


An examination of compassion fatigue risk in certified child life specialists



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ABSTRACT

Certified child life specialists (CCLSs) provide psychosocial interventions for children and families to manage potentially traumatic experiences in health care settings. Research on related professions indicates engaging in therapeutic relationships in high stress environments may place workers at risk for compassion fatigue. Results of an online survey using the Professional Quality of Life (*ProQOL-5*), completed by 154 CCLSs, showed that compassion fatigue risk in CCLSs was comparable to other helping professions. This risk was lower with peer support to debrief after patient fatality, and higher when working in intensive care and hematology/oncology units. Findings suggest need for compassion fatigue prevention, early identification, and support resources for CCLSs.

Certified child life specialists (CCLSs) empower pediatric patients and their families by enabling them to understand and manage challenging life events, including stressful health care experiences (Child Life Council, 2014). They are skilled in providing developmental, educational, and therapeutic interventions to help children cope with the stresses of medical treatment (Bandstra et al., 2008; Thompson, 2009). Utilizing a comprehensive theoretical foundation of child development, play, family theories, and stress-coping models, the work of CCLSs within the interdisciplinary medical team uniquely and importantly promotes the child's emotional health, growth and development, and effective coping during hospitalization (Thompson, 2009). Interaction with a CCLS during a hospital admission leads to lowered patient anxiety, shorter hospital stays, and higher patient satisfaction (Brooke & Janslewitz, 2012; Magrab & Bronheim, 1976). Child life services are widely recognized by pediatric and accrediting organizations, such as the American Academy of Pediatrics and The Joint Commission, to be vital for providing quality care in a variety of inpatient and outpatient health care settings (American Academy of Pediatrics, 2006; Magrab & Bronheim, 1976).

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The core of each CCLS's interaction includes establishing therapeutic relationships with patients, assisting with coping, and supporting family involvement in their child's care and medical decision making (AAP, 2006). A successful child life intervention requires a psychological and emotional commitment to the patient and/or family members, yet research on caregiving professions indicates this commitment, particularly in relationships that are emotionally charged and/or prolonged, may be detrimental to the psychological wellbeing of the professional (Figley, 1995).

Compassion fatigue in helping professions

Exhibiting vulnerability in a difficult and emotional environment (such as dealing with trauma, disability, or illness) can be wearing over time (Figley, 1995, 2002). These adverse effects have been documented in many disciplines, including social work (Adams, Figley, & Boscarino, 2008), nursing (Kilfedder, Power, & Wells, 2001), and emergency medical service workers (McCammon, Durham, Allison, & Williamson, 1988). While the success of helping professions resides in a worker's ability to be present with patients (expressing authenticity and empathy), engaging in these behaviors for prolonged periods of time may increase risk for development of post-traumatic stress disorder (PTSD)-like symptoms (Conrad & Kellar-Guenther, 2006). These experiences may place individuals at risk for internalizing the negative experiences of their patients, in turn leading professionals to experience the very avoidance and numbing they are helping their clients to overcome (Conrad & Kellar-Guenther, 2006; Truax, 1966).

A condition in which prolonged exposure to stress in the work environment leads to psychological distress was described by Maslach and Jackson (1984) as the concept of *burnout* (BO), which may result in cynicism, emotional exhaustion, inefficacy, self-perception of impaired work capability, and ultimately depersonalization of clients and decreased work productivity (Maslach & Jackson, 1984; Valent, 2002). Moreover, Figley (1995) recognized that within helping professions, there is often a cost to caring above and beyond BO, which he termed as *secondary traumatic stress* (STS), referring to the work-related trauma (primary and secondary) that influences the way a professional engages in his or her workplace. Approximately 7% of professionals working with traumatized individuals exhibit symptoms of PTSD, although they themselves have not personally been traumatized (Meadors, Lamson, Swanson, White, & Sira, 2009; Thomas & Wilder, 2004). Figley (1995) also postulated that the combination of BO with the negative repercussions that come from direct and indirect trauma exposure cause a condition unique to helping professions, known as *compassion fatigue* (CF). This term (CF) is used in the literature when discussing the negative repercussions of professional caregiving, including the stress derived from work related

trauma as well as the anger, depression, and frustration that may result from BO (Figley, 1995; Meadors et al., 2009).

Several factors play a protective role in promoting the emotional wellbeing of caregiving professionals. Among those factors is *compassion satisfaction*, defined 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). Individuals who experience satisfaction in their positions typically have a decreased risk for CF (Figley, 1995). Protection against CF is also linked with higher levels of experience, developed sense of professional knowledge and skills, and job satisfaction (Burtson & Stichler, 2010). Social support within the work place, such as the ability to debrief after a patient fatality, is also critical in maintaining the emotional wellbeing of health care staff (Keene, Hutton, Hall, & Rushton, 2010; Kilfedder et al., 2001; Shuck, Shuck, & Reio, 2013).

Compassion fatigue research in child life

In their caregiving role, CCLSs face daily stresses/challenges which are routinely present in pediatric health care settings (Brinson, 2012; Holloway & Wallinga, 1990). However, research is very limited regarding CF in CCLSs. While a significant prevalence of BO among CCLSs was documented in an earlier study by Holloway and Wallinga (1990), that research did not examine CF risk. Later investigation uncovered that environmental stressors play a role in determining satisfaction with one's employment, and low job satisfaction was predictive of both high BO risk and high intention to leave one's position (Munn, Berber, & Fritz, 1996). Recent research regarding the relationship of emotional labor and task performance among CCLSs revealed that supportive environment and perceptions of success in the workplace directly impacted performance levels (Shuck et al., 2013).

Only two studies have included CCLSs in their samples to investigate CF risk. While Meadors and colleagues (2009) examined secondary trauma among health care professionals (e.g. chaplains, nurses, physicians), including child life workers, these CCLSs were not the focus of the study. Brinson (2012) examined the risks of CF in the CCLS population, and reported that about 75% of specialists were at risk for CF, and also identified that effective supervision has a potential role in mitigating these effects in CCLSs. Thus, the present study adds to the literature regarding CF risk in child life professionals and how it compares to other caregiving professions.

Role of external factors in compassion fatigue risk

Research indicates that risk for CF is impacted by the specific stressors associated with the particular medical specialty units within a hospital

(Burtson & Stichler, 2010; Maytum, Heiman, & Garwick, 2004). For example, pediatric nurses are at greater risk for developing CF when working primarily with patients with chronic conditions than with patients requiring acute care (Maytum et al., 2004). Similarly, individuals working in intensive care units (Crider & Pate, 2011; Meadors & Lamson, 2008), hematology/oncology units (Palmer, Kagee, Coyne, & DeMichele, 2004), and with exposure to high a frequency of trauma (Cunningham, 2003) are at increased risk for direct and indirect trauma exposure and its subsequent consequences. Brinson (2012) reported that individuals in one person child life departments are at increased risk for CF and BO, suggesting a lack of perceived social support in the workplace (Brinson, 2012). Given the fact that external factors (individual and environmental) play a role in determining risk for CF among helping professions, the current research explores if CCLSs differ in risk for CF based on location of employment (i.e. medical specialty units) within the hospital.

Current study

Using the systems theory approach, which recognizes that individuals are part of a greater system of interrelated factors and people (Bowen, 1966; White & Klein, 2008), the present study acknowledges that the interactions of the CCLS with his/her patients, coworkers, and supervisors will influence the dynamic of the work environment and quality of life for that worker, and vice versa. This theory also suggests that external factors can impact the way an individual responds to the stressors in his/her environment; thus the type of medical specialty unit assignment can be considered an additional risk factor in CF development.

The literature documents risk for this condition in other health care professions and suggests that environmental factors (such as exposure to trauma and department size) as well as personal factors (age and experience) affect an individual's risk level (Burtson & Stichler, 2010; Cunningham, 2003; Figley, 2002).

While the current research was guided by the hypotheses that the distribution of risk for CF within the CCLS population will be similar to risk distribution found in previously studied health care professions, assuming the interaction similarities between helping professions and child life practice, the research team did not expect to find any significant differences. However, due to exploratory nature of the study, the following research questions were investigated:

- (1) What is the distribution of risk for CF within the CCLS population in comparison to risk distribution found in previously studied health care professions?
- (2) Is there a relation between environmental factors (e.g., size of department, patient acuity, opportunities to debrief after a fatality) and CF risk among CCLSs?

- (3) Is there a difference in distribution of compassion fatigue risk in CCLSs based on environmental differences between different medical specialty units (e.g. emergency room, ICU, hematology/oncology)?

Methods

Data collection

This study was approved by the institutional review board of the authors' institution. After receiving permission from the Child Life Council to recruit CCLS participants via their organization's online forum, data were collected from 154 CCLSs using Qualtrics software. Students or other forum users who were not certified child life professionals were excluded. Although there are approximately 5,000 members of the CLC, this number includes a sizeable number of non-certified members, including students, retirees, associates or interdisciplinary professionals, and vendors. As such, it would be unfeasible to accurately quantify the number of non-responders in this investigation. A 4-stage data collection process (advanced introductory electronic notification regarding study, the invitation to participate with the survey link, and 2 reminder notifications) was undertaken to increase participant response. Informed consent was obtained online prior to accessing the link of the survey. The survey took on average 15–20 minutes to complete. Participation in the study was voluntary and no identifiable information was collected.

Sample and measures

Demographic

In addition to demographic information (gender, age, education, ethnicity), participants reported on years of experience in the field, size of department, and medical specialty unit. They also reported on risk factors for CF in their workplace including: level of patient acuity, number of patients who have been traumatized and seen in the past month, time since the last interaction with such a patient, and time since last experience with a patient who had died. The survey also included questions on opportunities to debrief after a patient fatality, as well as a question about the last time the specialist experienced satisfaction from a seeing a patient recover.

Professional Quality of Life

The ProQOL-5 (Stamm, 2010) was used to measure professional quality of life. This is a 30-item standardized tool which assesses the positive and negative effects of working in the high stress environment of helping professions. The instrument includes three subscales: two subscales of

compassion fatigue: burnout (BO) and secondary traumatization stress (STS) and the compassion satisfaction subscale (CS). It is important to note that the Pro-QOL-5 does not measure the prevalence of these conditions but rather the risk an individual faces for developing them in the future.

All measured variables (BO, STS, and CS,) are created by taking the sum of each subscale and converting the raw score into a *t*-score using the 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, Stamm (2010) suggested using percentile cut-off scores to determine risk levels. Thus, 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" for these conditions.

CF is measured by two subscales with 10 items each (Stamm, 2010). BO, the first component of compassion fatigue, refers to feelings of anger, depression, or hopelessness in dealing with difficulties in the workplace. Participants were asked to rate their attitudes using a 1 (never) to 5 (very often) on Likert-type scale in response to 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 normative cut-off percentile scores described above, low risk for BO is identified by a cut off score of 43, medium risk is identified within the range of 44 and 55, and high risk levels are assigned to participants with scores at, or above, 56 (Stamm, 2010). Higher scores on this subscale correspond to increased risk and effects of burnout. The reliability score for the BO subscale reported as $\alpha = 0.75$ (Stamm, 2010); within the present study, reliability was $\alpha = 0.70$, which is acceptable for psychological research (Nunally, 1978; Pallant, 2007).

STS (Stamm, 2010) was measured using the second component of compassion fatigue, with a 10-item subscale, which documents the negative effects of exposure to direct and indirect trauma within the workplace by recording the occurrence of behaviors that could indicate risk for this condition. Participants reported incidences of sleep difficulties, intrusive images, or other symptoms consistent with PTSD on a Likert-type scale ranging from 1 (never) to 5 (very often). Using the manual (Stamm, 2010), low risk for STS is identified as a score at or below 42, medium risk is in the range of 43 and 55, and with a high risk is cut off of 56. Higher scores on this subscale are indicative of higher risk for experiencing secondary traumatic stress. Reliability for the STS scale is reported as $\alpha > 0.81$ (Stamm, 2010). In the present sample, this scale had reliability of $\alpha = 0.76$ (Nunally, 1978; Pallant, 2007).

CS was measured using the compassion satisfaction subscale (Stamm, 2010) which is a 10-item subscale that identifies positive feeling regarding one's ability within the job and the perception/ability of that job to make a difference in greater society. Participants rated their perception on a Likert-type scale from 1 (never) to 5 (very often). Examples of items include: "I feel invigorated after working with my patients" and "I believe I can make a difference through my work". 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 above a score of 57, with medium compassion satisfaction identified as scores 45–56 (Stamm, 2010). Higher scores correspond to greater compassion satisfaction within one's profession. This subscale reported reliability was $\alpha = 0.88$ (Stamm, 2010); the reliability for the present study was $\alpha = 0.89$.

Data analyses

The data were imported from Qualtrics software, modified and coded based on medical specialty unit of the respondents. When participants indicated they worked in different areas throughout the day, their results were coded as multiple workplaces. Researchers identified three medical units as being uniquely different in working experience: emergency departments, intensive care unit (ICU)/neonatal intensive care unit (NICU), and hematology/oncology units (Cunningham, 2003; Maytum et al., 2004; Palmer et al., 2004). Participants were coded as having exposure to each of these units if they reported having coverage responsibilities on these units at some point during their work week. Descriptive statistics frequencies and percentages were analyzed using SPSS 18.0 statistical software. Analyses of the mean differences between groups and in special unit location were assessed by one-way analysis of variance (one-way ANOVA). Tukey post hoc analysis was performed to determine statistical significance between groups. Chi-square analysis was used to determine whether the distribution of risk for burnout, secondary traumatic stress, and compassion satisfaction is statistically different from similar helping professions. Correlation analysis was performed to evaluate the association between measured variables. For all analyses $p < 0.05$ was used as statistically significant difference between groups.

Results

Participants' Characteristics

Participants' Characteristics included 154 CCLSs. The sample was primarily female ($n = 151, 98.0\%$), and White ($n = 144, 93.5\%$), with the remainder of

participants identifying as Hispanic/Latino ($n = 6$, 3.9%), Asian ($n = 2$, 1.3%), or Black ($n = 2$, 1.3%). The participants ranged in age from 23 to 57 years ($M = 32.35$, $SD = 8.42$), with a median age of 29 years. The average time spent in the current position was 3.86 years ($SD = 4.69$); the total time spent working as a child life specialist averaged 7.35 years ($SD = 6.96$). Participants worked in a midsized child life department ($M = 18.68$, $SD = 22.9$). See [Table 1](#) reporting employment of CCLSs in different medical specialty units.

Over half of the participants ($n = 84$, 54.5%) reported being exposed to a patient who had been traumatized within the past 7 days, while another 44 (28.6%) reported exposure within the past month, 12 (7.8%) within the past 6 months, and 11 (7.1%) within the past year. Only 2 (1.4%) respondents had never dealt with trauma in the workplace. Eighteen participants (12.0%) stated they had dealt with the death of a patient in the past 7 days, 37 (24.0%) in the past month, 40 (31.8%) in the past 6 months, and 43 (27.9%) in the past year. Seven (4.5%) participants reported that they had never dealt with the death of a patient.

Among the participants who had experienced a patient fatality during their careers, almost two thirds ($n = 99$, 64.2%) had been given the opportunity to debrief with child life peers after the fact. In response to the question “When was the last time you received satisfaction from a patient’s recovery?”, 34 (22.0%) participants reported receiving daily satisfaction from seeing patient recovery, 56 (36.4%) reported satisfaction in the past 7 days, 44 (28.6%) in the past month, and 16 (10.4%) specialists reported their last experience of satisfaction due to a patient’s recovery was in the past 6 months. Three (1.9%) specialists reported not experiencing this satisfaction in the past year, and only one participant reported never having had that particular experience.

Participants were also coded based on whether they reported providing coverage to locations having distinct working environments as identified in the literature. 43 (28.0%) reported having at least some daily contact with patients in an ICU setting (pediatric or neonatal), 36 (23%) reported

Table 1. Child life specialists in specific medical specialties.

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 (e.g., neurology, cardiology)	18	11.8
ICU/NICU	17	11.1
Other (not specified)	10	6.5
Radiology	8	5.2
Indirect	4	2.6

*One respondent did not complete the question based on ($N = 153$).

involvement with an emergency department, and 25 (16.0%) spent some time every day with children on the hematology/oncology unit.

Statistical analyses

Risk for compassion fatigue, burnout, and secondary traumatic stress in CCLS

The first aim of the current study was to examine how risk for compassion fatigue in the CCLS population compared to the normative percentile cut off scores calculated by the author of the Pro-QOL-5 (Stamm, 2010). Chi-square test indicated that there were no significant differences between the distribution of risk in the normative population reported in the manual and the current sample for STS ($\chi^2 [2, n = 154] = 2.94, p > 0.05$) for BO ($\chi^2 [2, n = 154] = 0.221, p > 0.05$). Additionally, there was no significant difference between the sample and normative population for the third component of the Pro-QOL-5, CS ($\chi^2 [2, n = 154] = 0.49, p > 0.05$). Thus, CCLS professionals revealed similar risk distributions to that of the normative population documented in the Pro-QOL-5 (Stamm, 2010).

Compassion fatigue variables and individual and environmental factors

A series of one-way ANOVAs were used to test the relationships between categorical workplace factors and professional quality of life (i.e. BO, STS, CS) and no significant findings were reported. Mean scores on both CS and BO differed significantly based on the last time a specialist received satisfaction from seeing a patient recover: One way ANOVA confirmed the effect of frequent recovery satisfaction on overall CS scores, $F(5,148) = 3.65, p < .01$. Thus, CS 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 6 months ($M = 47.23, SD = 10.83$). Frequency of perceived satisfaction also had an effect on BO scores, $F(5,148) = 2.29, p < 0.05$, as participants with more frequent job satisfaction had lower BO scores than those with less frequent satisfaction.

Debriefing with child life staff also related to lower risk for BO, $t(151) = 4.02, p < .05$. Mean scores for BO were significantly higher for those who did not discuss previous traumatic events ($M = 53.65, SD = 10.82$) compared to those who did have that opportunity ($M = 48.71, SD = 9.28$).

Compassion fatigue risk based on medical specialty unit

Chi-square tests were run between work environment variables and the three specified units previously highlighted based on stressors (ICU/NICU, emergency department and hematology/oncology). These analyses indicated a significant association between working in an ICU and exposure to a patient fatality, $\chi^2(4, n = 151) = 12.56, p < 0.05, \phi = 0.29$. Thus, participants

working in the ICU reported greater exposure to patient deaths. Whereas only 34 (30.9%) child life specialists not working in an ICU had experienced a death in the past month and 38 (34.5%) non-ICU workers had not experienced a patient fatality in the past year, each CCLS working in the ICU had experienced fatality at some point, with 25 (58.9%) specialists reported experiencing the death of a child within the past month.

Likewise, Chi-square tests indicated differences in acuity of patients and exposure to fatalities for specialists working with the emergency care and patients in the hematology/oncology units. A significant relationship existed between working in an emergency department and the severity of patients' illness or injuries, $\chi^2(3, n = 151) = 19.64, p < 0.05, \phi = 0.36$ (see Table 2). CCLSs working in the emergency department dealt primarily with children with acute concerns or a combination of children with acute and chronic conditions. In contrast, not a single specialist working on a hematology/oncology unit reported engaging solely with patients with acute care needs; every patient had some type of underlying prolong chronic issue (see Table 3). A Chi Square test demonstrated a significant association between working with patients on the hematology/oncology units and patient acuity, $\chi^2(4, n = 151) = 20.08, p < 0.05, \phi = 0.37$, which indicates that working in an emergency department or with children on the hematology/oncology units increased the likelihood that a CCLS was exposed to a patient fatality. While less than a third of specialists working outside the emergent care environment had experienced a patient death in the past month, half of emergency care CCLSs reported a death in the past 30 days. This difference was significant, $\chi^2(4, n = 151) = 11.93, p < 0.05, \phi = 0.28$. Additionally, only two of those working in an emergency setting had gone a year without witnessing a fatality, as opposed to a third ($n = 45$) of those working in other units. Likewise, working in a hematology/oncology setting was

Table 2. Differences in patient acuity based on emergency care coverage.

Acuity of patients	Child Life Specialists with emergency room coverage		Child Life Specialists without emergency room coverage	
	<i>n</i>	%	<i>n</i>	%
Primarily Acute	11	30.6	13	11.1
Both Acute and Chronic	24	66.7	60	50.4
Primarily Chronic	1	2.8	42	35.9
No Direct Patient Care	–	–	3	2.6

Table 3. Differences in patient acuity based on hematology/oncology coverage.

Acuity of patients	Child Life Specialists with hematology/oncology coverage		Child Life Specialists without hematology/oncology coverage	
	<i>n</i>	%	<i>n</i>	%
Primarily Acute	–	–	24	18.8
Both Acute and Chronic	9	36.0	75	57.8
Primarily Chronic	16	64.0	27	21.2
No Direct Patient Care	–	–	3	2.3

significantly associated with higher frequency of patient deaths, $\chi^2(4, n = 151) = 14.82, p < 0.05, \phi = 0.31$. Seventeen (68%) of CCLSs working in hematology/oncology units had dealt with the death of a patient in the past month in contrast to the 29.7% ($n = 38$) of other workers.

While the risk distribution for the entire sample for all three Pro-QOL-5 conditions (BO, STS, CS) showed no difference to the aggregate norm data presented in the instrument's manual, when specialists with ICU experience were isolated from the rest of the sample, a chi-square test indicated a difference in population distribution into risk level groups for STS when compared to the rest of the sample, $\chi^2(2, n = 43) = 0.63, p < 0.05$. A similar result was found for STS risk level when compared to CCLS working in hematology/oncology units with the standardized norms, $\chi^2(2, n = 25) = 1.32, p < 0.05$.

Discussion

Professional caregiving may extract a significant toll on workers' emotional and psychological wellbeing and child life workers are not immune to this phenomenon. However, only few studies have examined working environments of CCLSs, including possible risk for experiencing secondary fatigue. Being able to recognize precursors of BO and secondary traumatization (e.g., decreased productivity, depersonalization of clients, PTSD symptoms), and fully understanding and documenting these risk factors is vital to the psychological health of those in this field (Shuck et al., 2013; Valent, 2002); it may also have an impact on job retention and turnover of child life workers. While investigating the patterns of distribution for CF risk within the CCLS population, findings revealed that taken as a whole, the present sample showed similar distribution in risk levels as did the overall population of professional caregivers represented in the Pro-QOL-5 (Stamm, 2010), confirming that CF has a presence within child life practice similar to other helping professions highlighted in the literature.

The second aim of the study examined how risk for CF might differ for individuals based on characteristics of their workplace. Previous studies recognized that both peer and supervisory level social support within the workplace may provide resiliency for CF (Munn et al., 1996; Seti, 2008). The results of the current study revealed that the ability to debrief with peers after a patient fatality was significantly related to reducing risk for developing BO. Participants who had the opportunity to debrief with colleagues after an emotionally traumatic experience were less in danger of developing the condition than those without such an opportunity. These findings coincide with studies on comparable disciplines (Kilfedder et al., 2001; Seti, 2008), indicating that interprofessional and peer-level social support within the workplace provide protection to an individual against the hazards of CF.

Significant associations between CF and patient interactions, including the satisfactory experience of watching a patient recover and the negative exposure of working with a traumatized individual, have been previously well documented (Burtson & Stichler, 2010; Conrad & Kellar-Guenther, 2006). Based on the finding of this study, the experiences of the work place/environment play a significant role in determining risk for emotional exhaustion; however, more research is needed to explore how the variations in these experiences (e.g., exposure to traumatized patients, seeing patients recover and leave) between different medical specialty units affect risk for CF.

Research on the working conditions of different helping professionals has suggested that analyzing individuals' risk based on the profession alone may not be sufficient to account for the differences between medical specialty units (Maytum et al., 2004; Meadors & Lamson, 2008). Variables related to individuals' coping factors (temperament, age, gender, experience, peer support, other) may also play a role in risk for secondary traumatization. The findings of the study did not reveal risk levels to be significantly associated with age or time working as a CCLS. Even as these results are contradicting to previous findings, which documented a positive correlation between coping ability with both age and experience with a position (Adams et al., 2008; Burtson & Stichler, 2010), it is important to note the lack of significance may be the result of the limited sample size, the relatively smaller mean (7.35 years) in longevity of employment, and with average time in current position (3.86 years) rather than an indication that those relations are nonexistent.

While discussing three distinct unit environments—the ICU (both pediatric and neonatal), emergency department, and hematology/oncology—specialists in all three areas reported working with fatalities in patients more frequently than the rest of the sample. The CCLSs in the emergency department and hematology/oncology units each saw a significantly different composite of patients with acute versus chronic needs when compared to patients in other units. Specialists in emergent care deal with a higher proportion of patients with acute (critical and short-term) needs than specialists without this exposure, while CCLSs in hematology/oncology units reported primarily caring for patients with chronic concerns. Based on study findings, CCLSs who provided services in the ICU or hematology/oncology environments reported to have higher number of child life specialists falling in the medium and high risk categories for STS when compared to the normative population. At the same time, CCLSs in the emergency department showed no such difference. A possible explanation is the first two environments (i.e., ICU and hematology/oncology) both involve interactions with patients who require extensive emotional involvement over a long period of time, resulting in opportunities for developing personal relationships that can lead to an emotional burden linked to BO and STS (Michelson et al., 2011; Najjar, Davis,

Beck-Coon, & Carney Doebbeling, 2009). Emergency room child life specialists, in contrast, work with a high number of patients, with a fairly quick turnover (Saladino, 2005). Although the patients in the emergency department often require extensive interactions for a brief period of time, some interactions with positive prognosis of medical condition and outcome may protect the caregiver from forming emotional attachments with their patients, resulting in lesser risk for compassion fatigue. While these findings provide initial insight towards understanding the dynamics of compassion fatigue development in CCLSs, additional research is needed.

Limitations

Although the current research has significant implications for future research and policy concerning CF, it is not without limitations. The sample size was admittedly limited and may not represent the entire CCLS population. The current sample was fairly homogenous (predominantly White females), which displays the current gender and ethnic trends within the child life profession. However, several factors may be responsible for this lack of diversity, including the online data collection method used. While the majority of CCLSs are required to utilize the Internet and computer during their daily work, online recruitment method would inherently exclude subsets of specialists who do not regularly use online communication and the forums. Future research would benefit from the use of alternate recruitment and data collection strategies (e.g., paper surveys), which may reach untapped portions of the population.

The results of this study are also in part limited by the constraints of the survey measures. Despite its strengths, the Professional Quality of Life measure is an evaluation of possible risk, with suggested cut off points for determining threat level. While it is possible to make conjectures about the factors that increase or decrease risk for developing CF, BO, and STS, one cannot make any sort of conclusive statements about the actual occurrence of these disorders. Additionally, the scale does not include a single CF variable, instead requiring researchers to distinguish between the two variables, and does not take into account individuals' own temperament, coping style, training, and resiliency levels. Further research using diagnostic and more decisive methods to document the actual prevalence of CF among CCLSs is indicated.

Implications for practice

In spite of limitations, the current study has significant implications for informing child life professionals, hospital administrators, and policies regarding CF. The first line of defense for any condition is knowledge

and prevention, thus the earlier individuals take action, the better. As the CLC (which oversees certification for practicing CCLs) continues to update coursework requirements of incoming specialists, it benefits the future of the profession to require that academic programs include content on the possible psychological consequences for working in this field. Including a component of self-care into the foundational competencies should be suggested and required for the certification exam. While effective self-care is linked to lower risk for CF in the field of nursing (Burtson & Stichler, 2010), one can also hope that focusing on these preventative measures may also increase job retention, field longevity, and productivity among CCLs.

Implementation of policies and procedures to assist employees who are at risk for, or may have developed, CF may be beneficial. Working in particular units (ICU, hematology/oncology, and emergency department) exposes individuals to different levels of risk; individuals who work in departments with chronic populations and a high number of fatalities are at increased risk. Creating a rotating schedule that allows specialists to alternate coverage between high and low risk units should be discussed by administrators. Those specific departments may also benefit from developing assistance programs that target the specific needs of employees on each unit, perhaps offering more intensive education programs to individuals in high-risk locations (e.g. hematology/oncology, or the ICU). High levels of peer or inter-professional support within the workplace can counteract the emotional toll taken on workers (Adams et al., 2008). Debriefing after a patient fatality has also been shown as effective for helping professionals to manage their grief (Keene et al., 2010). Implementing workplace support programs that provide emotional assistance to CCLs directly involved in care of patients with high intensity needs, regardless of outcome, may be beneficial to improving the general dynamic of a child life department.

High perception of receiving social support from supervisors is related to lesser impact from the stressors associated with professional caregiving (Brinson, 2012; Munn et al., 1996). Thus, instituting clinical supervision models, for both accountability and support, is another option, particularly in cases of younger, less-experienced workers. It also may be beneficial for all helping professions, including child life, to incorporate education on CF risk to students and child life interns in the beginning of their careers.

The findings of this study indicate a significant need for further research on understanding the unique experience of child life specialists engaging with pediatric patients. Given the serious implications CF has on the emotional wellbeing of its victims, it also imperative that policies aimed at effectively preventing and alleviating the symptoms be developed. In response to a lack of child life-focused research in the healthcare field, the present study provides new insight regarding the threat of CF for this unique population

within the health care team. By improving the quality of life for helping professionals, one can improve the quality of care they provide to children and families.

Conflicts of interest

There are no competing interests. None of the authors have financial disclosures or conflicts of interest to report.

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