests that rest-taking leading to pastoral renewal has been anecdotally linked to burnout and stress resistance, resiliency, and productivity.”

The importance of developing and employing self-care practices and appropriate boundaries on a daily basis can no longer be ignored by the individual (DC) ministries staff,

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their families, or the organizations that employ (DC) ministries staff. Research, observations, and experience all reveal that allowing for spiritual renewal practices, rest-taking practices, and support systems practices make a significant impact in the replenishing the mental, emotional, physical, relational, and spiritual aspects and quality of work and life of the individual in ministry and their families. “Researchers have demonstrated that experiences and feelings from one domain of life are transferred onto other areas or domains; that is, experiences from work have been found to spillover into family life; meanwhile, experiences at home have been found to spillover onto work (Demerouti, Bakker, & Schaufeli 2005; Grzywacz & Marks 2000; Hammer, Cullen, Neal, Sinclair, & Shafiro 2005; Thompson & Prottas 2005).

Negative spillover has been understood as an issue of limited resources; the multiple domains of life have made demands on an individual and have been in competition for attention, mental energy, and motivation. These are resources each individual has in limited supply (Goode 1960; Grzywacz & Marks 2000; Hammer et al. 2005), whereas the theory of positive spillover has postulated that involvement in multiple roles aids ones sense of accomplishment, self-efficacy, and energy (Hammer et al. 2005). It seems that participation in multiple roles provides a protective factor when failure or struggles are encountered due to multiple role identification (Sieber 1974).”

Based on previous research, it is plausible that high marital-satisfaction of a pastor’s spouse may have positively impacted the pastor’s family-to-work spillover, tempering the effects of burnout. Thus, in an examination of the elements which have contributed to pastoral thriving, in order to protect against burnout and attrition, the role of spillover seems an essential element. It has appeared that spouses with

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91 Anderson, Cara J. *Pastoral Burnout and Marital Satisfaction*. Fuller Theological Seminary. 2010. 12.
high levels of marital-satisfaction may have provided a protective factor for their spouse in ministry through the means of spillover.\footnote{Anderson, Cara J. \textit{Pastoral Burnout and Marital Satisfaction}. Fuller Theological Seminary. 2010. 14.}

From a pastoral counseling perspective, it is clear that appropriate pastoral guided ‘self-care’ training can have a positive and meaningful impact of the mental, emotional, physical, relational, and spiritual issues that can have such a deleterious effect upon the professional and personal lives of (DC) ministries staff. Second, this research, survey results, and subsequent training will become the basis to provide ‘self-care’ coaching of (DC) ministries staff on how to develop better coping skills for dealing with these issues, demands, and expectations while working in residential treatment facilities in childcare. Third, it will present biblically-based, hope-filled approaches for both the individual (DC) ministries staff and their families, in addition to useful information and tools that equip, encourage, and empower, and if employed consistently will help them be successful in coping with the mental, emotional, physical, relational, and spiritual tolls that (DC) ministries will have on them, and their families, so that they might enjoy a greater quality of life with personal and professional fulfillment and success. Fourth, it will provide opportunities for the additionally pastoral services of coaching, pastoral counseling and/or referrals for professional counseling. Fifth, it will provide the organizations that employ (DC) ministries staff with the necessary information needed to better address the issues, demands, and expectations that adversely affect (DC) ministries staff, and with the ‘self-care’ training, morale building, and employee engagement resources to better address organizational (DC) ministries staff recruiting, retention and release issues.
CHAPTER 6

CONCLUSION

The work in the human services field is fraught with challenges. Working with people is rarely easy, or always pleasant, and never without its share of issues, demands, and expectations. Working with people often gets ugly, messy, and taxing…on multiple levels—mentally, emotionally, physically, relationally, and spiritually. The issues, demands, and expectations related to the work of (DC) ministries in (RTC/F’s) working with children and/or youth is no different, yet it is unique.

The work of (DC) ministries in (RTC/F’s) working with children and/or youth in childcare shares the issues related to ministry work—always being on demand, always being on display, and always being on-duty; these are issues that can challenge even the most dedicated and devoted in spirit. Then, there are those demands specific to (DC) ministry: the stressors of secondary traumatic stress, compassion fatigue, burnout, and the toxic spillover that often accompany the work of (DC) ministries. Then, as with many other human service positions there are those expectations placed upon them by the organizations they are affiliated with often include having to work in different types of work environments; group homes, psychiatric units, foster homes, and step-down units; working short shifts, long shifts, days and nights, or awake-night shifts, or working alone while working as (DC) ministries staff of children and/or youth in residential treatment facilities in childcare (Bertolino & Thompson 1999; Hyde 2001).  

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1 Bertolino, B. & Thompson, K. *The Residential Youth Care Worker In Action: A Collaborative, Competency Based Approach.* (New York: Haworth Mental Health Press, 1999)

The issues, demands, and expectation are significant. The toll of working in (RTC/F’s), whether in public or private non-profit as (DC) ministries staff with children and/or youth in childcare can be taxing mentally, emotionally, physically, relationally, and spiritually. The toxic spillover of the stressors of secondary traumatic stress, compassion fatigue, burnout, and the toxic spillover that often accompany the work of (DC) ministries can have a deleterious effect on the staff person and their families. The difficulties of an inflexible work pattern, the lack of establishing appropriate boundaries between one’s professional life and personal life, and changing family needs lead to an out of balance work and family life, which also impacts (DC) ministries staff turnover (Human Services Workforce Reform 2003; Colton & Roberts 2004).

Existing research, the phenomenological research, and the online survey results reveal that such tolls contribute significantly to the high turnover of (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth in childcare. The U.S. Department of Labor statistics reports that the turnover rate in the United States is 3.3 percent across multiple industries. Yet, existing research reveals that the estimated annual turnover for those working as (DC) ministries staff working in (RTC/F’s), as between 26 to 41 percent (Curry, McCarragher, & Dellmann-Jenkins 2005; Whitebook, Philips, & Howe 1989) (Also see Dietzel & Coursey 1989; Manlove & Guzell 1997; Onyett, Pillenger, & Muijen 1997; Ross 1983; Whitaker 1996).4

One of the (RTC/F’s) that participated in the research study and online survey experienced an average annual turnover rate for (DC) ministries staff in 2015 at fifty-eight

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percent. This same (RTC/F) records annual turnover rates for (DC) ministries staff for the period from 2008 to 2015 (Current) as:

**TABLE 1.4 Direct-Care Staff Turnover Rates At Example (RTC/F):**

<table>
<thead>
<tr>
<th>Year</th>
<th>Turnover Rate</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>28.07% (28%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2008 to 09-30-2009)</td>
</tr>
<tr>
<td>2009-10</td>
<td>46.05% (46%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2009 to 09-30-2010)</td>
</tr>
<tr>
<td>2010-11</td>
<td>41.81% (42%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2010 to 09-30-2011)</td>
</tr>
<tr>
<td>2011-12</td>
<td>27.50% (27%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2011 to 09-30-2012)</td>
</tr>
<tr>
<td>2012-13</td>
<td>30.90% (31%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2012 to 09-30-2013)</td>
</tr>
<tr>
<td>2013-14</td>
<td>17.30% (17%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2013 to 09-30-2014)</td>
</tr>
<tr>
<td>2014-15</td>
<td>57.57% (58%)</td>
<td>‘Direct-Care’ Staff Turnover (10-01-2014 to 09-30-2015)</td>
</tr>
</tbody>
</table>

On average, the annual (DC) ministries staff turnover for this (RTC/F) for the last seven years (2008-2015) was 35.57% (36%). This average annual (DC) ministries staff turnover for this (RTC/F’s) corresponds with the statistics of 26 to 41 percent presented from the research of Curry, McCarragher, and Dellmann-Jenkins (2005), and Whitebook, Philips, and Howe (1989) (Also see Dietzel & Coursey 1989; Manlove & Guzell 1997; Onyett, Pillenger, & Muijen 1997; Ross 1983; Whitaker 1996; as noted above. Of significance is the average time in service is less than two years.

These statistics correspond with the research of Colton and Roberts, (2007), which suggests that the annual turnover rates for (DC) ministries staff working in (RTC/F’s) with children and/or youth in child care range from 30 to 40 percent, while the average time in

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position is less than two years (United States General Accounting Office 2003; American Public Human Services Association 2004).  

Significant to this research study is the annual turnover rates of between 26 to 41 percent for (DC) ministry staff working with children and/or youth in (RTC/F’s). This average is considerably higher than the 11 to 15 percent annual turnover rate for (DC) ministries staff working in (RGH’s) with children and/or youth with fewer mental and emotional issues and/or behavior challenges, which reach a high of 20 percent reported in some (RGH’s) in North America and the United Kingdom.

The turnover rate for (DC) ministries staff working in (RTC/F’s) have an astonishingly high turnover rate due primarily to the stressors directly related to the nature of working with children and/or youth with moderate to severe mental and emotional disorders, and also behavioral challenges. It is these children and/or youth that are commonly placed in Level II, III environments of a (RTC/F). The stressors of burnout, (STS), (VT), and (CF) that are often experienced as a result of the issues associated with the work of (DC) ministry, combined with the demands associated with the work of (DC) ministries in (RTC/F’s); and the expectations placed upon (DC) ministries staff by the organizations that employ them. This research reveals that turnover is significantly higher at Levels II, III, IV, and PRTF “levels of care.” The issues, demands, and expectations of working with the children and/or youth in care at these higher “levels of care” that contributes significantly to the higher (DC) ministries staff turnover. Yet it is not the only factor in (DC) ministries staff turnover.

The issues associated with the work of ministry, the demands specifically associated with the work of (DC) ministries working with children and/or youth in residential childcare,

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7 Ibid. 133-134.

8 Ibid. 134.
and the expectations placed upon them as (DC) ministries staff by the organizations that employ them are exacerbated at each increasing “levels of care.”

The prior research, the phenomenological research, as well as the research for this study and the online survey results of (DC) ministry staff reveal the deleterious toll of the issues, demands, and expectations combined with the toxic spillover of the work of (DC) ministries in (RTC/F’s) working with children and/or youth in childcare is a challenging vocation, which is exacerbated at each “level of care” with the increasing mental and emotional disorders, and behavioral challenges that contribute significantly to (DC) ministries staff turnover. It is not the only causal factor. Decker et al. (2002) found statistical correlation between lower scores on the Maslach Burnout Inventory, and protective factors such as education, age, and levels of support and supervision. Heavy workloads, poor pay, the low status of the work, and poor supervision impacted turnover rates on both sides of the Atlantic (Fleischer 1985; Fleischer 1985; Samantrai 1992; Rycraft 1994; Dickinson & Perry 2002; Human Services Workforce Reform 2003; United States General Accounting Office 2003; McCarthy 2004; Association of Directors of Social Services 2005; Child Welfare League of America 2005; Department for Education and Skills 2005).9

In addition to these issues, demands, and expectations specific to (DC) ministries work in (RGH’s), or (RTC/F’s) in childcare working with children and/or youth, there are the additional issues, which include working with insufficient training to meet the demands of the types of youth in care. Many organizations provide onsite pre-service and annual in-service training for (DC) ministries staff working in (RGH’s), (RTC/F’s), Children’s Homes, Schools and Academies; however, many organizations do not have onsite training, and rely

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on out-sourced third party training to fulfill mandated annual training requirements which range from twenty hours to forty hours of mandated annual training requirements. This means that (DC) staff working in (RTC/F’s) in childcare with children and/or youth is required to receive and maintain a specialized mandated annual training for continued certification and employment.

To maintain appropriate staff to resident ratio’s established by each state’s (DSS) and licensing bureaus. Often, however, (DC) ministries staff must deal with inadequate staffing. Additional (DC) ministries staff may be on-duty, yet often due to inadequate training, lack of experience, immaturity, poor work ethic, or mere personality conflicts with fellow staff, these may result in inadequate staffing to residents ratios. (DC) ministries staff by the very nature of the demands of working in (RTC/F’s) in childcare with children and/or youth must endure undesirable work schedules. Children and youth have needs, wants, and desires and often these occur at the least opportune times; thus, the work of residential childcare is a twenty-four hour a day, seven day a week, three-hundred and sixty-five day a year effort. (DC) ministries staff’s day typically begins with their workday starting at six o’clock in the morning and often goes to ten o’clock at night when the last youth are in their rooms and lights are out. Yet, all too often, the day is not over even then. Children and/or youth can have needs that extend beyond the typical sixteen-hour workday. Ministry often takes place at the most inopportune times, yet can be most impactful, for it is then that real relationships are established and this becomes the catalyst for growth and change. (DC) ministries staff at times work excessively long work shifts. Occasionally due to staff shortages, staff vacations, or staffing emergencies, sometimes (DC) ministries staff work beyond the assigned seven days on-duty, seven days off schedule, or nine days on-duty and four days off, or ten days on-duty as required by the organizations that employ them. Often times (DC) ministries staff are
required to work additional day’s on-duty to cover staff shortages to meet the needs of children and/or youth in care for the organization.

Low salaries too are a source of (DC) ministries staff turnover. According to the U.S. Department of Labor statistics, there are approximately 18,800 persons working as (DC) ministries staff in the United States. The average annual income for those working in (DC) ministries in (RTC/F’s) in childcare with children and/or youth is $24,250.00 and averaging just $11.66 per hour.\footnote{“U.S. Department of Labor Statistics for ‘Direct-Care’ Workers” Accessed July 24, 2015 at the U.S. Department of Labor website at: http://www.bls.gov/jlt/}

In addition, (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth often work with poor benefits, poor living conditions, poor housing, and an overall poor quality of life. The organizations that employ (DC) ministries staff are often non-profit organizations that by nature operate on a combination of charitable donations and public funding from state and federal sources, however much of this funding is restricted for operational costs associated directly with childcare. Benefits are often basic care benefits and do not include pastoral, or professional counseling for mental, emotional, physical, relational, and spiritual care. All too often (DC) ministries staff are unaware of their own needs for ‘self-care’, and lack adequate training for ‘self-care’ to address these issues. Also, (DC) ministries staff suffer the deleterious effects of burn-out, (STS), (VT), and (CF), which takes its toll on the (DC) ministries staff, which has a toxic-spillover from the staff’s professional life into the staff’s personal life and can additionally have a deleterious effect on their spouses, and their families.

As if this is not enough, (DC) ministries staff often must take up residence in sub-par housing. Often the housing for (DC) ministries staff is housing that is an apartment within
the residential unit itself: cottage, dormitory, or house; or share and apartment with
roommates, or have and apartment that shares common areas, i.e., kitchen and laundry areas
with other staff, and/or residents. Most would consider this as less than ideal. Adequate
housing for (DC) ministries staff is an additional cost many organizations struggle to provide.
Organizations that operate (RTC/F’s) in childcare with children and/or youth operate
facilities that are often in rural areas where land was readily available and inexpensive. Often
these facilities are located a considerable distance from major urbanized areas which offer,
what most in today’s culture desire for in and overall quality of life for (DC) ministries staff,
spouses, and their families. This would include a healthy environment, quality schools,
quality healthcare and emergency healthcare facilities, desirable housing, engaging
employment opportunities with growth potential, opportunities for gaining material wealth,
diverse shopping, proximity to refreshing, revitalizing, and renewing through meaningful
religious and varied cultural activities, entertainment, sporting events and recreation
activities, food and drink establishments, as well as perhaps other more individualistic
preferences, i.e., proximity to the beach, the mountains, the urban areas, etc.

Often (DC) ministries staff operate under inadequate supervision, with ill-defined job
responsibilities, inadequate supervision, poor communication, insufficient resources, and the
discouragement of working in an environment that fosters and expects a high (DC) ministries
staff turnover. While these factors clearly contribute to the high turnover of (DC) ministries
staff working in (RTC/F’s) in childcare with children and/or youth, the factor often cited for
(DC) ministries staff voluntarily vacating their positions is the increasing unease with the
mental and emotional issues of the children and/or youth in care. In addition, the behavioral
issues are presented by the children and/or youth in care. These behavioral issues are often
manifested in the actions of the children and/or youth toward (DC) ministries staff, with the increasing likelihood for physical violence and the frequency of verbal abuse.\textsuperscript{11}

Clearly, there are issues, demands, and expectations associated with the work of (DC) ministries in (RTC/F’s) in childcare with children and/or youth. Much about this type of work will not change, i.e., the nature of the work, and the type of children and/or youth in care. However, there is considerable room for improvement in regards to the way organizations view (DC) ministries staff’s importance to the overall success of the organizations mission. Colton and Roberts write,

“Some commentators (see for example, Gibson et al. 2004) have pointed to the crisis of confidence in residential care: a service characterized by a disempowered staff base. Clearly, those who work with children and young people in the residential setting are faced with a ‘…complex, diverse and demanding task…’ (Hicks et al. 1998, p. 367). It is imperative that they are able to access appropriate training, supervision and support to enable them to manage that task. If quality services are to be provided in residential care, it is essential that skilled personnel are retained (McDonnell & Wilson-Simpson 1994).”\textsuperscript{12}

It is to the retention of (DC) ministries staff that this research project and online survey has been directed. While it is not within the scope of this project to address every issue, demand, and expectation to its fullest, it is paramount for this project that the issues, demands, and expectations overall that manifest themselves in the stressors of burn-out, (STS), (VT), and (CF) that have such a deleterious impact on the professional and personal life of (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth, and subsequently have a deleterious impact on their families.

To adequately address these issues, demands, and expectations, and the stressors associated with the work of (DC) ministries in (RTC/F’s) in childcare working with children


\textsuperscript{12} Ibid.
and/or youth substantive changes in the manner that organizations address these issues are required. In consideration of the prior research and the phenomenological research, and the related online survey data, conducted for this project have led to the following recommendations:

The issues associated with the work of ministry, combined with the demands specific to the work of (DC) ministries in (RTC/F’s) in childcare, the expectations on (DC) ministries staff by the organizations that employ them, and the stressors these create can all have a deleterious effect. The effects of these stressors on (DC) ministries staff, and on their families typically manifests themselves in the mental, emotional, physical, relational, and spiritual aspects of their professional and personal lives.

For those professionals in ‘helping fields’, like (DC) ministries staff working in (RTC/F’s) in childcare; learning how to develop appropriate ‘self-care’ skills is paramount. Following adequate ‘self-care’ awareness training, there must also be the daily employment of ‘self-care’ practices. Additionally, appropriate coaching, and pastoral counseling and as necessary referrals to clinical counseling, can work together to assist (DC) ministries staff in effectively combating these stressors, and their toxic spillover that can have such deleterious effect on their professional and personal lives. Finally, the organizations that employ (DC) ministries staff should acknowledge the role their administrative policies and approaches play in fostering an unhealthy workplace environment that ignores the reality of these issues, demands, and expectations placed upon (DC) staff. These organizations then should then adopt employee engagement practices that seek to provide a workplace environment that allows (DC) ministries staff to be heard, valued, and included in the programming decisions that can help alleviate, and potentially mitigate some of these issues, demands, and expectations. This proactive strategic approach could reap both short and long-term dividends for the individual (DC) ministries staff, their families, and the organizations that
employ them. These efforts in ‘Self-care’ training, appropriate coaching, and pastoral counseling efforts should be combined with organizational employee engagement practices that demonstrate to (DC) ministries staff that they have been heard, valued, and included, could make significant strides in helping to create a healthy workplace environment for all. Harms, Ray, and Rolandelli (1998) offer the following suggestions toward providing (DC) ministries staff support, writing,

“The book, Avoiding Burnout, lists three essential needs of caregivers that must be addressed if child care providers are to be productive and satisfied with their jobs [Jorde-Bloom 1982]. Child care providers need to be with colleagues who understand the day-to-day stresses they face. Creating support networks and developing community contacts will help prevent burnout and provide staff members with rich resources for new ideas…Caregivers need to feel that what they are doing is worthwhile and that they are recognized for their efforts…Caregivers feel respected and competent when they are able to make decisions about matters that affect them directly. Staff turnover affects program quality. To maintain quality programs, consider providing adequate pay, offering flexible scheduling, giving caregivers reasonable amounts of vacation time, providing “mental health days,” allowing them respites from the pressures of caring for children; providing lounges or designated areas where staff members can relax; and training competent substitute caregivers.”

Organizational employee engagement practices should seek to provide support for (DC) ministries staff through identifying the cares and concerns of staff, and then work together with (DC) ministries staff to identify the means to provide that support. This process includes the following steps:

First, there must be an acknowledgement and willingness to address these issues, demands, and expectations that contribute to these stressors in the lives of (DC) ministries staff by the organizations that employ them through employee engagement practices, and mandatory ‘self-care’ training. There must be an intentionality by these organizations to develop a ‘self-care’ training program, or provide (DC) ministries staff and supervisors with

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the opportunities to engage in regularly scheduled out-sourced ‘self-care’ training.

Appropriate ‘self-care’ training, coaching and pastoral counseling, and as necessary, referral to other professional therapeutic counseling must be developed to address the specific needs of (DC) ministries staff. To be effective, this ‘self-care’ training must be followed by the daily employment of ‘self-care’ practices that are designed to specifically combat the issues, demands, and expectations encountered daily by the individual (DC) ministries staff person. In addition, organizations would do well to provide incentives for those that demonstrate regularly employed ‘self-care’ practices as recommended by the training they have received.

It would be of a significant benefit to (DC) ministries staff that they have regular access to coaching and pastoral counseling to help staff who are struggling against the stressor professionally and personally.

Second, (DC) ministries staff must understand that early recognition and employed ‘self-care’ practices both in and out of the workplace are key to creating and maintaining professional and personal wellness. However, for many, ‘self-care’ is not a priority. All too many (DC) ministries staff focus only on others, placing themselves last. Sadly, this often means that these (DC) ministries staff will likely not last—either professionally, or personally. For those in (DC) ministries in (RTC/F’s) in childcare to be successful professionally and personally they must develop a regiment of ‘self-care’ practices that provide for their mental, emotional, physical, relational, and spiritual replenishment.

Third, it is paramount for the professional and personal well-being of the (DC) ministries staff working in (RTC/F’s) in childcare that they appreciate their need for ‘self-care’ training and daily employment of ‘self-care’ practices. It is equally important that the organizations that employ (DC) ministries staff in (RTC/F’s) in childcare recognize the issues, demands, and expectation on these staff, and develop and/or include ‘self-care’ training for (DC) ministries staff.
Fourth, it is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation.

Fifth, central to this approach is an appropriate understanding that ‘self-care’ actually increases a caregiver’s—(DC) ministries staff’s capacity to care for others. “For those in the helping professions, early recognition and improved self-care both in and out of the workplace are key to creating wellness. Many caregivers focus on others at the expense of their own well-being. It is crucial for them to replenish themselves and commit to having a life outside of work that includes daily nurturing activities. People often understand this concept intellectually, but the knowledge does not necessarily lead to taking better care of themselves. It is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation. Self-care actually increases a caregiver’s capacity to care for others. Self-care, however, is not just about making healthy lifestyle choices — it is about being present with one’s feelings, sensations, and intuitive guidance in order to detect what is best in any given moment.”

This research reveals that those in ‘helping fields’, like (DC) ministries staff, report increased compassion satisfaction which strongly negatively correlate with numerous items on the burnout, (STS), (VT), and (CF) subscales. In short, those in ‘helping fields’ who were able to develop coping skills to better enable them to more effectively deal with the stressors associated with their work were better able to perform their work with a greater sense of well-being and experienced greater professional and personal

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satisfaction. This sense of well-being and professional and personal satisfaction translated into improved attitudes, increased work performance, and better overall quality of care for those they serve. Portnoy (2011) asserts that those in ‘helping fields’ who “had higher compassion satisfaction scores were more interpersonally “fulfilled,” as defined by scores on “being happy,” “being me,” and “being connected to others.”15 These professionals in ‘helping fields’ “did not feel as trapped and did not experience difficulty separating personal life and work. They were less likely to feel exhausted, bogged down or “on the edge.”16 Clearly, the development and daily practice of ‘self-care’ strategies plays a significant role in achieving mental, emotional, physical, relational, and spiritual well-being, and is paramount to professional and personal fulfillment.

Examples of recommended ‘self-care’ practices in the contemporary context for the mental, emotional, physical, relational, and spiritual aspects of an individual’s life are that they might achieve work-to-life balance. In addition, there are also a number of resources available that advocate for the establishment of appropriate boundaries to maintain a work-to-life balance. However, for all of the examples that are available, and for all of the awareness brought for the need to develop and employ ‘self-care’ practices, and establish appropriate boundaries—most people do not heed the counsel available, nor do they take advantage of the benefits that the ‘self-care’ practices and boundaries would reap, for themselves, or for their families.

‘Self-care’ awareness training, both pre-service, and in-service training can reap benefits for the (DC) ministries staff and the organizations that employ them. Also, pastoral counseling can be of a benefit to (DC) ministries staff, supervisors, and administrative

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16 Ibid.
personnel as well, as this may well help mitigate some of the very issues that exacerbate the high turnover rates of (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth. This research project does not pretend to be a panacea for every issue associated with the work of (DC) ministries, nor does it promise that it will be effective in every situation with every individual. As with any individual needing counseling, there must first be an awareness of the need for help, and secondly, a willingness to seek help.

As stated earlier, it is well accepted that when people are in a crisis they often seek out the counsel of a clergy member for guidance. (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth will encounter the issues, demands, and expectations associated with this line of work, and the stressors of burn-out, (STS), (VT), and (CF) and these stressors will have a deleterious impact on their professional and personal lives as well as their families. However, these (DC) ministries staff and their families can be made aware of these stressors through appropriate training, and when encountered can employ the ‘self-care’ practices and the establishment of healthy boundaries to mitigate the effect and impact on their lives. When, and if it is needed, they can seek out pastoral counseling to find the means to better deal with the stressors in their lives, and find the resources needed for a greater professional and personal fulfillment.

In pastoral counseling, there are a number of pastoral counseling approaches, whether nouthetic counseling, a form of pastoral counseling that employs only the use of Scripture and a focus on Christ, and the power of the Holy Spirit to facilitate change and healing. The pastoral counselor may also employ nouthetic counseling and some combination of approaches dependent upon their personal expertise, and application appropriateness that merge for an eclectic approach, the aim of pastoral counseling is to admonish, correct, or instruct. The motivations for providing the pastoral counseling may vary and stem from confrontation, concern, or change, the aim is to promote Christ, the truths of God’s Word, the
power of the Holy Spirit to facilitate change in the innermost being for Christian maturity and greater growing Christ-likeness. The overall impact of effective pastoral counseling cannot be fully measured; yet the impact on a life, a peace with God, self and others as a result can be greater personal and professional fulfillment.

Pastoral counseling can be the catalyst for helping others understand the importance of establishing and maintaining biblical ‘self-care’ practices and boundaries is central to the pastoral care and counseling provided to guide others to mental, emotional, physical, relational, and spiritual well-being.

Those in (DC) ministries provide an invaluable service to the organizations that employ them on multiple levels. Too these staff provide and invaluable service to our society. The families of these children and/or youth would often times have nowhere else to turn for care for those in need of residential treatment and care. Regardless of one’s definition of the word “ministry”, or the field of ministry, whether full-time or volunteer, or even the reason one entered that ministry; ministry with its office, duties, and work requirements can be taxing to the individual and their families: mentally, emotionally, physically, relationally, and spiritually. The issues associated with the work of ministry: always being on demand, always being on display, and always being on duty is overwhelming to even the hardest of souls, and the most dedicated of ministers and their families.

The toll of ministry on those that minister and their families can be significant. The expectations of the office, duties and/or work of ministry can be overwhelming, and added to this are the demands placed upon the individual and their families: mentally, emotionally, physically, relationally, and spiritually. All too often, this is ignored to a deleterious effect on both. The impact on the individual minister and their families can no longer be ignored.
Research points to the growing need of ministering to those who minister, particularly those in “helping” ministries; whether in direct-care, and other direct-contact ministries.

“Many, including leaders in denominational offices, have studied clergy wellness. In Mental Health Issues among Clergy and Other Religious Professionals: A Review of Research (Journal of Pastoral Care and Counseling, Winter 2002), Andrew Weaver includes these valuable recommendations:

“Psychological assessment of ordination candidates to identify problems and judge suitability for vocation. Recruitment of younger candidates; Professional consultation, supervision, and spiritual direction throughout career; retreats, sabbaticals, and networking with fellow clergy; leadership training; clinical pastoral education; training in pastoral counseling and monitoring indications for mental health referral; congregational education about pastoral stress, reasonable expectations, and conflict resolution; formal pastoral review procedures; conflict mediation and appeal mechanisms for pastors asked to resign; clergy family support with higher salaries, vacation allowance, physical and mental health benefits; help with spouse employment, child adjustment, and building social networks; and confidential pastor and family counseling.”

These are all options available to better minister to those who minister. Many too have researched the impact on those whose ministry is outside the scope of the office, duties, or work of a religious minister, that is, one who is a pastor, preacher, teacher, or evangelist. In addition, there are those whose work in full-time ministry is of a more practical, pragmatic “hands-on” demonstration of their Christian faith and beliefs. Their ministry is lived out daily amongst those they minister to in word and deed; they do the work of ministry in (DC) ministries staff ‘care-giver’ positions in (RGH’s), (RTC/F’s), Schools, and Academies in childcare working with ‘at-risk’ children and/or youth, or in homes for the developmentally


disabled, in hospitals, assisted living centers, retirement homes, and hospices. Others do the work of ministry as chaplains in hospitals, corporations, the military, and with police and fire departments. Ministry takes on a much broader and perhaps less widely accepted understanding that more fully encompasses a more biblically accurate and appreciated definition. The scope of this research study and online survey focused solely on (DC) ministry staff working in (RGH’s), (RTC/F’s), Schools, and Academies working with children and/or youth.

As Weaver’s recommendations revealed that leaders in denominational offices have studied clergy wellness; perhaps similarly leadership of organizations that operate (RGH’s), (RTC/F’s), or Schools, or Academies that employ (DC) ministries staff should also consider how some of these ideas could be modified for this particular application and implemented to resolve recruiting and retention and wellness issues for (DC) ministries staff working in (RTC/F’s) in childcare. Possible parallel recommendations include: recruitment of recent college graduates, candidates with an educational background in psychology, sociology, and/or youth ministry. Provide professional pastoral and/or clinical consultation opportunities when desired. Provide regular weekly team leadership supervision, and weekly on-duty spiritual growth and worship services and spiritual (pastoral) counseling throughout career. Provide semi-annual retreats, vacations for personal refreshment and renewal. Provide networking opportunities for professional growth and enhancement. Provide for annual leadership training for all levels of supervisors. Provide adequate pre-service training for staff working with children and/or youth with trauma related mental and emotional issues, and moderate to severe DSM diagnosed behavior issues. Monitoring of indications for mental health concerns and work related stress, burnout, (STS), (VT), and (CF). Provide mandatory pre-service and semi-annual in-service ‘self-care’ training, as well as confidential pastoral, marriage, and family counseling and/or as needed employee assistance programs,
which provide for professional clinical counseling. Finally, organizations can provide educational opportunities to better inform families of employees about the demands of (DC) ministry, as well as pastoral counseling and conflict mediation and resolution services.

In addition, organizations should consider the investment made in employees with an eye toward employee retention, offering higher salaries, vacation allowances, and physical and mental health benefits help with family adjustments and social support systems with increased family related activities sponsored by the organization.

Significant to this outcome is the often cited lament of (DC) ministries staff that the organization cares more for the needs and wants of the children and/or youth in care, then the needs and wants of the (DC) ministries staff, the very individuals that are instrumental in fostering the therapeutic relationships with the children and/or youth in care that lead to growth and change. Without these front line workers, the milieu of services for children and/or youth will be largely ineffective. No argument is offered that the mission of residential treatment facilities cease being focused on providing for the needs of the children and/or youth in care. What is proposed, however, is a parallel focus that seeks to provide an employee engagement emphasis, which allows (DC) ministries staff to experience a healthy workplace environment where they are heard, valued, included, and empowered in the decision-making processes. This observation is shared by Durrant (1993), who writes,

“…my observation is that most “therapeutic” work is often carried out by the residential staff rather than by designated therapists. That is, the most effective “clinicians” are usually the staff who are lowest in the administrative and professional hierarchy (and usually paid less). I have met residential staff—youth workers, childcare workers, and nurses—in various parts of the world, who feel undervalued and unsupported. They feel a responsibility to ensure that things run smoothly, but only receive comments from management when something is going wrong…I believe the single, most important variable in the effectiveness of residential programs is the extent to which the “frontline” staff experience themselves as valued and supported. Too many
agencies put too much work into focusing on the children and adolescents at the expense of directing resources towards staff.”

The statement by Durrant compliments the suggested parallel process of focusing on the children and/or youth in care, as well as the (DC) ministries staff and provides a winning combination for everyone involved.

When the organization employs ‘self-care’ awareness training, and employee engagement practices that foster a healthy workplace environment that allows (DC) ministries staff to feel heard, valued, included and empowered in the decision-making processes the (DC) ministries staff win.

When (DC) ministries staff feel better about what they do, and how they do it, and feel better about the organizations that employ them, they are more inclined to remain with the organization longer, and provide better overall services; the organization wins.

When the organization provides a healthy workplace environment, and the (DC) ministries staff are satisfied with a greater professional and personal, or work-to-life balance; their continued quality work provides the very stability that is the proven conduit to the very therapeutic relationships that foster growth and change with the children and/or youth in care; and as a result, the children and/or youth in care win.

Finally, the organization most likely retains these key personnel for longer periods of time. As an added benefit, annual turnover rates decline, providing for a more stable employment environment whereby therapeutic relationships can flourish and the children and/or youth in care can be availed to the milieu of services. The organization retains these key staff, turn-over rates decline, hiring and training costs become more manageable, the organization attains a greater success rate with the children and/or youth in care, and referrals

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increase, and profit margins increase. Stakeholders at all levels are satisfied with the results. The organization wins. Everyone wins.

It is time for the church, for para-church organizations, children’s homes, (RTC/F’s) and for society as a whole to consider the issues, the demands and the expectations placed upon those in ministry, particularly those in (DC) ministries “helping fields” positions at every level, and those of their families as well.

As a society, our reliance upon those who do the work of ministry is great, and our care for them should be as well, caring for them as a person would for themselves: mentally, emotionally, physically, relationally, and spiritually; for Scripture teaches us, “The King will reply, ‘Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me.’” (Matthew 25:40 (NIV) 20

(DC) ministries staff may not have the recognition they deserve, but they should have our support, and gratitude as they serve day in and day out, in one of the most challenging of all the “helping fields” vocations. It is an incredibly taxing vocation: mentally, emotionally, physically, relationally, and spiritually. Raising children and/or youth is hard, it is even harder when they experience moderate to severe mental and emotional disorders, and are behaviorally challenged. It is even more difficult when they are not your children and/or youth.

In closing, for those who struggle daily with the work of ministry, and their families, it is encouraging to remember the truths of God’s Word as reflected in Crabb’s comments,

We will soon sense our inadequacy to change what needs to be changed, we will face the truth that a troubled, hardened, foolish heart needs to be impacted and that only the Holy Spirit of God can make that happen. At that point, we will have only two choices: Yield to despair or find God. If we begin looking for God, we will then enter a whole new battle. We will be thrown onto God, we will long to see His face, we will wrestle with our fears and doubts in His presence, we will seek Him with all our hearts. Because He promised to let us

find Him when we seek Him with a stronger passion than we seek anything else (such as solutions or relief), we will find Him. We will find Him in His Word. After a long fall through darkness, we will land on the truth of His eternal, almighty, and loving character, and we will believe He is always up to something good. And we will find Him within us in the form of holy urges, good appetites, and wise inclinations that reflect the character of Christ. In our familiar language, the energy of Christ is released most fully when we most completely come to the end of ourselves.  

To echo this, it would be spiritually wise to consider that whenever people enter into the spiritual work of ministry, in whatever capacity in a “helping field”, especially the work of (DC) ministries in (RTC/F’s) working with children and/or youth, the work will be more than any individual can do in their own strength, intellect, education, experience, or abilities. The issues, demands and expectations of ministry require those in ministry work to rely on God’s Word, God’s Spirit, and God’s people to be resources for wisdom, strength, and resources. For people to attempt to do God’s work in their own strength is pure folly, and will lead to inevitable overload. God never said the work and life of ministry would be easy. “….we need to remember that God doesn’t promise to protect His children from struggles, heartache, or failure. The experience of difficulties need not threaten our faith if we understand God’s purposes for them. J. I. Packer noted:

    God….is very gentle with young Christians, just as mothers are with very young babies. Often the start of their Christian career is marked by great emotional joy, striking providences, remarkable answers to prayer, and immediate fruitfulness in their first acts of witnessing; thus God encourages them, and establishes them in ‘the life.’ But as they grow stronger, and are able to bear more, He exercises them in a tougher school. He exposes them to as much testing by the pressure of opposed and discouraging influences as they are able to bear—not more (see the promise, 1 Corinthians 10:13), but equally not less (see the admonition, Acts 14:22). Thus He builds our character, strengthens our faith, and prepares us to help others.”

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21 Crabb, Jr., PhD. Lawrence (Larry) J. *Connecting: Healing For Ourselves and Our Relationships.* (Nashville: W Publishing Group, 1997), 179.

The experience of difficulties, then, may challenge our perceptions of God’s goodness and purpose, but times of suffering give us the opportunity to see Him more accurately, trust Him more deeply, and gain compassion for others who endure suffering too.”23 As a former (DC) ministries staff person at (RTC/F’s), and now as a Director of Pastoral Care/Chaplain and Campus Pastor at a (RTC/F), I work side by side with (DC) ministries staff and it is my heart’s desire to minister to those, who minister to others. This is why I chose to begin and end this thesis with the prayer found in Romans 1:8-12,

“First, I thank my God through Jesus Christ for all of you, because your faith is being reported all over the world. God, whom I serve in my spirit in preaching the gospel of his Son, is my witness how constantly I remember you in my prayers at all times; and I pray that now at last by God’s will the way may be opened for me to come to you. I long to see you so that I may impart to you some spiritual gift to make you strong—that is, that you and I may be mutually encouraged by each other’s faith.” (Romans 1:8-12 (NIV)

May God minister to pastors and pastoral counselors, providing the wisdom, strength and courage needed, that they may in turn minister to those, who minister to others who are among the most vulnerable and in need of direct-care.

BIBLIOGRAPHY


*Compassion Fatigue*. Accessed April 14, 2015 at the Compassion Fatigue.org website at: http://www.compassionfatigue.org/pages/healthprogress.pdf


APPENDIX A

ONLINE SURVEY RESULTS

Research Study And Online Survey Of 'Direct-Care' Ministries Staff Working In Residential Treatment Facilities in Childcare With 'At-Risk', and/or Behaviorally Challenged Children, and Youth.

Q1 Please identify what organization you work for.

Answered: 128  Skipped: 0

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Q4 I am well trained by my organization for the job I do.

Answered: 101    Skipped: 27

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Q5 I find my job fulfilling.

Answered: 101   Skipped: 27

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Q6 I am often mentally overwhelmed at work.

Answered: 100  Skipped: 28

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Q7 I often seek to relieve the stress of my work.

Answered: 101  Skipped: 27

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Q8 I feel as though I make a positive impact at work.

Answered: 100    Skipped: 28

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Q9 I feel emotionally supported by my organization.

Answered: 100    Skipped: 28

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Q10 I feel valued at my organization.

Answered: 100    Skipped: 28

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EMOTIONAL: 3.90
Q11 I often feel emotionally stressed at work.

Answered: 100  Skipped: 28

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Q12 I feel as though my job has negatively impacted my life.

Answered: 100    Skipped: 28

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Q13 I often feel physically exhausted after my work shift.

Answered: 100    Skipped: 28

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**Basic Statistics**

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Q14 I often feel the need to relieve the stress of my job.

Answered: 100    Skipped: 28

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Q15 I often feel overly tired while at work.

Answered: 100  Skipped: 28

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Basic Statistics

- Minimum: 1.00
- Maximum: 5.00
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- Mean: 2.81
- Standard Deviation: 1.02
Q16 I have called in sick to work when I was not sick.

Answered: 100    Skipped: 28

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Q17 I feel as though my job has taken a physical toll on me.

Answered: 100    Skipped: 28

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**Q18 I feel relationally isolated at work.**

Answered: 100  Skipped: 28

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Q19 I feel as though my job has had a negative impact on my relationships outside of work.

Answered: 100    Skipped: 28

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Q20 I get along well with my co-workers.

Answered: 100    Skipped: 28

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Q21 I feel as though my opinions about work matter to my co-workers.

Answered: 100    Skipped: 28

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Q22 I feel as though I am an important part of the organization.

Answered: 100   Skipped: 28

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Q23 I feel as though the organization cares about my spiritual well-being.

Answered: 99    Skipped: 29

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Q24 I feel my spiritual beliefs are challenged by my job.

Answered: 100    Skipped: 28

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Q25 I have opportunities for personal spiritual renewal.

Answered: 100    Skipped: 28

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Q26 I have sufficient opportunities for personal spiritual development.

Answered: 100  Skipped: 28

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Q27 I feel it is important to find harmony in my life with my work and my spiritual life.

Answered: 100    Skipped: 28

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Q28 I feel as though I am well paid for the work I do.

Answered: 98    Skipped: 30

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Q29 I feel as though my job is challenging.

Answered: 99    Skipped: 29

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Q30 I often feel like the tasks assigned to me by my supervisor help me grow professionally.

Answered: 100  Skipped: 28

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Q31 I feel as though there are opportunities to get promoted where I work.

Answered: 98    Skipped: 30

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Q32 I feel as though I am supervised effectively at work.

Answered: 99    Skipped: 29

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Q33 I am satisfied with my employee benefits.

Answered: 100    Skipped: 28

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Q34 I am satisfied with my job.

Answered: 100    Skipped: 28

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Q35 I trust my supervisor.

Answered: 100    Skipped: 28

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Q36 I feel as though my organization cares about its employees.

Answered: 98    Skipped: 30

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Q37 I feel as though my opinions about my work matter to my supervisor.

Answered: 99  Skipped: 29

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Q38 I feel as though my supervisor has realistic expectations of me.

Answered: 100    Skipped: 28

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Q39 I like working for my organization.

Answered: 100  Skipped: 28

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<td>38.00%</td>
</tr>
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<td>11.00%</td>
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<td>1.00%</td>
</tr>
<tr>
<td>Strongly Disagree</td>
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<td>1.00%</td>
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Basic Statistics

- **Minimum**: 2.00
- **Maximum**: 5.00
- **Median**: 4.50
- **Mean**: 4.37
- **Standard Deviation**: 0.72

**Weighted Average**: 4.37
Q40 I look forward to coming to work.

Answered: 98   Skipped: 30

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<td>3.06%</td>
<td>17.35%</td>
<td>39.80%</td>
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Basic Statistics

<table>
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<th>Mean</th>
<th>Standard Deviation</th>
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<tr>
<td>2.00</td>
<td>5.00</td>
<td>4.00</td>
<td>4.16</td>
<td>0.82</td>
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Q41 I am likely to look for another job outside the organization within the next year.

Answered: 98    Skipped: 30

**MORALE**

<table>
<thead>
<tr>
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<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
<th>Total</th>
<th>Weighted Average</th>
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<td>23.47%</td>
<td>18.37%</td>
<td>7.14%</td>
<td>2.04%</td>
<td>98</td>
<td>1.90</td>
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**Basic Statistics**

<table>
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<th>Mean</th>
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<td>1.00</td>
<td>5.00</td>
<td>2.00</td>
<td>1.90</td>
<td>1.06</td>
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</table>
Q42 I feel that I have career growth and development potential with my organization.

Answered: 99    Skipped: 29

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<tr>
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<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
<th>Total</th>
<th>Weighted Average</th>
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<tr>
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<td>12.12%</td>
<td>20.20%</td>
<td>46.46%</td>
<td>14.14%</td>
<td>99</td>
<td>3.48</td>
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**Basic Statistics**

<table>
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<th>Mean</th>
<th>Standard Deviation</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1.00</td>
<td>5.00</td>
<td>4.00</td>
<td>3.48</td>
<td>1.10</td>
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APPENDIX B

ONLINE SURVEY RESULTS SUMMARY ANALYSIS

<table>
<thead>
<tr>
<th>Category</th>
<th>Survey Question</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>SD</th>
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</thead>
<tbody>
<tr>
<td>MENTAL:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>“I am mentally prepared for the job that I do.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.49</td>
<td>0.68</td>
</tr>
<tr>
<td>Q4</td>
<td>“I am well trained by my organization for the job I do.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.16</td>
<td>0.85</td>
</tr>
<tr>
<td>Q5</td>
<td>“I find my job fulfilling.”</td>
<td>1.00</td>
<td>5.00</td>
<td>4.46</td>
<td>0.78</td>
</tr>
<tr>
<td>Q6</td>
<td>“I am often mentally overwhelmed at work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>2.99</td>
<td>1.07</td>
</tr>
<tr>
<td>Q7</td>
<td>“I often seek to relieve the stress of my work.”</td>
<td>1.00</td>
<td>5.00</td>
<td>3.38</td>
<td>0.96</td>
</tr>
<tr>
<td>TOTAL WEIGHTED AVERAGE</td>
<td>..........................................................</td>
<td>5.00</td>
<td>25.00</td>
<td>19.48</td>
<td>4.34</td>
</tr>
</tbody>
</table>

This statistical data reveals that although respondents feel they are mentally prepared and trained to do the job, nearly three-quarters of the respondents feel they are mentally overwhelmed while at work, and often seek to alleviate the mental stress of the work through some ‘self-care’ practice. Clearly, (DC) ministries staff responded that they are mentally taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

EMOTIONAL:

| Q8                | “I feel as though I make a positive impact at work.”                           | 1.00| 5.00| 4.24 | 0.76|
| Q9                | “I feel emotionally supported by my organization.”                             | 1.00| 5.00| 3.94 | 1.01|
| Q10               | “I feel valued by my organization.”                                            | 1.00| 5.00| 3.90 | 0.97|
| Q11               | “I often feel emotionally stressed at work.”                                   | 1.00| 5.00| 3.02 | 1.16|
| Q12               | “I feel as though my job has negatively impacted my life.”                     | 1.00| 5.00| 1.88 | 0.93|
| TOTAL WEIGHTED AVERAGE|..........................................................| 5.00| 25.00| 16.98| 4.83|

This statistical data reveals that although respondents feel they are emotionally making a positive difference at work, and feel supported by their organizations, more than half of the respondents feel they are emotionally overwhelmed at work, and seek to alleviate the emotional stress of the work through some ‘self-care’ practice. Clearly, (DC) ministries staff responded that they are
emotionally taxed because of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

**PHYSICAL:**

Q13 “I often feel physically exhausted after my work shift.” 1.00 5.00 3.36 1.02
Q14 “I often feel the need to relieve the stress of my job.” 1.00 5.00 3.33 1.00
Q15 “I often feel overly tired while at work.” 1.00 5.00 2.81 1.02
Q16 “I have called in sick to work when I was not sick.” 1.00 5.00 1.23 0.61
Q17 “I feel as though my job has taken a physical toll on me.” 1.00 5.00 2.41 1.16

TOTAL WEIGHTED AVERAGE…………………………………..5.00…..25.00…13.14…..4.81

This data reveals that although respondents feel they are physically exhausted after a work shift; and often feel tired while at work; and that more than half of the respondents feel the need to relieve the physical stress of the work through some ‘self-care practice; most reported they would not abuse sick leave, when they were not actually sick as part of the ‘self-care’ practice. Clearly, (DC) ministries staff responded that they are physically taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare

**RELATIONAL:**

Q18 “I feel relationally isolated at work.” 1.00 5.00 2.19 1.11
Q19 “I feel as though my job has had a negative impact on my relationships outside my work.” 1.00 5.00 2.20 1.19
Q20 “I get along well with my co-workers.” 1.00 5.00 4.26 0.77
Q21 “I feel as though my opinions about work matter to my co-workers.” 1.00 5.00 3.93 0.92
Q22 “I feel as though I am an important part of the organization.” 1.00 5.00 3.97 0.89

TOTAL WEIGHTED AVERAGE…………………………………..5.00…..25.00…16.55…..4.88

This data reveals that just under half of the respondents feel they are relationally isolated at work, and also feel that their job has had a negative impact on their relationships outside of their work. Most get along well with their co-workers and feel their opinions about work matter to
their co-workers, and also that they feel valued by their organizations. Clearly, (DC) ministries staff responded that they are relationally taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

SPIRITUAL:

Q23 “I feel as though the organization cares about my spiritual well-being.”
Q24 “I feel my spiritual beliefs are challenged by my job.”
Q25 “I have opportunities for personal spiritual renewal.”
Q26 “I have sufficient opportunities for personal spiritual development.”
Q27 “I feel it is important to find harmony in my life with my work and my spiritual life.”

TOTAL WEIGHTED AVERAGE………………………………….5.00.....25.00….18.01…..4.99

This data reveals that although respondents feel it is important to find harmony in their lives with their work and spiritual beliefs, that they believe that the organization cares about their spiritual well-being, and have opportunities for spiritual renewal and spiritual development, half of the respondents feel their spiritual beliefs are challenged by their job. Clearly, (DC) ministries staff responded that they are spiritually taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

MORALE:

Q28 “I feel as though I am well paid for the work I do.”
Q29 “I feel as though my job is challenging.”
Q30 “I often feel like the tasks assigned to me by my supervisor help me grow professionally.”
Q31 “I feel as though there are opportunities to get promoted Where I work.”
Q32 “I feel as though I am supervised effectively at work.”
Q33 “I am satisfied with my employee benefits.”
Q34 “I am satisfied with my job.”
Q35 “I trust my supervisor.”
Q36  “I feel as though my organization cares about its employees.” 1.00  5.00  3.98  0.98
Q37  “I feel as though my opinions about my work matter to my supervisor.” 1.00  5.00  4.04  1.05
Q38  “I feel as though my supervisor has realistic expectations of me.” 1.00  5.00  4.04  0.90
Q39  “I like working for my organization.” 1.00  5.00  4.37  0.72
Q40  “I look forward to coming to work.” 1.00  5.00  4.16  0.82
Q41  “I am likely to look for another job outside the organization within the next year.” 1.00  5.00  1.90  1.06
Q42  “I feel I have career growth and development potential with my organization.” 1.00  5.00  3.48  1.10

TOTAL WEIGHTED AVERAGE……………………………………..15.00…..75.00…55.83…14.25

This data reveals that although respondents feel that they like the organizations that they are employed with, like the job they do, feel that they are challenged and compensated appropriately, like their supervisors, feel valued by the organization and their supervisor, and also trust their supervisor. Still, nearly one-third of the respondents reported they would most likely seek employment with another organization within the next year. Clearly, there is a disconnection with the organization at some level.
APPENDIX C

DISSERTATION DEFENSE POWERPOINT PRESENTATION

THE CHALLENGES AND BIBLICAL ‘SELF-CARE’ STRATEGIES FOR ‘DIRECT-CARE’ STAFF IN RESIDENTIAL TREATMENT FACILITIES

A Thesis Project Submitted to Liberty University School of Divinity
In partial fulfillment of the requirements for the degree Doctor of Ministry
By Michael Patrick Jones
February, 2016

THESIS ABSTRACT:
MINISTERING TO THOSE IN "DIRECT-CARE" MINISTRIES

“Ministry” is more than just pastoral duties within the context of the church. Those in ministry, particularly those in ‘Direct-Care’ positions working in Residential Treatment Facilities in childcare face a plethora of issues that tax them mentally, emotionally, physically, relationally, and spiritually. This project will provide biblically based engaging, edifying, encouraging, and equipping ministries to enable those who are in ‘Direct-Care’ positions to develop ‘self-care’ practices to address these issues.

This thesis will investigate the causes and effects that impact those in ‘Direct-Care’ ministry to experience disillusionment, discouragement, depression, despair, defeat and/or departure from ministry; identify ‘self-care’ practices that those in ‘Direct-Care’ ministries, and their families can employ to remain successful in their ministries. This thesis will be developed using existing research on the causes and effects; steps to avoid ministry failure; online surveys with those in ‘Direct-Care’ ministry, and non-recorded interviews with professionals, and related sources and current data.
INTRODUCTION:

What is ministry? Ministry has been defined by many within the context of the governmental agencies, para-
church organizations, and religious institutions, most specifically within the context of the office, duties or
work of a religious minister. However, ministry, even
within the context of an Evangelical Christian
understanding, encompasses so much more than just
the office, duties, or work of a religious minister, one
who is a pastor, preacher, teacher, or evangelist. Yet,
the English word “ministry” is defined in the Merriam-
Webster dictionary as: “min-is-tré articulated as the
noun “mi-na-stré”: the ministry: “ministry” includes
those who perform the work of ministry both within
the context of church/chaplaincy/para-church ministry
vocations; and those working in “helping” fields
ministering to others in various vocations in direct-care
“helping” positions.

There are many examples of such “helping positions.” “Helping positions”
and/or “helping fields” are those vocations that are human service-oriented fields
that work directly with people. Vocations in “helping fields” implies people
working directly with people, means interacting with people in such a way that
the individual invests something of himself/herself to provide for another in the
mental, emotional, physical, relational, social, and spiritual aspects of their lives.

Vocations in “helping fields” with reported high levels of stress are as varied as
the causes of the stressors resulting in burnout, secondary traumatic stress (STS),
vicarious trauma (VT), and compassion fatigue (CF) include: social workers,
licensed clinical social workers, therapists, recreation-therapists, counselors,
psychologists, psychiatrists, psychiatric aides (nurses), pastors, chaplains,
teachers, nurses, nursing assistants, home health-aides, emergency medical
technicians (EMT’s), police officers, crime scene investigators, lawyers, hospice
workers, and ‘direct-care’ staff; these professionals working in residential
treatment centers/facilities (RTC/F’s) with children and/or youth in childcare.
Why people choose to pursue such a “helping field” vocation or ministry work is as diverse as the types of ministry in a contemporary context. Many people enter full-time vocational ministry in various religious and faith-based organizations for a variety of reasons: faith-based, familial, and personal. For those who enter the ministry in the Evangelical Christian faith, it is typically because they believe they are “called” of God—set apart and ordained for a particular ministry. For many, they enter the Evangelical Christian ministry with the specific intent on ministering to others, either those who have already become adherents of the Christian faith—pastors, preachers, teachers, etc.

Others pursue a ministry specifically to those who have no allegiance to the Christian faith, yet may be open to the evangelistic outreach efforts, apologetics and/or missionary work of an individual, agency, or para-church organization. These are evangelists, apologists, and missionaries. Most would argue that their ministry is intended to reflect God’s love, mercy, and grace in a manner that demonstrates in word and deed the teachings of the Bible, the Judeo-Christian faith, and encompassed the life, ministry, and examples of the Lord Jesus Christ. Few would counter their position.

In addition, there are those whose work in full-time ministry is of a more practical, pragmatic “hands-on” demonstration of their Christian faith and beliefs. Their ministry is lived out daily amongst those they minister to in word and deed. They do the work of ministry in ‘Direct-Care’ (DC) ministries staff positions in (RTC/F’s) in childcare working with ‘at-risk’ children and/or youth, or in homes for the developmentally disabled, in hospitals, assisted living centers, retirement homes, and hospices. Others do the work of ministry as chaplains in hospitals, corporations, the military, and with police and fire departments. Thus, ministry takes on a much broader and perhaps less widely accepted understanding that more fully encompasses a more biblically accurate and appreciated definition.
Some enter the world of full-time vocational ministry out of a sense of idealism with a desire to help others. This sense of idealism motivates some to do something more with their lives then earn a paycheck. “Idealism” is central to their purpose for working in a “helping field” vocation. They identify a need, and as these individuals are compassionate and caring, people-centered, service-oriented individuals, they look for positive ways to impact the lives of others in meaningful ways in filling that need. Interestingly enough, individuals from all camps (can and will likely) find themselves struggling with the same realities of the work of ministry. These realities often take their toll on the individual and their families.

Most people begin a career in full-time vocational ministry with an idealism rife with expectations that their career in a “helping field” will allow them to utilize their natural abilities, talents, education, experience, spiritual gifting, and fulfill their God-given callings. This idealism, however, soon gives way to reality when the demands of the office, and the expectations of others, (combined with those stressors that are self-imposed; the duties of the position; and the workload of ministry) begin to take their toll on them and their families.

Simply stated those in ministry and their families often feel as though they are always deluged with drama, always on demand, always on duty, and always on display. The toll of these stressors often manifests with deleterious effects on the mental, emotional, physical, relational, and spiritual aspects of their lives and that of their families. While these stressors are a part of ministry, these stressors as well as burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF), and the toxic spillover often accompany the work of ‘Direct-Care’ (DC) ministries.

Then there are the expectations placed upon those in ‘Direct-Care’ ministries staff by the organizations that employ them, such as: insufficient training to meet the mental and or emotional, physical demands of the types of children and/or youth in care, inadequate staffing, undesirable work schedules or excessively long work shifts, low salaries, poor benefits, poor job conditions, ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high ‘Direct-Care’ ministries staff turnover.
The issues, demands, and expectations combined create an environment ripe for (DC) ministries staff to struggle with the stressors associated with this type of ministry work. These stressors must be addressed for the overall personal and professional fulfillment and well-being of the (DC) ministries staff, as well as their families, and for their continued ministry success at their given placement of service.

The goal of this thesis project: *The Challenges And Biblical 'Self-Care' Strategies For 'Direct-Care' Staff In Residential Treatment Facilities*, research study and online survey is to develop a greater understanding and awareness of the mental, emotional, physical, relational, and spiritual issues, demands, and expectations that become those stressors placed upon those in ‘Direct-Care’ (DC) ministries positions, specifically those who work in Residential Treatment Centers/Facilities (RTC/F’s) in childcare; as well as the impact it places upon on themselves, there is the toll it takes on their families, and the organizations with which they are affiliated. This thesis project, research study and online survey will also briefly acknowledge how the impact of these issues, demands, and expectations and stressors on (DC) ministries staff impacts the organizations that employ (DC) ministries staff.

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**VALUE:**

The value of this project can appreciated on multiple levels.

- First, it will provide directional ‘self-care’ awareness training on the impact of the mental, emotional, physical, relational, and spiritual issues that impact the professional and personal lives of (DC) ministries staff.

- Second, this research, survey results, and subsequent training will become the basis to provide ‘self-care’ coaching of (DC) ministries staff on how to develop better coping skills for dealing with these issues, demands, and expectations while working in (RTC/F’s) in childcare.

- Third, it will present biblically-based ‘self-care’ recommendations for both the (DC) ministries staff and his/her family that equips, encourages, and empowers. These benefits, combined with organizational employee-engagement practices if employed regularly could help them be successful in coping with the mental, emotional, physical, relational, and spiritual tolls that (DC) ministries staff will have on them and their families. Thus, they might enjoy a greater quality of life with personal and professional fulfillment and success.
• Fourth, it will provide opportunities for additionally pastoral services of coaching, pastoral counseling, and/or referrals for professional counseling.

• Fifth, it will provide the organizations that employ (DC) ministries staff with the necessary information needed to address the issues, demands, and expectations that adversely impact (DC) ministries staff. Combined with the ‘self-care’ awareness training, morale building, and employee engagement resources senior administrators can better address organizational (DC) ministries staff recruiting, retention, and release issues.

CHAPTER 1:
The History of ‘Direct-Care’ Ministries in Residential Treatment Facilities in Childcare in the United States
This chapter outlines the historical nature of the work of ‘Direct-Care’ ministries in the United States of America, from before 1800 to the present, its evolution, from orphanage to academies, schools, to Residential Group Home’s and/or Residential Treatment Centers/Facilities. How in the early period of this country’s formation, the needs of dependent children, youth and adults were generally met through indenture, almshouses, or charity of neighbors. Through 1.) Relief programs, a public assistance program for poor families and children consisting of a meager dole paid by the community to maintain families in their own homes; 2.) Farming-out, a system whereby individuals or group of paupers were auctioned off to citizens who agreed to maintain the paupers in their homes for a contracted fee; 3.) Almshouses or poorhouses, institutions established and administered by public authorities in large urban areas for the care of destitute children and adults; and 4.) Indenture, a plan for apprenticing children to households where they would be cared for and taught a trade, in return for which they owed loyalty, obedience, and labor until costs of their rearing had been worked off. Most of the orphanages in the United States were established by religious organizations during the eighteenth and nineteenth centuries.

Later following World War II, most orphanages in the United States were closing, leaving only a handful of orphanages remaining. However, during the Civil Rights movement, orphanages became associated with substandard care of the children and youth in care, poor food and accommodations, and a lack of support services due to insufficient funding. A shift from the orphanage “congregate” style of dorm living to a more home/family “cottage” style living became the preferred approach toward residential childcare living.

It was during the 1950s and 1960s, a period of intense scrutiny and criticism of residential childcare forced significant changes to occur. By the mid 1970’s many of these orphanages had changed to become organizations that operate as Residential Group Home’s, or Residential Treatment Centers/Facilities. These organizations now provide residential care for many youth that in times past would have found a home in an orphanage.
Today the primary difference between Residential Group Home’s and Residential Treatment Centers/Facilities is the “levels of care” or “continuum of care” provided for the clinical continuum of services, referred to as “milieu of services” for the children and/or youth in residential care. These levels of care followed along with many of the other changes that began after WWII.

These changes in residential childcare led most orphanages in the United States to evolve into Residential Group Home’s and/or Residential Treatment Centers/Facilities that operate under a “level of care” model, offering a “continuum of care” and a “milieu of services” to provide a person-centered approach for the children and/or youth in residential care.

These changes in the “levels of care” too required changes for the staff working at these Residential Treatment Centers/Facilities, new demands meant new training requirements. At each increasing “level of care,” the severity of the mental, emotional, and behavioral challenges faced by ‘Direct-Care’ ministry staff as part of their work with children and/or youth in Residential Treatment Centers/Facilities in childcare today increases, which further exacerbates the issues, demands, and expectations that lead to burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF).

CHAPTER 2:
The Challenges Associated With The Work Of ‘Direct-Care’ Ministry In Residential Treatment Facilities
Those providing ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare service children and youth ages 1 to 21 from widely diverse backgrounds and range of abuse and neglect. The children and youth also often struggle with the mental and emotional disorders, physical, relational, and behavioral, as well as academic consequences of their having witnessed and/or experienced violence, verbal, mental, emotional, physical sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes that have proven detrimental to their well-being. These same children and youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis requiring psychotropic medication use, as well as regular counseling and therapy. Revisions in the required training came as a result of the needs of children and/or youth coming into Residential Treatment Centers/Facilities childcare. The mental, emotional, physical, relational, academic and spiritual needs of children and youth in Residential Treatment Centers/Facilities today require far more demanding care. Those compound the already taxing nature of the issues, demands and expectations on those working in Residential Treatment Centers/Facilities in childcare in ‘Direct-Care’ ministries is equally demanding.


This thesis, research study and online survey seek to reveal how providing ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare working with children and/or youth exposes those working in ‘Direct-Care’ ministries to a plethora of stressors: the issues related to ministry work—always being on demand, always being on display, and always on-duty; those demands specific to ‘Direct-Care’ ministries, working with children and/or youth from widely diverse socio-economic backgrounds, ages, ethnicities, and genders who have experienced abuse and/or neglect, and as a result struggle with mental and emotional disorders, as well as physical, relational, and behavioral challenges. Having witnessed and/or experienced violence, verbal, mental, emotional, physical and/or sexual abuse, neglect, and/or abandonment, or other harsh circumstances in their family homes have proven detrimental to their well-being. These same children and/or youth often have histories of substance abuse, criminal activity, sexual offending, suicidal ideation, prior psychiatric hospitalizations, and psychiatric diagnosis, requiring psychotropic medication use, as well as regular counseling and therapy.


There are four different strata within the continuum of care of residential treatment for children and/or youth: treatment foster-care Treatment Foster-Care, Residential Group Home’s, Residential Treatment Centers/Facilities, and Impatient Psychiatric Residential Treatment Facilities. These strata are also referred to as the “levels of care” outlining the clinical “continuum of care” and “milieu of services” for the children and/or youth in residential care. These “levels of care” are at times referred to as Level I, II, III, IV, and (PRTF). The staffing structures may include family and program type settings or higher levels of care requiring greater levels of supervision and/or clinical care. The “levels of care” greatly depend on what is available at the time placement is needed, and what “level of care” would be most appropriate for the children and/or youth based on their demonstrated behaviors, DSM-V diagnosis, mental and emotional disorders, and their physical and/or educational needs. As many of these children have suffered abuse/neglect within their own families and, as a result, have a great deal of trouble adjusting to a family setting, these “levels of care”—“continuum of care,” “milieu of services” are meant to provide the appropriate “level of care” and services for the child and/or youth receiving services.

Each “level of care” in Residential Treatment Center/Facilities in childcare provide a “milieu of services” at various levels of supervision ranging from minimal to constant—‘sight and sound’ to clinical care with round the clock staffing care. Too, the “levels of care” are equally dictated by the levels of cooperation by the children and/or youth in care. As many of the children and/or youth in Levels II, III, IV, and (PRTF) “levels of care” are not always accepting of the treatment process a higher level of supervision is required, and often such security includes a ‘sight and sound” approach to begin the treatment process. In these ‘levels of care’ II, III, IV, and (PRTF), the children and/or youth may have histories of element from treatment facilities. As a result, the continuum of care and services provided for the children and/or youth in care: mental, emotional, physical, educational, and spiritual care must also be met in a secure setting provided by the residential provider. Typically, the treatment (therapeutic, psychiatric, psychological, medical, vocational, recreational, and educational) needs of children and/or youth in care at this level are so extreme that these activities can only be undertaken in a therapeutic context. These services are conducted in a manner that is fully integrated into ongoing treatment.
CHAPTER 3:
The Stressors Associated With The Work Of ‘Direct-Care’ Ministry In Residential Treatment Facilities

There are issues related to the work of ministry. There are demands unique to the work of ‘Direct-Care’ ministries, and there are also expectations associated with the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare can take a result in burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF). These issues, demands, and expectations, and the stressors that result can have a deleterious toll on the mental, emotional, physical, relational, and spiritual well-being of the ‘Direct-Care’ ministries staff and their families. These are exacerbated with each increasing ‘levels of care’ required to meet the mental and emotional disorders, and behavioral challenges of the children and/or youth in care. In a Level II, III, and IV Residential Treatment Center/Facility as well as Psychiatric Residential Treatment Facility, ‘Direct-Care’ ministries staff daily encounter behaviors from children and/or youth who have significant psychological, behavioral, and emotional disorders, as well as behavioral issues that bring them into care. ‘Direct-Care’ ministries staff deal with behaviors ranging from the inability to follow directions, and/or conform to the structure of school, home or community, violent arguments, self-injurious behavior, risk taking, sexual promiscuity, self-harm and suicidal ideations and actions, physical alterations, verbally aggressive and provocative and/or profane language and severe property damage incidents.

‘Direct-Care’ ministries staff must also interact with Department of Social Services; and court appointed personnel such as Guardian Ad Litem’s, Probation and/or Parole Officers; and must also engage with school officials and teachers over frequent school related issues; as well as family and/or legal guardians. In their role as a surrogate-parent, ‘Direct-Care’ ministries staff have a number of duties in providing care and supervision of these children and/or youth.

In addition to providing for the children and/or youths care, ‘Direct-Care’ ministries staff must also remain vigilant for a moderate to high risk behaviors: for children and/or youth abusing medications, acting in self-harm behaviors, sexually victimizing others and eloping. Finally, as there is also and increasing likelihood that children and/or youth coming into care will struggle with Diagnostic and Statistical Manual of Mental Disorders, fifth Edition, (DSM-V) diagnosed behavior issues, mental, emotional traumas related to their experiences, and/or have the presence of severe affective, cognitive or developmental delays/disabilities. These all require ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities with children and/or youth in childcare maintain a constant awareness of the status of the children and/or youth in care, and keep those in care in constant ‘sight and sound’ supervision.


The work of ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities in childcare have expectations placed upon them by the organizations that employ them. Those that work as ‘Direct-Care’ ministries staff in residential childcare facilities have what is considered to be one of the most difficult and emotionally exhausting positions in the “helping fields” careers. These expectations often include working with insufficient training to meet the demands of the types of children and/or youth in care; inadequate staffing, undesirable work schedules or excessively long work shifts, low salaries, poor benefits, poor job conditions, ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high ‘Direct-Care’ ministries staff turnover.

The issues, demands, and expectations combined create and environment ripe for ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare to struggle with the stressors associated with this type of ministry work; and lead to excessively high turnover rates.


Existing research demonstrates that the stressors associated with the 'Direct-Care' ministries work in Residential Treatment Centers/Facilities in childcare include: burnout, Secondary Traumatic Stress, vicarious trauma, and compassion fatigue and the toxic spillover that often accompany the work of 'Direct-Care' ministries. In addition, how these issues and demands, combined with those expectations placed upon them by the organizations with which they are affiliated, can create an environment that is detrimental to the individual 'Direct-Care' ministries staff, and their families.

Many studies have been conducted on the negative impact that workplace expectations have on those working in 'Direct-Care' positions in Residential Treatment Centers/Facilities in childcare. These studies reveal that these additional expectations and subsequent stressors include insufficient training to meet the demands of the types of youth in care, inadequate staffing, undesirable work schedules or work shifts, low salaries, poor benefits, poor job conditions, undefined job responsibilities, a lack of appropriate supervision, poor communication, insufficient resources, and the loss of other staff due to high 'Direct-Care' ministries staff turnover.

In addition, there are the stressors placed upon 'Direct-Care' ministries staff of unrealistic expectations and demands placed upon them by the organization's mid-level management and senior administrative staff, the courts, social workers, guardian ad litems, school officials, and even parents. This often exacerbates the already overwhelmed 'Direct-Care' ministries staff with thoughts and feelings of being mentally, emotionally, physically, relationally, and spiritually exhausted and they become ideal candidates for burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF).

These expectations alone would be enough to discourage even the most hardy and well-intentioned individual to reconsider their level of commitment to a ministry role, or an organization. Added to the issues associated with the work of ministry, and the demands specific to 'Direct-Care' ministries work, these issues, demands, and expectations create an environment that is detrimental to the professional and personal success of 'Direct-Care' ministries staff, their families, and the overall success of the organizations that employ them.
Research reveals that these stressors can be addressed with “self-care” awareness training for ‘Direct-Care’ ministries staff to help them become aware of the issues, demands, and expectations that create and environment that fosters these stressors of the work associated with ‘Direct-Care’ ministries in residential care, that for their overall personal and professional fulfillment and well-being, as well as their families, and for their continued ministry success at their given placement of service, as well as the continued success of the organization’s mission of working with the children and/or youth in care.

Additionally, organizations that operate residential childcare centers must also reconsider the importance of implementing employee-engagement practices, that work to foster a workplace environment that recognizes the issues, demands, and expectations of the work of ‘Direct-Care’ ministries staff in residential treatment centers/facilities and work with staff to mitigate, and alleviate where possible the causes of these stressors.

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CHAPTER 4:
The Current Research, Phenomenological Research, And The Online Survey Research Data And Analysis
This chapter supports the preceding chapter’s historical research to date, the phenomenological research, and the online survey research data and analysis for this thesis. Through the combined research of the current (existing research), and the phenomenological research, statistical data was developed from this research study, and the results of the online survey of ‘Direct-Care ministries staff working in Residential Treatment Centers/Facilities in childcare was used to support this thesis.

The statistical data developed from the research study and the results of the online survey reveal the prevalence of the issues associated with the work of ministry; the specific demands of working in residential treatment facilities in childcare; and the expectations placed upon ‘Direct-Care’ ministries staff by the organization’s that employ them.

It is these issues, demands, and expectation that foster an environment ripe with the stressors of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue, that are detrimental to the ‘Direct-Care’ ministries staff’s personal and professional well-being.

While the prevalence of these issues, demands, and expectations may vary from organization to organization, this research study and its results from the online survey reveal that the responses follow a well-established norm. The issues, demands and expectations create an environment that left unaddressed contributes significantly to the stressors of burnout, secondary traumatic stress, vicarious trauma, compassion fatigue, and ultimately lead to the departure of ‘Direct-Care’ ministries staff from their chosen field of ministry and/or organization.
EXISTING RESEARCH:

Research studies spanning more than twenty-five years reveals universally that those working in human services, particularly those working in “helping fields” are prone to the deleterious effects of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF).

Many of these studies have addressed these stressors and the deleterious impact they have had on the individual. While some of these studies have focused their research on those working as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities in childcare servicing children and/or youth. Few of these studies have directed their research into the impact of the issues, demands, and expectations specific to this ministry, and the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) that are associated with working in higher ‘levels of care’ with mentally and emotionally disordered, and/or behaviorally children and/or youth in Residential Treatment Centers/Facilities in childcare.

The work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities with children and/or youth in childcare is among the most challenging of the “helping fields” professions.

While there are challenges working in any of the human services fields, each with its own issues, demands, and expectations and each with its own stressors, none are as uniquely challenging as working in ‘Direct-Care’ in Residential Treatment Centers/Facilities with children and/or youth in childcare. This is largely due to the levels of care required for the clinical continuum of services for the children and/or youth in residential care.

There are even significant differences to the issues, demands, and expectations placed upon those who provide ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities versus those that provide ‘Direct-Care’ ministries in Residential Group Home’s in childcare servicing children and/or youth.

Again, the primary difference between Residential Group Home’s and Residential Treatment Centers/Facilities are the “levels of care” provided for the clinical “continuum of services,” or “milieu of services” for the children and/or youth in residential care.
While there are a number of similarities between Residential Group Home’s, and Residential Treatment Centers/Facilities, in that both provide residential childcare to children and/or youth in need, there are also significant differences that set the two apart. Residential Group Home’s are generally considered to operate as Level I type facilities providing residential care for children and/or youth minimal emotional and/or behavioral issues; and typically provide for any therapeutic needs through outsourcing these services.

Residential Treatment Centers/Facilities provide a “continuum of care” to children and/or youth on level two, three, and four status, requiring higher levels of supervision, care, and/or mental, emotional and/or behavioral therapeutic treatment. These distinctions exist across the United States, however many states have moved away from leveling systems, a means to identify the continuum of care provided by a residential childcare facility. As a result many organizations providing residential care for children and/or youth operate with multiple “levels of care” under one model or continuum of care—often referred to as a “person-centered plan” approach—a unique, individually-focused approach to planning and providing for children and/or youth in need of services and support.

In short, Residential Treatment Centers/Facilities can provide residential care, and a “continuum of care,” or milieu of services for children and/or youth of a level two, and/or level three status. And under certain conditions, also children and/or youth on step-down from level four facilities, and in some cases step-downs from level five facilities; all at the same Residential Treatment Centers/Facilities.

As a result, the issues, demands, and expectations as well as the stressors associated with the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities with children and/or youth in childcare often result in burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue.

This research project sought to reveal the impact of the issues, demands, and expectations, and the stressors associated specifically with ‘Direct-Care’ work in Residential Treatment Centers/Facilities working with children and/or youth in childcare on the mental, emotional, physical, relational, and spiritual aspects of ‘Direct-Care’ ministries staff professional and personal lives.
PHENOMENOLOGICAL RESEARCH:

The phenomenological research resulted from the years this author spent working as a ‘Direct-Care’ ministries staff working in Residential Group Home’s and Residential Treatment Centers/Facilities with children and/or youth in childcare. Having worked as a ‘Direct-Care’ ministry staff, and as a Director of Pastoral Care/Chaplain and Campus Pastor providing ministry to residents and staff at Residential Treatment Centers/Facilities, there have been sufficient opportunities from my own personal experience as well as the input and insights gained of my interactions with current ‘Direct-Care’ ministries staff from which to establish the phenomenological research. As with any phenomenological research study that attempts to gain insight into the perceptions, perspectives and experiences of their particular situations. This research project too sought to understand (DC) ministries staff’s perceptions, perspectives, and experiences of their particular situations.

This phenomenological research was central to this thesis project understanding how the issues, demands, and expectations specific to working as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities with children and/or youth in childcare impacts the individual ‘Direct-Care’ worker in the mental, emotional, physical, relational, and spiritual aspects professionally and personally.

This phenomenological research experience includes having had opportunities to work at four different residential care facilities with children and/or youth in childcare working with level II, III, and IV children and/or youth at a group home facility, and Residential Treatment Centers/Facilities. These four varied placements afforded multiple opportunities for phenomenological research, engaging with other ‘Direct-Care’ ministries staff to learn from our shared experiences.
The phenomenological research gained from working in this field of ministry, and from these encounters with other ‘Direct-Care’ ministries staff became the genesis for this thesis project, research study and online survey.

It was as a direct result of this phenomenological research—my own experience working in ‘Direct-Care’ ministries, and the informal research gained from working with other ‘Direct-Care’ ministries staff in Residential Group Home’s and Residential Treatment Centers/Facilities with children and/or youth in childcare that revealed significant concerns over the issues, demands, and expectations, and the stressors associated with the work of ‘Direct-Care’ ministries that contribute to the premature departure from this type of ministry.

A review of the existing research of the issues, demands, and expectations and the subsequent stressors associated with working as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities with children and/or youth in childcare reveals the prominence of burnout, secondary traumatic stress, vicarious trauma and compassion fatigue as a common occurrence in ‘Direct-Care’ ministries in residential care working with children and/or youth as with many “helping fields.”

The current research and the phenomenological research reveal that these stressors can negatively affect the lives of ‘Direct-Care’ ministries staff, quality of their professional and personal lives. Of equal importance was how the issues, demands, and expectations and the associated stressors of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue that often accompany the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities working with children and/or youth in childcare can a deleterious effect upon them professionally and personally. It can impact the individual ‘Direct-Care’ ministries staff person, but their families, the organizations that employ them, and ultimately to the children and/or youth in care.
ONLINE SURVEY RESEARCH:

This thesis project: The Challenges And Biblical ‘Self-Care’ Practices For ‘Direct-Care’ Staff In Residential Treatment Facilities sought to examine the current research. Then make a review of the current research against the phenomenological research for comparison. Then conduct the online survey with multiple organizations with multiple ‘Direct-Care’ ministries staff in an effort to verify the existing current research, the phenomenological research.

In addition, to gain a greater understanding and awareness of how the issues, demands, and expectations, specific to the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities and the subsequent stressors placed upon those in ‘Direct-Care’ ministry working in Residential Treatment Centers/Facilities with children and/or youth in childcare adversely impacts the mental, emotional, physical, relational, and spiritual aspects of the staff, their families, and the organizations that employ them.

Additionally, how the impact of these stressors upon those in ‘Direct-Care’ ministries working in Residential Treatment Centers/Facilities with children and/or youth in childcare takes its toll on their families, and the organizations with which they are affiliated.

There have been numerous studies on the effects of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue on those working in human services fields, particularly those in ‘helping fields.’ Few of these studies however limited their research to the deleterious effects, and subsequent impact of these stressors on the mental, emotional, physical, relational, and spiritual aspects on ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities with children and/or youth in childcare as does this research project.
**METHODS:**

**SUBJECTS:** First, I established a workable 500 mile geographic area of research for the study from my current work/study location near Wilmington, NC. This roughly covers the areas of North Carolina, South Carolina, Virginia, Maryland, District of Columbia, Tennessee, Georgia, and parts of Alabama, Kentucky, and West Virginia. Then identify those organizations within a 500 mile geographical area (of my current work/study location), that provide ‘Direct-Care’ ministry in a Residential Group Home or Residential Treatment Center/Facility environment to children and/or youth, with mental, emotional disorders and behavioral and/or developmental disabilities. It was further determined that those Residential Group Home’s and Residential Treatment Centers/Facilities for childcare whose residential clientele has a minimum of 40 persons, and whose ‘Direct-Care’ ministries staff is at a minimum of 15 persons. Then a review of a listing of organizations within that geographical radius was made to determine the 158 organizations that fit the stated criteria, and thus were identified as potential candidates for contact to request their organization ‘Direct-Care’ ministries staff’s participation in the research study. That number then became the initial pool of target organizations.

That pool of target organization candidates was then further reviewed for how these organizations would meet the greater refined stated criteria; and of the initial 158 total organizations, only 35 total organizations were selected as potential target organizations. This became the final pool of target organizations to approach for participation in the online research survey and study.

Having identified those target organizations, contact the CFO/President and/or Chief Operating Officer via certified mail, with a letter of introduction. The letter of introduction will include: a.) the reason for contacting their organization, b.) the desire to utilize that organizations (DC) ministries staff’s participation in research, c.) the potential benefits of the summary of survey data to the organization, d.) a sample of the survey, e.) the researchers contact information, f.) a web-link to the online survey, g.) an assurance of anonymity for all survey participants will also be provided.
The online survey portal will be monitored for 30 days following the mailing of the initial letter of introduction to see which organizations ‘Direct-Care’ ministries staff have completed the online survey. If there is no online activity noted by a target organization within 30 days after the initial mailing, I plan to mail out a second or follow-up letter and make a telephone call to the leadership of those target organizations, requesting again that the organization’s leadership reconsider the benefits of ‘Direct-Care’ staff’s participation in the online research survey. The intent would be to gain the participation of as many of the target organizations in the research study and online survey.

The online survey portal will be again monitored for 30 days following the mailing of the second or follow-up letter to see which organizations ‘Direct-Care’ ministries staff have completed the online survey.

If after the second or follow-up mailing, there is no activity by an organization, there will be no further attempts to contact that organization’s leadership for their organization’s participation in the online research survey and study. The intent would be to gain the organizations participation in the research study and online survey.

Those organizations that have not responded would have their organizational information removed from the online survey portal. The research study and online survey would then be closed except to those organizations that have already begun participation in the research study and online survey. The intent here would be to develop a research window that would allow for a timely completion of the research project. It was expected that only 10% of the 35 target organizations would respond, or (3) Residential Group Home’s and/or Residential Treatment Centers/Facilities; and of those only approximately 50% of their ‘Direct-Care’ ministries staff will voluntarily participate in the research study and online survey. Out of approximately (60) eligible ‘Direct-Care’ ministries staff, only a total of (30) are expected to participate. Thus the overall goal for the research study and online survey was adjusted to a minimum of (3) organizations; and/or (30) ‘Direct-Care’ ministries staff.

When the organization has agreed/given their authorization to have their ‘Direct-Care’ ministries staff participate in the research study and online survey, they will then provide their organization’s ‘Direct-Care’ ministries staff with the web-link to the online survey that they may participate in the online survey.
The ‘Direct-Care’ ministries staff would then follow the web-link provided to the “Introduction” page, where they will select from the “Drop-Down” the name of their organization. They will then be redirected to the “Informed Consent Information” pages, and then to a “Statement of Consent” page where they will be provided the option to “Take the Survey” or “Disagree” for their “Informed Consent Information” document completion. The ‘Direct-Care’ ministries staff survey participant then follows the prompts to complete the online survey’s forty questions, which should take no more than 15 minutes to complete. The ‘Direct-Care’ ministries staff survey participant upon completing the online survey’s questions, will be directed to a survey completion page, which ends with a “Done” option. Once the “Done” option is selected the ‘Direct-Care’ ministries staff survey participant will be automatically logged off, and that individual’s survey is then finalized.

To achieve anonymity for the survey participants, ‘Direct-Care’ ministries staff participants of the organization who participate in the survey will only be identified by a sub-numerical identifier associated with the organizations numerical identifier, thus creating and maintaining an anonymous survey portal for their staff’s participation in the survey.

The sub-numerical identifier for these direct-care staff participants is identifiable only as attached to that of the organizational numerical identifier. No other identifier will be captured. The entire numerical identifier “string” would follow a type pattern as the following example illustrates:

Organization: ABC, Inc.: ABC, Inc. (Organizational Identifier)
Staff: ‘Direct-Care’ Staff Participant: 001 (Individual Identifier)
Date of Survey: (April 1, 2015): 04012015 (Date Identifier)

The combined numerical identifier string would then be read as: ABC, Inc. 001-0401-2015.

All of the data retrieved from that numerical identifier would then be specific to that organization. All the data retrieved from that numerical identifier would then be specific to that organization. Yet could also enhance the findings for the overall research project.
Further the summary of data captured from the survey could be provided for the organization's leadership contact (President, Chief Executive Officer, Chief Operating Officer, Vice-President of Residential Services, Residential Director, etc.) in an effort to generate further interest in services which could be provided to the organization that are intended to address these areas of concern as reported by the organization's 'Direct-Care' ministries staff.

This thesis project and research study will keep the hard copies of research study materials and online survey information including the authorized "Informed Consent Information" forms (pages) and completed survey's data received in a locked drawer and/or locked filing cabinet, and the digital records of the data from the authorized "Informed Consent Information" and online surveys in a password protected computer file. Once the thesis project and research study is completed, these documents on file will be kept on file for 3 years and will then be destroyed.

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**INSTRUMENTS:**

A forty-two question online survey was created to: (1) identify the organization's participating in the research study and online survey, (1) appropriate and voluntary participation in the online survey, and (5) "Mental" aspects of 'Direct-Care' work, (5) "Emotional" aspects of 'Direct-Care' work, (5) "Physical" aspects of 'Direct-Care' work, (5) "Relational" aspects of 'Direct-Care' work, (5) "Spiritual" aspects of 'Direct-Care' work, and, (15) "Morale" aspects of 'Direct-Care' work. Similar to the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981) a twenty-five question survey was created to measure hypothesized levels of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue of the 'Direct-Care' ministries staff survey participant's mental, emotional, physical, relational, and spiritual aspects.

Like the Maslach Burnout Inventory (MBI), this instrument sought to measure the frequency and intensity these respondents dealt with the issues, demands, and expectations associated with their work that resulted in burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue.

As with the Maslach Burnout Inventory (MBI), this instrument sought to measure levels of emotional exhaustion (EE): feeling emotionally worn down and exhausted by the work. Personal Accomplishment (PA): feelings of competence and accomplishment in work. Depersonalization (DP): and increasing awareness of personal detachment, and feelings of impersonal response, increased attitudes of uncaring and unfeeling toward the needs of others.

Additionally, similar to the Work Environment Scale (WES) (Moos, 1981) the online survey sought to measure the work place environment and morale in the work place using a ten-question portion in the survey.


Here like the Work Environment Scale, the survey respondents were measured on: (1) Involvement—the extents to which workers are concerned about and/or are committed to their jobs. (2) Peer cohesion—level of friendliness and support in co-workers. (3) Supervisory support—perceived support from management. (4) Autonomy—the degree to which workers are encouraged to be self-sufficient and to make their own decisions. (5) Task orientation—the extent to which the work place environment is efficient and effective. (6) Work pressure—the extent to which the issues, demands, and expectations, the press of work dominates the job experience. (7) Clarity—the extent to which workers know what the rules, and policies, model of care, and requirements of the job are, and whether the workers feel those have been and are being communicated both from management and to and from peer workers. (8) Control—the extent to which management and immediate supervisors use rules, policies, and expectations (implied or stated) to maintain control over staff. (9) Physical comfort—whether workers feel physically safe in the work place, and the pleasantness of the physical surroundings.

The survey also included aspects of the Attributions of Therapeutic Outcome measure (ATO) (Cooley & Savicki, 1983, April) which is a twenty-five question tool to measure the types of attributions therapists make about outcomes in their clients. Similar to the ATO, this survey sought to determine whether the (DC) staff were concerned whether their work with the children and/or youth in care was effective and instrumental in creating positive and lasting change.

Lastly, under the morale heading, the survey itself was designed in a Likert-type scale design. The online survey was used to provide a rating scale to capture the correlation of the variables of work force contentment, and satisfaction or the adverse for the ‘Direct-Care’ ministries staff measuring overall job satisfaction, with salary, job challenge, job characteristics, job promotion and career growth potential, peer support, supervisor support, trust, and expectations, and effectiveness. Also queried: employee benefits, perception of organizational concern about employee well-being, and employee engagement, employee satisfaction with organization, employee morale, and the likelihood that ‘Direct-Care’ ministries staff surveyed would pursue employment elsewhere within the coming year. (See Tables 1 and 2).


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**Table 1. Direct-Care Ministries Staff Sampling Research Study and Online Survey—Survey Information**

<table>
<thead>
<tr>
<th>Sample Size:</th>
<th>N = 128</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Age:</td>
<td>18</td>
</tr>
<tr>
<td>Gender:</td>
<td>Male and Female</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>All (Single/Married/Divorced)</td>
</tr>
<tr>
<td>Education Status:</td>
<td>All (GED/High School Diploma/College/Masters)</td>
</tr>
<tr>
<td>Employment Status:</td>
<td>Full time / Part time</td>
</tr>
<tr>
<td>Employment Position:</td>
<td>‘Direct-Care’ ministries staff at a (RTC/F’s)</td>
</tr>
<tr>
<td>Range For Field of Study:</td>
<td>500 Geographical Sq. Mi. From Wilmington, NC.</td>
</tr>
<tr>
<td>Organizations Surveyed:</td>
<td>10</td>
</tr>
</tbody>
</table>
DISCUSSION:

The online survey results clearly identify that ‘Direct-Care’ ministry staff working in Residential Treatment Centers/Facilities with children and/or youth in childcare face issues, demands, and expectations associated with the work of ‘Direct-Care’ ministries that fosters the stressors of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue. In the five aspects surveyed: mental, emotional, physical, relational, spiritual, and the aspect of morale the overall combined survey results indicate:

**TABLE 3.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Survey Question</th>
<th>Min / Max / Mean / SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q3</td>
<td>“I am mentally prepared for the job that I do.”</td>
<td>1.00 / 5.00 / 4.49 / 0.05</td>
</tr>
<tr>
<td>Q4</td>
<td>“I am well trained by my organization for the job I do.”</td>
<td>1.00 / 5.00 / 4.16 / 0.35</td>
</tr>
<tr>
<td>Q5</td>
<td>“I find my job fulfilling.”</td>
<td>1.00 / 5.00 / 4.46 / 0.78</td>
</tr>
<tr>
<td>Q6</td>
<td>“I am often mentally overwhelmed at work.”</td>
<td>1.00 / 5.00 / 3.99 / 1.07</td>
</tr>
<tr>
<td>Q7</td>
<td>“I often seek to relieve the stress of my work.”</td>
<td>1.00 / 5.00 / 3.38 / 0.96</td>
</tr>
<tr>
<td>TOTAL WEIGHTED AVERAGE</td>
<td></td>
<td>4.00 / 5.00 / 19.48 / 4.35</td>
</tr>
</tbody>
</table>

This statistical data reveals that though respondents feel they are mentally prepared and trained to do the job, nearly three-quarters of the respondents feel they are mentally overwhelmed while at work, and often seek to alleviate the mental stress of the work through some ‘self-care’ practice. Clearly, ‘Direct-Care’ ministries staff responded that they are mentally taxed as a result of the role as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities working with children and/or youth in childcare.

EMOTIONAL:

<table>
<thead>
<tr>
<th>Category</th>
<th>Survey Question</th>
<th>Min / Max / Mean / SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8</td>
<td>“I feel as though I make a positive impact at work.”</td>
<td>1.00 / 5.00 / 4.24 / 0.76</td>
</tr>
<tr>
<td>Q9</td>
<td>“I feel emotionally supported by my organization.”</td>
<td>1.00 / 5.00 / 3.94 / 1.01</td>
</tr>
<tr>
<td>Q10</td>
<td>“I feel valued by my organization.”</td>
<td>1.00 / 5.00 / 3.90 / 0.90</td>
</tr>
<tr>
<td>Q11</td>
<td>“I often feel emotionally stressed at work.”</td>
<td>1.00 / 5.00 / 3.02 / 1.36</td>
</tr>
<tr>
<td>Q12</td>
<td>“I feel as though my job has negatively impacted my life.”</td>
<td>1.00 / 5.00 / 1.88 / 0.93</td>
</tr>
<tr>
<td>TOTAL WEIGHTED AVERAGE</td>
<td></td>
<td>5.00 / 25.00 / 16.98 / 4.83</td>
</tr>
</tbody>
</table>

...
This statistical data reveals that though respondents feel they are emotionally making a positive difference at work, and feel supported by their organizations; more than half of the respondents feel they are emotionally overwhelmed at work, and seek to alleviate the emotional stress of the work through some ‘self-care’ practice. Clearly, ‘Direct-Care’ ministries staff responded that they are emotionally taxed because of the role as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities working with children and/or youth in childcare.

**PHYSICAL:**

<table>
<thead>
<tr>
<th>Q</th>
<th>Statement</th>
<th>1.00 / 5.00 / 3.36 / 1.02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q13</td>
<td>“I often feel physically exhausted after my work shift.”</td>
<td></td>
</tr>
<tr>
<td>Q14</td>
<td>“I often feel the need to relieve the stress of my job.”</td>
<td>1.00 / 5.00 / 3.33 / 1.00</td>
</tr>
<tr>
<td>Q15</td>
<td>“I often feel overly tired while at work.”</td>
<td>1.00 / 5.00 / 2.81 / 1.02</td>
</tr>
<tr>
<td>Q16</td>
<td>“I have called in sick to work when I was not sick.”</td>
<td>1.00 / 5.00 / 1.23 / 0.61</td>
</tr>
<tr>
<td>Q17</td>
<td>“I feel as though my job has taken a physical toll on me.”</td>
<td>1.00 / 5.00 / 2.41 / 1.16</td>
</tr>
</tbody>
</table>

**TOTAL WEIGHTED AVERAGE**........................................................................5.00...25.00...13.14...4.81

This data reveals that though respondents feel they are physically exhausted after a work shift; and often feel tired while at work; and that more than half of the respondents feel the need to relieve the physical stress of the work through some ‘self-care practice; most reported they would not abuse sick leave, when they were not actually sick as part of the ‘self-care’ practice. Clearly, ‘Direct-Care’ ministries staff responded that they are physically taxed as a result of the role as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities working with children and/or youth in childcare.

**RELATIONAL:**

| Q18 | “I feel relationally isolated at work.”                                  | 1.00 / 5.00 / 2.19 / 1.11 |
| Q19 | “I feel as though my job has had a negative impact on my relationships outside my work.” | 1.00 / 5.00 / 2.20 / 1.19 |
| Q20 | “I get along well with my co-workers.”                                   | 1.00 / 5.00 / 4.26 / 0.77 |
| Q21 | “I feel as though my opinions about work matter to my co-workers.”       | 1.00 / 5.00 / 3.93 / 0.92 |
| Q22 | “I feel as though I am an important part of the organization.”           | 1.00 / 5.00 / 3.97 / 0.89 |

**TOTAL WEIGHTED AVERAGE**........................................................................5.00...25.00...16.55...4.86
This data reveals that just under half of the respondents feel they are relationally isolated at work; and feel that their job has had a negative impact on their relationships outside of their work. Most get along well with their co-workers; and feel their opinions about work matter to their co-workers; and that they feel valued by their organizations. Clearly, (DC) ministries staff responded that they are relationally taxed as a result of the role as (DC) ministries staff in (RTC/F’s) working with children and/or youth in childcare.

**SPIRITUAL:**

Q23 “I feel as though the organization cares about my spiritual well-being.”
Q24 “I feel my spiritual beliefs are challenged by my job.”
Q25 “I have opportunities for personal spiritual renewal.”
Q26 “I have sufficient opportunities for personal spiritual development.”
Q27 “I feel it is important to find harmony in my life with my work and my spiritual life.”

TOTAL WEIGHTED AVERAGE .................................................. 5.00...2.00...1.81...4.99

This data reveals that though respondents feel it is important to find harmony in their lives with their work and spiritual beliefs, and believe that the organization cares about their spiritual well-being; and have opportunities for spiritual renewal, and spiritual development, half of the respondents feel their spiritual beliefs are challenged by their job. Clearly, ‘Direct-Care’ ministries staff responded that they are spiritually taxed as a result of the role as ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities working with children and/or youth in childcare.

**MORALE:**

Q28 “I feel as though I am well paid for the work I do.”
Q29 “I feel as though my job is challenging.”
Q30 “I often feel like the tasks assigned to me by my supervisor help me grow professionally.”
Q31 “I feel as though there are opportunities to get promoted where I work.”
Q32 “I feel as though I am supervised effectively at work.”
Q33 “I am satisfied with my employee benefits.”
Q34 “I am satisfied with my job.”
Q35 “I trust my supervisor.”
Q36 “I feel as though my organization cares about its employees.”

TOTAL WEIGHTED AVERAGE .................................................. 5.00...5.00...3.90...1.06...3.98...0.98
Q37  “I feel as though my opinions about my work matter to my supervisor.”  1.00 / 5.60 / 4.04 / 1.05
Q38’ “I feel as though my supervisor has realistic expectations of me.”  1.00 / 5.00 / 4.04 / 0.90
Q39  “I like working for my organization.”  1.00 / 5.00 / 4.37 / 0.72
Q40  “I look forward to coming to work.”  1.00 / 5.00 / 4.16 / 0.82
Q41  “I am likely to look for another job outside the organization within the next year.”  1.00 / 5.00 / 4.00 / 1.00
Q42  “I feel I have career growth and development potential with my organization.”  1.00 / 5.00 / 3.48 / 1.10

TOTAL WEIGHTED AVERAGE.................................................................................. 5.00 75.00 55.83 14.25

This data reveals that though respondents feel that they like the organizations that they are employed with, and like the job they do, and feel that they are challenged, compensated appropriately, and like their supervisors, feel valued by the organization, and their supervisor, and trust their supervisor. Still, nearly one-third of the respondents reported they would likely seek employment with another organization within the next year. Clearly, there is a disconnect with the organization at some level.

The current research, the phenomenological research, and the online survey research and data analysis reveal that these additional expectations and subsequent stressors include:

- Insufficient training to meet the demands of the types of youth in care;
- Inadequate staffing;
- Undesirable work schedules, or work shifts;
- Low salaries;
- Poor benefits;
- Poor job conditions;
- Undefined job responsibilities;
- A lack of appropriate supervision;
- Not treated as professionals: Not heard, valued, or included in decisions;
- Poor communication;
- Insufficient resources;
- Loss of fellow ‘Direct-Care’ ministries staff members due to high turnover.
In addition there are the stressors placed upon ‘Direct-Care’ ministries staff of unrealistic expectations and demands placed upon them by the organizations mid-level management and senior administrative staff, the courts, social workers, guardian ad item’s, school officials, and even parents. These often exacerbate the already overwhelmed, ‘Direct-Care’ ministries staff mentally, emotionally, physically, relationally, and spiritually exhausted and ideal candidates for burn-out, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF).

This thesis asserts that it is the issues, demands, and expectations specifically associated with the work of ‘Direct-Care’ ministries work in Residential Treatment Centers/Facilities with children and/or youth in childcare, in particular the increased demands placed upon them, that the increased demands that increasing “levels of care” at Level’s II, III, and IV, and PRIF “levels of care” bring to this type of “helping field” ministry.

Moreover, that these issues, demands, and expectations and their associated stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) can and often do lead to premature departure from this “helping field” ministry.

This thesis further asserts that the deleterious effects of these stressors adversely impacts the ‘Direct-Care’ ministry staff, their families, the organizations that employ them, and ultimately the children and/or youth in care. Concern over the overall impact on ‘Direct-Care’ ministries staff, their families, and the organizations that employ them, and the children and/or youth in care, can and should be motivation to addressed these concerns with a combination of appropriate ‘self-care’ awareness training; encourage and provide incentives for employment of ‘self-care’ practices by ‘Direct-Care’ ministries staff. Lastly through organizational employee engagement practices to aid them in greater professional and personal fulfillment, which will also provide the organizations with resources to address ‘Direct-Care’ ministries staff recruiting and retention issues.

The purpose of this thesis, research study and online survey was two-fold: 1.) identify the impact of the stressors of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue on ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities working with children and/or youth in childcare; and its deleterious impact as toxic spillover on their spouses, families, co-workers, and the organizations that employ them, and ultimately the children and/or youth in care. And 2.) provide biblically sound ‘self-care’ practices to alleviate and/or mitigate the stressors associated with this “helping field” vocation.
THE CHALLENGES AND STRESSORS

BURNOUT / SECONDARY TRAUMATIC STRESS / COMPASSION FATIGUE

BURNOUT:

“Burnout is a defense mechanism characterized by disengagement; Stress is characterized by over-engagement.

In burnout, the emotional damage is primary; In stress, the physical damage is primary.

The exhaustion of burnout affects motivation and drive; The exhaustion of stress affects physical energy.
BURNOUT:

Burnout produces demoralization; Stress produces disintegration.

Burnout can best be understood as a loss of ideals and hope; Stress can best be understood as a loss of fuel and energy.

Burnout produces a sense of helplessness and hopelessness; Stress produces a sense of urgency and hyperactivity.

Burnout produces paranoia, depersonalization, and detachment; Stress produces panic, phobia, and anxiety.

Source: Burnout, Stress & Compassion Fatigue: Managing Yourself. 2012.

BURNOUT:

Emotional Exhaustion (EE) occurs when one is over-invested and involved in the problems of others. In time, this over-involvement could lead to feelings of emptiness, being drained, and having nothing left to give.

Depersonalization (DP), or a sense of indifference towards the needs of others, occurs subsequent to emotional exhaustion as a form of detachment in order to protect one from being depleted.

Detachment can lead to the third element of burnout, specifically feelings of guilt, referred to as reduced Personal Accomplishment (PA).

These feelings arise as one comes to recognize his or her symptoms of depersonalization as characterological rather than situational, concluding that he or she is a bad person for not giving or caring more.

Source: Burnout, Stress & Compassion Fatigue: Managing Yourself. 2012.
BURNOUT:

“Job burnout was first recognized as a psychological problem among healthcare and social service professionals in the 1970s (Pines and Maslach 1978). Extensive interviews with such workers revealed they often experienced emotional depletion and loss of motivation resulting from prolonged emotional stress encountered in their jobs.

Subsequent research identified the three distinct features now recognized as comprising burnout: emotional exhaustion (EE), depersonalization (DP) (a defense mechanism by which caregivers and service providers experience emotional distance from their clients), and feelings of ineffectiveness or lack of personal accomplishment (PA) (Maslach 2003; Maslach et al. 2001).

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BURNOUT:

Burnout was originally conceptualized as a response to job stress produced by the demands of helping needy clients (Maslach 1982).

It was quickly realized, however, that institutional/organizational factors seemed to contribute to burnout (Maslach and Florian 1988; Maslach and Leiter 1997).
SECONDARY TRAUMATIC STRESS:

As was the case with burnout, research on secondary traumatic stress (STS) emerged from observations of psychological problems among caregivers (Figley, 1995; Kadambi and Ennis 2004).

Like burnout, STS was primarily conceptualized as a response to the stress of interpersonal interactions between helper and client. As Jenkins and Baird (2002) stated, burnout and STS “are similar in that they result from exposure to emotionally engaging clients via interpersonally demanding jobs, and represent debilitation that can obstruct providers’ services” (p. 423).”


SECONDARY TRAUMATIC STRESS:

Unlike burnout, STS continues to be viewed mainly as a response to dealing with clients, specifically people who have been traumatized.

Figley (1995), who coined the term “Compassion Fatigue” in reference to STS among mental health professionals, described STS as “the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other.”
SECONDARY TRAUMATIC STRESS:

These syndromes have five basic components:

1. Frequent Intense Encounters With Clients;
2. Physical And Mental Fatigue States;
3. Challenges To Values, Beliefs And World View;
4. Exposure To Traumatized Clients; And
5. Expectable Stress Responses.

SECONDARY TRAUMATIC STRESS:

Some of these components are elements of burnout, along with feelings of disillusionment, isolation, and emotional distancing also occur in both STS and burnout (Figley 1995).

However, STS has a more clear operational definition than vicarious traumatization (Kadambi and Ennis 2004) and is distinguished from burnout in that its core symptoms are similar to the symptoms of post-traumatic stress disorder (PTSD), including flashbacks, nightmares, and intrusive thoughts (Figley 1995).
COMPASSION FATIGUE, BURNOUT, SYMPTOMS:

Mental (Cognitive)

Lowered concentration, apathy, rigidity, disorientation, minimization, preoccupation with trauma

Emotional

Powerlessness, anxiety, guilt, anger, numbness, fear, helplessness, sadness, depression, depleted, shock, blunted or enhanced affect. Experiencing troubling dreams similar to a patient’s dream. Suddenly and involuntarily recalling a frightening experience while working with a patient or family.


COMPASSION FATIGUE, BURNOUT, SYMPTOMS:

Physical (Somatic)

Sweating, rapid heartbeat, breathing difficulty, aches and pains, dizziness, impaired immune system, headaches, difficulty falling or staying asleep

Relational (Behavioral)

Irritable, withdrawn, moody, poor sleep, nightmares, appetite change, hyper-vigilance, isolating

Source: http://www.compassionfatigue.org/pages/burnoutproperties.pdf
COMPASSION FATIGUE, BURNOUT, SYMPTOMS:

Spiritual

Questioning life’s meaning, pervasive hopelessness, loss of purpose, questioning of religious beliefs, loss of faith/skepticism

STRESSORS:

“A wide range of institutional factors is believed to contribute to burnout. Issues such as an autocratic administrative style, limited opportunities for promotion, lack of autonomy, lack of appreciation or rewards (salary, vacation time, etc.) may lower self-esteem over time (Maslach et al. 2001; Weiner 1989). On the other hand, cost-effectiveness measures that lead to understaffing and/or high caseloads may undercut one’s ability to properly perform one’s functions, lowering one’s sense of self-efficacy (Lewandowski 2003). Whatever the case may be, burnout tends to build-up relatively slowly across time, with some studies indicating it may take years to develop (Maslach and Florian 1988; Maslach et al. 2001). Hence, many studies have used time measures without looking at the actual factors that contribute to burnout. Two of the most commonly used time measures in research on burnout are years in the same position and years in the same profession.”

STRESSORS:

“Workload has also been shown to contribute to burnout (e.g., Farber and Heifetz 1982; Maslach and Florian 1988). More demanding workloads impinge on helpers’ ability to perform their duties effectively, thereby lowering their sense of self-efficacy. Since over-functioning is a common characteristic of helpers, they may not recognize that their workload is the problem and may instead internalize the cause. The number of hours per week of direct client contact is the most commonly used measure of workload in studies of therapists, counselors, social workers, and chaplains (e.g., Ackerley et al. 1988; Coady et al. 1990; Flannelly et al. 2005a, b; Ross et al. 1989; Vredenburgh et al. 1999). All of the studies just cited reported that one or more measures of burnout increased with hours of patient contact.”


CHAPTER 5:

The Recommended Biblical ‘Self-Care’ Training and Practices And Pastoral Counseling Interventions For ‘Direct-Care’ Ministries Staff
A plethora of existing research, as well as this writer’s research reveals that the issues, demands, and expectations associated with the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare is among the most stressful of all the “helping field” vocations. Addressing the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF), can have deleterious effect on the individual staff, as well as their families. The effects of these stressors on ‘Direct-Care’ ministry staff, and on their families often manifests themselves in the mental, emotional, physical, relational, and spiritual aspects of their professional and personal lives.

In addition, these effects often begin with the individual ‘Direct-Care’ ministry staff person, or their families as they fail to grasp the dynamic impact of, or cause of such stress. Often misperceiving the true cause of these stressors, ‘Direct-Care’ ministry staff often attribute the effects of these stressors to personal weaknesses, failings, or personality flaws.

When these stressors and their deleterious effects begin to take their toll, a pastor or pastoral counselor is often the first person that ‘Direct-Care’ ministry staff and their families seek out for counsel.

It is paramount that the pastor or pastoral counselor grasp that “much counseling has to do with problem management or reduction. To state this positively, much Christian counseling has to do with learning and applying the principles of kingdom living to the chronically recurring sins, fears, failures, and dark areas of our life.”

“The work of preaching and counseling, when blessed by the Holy Spirit, enables men through the gospel and God’s sanctifying Word to become pure in heart, to have peaceful consciences, and to trust God sincerely. Thus the goal of nouthetic counseling is set forth plainly in the Scriptures: to bring men into loving conformity to the law of God.”


Whether pastors and pastoral counselors practice a solely nouthetic approach, or a nouthetic approach combined with other counseling approaches for a more eclectic approach overall to pastoral counseling, they strive to provide a genuine hope, help, and healing that begins with God’s Word.

Pastors and Pastoral Counselors seek to include the God’s Word, the Bible, God’s Holy Spirit, and an approach that incorporates into each counseling session God’s power to bring about growth and healing. “The goal of a helping relationship is to promote growth. More specifically, the goal of the helping relationship in Christian counseling is to help people enter into a richer experience with God and others (Crabb, 1977).”

While not every ‘Direct-Care’ ministries staff working with children and/or youth in residential childcare is a Christian, those that come to a pastor or pastoral counselor should expect that the pastor or pastoral counselor will reference God, and the Holy Spirit, will utilize God’s Word—the Bible as the primary resource for hope, help, and healing. Even those that are not Christians can still appreciate the value of the timeless teachings of the Bible. McMinn writes, “Some have suggested using the Bible as a self-help book with religious clients. Even Albert Ellis, a self-proclaimed atheist and outspoken opponent of devout religious faith, had this to say about the Bible in a recent article: “I think that I can safely say that the Judeo-Christian Bible is a self-help book that has probably enabled more people to make more extensive and intensive personality and behavioral changes than all professional therapists combined.” This is equally appropriate for the pastor or pastoral counselor working with ‘Direct-Care’ ministries staff and their families struggling with the effects of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue.
BIBLICAL ‘SELF-CARE’ PRACTICES:

“Boundaries for Christians are designed to protect Christ-like values and help us live a lifestyle consistent with Christian principles.” (Wilson & Hoffman, 2007) A fundamental tenet of the Christian faith is discipleship—growing in greater and growing Christlikeness, developing Christ-like values helps believers live out Christ-like principles; central to this aim is maintaining appropriate and healthy boundaries. Examples of Christ-like principles and values found in Scripture provide commands, instructions and guidelines on how to live successful Christian lives. Believers in Jesus Christ are to be indwelled, empowered, and equipped by the Holy Spirit of God. God’s Word is replete with God’s commands that we establish appropriate boundaries to maintain a healthy balance, some of these biblical instructions are meant to protect us mentally, emotionally, physically, relationally, and spiritually. Examples of biblical texts that address these aspects of the total person are:


MENTALLY:

The Bible states how those who are believers are to develop a renewed pattern for what they think on, and how they are to think about themselves before God, and others. We are urged to not be conformed to the pattern—ways of the world, but rather to be transformed by the renewing of our mind. It is only then that we will be able to both discern and determine God’s will. Establishing mental ‘self-care’ practices includes establishing boundaries that include how and what we think on.

“Therefore, I urge you, brothers and sisters, in view of God’s mercy, to offer your bodies as a living sacrifice, holy and pleasing to God—this is your true and proper worship. Do not conform to the pattern of this world, but be transformed by the renewing of your mind. Then you will be able to test and approve what God’s will is—his good, pleasing and perfect will. For by the grace given me I say to every one of you: Do not think of yourself more highly than you ought, but rather think of yourself with sober judgment, in accordance with the faith God has distributed to each of you.” (Romans 12: 1-3 (NIV)

Establishing sound mental ‘self-care’ practices also includes grasping that at times when we may not have all the answers that we seek. We need to learn how to rely on God’s Holy Spirit, and God’s Word to enlightened, and also inform our decisions and course.

“Trust in the LORD with all thine heart: and lean not unto thine own understanding. 5 In all thy ways acknowledge him, and he shall direct thy paths.” (Proverbs 3:5-6 (KJV))

Developing a mental ‘self-care’ practice that is biblically based includes having and understanding that God’s ways are not our ways. We have only a finite understanding of things, with a limited perspective. God’s Word and Spirit, provides for insight and wisdom that eclipses our own.

“6 For My thoughts are not your thoughts, Nor are your ways My ways,” says the LORD. 7 “For as the heavens are higher than the earth, So are My ways higher than your ways, And My thoughts than your thoughts.” (Isaiah 55:8-9 (NKJV))

Believer’s way of thinking is now under the authority of God’s Word, which is God-breathed and useful for teaching, rebuking, correcting, and training in all righteousness (2 Timothy 3:16).

In addition to the Word of God—the Bible, there is the indwelling Holy Spirit, and the godly council of other believers. Together, they become the foundation for establishing sound mental ‘self-care’ practices and the boundaries that protect a believer’s mental well-being. Believers are to place themselves under the authority of God’s Word, God’s Holy Spirit.

They are admonished to seek out the godly council of mature believers. God’s Word, teaches, rebukes, corrects, and trains us that we alter our way of thinking to God’s way of thinking. God’s Holy Spirit guides them in all truth (John 16:5-15). He will enable them, and empower them, and equip them for service to God and He will bear the fruit of godliness in and through them (Galatians 5:22-23); these become the hallmarks which identify growing and maturing believers in Jesus Christ. They are also some of the means by which God provides healthy mental ‘self-care’ practices and boundaries we require to maintain sound mental health.
EMOTIONALLY:

The Bible also provides for how believers are to maintain and appropriate and biblically based emotionally healthy perspective. The Bible reveals how believers are to respond to what their emotional responses to what they think, feel, and experience. When people are taxed mentally, emotionally, physically, relationally, and spiritually, their emotions can often be unstable and erratic. Research reveals that under such conditions anxiety grows. God’s Word speaks directly to how a believer should address anxiety—with praise, prayer and petition, which yields the peace of God.

“Do not be anxious about anything, but in every situation, by prayer and petition, with thanksgiving, present your requests to God. And the peace of God, which transcends all understanding, will guard your hearts and your minds in Christ Jesus. Finally, brothers and sisters, whatever is true, whatever is noble, whatever is right, whatever is pure, whatever is lovely, whatever is admirable—if anything is excellent or praiseworthy—think about such things. Whatever you have learned or received or heard from me, or seen in me—put it into practice. And the God of peace will be with you.”

(Philippians 4:6-9 (NIV))

Protecting what we expose our hearts and minds to is central to establishing sound emotional ‘self-care’ practices and the boundaries that protect them. For it is from what good we store up inside us that is the good, we draw from, just as it is from the evil that we store up inside us, that we draw evil out from within us. In short, what we expose ourselves to becomes what we take in and it is from what we have taken in that we then draw on especially in times of stress or duress.

“Make a tree good and its fruit will be good, or make a tree bad and its fruit will be bad, for a tree is recognized by its fruit. You brood of vipers, how can you who are evil say anything good? For the mouth speaks what the heart is full of. A good man brings good things out of the good stored up in him, and an evil man brings evil things out of the evil stored up in him. But I tell you that everyone will have to give account on the day of judgment for every empty word they have spoken. For by your words you will be acquitted, and by your words you will be condemned.”

(Matthew 12:33-37 (NIV))
PHYSICALLY:

God's Word too provides the basis for establishing physical boundaries and 'self-care' practices. The Bible provides for how believers are to maintain boundaries for physical health through observing God-given 'self-care' practices. The Bible reveals that physical 'self-care' is part of God's plan for establishing and maintaining overall good health.

"Physical training is good, but training for godliness is much better, promising benefits in this life and in the life to come." (1 Timothy 4:8 (NLT))

Sound physical health is important as pertaining to the physical body of a person (somatically), and also pertains to the whole person—mentally, emotionally, physically, relationally, and spiritually. As believers, we learn that we are indwelt with the Holy Spirit of God, and thus become the temple of the living God.

"19 Don't you realize that your body is the temple of the Holy Spirit, who lives in you and was given to you by God? You do not belong to yourself, 20 for God bought you with a high price. So you must honor God with your body." (1 Corinthians 6:19-20 (NLT))

In addition, the Bible makes a brief reference that whatever a person does for the physical body; they should do with God's glory in mind.

"So whether you eat or drink or whatever you do, do it all for the glory of God." (1 Corinthians 10:31 (NIV))

Yet, believers are admonished to discipline their bodies—to keep it under control. Here, Paul models what it is to not be consumed by one's appetites of the flesh, but rather to be controlled by the Word of God, and the leading of God's Holy Spirit.

"27 I discipline my body like an athlete, training it to do what it should. Otherwise, I fear that after preaching to others I myself might be disqualified." (1 Corinthians 9:27 (NLT))


RELATIONALLY:

The Bible provides for how believers are to maintain boundaries for healthy relationships through observing God-given ‘self-care’ practices. The Bible reveals that relational ‘self-care’ begins with a right relationship with God. God’s Word reveals a concentrically outward focus that enables healthy relationships with the self, with God, and with others. The Bible reveals how a person develops a proper perspective of the self with God, which enables healthy relationships with others. How we are to perceive ourselves—not thinking more of ourselves that we would look down on others. When we humble ourselves—think soberly about who we are before the Creator God of the universe, our Maker, we find ourselves grasping the gift of God’s mercy, love, and grace in Christ. We then understand that we are sinners in need of a Savior, and upon turning to Christ, find peace as we draw near to God, and He draws near to us.


="^6 And he gives grace generously. As the Scriptures say, “God opposes the proud but gives grace to the humble.”

7 So humble yourselves before God. Resist the devil, and he will flee from you. 8 Come close to God, and God will come close to you. Wash your hands, you sinners; purify your hearts, for your loyalty is divided between God and the world. 9 Let there be tears for what you have done. Let there be sorrow and deep grief. Let there be sadness instead of laughter, and gloom instead of joy.
10 Humble yourselves before the Lord, and he will lift you up in honor.” (James 4:6-10 (NLT)

With the grace that is then given those who turn to God in Christ, we are then able to through the faith in Christ, and the power of God’s indwelling Holy Spirit to break the sin of self-centeredness, self-absorption, and selfishness, that our attentions, and interests might first be God’s and then to the plight of others around us.

Because of the privilege and authority God has given me, I give each of you this warning: Don’t think you are better than you really are. Be honest in your evaluation of yourselves, measuring yourselves by the faith God has given us.” (Romans 12:3 (NLT))

When we grasp the enormity of God’s gracious act in forgiving our sins through the sacrificial atoning death of Christ on Calvary’s Cross. We are then reminded of the need to pray for those who persecute us, and forgive those who have trespassed against us.

“If you forgive those who sin against you, your heavenly Father will forgive you. 15 But if you refuse to forgive others, your Father will not forgive your sins.” (Matthew 6:14-15 (NLT))

And,

“But I tell you, love your enemies and pray for those who persecute you,” (Matthew 5:44 (NIV))

And,

“But to you who are listening I say: Love your enemies, do good to those who hate you, bless those who curse you, pray for those who mistreat you. If someone slaps you on one cheek, turn to them the other also. If someone takes your coat, do not withhold your shirt from them. Give to everyone who asks you, and if anyone takes what belongs to you, do not demand it back. Do to others as you would have them do to you.” (Luke 6:27-31 (NIV))

And,

“But love your enemies, do good to them, and lend to them without expecting to get anything back. Then your reward will be great, and you will be children of the Most High, because he is kind to the ungrateful and wicked. Be merciful, just as your Father is merciful. “Do not judge, and you will not be judged. Do not condemn, and you will not be condemned. Forgive, and you will be forgiven. Give, and it will be given to you.” (Luke 6:35-38 (NIV))

And also,

“Teacher, which is the greatest commandment in the Law?” Jesus replied: “Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself.’ All the Law and the Prophets hang on these two commandments.” (Matthew 22:36-40 (NIV))

And,

“A new command I give you: Love one another. As I have loved you, so you must love one another. By this everyone will know that you are my disciples, if you love one another.” (John 13:34-35 (NIV))

And also,

“Love must be sincere. Hate what is evil; cling to what is good. Be devoted to one another in love. Honor one another above yourselves. Never be lacking in zeal, but keep your spiritual fervor, serving the Lord. Be joyful in hope, patient in affliction, faithful in prayer. Share with the Lord’s people who are in need. Practice hospitality. Bless those who persecute you; bless and do not curse. Rejoice with those who rejoice; mourn with those who mourn. Live in harmony with one another. Do not be proud, but be willing to associate with people of low position. Do not be conceited. Do not repay anyone evil for evil. Be careful to do what is right in the eyes of everyone. If it is possible, as far as it depends on you, live at peace with everyone.” (Romans 12: 9-18 (NIV))

God’s Word, and the tenets of the Christian faith outline the way we are to relate to self, to God, and to others. Having an appropriate self-awareness leads us to an appropriate awareness of who we are before a holy and righteous God, Who loved us even while we were His enemies—sinners (Romans 5:8).
SPIRITUALLY:

That His great love for us motivated God to act in our best interest and provide a way for us to be in right relationship with Him, through Jesus Christ His one and only Son, so that whoever would believe in Him would not perish but have eternal life. For God did not send His Son into the world to condemn the world, but in order that the world through Him might be saved. (John 3:16-17). This love then compels believers to live out this selfless love to a lost and dying world, to continue Christ’s mission—to seek and save the lost (Luke 19:10).

Everything we think, say, and do is then motivated by the love of God within us to achieve this end. Every relationship we have with others becomes a vehicle to that end. It requires us to establish biblical ‘self-care’ practices that keep us focused on maintaining healthy perspectives on our relationship with self, with God, and with others. It requires us to establish boundaries to ensure that our relationships are appropriate, healthy, and God honoring. The relationship we have as believers through faith in His Son—Jesus Christ, as empowered and enabled by His Holy Spirit to live victorious lives “in Christ.” God’s Word too provides the basis for establishing appropriate spiritual ‘self-care’ practices and boundaries that foster a vibrant and maturing spiritual life in Christ.

This begins with grasping, the two greatest commandments—love God, love others, as we love ourselves.

“Teacher, which is the greatest commandment in the Law?” Jesus replied. “ ‘Love the Lord your God with all your heart and with all your soul and with all your mind.’ This is the first and greatest commandment. And the second is like it: ‘Love your neighbor as yourself.’ All the Law and the Prophets hang on these two commandments.” (Matthew 22:36-40 (NIV)

And,

“If you love me, keep my commands....Whoever has my commands and keeps them is the one who loves me. The one who loves me will be loved by my Father, and I too will love them and show myself to them.” ....Jesus replied, “Anyone who loves me will obey my teaching. My Father will love them, and we will come to them and make our home with them. 24 Anyone who does not love me will not obey my teaching. These words you hear are not my own; they belong to the Father who sent me.” (John 14:15, 21, 23-24 (NIV)
BOUNDARIES:

It is clear from God’s Word that the whole of a person, the mental, emotional, physical, relational, and spiritual must achieve balance and harmony for total well-being. To achieve this, balance and harmony requires the person to establish appropriate ‘self-care’ practices and boundaries. Some would refer to such practices and boundaries as limits. Everyone has them, yet few acknowledge them until after these limits have been exceeded at the great detriment of themselves and those around them. Sczerboz writes, “While our culture resists the idea of limits, it is critical that we embrace them. They are like a fenced-in yard that protects young children. They are the hands of a friend, keeping us grounded so that we don’t hurt ourselves, others, or God’s work.”

Boundaries are limits. God established limits, boundaries for us to keep us safe from harm and evil. From the very beginning of human history, He demonstrated that limits, boundaries are important. Simply stated, when we establish and respect appropriate limits, boundaries they keep things how they are intended to be, and where they are intended to be, and it reminds us why they are intended to be that way.


Maintaining healthy boundaries can be more fully appreciated in the context of understanding how healthy margins are achieved. Swenson (2004) asserts, “The Formula for margin is straightforward: Power-Load=Margin. Power is made up of factors such as energy, skills, time, training, emotional and physical strength, faith, finances, and social supports. Load is made up of such factors as work problems, obligations and commitments, expectations (internal and external), debt, deadlines, and interpersonal conflicts. When our load is greater than our power, we enter into negative margin status, that is, we are overloaded. Endured long-term, this is not a healthy state. Severe negative margin for an extended period of time is another name for burnout. When our power is greater than our load, however, we have margin.” To establish appropriate boundaries is too look beyond the immediate, and grasp the larger picture. It is understanding that to accomplish the greater good of being available for continued effective ministry to those they minister to, those in ministry must consider appropriate boundaries a part of their self-care regimen, and paramount to the mental, emotional, physical, relational, and spiritual well-being of themselves, and their families. “When grounded in Christian values and principles, boundaries look beyond the perceived ‘needs’ of the moment, seeking God’s greater purpose in the world.”


To build upon the benefits of establishing appropriate and healthy boundaries, Hand and Fehr (1993) identified three practices and behaviors essential for pastoral health: (a) spiritual renewal practices, (b) rest-taking practices, and (c.) support system practices. “Despite the stress, some pastors are highly adaptive to the hardships of ministry and demonstrate effective coping mechanisms. These pastors utilize strategies for coping with ministry stress including hobbies, spiritual development, sports, and vacations (McMinn, Lish, & Trice 2005; Meek et al. 2003).” Also, according to Pector (2005), a “healthy lifestyle, social support, and work/life balance help pastors resist burnout…. Healthy meals, eaten at leisure and accompanied by stimulating conversation, nourish spirit as well as body…. Hobbies and recreation maintain social connectedness. Formal and informal fellowship with other clergy reduces professional isolation. Courses to learn about other faiths and cultures, meditation, counseling, leadership, conflict resolution, and other topics enrich the mind—and ultimately the congregation. Fatigued pastors can recruit lay help with chores and observe a weekly time of reflection.”


“Margin grants freedom and permits rest. It nourishes both relationship and service. Spiritually, it allows availability for the purposes of God. From a medical point of view, it is health-enhancing. It is a welcome addition to our health formula: Add a dose of margin and see if life doesn’t come alive once again.” (Swenson 2004)

This then is the goal of developing ‘self-care’ practices, and establishing appropriate boundaries. It is then that the whole of a person, the mental, emotional, physical, relational, and spiritual may achieve balance and harmony for total well-being.

It is not possible for a person to avoid the stressors of life. Neither is it likely that the (DC) ministries staff working in (RTC/F’s) in childcare will avoid with any measure of success the issues associated with the work of ministry; or the demands specific to the work of (DC) ministries; or the expectations placed upon them by the organizations that employ them.

Such balance and harmony requires the (DC) ministries staff working in (RTC/F’s) in childcare be intentional about learning how to develop and employ on a daily basis appropriate ‘self-care’ practices and boundaries. The benefits for the professional and personal well-being of the individual (DC) ministries staff and for their families depend on it.

HEALTHY SPILLOVER:

Just as the stressors from the issues related to the work of ministry, the demands specific to the work of (DC) ministries in (RTC/F’s) in childcare; and the expectations placed upon them by the organizations that employ them tend to have a toxic effect on the (DC) ministries staff individual, and their families. So too, the benefits of ‘self-care’ practices, and the benefits of establishing appropriate ‘self-care’ boundaries can become the catalyst for a healthy spillover.

Spillover describes how the experience of dissatisfaction or satisfaction in one sphere of an individual’s life may impact the individual’s other various spheres of life in regards to the mental, emotional, physical, relational, and spiritual spheres of the individual’s life. Spillover is also the means by which the experiences of one individual have had an impact upon the other spouse or family member. For those in (DC) ministries staff positions, this means that as a spouse their satisfaction experiences have been shown to influence the other spouse and contribute to a mutual affective experience (Demerouti et al. 2005; Kelloway & Barling 1994).
The research of Hammer and colleagues (2005) found that the spouses of those with a greater amount of positive family-to-work spillover had lower levels of depression than the spouses of individuals with lower levels of positive family-to-work spillover. This healthy spillover too had a positive impact on marital satisfaction. According to the research of Grywacz and Marks (2000), this has been related to higher levels of positive family-to-work spillover.

Emerging research reveals that the high level of marital satisfaction, which has been contributed to increased positive family-to-work spillover, has also been related to lower levels of depression. Research supports the observations that healthy families provided greater support, and a measure of insulation, which serves to lessen the negative and potentially toxic impacts related to workplace stress. The converse of this aspect of spillover is also equally applicable. Just as the positive aspects in the spheres of an individual’s life manifest healthy spillover, so too do the negative aspects in the spheres of an individual’s life can manifest toxic spillover onto those around them. This leaves those who are in the most intimate contact with the individual (DC) ministries staff vulnerable and susceptible to the impacts family-to-work spillover.

A study by Demerouti et al. (2005) found that negative work-to-family spillover for one spouse contributed to a mutual experience of exhaustion for husband and wife. According to the model of spillover designed by Demerouti et al., increased levels of exhaustion for one spouse, in turn affected the life satisfaction for both spouses.

Other studies (Hammer et al. 2005) have also found negative outcomes for spouses of those with high levels of negative work-to-family spillover.

Hammer and colleagues (2005) reported that husbands’ negative work-to-family spillover was a significant predictor of wives’ depression. The observations and research of Anderson (2010) into the interplay between intimate individuals suggests that the independent experiences encountered by one spouse would directly and indirectly affect the life experience of the other.

The affect related to both stressful and positive encounters has been shown capable of spillover between marriage partners, and this spillover may have impacted spouses’ successive approaches to life and ministry.”
The benefits of a healthy social support from spouses and families cannot be understated. This healthy spillover is instrumental in lessening the toxic impact of workplace stress on those working in (DC) ministries staff positions in (RTC/F’s) in childcare and their families. The ‘self-care’ practices that include mental, emotional, physical, relational, and spiritual ‘self-care’ practices and the establishment of appropriate boundaries addresses the intentionality of limiting the intrusion of the negative spillover associated with workplace stressors.

According to the research of Hobfoll (2002), who views social support as a process, this is particularly important when the personal resources of an individual in the mental, emotional, physical, relational, and spiritual aspects have been taxed and ‘margin’ is no longer available, social support from spouses and family members may be a key resource in and individual’s environment leading to improved mental health and other positive physical outcomes (Cohen et al. 1997; Cohen and Wills 1985).

The research of Galek, Flannelly, Greene, and Kudler (2011) also reveal that social support may also be viewed in the context of mental ‘self-care’ practices, in that in that the presence of intimate others in whom an individual can confide in provides an effective means of maintaining self-esteem (Sarason et al. 1987)."

Thus, the importance of having a healthy family support system cannot be understated. However, this does not negate the need for healthy workplace relationships and the social support of peers and supervisors.

Galek, Flannelly, Greene, and Kudler (2011) reveal in their research that the adverse effects on an individual who has a “lack of social support within an organization puts a strain on personal resources in response to occupational stress, which leads to burnout."
In contrast, work-related sources of social support enhance personal resources in response to stress, ameliorating burnout. From a systems perspective, it is likely that support from work colleagues, other than supervisors, would also be associated with lower burnout, and there is some evidence of this effect (Greenglass et al. 1997; Huebner 1994).

It is clear from emerging research that developing ‘self-care’ practices that are employed on a daily basis, and establishing appropriate boundaries to limit the impact of workplace stressors are required for the continued professional and personal success of those working in (DC) ministries, and their families.

However, it is equally clear that people will not develop ‘self-care’ practices or establish appropriate boundaries until they learn to appreciate what they are, and how they can be of a benefit to them professionally and personally. This requires a concerted and intentional effort on the part of the organizations that employ (DC) ministries staff to provide the necessary ‘self-care’ training for all (DC) ministries staff in an on-going manner.


Research demonstrates that “without commensurate renewal, the complex, competing, and stressful tasks of ministry often create conditions of spiritual, mental, physical, and social depletion and fatigue. (London & Wisemen 2003; Sanford 1982). As Diddams et al. (2004) stated, “Practicing rest bolsters psychological resiliency and personal agency” (p. 317), which serves as an essential element in stress management (Carver 1998). Chandler noted in her summary that Diddams’ research suggests that rest-taking leading to pastoral renewal has been anecdotally linked to burnout and stress resistance, resiliency, and productivity.”

The importance of developing and employing self-care practices and appropriate boundaries on a daily basis can no longer be ignored by the individual (DC) ministries staff, their families, or the organizations that employ (DC) ministries staff. Research, observations, and experience all reveal that allowing for spiritual renewal practices, rest-taking practices, and support systems practices make a significant impact in the replenishing the mental, emotional, physical, relational, and spiritual aspects and quality of work and life of the individual in ministry and their families.

“Researchers have demonstrated that experiences and feelings from one domain of life are transferred onto other areas or domains; that is, experiences from work have been found to spill over into family life; meanwhile, experiences at home have been found to spill over onto work (Demerouti, Bakker, & Schaufeli 2005; Grzywacz & Marks 2000; Hammer, Cullen, Neal, Sinclair, & Shafiro 2005; Thompson & Proutas 2005).

Negative spillover has been understood as an issue of limited resources; the multiple domains of life have made demands on an individual and have been in competition for attention, mental energy, and motivation. These are resources each individual has in limited supply (Goode 1960; Grzywacz & Marks 2000; Hammer et al. 2005), whereas the theory of positive spillover has postulated that involvement in multiple roles aids ones sense of accomplishment, self-efficacy, and energy (Hammer et al. 2005). It seems that participation in multiple roles provides a protective factor when failure or struggles are encountered due to multiple role identification (Seber 1974).”

Andersen, Casa J. Pastoral Burnout and Marital Satisfaction. Fulle Theological Seminary. 2010. 12.

Based on previous research, it is plausible that high marital-satisfaction of a pastor's spouse may have positively impacted the pastor's family-to-work spillover, tempering the effects of burnout.

Thus, in an examination of the elements which have contributed to pastoral thriving, in order to protect against burnout and attrition, the role of spillover seems an essential element. It has appeared that spouses with high levels of marital-satisfaction may have provided a protective factor for their spouse in ministry through the means of spillover.”

Andersen, Casa J. Pastoral Burnout and Marital Satisfaction. Fulle Theological Seminary. 2010. 12.

Ibid. 14.
From a pastoral counseling perspective, it is clear that appropriate pastoral guided ‘self-care’ awareness training can have a positive and meaningful impact of the mental, emotional, physical, relational, and spiritual issues that can have such a deleterious effect upon the professional and personal lives of (DC) ministries staff.

Second, this research, survey results, and subsequent training will become the basis to provide ‘self-care’ coaching of (DC) ministries staff on how to develop better coping skills for dealing with these issues, demands, and expectations while working in residential treatment facilities in childcare.

Third, it will present biblically-based, hope-filled approaches for both the individual (DC) ministries staff and their families, in addition to useful information and tools that equip, encourage, and empower, and if employed consistently will help them be successful in coping with the mental, emotional, physical, relational, and spiritual tolls that (DC) ministries will have on them, and their families, so that they might enjoy a greater quality of life with personal and professional fulfillment and success.

Fourth, it will provide opportunities for the additionally pastoral services of coaching, pastoral counseling and/or referrals for professional counseling.

Fifth, it will provide the organizations that employ (DC) ministries staff with the necessary information needed to better address the issues, demands, and expectations that adversely affect (DC) ministries staff, and with the ‘self-care’ training, morale building, and employee engagement resources to better address organizational (DC) ministries staff recruiting, retention and release issues.
With this in mind, this pastor and pastoral counselor approaches biblically recommended ‘self-care’ awareness training, and/or pastoral counseling intervention strategies with an eclectic approach that is firmly grounded in a nouthetic approach first and foremost.

Clinton, Hart and Ohlschlager assert that,

“Christian counseling and pastoral care is grounded upon the centrality of healing relationships with both vertical and horizontal dimensions. Like all counseling, it is dyadic in its horizontal dimension between two persons. As truly Christian counseling, it becomes uniquely triadic due to God’s presence in the vertical, supernatural dimension. In Christian counseling, the Holy Spirit is the third person in every counseling situation. Since this vertical dimension is unique to Christian counseling, it is essential that we begin healing pursuits with the relational God—with Father, Son, and Holy Spirit.”


They continue. “Mark McMinn recently called attention to the importance of theology in counseling when he stated: “Effective Christian counselors also consider theological perspectives at the same time that they engage in the various psychological tasks of counseling. Historical and systematic theology, biblical understanding, and Christian tradition are all valued and considered essential components of counseling.” Effective counselors, in McMinn’s view, are those given to “multitasking”—the ability to utilize insights and skills gained from the study of theology, psychology and spirituality simultaneously and appropriate for the benefit of the client.”


Pastors and pastoral counselors are in the business of Christian soul care. Hebrews 13:17 teaches that it is the work of spiritual leaders (pastors), and that they will be held accountable to God for the souls of those placed in their care. Clinton and Oilschläger write,

“Christian soul care is a journey of healing, sustaining, reconciling, and guiding. It includes both the care and cure of the soul. As such, Christian soul care makes abundantly clear that the care of souls is a Christian activity that expresses the love of God to the needs of the human soul. The term for “soul” in the Greek New Testament—psyche, which translated from the Hebrew word nepesh—was used 101 times and referred to one’s inner life, the self, the living personality. Furthermore, since the Hebrew and the Middle Eastern mind emphasized the essential unity or wholeness of the person, the term is used interchangeably with “spirit” (pneuma, or ruah in Hebrew), “heart” (kardia or leb in Hebrew), and “mind” (nous in the Greek). The biblical soul is the undifferentiated, immaterial life force that was created by God to be in relationship with him and, if redeemed, will live in eternity with him (Genesis 2:7; Deuteronomy 13:2; 1 Peter 1:22).”


Pastors and pastoral counselors today must minister to the whole of the person. That is to minister to the needs of the individual’s, whether mental, emotional, physical, relational, and/or spiritual well-being. This takes the issue of ‘soul care’ beyond the former limitations assumed by many, back to its historical and biblical roots. Anderson, Zuehlke, and Zuehlke address this writing,

“Theologians have not come to a complete agreement regarding the basic nature of humanity. Those adopting a trichotomous view believe we are composed of body, soul, and spirit. In this view, the soul includes mind, will, and emotions. Others take a dichotomous perspective and understand the soul and the spirit to be essentially the same. Those who incline toward this approach appeal to the fact that we are essentially material and immaterial, possessing an inner person and an outer person. A growing number of Bible scholars and therapists support a wholistic approach to the integration of the components of human nature.”


Townsend builds on this writing,

“All counselors, pastoral or not, implicitly or explicitly manage the boundary between personal faith, religious or spiritual knowledge, and psychotherapy. Because of their claim to engage the spiritual and religious lives of clients, pastoral counselors must be particularly complex since pastoral counseling is no longer contained as an extension of Protestant ministry or bound historically, philosophically, theologically, or institutionally to the context and practices of the church...Pastoral counselors must engage an increasingly plural world with a versatile, critically examined theological vocabulary that expresses the discipline’s voice in relation to the following:

Intra-Christian counseling contexts that cross boundaries between Protestant, Catholic, Orthodox, conservative evangelical, Holiness, and other traditions;

Conservatives about counseling and human well-being in interreligious contexts;


Public policy and its effect on physical, psychological, and spiritual life as expressed in community mental health and other social service agencies; and, Public policy affecting human physical, psychological, and spiritual welfare as expressed by legislation and social action.

Dialogue in these larger arenas—and work with expanding diversity of client populations—requires pastoral counselors to be clear about how they manage the boundaries between behavioral sciences and theology, or spirituality and psychotherapy.”

Pastors and Pastoral Counselors seeking to minister from a wholistic approach, minister to every aspect of the individual (DC) ministries staff person: whether their needs be mental, emotional, physical, relational, or spiritual. Pastor’s and pastoral counselors understand that God’s Word teaches and research reveals that the one must be in harmony mentally, emotionally, physically, relationally, and spiritually—to achieve that harmony and balance, or all aspects of the person’s life can be adversely effected.

To help ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities with children and/or youth the organizations that employ them must provide ‘self-care’ awareness training for new staff, and regular on-going ‘self-care’ awareness training for staff currently filling this role. Provide incentives for regular ‘self-care’ practices by ‘Direct-Care’ ministries staff. Additionally, organizations must institute appropriate employee engagement practices that seek to address the issues, demands, and expectations that foster such workplace stressors, and seek to mitigate these stressors with ‘self-care’ awareness training, ‘self-care’ practice incentives, employee engagement practices, and workforce improvement processes that are inclusive of every level of work force strata in the daily decision-making processes that directly impact ‘Direct-Care’ ministries staff.

Organizations must accept that there is a plethora of research from the last twenty-five years; much of it by the experts referenced in this paper. The experts in the fields of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF) that have been referenced in this project demonstrate through their writings and research that these deleterious effects cannot be attributed solely to the individual, but rather to a large degree as a result of the issues, demands, and expectation placed upon them in the workplace by administrators, supervisors, clients, stakeholders at every level.

The organization by extension of its administrators, supervisors, client’s, and stakeholders, however are largely the cause for, and continue to be the perpetuator of many of these stressors, even ignoring and denying their culpability in failing to address the issues, demands, and expectations, as well as the stressors that result. This not only compounds the problems experienced by ‘Direct-Care’ ministries staff, it fosters and environment that is unhealthy on multiple levels all of which impact the mental, emotional, physical, relational, and spiritual aspects of the employees, as well as employee morale, which impacts adversely the overall quality of services provided.
How the organization responds to the needs of ‘Direct-Care’ ministries staff struggling with the deleterious effects of burn-out, secondary traumatic stress, vicarious trauma, and compassion fatigue is central to mitigating the impact of the stressors associated with the work of ‘Direct-Care’ ministries staff working with children and/or youth in residential childcare; that negatively impact the individual ‘Direct-Care’ ministries staff, and their families.

This thesis asserts, this can be achieved through a combination of effective employee engagement practices that strive to allow the ‘Direct-Care’ ministries staff to feel heard, valued, and included in the day-to-day programming decisions. Where staff are encouraged, empowered and enabled to share their concerns, comments, and complaints and find a willingness on the part of administrators to work together with ‘Direct-Care’ ministries staff to resolve concerns, and mitigate as much as possible those issues, demands, and expectations associated with the work of ‘Direct-Care’ ministries working with children and/or youth in residential childcare. However, employee engagement practices alone however are insufficient to achieve this end. For those professionals in ‘helping fields’, like ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare; learning how to develop appropriate ‘self-care’ skills too is necessary. In fact, individual “self-care” is paramount.

Following adequate ‘self-care’ awareness training, there must also be the daily employment of ‘self-care’ practices by ‘Direct-Care’ ministries staff.

When senior administrators, mid-level supervisors, and ‘Direct-Care’ ministries staff recognize the value of organizational employee engagement practices, and ‘self-care’ awareness training, these must then be combined with appropriate supervisor coaching, and pastoral counseling which can work together to assist ‘Direct-Care’ ministries staff in effectively combating these stressors, and their toxic spillover that can have such deleterious effect on their professional and personal lives.

This thesis asserts this proactive five step strategic approach could reap both short and long-term dividends for the individual ‘Direct-Care’ ministries staff, their families and the organizations that employ them in mitigating the issues, demands, and expectations associated with the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare; and the stressors of burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue.
1.) First, there must be an acknowledgement and willingness to address these issues, demands, and expectations that contribute to these stressors in the lives of ‘Direct-Care’ ministries staff by the organizations that employ them. There must be an intentionality by these organizations to develop a ‘self-care’ training program, or provide ‘Direct-Care’ ministries staff and supervisors with the opportunities to engage in regularly scheduled out-sourced ‘self-care’ training.

Appropriate ‘self-care’ training, coaching and pastoral counseling, and as necessary, referral to other professional therapeutic counseling must be developed to address the specific needs of ‘Direct-Care’ ministries staff. To be effective this ‘self-care’ training must be followed by the daily employment of ‘self-care’ practices that too are designed to specifically combat the issues, demands, and expectations encountered daily by the individual ‘Direct-Care’ ministries staff person. In addition, organizations would do well to provide incentives for those that demonstrate regularly employed ‘self-care’ practices as recommended by the training they have received. It would be of a significant benefit to ‘Direct-Care’ ministries staff that they have regular access to coaching and pastoral counseling to help staff who are struggling against the stressor professionally and personally.

2.) Second, ‘Direct-Care’ ministries staff must understand that early recognition and employed ‘self-care’ practices both in and out of the workplace are key to creating and maintaining professional and personal wellness. However, for many, ‘self-care’ is not a priority. All too many ‘Direct-Care’ ministries staff focus only on others, placing themselves last. Sadly, this often means that these ‘Direct-Care’ ministries staff will likely not last—either professionally, or personally. For those in ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare to be successful professionally and personally they must develop a regimen of ‘self-care’ practices that provide for their mental, emotional, physical, relational, and spiritual replenishment.

3.) Third, it is paramount for the professional and personal well-being of the ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare that they appreciate their need for ‘self-care’ training and daily employment of ‘self-care’ practices. It is equally important that the organizations that employ ‘Direct-Care’ ministries staff in Residential Treatment Centers/Facilities in childcare recognize the issues, demands, and expectation on these staff, and develop and/or include ‘self-care’ training for ‘Direct-Care’ ministries staff.
4.) Fourth, it is important for individuals and their employers to recognize and challenge the spiritual and psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation.

5.) Fifth, central to this approach is an appropriate understanding that ‘self-care’ actually increases a caregiver’s—‘Direct-Care’ ministries staff’s capacity to care for others. Portnoy asserts,

“For those in the helping professions, early recognition and improved self-care both in and out of the workplace are key to creating wellness. Many caregivers focus on others at the expense of their own well-being. It is crucial for them to replenish themselves and commit to having a life outside of work that includes daily nurturing activities. People often understand this concept intellectually, but the knowledge doesn’t necessarily lead to taking better care of themselves. It is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent.”


Enlightened self-interest is quite different from narcissistic preoccupation. Self-care actually increases a caregiver’s capacity to care for others. Self-care, however, is not just about making healthy lifestyle choices—it is about being present with one’s feelings, sensations and intuitive guidance in order to detect what is best in any given moment.”

Portnoy asserts, that those in ‘helping fields’ who “had higher compassion satisfaction scores were more interpersonally ‘fulfilled,’ as defined by scores on ‘being happy,’ ‘being me,’ and ‘being connected to others.’ These professionals in ‘helping fields’ ‘did not feel as trapped and did not experience difficulty separating personal life and work. They were less likely to feel exhausted, bogged down or ‘on the edge.’”

Recommended ‘Self-Care’ Practices:

Clearly, the development and daily practice of ‘self-care’ strategies plays a significant role in achieving mental, emotional, physical, relational, and spiritual well-being. Examples of commonly recommended and employed ‘self-care’ practices for mental, emotional, physical, relational, and spiritual well-being, and improved work-to-life balance include:

MENTAL:

- Develop a habit of journaling to vent, express, and release negative thoughts, attitudes and distressed emotions.


MENTAL:

- Develop a habit of stimulating one’s mind and increasing intellectual excitement by reading, or continuing one’s professional education.

- Develop short-term, mid-range and long-term goals, which one can achieve within three, six, and twelve months or longer.

- Develop a habit, of learning to separate mentally ones’ professional life from one’s personal life in order to experience renewal.

MENTAL:

- Develop a habit of learning a new skill, or participating in a creative art or pastime. Begin exploring and implementing a hobby or activity that will bring one joy, inner peace, self-confidence, and happiness.

- Develop a habit of daily meditation, and mindfulness-based stress reduction practices.

- Seek out qualified and capable pastoral and as needed professional therapy.

EMOTIONAL:

- Develop a habit of listening to how you express your emotions—be honest with yourself and others, identify one’s own needs, put words to one’s emotions and learn to discuss them openly and honestly with trusted others to help ameliorate the stressors.

- Develop a habit of learning to separate emotionally ones’ professional life from one’s personal life in order to experience renewal.

- Develop a habit of positive ‘self-talk.’ —stop reinforcing negative thoughts, feelings in addition, past actions. Optimism and pessimism can affect one’s overall health and well-being. Positive self-talk that accompanies optimism can ameliorate the toxic effects of stress and plays a central role in effective stress management.

- Develop a habit of daily meditation, and mindfulness-based stress reduction practices.
EMOTIONAL:
- Develop healthy relationships with others both in and outside the workplace that provide appropriate social support.

- Develop and attitude of professional detachment (engaged (active) coping strategies) to better, protect from the toxic effects of depersonalization, (DP) and a decrease in personal accomplishment (PA) associated with the stressors of the workplace: Burnout, Secondary Traumatic Stress, Compassion Fatigue, Vicarious Trauma, and the toxic spillover that results.

- Develop healthy means to express your emotions through healthy and constructive avenues—hobbies developing skills other than verbalizing emotions, such as gardening, drawing, writing, playing and instrument, building something, take up writing poetry, stories, plays, songs, doing some painting, acting, or singing.

- Seek out qualified and capable pastoral/and as needed professional therapy.

PHYSICAL:
- Develop a habit of learning to separate physically ones’ professional life from one’s personal life in order to experience renewal.

- Develop a habit of eating nutritious meals regularly, maintain a healthy diet—consume good calories, not bad calories and exercise to burn more calories than one takes in.

- Develop a habit of daily exercise routines that include at least three times per week cardio exercise, for a minimum of 30 minutes per day (treadmill, elliptical, bicycle, etc., achieving 60-70% of heartrate of 220 minus age equals max heartRate for individual), and then at least twice per week, resistance/strength training and flexibility for 20-30 minutes each time. Vary the training routines to keep things interesting and enjoyable. Do things to exercise that are enjoyable, things that are more likely to be continued.

- Develop a habit of losing weight naturally and healthfully with exercise and proper eating. Do not Diet.


PHYSICAL:

- Develop a habit of getting a good night’s rest each night. Get nightly sleep rest of at least 6 to 7 1/2 hours of sleep each night.

- Develop a habit of enjoying non-sleep related rest and relaxation. Make time for leisure activities that have no purpose yet are enjoyable: funny movies, a walk on the beach, listen to music, read a good book, or spend time with a friend.

- Develop a habit of including ten to fifteen minutes in the sunlight each day.

- Seek out healthy outlets for physical exercise that create exciting, interesting and engaging opportunities for recreation and physical exercise. It has been reported that participation in leisure activities provides resources that can assist one in resisting the onset of stress or better cope with stress before it has an impact on one’s health.
RELATIONAL:

- Develop a habit of learning to separate relationally ones’ professional life from one’s personal life in order to experience renewal.

- Develop a habit of taking time to “un-plug” from work related activities, and enjoy and engage with spouses, and family members in restful, recreational, rewarding activities.

- Develop a habit of learning to say, ‘No!’ occasionally to others whose demands on you and your time place unreasonable expectations that interfere with your personal and/or family time. This helps to define what is most important in one’s life, and establishes healthy boundaries.

- Develop a habit of defining responsibilities—delegate what you can, to those who can, and what others can do, other than those things that you alone must do. This allows others opportunities for professional and personal growth; and create opportunities for freeing up one’s schedule for greater work-to-life balance.

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RELATIONAL:

- Develop a habit of intentionally stepping away from work related activities throughout the day, just to take a fifteen-minute break to pray (talk to God), call your spouse, call your family, talk to a friend, take a walk, or just enjoy the ‘self-care’ moment alone.

- Develop a habit of planning and taking time off away from the workplace and work related activities. It is important to plan, and take vacations with one’s spouse, and family. It is not the quantity of time—it is the quality of the time that matters most. It is all about creating fond memories and building relationships.

- Develop a habit of taking time to be alone with oneself to think, to dream, to rest.

- Seek out healthy relationships for personal fulfillment that create exciting, interesting and engaging opportunities to meet with and enjoy quality time with family and friends, and to develop healthy relationships with friends and coworkers outside of the workplace.
SPIRITUAL:

- Develop a habit of spending quality time with God in daily personal Bible study/devotions, meditating on God’s Word and allow the Holy Spirit to speak truth into your life circumstances and situations, both professional, and personal.

- Develop a habit of spending quality time with God in daily personal prayer time.

- Develop a habit of regular church fellowship and worship service attendance.

- Develop a habit of maintaining accountability with another trustful maturing believer who will be safe sounding board, and available accountability partner, and godly mentor.


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SPIRITUAL:

- Develop a habit of spending time in silence before God—just listening, looking and learning to hear from God.

- Develop a habit of fasting and praying on a weekly basis for clarity of thought, answer to prayer, for wisdom, courage to act, and/or strength to endure, and also spiritual victory over sin, and the forces of darkness that seek to bring confusion, doubt, fear, frustration, disillusionment, and discouragement. Fasting and prayer are practical demonstrations of one’s utter dependence on, and need for God.

- Seek out a Bible believing and preaching church to join. Seek out godly relationships and opportunities for personal spiritual growth and spiritual maturing; that create exciting, interesting and engaging opportunities to grow in one’s faith, participate in corporate worship; attend regular discipleship classes with one’s spouse, and family, or friends.

These examples of recommended ‘self-care’ practices abound in the contemporary context for the mental, emotional, physical, relational, and spiritual aspects of an individual’s life, that they might achieve work-to-life balance.

In addition, there are also a number of resources available that advocate for the establishment of appropriate boundaries to maintain a work-to-life balance.

However, for all of the examples that are available, and for all of the awareness brought for the need to develop and employ ‘self-care’ practices, and establish appropriate boundaries—most people do not heed the counsel available, nor do they take advantage of the benefits that the ‘self-care’ practices and boundaries would reap, for themselves, or for their families.

They do not know how to maintain a balance between their professional and personal lives.

HOW TO MAINTAIN:
BOUNDARIES:
Because burnout has such deleterious effects establishing appropriate boundaries is central for those in ministry and for their families.

“Boundaries define where one thing ends and another begins; differentiate what belongs to us from what belongs to someone else; distinguish our responsibility from someone else’s responsibility; and filter bad things out while either permitting or keeping good things in.

In short, boundaries help us prioritize and protect what matters to us. To define boundaries properly, it’s necessary to make value judgments. That is, boundaries are only important when they support our values.” (Swenson, Richard A. *Margin: Restoring Emotional, Physical, Financial, and Time Reserves to Overloaded Lives*. Colorado Springs. NavPress. 2004. 70.)

BOUNDARIES:
When those in ministry establish appropriate and healthy boundaries, both they and their families, as well as those they minister to, reap the benefits.

The importance of establishing boundaries is best understood in the context of margins. “Margin is the space between our load and our limits. It is the amount allowed beyond that which is needed. It is something held in reserve for contingencies or unanticipated situations.

Margin is the gap between rest and exhaustion, the space between breathing freely and suffocating. Margin is the opposite of overload. If we are overloaded we have no margin.” (Swenson. 2004) Wilson, Michael Todd and Brad Hoffman. *Preventing Ministry Failure: A ShepherdCare Guide for Pastors, Ministers and Other Caregivers*. Downers Grove. InterVarsity Press. 2007. 140.)
BOUNDARIES:

The key to returning to a healthy margin is establishing boundaries.

How that is accomplished creates both challenges and opportunities for personal, family, and corporate growth. It means making some changes.

“Boundaries for Christians are designed to protect Christ-like values and help us live a lifestyle consistent with Christian principles.” A fundamental tenet of the Christian faith is discipleship—growing in greater and growing Christlikeness, developing Christ-like values helps us live Christ-like principles; central to this is maintaining appropriate and healthy boundaries. Numerous examples of Christ-like principles and values can be found in Scripture, as appropriate boundaries.

BOUNDARIES:

“While our culture resists the idea of limits, it is critical that we embrace them. They are like a fenced-in yard that protects young children. They are the hands of a friend, keeping us grounded so that we don’t hurt ourselves, others, or God’s work.” (Scazzero, 2010.) Boundaries are limits. God established limits, boundaries for us to keep us safe from harm and evil. From the very beginning of human history, He demonstrated that limits, boundaries are important. Simply stated, when we establish and respect appropriate limits, boundaries they keep things how they are intended to be, and where they are intended to be, and it reminds us why they are intended to be that way. (Scazzero, Peter L. The Emotionally Healthy Church: A Strategy For Discipleship That Actually Changes Lives. Grand Rapids. Zondervan. 2003, 146.)
BOUNDARIES:

Maintaining healthy boundaries can be appreciated more keenly in the context of maintaining healthy margins. “The Formula for margin is straightforward: Power-Load=Margin. Power is made up of factors such as energy, skills, time, training, emotional and physical strength, faith, finances, and social supports. Load is made up of such factors as work, problems, obligations and commitments, expectations (internal and external), debt, deadlines, and interpersonal conflicts. When our load is greater than our power, we enter into negative margin status, that is, we are overloaded. Endured long-term, this is not a healthy state. Severe negative margin for an extended period of time is another name for burnout. When our power is greater than our load, however, we have margin.” (Swenson. 70.) Swenson, Richard A. Margin: Restoring Emotional, Physical, Financial, and Time Reserves to Overloaded Lives. Colorado Springs. NavPress. 2004. 70.)

BOUNDARIES:

To establish appropriate boundaries is to look beyond the immediate, and grasp the larger picture. It is understanding that to accomplish the greater good of being available for continued effective ministry to those they minister to, those in ministry must consider appropriate boundaries a part of their self-care regimen, and paramount to the mental, emotional, physical, relational, and spiritual well-being of themselves, and their families. “When grounded in Christian values and principles, boundaries look beyond the perceived ‘needs’ of the moment, seeking God’s greater purpose in the world.” (Wilson, Michael Todd and Brad Hoffman. Preventing Ministry Failure: A ShepherdCare Guide for Pastors, Ministers and Other Caregivers. Downers Grove. InterVarsity Press. 2007. 144.)
CHAPTER 6:
Conclusion

The work in the human services field is fraught with challenges. Working with people is rarely easy, or always pleasant, and never without its share of issues, demands, and expectations.

Working with people often gets ugly, messy, and taxing...on multiple levels—mentally, emotionally, physically, relationally, and spiritually.

The issues, demands, and expectations related to the work of “Direct-Care ministries in Residential Treatment Centers/Facilities working with children and/or youth is no different, yet it is unique.
The work of 'Direct-Care' ministries in Residential Treatment Centers/Facilities working with children and/or youth in childcare shares the issues related to ministry work—always being on demand, always being on display, and always being on-duty; these are issues that can challenge even the most dedicated and devoted in spirit. Then, there are those demands specific to 'Direct-Care' ministry: the stressors of secondary traumatic stress, compassion fatigue, burnout, and the toxic spillover that often accompany the work of 'Direct-Care' ministries. Then, as with many other human service positions there are those expectations placed upon them by the organizations they are affiliated with often include having to work in different types of work environments; group homes, psychiatric units, foster homes, and step-down units; working short shifts, long shifts, days and nights, or awake-night shifts, or working alone while working as 'Direct-Care' ministries staff of children and/or youth in residential treatment facilities in childcare.

“Direct-Care: The Residential Treatment Worker in Acute & Collaborative Community Based Approach” (New York: Haworth Mental Health Press, 1999)

“The issues, demands, and expectation are significant. The toll of working in Residential Treatment Centers/Facilities, whether in public or private non-profit as ‘Direct-Care’ ministries staff with children and/or youth in childcare can be taxing mentally, emotionally, physically, relationally, and spiritually.

The toxic spillover of the stressors of burnout, secondary traumatic stress (STS), vicarious trauma (VT), and compassion fatigue (CF), and the toxic spillover that often accompany the work of ‘Direct-Care’ ministries can have a deleterious effect on the staff person and their families.

Existing research, the phenomenological research, and the online survey results reveal that such tolls contribute significantly to the high turnover of ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare with children and/or youth in childcare.
The U.S. Department of Labor statistics reports that the turnover rate in the United States is 3.3 percent across multiple industries. Yet, existing research reveals that the estimated annual turnover for those working as ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities, as between 26 to 41 percent (Curry, McCarragher, & Dellmann-Jenkins 2005; Whitebook, Philips, & Howe 1989) (Also see Dietzel & Coursey 1989; Manlove & Guzell 1997; Onyett, Pillenger, & Muijen 1997; Ross 1983; Whittaker 1996).

The research of Colton and Roberts, (2007), which suggests that the annual turnover rates for ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities with children and/or youth in child care range from 30 to 40 percent, while the average time in position is less than two years (United States General Accounting Office 2003; American Public Human Services Association 2004).


Significant to this research study is the annual turnover rates of between 26 to 41 percent for ‘Direct-Care’ ministry staff working with children and/or youth in Level II, III, and IV Residential Treatment Centers/Facilities.

This average is considerably higher than the 11 to 15 percent annual turnover rate for ‘Direct-Care’ ministries staff working in Residential Group Home’s with children and/or youth with fewer mental and emotional issues and/or behavior challenges, which reach a high of 20 percent reported in some Residential Group Home’s in North America and the United Kingdom.

The research results indicate that the turnover rate for ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in Level II, III, and IV ‘levels of care’ have an astonishingly high turnover rate due primarily to the stressors directly related to the nature of working with children and/or youth with moderate to severe mental and emotional disorders, and also behavioral challenges at higher ‘levels of care.’

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The prior research, the phenomenological research, as well as the research for this study and the online survey results of ‘Direct-Care’ ministry staff reveal the deleterious toll of the issues, demands, and expectations combined with the toxic spillover of the work of ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities working with children and/or youth in childcare is a challenging vocation, which is exacerbated at each “level of care” with the increasing mental and emotional disorders, and behavioral challenges that contribute significantly to ‘Direct-Care’ ministries staff turnover. It is not the only causal factor.

Decker et al. (2002) found statistical correlation between lower scores on the Maslach Burnout Inventory, and protective factors such as education, age, and levels of support and supervision. Heavy workloads, poor pay, the low status of the work, and poor supervision impacted turnover rates on both sides of the Atlantic (Fleischer 1985; Fleischer 1985; Samantrae 1992; Yercraft 1994; Dickinson & Perry 2002; Human Services Workforce Reform 2003; United States General Accounting Office 2003; McCarthy 2004; Association of Directors of Social Services 2005; Child Welfare League of America 2005; Department for Education and Skills 2005).”

‘Direct-Care’ ministries staff must deal with inadequate staffing. Additional ‘Direct-Care’ ministries staff may be on-duty, yet often due to inadequate training, lack of experience, immaturity, poor work ethic, or mere personality conflicts with fellow staff, these may result in inadequate staffing to residents ratios. ‘Direct-Care’ ministries staff at times work excessively long work shifts.

Occasionally due to staff shortages, staff vacations, or staffing emergencies, sometimes ‘Direct-Care’ ministries staff work beyond the assigned seven days on-duty, seven days off schedule, or nine days on-duty and four days off, or ten days on-duty as required by the organizations that employ them.

Often times ‘Direct-Care’ ministries staff are required to work additional day’s on-duty to cover staff shortages to meet the needs of children and/or youth in care for the organization. Low salaries too are a source of ‘Direct-Care’ ministries staff turnover.

According to the U.S. Department of Labor statistics, there are approximately 18,800 persons working as ‘Direct-Care’ ministries staff in the United States. The average annual income for those working in ‘Direct-Care’ ministries in Residential Treatment Centers/Facilities in childcare with children and/or youth is $24,250.00 and averaging just $11.66 per hour.

‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare with children and/or youth often work with poor benefits, poor living conditions, poor housing, and an overall poor quality of life. In addition, ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare with children and/or youth often work with poor benefits, poor living conditions, poor housing, and an overall poor quality of life.

As if this is not enough, ‘Direct-Care’ ministries staff often must take up residence in sub-par housing. Often the housing for (DC) ministries staff is housing that is an apartment within the residential unit itself: cottage, dormitory, or house; or share and apartment with roommates, or have and apartment that shares common areas, i.e., kitchen and laundry areas with other staff, and/or residents. Most would consider this as less than ideal. Often these facilities are located a considerable distance from major urbanized areas which offer, what most in today’s culture desire for in and overall quality of life for ‘Direct-Care’ ministries staff, spouses, and their families.

‘Direct-Care’ ministries staff operate under inadequate supervision, with ill-defined job responsibilities, inadequate supervision, poor communication, insufficient resources, and the discouragement of working in an environment that fosters and expects a high ‘Direct-Care’ ministries staff turnover.

While these factors clearly contribute to the high turnover of ‘Direct-Care’ ministries staff working in Residential Treatment Centers/Facilities in childcare with children and/or youth, the factor often cited for ‘Direct-Care’ ministries staff voluntarily vacating their positions is the increasingly uneasy with the mental and emotional issues of the children and/or youth in care.

Finally, the organizations that employ (DC) ministries staff should acknowledge the role their administrative policies and approaches play in fostering an unhealthy workplace environment that ignores the reality of these issues, demands, and expectations placed upon (DC) staff.

These organizations then should then adopt employee engagement practices that seek to provide a workplace environment that allows (DC) ministries staff to be heard, valued, and included in the programming decisions that can help alleviate, and potentially mitigate some of these issues, demands, and expectations.

This proactive strategic approach could reap both short and long-term dividends for the individual (DC) ministries staff, their families, and the organizations that employ them. These efforts in ‘Self-care’ training, appropriate coaching, and pastoral counseling efforts should be combined with organizational employee engagement practices that demonstrate to (DC) ministries staff that they have been heard, valued, and included, could make significant strides in helping to create a healthy workplace environment for all.
Harms, Ray, and Rolandelli (1998) offer the following suggestions toward providing (DC) ministries staff support, writing,

“The book, *Avoiding Burnout*, lists three essential needs of caregivers that must be addressed if child care providers are to be productive and satisfied with their jobs [Jorde-Bloom 1982]. Child care providers need to be with colleagues who understand the day-to-day stresses they face. Creating support networks and developing community contacts will help prevent burnout and provide staff members with rich resources for new ideas...Caregivers need to feel that what they are doing is worthwhile and that they are recognized for their efforts...”

Caregivers feel respected and competent when they are able to make decisions about matters that affect them directly. Staff turnover affects program quality. To maintain quality programs, consider providing adequate pay, offering flexible scheduling, giving caregivers reasonable amounts of vacation time, providing “mental health days,” allowing them respite from the pressures of caring for children; providing lounges or designated areas where staff members can relax; and training competent substitute caregivers.”


Organizational employee engagement practices should seek to provide support for (DC) ministries staff through identifying the cares and concerns of staff, and then work together with (DC) ministries staff to identify the means to provide that support. This process includes the following steps:

First, there must be an acknowledgement and willingness to address these issues, demands, and expectations that contribute to these stressors in the lives of (DC) ministries staff by the organizations that employ them through employee engagement practices, and mandatory ‘self-care’ awareness training. There must be an intentionality by these organizations to develop a ‘self-care’ awareness training program, or provide (DC) ministries staff and supervisors with the opportunities to engage in regularly scheduled out-sourced ‘self-care’ awareness training. Appropriate ‘self-care’ awareness training, coaching and pastoral counseling, and as necessary, referral to other professional therapeutic counseling must be developed to address the specific needs of (DC) ministries staff. To be effective, this ‘self-care’ training must be followed by the daily employment of ‘self-care’ practices that are designed to specifically combat the issues, demands, and expectations encountered daily by the individual (DC) ministries staff person. In addition, organizations would do well to provide incentives for those that demonstrate regularly employed ‘self-care’ practices as recommended by the training they have received.
Second, (DC) ministries staff must understand that early recognition and employed ‘self-care’ practices both in and out of the workplace are key to creating and maintaining professional and personal wellness. However, for many, ‘self-care’ is not a priority. All too many (DC) ministries staff focus only on others, placing themselves last. Sadly, this often means that these (DC) ministries staff will likely not last—either professionally, or personally. For those in (DC) ministries in (RTC/F’s) in childcare to be successful professionally and personally they must develop a regiment of ‘self-care’ practices that provide for their mental, emotional, physical, relational, and spiritual replenishment.

Third, it is paramount for the professional and personal well-being of the (DC) ministries staff working in (RTC/F’s) in childcare that they appreciate their need for ‘self-care’ training and daily employment of ‘self-care’ practices. It is equally important that the organizations that employ (DC) ministries staff in (RTC/F’s) in childcare recognize the issues, demands, and expectation on these staff, and develop and/or include ‘self-care’ training for (DC) ministries staff.

Fourth, it is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation.

Fifth, central to this approach is an appropriate understanding that ‘self-care’ actually increases a caregiver’s—(DC) ministries staff’s capacity to care for others. “For those in the helping professions, early recognition and improved self-care both in and out of the workplace are key to creating wellness. Many caregivers focus on others at the expense of their own well-being. It is crucial for them to replenish themselves and commit to having a life outside of work that includes daily nurturing activities. People often understand this concept intellectually, but the knowledge does not necessarily lead to taking better care of themselves. It is important for individuals and their employers to recognize and challenge the psychological obstacles that get in the way of self-care, such as the belief that focusing on personal needs is selfish or indulgent. Enlightened self-interest is quite different from narcissistic preoccupation. Self-care actually increases a caregiver’s capacity to care for others. Self-care, however, is not just about making healthy lifestyle choices — it is about being present with one’s feelings, sensations, and intuitive guidance in order to detect what is best in any given moment.”
This research reveals that those in ‘helping fields’, like (DC) ministries staff, report increased compassion satisfaction which strongly negatively correlate with numerous items on the burnout, (STS), (VT), and (CF) subscales. In short, those in ‘helping fields’ who were able to develop coping skills to better enable them to more effectively deal with the stressors associated with their work were better able to perform their work with a greater sense of well-being and experienced greater professional and personal satisfaction. This sense of well-being and professional and personal satisfaction translated into improved attitudes, increased work performance, and better overall quality of care for those they serve.


It is well accepted that when people are in a crisis they often seek the counsel of a clergy member for guidance. (DC) ministries staff working in (RTC/F’s) in childcare with children and/or youth will encounter the issues, demands, and expectations associated with this line of work, and the stressors of burn-out, (STS), (VT), and (CF) and these stressors will have a deleterious impact on their professional and personal lives as well as their families. However, these (DC) ministries staff and their families can be made aware of these stressors through appropriate training, and when encountered can employ the ‘self-care’ practices and the establishment of healthy boundaries to mitigate the effect and impact on their lives. When, and if it is needed, they can seek out pastoral counseling to find the means to better deal with the stressors in their lives, and find the resources needed for a greater professional and personal fulfillment.
In pastoral counseling, there are a number of pastoral counseling approaches, whether nouthetic counseling, a form of pastoral counseling that employs only the use of Scripture and a focus on Christ, and the power of the Holy Spirit to facilitate change and healing. The pastoral counselor may also employ nouthetic counseling and some combination of approaches dependent upon their personal expertise, and application appropriateness that merge for an eclectic approach, the aim of pastoral counseling is to admonish, correct, or instruct.

The motivations for providing the pastoral counseling may vary and stem from confrontation, concern, or change, the aim is to promote Christ, the truths of God’s Word, the power of the Holy Spirit to facilitate change in the innermost being for Christian maturity and greater growing Christ-likeness. The overall impact of effective pastoral counseling cannot be fully measured; yet the impact on a life a peace with God, self and others as a result can be greater personal and professional fulfillment.

Pastoral counseling can be the catalyst for helping others understand the importance of establishing and maintaining biblical ‘self-care’ practices and that maintaining boundaries is central to the interventions of pastoral care and counseling provided to guide others to mental, emotional, physical, relational, and spiritual well-being.

Romans 1:8-12 (NIV) is the premise for this thesis, research study and online survey, which will then become the basis for a directed ‘self-care’ awareness training and pastoral care ministry to those working in (DC) ministries staff positions in (RTC/F’s) in childcare.

This directed ‘self-care’ awareness training will focus on providing ‘self-care’ training in five aspects of the whole person: Mentally, Emotionally, Physically, Relationally, and Spiritually.
Pastoral counseling can be the catalyst for helping others understand the importance of establishing and maintaining biblical 'self-care' practices and that maintaining boundaries is central to the interventions of pastoral care and counseling provided to guide others to mental, emotional, physical, relational, and spiritual well-being.

In summary, it’s all about leading others to take the next right steps toward hope. As a pastor and pastoral counselor I believe our greatest hope is found in a personal relationship with Jesus Christ!
March 27, 2015

Michael Patrick Jones
IRB Exemption 2146.032715: The Challenges and Recommended Self-Care Practices for Those Working in Direct-Care Ministries in Residential Treatment Facilities in Childcare

Dear Michael,

The Liberty University Institutional Review Board has reviewed your application in accordance with the Office for Human Research Protections (OHRP) and Food and Drug Administration (FDA) regulations and finds your study to be exempt from further IRB review. This means you may begin your research with the data safeguarding methods mentioned in your approved application and no further IRB oversight is required.

Your study falls under exemption category 46.101(b)(2), which identifies specific situations in which human participants research is exempt from the policy set forth in 45 CFR 46:101(b):

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Please note that this exemption only applies to your current research application, and any changes to your protocol must be reported to the Liberty IRB for verification of continued exemption status. You may report these changes by submitting a change in protocol form or a new application to the IRB and referencing the above IRB Exemption number.

If you have any questions about this exemption or need assistance in determining whether possible changes to your protocol would change your exemption status, please email us at irb@liberty.edu.

Sincerely,

Fernando Garzon, Psy.D.
Professor, IRB Chair
Counseling

(434) 592-4054

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