EXPLORING COMPASSION FATIGUE RISK IN CERTIFIED CHILD LIFE SPECIALISTS

by

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Within the pediatric health-care environment medical teams are becoming increasingly reliant on the efforts of certified child life specialists to decrease the stress for patients and their families. Research on related professions has revealed that engaging in therapeutic relationships with traumatized patients can place workers at risk for a condition called compassion fatigue. The present study explores how compassion fatigue, and related conditions, affects child life specialists, as well as identifying possible protective variables. One hundred and fifty four certified Child Life Specialists took an online survey that contained items measuring social support, self-care practices, and professional quality of life. Analyses revealed that risk levels for compassion fatigue in this field are comparable to related professions and that high levels of self care, social support and satisfaction in one's job (compassion satisfaction) are related to lower risk for compassion fatigue and other conditions. Implications of these findings for future research and in developing preventative measures are discussed.

EXPLORING COMPASSION FATIGUE RISK IN CERTIFIED CHILD LIFE SPECIALISTS

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LIST OF ABBREVIATIONS

AAP	American Academy of Pediatrics
BO	Burnout
CCLS	Certified Child Life Specialist
CF	Compassion Fatigue
CSDT	Constructivist Self-Development Theory
ISSB	Inventory of Socially Supportive Behaviors
MOS-SSS	Medical Outcomes Study Social Support Survey
Pro-QOL5	Professional Quality of Life 5
PTSD	Post-Traumatic Stress Disorder
SCAW	Self Care Assessment Worksheet
STS	Secondary Traumatic Stress
VT	Vicarious Traumatization

CHAPTER 1: INTRODUCTION

Within the realm of pediatric health-care, a growing field known as Child Life has emerged in response to an overwhelming need to provide care for the whole patient, not just the medical needs (Sorenson, Card, Malley & Strzelecki, 2009). Focused on a comprehensive understanding of child development, Certified Child Life Specialists (CCLS), seek to empower pediatric patients and their families to cope with the stress of traumatic experiences (such as hospitalization) through such methods as play and education (Thompson & Stanford, 1981). Although a relatively new discipline, child life work is already recognized by several major accrediting institutions as absolutely vital to providing quality care within pediatric institutions (AAP, 2006; Magrab & Bronheim, 1976; Thompson & Stanford, 1981).

However, the work of CCLSs, while quite rewarding, can extract a large emotional toll on the individuals in this field (Holloway & Wallinga, 1990). Successful interventions mandate an emotional engagement with the patient and family; repeatedly exposing oneself to a high level of vulnerability, particularly in a difficult and emotionally charged environment such as the hospital, can be wearing over time (Figley, 1995). With the onset of my own career in this field, I have observed the gradual onset of exhaustion, disengagement, and disillusionment in the professionals around me. These experiences have impressed upon me the need to better understand these conditions and to find ways to prevent their occurrences.

Within the literature many researchers have recognized that professional caregiving can often result in a distinct range of consequence as a result of taking on the burdens of others, called a great deal of things in the literature, such as: burnout, compassion fatigue, vicarious traumatization (Adams, Figley, & Boscarino, 2008; Figley, 1995; McCann & Pearlman, 1990). Although the literature on this topic has been rapidly expanding for many years, it has not as of

yet truly embraced this new field of child life. It is thus the goal of the current study to expand these topics to include the work of CCLSs. Additionally, we recognize that merely documenting these trends is not enough, particularly given the long-term effects that these conditions can have on individuals (Alkema, Linton, & Davies, 2008; Meadors & Lamson, 2008; Munn, Barber, & Fritz, 1996). Thus, another goal of this thesis is to identify protective factors or behaviors that can be used to prevent and alleviate the effects of this stress.

Within the literature, the Constructivist Self-Development Theory states that when placed in a threatening situation, the outcome for the individual will be a result of the interaction between that person's past experiences, coping strategies and cognitive schemas (McCann & Pearlman, 1990). Likewise, a systemic perspective emphasizes the need of an individual to pull from the support within a network and their own resources to reestablish equilibrium following a crisis (White & Klein, 2008). Using these theoretical frameworks as a reference, the present study seeks to not only identify patterns of risk for these conditions in this relatively new population of workers, but also to explore the effects of three specific protective factors (compassion satisfaction, self care, social support) as ways of ensuring that child life workers can continue productively in their jobs for a long time to come.

CHAPTER 2: LITERATURE REVIEW

A growing body of evidence indicates that the stressors associated with hospitalization may have significantly negative consequences for pediatric patients (AAP, 2006; Thompson & Stanford, 1981). As a result, many hospitals rely on the work of certified child life specialists (CCLSs) to provide developmentally appropriate interventions aimed at decreasing the trauma associated with medical care (Sorenson et al., 2009). Inherent in the work of a CCLS is the need to establish emotional rapport with patients through the formation of therapeutic relationships. However, research on professional caregiving indicates that consistent and prolonged engagement can be emotionally draining and may put workers at risk for developing compassion fatigue (Burtson & Stichler 2010; Killian, 2008). Although the success of helping professions resides in a worker's ability to be present with patients and express authenticity and empathy, engaging in these behaviors for prolonged periods of time has been shown to increase risk for development of Post-Traumatic Stress Disorder (PTSD) like symptoms (Conrad & Kellar-Guenthar, 2006; Showalter, 2010; Truax, 1966).

Many differing terms have been used to describe these symptoms including *burnout* (Maslach & Jackson, 1984) and *compassion fatigue* (Figley, 1995), and risk for this family of conditions has been well-documented in many caregiving populations including social work (Adams et al., 2008), chaplaincy (Taylor, Flannelly, Weaver, & Zucker, 2006), nursing (Kilfedder, Power, & Wells, 2001), and EMS workers (McCammon, Durham, Allison, & Williamson, 1988). To date, similar research on such conditions focused specifically on the CCLS population has been scarce. As this relatively new field of health care professionals continues to grow, in part bolstered by public support from American Academy of Pediatrics

(AAP, 2006), it becomes imperative that the forces behind secondary traumatization in this group be understood and inquiries be made into preventative measures for this population and related professions.

Compassion Fatigue in Helping Professions

The adverse consequences of professional caregiving have been acknowledged in the literature for many years however the literature has been slightly convoluted by lack of clarity in terminology amongst authors (Meadors et al., 2009). Symptoms present in helping professionals as a result of exposure to both primary and secondary trauma has been labled many things including *burnout* (Maslach & Jackson, 1984); *compassion fatigue* (Figley, 1995); *vicarious traumatization* (McCann & Pearlman, 1990); and *secondary traumatization* (Figley, 1995). Despite an underlying similarity in each of these conditions (i.e. response to trauma exposure), the terms are in fact unique operational definitions that each depict a specific response to trauma exposure (Meadors, Lamson, Swanson, White, & Sira, 2009). For clarity sake, the present study will use the following operational definitions as conceptualized by the original scholars.

Burnout

In 1984, Maslach and Jackson introduced the concept of "burnout" (BO), a condition where prolonged exposure to stress in the work environment (particular those of professional caregivers) can lead to psychological distress. Burnout has been documented in many helping professions including nursing (Grunfeld et al., 2000), social work (Burtson & Stichler 2010; Killian, 2008) and hospice caretakers (Alkema et al., 2008; Burtson & Stichler; Maslach & Jackson; Meadors et al., 2009). Scholars have discovered that burnout is associated with the routine hassles of employment such as dealing with deadlines, handing multiple or complex patient loads, and difficulties in interdepartmental interactions (McHolm, 2006; Najjar et al.,

2009). The condition may result in cynicism, emotional exhaustion, inefficacy, and a self-perception of impaired work performance, all of which in turn may lead to depersonalization of clients and decreased productivity at work (Maslach & Jackson, 1984; Valent, 2002). Nevertheless, the consensus among scholars remains that although burnout is a real consequence for those in professional caregiving work, the condition alone is not sufficient to account for the entire spectrum of emotional exhaustion experienced in helping professions.

Secondary Traumatic Stress

Burnout, as previously defined, is a condition that may be attributed to many different fields, however, in 1995, Figley recognized that there is an additional pressure associated only with workers in caregiving professions. Recent figures estimate that around 7% of professionals working with traumatized individuals exhibit symptoms of PTSD although they themselves have not personally experienced a traumatic event. (Thomas & Wilder, 2004; Meadors et al., 2009). Within the current literature, trauma is not used in the classic psychological sense. Medically, *trauma* is used to refer to a serious or critical body injury or shock, such as the result of a severe car crash or near drowning; psychologically, trauma may also refer to experiences that are emotionally distressing or painful, either for the patient, the healthcare professional, or both individuals (American Psychiatric Association, 2000; Saladino, 2005). Therapists working with traumatized individuals face repeated exposure to clients reliving past traumatic experiences as they strive for closure (Killian, 2008). Often in these fields individuals may be at risk for some level of secondary victimization.

Simply put, Figley (1995) recognized that there is a "cost to caring"; engaging with patients or clients sharing stories laden with fear and pain may place the professional under stress as he or she too begins to feel that fear and pain. He termed this phenomenon *secondary*

traumatic stress (STS), defined as ‘‘the natural and consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person’’ (Figley, 1995, p. 7). In later years, this definition has expanded to include all work-related trauma, primary and secondary, that influences the way a professional engages in his or her workplace (Stamm, 2010). The current research uses this expanded definition and defines secondary traumatic stress as negative feelings or reactions driven by both direct and indirect work-related trauma.

Compassion Fatigue

In 1995, Figley introduced the concept of *compassion fatigue* (CF), a type of burnout that also incorporates an appreciation of the specific effects of repeated exposure to direct and indirect trauma. More recently, compassion fatigue has been used as a general term to describe the negative aspects related to work as a helper, composed of the negative stress derived from work-related trauma as well as the anger, depression and frustration that may result from burnout. McCann and Pearlman (1990) note that compassion fatigue may eventually lead workers to emotionally disengage with clients; this process is comparable to the avoidance and numbing experienced by the very trauma survivors with whom these professionals engage. The capability of a professional resides in his or her ability to be present with patients and express authenticity, empathy and positive regard; these very behaviors may also place individuals at risk for internalizing the negative experiences of their patients (Conrad & Kellar-Guenthar, 2006; Showalter, 2010; Truax, 1966). In the past 25 years, scholars have identified significant risk for compassion fatigue in a variety of helping professions including medical personnel (Alkema et al., 2008; Jaworek, Marek, Karwowski, Andrzejczak, & Genaidy, 2010; Kowalski et al., 2010; McCammon et al., 1988; Taubman-Ben-ari & Weintroub, 2008), social workers (Bourassa,

2009; Fahy, 2007; Udipi, McCarthy Veach, Kao, & LeRoy, 2008) and human service personnel (Eastwood & Ecklund, 2008; Conrad & Kellar-Guenther, 2006; Seti, 2007; Tehrani, 2010). However, only minimal research has focused attention on the effects of compassion fatigue in the child life population.

A search on several prominent databases revealed that at the time of this research, only three studies had included the CCLS population in the identified sample. The first, conducted in 1990, focused only on the prevalence of burnout condition in CCLSs without regard to the effects of compassion fatigue (Holloway & Wallinga, 1990). This research learned that child life workers actually had lower risk for burnout when compared to other health care professionals and that role stress (particularly role ambiguity) and organizational variables were the highest predictors of burnout. The CCLSs included in the study scored significantly lower on scores of depersonalization (becoming negative or treating patients like objects instead of people) and significantly higher on scores of personal accomplishment when compared to other participants, while emotional exhaustion scores were comparable across the entire study sample. However, scores on the depersonalization and emotional exhaustion scales were higher if the individual experienced a lot of role ambiguity, that is, he or she felt that the CCLS role was not well-defined or understood by other healthcare professionals (Holloway & Wallinga, 1990).

Taken as a whole these findings suggest that similar to other medical professionals, child life workers are at risk for developing adverse reaction to their working conditions. In 1996, Munn, Barber and Fritz expanded on this work and explored factors that affect professional well-being in child life workers in addition to burnout prevalence. The researchers added measures to examine job dissatisfaction and intentions to leave employment to the burnout variable and included a limited number of external factors, such as social support. The findings concurred that

CCLSs may be at risk for developing burnout, and that inadequate administrative support was predictive of job dissatisfaction and intention to leave the job (Munn et al., 1996).

At the time the present research was conducted, only one study had addressed the presence of compassion fatigue in child life specialists, albeit indirectly (Meadors et al., 2009). The research team initially aimed to examine secondary trauma conditions in a variety of health care professionals; although this investigation did not initially seek to isolate CCLSs, due to lower response rates in the other populations (i.e. chaplains, nurses, physicians, other medical personnel) child life workers accounted for over half of the participants. As a result, many of the findings can be attributed largely to the professional experience of child life staff; thus the research of Meadors and his team can be taken to indicate that both burnout and compassion fatigue may significantly affect the child life specialist population. Given the scarcity of empirical evidence documenting the unique prevalence of compassion fatigue and related conditions in the child life population, one purpose of the present study is to provide additional research on the existence of these conditions.

The Role of Child Life

The Child Life Council as it exists today was established in 1982, but despite this relatively recent introduction of child life in the world of pediatric care, the specialty has already made a significant impact within the medical world as many reputable organizations have publically recognized the need for such services. The American Academy of Pediatrics' (AAP) most recent statement on child life services (2006) declares that "provisions of [child life services] is a quality benchmark of an integrated child health delivery system and an indicator of excellence in pediatric care" (p. 1757). Currently, AAP reports that child life programs are offered in a variety of settings including inpatient pediatric wings, emergency departments,

outpatient clinics, rehabilitation programs, hospice programs, primary care practices, and dental offices. Child life specialists work as members of the multidisciplinary health care team, collaborating with medical personnel, social workers, and therapists to provide comprehensive care for pediatric patients. The inclusion of child life specialists into the medical team is believed by many to be critical for promoting positive mental health during pediatric hospitalization (Magrab & Bronheim, 1976).

The CCLS occupies a unique role within the greater health care team as the primary goal of this specialty is to use developmentally appropriate interventions to promote effective coping with unfamiliar and traumatizing experiences for pediatric patients (Sorenson et al., 2009; Thompson & Stanford, 1981). Child life programming uses a foundation built in knowledge of developmental theories to "minimize the stress and anxiety experienced by children and to assure optimal growth and development" (Thompson and Stanford, p. 5). Although there are any number of interventions and activities that may achieve this goal, empirical studies of effective child life programming have indicated that most programs include therapeutic play, provision of medical information, psychological preparation, emotional support for patients and families, opportunities for self expression, and advocacy for patient and family rights (AAP, 2006; Bolig & Gnezda, 1984; Cole, Diener, Wright, & Gaynard, 2001; Thompson & Stanford, 1981).

Child life specialists work to establish therapeutic relationships with patients and families; these relationships are imperative for success in facilitating emotional coping and supporting family involvement in the child's care and medical decision-making (AAP, 2006). Research indicates that interventions aiming to foster mental health are only successful when they are enacted within the context of a supportive and trusting relationship (Broadhead et al., 1983; Gaynard et al., 1998). Successful child life therapy requires a psychological commitment

to the patient; if a child life worker is not emotionally engaged in activity with the child, he or she will be unable to correctly identify that child's affective condition and subsequently unable to develop effective interventions. However, empirical evidence on the nature of counseling professions indicates that engaging in therapeutic relationships with patients, particularly those emotionally charged or prolonged relationships can be mentally and emotionally draining for the therapist (Figley, 1995), or in this case, for child life workers.

Given the emotionally charged environment in which CCLSs work in on a daily basis, it stands to reason that similar to other helping professions, they too may be at risk for developing burnout or secondary traumatic stress. Additionally, the literature gives precedence to predict that risk for these conditions will not be universal across the field, but will in some ways be impacted by the specific stressors associated with particular location of employment. For example, patients are often classified as either *acute;* that is, having an illness or injury with a typically abrupt onset and rapid recovery, leading to a relative short hospital stay (e.g. a broken bone or tonsillectomy) or *chronic,* having an illness or injury that may require comprehensive care over a longer period of time (e.g. cancer or cerebral palsy). Research on compassion fatigue in nurses specializing in pediatric care has revealed that individuals working primarily with chronic patients, as opposed to primarily acute patients, are at significant risk for developing the condition (Maytum, Heiman, & Garwick, 2004).

Additionally, the literature documents that individuals working in Intensive Care Units (Meadors & Lamson, 2007), Oncology units (Palmer, Kagee, Coyne, & DeMichele, 2004), and with exposure to high a frequency of trauma (Cunningham, 2003) are at increased risk for exhibiting negative side effects associated with direct and indirect trauma exposure. Likewise, one would predict that child life workers in similar environments, such as those who regularly

engage with chronic patients or are regularly exposed to high intensity trauma cases, will be at increased risk for developing compassion fatigue as opposed to those working primarily with acute, short-term patients. The present research seeks to expand on current literature by documenting the degree of compassion fatigue risk for child life specialists, in part as a result of environmental risk factors inherent in their location of employment.

Protective Factors for Deterring Secondary Traumatization

Compassion Satisfaction

Although exploring the presence of these interrelated conditions within the child life population is certainly needed, documentation alone is not enough for protecting specialists against the effects of burnout and secondary traumatic stress. In addition to identifying the factors that influence the development of these conditions, the present study also seeks to expand research on methods of deterring the development of compassion fatigue. Within the existing literature, scholars have also identified several factors that may have a protective factor in promoting the emotional well-being of care-giving professionals. For example, when first remarking on the presence of compassion fatigue in social workers, Figley (1995, 2000) also identified reliance on social support and self-care practices as strategies for decreasing risk. Furthermore, a study of secondary traumatization in nursing staff indicated that decreased risk for compassion fatigue was associated with higher levels of experience, a more developed sense of professional knowledge and skills, and most importantly, job satisfaction (Burston & Stichler, 2010). Nurses who frequently experienced feelings of satisfaction for their work environment and believe that they make a difference in their work are less likely to be at risk for compassion

fatigue. Job satisfaction has been repeatedly maintained in recent literature as a means for minimizing the potential negative consequences of helping professions, in particular for its role in *compassion satisfaction*.

Current scholars have identified compassion satisfaction as "the level of satisfaction helping professionals find in their job and the degree to which they feel successful in their jobs" (Conrad & Kellar-Guenther, 2006, pp 1073-1074). Much empirical evidence suggests compassion satisfaction is negatively associated with risk for both burnout and compassion fatigue. A study of compassion fatigue in nurses found a positive relationship between quality of caring and compassion satisfaction, as individuals who felt that they were effective in their positions were more likely to be rated as higher in the quality of care they bestowed on patients (Burtson & Stichler, 2010). Moreover, research on compassion fatigue within social workers indicated that having a sense of mastery and satisfaction in one's job was negatively correlated with the onset of compassion fatigue and burnout (Adams et al., 2008). Furthermore, a study of child care workers found that participants who exhibited high levels of compassion satisfaction were statistically less likely to be at risk for burnout and compassion fatigue, (Conrad & Kellar-Guenther, 2006). These researchers discovered that compassion satisfaction may also be affected by the degree of support an individual feels from colleagues and work partners.

Social Support

Mounting empirical research continues to indicate that availability of social support is critical for maintaining emotional health in the workplace. Research on nursing staff indicates that high levels of social support are predictive of low risk for burnout (Garrosa, Rainho, Morena-Jimenez, & Monteiro, 2010; Kilfedder et al., 2001). This support can be both emotional (e.g. providing sympathy, demonstrating compassion) and instrumental (e.g. concrete behaviors

that provide assistance). Perception of strong levels of social support in child care workers was associated with decreased risk for burnout (Seti, 2007) and research on clinicians interacting with trauma survivors indicated that the levels of perceived social support from family, friends and the community were a significant predictor of higher levels of compassion satisfaction (Killian, 2008). More importantly, scholars are now recognizing that although receiving support from loved ones at home can be beneficial to the professional well-being of health care providers, the presence of instrumental, emotional and information support within the workplace is essential for decreasing risk for compassion fatigue and burnout (Adams et al., 2008). A study on the well-being of child life specialists indicated that receiving emotional and instrumental support from supervisors was predictive of positive professional and personal well-being (Munn et al., 1996).

Self-Care Behaviors

Discovery of the effects of social support on the emotional health of professional caregivers indicates that just as exposure to negative events within the workplace may lead to the development of harmful conditions; positive components of the environment may also be used to protect individuals against these afflictions. In addition to social support, researchers have also identified a number of coping strategies and behaviors that may decrease risk for compassion fatigue in helping professionals (Alkema et al., 2008; Eastwood & Ecklund, 2008). Within the literature, the term "self care practices" typically refers to activities that increase physical and psychological health in the individual and decrease negative impacts from cumulative stress (Alkema et al., 2008). Although scholars historically refer to leisure behaviors when discussing self care practices, spiritual activities such as prayer and meditation, and physical health behaviors (e.g. consumption of vitamins and supplements, getting sufficient sleep) have recently been included in these discussions (Eastwood & Ecklund, 2008; Van Hook & Rothenberg,

2009). Empirical evidence signifies that teaching self-care practices (e.g mind awareness, physical strategies to deal with stress, actively seeking social support) to new and inexperienced health care providers can actively decrease the risk of developing compassion fatigue (Shapiro, Brown, & Biegel, 2007).

Purposefully developing self care strategies may enable individuals to positively adapt to work related stressors and an intentional self-care plan encourages development of tools and resources that promote balance in both professional and personal life (Alkema et al., 2008; Keidel, 2000; Maytum et al., 2004). In response to mounting research highlighting the benefits of once non-traditional self-care strategies, many scholars now emphasize the need for developing a holistic self-care plan that incorporates many domains including physical, cognitive, emotional, spiritual, vocational, and social needs (Bush, 2009; Jones, 2005; Showalter, 2010). During weekly discussion groups of professional caregivers suffering negative effects from secondary trauma, McCann and Pearlman (1990) identified a variety of effective coping strategies including: striving for balance between personal and professional life; balancing a clinical and non-clinical responsibilities, being aware of personal boundaries, maintaining realistic expectations of individual limits, dedicating time for personal nurturing, and giving the self permission to experience emotional reactions in appropriate fashion. Likewise, a study on compassion fatigue in pediatric nurses recognized that deliberate self-care, particularly methods that highlight a respect of self and an individual's unique limitations is critical for maintaining emotional health (Maytum et al., 2004).

Although not all self-care practices are equal in their ability to combat emotional exhaustion, there is some evidence to indicate that the more activities an individual engages in (and the greater the variety) the healthier his or her emotional adjustment. A recent study on self-

care and risk for compassion fatigue and burnout in hospice care workers indicated the total number of self-care activities was negatively correlated with risk for compassion fatigue (Alkema et al., 2008). In this study by Alkema and colleagues, the more self-care strategies the professionals engaged in, the less likely they were to exhibit signs of compassion fatigue. Additionally, the researchers discovered compassion satisfaction was positively correlated with practices aimed at emotional health, such as spiritual self-care practices and balancing between professional and personal domains. Although these researchers have indicated many potential ways of decreasing risk for compassion fatigue in professional helpers that can be applied to child life specialists, at this time, there is a significant gap in the literature concerning CCLSs' own view on effective self-care strategies. The final over-arching objective for the current study is to bridge this gap and document CCLSs' use and perceptions of self-care practices.

Theoretical Frameworks

Constructivist Self-Development Theory

The primary theoretical framework used to inform the present study is the Constructivist self-development theory (CSDT). This theory was initially developed to explain the presence of vicarious traumatization (VT) within counseling therapists (McCann & Pearlman, 1990; Saakvitne, K., Pearlman, L., & the Staff of the Traumatic Stress Institute, 1996). VT is a term often used interchangeably with secondary traumatic stress, but more specifically refers to "the transformation of the therapist's or helper's inner experience as a result of empathic engagement with survivor clients and their trauma material" (Saakvitne et al.,1996, p. 25). CSDT places an emphasis on the interaction between the individual and his or her environment and experiences. This particular theory states that the way individuals react and deal with a novel threatening

situation is a result of the interactions of an individual's past experiences, coping strategies and cognitive schemas. The framework rejects an idea of passivity; scholars purport that reality is actively constructed in a bi-directional fashion. Past experiences and schemas can taint perceptions of reality, however at the same time individuals can actively channel responses into cognitive schemas for adaptive coping patterns (McCann & Pearlman, 1990).

The theorists behind this framework emphasize that the cognitive schemas used to interpret the environment are not static; they are ever evolving based on experiences, both positive and negative (McCann & Pearlman, 1990). VT is thought to occur when an experience of trauma disrupts one of the four basic assumptions identified by Epstein (1989): the world is meaningful, the world is benign, the individual self is worthy and people can be trusted. Within the helping professions, this may occur when the individual is asked to participate in a situation, or hears about an experience, that causes disruptions in one of those four assumptions (McCann & Pearlman, 1990). To combat these negative effects, the individual must then reconstruct his or her own frame of reference often through social interaction and self-care.

McCann and Pearlman (1990) indentified several strategies for combating VT and other secondary traumatization. First, the authors emphasized the need for social support among professionals. Professional isolation should be avoided at all costs, as interactions with others working with similar populations can provide emotional support in addition to professional advice on adaptive coping. The authors also express a need for self-reflection to increase awareness of one's own psychological needs and cognitive schemas, as well as identifying the individual's own unresolved trauma and conflict areas (McCann & Pearlman, 1990). Finally, this theory also emphasizes the need for self-care through a variety of strategies in order to prevent and actively reconstruct maladaptive frameworks.

Systems Theory

In addition to concepts derived from the CSDT framework, this present study also utilizes ideas from Systems Theory to inform the hypotheses. Child life specialists (like all health care professionals) do not exist in isolation during their daily work. Even individuals at smaller hospitals who may not work in conjunction with other child life specialists specifically will still interact daily with health care professionals of other fields in determining patient care. For this reason, it is appropriate to also apply a systems framework to the current research. Within systems theory, scholars recognize that individuals are part of a greater system of interrelated factors and people (White and Klein, 2008). The experiences of individuals within a system will affect other members, and a greater understanding of these dynamics comes in approaching the system as a whole, not breaking it down into isolated factors.

This theoretical approach informs the research by recognizing that the interactions of the CCLS with his or her patients, co-workers, and supervisors, will influence the dynamic of the work environment and quality of life for that worker, and vice versa. This relationship is both bi-directional and inherently complex. Coupled with tenants of the CSDT is a need to explore social interactions within a systems framework and recognition that the influence of each individual factor is affected by other features both within and outside the specialist's control. The research examines a range of risk and protective variables, with the understanding that they do not influence in isolation. The systems framework necessitates that our research examine a variety of risk and protective factors in order to understand the complete etiology of the various secondary trauma conditions.

The Present Study

The overarching objective for the present study is to fill a gap in the current literature on risk for compassion fatigue within the child life population. We predict that similar to other helping professions, the distribution of CCLS will follow normal patterns of risk for low compassion satisfaction and high burnout and secondary traumatic stress, however we expect that risk levels will vary for sub groups of the population. In particular, based on research indicating differential risk for various populations based on location of employment, we predict that working with specific populations or in specific units will present specialists with different types of environments that will then contribute to different risk levels (Cunningham, 2003; Palmer et al., 2004). In particular we believe that isolating individuals who work within an emergency department, the ICU, and with hematology/oncology patients will provide initial evidence that location of employment may increase the likelihood that specialists will encounter trauma and/or patient fatalities, which may then lead to different patterns of risk.

We also expect the results to indicate that similar to comparable studies, risk for these conditions may also vary based on certain demographic factors. Specifically, we expect to find that specialists with more years of experience will be at a lower risk for the conditions, as will those in larger departments (with theoretically more opportunities for social support). Additionally, using a CSDT framework, we predict that individuals with decreased professional isolation (i.e. those in larger departments) will be at decreased risk for developing secondary traumatic stress and burnout.

This present study also expands on previous work by investigating potential protective factors for minimizing the risk of compassion fatigue. In particular, the research seeks to provide preliminary data on the types of self care practices found to be useful by child life specialists,

and cataloging the relationships between different types of practices with decreased risk for the conditions. Although research on self-care in related helping professions has grown in the recent past, to our knowledge, this premise has never been applied to the child life specialist population. In addition to cataloging patterns of self-care, we expect our results to correspond with the findings of the aforementioned studies; that is to find a significant positive correlation between the number of self care practices child life specialists employ and decreased risk for compassion fatigue. Moreover, research on related professions has indicated that high levels of compassion satisfaction and perceptions of strong social support are associated with decreased risk for compassion fatigue and burnout (Adams et al., 2008). We expect to find comparable results. Finally, a Systemic theoretical approach reminds us that individuals do not exist in isolation during the workday. Thus, we predict that perceptions of social support from colleagues and supervisors, will have an influence on risk level for secondary trauma conditions.

Research Questions

Aim 1: Expanding current compassion fatigue literature to include the certified child life specialist population.

1. How does the distribution of risk within the child life specialist population compare to the risk distribution found in the greater helping profession population in terms of risk for low compassion satisfaction and high compassion fatigue (i.e. burnout and secondary traumatic stress)?

2. How does risk for these conditions differ for subsets of the population as determined by location of placement, size of child life department, length of work, etc?

Aim 2: Understanding the presence of self-care practices and professional social support within child life workers as potential resources for combating compassion fatigue (as identified by the Constructive self-development theory).

1. What types of self care strategies are utilized by child life specialists for combating the effects of compassion fatigue and burnout?
2. What types of self care practices are viewed as most and least effective?
3. How is social support perceived by child life specialists in regards to both to departmental colleagues and supervisors?

Aim 3: Exploring the effects of compassion satisfaction, social support, and self-care as potential efforts to decrease risk for compassion fatigue in child life specialists and other care-giving professionals.

6. How does compassion satisfaction relate to risk for burnout and secondary traumatic stress?
7. How does social support perceived from peer-level colleagues and supervisors relate to risk for burnout and secondary traumatic stress?
8. How do self-care behaviors associate with risk for burnout and secondary traumatic stress?

CHAPTER 3: METHODOLOGY

Data Collection

After receiving approval from the East Carolina University Institutional Review Board (Appendix A), the data for the current study were collected from 154 certified child life specialists from the Child Life Council Virtual Forums. Data were gathered with permission from the Child Life Council (CLC). Initial postings on the forum served to preliminarily inform the community of the upcoming survey and request participation, after which a link to the completed survey (created using Qualtrics software) was provided. Weekly reminder emails continued for three weeks after the initial launch. Informed consent was obtained through acceptance of an online informed consent document (Appendix B) prior to the survey, outlining any potential risks and rewards. Participation was entirely voluntary and compensation was not provided and participants were not individually identifiable.

Measures

Population Information

A basic demographic information sheet (Appendix C) was created by the researcher to gather data relevant to the study. Examples of items included: sex, age, education level, and ethnicity of the participants. In addition, this section included questions regarding the participant's work environment including: years of experience in the field, size of department, location of employment and questions regarding exposure to trauma.

Professional Quality of Life (ProQOL-5)

Professional quality of life was measured using a 30 item standardized tool commonly used in research to assess the positive and negative effects of working in the high-stress environment of helping professions (Stamm, 2010). The instrument (presented in Appendix C)

includes three subscales; compassion satisfaction subscale - (CS) and two subscales of compassion fatigue: burnout (BO) and secondary traumatization stress (STS).

All measured variables (compassion satisfaction, burn out and secondary traumatization) are created by taking the sum of each subscale and converting this raw score into a t-score using a scale developed by the instrument's author (Stamm, 2010). These t-scores are derived from a normative population distribution taken from the data of 200 studies on professionals in caregiving fields. Using this distribution, the author suggests using percentile cut-off scores to determine risk levels; individuals who score in the bottom 25% of the population are considered to be "low risk", scores in the top 25% of scores are considered "high risk", with the middle 50% being labeled as "medium risk". The Pro-QOL5 was designed to be a screening tool, not for diagnoses purposes; results only indicate the likelihood that an individual may suffer from a particular condition, not a guaranteed diagnosis.

Compassion satisfaction was measured using the compassion satisfaction subscale. Compassion satisfaction refers to the pleasure derived from positive outcomes in the work place. In helping professions, this construct includes feeling as though the individual can make a difference for his or her clients, pleasure from working with colleagues, or believing one has an ability to contribute to the community. Examples of items from this subscale include: "I feel invigorated after working with my patients" and "I believe I can make a difference through my work" (Stamm, 2010). The *compassion satisfaction subscale (*CS) has a total of 10 items identified as positive feelings regarding one's ability within the job, and the ability of that job to make a difference in greater society (Stamm, 2010). Using the suggested cut-off scores for analyzing risk levels, the bottom 25th percentile (low compassion satisfaction) is identified as scores up to 44, the top 25th percentile (high compassion satisfaction) is identified as anything

above a score of 57, with medium compassion satisfaction identified as scores 45-56 (Stamm, 2010). In the compassion satisfaction variable, higher scores are indicative of greater satisfaction within one's profession. This subscale reported reliability was $\alpha = .88$ (Stamm, 2010); the reliability for the present study was comparable at $\alpha = .89$

Compassion fatigue is measured by two subscales measuring the construct of *Compassion Fatigue*, each with ten items (Stamm, 2010). The first component, *burnout* (BO), refers to feelings of anger, depression, or hopelessness in dealing with difficulties in the workplace. This term directly correlates with the present's study's operational definition of *burnout* and is used as such. Burnout is measured using statements such as "I feel overwhelmed because my patient load seems endless" and "I find it difficult to separate my personal life from my life as a child life specialist" (Stamm, 2010). Using the cut-off percentile scores described above, low risk for burnout is identified by a cut off score of 43, high risk levels are assigned to participants with scores at, or above, 56, and medium risk is identified within the range of 44 and 55 (Stamm, 2010). Higher scores on this subscale are interpreted as increased risk for experiencing the effects of burnout. Reliability for the Burnout subscale is listed in the instrument manual as $\alpha = .75$; within the present study, reliability was slightly lower ($\alpha = .70$), but still within the acceptable range for psychological research (Nunally, 1978; Pallant, 2007).

Secondary Traumatization Stress was measured using the second subscale for compassion fatigue, titled *Secondary Traumatization Stress* (STS). This term refers to the negative effects of exposure to both direct and indirect trauma within the workplace (Stamm, 2010). As a result of this exposure, the individual may experience sleep difficulties, intrusive images, or other symptoms consistent with PTSD. Examples of items include "I am not as productive at work because I am losing sleep over traumatic experiences of a patient" and

“Because of my work, I have felt "on edge" about various things” (Stamm, 2010). Low risk for STS is identified as a score at or below 42, with a high risk cut-off of 56, and medium risk in the range of 43 and 55, as per the author’s suggestion (Stamm, 2010). Similar to burnout, higher scores on the STS subscale are indicative of higher risk for experiencing secondary traumatic stress. Reliability for the STS scale is generally reported as $\alpha > .81$; within the present study, this scale had a slightly lower reliability of $\alpha = .76$, but one well within the range of acceptability (Nunally, 1978; Pallant, 2007).

Self-Care Assessment Worksheet (SCAW)

Self care variables for the present study were measured using the Self-Care Assessment Worksheet (SCAW), a tool developed by Saakvitne, Pearlman, and the Staff of the Traumatic Stress Institute (1996) and informed by a CSDT approach, (see Appendix C). It measures an individual’s engagement in six areas of self-care (physical, psychological, emotional, spiritual, professional workplace and balance). Although this instrument has not as of yet been tested for psychometric properties, it has been utilized in past research to describe the ways a participant has engaged (or not engaged) in self care (Alkema et al., 2008). Each subscale lists a variety of self-care behaviors and asks participants to rate how frequently they engage in that activity on a Likert type scale ranging from 1-5 (1= *it never occurred to me,* 5 = *frequently*). Information on the number of items in each scale and possible scores can be found in Table 1. For each subscale, higher scores indicate increased participation in self-care strategies in that particular domain. Examples of items include: 1) Get enough sleep (physical), 2) Practice receiving from others (psychological), 3) Stay in contact with important people in your life (emotional), 4) Have experiences of awe (spiritual), 5) Take a break during the work day (professional), and 6) Strive for balance within your home-life and work day (maintaining balance).

Additionally, the current research added an item asking participants to identify the type of self-care strategies they believed to be most effective and least effective in promoting emotional and psychological health. Cronbach's Alpha for each subscale was high (>.91); specific reliability for each subscale can be seen in Table 1.

Social Support Measures

Perception of Social Support was assessed by using two measures aimed at capturing perceptions of social support for participants. First, *peer-level support* was measured using the seven item *Emotional/Information Support* subscale of the Medical Outcomes Study Social Support Survey (MOS-SSS) (Sherbourne & Stewart, 1991). Participants were asked "When working in the healthcare environment, people often look to coworkers for companionship, assistance and other types of support. During the last 30 days, how often have you found the following kinds of support from within your team (both interdisciplinary and departmental) when needed?" and then were presented with seven peer-level support items (e.g. Someone you can count on to listen to you when you need to talk). Participants rated frequency using a using a 5-point Likert scale ranging from "none of the time" (1) to "all of the time" (5). A Peer Support score was obtained by summing up all responses with higher scores indicating higher levels of perceived support (range = 7-35). Reported reliability of the entire MOS-SSSS is quite high (α >.91). The peer support variable reliability for the sample was .96 (Sherbourne & Stewart, 1991).

Supervisory Support was measured by using the *Emotional support* subscale of the Inventory of Socially Supportive Behaviors (ISSB) (Barrera & Ainlay, 1983). Participants rated 10 support scenarios on a Likert – type scale "0"(N/A) to "5" (About every day). This subscale centers on specific examples of supportive behaviors from an administrative level. For example: "Helped you understand why you didn't do something well"; "Let you know that he/she will

Table 1

Self-Care Assessment Worksheet Sub-Scale Break Down

Self-Care Domain	Number of Items	Min. Score	Max. Score	Reliability (α)
Physical	14	14	70	.95
Psychological	11	11	55	.92
Emotional	10	10	50	.94
Spiritual	16	16	80	.96
Workplace/Professional	11	11	55	.92
Maintaining Balance	2	2	10	.95

always be around if you need assistance". A score for Supervisor Support was obtained by summing up all responses with higher scores indicating higher levels of perceived support (ranging from 0 to 45) (Barrera & Ainley, 1983). During analysis, one item, "Assisted you in setting a goal for yourself," was dropped due to poor correlation with other items and the new nine item scale had a Cronbach's alpha of .89 to increase inter-item reliability (Pallent, 2007).

Data Analysis

The data from this study were imported from Qualtrics software and analyzed using Statistical Package for the Social Sciences (SPSS 18) software. Results were obtained from a variety of statistical tests, primarily including Pearson Product Correlations and one-way ANOVAs. The data were then modified and converted as needed. Participants were provided with an open ended response to the questions "What type of unit do you primarily work in at your current job?" Responses to these questions were wide spread and indicated that individual participants may work in a large number of areas throughout the day, so the 'primarily' location of employment was identified and participants were classified accordingly. Additionally, three areas were identified in the literature as being uniquely different in working experience (i.e. Trauma Centers, ICU/NICUs and Oncology units) and then coded individuals for any exposure during the day to these units (Cunningham, 2003; Maytum et al., 2004; Palmer et al., 2004).

Similar to the methods of Alkema, Linton, and Davies (2008) an Overall Social Support Index was calculated for both peer-level support and supervisor support by taking the mean score for each scale to the nearest whole number using simple rounding rules. Finally, to correct for inconsistent numbers of items in each type of self-care (e.g. physical, emotional, spiritual) that prevented cross-comparison across domains, an "Index Score" was calculated by taking the scores for each domain and dividing by the total number of points possible in that area.

CHAPTER 4: RESULTS

Descriptive Data of Participants

The final sample of participants included 154 certified child life specialists. The sample was primarily female (n = 151) and White (n = 144) with the remainder of participants identifying as Hispanic (n = 6), Asian (n = 2) or Black (n = 1). The participants ranged in age from 23 to 57 (M = 32.35, SD = 8.42) with a median age of 29 years. Sixty-one specialists (39.6%) reported themselves as being single and not living with a partner, 74 specialists (48.1%) stated that they were married, while the remaining 19 specialists were engaged, widowed, divorced or living with a partner but not married. The majority of participants (n = 101) were childless, while the other 41 respondents ranged from 1 to 4 children living at home. Eighty three specialists (54%) held a four year degree in a related field, 70 specialists (45%) had obtained a master's degree and one participant (< 1%) reported completing doctoral level work.

In regards to professional achievement, 123 participants (80%) hold the title of "Child Life Specialist", while another 20 participants (13%) report the title of supervisor, and ten participants (7%) fall into an "other" category (e.g. administration, education, art therapist). The average time spent in the current position was 3.86 years (SD = 4.69), with a range of one month to 26 years. The total time spent working as a child life specialist fell between 4 months and 30 years with an average of 7.35 years (SD = 6.96). Most participants worked in a medium sized department (M = 18.68, SD = 22.9) but reported department size ranged from as low as one individual to more than 130 members of the organizations. In regards to primary location of employment, a large number of participants reported working in either outpatient settings (n = 21), multiple locations throughout the hospital (n = 20), or the emergency department (n = 19). See Table 2 for full results of employment location.

Table 2

Location of Employment within the Hospital

Location of Employment	Frequency	Percent
Outpatient	21	13.7
Multiple	20	13.1
Emergency Department	19	12.4
Hematology/Oncology	18	11.8
Acute/General Pediatrics	18	11.8
Specialty Inpatient	18	11.8
ICU/NICU	17	11.1
Other	10	6.5
Radiology	8	5.2
Indirect	4	2.6

Participants were coded for any exposure to locations identified in the literature as having working environments with distinct characteristics that may influence exposure to either risk or protective factors. Twenty-eight percent of participants (n = 43) reported having at least some daily contact with an ICU setting (Pediatric or neonatal), 23% (n = 36) reported involvement with an emergency department, and 16% (n = 25) spent some time every day with the hematology/oncology population.

Over half of participants (54.5%) reported being exposed to a traumatized patient within the past seven days, while another 28.6% reported exposure in the past month, 7.8% in the past six months, and 7.1% in the past year. Only two respondents had never dealt with trauma in the workplace. Eighteen participants stated they had dealt with the death of a patient in the past seven days, 37 in the past month, 49 in the past six months and 43 in the past year. Seven participants reported that they had never dealt with a patient death. On the opposite end, 22.1% of participants reported that they received daily satisfaction from seeing patient recovery, 36.4% reported satisfaction in the past seven days, 28.6% in the past month, and 10.4% of specialist reported their last experience of satisfaction due to a patient's recovery was in the past six months. Three specialists had not experienced patient recovery in the past year and only one participant reported never having that particular experience.

Statistical Analyses

To explore our hypothesis that specialists working in different units of a hospital may in fact have completely different working experiences (and subsequently different exposure to potential risk factors), Chi-square tests for independence were run between work environment variables and the three specified units (ICU, Emergency department and hematology/oncology). The first work environment variable identified was exposure to death of a patient. To this end, a

Chi-square test for independence indicated a significant association between working in an ICU and exposure to a patient fatality, χ^2 (4, n = 151) = 12.56, $p < .05$, phi = .29. Participants working in the ICU reported greater frequency of patient deaths. Whereas only 30.9% of specialists not working in an ICU had experienced a death in the past month and 34.5% of non-ICU workers had not experienced a patient fatality in the past year (with seven participants indicating they had never dealt with a fatality), every single ICU specialists had experienced fatality at some point, with 58.9% reporting a death in the past month.

Likewise, analyses indicated differences in acuity of patients and exposure to fatalities for specialists working with the Emergent Care and Hematology/Oncology populations. A significant association exist between working in an Emergency department and the severity of patients' illness or injuries, χ^2 (3, n = 151) = 19.64, $p < .05$, phi = .36. (See Table 3).

Emergency department specialists were unlikely to have patients with purely chronic conditions, and instead dealt primarily with acute concerns or a combination of acute and chronic conditions. In contrast, as would be expected, not a single specialist working with the hematology/oncology population reported working solely with acute care patients; every patient had at least some type of underlying chronic concern (See Table 4). A Chi Square test for independence indicated there is also a significant association between working with hematology/oncology patients and patient acuity, χ^2 (4, n = 151) = 20.08 $p < .05$, phi = .37. Analyses indicated that working in an Emergency Department or with Hematology/Oncology patients increased the likelihood a specialist was exposed to a patient fatality. While less than a third of specialists working outside the Emergent Care environment had experienced a patient a death in the past month, half of emergency workers reported a death in the past 30 days. This difference was significant, χ^2 (4, n = 151) = 11.93, $p < .05$, phi = .28.

Table 3

Differences in Patient Acuity Based on Emergent Care Exposure

Acuity of Patients	Percent of Cases Seen:	
	Child Life Specialists with Emergent Care Exposure	Child Life Specialists without Emergent Care Exposure
Primarily Acute	30.6	11.1
Both Acute and Chronic	66.7	50.4
Primarily Chronic	2.8	35.9
No Direct Patient Care	0.0	2.6

Table 4

Differences in Patient Acuity Based on Hematology/Oncology Exposure

Acuity of Patients	Percent of Cases Seen:	
	Child Life Specialists with Hematology/ Oncology Exposure	Child Life Specialists without Hematology/ Oncology Exposure
Primarily Acute	--	18.8
Both Acute and Chronic	36.0	57.8
Primarily Chronic	64.0	21.1
No Direct Patient Care	--	2.3

Additionally, only 11.1% of those working in this setting had gone a year without a fatality, as opposed to a third of those working in other units. Likewise, working in a Hematology/ Oncology setting was also significantly associated with higher frequency of patient deaths, χ^2 (4, n = 151) = 14.82, $p < .05$, phi = .31. Sixty-eight percent of Hematology/Oncology CCLSs had dealt with a patient death in the past month in contrast to the 29.7% of other workers.

Compassion Fatigue, Burnout, and Secondary Traumatic Stress

With results indicating that working in specific units of a hospital does result in vastly disparate working environments, the next step was to discover if these discrepancies led to differential risk levels for burnout and compassion fatigue. A summary of the scores for the compassion satisfaction, burnout, and secondary traumatic stress for the normative comparison group, overall sample, and specified locations (i.e., emergency department, ICU, and hematology/ oncology) are presented in Table 5. Participants were split into low, middle, and high risk groups for the three conditions, using the cut-off scores previously mentioned (Stamm, 2010). An initial chi-square goodness-of-fit test indicated there were no significant differences between the distribution of risk in the normative population and current sample for compassion satisfaction (χ^2 (2, n = 154) = .49, p = .78), compassion fatigue (χ^2 (2, n = 154) = 2.94, p = .23, or burnout (χ^2 (2, n = 154) = .221, p = .90).

Overall, the distribution of the child life population into low, medium, and high risk groups for these conditions showed no significant difference from the sample presented in the instrument's manual. However, when the ICU child life specialist population was isolated, a chi-square goodness-of-fit test indicated a significant difference in population distribution into risk level groups for compassion fatigue when compared to the normative population, χ^2 (2, n = 43) = .63, $p < .05$. A similar result was found for compassion fatigue risk level when comparing the

Table 5

Comparison of Normative Data to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Subscale Scores for Sample and Specified Locations

Subscales		*N*	Mean	*SD*	Median	Mode
CS	Norm	1187	50.0	10.0	51.0	53.0
	Entire Sample	154	50.0	10.0	50.1	52.1
	ICU	43	43.4	11.4	49.1	46.1
	Hematology/Oncology	25	49.6	9.6	50.1	50.1
	Emergency Department	36	50.6	8.7	51.1	44.1
BO	Norm	1187	50.0	10.0	49.0	51.0
	Entire Sample	154	50.0	10.0	51.1	51.1
	ICU	43	49.8	10.5	48.7	37.0
	Hematology/Oncology	25	54.2	9.4	53.4	53.4
	Emergency Department	36	50.9	9.6	49.9	44.0
STS	Norm	1187	50.0	10.0	49.0	49.0
	Entire Sample	154	50.0	10.0	49.0	44.6
	ICU	43	49.6	9.4	49.0	44.6
	Hematology/Oncology	25	54.7	10.1	55.7	44.6
	Emergency Department	36	49.7	10.2	50.1	44.6

Hematology/oncology specialists with the standardized norms, χ^2 (2, n = 25) = 1.32, $p < .05$, however isolating the Emergency Department specialists did not lead to significant results.

Self-Care Variables

The mean scores, standard deviations, and ranges for each domain of self-care in the SCAW are listed in Table 6. High scores on a subscale indicate frequent participation in those types of activities, while lower scores indicate an absence of that type of self-care strategy. Maintaining Balance was identified as the most effective strategy for self care (37.2%), followed by physical self-care (20.3%), and emotional self-care (16.9%).The three least effective self-care strategies were reported as Workplace/ professional self care (34.5%), spiritual self-care (30.2%) and psychological self-care (15.1%). (See Table 7 for full results).

Social Support

The percentage break down of Index Scores for support variables can be seen in Table 8. Overall, participants reported relatively high levels of support from their peers. The average total score on the peer support variable was 26.7 of a possible 35 (*SD* = 6.73) with an Overall Social Support Index of 3.83. This means that on most items participants reported that they received support from their peers "some of the time" or "most of the time". In addition, on average 28.7% of participants reported that they felt supported by their peers "all of the time". When it came to supervisor support, participants reported that on average they were beneficiaries of supportive acts once or twice a week, with a mean of 18.25 of a possible 45 (*SD* = 7.63) and an index score of 2.03. However, approximately one third of participants (n = 50) had an index score of 1.0, indicating that on average their superiors did not offer the specified supportive acts at all.

Table 6

Summary of Self-Care Measures/Subscales

	Mean	*SD*	Min. Score	Max. Score	Index score
Physical	53.38	12.45	14	68	.76
Psychological	38.86	9.17	11	51	.71
Emotional	39.53	8.81	10	49	.79
Spiritual	60.09	15.19	16	78	.75
Workplace/Professional	39.52	9.59	11	51	.72
Maintaining Balance	8.60	2.06	2	10	.86

Table 7

Child Life Specialists' Ratings of Most and Least Effective Domains of Self-Care

Strategies Rated Most Effective		Strategies Rated Least Effective	
Domain of Self Care	Percent	Domain of Self Care	Percent
Maintaining Balance	37.2	Workplace/Professional	34.5
Physical	20.3	Spiritual	30.2
Emotional	16.9	Psychological	15.1
Spiritual	16.2	Physical	11.5
Psychological	5.4	Maintaining Balance	4.3
Workplace/Professional	4.1	Emotional	4.3

Table 8

Overall Social Support Index Scores for the Peer-level and Supervisor Social Support

	Availability of Support				
	None of the Time 1	A Little of the Time 2	Some of the Time 3	Most of the Time 4	All of the Time 5
MOS-SSS Index Score [a]	1.3%	10.7%	20.0%	39.3%	28.7%

Note. [a] = The Overall Social Support Index score was calculated by taking average score for all questions and rounding to the nearest whole number using traditional rounding rules.

	Frequency of Support Acts				
	Not At All 1	Once or Twice 2	Once a Week 3	Several Times a Week 4	About Every Day 5
ISSB Index Score [a]	33.3%	40.7%	16.0%	10.0%	---

Note. [a] = The Overall Social Support Index score was calculated by taking average score for all questions and rounding to the nearest whole number using traditional rounding rules.

Correlation Analysis

The results of Pearson Product-Moment Correlations between the CS, BO, and STS variables, population demographics, social support, and self care variables are presented in Table 9. In general, specific markers of the population including age, total time as a CCLS and number of staff members did not significantly correlate with any of the target variables, however negative relationships with borderline significance were found between time in current position and emotional self care (p<.081), maintaining balance (p <.065, and physical self care (p < .091).

The results of the Pearson Product-Moment Correlations between CS, BO, and STS, and the social support variables indicated that there are significant associations between perceptions of social support and risk for emotional exhaustion. Significant correlations exist between Peer Support and all three variables, with peer support being positively related to compassion satisfaction (r = .35,p < .05) and negatively related to burnout (r= -.41, p < .05) and secondary traumatization (r =-.21, p < .05). A similar significant correlation was found between supervisor support and compassion satisfaction (r= .23(p < .05) and burnout (r = -.26, p < .05). Significant positive associations were found between some self-care strategies and total peer support including physical self care (r = .18, p <.05), maintaining balance(r = .17, p <.05), and professional/workplace self care (r = .27, p <.05).

Supervisor Support was positively correlated (p <. 05) with psychological (r = .15, p <.05), spiritual (r = .16, p <.05), and professional/ workplace self care (r = .20, p <.05). The relationships we predicted would exist within the measures of professional life quality (compassion satisfaction, burnout, and secondary traumatic stress) did present themselves.

Table 9

Correlations between Demographics and Main variables

	Age	Staff	TC	TT	CS	BO	STS	Phys	Psy	Em	Sp	WP	MB	PS	SS
Age-Age in Years	1	-.15	.59*	.86*	-.03	.06	-.01	-.03	.00	-.10	-.02	-.02	-.10	-.06	-.13
Staff- Number of Staff Members		1	-.20*	-.16*	.11	-.02	-.00	.00	.04	.04	.00	.05	.04	.15	.11
TC-Time in Current Role			1	.70*	.09	-.06	-.03	-.14	-.12	-.14	-.06	-.13	-.15	-.06	-.10
TT- Total Time as a CCLS				1	.00	.04	-.02	-.02	-.02	-.10	-.00	-.07	-.10	-.07	-.07
CS- Compassion Satisfaction					1	-.59*	-.23*	.20*	.25*	.29*	.24*	.29*	.26*	.35*	.23*
BO-Burnout						1	.60*	-.25*	-.20*	-.30*	-.23*	-.34*	-.35*	-.41*	-.26*
STS-Secondary Traumatization							1	-.26*	-.14	-.23*	-.12	-.27*	-.32*	-.21*	-.01
Phys-Physical Self-Care								1	.89*	.89*	.82*	.82*	.81*	.18*	.12
Psy-Psychological Self-Care									1	.89*	.88*	.83*	.79*	.13	.15*
Em-Emotional Self-Care										1	.85*	.87*	.84*	.13	.12
Sp-Spiritual Self-Care											1	.77*	.75*	.09	.16*
WP- Workplace/Professional Self-Care												1	.81*	.27*	.20*
MB-Maintaining Balance													1	.17*	.11
PS- Peer-level social support														1	.31*
SS- Supervisor-level social support															1

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

Significant positive correlations ($p < .05$) exist between secondary traumatization and burnout with $r = .60$, $p < .05$ and negative correlations between compassion satisfaction with burnout ($r = .59$, $p < .05$), and secondary traumatization ($r = -.23$, $p < .05$). In regards to the relationship between risk for these conditions and the self care variables, compassion satisfaction was positively correlated with all aspects of self-care with $p < .05$ (See Table 9 for r values). In addition, with the exception of a borderline significant between spiritual care and secondary traumatization $r = -.12$, $p < .081$, burnout and secondary traumatization had significant ($p < .05$) negative correlations with each domain of self care (see Table 9 for r values). Increased frequency of behaviors in each area of self-care was statistically correlated with lower risk for both burnout and secondary traumatization.

ANOVA Analyses

To test the relationships between categorical population demographics and Peer Support Supervisor Support, self-care, and professional quality of life (i.e. BO, STS, CS), a series of one-way ANOVAs were conducted. Scores on both compassion satisfaction and burnout differed significantly based on the last time a specialist received satisfaction from seeing a patient recover. A one way ANOVA confirmed the effect of frequent recovery satisfaction on overall compassion satisfaction scores, $F(5,148) = 3.65$, $p = .004$. For example, compassion satisfaction scores were higher for participants who experienced patient recovery daily ($M = 55.07$, $SD = 9.04$) as opposed to those who had not experienced satisfaction in the past six months ($M = 47.23$, $SD = 10.83$). Analyses also confirmed that frequency of satisfaction had an effect on burnout scores, $F(5,148) = 2.29$, $p = .049$. However, in this case, participants with more frequent satisfaction had lower risk for burnout than those with less frequent occurrences. A one way between-groups ANOVA approached significance for the effect of frequency of trauma exposure

to secondary traumatization scores, F (5, 148) = 2.069, p = .072. More frequent exposure to trauma corresponded with higher levels of risk of secondary traumatization based on self-report.

Perceptions of both peer support and administrative support depended on several environmental factors. A one-way between-groups ANOVA between supervisor support scores and unit type, indicated that levels of perceived support from management varied based on location of employment, F(9,139) = 1.930, p = .05. Post-hoc comparisons using the Tukey HSD test indicated that mean scores for the supervisor support score differed significantly between specialists in multiple locations throughout the hospital (M = 22.74, SD = 8.83) and specialists in specialty inpatient units such as burn care or cardiovascular units (M = 14.35, SD = 5.97). Finally, the ability to debrief after the death of a patient had significant impact on social support perceptions and burnout risk. A one-way between-groups ANOVA confirmed the effect of debriefing with child life peers on peer support, F(2, 147) = 7.92, p = .001. Participants who were able to debrief with their colleagues scored significantly higher peer-level social support (M = 28.20, SD = 6.07), than those without that opportunity (M = 23.69, SD = 7.49). Likewise, debriefing with child life peers also had an effect on perceptions of supervisor support; F(2,147) = 4,84, p = .009; participants who were able to debrief following a patient fatality perceived more support from their administrators than those who did not. Debriefing with child life staff also led to lower risk for burnout, F (2, 151) = 4.02, p = .02. Mean scores for burnout were significantly higher for those who did not discuss the event (M = 53.65, SD = 10.82) compared to those who did have that opportunity (M = 48.71, SD = 9.28).

Finally, one-way between-group ANOVAS indicated that debriefing with members of the healthcare team outside of the child life staff also had a significant impact on perceptions of social support. Communication with other staff members post-patient fatality led to higher scores

on social support, $F(2, 147) = 7.43$, $p = .001$. Staff members of who were given the opportunity to debrief after a fatality had a higher peer-level support score (28.35, $SD = 5.36$) as opposed to those without this opportunity (24.06, $SD = 8.02$). In addition, perceptions of administrative support were also higher for individuals with the opportunity to debrief with members of other departments, $F(2, 147) = 4.16$, $p = .018$.

CHAPTER 5: DISCUSSION

Aim One: Documenting the Presence of Compassion Fatigue in Child Life Specialists

Although previous research has explored the emotional toll required of care-giving professionals, few of these efforts have been dedicated to the growing field of child life work. The first aim of the current study was to expand on the existing literature by providing preliminary data on the patterns of risk for compassion fatigue. The existing literature indicates that workers in helping professions who are exposed to traumatized individuals are at increased risk for developing compassion fatigue and burnout (Alkema et al., 2008; Figley, 1995; Thomas & Wilder, 2004). These trends have been well-documented in a variety of fields including medical staff (Burtson & Stichler, 2010); social workers (Fahy, 2007) and chaplains (Taylor et al., 2006). Although research on compassion fatigue has not specifically isolated the CCLS population, the research of Meadors et al. (2009) included CCLSs in a sample of health care workers that presented risk levels for the condition; this trend, along with research confirming the presence of burnout in child life specialists (Holloway & Wallinga, 1990), led us to predict that a stand-alone CCLS sample would exhibit similar patterns of risk.

We initially predicted that our sample of CCLSs would exhibit risk levels for burnout and secondary traumatization on par with other caregiving professionals, but that these risk levels would vary within the population based on a variety of external and internal factors. Research on the working conditions of different helping professionals has suggested that simply classifying individuals into groups based on profession is not enough to account for deviations within the work environment. For example, research on nursing has discovered that location of employment within the hospital can affect risk level for compassion fatigue, particular for those individuals employed in pediatric and intensive care units (Maytum et al., 2004; Meadors & Lamson, 2007).

Furthermore, the results indicated that individuals with more frequent of exposure to trauma are at greater risk for developing compassion fatigue. To this end, we predicted that risk for compassion fatigue would significantly differ in our sample due to exposure to three distinct units within the hospital (i.e. Emergent Care, ICU, Hematology/ Oncology); these differences we predicted would be associated to unique factors associated with those areas (e.g. numbers of trauma, chances for patient recovery). Additionally, we predicted that other characteristics such as length of time employed as a CCLS and department size would be inversely correlated with risk levels.

Data analysis revealed that taken as a whole, the present sample showed similar distribution of risk levels when compared to the overall population of professional caregivers as represented in the Pro-QOL5 (Stamm, 2010). That is, using the normative cut-off scores to determine categorical risk levels (as suggested by the authors based on the results of 200 published research articles on caregiving professionals), 25 % of our population fell into the 'low risk' group, 50% had a moderate risk, and 25% were considered high risk for developing secondary traumatic stress, burnout, and low compassion satisfaction. These findings indicate that the proportion of child life specialists who are risk for developing compassion fatigue is comparable to that of other caregiving professions. Contrary to the research of Holloway and Wallinga (1990) which found child life specialists to be at decreased risk for developing low compassion satisfaction or burnout, our results indicate that the CCLS population is actually comparable to other professions when it comes to developing conditions associated with exposure to trauma.

Based on past precedence in the literature, the current research team was interested in examining how patterns of risk changed when we isolated specific groups of our sample based on demographic characteristics. The researchers recognize that the working conditions of each unit in a hospital may be markedly different, and as the CSDT framework implicates the availability of support and resources in the environment as critical for determining adaptation to stress, we felt it important to use past research as a guide for identifying these differences within our own sample. For instance, past research on compassion fatigue in nurses revealed that higher levels of experience were associated with increased ability for self-care and subsequently, lower risk for compassion fatigue (Burston & Stichler, 2010). Contrary to this research, current data did not reveal any significant associations between risk level and age, size of department, or time working as a CCLS, however, it is possible that the lack of significance is a result of the limited size and nature of our specific sample rather than an absence of a relationship.

Previous research also led us to anticipate that different units within the hospital would require different levels of engagement as each location has a distinct patient care population with its own unique needs and requirements (Maytum et al., 2004). As a result of these differences, we expected to find variations in risk levels based on location of employment. Our preliminary results supported our conjecture that differences in environmental factors exist between specific units. For example, compared to other areas, our three focus locations (the ICU, emergency department, and hematology/oncology) had more frequent occurrences of patient fatalities. Additionally, the specialists in the Emergency Department and Hematology/Oncology each saw a significantly different composite of acute versus chronic patients when compared to other units. As expected, the emergent care situations saw a higher proportion of acute (critical and short-term) patients than specialists without this exposure, while hematology/oncology workers

reported primarily caring for patients with chronic concerns. These preliminary findings support our belief that specific units within the hospital may place individuals at differential risk for compassion fatigue and burnout, however additional research is needed to better understand the ramifications of these differences.

Our analyses indicated that experiencing more frequent satisfaction from a patient's recovery was significantly related to higher compassion satisfactions scores and lower risk for burnout, and that more frequent trauma exposure approached significance with risk for secondary traumatic stress. Moreover, perceptions of social support differed based on units within the hospital. Given that research indicates social support may decrease risk levels for both burnout and compassion fatigue (Seti, 2007), our findings support a preliminary theory that location of employment may present individuals with different protective and risk factors that play a significant role in the development of compassion fatigue. With this knowledge in hand, we then turned to analyzing how distribution of risk levels for low compassion satisfaction, burnout, and secondary traumatization varied based on exposure to three units previously mentioned. The specialists in the sample with exposure to the ICU and Hematology/Oncology populations both had significantly different patterns of risk for secondary traumatic stress when compared the overall sample, however significance did not extend to the Emergent Care specialists; thus our hypotheses were partially supported.

However, as the measure of professional quality of life (Pro-QOL5) is not intended to be a diagnostic tool but rather a screening measure, with suggested cut off points for determining risk level, it is possible that our analyses present an oversimplified picture of these associations, and additional delineations may lie between sub-populations that are not picked up by or analyses. Despite this caveat, the data provide evidence suggesting that comparable to other

helping professions, CCLSs are indeed at risk for experiencing the negative side effects associated with emotional engagement and trauma exposure. Additionally, these findings indicate that risk levels may not be universally consistent across the entire population, but rather may vary based on a number of internal and external characteristics.

Aim Two: Presence of Self-Care Behaviors and Social Support

The present study also purposed to provide preliminary data identifying potential recourses for protecting specialists against the negative effects of compassion fatigue. In particular, using a Constructivist Self-development theoretical framework, we focused attention on the use of self-care practices and social support as strategies for decreasing risk for secondary traumatization as suggested by Figley (1995, 2000) and McCann and Pearlman (1990). Current literature suggests that use of self-care strategies may be significantly effective in negating the effects of secondary traumatization (Alkema, Linton, & Davies, 2008), however efforts to explore these behaviors in child life specialists has been non-existent to this point. Our first goal to this end was to conduct exploratory research on the use of self care practices within the child life population and their perceived efficacy.

The specialists in our population identified the strategies aimed at promoting emotional health, physical health, and maintaining balance between profession and personal life as the most effective from the presented list. Comparing these findings to the results of the Strategy index score (calculated by taking the mean frequency score of each domain) revealed that the specialists' rankings corresponded with the most frequently used practices; the top three domains based on frequency were indeed emotional care, physical care and maintaining balance. These results indicate that CCLS are most frequently engaging in the types of self care they view as effective. Additionally, comparison of relationship strength between self care strategies and risk

for compassion fatigue indicate that scores for STS and BO were most affected by behaviors aimed at maintaining balance. More frequent engagement in behaviors for maintaining balance between work and home life led to decreased risk for secondary traumatic stress and burnout. This trend suggests that these strategies are viewed as most effective because they are indeed the practices most useful in combating emotional fatigue, however, additional research is needed to support this conjecture.

The results of analyses between time in current position and frequency of engaging in the three most effective domains of self-care strategies approached significance. Burston and Stichler (2010) discovered that individuals with longer tenure in a field were more apt to have the skills needed to combat secondary traumatization; in a similar fashion, our results suggest that individuals working for longer periods of time are more likely to engage in what are perceived as the most effective self-care strategies. However, due to the correlational nature of our own analyses, it is impossible to determine a directional cause in this relationship. It may be that individuals who engage in these types of self-care initially are more likely to prevail past the odds and work for longer periods of time without succumbing to empathetic disengagement. However, this trend could potentially represent a likelihood of longer tenures providing individuals with more opportunities to tryout different strategies, and eventually land on those most effective. Taken as a whole, these findings provide preliminary evidence to suggest that different types of self-care practices may in fact be more effective at decreasing risk and that preference for these strategies may vary based on individual characteristics.

In exploring potential resources for combating compassion fatigue, the current study also included the role of social support within the workplace. Prior research suggests that high levels of social support may play an important role in combating the negative effects of secondary

traumatization (Kilfedder et al., 2001; Seti, 2007), however prior to testing this hypothesis, it was necessary to discover if social support was perceived to be significantly present for our sample. Initial analyses confirmed that perceptions of social support from peers was quite high for our sample, and the majority of the participants perceived that peer-level support in the work place was consistent and available on a regular basis. Results also indicated that individuals who were given the opportunity to debrief with peers and supervisors following a bereavement were more likely to report feel high levels of support at work. Support behaviors from supervisors were perceived to occur with moderate frequency; although supervisors may not act in support daily, the behaviors generally occurred once or twice a week. However, a considerable portion of the sample stated that they did not ever feel themselves the recipient of supportive behaviors from their bosses.

Taken as a whole, our results do suggest that a supportive climate pervades the work environment of most participants. One point of note, although these results suggest that support is stronger from peers than supervisors, it is necessary to remember that the two measures are not entirely comparable. The MOS-SSS is used to document general perceptions of social support, and asks participants to judge the overall climate of support within the work environment, while the ISSB asks participants to recount the frequency of specific supportive behaviors. Future studies would benefit from using similar measures to measure both the climate and specific behaviors of support from peers and supervisors.

Aim Three: The Effects of Compassion Satisfaction, Social Support, and Self-Care on Compassion Fatigue Risk

The final goal of the current research was to take a step beyond exploratory and descriptive analyses and provide preliminary data on the associations between the various

resources previously mentioned in an effort to develop a foundation for identifying protective factors, and eventually creating programs aimed at targeting the population. Based on the findings of previous research we predicted that our data would implicate high compassion satisfaction (Figley 1995, 2000), strong social support (Killian, 2008) and effective self-care strategies (Alkema et al., 2008) as protective factors against the negative effects of secondary trauma. Our results did in fact support most of these hypotheses.

Consistent with our predictions, we did find a significant inverse relationship between reports of compassion satisfaction and risk for burnout and secondary traumatization. This means that individuals in our population who have experienced high levels of satisfaction with their job were less likely to suffer the negative side effects of compassion fatigue. These results are quite promising, but given the nature of our research design it is difficult to conclusively state any causal relationships. It is entirely possible that individuals without exposure to high levels of trauma (and thus at high risk for developing compassion fatigue) are also more likely to have a reason to be satisfied in their job, thus exposure to trauma would be the mediating variable between compassion satisfaction and risk. However, previous research on child care workers also found that experiencing high levels of compassion satisfaction did in fact contribute to low risk for compassion fatigue, giving us precedence to believe our findings are the result of similar patterns of interactions (Conrad & Kellar-Guenther, 2006). Taken together, our findings support a preliminary claim that efforts aimed at improving compassion satisfaction may also stymie the development of secondary traumatization and burn out, however additional research is needed to bolster this argument.

In 1996, the research of Munn, Barber, and Fritz revealed that receiving support from supervisors and peers had a protective effect on child life specialists. Specialists in supportive work environments were less likely to suffer from burnout or emotional exhaustion. Given these results, we expected to find that perceptions of social support from peers and supervisors would provide some level of protection from the negative effects of stress and trauma in the workplace for our sample. A Constructivist Self-Development theoretical approach also suggests that professional isolation can contribute to risk for developing vicarious traumatization, leading to a hypothesis that increased social support may then decrease the threat of secondary traumatization (McCann & Pearlman, 1990). Likewise, Systems Theory indicates that the relationships within a system (or work environment) can contribute to the ability to adapt to outside stressors and maintain equilibrium (White and Klein, 2008). Using these two frameworks to inform our research, we predicted perceptions of strong social support from both peers and supervisors would lead to diminished risk for compassion fatigue and burnout, and our findings corresponded with these beliefs.

Within this sample, perceived support from peers within the work place was indeed negatively correlated with risk for the conditions associated with trauma exposure; social support was also positively associated with levels of compassion satisfaction. Individuals who were given the opportunity to debrief after a fatality with their colleagues (a form of instrumental support) had decreased risk for compassion fatigue and burnout. Additionally, participants who felt they received consistent support from their supervisors had higher satisfaction within their job and were less likely to be at risk for developing burnout, although the relationship was not significant between support and secondary traumatization. This anomaly may indicate that administrative support is more beneficial in preventing burnout as this condition is more closely

related to administrative pressures than day to day adaptation to stress. Supervisors may also be less involved with the immediate effects of exposure to trauma. Although supervisors can certainly provide support following a traumatic event, they are less likely to actively be a part of the coping process.

Social support has consistently been cited in the literature as a critical method for promoting emotional health in professional caregivers in both direct and mediating way (Seti, 2007). Our analyses were informed by research indicating that self-reports of compassion satisfaction are in part influenced by the degree of support an individual feels from colleagues and work partners (Conrad & Kellar-Guenther, 2006). Recently, scholars have also recognized that the presence of instrumental, emotional and information support within the workplace is vital for lowering compassion fatigue (Adams et al., 2008). Research on nursing staff has maintained these principles by presenting findings that perceptions of social support (both emotional and instrumental) are predictive of low risk for burnout (Garrosa, Rainho, Morena-Jimenez, & Monteiro, 2010; Kilfedder et al., 2001).

Additionally, social support may decrease risk for secondary traumatization through indirect methods. Participants in our study who reported strong professional social support from peers also engaged in more physical self care, maintaining balance and workplace care acts than those with low levels of support. Likewise, individuals who believed that their direct supervisors provided adequate social support engaged in more frequent professional, psychological and spiritual self-care. At this point in time it is in unclear whether self care acts or social support are simply associated or if one or the other may actually have a causal effect. Perhaps working in a supportive environment means more opportunities for self care or perhaps individuals who are in better emotional health (as a result of engaging in self-care practices) are more likely to get along

with their colleagues. Although additional research is needed to confirm these preliminary conclusions, our research indicates that a significant link exists between professional support and self care practices.

The literature also indicates that discovering means of encouraging self-care may be crucial for developing future programs aimed at combating compassion fatigue in the future (Alkema et al., 2008). Several studies in the literature indicates that intentional self-care enables professionals to positively adapt to a work related stressors and promotes balance in both professional and personal life (Alkema et al., 2008; Keidel, 2000). Additionally, the research of Shapiro, Brown, and Biegel (2007) on the emotional health of new and inexperienced health care providers discovered that teaching self-care practices, such as physical ways of dealing with stress and actively seeking social support, decreased risk for developing compassion fatigue. Current scholars concur that professional caregivers must place effort in developing a holistic self-care plan that incorporates many domains of self care (e.g. physical, cognitive, emotional, spiritual, vocational and social needs) in order to facilitate optimal emotional health (Bush, 2009; Jones, 2005; Showalter, 2010).

Given the emphasis in current literature on the need for self-care in related fields, our study included measures for measuring the effect of self-care on the risk for compassion fatigue within the child life population. The study of Alkema and colleagues (2008) regarding the efficacy of self care practices on decreasing risk for secondary traumatization among hospice professionals led us to predict that risk for burnout and secondary traumatic stress would be negatively correlated with frequency and quantity of self-care activities. In general our hypothesis was supported in that patterns of relationships between the self-care domains and the professional quality of life variables followed our expected trajectories. All types of self-care

were positively correlated with compassion satisfaction, and with the exception of a borderline relationship between spiritual care and secondary traumatization, a significant negative relationship was found between self care and the compassion fatigue subscales (i.e. burnout and secondary traumatic stress). The more frequently individuals engaged in self-care the more likely they were to be satisfied with their job and the less likely they were to be at risk for poor emotional health. These findings suggest that increased emphasis on self-care in a multitude of domains decreases risk for negative reactions to trauma exposure in the workplace. Although support on these relationships is still preliminary, the results are encouraging and may provide a starting point for research in the future.

Limitations

Although the current research has significant implications for future research and policy concerning compassion fatigue, it is not without limitations. Although our sample was certainly within the parameters set for obtaining statistically significant and meaningful findings (Nunally, 1978; Pallant, 2007), the sample size was admittedly limited and may not represent the entire CCLS population. Our participants tended to be categorized as white and female with only a limited number of years experience. Although this trend may be reflective of the actual demographics of child life workers, and not the result of a selection bias, several factors may have influenced this lack of diversity. First, our survey was only available online. Although we can assume the majority of child life workers are required to utilize the internet and computer during their daily work (and are thus technologically competent), the older generation may not be as comfortable with this method of data collection. Additionally, our study specifically used the internet forums associated with the Child Life Council to recruit participants; if the demographic of forum users differs from the general child life population, our recruitment

methods would inherently exclude subsets of specialists who do not regularly use the forums. Future research would benefit from the use of alternate recruitment and data collection strategies that may reach untapped portions of the population (e.g. paper or phone surveys).

Additionally, the results of this study were further complicated by a lack of clarity in the research regarding terminology. As addressed by the work of Meadors and colleagues in 2009, with in the self-care literature, the terms of *vicarious traumatization, secondary traumatization, burnout, compassion fatigue,* etc are often used interchangeably, although they each may have their own unique meanings. Although the research team of the present study attempted to eliminate any discrepancies by selecting measures that fit our own operational definitions, a lack of clarity in terminology amongst scholars may convolute the findings of this study. Future research would be well-served by further efforts to elucidate specific terminology.

Furthermore, the results of this study are also in part limited by the constraints of the measures included in the online survey. For instance, despites its strengths, the Professional Quality of life measure was never intended to be a diagnostic tool, rather an evaluator of risk. Although our results can then be used to make conjectures about the factors that increase or decrease risk for developing the varied conditions, we cannot make any sort of conclusive statements about the actual occurrence of these disorders. Future research may benefit from using more decisive methods to document the actual presence of burnout or compassion fatigue, although this may prove cost-ineffective or time consuming. Moreover, the instrument used to document self-care practices was not designed in a way that provided for easy comparison across domains or allowed for participants to contribute their own methods of self-care. The results of this study may have been better informed with open-ended questions that could provide qualitative data from participants concerning their own philosophy and plans for self-care.

Finally, the results of this study are limited in part by the primarily correlational research design. Given the type of data collected (as a result of the specific instruments used) and the exploratory goals on the study, correlation analyses seemed most appropriate for scouting out preliminary associations between the many variables. However, an inherent limitation in this type of research is the inability to form any casual conclusions about the relationships between factors. Although our research certainly can be used to inform future studies and provide direction to programming aimed at promoting emotional health for professional caregivers, the results do not lend to decisive statements about the nature of these relationships. For example, although the results lead us to a conjecture that social support and self care individually are useful for decreasing risk, more complex analyses examining the way the two factors interact with each other as well as data that can conclusively indicate that their presence proceeds a decrease in risk may be more useful for actually implementing strategies in the workplace. The current research certainly provides a foundation for launching similar research, but given the type of data presented, the results are not conclusive independently.

Recommendations for the Future

The findings of the present study have multiple implications for future research and policy. Initially, it will be important for other scholars to continue documenting the patterns of risk for compassion fatigue within this population and how it varies based on other personal and professional characteristics. Additionally, research is needed to better understand the implications that this condition may have on the quality of care provided by child life specialists. Simply documenting that a threat exists does not merit widespread policy reform; research is needed to indicate that this threat has a significant impact on the way child life work enacted.

For instance, research in nursing indicates that nurses who have higher scores of job satisfaction and compassion satisfaction were rated as having a better quality of care than those with lower scores (Burston & Stichler, 2010). Burnout has been implicated as a precedent to depersonalization of clients and decreased productivity at work for individuals in other caregiving professions (Maslach & Jackson, 1984; Valent, 2002). Burnout also is thought to lead to lowered morale, decreased quality of care for patients, and financial consequences, such as high absenteeism (Jones & Gates, 2007; Portnoy, 2011; Ragsdale, Burns, & Houston, 1991). Similarly, a study on compassion fatigue in nurses indicated that the condition may also cause damage to the provider-patient relationship and increase medical care costs (Fu & Chen, 2011). Finally, research has also indicated that increased burnout is associated with greater intentions to leave employment in child life specialists (Munn, Barber, & Fritz, 1996).

Additional research is needed to asses if compassion fatigue leads to comparable results in the professional experience of child life workers. One negative consequence already has preliminary support in the current research. The majority of the participants in the present study had been working in the field for less than 10 years, potentially indicating high turnover with in the field. The literature on compassion fatigue, particularly in relation to child life specialists, would benefit from empirical evidence confirming that compassion fatigue is related to turnover in this field.

In regards to policy, the present findings also have implications in reform for both academic and practical approaches. Within the literature, there is evidence to suggest that teaching self-care strategies to new and inexperienced professionals may lead to decreased risk for compassion fatigue (Shapiro, Brown, & Biegel, 2007). Given this information, it may be useful for academic programs to include coursework informing upcoming specialists about the

dangers of compassion fatigue and the importance of developing effective self-care strategies. Additionally, the Child Life Council (which over sees certification for practicing CCLSs) may be benefited by including a component of self-care into foundational competencies.

On a departmental level, specific institutions would benefit from developing their own self-care programming that includes both the child life department as well as other members of the health care team. The current research and the CSDT perspective implicate relationships with colleagues outside the field of child life as critical for maintaining emotional health. Furthermore, these programs should not be universally applied to all individuals. The findings reported here indicate that working in particular environments may expose individuals to different types of risk and protective factors. Just as risk for compassion fatigue is not universal across the field neither should be efforts to counteract its negative effects. Perhaps offering more intensive programs to individual in high-risk locations (e.g. Hematology/Oncology, or the ICU) would be beneficial. Additionally, given that each individual will uniquely respond to the stressors in his or her environment based on specific cognitive schemas and experiences, establishing a baseline prior to work as a child life specialist may be useful in monitoring each person's own emotional health.

Conclusions

In spite of these limitations, the current study has significant implications for informing future research and policy regarding the effects of secondary traumatization for both the child life and greater helping profession populations. Mounting empirical evidence continues to implicate to the stress and trauma associated with emotional engagement in high-stress environments as the cause for many of the negative side effects experienced by these professionals (Figley, 1995; Meadors et al., 2009). The present study serves as a launching pad

both for focusing future efforts on understanding the unique experience of child life specialists engaging with pediatric patients, as well as for creating more effective efforts towards decreasing the effects of these conditions across the general population. In response to a lack of child life-focused work in the literature, the present research provides new information regarding the threat of compassion fatigue for this unique population. Using a multi-faceted approach, informed by both the CSDT and Systems Theory frameworks, we have also identified social support from peers and supervisors, job satisfaction and self-care strategies as potential components of a emotional health initiative. Overall, it is imperative that efforts towards understanding the etiology of and protection from burnout and compassion fatigue be continued by future scholars. If we can improve the quality of life for our helping professionals, we can in turn improve the quality of care they can provide.

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APPENDIX A: IRB APPROVAL LETTER

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board Office
1L-09 Brody Medical Sciences Building• 600 Moye Boulevard • Greenville, NC 27834
Office **252-744-2914** • Fax **252-744-2284** • **www.ecu.edu/irb**

Date: December 10, 2010

Principal Investigator: Bethany Fisackerly, Graduate Student
Dept./Ctr./Institute: Child Development and Family Relations, College of Human Ecology
Mailstop or Address: fisackerlyb09@students.ecu.edu

RE: **Exempt Certification**
UMCIRB# **10-0718**
Funding Source: Unfunded

Title: Stressors, Social Support, and Self-care in the Child Life Specialist Population

Dear Ms. Fisackerly:

On 12/10/2010, the University & Medical Center Institutional Review Board (UMCIRB) determined that your research meets ECU requirements and federal exemption criterion #2 which includes research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior on subjects 18 years of age or older, unless:
(a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
(b) 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.

It is your responsibility to ensure that this research is conducted in the manner reported in your Internal Processing Form and Protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

The UMCIRB Office will hold your exemption application for a period of five years from the date of this letter. If you wish to continue this protocol beyond this period, you will need to submit an Exemption Certification Request at least 30 days before the end of the five year period.

Sincerely, KWB

Chairperson, University & Medical Center Institutional Review Board

pc: Natalia Sira, PhD

APPENDIX B: ONLINE INFORMED CONSENT DOCUMENT

Title of Research Study:
Stressors, Social Support, and Self-care in the Child Life Specialist Population

Principal Investigator:
Bethany Fisackerly, BS
Institution:
East Carolina University
Address:
127 Venice Rd Rotunda West, FL 33947
Telephone #:
239-357-2849

INTRODUCTION

You have been asked to participate in a research study being conducted by Bethany Fisackerly, BS and Dr. Natalia Sira, PhD. The research team is interested in better understanding the unique experience of working as a Certified Child Life Specialist. We are interested in documenting the specific stressors CCLS face on a daily basis and identifying the levels of social support available to this population. We are also interested in learning what self care strategies child life specialists find effective in coping with the pressures associated with this field. You were selected to participate in this study due to your current or recent position as a child life specialist.

PLAN AND PROCEDURES

If you agree to participate in this study you will be asked to fill out a short questionnaire that identifies the specific stressors present in your work environment, your reactions to these stressors, perceptions of social support, and the types of coping strategies you use to deal with the strain of your job. This questionnaire will be administered online through a survey software program, Qualtrics. This questionnaire should take between 10-15 minutes to complete. The information that you provide will be transferred into a data base and your name will not be affiliated with your results. All information will be protected to maintain confidentiality. You may request a copy of your consent form for your records by contacting the investigator.

POTENTIAL RISKS AND DISCOMFORTS

There are no potential physical risks to you. You do not have to answer any questions that make you feel uncomfortable. You may experience some distress as you recall specific traumatized patients that you have cared for in the past. If you experience any negative effects (such as feelings of anger, frustration, sadness, etc.) while filling out the questionnaire, we encourage you to discuss these feelings with a therapist or counselor in your area. Information regarding therapy services and additional resources can be provided to all participants by the researchers upon request based on geographic location.

POTENTIAL BENEFITS

By participating in this study you will be contributing to research that could lead to enhancement of work environments and exploring provider care for Child Life Specialists. You will be assisting the researchers in better understanding the types of pressure experienced in this field,

and in identifying potential means of protecting workers from experiencing burnout. You may also receive new ideas for coping strategies you can start using immediately in your daily life.

SUBJECT PRIVACY AND CONFIDENTIALITY OF RECORDS
Any identifying or contact information obtained will only be used by members of the research team for the purpose of inviting you to participate. It will not be shared with anyone other than those conducting the study. Your name will not be connected with this study in any way. You will only be identified by a code number on any answer forms that you complete. You will not be identified by description and/or name in any written report or oral presentation.

COSTS OF PARTICIPATION
There will be no additional costs to you for participating in the study.

COMPENSATION
There will be no compensation to you for participating in the study.

VOLUNTARY PARTICIPATION
Participating in this study is completely voluntary. If you decide not to be in this study after it has already started, you may stop at any time without losing benefits that you should normally receive. You may stop at any time you choose without penalty.

PERSONS TO CONTACT WITH QUESTIONS The investigators will be available to answer any questions concerning this research, now or in the future. You may contact the investigators, Bethany Fisackerly or Natalia Sira at phone numbers 239-357-2849 or 252-328-5544. If you have questions about your rights as a research subject, you may call the Chair of the University and Medical Center Institutional Review Board at phone number 252-744-2914 (days).

CONSENT TO PARTICIPATE
Title of research study: Stressors, Social Support, and Self-care in the Child Life Specialist Population: I have read all of the above information and agree to participate in this study.

- ❍ I agree to participate in this research study
- ❍ I do not agree to participate in this research study

APPENDIX C: SURVEY TOOL

Q2 Please answer the following demographic questions about yourself, your education and your employment.

Q3 What is your gender?

- ❍ Male (1)
- ❍ Female (2)
- ❍ Other (3) _____

Q7 How do you describe your ethnic and/or racial background?

- ❍ African American or Black (1)
- ❍ White (2)
- ❍ American Indian (3)
- ❍ Asian (4)
- ❍ Native Hawaiian or Other Pacific Islander (5)
- ❍ Hispanic or Latino (6)
- ❍ Other (Please Specify) (7) _____

Q9 What is your age?

Age (In years) (1)

Q11 What is your marital status?

- ❍ Single, not living with a partner (1)
- ❍ Single, but living with a partner (2)
- ❍ Engaged (3)
- ❍ Married (4)
- ❍ Separated (5)
- ❍ Divorced (6)
- ❍ Other relationship (please specify) (7) _____

Q12 How many children do you have?

Q43 Are you currently certified as a child life specialist?

- ❍ Yes (1)
- ❍ No (2)

Q13 What is your official title/role in the Child Life Department of your hospital? (Check all that apply)

- ❑ Child Life Specialist (1)
- ❑ Child Life Supervisor/Manager/Director (2)
- ❑ Child Life Aide/Assistant (3)
- ❑ Internship Coordinator (4)
- ❑ Music Therapist (5)
- ❑ Art Therapist (6)
- ❑ Therapeutic Recreation Specialist (7)
- ❑ Other (please specify all other titles) (8) _____

Q40 How many staff members are included in your child life department (include all certified specialists, supervisors, aides, etc)

Q14 What type of unit(s) do you primarily work in at your current job? (e.g. PICU, NICU, Emergency Dept., Outpatient clinic, Radiology, Administration, Hospice, etc)

Q15 How long have you worked in this particular role(s)?

Q16 How long have you worked as a child life specialist in total?

Q19 Please select the degrees and/or certifications you current hold

- ❑ 2-year College Degree (1)
- ❑ 4-year College Degree (2)
- ❑ Master's Degree (3)
- ❑ Doctoral Degree (4)
- ❑ Professional Degree (JD, MD) (5)
- ❑ Professional certification (please specify) (6) _____

Q22 Please answer the following questions about your experience working with pediatric patients. Use the following definition to assist you in your answers: Trauma is defined as a person experiencing an event or events that involved actual or traumatized death or serious injury or threat to the physical integrity of self or others.

Q27 How many hours of direct patient care do you have in a typical work day?

- None (1)
- 1-3 hours (2)
- 4-6 hours (3)
- 7-9 hours (4)
- More than 9 hours (5)

Q28 What is the acuity level of the patients that you directly care for?

- Most of the patients have acute healthcare concerns (1)
- Some of the patients have acute healthcare concerns and some have chronic or terminal healthcare concerns (2)
- Most of the patients have chronic or terminal healthcare concerns (3)
- I do not directly care for patients (4)

Q24 When was the last time you directly cared for a patient who was traumatized?

- Never (1)
- Within the last seven days (2)
- Within the last month (3)
- Within the last 6 months (4)
- Over a year ago (5)

Q26 How many traumatized patients have you cared for within the past month?

- none (1)
- 0-10 (2)
- 10-20 (3)
- 20-30 (4)
- More than 30 (5)

Q41 When was the last time you received satisfaction from a patient's recovery?

- Daily (1)
- Within the last seven days (2)
- within the last month (3)
- With in the last 6 months (4)
- Over a year ago (5)
- Never (6)

Q23 When was the last time you were directly involved with a pediatric or neonatal patient death?

- Never (1)
- Within the last seven days (2)
- Within the last month (3)
- Within the last 6 months (4)
- Over a year ago (5)

Q25 After that death, did you have the opportunity to debrief with your child life peers?

- Yes (1)
- No (2)
- n/a (3)

Q44 After that death, did you have the opportunity to debrief with other members of the interdisciplinary team?

- Yes (1)
- No (2)
- n/a (3)

Q29 When you provide care to people you have direct contact with their lives. As you may have found, your compassion for your patients can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a child life specialist.Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

Q30 In the last 30 days...

	Never (1)	Rarely (2)	A Few Times (3)	Somewhat Often (4)	Often (5)	Very Often (6)
I am happy (1)	❍	❍	❍	❍	❍	❍
I am preoccupied with more than one patient. (2)	❍	❍	❍	❍	❍	❍
I get satisfaction from being able to help my patients. (3)	❍	❍	❍	❍	❍	❍
I feel connected to others (4)	❍	❍	❍	❍	❍	❍
I jump or am startled by unexpected sounds (5)	❍	❍	❍	❍	❍	❍
I feel invigorated after working with my patients (6)	❍	❍	❍	❍	❍	❍
I find it difficult to separate my personal life from my life as a child life specialist (7)	❍	❍	❍	❍	❍	❍
I am not as productive at work because I am losing sleep over traumatic experiences of a patient (8)	❍	❍	❍	❍	❍	❍

I think that I might have been affected by the traumatic stress my patients (9)	❍	❍	❍	❍	❍	❍
I feel trapped by my job as a child life specialist. (10)	❍	❍	❍	❍	❍	❍
Because of my work, I have felt "on edge" about various things. (11)	❍	❍	❍	❍	❍	❍
I like my work as a child life specialist (12)	❍	❍	❍	❍	❍	❍
I feel depressed because of the traumatic experiences of my patients (13)	❍	❍	❍	❍	❍	❍
I feel as though I am experiencing the trauma of someone I have helped. (14)	❍	❍	❍	❍	❍	❍
I have beliefs that sustain me (15)	❍	❍	❍	❍	❍	❍
I am pleased with how I am able to keep up with child life techniques	❍	❍	❍	❍	❍	❍

and protocols. (16)						
I am the person I always wanted to be (17)	❍	❍	❍	❍	❍	❍
My work makes me feel satisfied (18)	❍	❍	❍	❍	❍	❍
I feel worn out because of my work as a child life specialist (19)	❍	❍	❍	❍	❍	❍
I have happy thoughts and feelings about my patients and how I could help them (20)	❍	❍	❍	❍	❍	❍
I feel overwhelmed because my patient load seems endless. (21)	❍	❍	❍	❍	❍	❍
I believe I can make a difference through my work (22)	❍	❍	❍	❍	❍	❍
I avoid certain activities and situations because they remind me of frightening experiences of my	❍	❍	❍	❍	❍	❍

patients (23)						
I am proud of what I can do to help (24)	❍	❍	❍	❍	❍	❍
As a result of my work, I have intrusive, frightening thoughts. (25)	❍	❍	❍	❍	❍	❍
I feel “bogged down” by the system (26)	❍	❍	❍	❍	❍	❍
I have thoughts that I am a “success” as a child life specialist (27)	❍	❍	❍	❍	❍	❍
I can’t recall important parts of my work with trauma victims (28)	❍	❍	❍	❍	❍	❍
I am a very caring person (29)	❍	❍	❍	❍	❍	❍
I am happy that I chose to do this work (30)	❍	❍	❍	❍	❍	❍

Q43 When working in the healthcare environment, people often look to coworkers for companionship, assistance and other types of support. During the last 30 days, how often have you found the following kinds of support from within your team (both interdisciplinary and departmental) when needed?

	None of the time (1)	A little of the time (2)	Some of the time (3)	Most of the time (4)	All of the time (5)
Someone you can count on to listen to you when you need to talk (1)	❍	❍	❍	❍	❍
Someone to give you good advice about a crisis (2)	❍	❍	❍	❍	❍
Someone to give you information to help you understand a situation (3)	❍	❍	❍	❍	❍
Someone to confide in or talk to about yourself or your problems (4)	❍	❍	❍	❍	❍
Someone to turn to for suggestions about how to deal with a personal problem (5)	❍	❍	❍	❍	❍
Someone who understands your problems (6)	❍	❍	❍	❍	❍
Someone whose advice you really want (7)	❍	❍	❍	❍	❍

Q38 Oftentimes the relationship people have with their supervisors can have an impact on their satisfaction in the work environment. Please think about your direct supervisor and rate how often during the last 30 days you feel he or she has offered you support through the following ways:

	Not at all (1)	Once or Twice (2)	Once a week (3)	Several times a week (4)	About every day (5)	N/A (6)
Was right there with you (physically) in a stressful situation (1)	❍	❍	❍	❍	❍	❍
Told you what she/he did in a situation that was similar to yours. (2)	❍	❍	❍	❍	❍	❍
Let you know that you did something well. (3)	❍	❍	❍	❍	❍	❍
Told you that she/he would keep the things that you talk about private-just between the two of you. (4)	❍	❍	❍	❍	❍	❍
Assisted you in setting a goal for yourself. (5)	❍	❍	❍	❍	❍	❍
Made it clear what was expected of you. (6)	❍	❍	❍	❍	❍	❍
Expressed	❍	❍	❍	❍	❍	❍

esteem or respect for a competency or personal quality of yours. (7)						
Helped you understand why you didn't do something well. (8)	❍	❍	❍	❍	❍	❍
Let you know that he/she will always be around if you need assistance (9)	❍	❍	❍	❍	❍	❍
Expressed interest and concern in your well-being. (10)	❍	❍	❍	❍	❍	❍

Q32 Below is a list of strategies many people employ to maintain self-care. Please rate each strategy in terms of how frequently you deliberately use the method as a way of handling the stress that results from your employment as a child life specialist:

Q33 Physical Self-care

	Frequently (1)	Occasionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Eat regularly (e.g. breakfast, lunch and dinner) (1)	❍	❍	❍	❍	❍
Eat healthy (2)	❍	❍	❍	❍	❍
Exercise (3)	❍	❍	❍	❍	❍
Get regular medical care for prevention (4)	❍	❍	❍	❍	❍
Get medical care when needed (5)	❍	❍	❍	❍	❍
Take time off when needed (6)	❍	❍	❍	❍	❍
Get massages (7)	❍	❍	❍	❍	❍
Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun (8)	❍	❍	❍	❍	❍
Take time to be sexual—with yourself, with a partner (9)	❍	❍	❍	❍	❍
Get enough sleep (10)	❍	❍	❍	❍	❍
Wear clothes you like (11)	❍	❍	❍	❍	❍
Take vacations (12)	❍	❍	❍	❍	❍
Take day trips or mini-vacations (13)	❍	❍	❍	❍	❍

Make time away from telephones and internet (14)	❍	❍	❍	❍	❍

Q34 Psychological Self-Care

	Frequently (1)	Occasionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Make time for self-reflection (1)	❍	❍	❍	❍	❍
Have your own personal psychotherapy (2)	❍	❍	❍	❍	❍
Write in a journal (3)	❍	❍	❍	❍	❍
Read literature that is unrelated to work (4)	❍	❍	❍	❍	❍
Do something at which you are not expert or in charge (5)	❍	❍	❍	❍	❍
Decrease stress in your life (6)	❍	❍	❍	❍	❍
Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings (7)	❍	❍	❍	❍	❍
Engage your intelligence in a new area, e.g. go to an art museum, history exhibit,sports event, auction, theater performance (8)	❍	❍	❍	❍	❍

Practice receiving from others (9)	❍	❍	❍	❍	❍
Be curious (10)	❍	❍	❍	❍	❍
Say “no” to extra responsibilities sometimes (11)	❍	❍	❍	❍	❍

Q35 Emotional Self-Care

	Frequently (1)	Occassionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Spend time with others whose company you enjoy (1)	❍	❍	❍	❍	❍
Stay in contact with important people in your life (2)	❍	❍	❍	❍	❍
Give yourself affirmations, praise yourself (3)	❍	❍	❍	❍	❍
Love yourself (4)	❍	❍	❍	❍	❍
Re-read favorite books, re-view favorite movies (5)	❍	❍	❍	❍	❍
Identify comforting activities, objects, people, relationships, places and seek them out (6)	❍	❍	❍	❍	❍
Allow yourself to cry (7)	❍	❍	❍	❍	❍
Find things that make you laugh (8)	❍	❍	❍	❍	❍
Express your outrage in social action, letters and donations, marches,	❍	❍	❍	❍	❍

protests (9)					
Play with children (10)	❍	❍	❍	❍	❍

Q39 Below is a list of strategies many people employ to maintain self-care. Please rate each strategy in terms of how frequently you deliberately use the method as a way of handling the stress that results from your employment as a child life specialist:

Q36 Spiritual Self-Care

	Frequently (1)	Occasionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Make time for reflection (1)	❍	❍	❍	❍	❍
Spend time with nature (2)	❍	❍	❍	❍	❍
Find a spiritual connection or community (3)	❍	❍	❍	❍	❍
Be open to inspiration (4)	❍	❍	❍	❍	❍
Cherish your optimism and hope (5)	❍	❍	❍	❍	❍
Be aware of nonmaterial aspects of life (6)	❍	❍	❍	❍	❍
Try at times not to be in charge or the expert (7)	❍	❍	❍	❍	❍
Be open to not knowing (8)	❍	❍	❍	❍	❍
Identify what is meaningful to you and notice its place in your life (9)	❍	❍	❍	❍	❍
Meditate (10)	❍	❍	❍	❍	❍
Pray (11)	❍	❍	❍	❍	❍
Sing (12)	❍	❍	❍	❍	❍
Spend time with children (13)	❍	❍	❍	❍	❍
Have experiences of awe (14)	❍	❍	❍	❍	❍
Contribute to causes in which you	❍	❍	❍	❍	❍

believe (15) Read inspirational literature (talks, music, etc.) (16)	❍	❍	❍	❍	❍

Q37 Workplace or Professional Self-care

	Frequently (1)	Occasionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Take a break during the workday (e.g. lunch) (1)	❍	❍	❍	❍	❍
Take time to chat with co-workers (2)	❍	❍	❍	❍	❍
Make quiet time to complete tasks (3)	❍	❍	❍	❍	❍
Identify projects or tasks that are exciting and rewarding (4)	❍	❍	❍	❍	❍
Set limits with your clients and colleagues (5)	❍	❍	❍	❍	❍
Balance your caseload so that no one day or part of a day is “too much” (6)	❍	❍	❍	❍	❍
Arrange your work space so it is comfortable and comforting (7)	❍	❍	❍	❍	❍
Get regular supervision or consultation (8)	❍	❍	❍	❍	❍
Negotiate for your needs (benefits, pay raise) (9)	❍	❍	❍	❍	❍

Have a peer support group (10)	❍	❍	❍	❍	❍
Develop a non-trauma area of professional interest (11)	❍	❍	❍	❍	❍

Q38 Maintaining Balance

	Frequently (1)	Occasionally (2)	Rarely (3)	Never (4)	It never occurred to me (5)
Strive for balance within your work-life and workday (1)	❍	❍	❍	❍	❍
Strive for balance among work, family, relationships, play and rest (2)	❍	❍	❍	❍	❍

Q40 Which type of strategy have you found to be most beneficial for promoting your own emotional and psychosocial health?

- ❍ Physical self-care (1)
- ❍ Psychological self-care (2)
- ❍ Emotional self-care (3)
- ❍ Spiritual self-care (4)
- ❍ Workplace or Professional Self-Care (5)
- ❍ Maintaining Balance (6)

Q41 Which type of strategy have you found to be least beneficial for promoting your own emotional and psychosocial health?

- ❍ Physical self-care (1)
- ❍ Psychological self-care (2)
- ❍ Emotional self-care (3)
- ❍ Spiritual self-care (4)
- ❍ Workplace or Professional Self-Care (5)
- ❍ Maintaining Balance (6)