Compassion Fatigue: Moving From Fatigued to Resilient

Combined Sections Meeting 2014

Speaker(s):
Kelly Doszak McArdle, PT, DPT, OCS, cert MDT
Lisa Hoglund, PT, PhD, OCS, Cert. MDT
Risheeta Joshi, DPT
Susan Klappa, PT, PhD

Session Type: Educational Sessions
Session Level: Basic

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Section on Health Policy & Administration
of the American Physical Therapy Association
COMPASSION FATIGUE: MOVING FROM FATIGUED TO RESILIENT – BE A CATALYST FOR HEALING IN TODAY’S HEALTHCARE ENVIRONMENT!
COMBINED SECTIONS MEETING 2014
Las Vegas, NV ◊ February 04-06, 2014
Feb. 4, 2014  8:00 – 10:00 am
Venetian Hotel and Resort
Casanova Ballroom: Room 505

Speakers:
♦ Kelly DuszakMcArdle, PT, DPT, OCS, Cert. MDT, Clinical Specialist Physical Therapist, Physical Medicine and Rehabilitation Department, Mercy Philadelphia Hospital, 501 South 54th Street, Suite 127, Philadelphia, Pa. 19143 Email: k duszak@mercyhealth.org.

♦ Risheeta K. Joshi, PT, DPT, Outpatient Manager, Physical Medicine and Rehabilitation Department, Mercy Philadelphia Hospital, 501 South 54th Street, Suite 127, Philadelphia, Pa. 19143. Email: rjoshi@mercyhealth.org.

♦ Susan G. Klappa, PT, PhD – Associate Professor, Stefani Doctor of Physical Therapy Program, University of Saint Mary, Leavenworth, KS. 66048 Email: sue.klappa@stmary.edu.

♦ Lisa T. Hoglund, PT, PhD, OCS, Cert MDT – Assistant Professor, Department of Physical Therapy, University of the Sciences, Philadelphia, PA, 19104. Email: l.hoglund@usciences.edu.

*ATTENTION ALL ATTENDEES: Please take the time to print out, complete and bring the ProQOL Survey located at the end of this handout as Appendix 1 prior to this session.

Presentation Description: Regardless of practice setting, Physical Therapists (PT's) face daily clinical and administrative demands. Additionally, patients seeking care bring a variety of their own issues to the treatment encounter. Compassion is a fundamental behavior outlined in the APTA Code of Ethics and one of our professional core values. But what happens when we become “fatigued” in our compassionate care when delivering Physical Therapy (PT) services? Compassion Fatigue (CF) refers to the behavioral, cognitive, and psychological changes caregivers experience when dealing with patients or clients. CF has been studied in other healthcare professionals but little is known about its impact on PT's. If undetected, it can lead to self-destructive behaviors or career changes. In today’s environment of healthcare reform, increased productivity demands, pay for performance model's, PT's may experience some degree of CF no matter their practice setting and may not even be aware of it. The ability to recognize the signs and symptoms of CF is the first step in the healing process. Can we predict those clinicians who are at risk for CF? How do we best assist PT's who are experiencing CF? This session will focus on the body’s response, stages, and physiological regulation of CF. Discussions will also include case reports, strategies for healing and prevention, and possible incorporation into academic programs and education.

Key Words: Compassion Fatigue, Compassion Satisfaction, Burnout

Presentation Objectives: At the conclusion of this session, the participant will be able to:

1. Define compassion fatigue (CF), its symptoms, and five stages.
2. Identify current individual stage of CF and give examples of applicable feelings or symptoms.

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3. Identify five resiliency strategies for “self-treatment” of CF or for assisting colleagues with CF.
4. Identify how a person’s current CF levels may not only impact themselves but other individuals, professionals, and members of their current workplace and membership organizations.
5. “Self-gauge” future individual and organizational CF levels and implement strategies in promotion of lifelong learning, professional development, and support of programs and missions, including a variety of clinical and academic settings.
6. Discuss the potential presence of CF in individuals working in non-clinical positions, including academia, management, or administration.

OUTLINE

Compassion Fatigue: Moving from Fatigued to Resilient - Be a Catalyst For Healing In Today’s Healthcare Environment

Risqueeta K. Joshi, PT, DPT
Mercy Philadelphia Hospital
501 South 54th Street, Suite 127
Philadelphia, PA 19143
Email: risheeta@verizon.net

- Compassion Fatigue
  • Everyday, in every practice setting Physical Therapists face clinical and administrative demands
  • The patients themselves, also bring their own issues to each treatment encounter
  • Compassion is a fundamental behavior outlined in the APTA Code of Ethics and one of our professional core values

- What is Compassion Fatigue (CF)?
  • Describes the “cognitive, emotional and behavioral changes that caregivers experience from indirect exposure to clients”
    (Craig, CD, Sprang D 2010)
  • CF has been studied in other healthcare professionals, little known about CF in PTs
  • Undetected, CF can lead to career changes or self-destructive behavior

- Compassion Satisfaction
  • Positive sentiment provider experiences when able to empathetically connect and feel a sense of achievement in the care giving process
  • Reinforced when providers see pts get better and believe they made a difference
  • Vital part of being emotionally fulfilled by one’s work in the human services field
    (Slatten, L, 2011)

- Hardiness Trait
  • Set of 3 dimensions:
    – Commitment: meaningfulness of life
    – Control: the ability to influence the course of events in one’s life

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Challenge: the expectation that it is normal for life to change

- Compassionate Process
  - Hold deep feelings about another’s suffering
  - Puts the interests of the patient in the forefront
  - Want to help, provide assistance to those who are struggling and provide protection for the victimized

- Compassion Fatigue
  - “a state of exhaustion and dysfunction (biologically, psychologically, and socially) as a result of prolonged exposure to secondary trauma or a single intensive event”
    
    (Slatten, L. 2011)

- Compassion Fatigue
  - Compassion Fatigue can result from synergistic effect of:
    - Primary Traumatic Stress
    - Secondary Traumatization
    - Burnout

- Compassion Fatigue vs. Post-traumatic Stress Disorders
  - Mimics symptoms of PTSD
    - Re-Experiencing / Intrusion
    - Avoidance/ Numbing

- What is Burnout?
  - “A psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment:
    - Perceived demands outweigh perceived resources
      

- Compassion Fatigue vs. Burnout
  - CF: number one stressor is the events in the patients’ lives

  - Burnout: can result from numerous stressors:
    - Patients with challenging traits
    - Burnout surfaces when the stressors are unrelenting

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– Context of the job: i.e. abusive bosses, inconsiderate behavior by physicians, high patient loads, severe organizational stress, limited resources, low salaries, changing shifts, demanding work unclear role expectations, unrelenting paperwork, staff shortages, inadequate supervision

- Role of the Two Nervous Systems
  - In Regulation of Compassion Fatigue

- Our goal for ourselves…
  - Non anxious presence vs. chronic anxious presence
  - Non anxious presence requires
    - Soft pelvic floor
    - Parasympathetic vs. sympathetic
    - Reciprocal inhibition
  - Outcomes of non-anxious presence:
    - Maximize performance, resiliency, neo-cortical functioning, transformational

- Two Nervous Systems
  - Parasympathetic Dominance
    - Maximal Cognitive and Motor Functioning
    - Intentional
    - Creative Problem Solving
    - Transformation

- Parasympathetic Dominance
  - Mobility and decision making capacity
  - Muscle relaxation = comfort
  - Problems = Challenge
  - Peak Performance (motor and cognitive)
  - Intentionality (internal locus of control)
  - Self-Regulation
  - “Healer” and “Transformer” of anxiety/traumatic stress

- Two Nervous Systems
  - Sympathetic Dominance
    - Compromised cognitive and motor functioning
    - Reactive
    - Coercive or hesitant
    - Learned through fear and trauma
    - “Fight/flight”
    - Increased threat perception (hyper-vigilance)
    - Reactivity- external locus of control
    - Carrier of anxiety and traumatic stress
Sympathetic Dominance
• How do you know when you are stressed?
  • Lose enjoyment
  • Physical Tension
  • Memory or Perception Gaps
  • Tired/ Sleep Disruptions
  • Other:

Goal is Compassion Fatigue Resiliency
• Non-Anxious Presence vs. Chronic Anxious Presence
• Reciprocal Inhibition
  – Self-awareness of changes in body, stressors and how to calm self
• Humor vs. Self-Care

Sensorimotor Approach
• Daniel Siegel, MD
  – “Without the balance of nonlinguistic world images, feelings, and sensations, the seduction of words and ideas can keep us from direct experience in our daily life and professional work”
  – Focus primarily on word-based thinking and narratives can keep people on surface and trauma/grief may remain unresolved

Sensorimotor Approach
• An overemphasis on logical, linguistic, and literal thinking vs. nonlinguistic may tilt balance of our minds away from holistic, sensorimotor, stress reducing, image based self regulatory function
• Linking these 2 very different but important ways of knowing creates balance in our lives and in our understanding of our own complex human experiences like grief, compassion fatigue, traumatic stress

Stress = Perception of Threat
• High Anxiety = Increased basal ganglia activity
• Sympathetic Dominance
• Normal = Decreased activity of the basal ganglia
• Parasympathetic Dominance

Neuroimaging and Stress
• Studies of traumatized people demonstrate that while under increased stress, the higher-level brain areas involved in executive functioning decrease in activity.
  – Planning for future
  – Anticipating the consequences for one’s actions

Compassion Fatigue: Intrusive Symptoms
• Thoughts and images associated with patients’ experiences
• Patient or work issues encroach on personal time
• Inability to “let go” of work-related matters
• Thoughts and feelings of inadequacy
• Sense of entitlement or “specialness”
• Personal activities interrupted by work related issues

❖ Compassion Fatigue: Avoidance Symptoms
• Silencing Response: Avoiding hearing pt’s experiences
• Loss of enjoyment in activities/cessation of self-care activities
• Loss of hope for/sense of dread in working with certain pt’s
• Isolation
• Relationship Dysfunction
• Loss of sense of competence

❖ Compassion Fatigue: Arousal Symptoms
• Increased anxiety/worry
• Impulsivity/Reactivity
• Increased frustration/anger
• Difficulty concentrating
• Somatic Symptoms
• Change in weight or appetite
• Sleep disturbance

❖ Compassion Fatigue: Silencing Response
• Diminished capacity to listen and communicate
• Loss of confidence
• Subtle manipulation of clients or falsification to avoid traumatic or painful material
• Diminished effectiveness

❖ Compassion Fatigue: Symptom Overview
• Difficulty separating work and personal life
• Lower frustration tolerance
• Dread of care-giving, loss of hope
• Ineffective or self-destructive self-soothing behaviors
• Diminished sense of purpose and enjoyment in activities
• Diminished capacity for intimacy

❖ Other terms…
• Roshi Joan Halifax, PhD.

Transcript notes from Compassion Edge States: Roshi Joan Halifax on Caring Better.

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“Inside Compassion: Edge States, Contemplative Interventions, Neuroscience”

- Edge states: where the individual’s identity is challenged
  - Includes *pathological altruism*: where we harm ourselves physically or mentally when we engage in the care of others

- Edge states: Burnout or Vital Exhaustion
  - Affects caregivers, teachers at university or wherever
  - Not able to actually establish correct agreements or boundaries with the institution for whom they are working, and as a result, become *completely depleted* (Halifax, 2013)

- Edge State: Secondary Trauma or Vicarious Trauma
  - Just being exposed to people who are suffering
  - As a caregiver, you hear stories of pain, trauma, suffering, abuse, and violence- it begins to get to you
  - You begin to suffer these affects vicariously (e.g., when people come back from the war) (Halifax, 2013)

- Even we as citizens…
  - Bombarded by media images, enter into a state of moral distress and futility
  - Moral distress where we see that something needs to happen → profound moral conflict because we can’t do anything about it
  - Enter state of moral outrage or states of avoidance (Halifax, 2013)

- Not compassion fatigue…
  - But *empathic distress*
    - “There is a resonance but we are not able to stabilize ourselves when we are exposed to this kind of suffering”
  - We have resilience when we are more stabilized and we can face the world with more buoyancy
    - Where we have more capacity to actually address profound social and environmental issues (Halifax, 2013)

**References:**

3. Rank M. Compassion Fatigue and Resiliency: Course Notes, Cherry Hill NJ. December 2011. Sponsored by Premier Education Solutions LLC.

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Compassion Fatigue: Moving From Fatigued to Resiliency. Be a Catalyst in Today’s Healthcare Environment

Kelly Duszak McArdle, PT, DPT, OCS, Cert. MDT
Clinical Specialist Physical Therapist
Mercy Philadelphia Hospital
501 South 54th Street
Philadelphia, Pa. 19143
Email:kduszak@mercyhealth.org

➢ Compassion Fatigue Risk Factors

➢ Healthcare Professionals/ Helpers at Risk

- Physicians/ Nurses(Oncology, Hospice, Pediatrics, ICU, Trauma, Psychology, Home Health); Emergency Medical Technicians, Social Workers/ Case Managers, Child Welfare Workers, Chaplains, Certified Nursing Assistants/Aides, Volunteers, and Family Members
  (Craig 2010; Showalter 2010; Potter 2008; Badger 2008; Hooper 2010)

- Allied Healthcare Professionals  Physical Therapists, Physical Therapist Assistants, Occupational Therapists, COTA, Speech Therapists, Rehabilitation Aides/Technicians, Administrative Assistants, and Non- Clinical positions such as, Academia???

➢ Risk Factors:
  o Personal
    - Women> Men
    - Low self-esteem
    - Hx of exposure to abuse/trauma
    - Perfectionist/High Standards
    - Lack of self-awareness
      - (Killian 2008; Potter2008)

  o Occupational
    - Helping/Service professions
    - Lack of supportive work environment
    - Intensity of work: long hours, increased caseloads and responsibilities
    - High standards of care
    - Increased productivity expectations
• Business Models

○ *Occupational Specific to PT*
  ▪ Increased productivity/demands
  ▪ Decreased staffing
  ▪ Organizational stressors: Company/system mergers
  ▪ Movement from Mission Values to Business Models
  ▪ Electronic medical records
  ▪ Increased case management demands
    ○ Increased paperwork demands/defensible documentation, Obtaining insurance authorizations
    ○ Insurance/referral tracking
    ○ Medicare: G Coding
    ○ Co-pays/Reimbursement Issues
  ▪ Management Positions:
    ○ See above examples
    ○ Continuing development of programs for departments with above changes, dealing with staffing issues related to above.
  ▪ Academia
    ○ Advising
    ○ Service Expectations
    ○ Scholarship/research expectations
    ○ Teaching loads
    ○ Dealing with the students and/or families issues or possible involvement

➢ **Effects on the Individual**
  ○ Decreased self-esteem/worth
  ○ Depression/Anxiety
  ○ Withdrawal from family, friends, colleague relationships
  ○ Unable to help self
  ○ Lack of sleep, exercise, recreational or enjoyable activities
  ○ Burnout and/or leaving jobs/ profession

➢ **Effects on the Organization**
  ○ Decreases in
    ▪ Morale
    ▪ Job satisfaction
    ▪ Productivity
    ▪ Referrals
    ▪ Patient satisfaction levels
    ▪ Ability to recruit new staff
    ▪ Professional Development/Enthusiasm
  ○ Increases in

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- Absenteeism
- Workman’s compensation issues
- Staff reluctance to change; Staff complaints, relationship changes, and issues; Staff expectations counseling needed; and Staff turnover
- Patient/Physician complaints regarding service
  - (Slatten 2011)

**Effects on the Profession (Potential)**
- Participation at and/or contributions to local, state, and national organizations or activities
- Participation/attendance at internal or external Continuing Education Activities
- Voluntary journal clubs, study groups, research activities
- Contributions to organizations/special causes
  - Contributions to PA-C/Volunteerism
- Clinical Instructors/Mentoring
- Professional Development

**5 Phases of Compassion Fatigue**
- **Zealot Phase:** Idealistic; Enthusiasm overflows; Ready, committed, involved, and available; Want to make a difference; Volunteer; and Willing to go extra mile
- **Irritability Phase:** Oversights /lapses in concentration, mistakes; Downplay efforts at wellness, recovery, or hope; Use of humor strained/inappropriate; Avoid conversations or become short in communication; Unfair talk about medical/mental health problems; and Daydream or distance self
- **Withdrawal Phase:** Complaints regarding efforts; Personal life problems; Resist talking about our caregiving; Neglect friends, family, coworkers, and ourselves
- **The Zombie Phase:** Sadness/depression turns outward; Anger/blame others; Others become incompetent, ignorant or incapable; Develop disdain for our work; Loss of patience, sense of humor; and No time for joy or exercise
- **Pathology vs. Renewal/Maturation:** Overwhelmed; Consider leaving the job or profession; Somatic illness; and Perpetuity of symptoms; or Development of Hardiness, Resiliency, and Transformation
  - (Rank 2011; Alkema 2008)

**Assessments**
- ProQOL (Professional Quality of Life Survey) (ProQOL)
- Compassion Fatigue Self-Test
- Life Stress Test
  - (Showalter 2010)
  - [http://www.proqol.org/HelperPocketCard.html](http://www.proqol.org/HelperPocketCard.html)
  - [http://www.compassionfatigue.org/pages/compassionfatigue.html](http://www.compassionfatigue.org/pages/compassionfatigue.html)
The ProQOL
- Measures Compassion Fatigue through Compassion Satisfaction (CS), Burnout, Secondary Traumatic Stress (STS) and Compassion Fatigue
  - Compassion Fatigue has three subscales measured by ProQOL

- **Burnout**
  - **Burnout Scale**
    On the burnout scale you will need to take an extra step. Starred items are “reverse scored.” If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are *not* happy so you reverse the score you wrote to “5”.
    - *1. ____ = ____   17. ____ = ____
    - *4. ____ = ____   19.____
    - 8.______ 21.____
    - 10.______ 26._____
    - *15.____ = ____  29.____ = ____
    Total = ______
    The sum of my burnout questions is____, so my score equals____ and my burnout level is____.

- **Secondary Traumatic Stress (STS)**
  - **Secondary Traumatic Stress Scale**
    Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added them up, you can find your score on the table to the right.
    - 2. ____  14.____
    - 5.______ 23._____ 
    - 7.______ 25._____
    - 9.______ 28.____
    - 11.____
    - 13.____
    - Total : ______
    - The sum of my secondary traumatic stress scale is____, so my score equals____ and my STS level is____.

- **Compassion Satisfaction**
  - **Compassion Satisfaction (CS) Scale**
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- Copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.
  - 3. _____ 18.______ 27._____
  - 6. ____ 20.______ 30._____
  - 12. ____ 22.______ Total:____
  - 16. ____ 24._____

- The sum of my Compassion Satisfaction questions is _____, so my score equals______ . And my Compassion Satisfaction level is______.
  - http://www.proqol.org/Helper_Pocket_Card.html

- **Intervention/Healing Strategies**
  - **Individual: 5 Antibodies to Rx Compassion Fatigue**
    - **Self Regulation**
      - Relaxation of Pelvic Floor/ Jaw Musculature
      - Regains neocortical function in < 30 seconds
      - Impossible to experience stress- comfortable in one’s own skin
    - **Intentionality**
      - Mission Driven, Internal Locus of Control
      - Principle Based
      - Tolerance for pain and growth
      - Maturation of Spirituality
      - Psychological Hardiness
      - Self Validation
      - Connection
      - Self Care
    - **Self-Validated Caregiving**
      - Caregiving from Mission statements
      - Resolution of attached trauma
      - Resilient to judgment
      - Sense of strength balanced with humility
      - Resiliency
    - **Connection and Support**
      - Inner circle
      - Empowering select few to confront when symptomatic
      - Ability to “ tell on self”
      - **Accountability**
      - Authentic self
      - Resolve attachment trauma- move on
- Create community
- “Debriefing”

- Self Care
  - Refueling Vaccine- Fuel for Enduring the burning
  - Active instead of passive
  - Aerobic exercise activity 3 x a week
  - Music/Art/Sport
  - Solitude/Nature/Spirituality
  - Intentional Plan
  - Prayer
  - Meditation/Yoga
    - (Rank 2011; Killian 2008; Alkema 2008)

- Organization
  - Encourage environment where compassion is expected, recognized, valued, and celebrated
  - Development of an optimal caseload mix
  - Consider offering holistic self-care activities or stress reduction courses
  - Example Mercy meditation
  - Formal mentoring program
  - Renewal and restructuring to support human development, increased autonomy
  - Team Meetings
    - (Slatten 2011; SHOWALTER 2010)

➢ Presence of Compassion Fatigue In Physical Therapists and Strategies for Resiliency: A Case Report

- Background:
  - CF has been studied in several healthcare professional but there is limited research in PT

- Purpose
  - To determine if PT’s working at Inpatient and Outpatient urban hospital experience CF
  - To look at staff awareness and presence of CF prior to and after staff educational session on the topic
  - To introduce and examine use of coping strategies staff may use after education program

- Description/Process
  - 1. 5 hour educational session focusing on:
    - Symptoms, and stages of CF, role of parasympathetic and sympathetic nervous systems, goals of CF resiliency, coping strategies, 15 minute meditation
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- Pre- and Post-educational session surveys including ProQOL’s:
- Determined general awareness, personal experiences, and presence of CF, staff questionnaire of symptoms
- Coping strategies staff currently utilized or those they planned to utilize
- 6 week post education surveys looked at awareness of and changes in CF symptoms as well as coping strategies utilized

- **Outcomes**
  - 93% of staff w/ average or low levels of CF, 7% w/ high levels of CF
  - Mentoring Program, utilization of Evidence Based Practice (EBP) may have resulted in lower levels of CF in staff
  - 6 week Post Education follow up surveys indicate no significant change in burnout, ST, CF.
  - Survey indicated staff felt validated or more aware regarding their CF symptoms and felt CF symptoms may depend on how they feel “physically” at time

- **Discussion**
  - Future Studies/ Research areas of CF in variety or rehabilitation settings; Use or development of an alternative assessment tool (DISC)

<table>
<thead>
<tr>
<th>Pre-Education Surveys (N=12) 6 Week Post Education Surveys(N=8)</th>
<th>High Pre-Education</th>
<th>High Post-Education</th>
<th>Avg Pre-Education</th>
<th>Avg Post-Education</th>
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<tr>
<td>Burnout</td>
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<td>27%</td>
<td>25%</td>
<td>73%</td>
<td>75%</td>
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</table>

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Mercy Philadelphia Hospital Physical Medicine and Rehabilitation Department  
Sister Mary Joan Hart, Manager of Pastoral Care and Services, Mercy Philadelphia Hospital

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12. Rank M. Compassion Fatigue and Resiliency: Course Notes PhD, Cherry Hill NJ. December 2011. Sponsored by Premier Education Solutions LLC.


### COMPASSION FATIGUE: A Model for Re-entry after Disaster Relief Work in Haiti

Sue Klappa PT, PhD
Associate Professor
University of Saint Mary
Stefani DPT Program
Leavenworth, KS
Email: sue.klappa@stmary.edu

0 **Introduction: Physical Therapists & Disaster Relief Work**

0 7.0 magnitude earthquake in Port-au-Prince, Haiti

0 January 12th, 2010

0 7.8 billion dollars in damages

0 230,000 deaths

0 300,000 injured

(United Nations, 2011; USAID, 2010)

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Re-Entry Study Purpose

- To investigate the re-entry process of health care providers, including physical therapists who participated in relief work in Haiti

Research Questions

- What is the return experience of physical therapists and other health care providers who have volunteered in Haiti?
- What are the levels of compassion fatigue, secondary trauma, and burnout experienced by health care workers upon their return from Haiti?
- Is it possible to predict who is at risk for developing compassion fatigue?

Methods: Mixed-Methods approach

Phase 1: Survey tool
- Participants: n=90
- Professional Quality of Life (ProQOL) survey (Stamm & Hundall, 2010)

Phase 2: Phenomenological interviews
- Participants: n=15

Methods: Diagram of Research

Results

- Quantitative: ProQOL Survey (Phase 1)
- Quantitative: Phenomenological Interviews (Phase 2)

Results: Demographic Info:

- Participants (n= 90) recruited from NGOs who met inclusion criteria
- Occupation Distribution:
  - Pharmacists (2%)
  - Physicians (10%)
  - Physical Therapists (44%)
  - Physician Assistants (1%)
  - Occupational Therapists (6%)
  - Prosthetists (6%)
  - Nurses (17%)
  - Logistics & Administrators (14%)

Participants (Phase I - Continued)
Debriefing provided?
- 27% Yes; 73% No

Home countries:
- United States (93%)
- Canada (4%)
- Haiti (1%)
- Japan (1%)
- Netherlands (1%)

Quantitative PROQOL Results

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean Score</th>
<th>Standard Deviation</th>
<th>Level relative to normal</th>
<th>Cronbach’s alpha p &lt; .001</th>
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<tbody>
<tr>
<td>Secondary Trauma*</td>
<td>21.04</td>
<td>7.64</td>
<td>Low</td>
<td>.90</td>
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<tr>
<td>Burnout*</td>
<td>19.25</td>
<td>6.58</td>
<td>Low</td>
<td>.87</td>
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<tr>
<td>Compassion Satisfaction</td>
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*Factor analysis revealed these variables were components of compassion fatigue (CF) among participants.

Correlations

- Pearson Correlation Coefficients however, revealed that Compassion Satisfaction and Trauma Scores were inversely related (-.230, p < .05).
- Compassion Satisfaction and Burnout Scores were also inversely related to each other (-.586, p < .001).
- Trauma with Burnout: Positively correlated (.637, p < .001) and were revealed to be components of CF by factor analysis.
- All were statistically significant.

BUT . . . Factor Analysis Revealed

- There were 2 factors associated with Trauma and 2 associated with Burnout.
- For Trauma, there were external and internal control factors that affected the Trauma score and that 68% of the variance in Trauma was explained by these factors.
- For Burnout, there were both external and internal strategies that affected the Burnout score with 66% of the variance in Burnout being explained by these factors.
Regression Analysis

- Compassion Fatigue could be predicted from a participant’s Burnout and Secondary Trauma scores on the ProQOL.

Model: Predicting Compassion Fatigue

CF = 5.219 + .174 (Trauma Ave.) - .650 (Burnout Ave)

Qualitative Themes: Phase 2

- Personal
- Family
- Professional
- Creative Coping Strategies
- Suggestions for Re-entry Processing

One Description of CF

- You know, in Haiti, we had people traveling for 5 hours to see us and they would wait all day if that was necessary. And then to have people back home here that would just cancel on you last minute, or complain about their appointment time or how horrible their life was because they had back pain once in the last two weeks or that they did not like their cane, well, that was really, really difficult. I think it probably took me about a month and a half to feel like I had the same passion for my work at home as before Haiti. I wanted to say, ‘Whatever! You have access to all these doctors, why are you complaining? You are just so spoiled.’ But I didn’t. It was just a difficult transition back to work. It took a lot longer than I thought it would. You know, my patience did get better but I couldn’t empathize with the American healthcare setting for like a month and half. It was hard getting back to work.”MC” PT, USA

Creative Coping Themes

- Journaling
- Social networking
- Creative writing/Song writing/Dance
- Giving Presentations

Suggestions for Reentry Process

- Social support most important
- Social networks suggested included:
  - Online community board
  - Facebook™
  - Skype™
  - Email lists
- Official debriefing sessions
Discussion

- **Re-entry challenges** were unexpected and influenced significant aspects of life upon return home.

- **Factor analysis** revealed **Secondary Trauma** and **Burnout** are two contributing components to **CF** which the ProQOL did not initially demonstrate as being crucial components . . .

- Therefore, when levels of **Secondary Trauma** and **Burnout** are grouped together as **CF**, participants’ interactions with patients and others were affected.

- **Trauma Locus of Control**: Internal & External

- **Burnout**: Internal or External Strategies available influenced the reentry process.

Strengths/Limitations of Study

**Strengths**:
- Adequate Sample size ALLOWED FR SATURATION
  - ProQOL survey (n= 90)
  - Interviews (n= 15)
- Thick, rich descriptions of the Re-Entry Experience were obtained
- Phenomenological interviews performed by experienced interviewer
  - Bracketed prior to interviews: Reflective journaling
- Interviewer not involved in identification and analyzing of themes
  - Limited bias

**Limitations of Study**:
- Results do not apply to every disaster
- Experiences are specific to this group of health care providers
- The ProQOL is meant to be administered within 30 days of the experience (Stamm & Hundall, 2010)

Conclusions & Implications for PT

- Social Responsibility is important . . . BUT . . .

- We need to better anticipate support needed for those who engage in this DRW.

- Professional organizations need to provide resources to aid in easing the re-entry process.

Questions
Acknowledgements

- Our Participants
- My Student Research Team:
  - Kelsey Leeman DPT
  - Andrea Olson DPT
  - Abby Rassat DPT
  - Rita White DPT
- Donna Roles, Administrative Assistant
- DPT Faculty and Librarians
- Dr. David Fike PhD, UIW Research Statistician

REFERENCES


Compassion Fatigue: Moving From Fatigued to Resilient – Be a Catalyst for Healing
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Compassion Fatigue, Burnout, and Compassion Satisfaction in Academia: Presence in Healthcare Professional Program Faculty and Traditional Higher Education Faculty

Lisa Hoglund PT, PhD, OCS, Cert MDT
Assistant Professor
University of the Sciences
Department of Physical Therapy
Philadelphia, PA
Email: l.hoglund@usciences.edu

Compassion Fatigue, Burnout, and Compassion Satisfaction in Teaching

- Teaching
  - Caring & human services profession
  - Stressful occupation
    - Administrative workload
    - Student behavior problems
    - Student emotional issues
  - Exposed to secondary trauma – students
    » McCormick & Barnett, 2011

Stress in Higher Education

- Insecure positions
- Higher workload
- Increased time spent on administrative tasks
- Demands of research and teaching
  - Tension → emotional exhaustion
    - Taris, et al., 2001

Teaching & Burnout

- Burnout
  - Component of Compassion Fatigue
  - Chronic stress in the workplace
  - Dimensions of burnout
    - Emotional exhaustion
      - Decreased emotional reserves
    - Depersonalization
      - Growing cynical & negative approach towards others
    - Reduced personal accomplishment
      - Decreased work satisfaction

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University Faculty: 4 Dimensions of Burnout

- Emotional exhaustion
- Depersonalization
  - “mental distance” towards fellow workers & people for whom one works – students, patients, clients
- Cynicism
  - “mental distance” towards work – teaching, research, administrative duties
- Reduced personal accomplishment
  - Salanova M, et al. 2005

University Faculty and Well-Being

- Well-Being in Faculty
  - Varies according to work profile
- Work Profiles
  - Teaching cluster
  - Research cluster
  - Management cluster
  - Teaching & Research cluster
  - Vera M, et al. 2010
- Research cluster
  - Lowest burnout
  - Highest work engagement & intrinsic satisfaction
    - But … research also a source of dissatisfaction – insufficient time
    - Oshagbemi T, 1997
- Management cluster
  - Highest burnout
  - Lowest work engagement & intrinsic satisfaction
    - Vera M, et al. 2010

University Teaching Staff & Burnout

- Comparable with other service sector employees
  - Teachers
  - Healthcare professionals
- Predictors of burnout
  - Strong predictor: high number of students
  - Other predictors
    - Gender
      - Males: higher depersonalization scores
      - Females: higher emotional exhaustion scores
    - Age
      - Younger: more vulnerable to emotional exhaustion
      - Watts & Robertson, 2011

Burnout in Nurse Academics

- Study of burnout in faculty at 2 institutions
  - Personal & workplace factors
  - Lower personal achievement

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Age ≤ 30 yrs
- Depersonalization
  - Single status
- Emotional exhaustion
  - No associated personal or workplace factors
  - Kizilci S, et al., 2012

Burnout in Physical Therapy Academics
- Currently no reports
  - Also no current report for Compassion Fatigue, Compassion Satisfaction, Burnout
- Burnout reported for physical therapy students, orthopaedic physical therapists, PTs at rehab hospitals
  - Balogun, et al. 1999
  - Wandling & Smith, 1997
  - Donohoe, et al. 1993

Compassion Fatigue, Burnout, & Compassion Satisfaction in Academia
- Pilot study: health care professional program faculty vs. liberal arts faculty
- Small, private university
- Variables
  - Advising students
  - Teaching hours
  - # students/class
  - Clinical practice
  - Years in academia
- Preliminary results
  - Compassion fatigue
  - Burnout
  - Compassion satisfaction
- Relationship to coping mechanisms
- Relationship to personal and workplace factors

Acknowledgements
- Our participants
- My co-investigator
  - Linda Robinson, PhD
  - Department of Behavioral and Social Sciences
  - University of the Sciences

References: Compassion Fatigue in Academia

**PANEL DISCUSSION**

**Thank You/Questions**
### APPENDIX 1: ProQOL Tool

**Professional Quality Of Life Survey**

**Mother’s Maiden Name:**

**Last 4 digits Primary Phone Number:**

© B. Hudnall Stamm, 2009-2012. *Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL) – www.proqol.org*. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold. Those interested in using the test should visit www.proqol.org to verify that the copy they are using is the most current version of the test.

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

When you *treat* people you have direct contact with their lives. As you may have found, your compassion for those you *treat* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *physical therapist*. 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

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. I am happy.</td>
<td>2. I am preoccupied with more than one person I <em>treat/help</em>.</td>
<td>3. I get satisfaction from being able to <em>treat/help</em> people.</td>
<td>4. I feel connected to others.</td>
<td>5. I jump or am startled by unexpected sounds.</td>
</tr>
<tr>
<td></td>
<td>6. I feel invigorated after working with those I <em>treat/help</em>.</td>
<td>7. I find it difficult to separate my personal life from my life as a <em>physical therapist/helper</em>.</td>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I <em>treat/help</em>.</td>
<td>9. I think that I might have been affected by the traumatic stress of those I <em>treat/help</em>.</td>
<td>10. I feel trapped by my job as a <em>physical therapist/helper</em>.</td>
</tr>
<tr>
<td></td>
<td>11. Because of my <em>helping</em>, I have felt &quot;on edge&quot; about various things.</td>
<td>12. I like my work as a <em>physical therapist/helper</em>.</td>
<td>13. I feel depressed because of the traumatic experiences of the people I <em>treat/help</em>.</td>
<td>14. I feel as though I am experiencing the trauma of someone I have <em>treated/help</em>.</td>
<td>15. I have beliefs that sustain me.</td>
</tr>
<tr>
<td></td>
<td>16. I am pleased with how I am able to keep up with <em>treatment/helping</em> techniques and protocols.</td>
<td>17. I am the person I always wanted to be.</td>
<td>18. My work makes me feel satisfied.</td>
<td>19. I feel worn out because of my work as a <em>physical therapist/helper</em>.</td>
<td>20. I have happy thoughts and feelings about those I <em>treat/help</em> and how I could treat them.</td>
</tr>
<tr>
<td></td>
<td>21. I feel overwhelmed because my case <em>work load</em> seems endless.</td>
<td>22. I believe I can make a difference through my work.</td>
<td>23. I avoid certain activities or situations because they remind me of frightening experiences of the people I <em>treat/help</em>.</td>
<td>24. I am proud of what I can do to <em>treat/help</em>.</td>
<td>25. As a result of my <em>helping/treating</em>, I have intrusive, frightening thoughts.</td>
</tr>
</tbody>
</table>

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26. I feel "bogged down" by the system.
27. I have thoughts that I am a "success" as a [physical therapist/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.

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

**Compassion Satisfaction**
Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

**Burnout**
Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

**Secondary Traumatic Stress**
The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a...
particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

**Compassion Satisfaction Scale**
Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

**Total:** _____
The sum of my Compassion Satisfaction questions is _____ . So My score = _______ And My Compassion Satisfaction level

<table>
<thead>
<tr>
<th>The sum of my CS questions is</th>
<th>SO My score equals</th>
<th>And my compassion Satisfaction Level is</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Around 50</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

**Burnout Scale**
On the burnout scale you will need to take an extra step. Starred items are “reverse scored.” If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are not happy so you reverse the score you wrote. For example if you wrote a score of “1” you reverse it to “5”; if you wrote a score of “2”, you reverse it to “4”.

*1. _____ = ____
*4. _____ = ____
8. _____
10. _____
*15. _____ = ____

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The sum of my Burnout Questions is ______ So my score equals ______ And my burnout level is:

<table>
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<tr>
<th>The sum of my burnout questions is</th>
<th>So my score equals</th>
<th>And my burnout level is</th>
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<tr>
<td>22 or less</td>
<td>43 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
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<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

**Secondary Traumatic Stress Scale**

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added them up you can find your score on the table to the right.

The sum of my Secondary Trauma questions is ______. So my score equals ______ And my Secondary Traumatic Stress level is ______.

<table>
<thead>
<tr>
<th>The sum of my Secondary Trauma questions is</th>
<th>So My Score equals</th>
<th>Any my Secondary Traumatic Stress level is</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
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<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>57 or more</td>
<td>High</td>
</tr>
</tbody>
</table>
Appendix 2: Compassion Satisfaction/Fatigue Survey

Please take the time to complete this survey and enter the information below. Thanks in advance for your cooperation!

Mother’s Maiden Name:

Last 4 digits Primary Phone Number:

1. Gender:
2. Age:
3. Race:
4. State you practice in?
5. Are you a PT or PTA?

6. Position/ Title:

7. Primary Work-Practice Setting (ie acute care, outpatient, emergency care, rehab, academia, management):

8. Secondary Work-Practice Setting:

9. Other:

10. Total years experience as PT/ PTA?

11. Total Years in current Position/ Setting:

12. Other positions held:

___________________________________ How long: ________________

___________________________________ How Long: ________________

___________________________________ How long: ________________

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13. Clinical Specialty/Certifications/ Additional Training:

14. Level of Education/ Highest Degree Earned?

15. Patient types or Primary Diagnoses seen in your setting/ Department:

16. Caseload mix or work responsibilities

Prior to this session, had you ever heard of Compassion Fatigue?

Did you find you had symptoms of Compassion Fatigue?

If yes, explain briefly:

Did you find you had symptoms of Burnout?

If yes, explain briefly.

Did you find this to be helpful to you in your current position in dealing with challenges at work?

If yes, explain briefly.

What did you find most helpful or like most?

Did you find anything unhelpful or feel this was not applicable to you? What strategies do you already use to help deal with symptoms of compassion fatigue (if applicable)

_____ Talk with a spouse family member

_____ Talk with your work supervisor, or Mentor/ colleague

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____ Talk with friends or colleagues

____ Talk with counselor or religious or spiritual guide person, such as a minister, priest, rabbi, nun or other spiritual mentor

____ Pray or talk to a deity

____ Exercise

____ Read

____ Dine out or get together with friends

____ Exercise or Other activities (Yoga, Pilates, Meditate)

____ Play (ie. Musical instrument, read, or hobbies)

____ Retire for evening to get sufficient sleep

____ Take a day off

____ Take a vacation

____ Write in a journal

____ Listen to Music

____ Watch TV

____ Alcohol / Nicotine or other substance use

____ Other:

If not already using strategies and you found identified yourself as having symptoms of compassion, fatigue, burnout or even challenges at work, what strategies do you think you will use in next 2-3 months?
Appendix 3: Mercy Health System - Informed Consent Document for Human Subjects

Research

Department: Physical Medicine and Rehabilitation

Principal Investigator: Kelly Duszak McArdle, PT, DPT, OCS, Cert. MDT

Telephone: 215-748-9160

Co-Investigator(s): Risheeta K. Joshi

Telephone: 215-748-9160

Co-Investigator(s): Susan Klappa, PT, PhD

Telephone: 913-758-4398

Co-Investigator(s): Lisa Hoglund, PT, PhD

Telephone: 215-596-8541

Medical Title: Compassion Fatigue: Moving from Fatigued to Resilient - Be a Catalyst for Healing in Today's Healthcare Environment!

What Is an Informed Consent?

You are being asked to take part in a research study. Before you can make a knowledgeable decision about whether to participate, you should understand the possible risks and benefits related to this study. This process of learning and thinking about a study before you make a decision is known as informed consent and includes:

- Receiving detailed information about this research study;
- Being asked to read, sign, and date this consent form, once you understand the study and have decided to participate. If you don’t understand something about the study or if you have questions, you should ask for an explanation before you sign this form;
- Being given a copy of your signed and dated consent form to keep for your own records.

Introduction and Study Purpose

Healthcare professionals are regularly exposed to stressors that may result in compassion fatigue, burnout, and compassion satisfaction. Compassion fatigue (CF) refers to the thoughts and emotions that caregivers experience when dealing with patients or clients. The purpose of this study is to determine if CF, burnout, or compassion satisfaction is present in physical therapists (PT’s) in a variety of settings. The results may help PT’s to “Self–gauge” future individual and organizational CF levels and implement coping strategies to promote professional longevity, lifelong learning, professional development, and support of programs and missions.

Procedures/Treatment

If you participate in this study, you will be asked to complete the Professional Quality of Life 5 Measure (ProQOL5) to determine the presence of any of the above variables. You will also be asked to complete an anonymous survey on general awareness and symptoms of CF and coping strategies that will include demographics such as age, gender, year of practice, practice setting, areas of clinical specialties in which you practice. The surveys will take about 15-20 minutes to complete. You will also be provided with a two hour education session focusing on: definition of CF, burnout, compassion satisfaction, and coping strategies.
compassion satisfaction; differentiation between post-traumatic stress syndrome and secondary traumatization; role of the sympathetic and parasympathetic nervous systems in CF regulation; stages of each response; goals of CF resiliency; and coping and interventions strategies. Strategies included development of mission statements, narratives, self-regulation and self-care activities. You will be contacted approximately 6 months later to do a follow up anonymous survey on symptoms of CF and coping strategies that will include demographics such as age, gender year of practice, practice setting, and areas of clinical specialties in which you practice, and barriers to implementing coping strategies. The surveys will take about 20-30 minutes to complete. All of your information will be kept confidential and your surveys will be assigned a subject number.

Risks/Discomforts You may recall some unpleasant moments when you were experiencing CF yet previous studies have found sharing stories regarding feelings of CF was helpful to members in moving through CF and secondary trauma caused by listening to patient situations of trauma.

Alternative Treatments
Your alternative is not to participate in this study.

Confidentiality
Any surveys obtained will be kept in a locked file cabinet by the principal investigator. All surveys will be scanned and submitted to a password protected dropbox that can only be accessed by the investigators involved in the study. Any results will be reported in aggregate and no personal information such as name, address, or employer will be released.

You may quit the study and revoke permission to use and share your surveys at any time by contacting the principal investigator, in writing, at: Kelly Duszak McArdle, PT, DPT, OCS, Cert MDT; Mercy Philadelphia Hospital, Physical Therapy Department, Suite 127, 501 South 54th Street, Philadelphia, PA 19143

If you quit the study further collection of your survey data will be stopped, but information that has already been collected may still be used.

Compensation in the Case of Injury
No financial compensation is available.

Benefits to Subject
You may benefit directly from your participation in this study. However, although you may not benefit directly from this research, there may be a benefit to society, in general, from the knowledge gained in connection with your participation in this study.

Payment
You will not receive payment for your participation in this study.
Contact Information

You may ask any questions you may have now. If you have any questions or concerns about this research, call the Principal Investigator, Dr. Kelly Duszak McArdle at 215-748-9160 or kduszak@mercyhealth.org. Should you have any questions regarding your rights as a research participant, you may contact Mercy Catholic Medical Center’s Institutional Review Board, which is concerned with the protection of participants in research studies, at Telephone: (610) 237-4975.

Significant New Findings

As the research progresses, any significant new finding(s), beneficial or otherwise, will be told to you and explained as they relate to the course of your participation.

Disclosure of Financial Interest

Dr. Duszak McArdle, Dr. Joshi, Dr. Susan Klappa, and Dr. Lisa Hoglund, the investigators conducting this study, have no financial interests to disclose.

Costs of the Research: None

Voluntary Consent and Subject Withdrawal

You voluntarily consent to be in this research study. You have been told what being in this study will involve, including the possible risks and benefits.

You may refuse to participate in this investigation or withdraw your consent and discontinue participation in this study without affecting your ability to receive medical care at Mercy Catholic Medical Center.
Non-Waiver of Legal Rights Statement

By your agreement to participate in this study, and by signing this consent form, you are not waiving any of your legal rights.

In order to be in this research study, you must sign this consent form.

You affirm that you have read this consent form. You have been told that you will receive a copy.

Signatures:

______________________ (Date)
Your Name (please print or type)

______________________ (Date)
Your Signature

______________________ (Date)
Witness Signature
(Only required if subject understands and speaks English, but cannot read English, or if subject is blind or cannot physically sign the consent form—delete if inapplicable)

______________________ (Date)
Name of Person Conducting Consent Interview

______________________ (Date)
Signature of Person Conducting Consent Interview

______________________ (Date)
Signature of Principal Investigator or Co-Investigator