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A Thematic Approach to Understanding Compassion Fatigue, Burnout, and Barriers to Self-Care in Pediatric Healthcare Providers of Medically-Ill Children

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A Thematic Approach to Understanding Compassion Fatigue,

Burnout, and Barriers to Self-Care in Pediatric Healthcare

Providers of Medically-Ill Children

A Clinical Dissertation Presented to

The University of San Francisco

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In Partial Fulfillment of the Requirements for the

Degree of Doctor of Psychology

By

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PsyD Program Signature Page

This dissertation, written under the direction of the candidate's dissertation committee and approved by members of the committee, has been presented to and accepted by the faculty of the PsyD Program in Clinical Psychology in partial fulfillment of the requirements for the degree of Doctor of Psychology. The content and research methodologies presented in this work represent the work of the candidate alone.

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Table of Contents

Abstract

Due to the nature of their work, healthcare providers working in pediatric settings may be especially vulnerable to experiencing negative consequences of compassion fatigue and burnout. Pediatric healthcare providers often work long hours in the hospital to manage children with acute and chronic medical concerns. Within this setting, unpredictable outcomes and potential for death when caring for this fragile population may contribute to short-and long-term effects on not only caregivers but also healthcare providers. Healthcare providers typically work on an interdisciplinary team within the pediatric hospital setting which can include medical doctors, nurses, social workers, psychologists, psychiatrists, and child life specialists. Providers come from a variety of academic and training backgrounds which may have different approaches with regard to managing challenges that arise in response to providing care for such a medically fragile population.

The present study sought to examine healthcare providers' experiences of compassion fatigue and burnout as factors related to working in pediatric settings. Additionally, this study sought to understand health care providers' self-care practices as well as the barriers they encounter in attending to their mental health. Interviews with nine healthcare providers yielded six emerging themes. The themes included: (1) attitudes and awareness, (2) barriers to self-care, (3) impact on work/personal life, (4) coping strategies, (5) lack of systemic measures and resources, and (6) promotion of self-care in the workplace. The emerging themes expressed by the participants provide insight into their perceptions and experiences of compassion fatigue and burnout. Findings have clinical implications with regard to enhancing support of pediatric healthcare providers and provide justification for increased research with this population.

A Thematic Approach to Understanding

Compassion Fatigue, Burnout, and Barriers to Self-Care in

Pediatric Healthcare Providers of Medically-Ill Children

"There is a cost to caring. Professionals who listen to clients' stories of fear, pain and suffering may feel similar fear, pain and suffering because they care" (Figley, 1995, p. 1). *Compassion fatigue (CF)* and *burnout* (BO) are widely used terms in healthcare, and a significant number of studies have surfaced over the past decade indicating that these issues affect health care providers across various disciplines. Although many studies exist on these topics (Austin et al., 2009; Meyer et al. 2016; Robins et al., 2009), few explore the various ways in which pediatric providers working with medically-ill children experience CF and BO and how these concerns may manifest across disciplines.

Quantitative research has provided a relatively robust foundation for understanding the prevalence and risk factors for CF and BO among healthcare providers in a variety of settings and who work with a number of different populations (Branch & Klinkenberg, 2002; Maytum et al., 2010). Existing studies identify the need for greater staff and provider awareness and education surrounding these concepts (Meadors & Lamson, 2008; Figley, 2002; Austin et al., 2009), as this information may help reduce CF and BO and their associated consequences. There also remains a need for understanding risk factors of developing CF and BO among providers who work in interdisciplinary settings, and in particular, with medically-ill children. Pediatric healthcare providers working with medically-ill children are frequently exposed to treating challenging, complex diagnoses and may even face the loss of patients during their career. Due to the nature of the work, the compassion needed to serve this population, and the toll it takes on the individual, additional qualitative research is necessary to seek to understand the experiences,

impact and potential barriers to self-care that may arise for pediatric healthcare providers. The current study utilized a qualitative approach to build upon data from existing studies by examining various healthcare providers' awareness of, experiences with, and coping strategies in response to CF and BO occurring in their work with medically-ill children. The current study also sought to identify potential barriers for self-care across disciplines and understand reasons for variation. Lastly, this research has attempted to identify useful strategies that providers use or recommend to promote awareness and prevention/treatment of CF and BO within various disciplines that are responsible for the care and treatment of medically-ill children.

Literature Review

This purpose of this literature review is to understand the concepts, impact, and barriers to intervention surrounding Compassion Fatigue (CF) and Burnout (BO), specifically within pediatric healthcare providers. First, this review will define CF and BO as they were conceptualized in this study and contrast these terms to other related constructs which are sometimes used interchangeably with CF and/or BO. I will also discuss the role that CF and BO play in the experiences of pediatric healthcare providers and highlight gaps in the literature surrounding interdisciplinary healthcare teams working with medically-ill children.

Definition of Terms

The literature that describes phenomena experienced by healthcare providers whose work can present challenging and sometimes traumatic scenarios employs many terms to describe these experiences. This section will define and differentiate a few of the common terms that are often used interchangeably; namely, *CF*, *BO*, *secondary traumatic stress (STS)*, and *vicarious trauma (VT)*. Additionally, *self-care* will be defined to aid in the understanding of CF and its effects specifically for interdisciplinary pediatric providers. The study focused on exploring an

in-depth understanding of and concrete identification of CF and BO, as these terms are frequently used within the literature on healthcare providers.

CF is defined as "a state of exhaustion and dysfunction (biologically, psychologically and socially) as a result of prolonged exposure to compassion stress" (Figley, 1995, p. 253). Historically, CF was used to describe "public weariness" which resulted in a decrease in of empathy towards social issues/crises (Austin et al., 2009, p. 196). However, according to Austin et al. (2009), the term shifted to describe health care providers' lack or loss of empathy and compassion for clients in healthcare settings. The authors described a shift that occurred in the 1990s when health professionals started to utilize CF to describe the "cost of caring" or the emotional toll which resulted when health care providers were emotionally connected and empathic with their patients (Austin et al., 2009, p. 196). Additionally, Figley (2002) described a continuum along which CF occurs, affecting cognitive, emotional, personal, behavioral, somatic, work performance and spiritual domains of life.

A similar, but distinct term, BO, is defined as "a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support" (Jenkins & Baird, 2002, p.424). The term BO is very closely associated with the "erosion of a positive psychological state" (Schaufeli et al., 2008; p 204). BO is often used interchangeably with CF, but   they are in fact two separate terms, and Schaufeli et al. (2008) sought to define the term independently of CF:

> As a metaphor for the draining of energy, BO refers to the smothering of a fire or the extinguishing of a candle. It implies that once a fire was burning but the fire cannot continue burning brightly unless there are sufficient resources that keep being replenished (p. 205).

Definitions of BO vary across countries; where some describe BO as a medical diagnosis, and others identify it as a non-stigmatized and accepted label. Other countries, such as the United States, varies in context from where it embeds BO "across several broad social, economic, and cultural developments" (Schaufeli et al., 2009, p. 206). According to Schaufeli et al. (2009), the term BO varies in both culture and context. It is important to view and investigate CF and BO as separate constructs, as the literature states that CF is not interchangeable with, but instead, a precursor to BO. With awareness and prevention or reduction of CF, BO may in turn be reduced.

Secondary traumatic stress (STS) and vicarious trauma are other terms that are similar to CF and BO but have identifiable differences. STS is defined as both the symptoms and emotional responses to the indirect exposure of trauma surrounding the work with an individual experiencing trauma (Cieslak et al., 2013; Robins et al., 2009). Although in earlier studies, STS was thought to be synonymous with CF, more recent literature has separated the two terms. There appears to be some overlap between the two constructs, but there are identifiable conceptual differences (Jenkins & Baird, 2002). STS refers to the symptoms and responses from working with individuals who have experienced trauma which provides some overlap with CF, but more closely relates to the concept of posttraumatic stress disorder (Figley, 1995). Not all individuals who experience CF have necessarily worked with individuals who have experienced trauma.

Vicarious trauma is another term that studies have used interchangeably with STS, however, this is referring to the "cumulative process" in which a provider experiences the client's traumatic material through their own inner experience (Robins et al., 2009).

Self-care is an important concept within the literature and can be one way to alleviate symptoms of CF and BO. Self-care is generally described as the "activities or processes that are initiated and managed by the worker for the purpose of supporting one's health and well-being, attending to one's needs, or providing stress relief" (Bressi & Vaden, 2017, pp. 34-35). Some of these activities or strategies may include listening to music, art, journaling or exercise (Gazelle et al., 2014; Maytum et al., 2004). Some studies identify mindfulness interventions as promoting positive outcomes in healthcare providers, such as decreasing symptoms of BO (Moody et al., 2013; Irving, Dobkin & Park, 2009). Specifically addressing psychologists, Dattilio (2015) argues that professional identity is developed during training, and that self-care is integrated into this identity, suggesting the importance of creating and utilizing self-care practices in one's training years. There is limited literature regarding understanding existing barriers to practicing self-care or other activities that may reduce CF and BO for healthcare providers. Some studies describe the need, especially within the mental health field, for destigmatizing seeking outside support, as this may be one reason that providers do not pursue formal channels of support (Zerubavel & O'Dougherty Wright, 2012).

Prevalence of Compassion Fatigue and Burnout Among Healthcare Providers

According to Meadors and Lamson (2008), "unexpressed grief in health care providers who care for chronically-ill children may lead to the development of some symptoms of CF (p. 24)." With limited space or time to express grief after the loss of a child under their care, providers may experience negative long-term effects that impact them personally and professionally. One can only imagine how difficult it must be for a parent or family member to have a chronically- or critically-ill child. With many visits to the doctor and stays in the hospital for various treatments, this situation can be traumatizing for both the child and the family.

However, the experience of pediatric direct care providers can be easily overlooked. Much of

the extant literature illustrates the impact on nurses in hospital units, although many identified

symptoms of CF and BO and associated risk factors also appear within other disciplines of

healthcare providers (Bush, 2009; Maytum et al., 2010; Austin et al., 2009; Meyer et al, 2015;

Lee et al., 2015). Many medical providers across disciplines experience symptoms of CF and

BO, according to a study by Huggard & Dixon (2011). In a study of 296 health care

professionals primarily focused on nurses (but including other healthcare providers), 30.9% had

a high risk for developing CF, and 26.9% had a high risk for developing BO (Branch &

Klinkenberg, 2015). In another study focused on examining BO and CF in 253 medical doctors

in various specialty disciplines programs using the Professional Quality of Life scale (ProQOL),

17.1 % were at risk of developing CF, while 19.5% were at risk for BO. Differences have also

been documented based on level of experience where prevalence of compassion fatigue or

burnout was relatively low (5%) for trauma specialists, but higher for less experienced clinicians

(Craig & Sprang, 2009). Implications were similar to other studies in that both doctors and other

healthcare professionals are at risk for experiencing CF, BO, or both when working directly with

patients (Sinclair et al., 2017), although few studies have been conducted with pediatric

healthcare providers caring for medically-ill children.

Recent studies have focused more closely on BO among pediatric medical residents,

oncologists, and physicians caring for dying children. In one nationwide longitudinal (5-year)

study of 1804 pediatric medical resident participants, the researchers identified that 20-30% of

participants were currently experiencing burnout during any year of the study (Kull et al., 2019).

Another study identified possible long-term strategies for measuring the prevalence of BO in

pediatric residents which included a 1-2 item screener which had been modified from Maslach

Pediatric Burnout Scale. The brief screeners had "reasonable sensitivities, specificities,

likelihood ratios, and construct validity, and they may be useful for tracking burnout symptoms

in pediatric residency training programs" (Kemper et al., 2018, p. 251). Additionally, several

other studies identified the prevalence of BO in pediatric physicians and need for intervention,

specifically in more specialty clinics such as oncology, hematology, and palliative care (Beaune

et al., 2017; Whitford et al., 2018).

Risk and Protective Factors Associated with Compassion Fatigue and Burnout

Several quantitative studies have considered personal and professional factors of

developing CF amongst healthcare professionals. In one study of 182 health care providers, 93

medical and 89 mental health providers completed measures of CF, emotion management, trait

emotional intelligence, coping strategies and negative affect. Their findings indicated that both

trait emotional intelligence and emotion management were inversely related to CF (Zeidner et

al., 2013). The study indicated that flexible use of coping strategies and effectiveness of

strategies was found to be an important factor in early identification of CF, in comparison to the

level of usage of coping strategies (Zeidner et al., 2013). Additionally, individuals who have the

ability to demonstrate both compassion and empathy towards others have the greatest risk overall

for experiencing the impact of CF when presented with grief and loss in the workplace (Figley,

2005). Providers who are younger, with less experience are at greater risk of experiencing BO

(Craig & Sprang, 2009).

Some studies have also focused on identifying factors that prevent or decrease symptoms

related to CF and BO. Craig & Sprang (2009) found that the use of evidence-based practices

with clients who have experienced trauma will in turn decrease a provider's risk of experiencing

CF and BO. The authors described that the use of evidence-based practices may allow the

providers to feel more equipped and improve confidence in addressing the trauma presented. Alternatively, an increase in number of years of experience and use of evidence-based practice in interventions with clients has been shown to indicate lower levels of CF among behavioral health professionals (Craig & Sprang, 2009). These findings indicate the need to understand the possible ways in which providers in varying disciplines experience CF and BO, as well as the ways in which they may need support in understanding how to prevent and/or reduce the impact of CF and BO symptoms.

Other studies focused primarily on mental health professionals in a pediatric setting and the factors that may predict or help reduce CF and BO. For example, de Figueriredo et al. (2014) examined perceptions of CF and BO utilizing a mixed-model method, where participants, consisting of psychologists, social workers, case managers and student trainees were surveyed and placed in focus groups. The participants were recruited from a pediatric setting that treated highly traumatized children and adolescents aged 0-5. The researchers found that there are various individual, professional, and organizational factors at play that appear to either buffer or increase the participants' likelihood of experiencing CF and BO. Some examples of these factors include previous trauma history, idealism and enthusiasm associated with early career, and demands of the workplace (de Figueriredo et al., 2014).

Branch & Klinkenberg (2015) examined the correlates of CF among pediatric healthcare providers including nurses, psychologists, medical doctors, social workers, child life specialists and others. Unlike other studies, age, education level, and work category/experience were not found to significantly relate to CF across these providers. It may be possible that these factors were indicated as non-significant due to the broad categories in which participants were placed into. For example, some categories included nurse/non-nurse, age <40 or >40, or healthcare

experience <10 years or <10 years (Branch & Klinkenberg, 2015). Perhaps with a more

narrowed range within each category, the results may show significance for one or more of those

factors relative to CF and BO. However, results did indicate that nurses specifically working in

the pediatric care unit (PICU) scored higher than non-nurses for risk of BO, as providers within

these units are consistently exposed to trauma, death, and the grief of families (Branch &

Klingenberg, 2015). This study had a major limitation in the way that the researchers

dichotomized participants into nurses and non-nurses to investigate differences between these

two groups. Their study did not explore the experiences of providers from various disciplines,

but rather specifically focused on the implications for nurses (Branch & Klinkenberg, 2015).

Most recently there has been a focus on understanding the spectrum of CF across healthcare

providers in order for providers to have the ability to provide the best quality of service to their

patients (Sinclair et al., 2017).

Impact of Compassion Fatigue and Burnout in Pediatric Healthcare Settings

Healthcare providers working in pediatric intensive care units (PICU) and neonatal

intensive care units (NICU) are presented with medically-ill children and premature babies who

have typically experienced some trauma that is life-threatening and has a significant effect on the

child and family. Literature concerning pediatric healthcare providers across disciplines and the

impact of CF is limited. Maytum et al. (2004) conducted a qualitative study with 20 nurses who

"commonly and episodically" experienced CF, and who reported being aware of their symptoms

of CF (p. 171).   Participants reported that insight and awareness of the experienced symptoms

helped them to start to develop coping strategies to reduce symptoms of CF and prior to

experiencing BO (Maytum et al., 2004). Despite a growing literature base with regard to CF and

BO in the healthcare community, studies are generally more skewed toward pediatric nurses,

with less attention to other medical or mental healthcare providers (Merk, 2018; Lee et al.,

2018).

      Given the nature of care and amount of time that each provider spends with the patient,

exposure to very challenging work, which often includes traumatic events, is almost inevitable

(Meadors et al., 2009). Limited awareness of CF and BO and the potential role played by trauma

exposure in the workplace in creating symptoms of CF and BO may result in the worsening of

overall functioning and wellbeing of pediatric healthcare providers. Additionally, not only is the

individual provider affected by prolonged, untreated symptoms, but also the workplace as a

whole (Pfifferling & Gilley, 2000). Problems also occur in many variations across the

workplace, including decreased productivity, higher turnover and increased absences (Wright,

2004). There is a certainly a presence and significant impact of CF and BO amongst pediatric

healthcare providers working with this population, and a need to understand more of the factors

contributing to CF and BO from perspectives of providers among various disciplines. A more

recent study even focused on the impact of the employer, which included high turnover rates,

increased worker's compensation costs, "friction" within the whole organization (i.e. between

employees, management, etc.) and frequent absenteeism amongst employees (Lee et al., 2018).

Additionally, CF in social workers has "spilled over" into participant's marriages and

significantly decreased marital quality (Finzi-Dottan et al., 2018).

Efforts to Reduce or Prevent Compassion Fatigue and Burnout

      Some efforts have been made in respect to addressing CF and BO, however, much of the

literature emphasizes the lack of implementation of these programs for a variety of reasons and

describes the need for greater systemic efforts (Maytum et al., 2004; Bush, 2009; Robins et al.,

2009). One study examining CF and BO in a group of nurses working with a pediatric population

with chronic conditions focused on identifying triggers and coping strategies (Maytum et al., 2004). The study interviewed 20 nurses about their experience with CF and BO and their efforts to decrease the impact of these phenomena. Nurses in this study reported experiencing CF both regularly and "episodically" and suggested that having insight and experience aided them in their development of both short-term and long-term coping strategies to reduce CF and BO. Implications of this study discussed the need for nurses to have the ability to identify CF and to develop various coping strategies to decrease BO (Maytum et al., 2004). Although this study emphasized the implications for the nurses, having insight and experience within the overall healthcare field may aid other providers in reducing the likelihood of experiencing CF and BO as well.

Other suggestions for addressing CF and BO in healthcare include setting-wide programs (Bush, 2009; Robins et al., 2009), and some focused more specifically on interventions for CF and BO and specifically as it relates to the reduction of suicidal ideation in nursing staff (Lee et al., 2018). According to Bush (2009), factors such as problem-solving strategies, hardiness and social support should be included in prevention programs. Recommendations from Robins et al. (2009), suggest that having hospital leaders present awareness, and both normalizing and offering support for pediatric healthcare providers could decrease the risk of long-term effects of both CF and BO following prolonged exposure to trauma in the workplace. Few programs provide hospital-specific educational seminars (Meadors et al., 2008), wellness programs (Zadeh et al. 2012), or pilot mindfulness and self-care programs (Moody et al., 2013; Klein et al., 2018). Given that these programs were implemented in single settings for research purposes, they were limited in the ability to provide awareness of CF and BO symptoms, or promote useful coping strategies across disciplines. Although some programs have been studied, similarly to the

literature, more of the focus remains on pediatric nursing staff. By providing institutional

supports increasing awareness of the importance of self-care would be beneficial in decreasing

symptoms for providers in pediatric healthcare settings (Robins et al., 2009).

Pediatric health care providers working with medically-ill children need awareness of

both the symptoms of CF and BO, as well as the barriers that may prevent them from engaging

in management or treatment of those symptoms. Additionally, they must be provided with

information on not only the impact of CF and BO on their lives, but also techniques to manage

their stress and symptoms of CF and BO.

Summary of Literature Review

Some limitations in the existing research on CF and BO include: lack of understanding of

pediatric providers' experiences of and perspectives concerning CF and BO; few studies focused

on understanding various important factors that may increase/decrease risk of CF and BO; and

lack of discipline-focused (i.e. nursing, medicine, psychology) approaches to awareness of CF

and BO and intervention efforts. Some of these limitations may contribute to reduced

effectiveness of proposed educational prevention programs, as they may not be tailored towards

the correct discipline based on training and experience. Little is known about how providers

who work with medically-ill children describe the challenges they face, and specifically their

awareness of the higher risks for CF and BO when working this population. Additionally, many

of the studies to date do not provide a thorough understanding of how healthcare providers

practice self-care or the barriers to utilizing self-care and other coping strategies within various

disciplines. More qualitative research is needed to support awareness of these phenomena as

well as to understand how settings can improve the professional quality of life for providers who

are responsible for such critical care.

Research Questions

The following research questions were addressed in the study:

1. How does awareness of CF and BO vary across disciplines working in pediatric settings that serve medically-ill children?

    a. To what extent do providers from various disciplines experience and explain CF/BO?

2. What are the factors that impact providers' current utilization of self-care?

    a. How is self-care emphasized in the workplaces of these providers?

        i. How effective is self-care in reducing CF and BO?

    b. Barriers (including stigma)

    c. Promoters (More time/experience, etc.)

Methods

Participants and Setting

  Nine healthcare providers working in pediatric settings that serve medically-ill children participated in a 30-minute individual interview. According to Fugard & Potts (2014), "current guidelines for thematic analysis are varied, ranging from around 2 [participants] to over 400" (p. 679). The nine participants recruited varied in gender, geographic location, title/degrees, and number of years in the field. Of the nine participants, eight were female and one was male; they included social workers, nurses, pediatricians, child life specialists, and psychology interns. The participants ranged in years of experience from less than one year to over ten years (see Table 1 for additional details).

Recruitment Procedures

  The study aimed to recruit pediatric providers at different levels of their training from a range of disciplines including psychology, psychiatry, social work, medicine, nursing, and child life. Snowball sampling was utilized to recruit participants working with medically-ill children within pediatric departments/children's hospitals nationwide. Additionally, emails were sent to listservs and individuals inviting them to share information with qualified professionals interested in participating in the study. Individuals with interested communicated with me via e-mail to receive additional information and received a link to the pre-screening questionnaire (Appendix A) to determine their eligibility. Participants were eligible for the study if they worked in a setting serving medically-ill children for at least 50% of their work hours; spoke English; and were at least 18 years of age. Eligible participants were then scheduled to participate in in an interview via Zoom (online teleconferencing) and provided with a consent form and two brief questionnaires to complete prior to their interview.

Measures

Participants were asked to complete two self-report measures to obtain demographic information

and a measure of their current level of compassion fatigue and burnout. Following the

completion of these measures, providers participated in an interview that I facilitated and audio

recorded for the purposes of data analysis.

      Demographic questionnaire. This questionnaire is found in Appendix B and was used

obtain general demographic and background information about participants.

      Professional Quality of Life Scale (ProQOL; Stamm, 1995). The ProQOL is a 30-item

questionnaire that measures both positive and negative effects of helping others who have

experienced trauma and suffering. Respondents used a 5-point likert scale that ranges from 1

(Never) to 5 (Very often) to indicated how frequently they have felt in the last 30 days for each

item. The ProQOL has been used widely among healthcare provider samples. The ProQOL has

good reliability and validity and takes approximately 10 minutes to complete. The measure is

scored by adding up the items that are connected to each scale. The scores determine the various

levels; low (22 or less), average (23-41) and high (42 or more). Although the ProQOL data were

not as meaningful in aggregate due to the small sample size, I have utilized these data

descriptively to examine current levels of compassion fatigue and burnout among participants to

inform my understanding of themes in the discussion. See Appendix C for a copy of this

measure.

      Individual interview guide. The individual interview guide may be found in the

Appendix D. This interview guide contains questions that correspond to my research questions

and will help support the relative standardization across interview. Individual interviews were

utilized rather than focus groups, to allow participants the space to openly share their experience with CF and BO.

Relationship to the Topic

As the researcher, I have had a variety of experiences within inpatient, outpatient and residential pediatric medical settings. During my clinical training, I was able to recognize changes in my mood, and lack of emotional connection with my clients. However, it took many months before I was able to label the emotional responses that I was having in response to my work with medically-ill children as CF. At that time, I believe I had already reached a point of feeling symptoms of BO, from prolonged exposure and unresolved emotional responses. Given my experiences of CF and BO, I felt the need for further exploration of other's experiences and a better understanding of other providers interpretation and ideas that they may be able to provide in finding helpful strategies to alleviate some of these symptoms of CF and BO.

Ethical Considerations

All participants have been treated ethically, according to the ethical guidelines of the American Psychological Association (APA), and approval was granted from the USF Institutional Review Board. No risks have been identified at this time as a result of participating in this study. All precautions possible were taken to ensure that the study thoroughly met all ethical requirements set forth by APA.

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Analysis

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Methodology

A qualitative approach was chosen for this study, as the purpose was to gain an understanding of the lived experiences of CF and BO amongst pediatric healthcare providers treating medically-ill children. Given the extensive amount of quantitative literature on CF and

BO, this qualitative study sought to aid in a more in-depth interpretation of how providers

experience CF and BO. A thematic analysis was utilized, which is defined as "a method for

identifying, analyzing, and reporting patterns (themes) within data" (Braun & Clark, 2006, p. 6).

As Fugard and Potts (2014, p. 669) further describe, "thematic analyses are widely used in

psychology, healthcare research, social research and beyond. Topics addressed are diverse,

including understanding experiences, understandings, perceptions, practices, and causal factors

underlying phenomena." The approach allows for flexibility, despite methodology or theoretical

framework. Thematic analysis seeks to identify themes which emerge in the data through a

pattern of responses and overall develop a better understanding of the perceptions and

experiences of participants. Furthermore, the analysis sought to "identify descriptions of the

phenomenon; cluster into discrete categories to describe the 'essence' or core commonality of

structure and the experience" (Stark & Trinidad, 2007, p. 1373). The analysis of this study

closely followed Braun & Clark's (2006) 6-phases of thematic analysis which include (1)

Become familiar with the data, (2) Generate initial themes, (3) Search for initial codes, (4)

Review themes, (5) Define themes, and (6) Write up report, (included in Figure 1), and 15-point

checklist for good thematic analysis. A visual depiction of this process is available in Figure 2.

Data Analysis

Semi-structured interviews were audio recorded and transcribed via Zoom. The

transcripts were reviewed twice in comparison to the audio recording to ensure accuracy of the

data. All data gathered have been stored electronically on the researcher's password protected

computer. Data gathered during the interviews were coded and analyzed through a qualitative

research software program, ATLAS.ti. The software was chosen due to the low cost to students

and the ability to analyze and code a range of data, including text documents, audio, and graphics.

Results

ProQOL

Due to the small sample size, the ProQOL was utilized descriptively to aid in understanding and analyzing the data. All of the nine participants' ProQOL scores fell into the "low" range across 2 domains (i.e. burnout and secondary traumatic stress) with scores ranging from 13-20, and "high" or "average" range across 1 domain (compassion satisfaction) with scores ranging from 38-47. Of note, the participant's self-report questionnaire scores on the ProQOL were consistent with data gathered from self-report in individual interviews.

Thematic Analysis

Thematic analysis identified six emerging themes from the data. The themes were: (1) attitudes and awareness, (2) barriers to self-care, (3) impact on work performance and personal life, (4) coping strategies, (5) lack of systemic measures and resources, and (6) promotion of self-care in the workplace. The themes emerged from the nine participants interviewed and provided some insight into their perceptions and experiences with CF and BO.

Attitudes and awareness. Many participants described varying attitudes about symptoms and perceptions of other's experiences of CF and BO, and overall reported a lack of awareness of CF and BO among themselves and their colleagues. Based on the initial screeners and participant interviews, four participants endorsed never experiencing CF or BO but had seen colleagues who had exhibited some symptoms. The other five participants had endorsed some varying levels of CF and BO in themselves in previous jobs or earlier years in their current jobs. Interestingly, 3 out of 4 of the participants were physicians, and it seemed CF was not an overly

familiar term, while the other participant was a psychology intern and endorsed being very early in her training and career. It may be important to note that due to the lack of knowledge and education of symptoms associated with CF, some of these participants may be unaware of the symptoms of CF and the progression into BO.

Some participants described colleagues as having "a bad attitude" at work as a manifestation of CF and BO, while others described the lack of awareness some colleagues had for symptoms of CF and BO. One participant stated, "I think people that have bad attitudes get burned out." Some of the statements from participants included an overall lack of awareness and training around CF and BO, in which one participant stated when referring nurses in general, "[they] seem to not have the knowledge or the competency" (participant 2) and one participant articulated:

> What I've noticed from like especially nursing staff is that they don't receive like any training on patients with mental health symptoms and that can be really challenging for them…so then, I think that, that really makes it difficult if you don't have adequate training, and sometimes that's when people get burnt out (participant 1).

One physician also felt that CF and BO had been recognized and discussed sufficiently, as they stated, "I think it's been talked about enough and recognized enough, everyone knows it is an issue" (participant 8). Additionally, many of the participants (nurse and non-nurse) identified the lack of training and awareness of CF and BO specifically for nurses. The rationale provided behind needing to provide nurses with more training in these areas was based on the fact that nurses often move about through many clinics or specialty units where they are most needed and do not receive additional training or education.

Barriers to self-care. Participants described many challenges which made engaging in self-care difficult or unattainable. For example, all nine participants endorsed various obstacles such as the lack of time, demand for high productivity, and stigma. As one participant stated, "a huge barrier is just so much work to do, and only have a limited amount of people to do it" (participant 1). Another participant went on to say, "some companies have like a focus more on money rather than patient care or employee satisfaction or mental health. So that is like productivity vs. self-care" (participant 5). Consistently across all participants, the theme of time and productivity was present, as one additional participant stated "then not meeting, you know, the expectations for productivity. If you're taking time out to do those [self-care activities] things" (participant 7) While many participants focused on time/productivity as barriers, others mentioned the stigma behind taking time for self-care and endorsed worries of being labeled, in one example a participant stated "I think it comes off as a sign of weakness that you can handle your job. You can't handle the pace" (participant 4).

Impact on work performance and personal life. All participants endorsed symptoms that they experienced or have acknowledged colleagues experiencing that have impacted their work performance and/or personal life. Symptoms endorsed consistently by six participants included feeling isolated and fatigued. For example, "whenever someone would ask, like, do you want to go out and be like, no, I don't want to go out, not today" (participant 3), and,

> I think it drastically affected my personal life. I feel like I was just completely
>
> disconnected from everyone. Like I was on an island by myself, and you can see
>
> everyone around me, but that willingness to interact with them was completely gone
>
> (participant 2).

Participants described various challenges in keeping up with household tasks, day-to-day chores and even in having positive personal interactions with family members. Participant 2 stated, "even doing chores was just so exhausting and was so overwhelming to me that I would end up being a couch potato." In discussing work impact, one participated stated, "people like, stop enjoying their job, they seem to sometimes withdraw, and are like less motivated to kind of do the best they can or really motivate themselves" (participant 3). Another participant described how symptoms from work can impact your personal life: "I think those symptoms, you know, carry over into your personal life. If you're not happy at work, it's harder to be happy at home" (participant 8) Additionally, two participants described not wanting to go to work at all; as one articulated, "it is a terrible feeling like I don't want to go to work, I don't want to help these people" (participant 1) and "one thing that tends to happen is I start worrying about going to work" (participant 2).

   Coping strategies. Despite many barriers, some participants who had experienced symptoms of CF and BO in the past had endorsed developing positive coping strategies to aid in managing symptoms or preventing them from returning. The strategies suggested can be further subcategorized as active/instrumental and psychological/cognitive.

   Active/instrumental. One participant actively separating work and home, they stated, "trying to create distance, whether it's physical or emotional, being at work or outside of work" (participant 9). Other participants emphasized the importance of taking time off or away from work: "making sure you get some vacation or rest," (participant 5) and "take days off, you know, sometimes you need to use your sick days when you're not sick and you just need a day off for yourself" (participant 1). Some participants endorsed taking 20-30 minutes for themselves each day and engaging in a variety of activities including going to the gym and leaving all electronics

behind, starting a new sport (i.e. boxing), or even keeping a consistent sleep schedule. Some

participants also considered setting boundaries for work (i.e. schedule, limiting caseload, not

taking work home) as an important coping strategy. The social work participant endorsed

something very specific to that field of work which included changing jobs, and stated,

> As social workers, we typically change fields or lines of service every three to five years
>
> with because, well, yeah, just because you're serving really difficult populations and the
>
> more difficult the population, you know, the more fatigue you have.

From the various active/instrumental coping strategies participants endorsed, it was interesting to

note that only one individual (a psychology intern) stated that they utilized therapy, albeit

infrequently: "And like therapy, that's definitely something that I take advantage of, but certainly

not as much as I should."

  Psychological/cognitive. Some participants describe "emotionally" distancing themselves

from their patients in order to manage their symptoms: "you have to separate yourself

emotionally from situations and start to distance [yourself] to stay safe" (participant 7). One

participant stated, "I have like become a lot better at boundaries for myself" (participant 9) and

another said, "It's okay to acknowledge you can't be Superwoman" (participant 7). Several

participants also discussed the importance for self-care through "reminding yourself of all of the

things you are grateful for," (participant 6) and finding "outlets" to cope (participant 2).

  Lack of systemic measures and resources. There was a split between participants who

felt their workplace had implemented valuable systemic measures and resources for employees,

and others who felt that the workplace had nothing in place to help prevention or management of

symptoms of CF and BO. Referring to the lack of measures, one participant stated, "Um, there

aren't any that I've known about and I've been there for a year. It's not talked about ever, and

yeah, so there is nothing within the agency that I know of" (participant 9 – outpatient hospital clinic). All individuals also discussed ideas for systemic measures or resources in which they felt would be beneficial for their workplace to implement. For example, one participant said:

> I think that there should be an in-house counselor for staff to be able to go to talk to with when something really difficult happens, you know, like if they see a trauma or if they see something really terrible, or they lose a patient, they should be able to go and talk to someone about it and not have to, you know, go through their own resources when they're struggling, when they finally hit that breaking point because finding someone on your own is a process (participant 4 – inpatient hospital unit).

Several participants discussed that there may be resources in place, but not accessible during work hours or suitable hours for full-time employees, for example: "I think you know, again, like just making resources available that people are actually comfortable using, that are on a schedule that makes them accessible and available [to employees]" (participant 7 – outpatient hospital clinic). More than half of the participants also made mention of the need for more resources and education on symptoms and resources. One participant said:

> I feel like if there were like, a reading list, or even an audiobook list, for people to be more aware of what compassion fatigue and burnout looks like in the workplace, then we could all learn how to positive cope with it, in the early stages of it (participant 1 – inpatient specialty hospital unit).

Some additional resources which participants suggested included; "handouts with hotlines, monthly manager check-ins, peer support groups and specific CF and BO trainings for staff" (participants 2 – inpatient hospital unit, 4 – inpatient hospital unit, and 6 – outpatient hospital clinic, respectively). Specific to the participants who are physicians, they stated having "access

to a medical assistant" allowed them to feel less burnout and improve patient compassion and care through decrease of the administrative workload.

>   **Promotion of self-care in the workplace.** In addition to general systemic measures and resources that some workplaces provided, a few agencies in which participants worked went above and beyond to promote self-care in the workplace. Some participants discussed the use of mindfulness and teambuilding activities which increased direct self-care in the workplace. In one example, a participant said,

> We would have team building exercises and they were just really fun, we also had like an outing with the entire child life team and we all had dinner and just seeing each other like outside of work in a very positive setting, I think, can really help reduce that compassion fatigue (participant 3).

Another individual endorsed wanting more self-care activities offered at work and stated, "I definitely think like, more like self-care activities could be really helpful" (participant 2). Other participants suggested that self-care could be promoted by having the optionality to block schedules or take time off to engage in self-care in a variety of ways (vacation, therapy, mindfulness classes, etc.). One participant stated, "so like now mindfulness classes [for providers] is just starting" (participant 8) in reference to a recent lunch-time mindfulness class that started being offered for employees. Several participants discussed the importance of having planned days off for vacation, in one participant example; "You know, plenty of vacation time and just understanding that the field that we're in requires self-care and time and resources for us to do that" participant 7).

Discussion

Purpose of the Study

The research surrounding prevalence and impact of CF and BO is relatively well developed and has been documented through many quantitative studies (Zeidner et al., 2013; Figley, 2005; Craig & Sprang, 2009). However, several gaps within the literature exist in regard to understanding the experience of providers working with medically-ill children, as well as consideration of the self-care strategies and other efforts to address CF and BO among this population. Additionally, much of the literature largely reflects studies that were focused on one type of healthcare provider. For example, some initial studies focused on examining CF and its impact on nurses within the hospital setting (Austin et al., 2009; Maytum et al., 2010), while more recent studies have started to explore the impact of CF on medical doctors and other healthcare providers (Huggard & Dixon, 2011; Branch & Klinkenberg, 2002).

The present study sought to start bridging the gap in the literature between the quantitative results and the qualitative literature to gain an understanding of the experiences of this population. Given these gaps in the research, prompting providers to talk about their experiences and the barriers to self-care activities has provided an important addition to the current literature. It is important to note that from the initial findings of the ProQOL, it is possible that the experiences and perceptions of participants may have yielded more variability if some of the participants had in fact been experiencing moderately higher levels of compassion fatigue and burnout at the time of their interview. Furthermore, this study adds to the foundation of current research and provides richer, more detailed information regarding the perceptions and experiences of this population as it pertains to CF and BO. The findings help to gain insight into useful strategies that may promote the use of self-care and in turn reduce symptoms of CF and BO in pediatric healthcare providers.

Themes

Following Braun & Clark's (2006) framework for thematic analysis, the initial themes were identified, reviewed and final themes were defined for the study. The results of the study suggested six emerging themes that were commonly endorsed by participants (see Table 2). The themes included: (1) attitudes and awareness, (2) barriers to self-care, (3) impact on work performance and personal life, (4) coping strategies, (5) lack of systemic measures and resources, and (6) promotion of self-care in the workplace. The emergent themes provided initial insight into the experiences of pediatric healthcare providers, specifically in the context of the research questions of the study (i.e. barriers to self-care, promoters of self-care, variability in experience of CF and BO for pediatric healthcare providers based on training discipline). The identified themes could be utilized for more specific research focused on addressing symptom reduction and the impact of CF and BO in the workplace.

Attitudes and awareness. All nine participants discussed varying levels of awareness and attitudes or perceptions of individuals about symptoms of compassion fatigue/burnout. Some participants endorsed the needs for awareness and education to address negative attitudes and view of some individuals in the workplace who may not fully understand the concepts or symptoms associated with CF and BO. Consistent with the need for additional qualitative research as discussed, the theme of attitudes and awareness were lacking in much of the existing quantitative research. One study on pediatric nurses mentioned, "participants reported insight and awareness of the experienced symptoms helped them to start to develop coping strategies to reduce symptoms of compassion fatigue and prior to experiencing burnout" (Maytum et al., 2004). However, in this study, it was interesting to note that four of nine participants also stated the need to implement additional training and education around CF and BO, specifically for nurses.

According to participants' experiences in the workplace it appears individuals across disciplines and educational backgrounds have varying perceptions of awareness and overall attitudes in regard to CF and BO. From the data, it appeared most of the physicians (pediatricians, pediatric gastroenterologists) were less familiar with the term compassion fatigue or the awareness of associated symptoms of implications. Another interesting pattern of note included that all three of the physician participants had reported never experiencing burnout during their careers, but one mentioned the high levels of burnout experienced during residency amongst current residents in which she supervises. It is hard to say whether the number of years in their career (and out of residency) has contributed to this report of (or lack thereof) experience.

This study also provides insight into areas that could be utilized for future research in not only understanding awareness and attitudes of employees, but also those of higher administration within healthcare systems. From the interviews and varying disciplines of participants, the data suggested that pediatricians or physicians also had little to no knowledge about the concept of CF and were aware of BO but all three had not endorsed any historical or current experiences of CF or BO. It appeared that participants with the most knowledge, training and optimistic attitudes in regard to the concepts of CF and BO, included the social worker, child life specialist, and one of the psychology intern participants, suggesting an imbalance of knowledge and training in these topics across healthcare fields.

Barriers to self-care. Given the lack of existing literature on understanding this area of pediatric healthcare provider's experiences, this study sought to gain additional information on barriers to self-care. All nine participants endorsed varying barriers to engaging in self-care, including lack of time, high productivity expectations, fatigue and stigma. Considering the lack

of existing research in this area, these data provide foundational research and justify additional

efforts to understand barriers to self-care and treatment in reducing symptoms of CF and BO.

Additionally, data gathered can aid in determining how to intervene appropriately and efficiently

to potentially prevent CF and BO in pediatric healthcare providers. Consistent with existing

literature which has identified the need for increased efforts reducing symptoms of CF and BO in

pediatric healthcare providers through various self-care strategies (Maytum et al., 2004), this

study also provides insight into another area of concern which emphasizes the barriers in which

pediatric healthcare providers may face in practicing and engaging in self-care.

Impact on work performance and personal life. All nine participants were able to

identify areas of impact on work and personal life, whether for themselves or for a close

colleague or friend. Consistent with the literature on the impact of CF and BO, the participants

endorsed an impact both on their personal lives but also on the workplace as a larger system. As

Pfifferling & Gilley (2000) stated, "not only is the individual provider affected by prolonged,

untreated symptoms, but also the workplace as a whole" (p. 39). The participants stated several

areas of impact at work which included not wanting to attend work, noticing that others would be

having increased absences, lack of desire or passion to care for patients. Participant-endorsed

impact on work performance and environment is consistent with Wright (2004) who described

issues with poor productivity, high absenteeism and increased turnover in staff. Additionally,

participants noted issues in communicating with partners or family members at home, which was

also consistent with a recent study by Finzi-Dottan et al., 2018, which explored the impact CF

has on marital quality in social workers. Furthermore, participants across all disciplines

acknowledged that individuals experiencing CF or BO are prone to symptoms such as social

withdrawal, fatigue, and a sense of worry about going to work. It would be helpful to continue to

explore areas in which work performance is impacted by CF and BO in order to better inform

and educate healthcare administrators on the impact this could be having on employees and

effectiveness or quality of care to patients.

        Coping strategies. For the five participants who had previously experienced CF or BO,

they were able to identify coping strategies to reduce or prevent symptoms. From existing

literature, there were no available studies that explored more in-depth coping strategies utilized

by this population. For this study, the coping strategies identified were categorized into two

different types. One of areas in which participants mentioned utilized coping strategies focused

more on the active/instrumental strategies in which they tried to implement into their daily

routines. Some of these included taking days off (sick days, mental health days, vacation days),

separating yourself from work, going to the gym or starting a new sport, reducing electronic time

and keeping a consistent sleep schedule. Another subgroup of coping strategies included the

psychological/cognitive. Some participants endorsed coping strategies which included setting

boundaries for oneself, acknowledging limits, and reminding oneself of things to be grateful for.

It was also important to note that only one participant (a psychology intern) mentioned the use of

therapy as a coping strategy, but furthermore endorsed that she does not fully utilize this coping

strategy as much as she should. It would be important to continue to study additional coping

strategies for individuals and potentially gain a better understanding of the lack of utilization of

therapy as a coping strategy or even the lack of knowledge around the identification of therapy as

a coping strategy among pediatric healthcare providers.

        Lack of systemic measures and resources. About half of the participants reported they

felt that there were no systemic measures or resources in place in the workplace to aid in

managing CF and BO, while the other half reported being aware of a number of policies and

resources in place for employees to utilize. Consistent with the literature (Maytum et al., 2004; Bush, 2009; Robins et al., 2009), half of the participants reported lack of implementation of these programs for a variety of reasons (i.e. high productivity demand, lack of time) and described the need for increased systemic measures and resources. Other participants stated that there were already significant resources in place to aid in managing CF and BO. Some of the resources included counselors, mindfulness classes/groups, peer support groups, or an emphasis in supervision on self-care, but the complaint was often more of the lack of time and scheduling conflicts in utilizing some of these resources. Other systemic measures for some participants included having access to paid days off (i.e. sick days, vacation days). Many participants were forthcoming with suggestions for implementation of additional resources or systemic measures. Some of the suggested resources included monthly check-in meetings with managers, audiobook lists, handouts or reading lists (providing information on CF and BO), or focused trainings for staff. Consistent with the literature, many of the participants endorsed systemic measures directly targeting increase awareness and training would be beneficial in helping employees to understand and reduce symptoms of CF and BO (Robins et al., 2009). It will be important for research to continue to focus on areas of growth for healthcare administration in implementing additional systemic measures and resources, as this also aligns with recommendations from existing research (Meadors et al., 2008).

       Promotion of self-care in the workplace. An additional area of focus discussed by a few participants included strategies to promote self-care in the workplace. Some of these suggestions included adding more mindfulness and self-care classes or groups, increasing planned outings with teams or co-workers, having the ability to block off their schedule to attend mindfulness and self-care classes. One participant also mentioned reminding or educating

healthcare administration that the field of work requires them to be present and in turn increases

the need to take vacation and sick days as they become aware of symptoms of CF and BO.

Although many participants did not discuss areas that may promote self-care in the workplace,

those who did provided reasonable suggestions and this signals the importance of

communication between administrative and clinical staff in healthcare settings. Many

administrators who do not regularly interface with the challenging scenarios that providers do

may be unaware of how the inclusion of certain practices in the workplace can relieve stress,

traumatic reactions, and enhance support of their staff. Increased awareness and education

among healthcare administrators can better enable them to understand employees' perceptions of

what may be most effective to promote use of self-care within the workplace. To my knowledge,

no studies exclusively report on promotion of self-care in the workplace for pediatrics healthcare

providers. This could be an area for further exploration, as healthcare administration becomes

more aware of the need for systemic measures or resources.

Limitations

Several limitations were identified in this study. Of the nine participants, only one

identified as male and eight identified as female, perhaps limiting the external validity of the

findings to male pediatric providers. However, the number of years in the field was relatively

diverse. One area of focus for the study had questioned the variability in experiences of

healthcare providers from different fields of training (i.e. physicians, nurses, psychiatrists,

psychologists, etc.). Unfortunately, due to challenges with recruitment, the group of participants

did not include any licensed psychologists of psychiatrists. Furthermore, with the limited

diversity of participant areas of training, it is difficult to fully understand how the perceptions

and experiences may across various disciplines.

A related limitation existed in regard to the lack of diversity of participants as it pertains to racial/ethnic background and cultural/linguistic competence. The participants of this study consisted of three participants from racial/ethnic minority groups (Asian – one participant; Latinx – two participants), and six participants who identified as White. It would be important to consider various cultural factors during future recruitment efforts and interviews, as this may pose additional considerations and challenges regarding recruitment of a diverse participant sample. Furthermore, low endorsement of symptoms both on self-screeners and during interviews due to cultural background (i.e. not trusting of a White researcher, hesitancy regarding research, cultural beliefs and stigma around sharing challenges/symptoms with an unknown individual) may also be important factors to explore further in future studies. Additionally, linguistic factors may also play a role in understanding the concepts of CF and BO among participants for whom English is not their first language (i.e. translation/language barriers). Furthermore, bilingual participants may already be experiencing burnout due to high caseloads/lack of resources available in their workplace for patients (i.e. providers whom can translate/provide services in another language).

Due to recruitment challenges, a restriction existed in that interviews were only being conducted via Zoom audio (audio/video teleconferencing service). Given the nature of qualitative research, additional information may have been gathered through note-taking of the experience of the participants within an in-person interview, and participants may have been more forthcoming about challenges they have encountered in the field if they were interviewed face-to-face. The Zoom interviews, although efficient, may have ultimately limited the rapport between the research and participant, and might have contributed to the low endorsement of symptoms during interviews.

Few participants in this study endorsed current symptoms of CF or BO, limiting the variance across participants. Based on the initial screeners, including ProQOL, all of the nine participants endorsed low levels of compassion fatigue or burnout. Given this restricted range of responses, it may be important to utilize enrollment screeners or target recruitment in a way to increase diversity in variance of CF and BO symptoms. Additionally, it may be important to utilize alternative interviewing techniques, in-person probing during interviews, or vary the terminology for CF/BO; these strategies could potentially uncover more detailed and rich information regarding participants' experiences, even if they initially report low levels of CF and/or BO. Additionally, these strategies may enable the researcher to gather additional information on reasons for low endorsement of symptoms and to explore the possibility that this may be linked to perceptions of guilt/shame by the participant.

Future research

This study was one of a limited number of qualitative studies that emphasize understanding the experiences of compassion fatigue and burnout, and more specifically within pediatric healthcare providers. Future research should continue to expand on gaining additional insight into experiences across disciplines within pediatric healthcare providers, specifically including psychologists and psychiatrists, and perhaps in various specialty settings (i.e. oncology, hematology, transplant units). Utilization of the ProQOL scale may be beneficial in gaining additional information that may contribute to a better understanding of variability between participants. Another area of future research could focus on interviewing higher-level administrators in hospitals and healthcare clinics about their awareness of CF and BO, and potential concerns about employee absences, turnover and quality of care, to better understand the barriers to implementation of resources for employees. Furthermore, feedback and possible

areas of intervention could be provided and explored with administrators to help aid in bridging

the gap to providing additional resources to employees to prevent or reduce the symptoms and

impact of CF and BO in the workplace, and in turn improve the overall quality of life for their

employees. When hospitals can enhance the knowledge and awareness of their staff with regard

to CF and BO, they will in turn aid them in taking care of themselves on a personal and

professional level to ensure the best care for their patients (Meadors & Lamson, 2008).

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Table 1

Participant Demographics

Participants	$n = 9$
Gender	
F	8
M	1
Race	
White	6
Asian	1
Latinx	2
Level of Education/Degree	
MD	3
PsyD (In progress)	2
BSN	1
RN	1
LCSW	1
MS	1
Title	
Pediatrician	2
Pediatric Gastroenterologist	1
Nurse	2
Psychology Intern	2
Social Worker	1
Child Life Specialist	1

Length of Time in Career	
0-4 Years	4
5-9 Years	2
10+ Years	3

Table 1 (continued)

Geographic Location	
New York	2
California	4
Oregon	3

Table 2

Experiences of Compassion Fatigue and Burnout

Themes	Definition/Examples
Attitudes and Awareness	Views or perceptions of symptoms and experiences of compassion fatigue (CF) and burnout (BO) (i.e. bad attitude, lack of knowledge/training)
Barriers to Self-Care	Challenges or obstacles which made engaging self-care difficult or unattainable (i.e. time, productivity, weak)
Impact on Work Performance/Personal Life	The symptoms which had an impact on work performance or personal life engagement (i.e. not caring about patients, isolation, not wanting to go to work)
Coping Strategies	Things that individuals utilized to improve symptoms and take care of themselves (i.e. going to the gym, talking to others, consistent sleep schedule)
Lack of Systemic Measures and Resources	No (or minimal) existing resources or policies in the workplace to aid employees in addressing compassion fatigue, burnout or self-care (i.e. no counselors, no days off)
Promotion of Self-Care in the Workplace	Resources and policies in place or that employees would like to see in place to aid in helping employees to utilize self-care (i.e. on-site counselors, mindfulness, allotted days off)

Figure 1.

Six Phases of Thematic Analysis

Become familiar with the data

Generate initial codes

Search for themes

Review themes

Define themes

Write-up

(Braun & Clarke, 2006)

Figure 2. A 15-point checklist for a good thematic analysis

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
Coding	2	Each data item has been given equal attention in the coding process
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
	4	All relevant extracts for each theme have been collated
	5	Themes have been checked against each other and back to the original data set
	6	Themes are internally coherent, consistent, and distinctive
Analysis	7	Data have been analysed – interpreted, made sense of - rather than just paraphrased or described
	8	Analysis and data match each other – the extracts illustrate the analytic claims

	9	Analysis tells a convincing and well-organised story about the data and topic

Figure 2. (continued)

	10	A good balance between analytic narrative and illustrative extracts is provided
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated
	13	There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'

(Braun & Clarke, 2006)

Appendices

Appendix A

Prescreening Questionnaire

Indicate your answers (Y/N) to the following questions:

I am 18 years of age or older:

I am a provider working in a pediatric setting that serves medically-ill children:

I work with medically-ill children for 50% or more of my working hours:

Availability:

From the following list, please indicate the dates and times during which you would be available for an interview:

Time A

Time B

Time C

Time D

Contact information:

Please include the best e-mail address and phone number to reach you in order to confirm your attendance to the interview:

Appendix B

Demographics Questionnaire

Age:

Gender:

Ethnic/Racial Identity:

Highest level of education:

Professional Degree:

License/Credentials:

Hospital Department:

Title:

Length of time working at your current location:

Length of time working in pediatric settings:

Appendix C

Professional quality of life scale (PROQOL)

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

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

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

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

Appendix D

Interview Guide

Hello, my name is Courtney and I will be conducting our interview today. I am working on a research study at University of San Francisco, and you have been invited to discuss the concepts of compassion fatigue and burnout in your workplace.

First, I want to thank you for taking the time out of your day to come here and discuss your ideas. In this interview, you are the expert and I am learning from you. Additionally, participation is completely voluntary, and I will be asking for your consent before we get started.

When we begin, I will be asking several questions to help facilitate the interview, but please feel free to add any additional areas of importance that may describe your experiences in the workplace. Your personal views and opinions are important to me. There are no correct or incorrect answers, and you are welcome to openly discuss your opinions to each question. The conversation will be audio recorded, and the purpose of this is solely for research. Only myself and my research assistant will be reviewing the tape, to avoid missing anything important. Please note that no names or personal information will be used in the final report.

The discussion will last approximately 30 minutes, and again, I want to thank you for your participation in this today, and I really appreciate your help! Do you have any questions before we get started?

Introduction:

Could you state your name, title, and department?

Topics:

1. *What do you feel is the most rewarding part of your job?*

2. *What do you feel is the most challenging part of your job?*

Appendix D (continued)

3.   *What do you know about Compassion Fatigue (CF) and Burnout (BO)?*

4.   *If you have experienced CF or BO, can you share what they look like for you?*

   a.   *Prompt (if needed): I am asking about any symptoms that you might have experienced because of CF or BO.*

5.   *How does CF and BO affect your work with patients?*

6.   *How does CF and BO impact your personal life?*

7.   *What do you do or have you done in the past to reduce symptoms of CF and BO?*

8.   *What systemic measures, if any are in place at or through your work settings to help employees manage symptoms of CF and BO?*

   a.   *Prompt (if needed): What do you feel could be done to aid in managing these symptoms?*

9.   *What barriers do you face in managing symptoms of CF and BO?*

10. *How do you feel stigma may impact management or treatment of CF/BO for yourself or colleagues?*

   a.   *Prompt (if needed): Either through self-care or formal treatment*