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Compassion Fatigue Among Help Me Grow Care Coordinators: A Case Study

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COMPASSION FATIGUE AMONG HELP ME GROW CARE COORDINATORS:
A CASE STUDY

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A DISSERTATION

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COMPASSION FATIGUE AMONG HELP ME GROW CARE COORDINATORS:
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ABSTRACT

The purpose of this exploratory sequential mixed methods case study was to explore the perceptions of the prevalence and impact of compassion fatigue among Help Me Grow (HMG) care coordinators throughout the United States. Guided by the compassion fatigue and professional quality of life theories as the conceptual framework, the prevalence of compassion fatigue was explored quantitatively through the Professional Quality of Life questionnaire (ProQOL) and the impact of compassion fatigue was explored qualitatively through semi-structured, open-ended interviews. The ProQOL questionnaire results indicated that no participants were experiencing compassion fatigue. Seven key themes emerged from the qualitative interviews, including (a) developing relationships and establishing trust with families, (b) love of being a care coordinator, (c) empathy and compassion required, (d) communication skills required, (e) physical and emotional symptom, (f) struggle to establish boundaries, and (g) self-care and external support as coping strategies. Findings of this study revealed that although all study participants reported low levels or risk of compassion fatigue according to the ProQOL questionnaire results, participants seem to be experiencing the impacts of compassion fatigue based on the narratives shared during the interviews.

Keywords: Burnout, Care Coordinators, Compassion Fatigue, Compassion Satisfaction, Help Me Grow, Secondary Traumatic Stress, Self-care, Professional Quality of Life, Professional Quality of Life Scale (ProQOL)

University of New England

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DEDICATION

I dedicate this work to my family. Mom, the laughs from your stories about hummingbirds, neighborhood cats, and secret shoppers at Publix have been a great distraction during stressful times throughout this journey. Dad, thank you for always being there to listen and give advice. You have always been my sounding board and I am so grateful for that. Thank you both for giving me a life I never would have had and for always believing in me, even when I did not believe in myself. Thank you for the unconditional love you have given me, sacrifices you have made, and privileges that you have afforded me.... I would not be who I am, or where I am, without you both.

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CHAPTER 1: INTRODUCTION

“The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet,”

Remen, 2006, p. 48

Humans are deeply caring individuals that are taught to care for the needs of others before tending to personal needs (CFAP, 2020). Workers that are positioned in caregiving or helping environments are regularly faced with heart-wrenching or emotional challenges (CFAP, 2020). The occupational hazard of working with individuals that have experienced distress or trauma is known as compassion fatigue (Day & Anderson, 2011; Showalter, 2010). Specifically, working with children and families who are experiencing fear, pain, and suffering can have significant effects on the professionals assisting them and may contribute to the development of compassion fatigue (Branch & Klinkenberg, 2015; Geoffrion, Morselli, & Guay, 2016). Care coordinators within the Help Me Grow (HMG) system work directly with children and families that have questions or concerns about their child’s development and/or assistance accessing basic and essential needs (Therriault et al., 2020). Care coordinators develop strong relationships with those they serve through constant communication and unfailing emotional support, and by addressing their concerns, questions, and needs (Therriault et al., 2020; R. Gabriel, personal communication, June 21, 2020). The consistent support that is provided to families can take a toll on care coordinators’ well-being and make them vulnerable to compassion fatigue (Geoffrion et al., 2016).

Figley (1995) defines compassion fatigue as a state of “bearing the suffering of clients” (p. 7). It is the tension and preoccupation of healing those that are suffering that results in secondary traumatic stress for the helper (Figley, 1995). The Compassion Fatigue Awareness

Project (2020) describes compassion fatigue as a set of symptoms, not a disease. These symptoms, which include a combination of physical, emotional, or spiritual exhaustion or depletion, are elevated displays of chronic stress resulting from working with those who have experienced emotional or physical pain and distress (Figley, 1995; CFAP, 2020).

Compassion fatigue is a broadly defined concept (CFAP, 2020) that can have negative consequences to those that help or care for others in multiple aspects of their professional and personal lives (Adimando, 2018). Workers that experience compassion fatigue may begin to reduce the compassion and empathy that they provide for patients or clients they serve (Lombardo & Eyre, 2011). Other potential work-related consequences include decreases in quality and safety of the care that is provided, job satisfaction, employee retention, and productivity, and level of employee-employer engagement (Anderson, 2000; Lombardo & Eyre, 2011). The consequences of compassion fatigue that may affect the individual directly include risks to their physical and emotional well-being (Kapoulitsas & Corcoran, 2015; Figley, 1995). Symptoms include disturbances to sleep patterns, concentration problems, muscle tension, and increased headaches (Figley, 1995; Figley, 2002; Lombardo & Eyre, 2011).

While the current literature presents the existence of compassion fatigue among a variety of professions (Turgoose & Maddox, 2017), there is a gap in the literature regarding the prevalence of compassion fatigue among care coordinators (Au, Kehn, Ireys, Blyler, & Brown, 2018). Care coordination is the process that links or facilitates people to needed services and resources in a coordinated, collaborative, and integrated effort (AAP, 1999; Au et al., 2018). Care coordinators work to address all needs that a child or family might have by linking and referring families to local resources (Au et al., 2018). Care coordinators within the Help Me Grow (HMG) system provide empathy and support (Werdhani et al., 2018) to children and

families as they navigate through the early detection and intervention process (Cornell et al., 2018; Cornell et al., 2019). The empathy and support that HMG care coordinators provide to the children and families they serve make them vulnerable to emotional exhaustion and compassion fatigue (Hansen et al., 2018).

HMG is a system model that aims to build comprehensive, effective, and organized early childhood systems of community resources working towards a shared goal (Therriault et al., 2020). HMG promotes the healthy development of children by supporting early detection and intervention of developmental delays and helping families to access basic and essential human needs (Cornell et al., 2018; United Way Worldwide, 2020). In 2019, there were 104 HMG systems in 31 states (Therriault et al., 2020). Any family that resides in an HMG service area may contact HMG through the system's centralized access point (CAP), typically a phone center or call line (Therriault et al., 2020). The only eligibility criteria is the child's residence and age, which differs across HMG systems. Through this line, HMG care coordinators solicit any concerns or questions that families may have about the health, development, behavior, or learning of their child (Therriault et al., 2019). The care coordinator will offer a free developmental or behavioral screening that will help assess their child's development, review the results with the family, and link children and families to needed services (including child development services and basic needs/human services) (Honigfeld et al., 2012). Once referrals have been made, the care coordinator stays in constant communication with the family, helping them develop a plan of care and to navigate the system, then following up with families to ensure successful connection to services (Silow-Carroll & Hagelow, 2010).

Care coordination is especially important for children. Care coordination for children and youth often requires support through communication and relationships (AAP, 2014). Models that

are centered around early intervention provide family-focused coordination of care to connect families and children with needed resources that can help address the child's developmental concerns or delays and optimize the child's health (Ideishi, O'Neil, Chiarello, & Nixon-Cave, 2010). Following these models, HMG care coordinators support children by prioritizing the child and their family's needs to maximize the potential of the family's ability to thrive (Therriault et al., 2020).

The HMG system provides an opportunity for families to get connected to community resources to help them thrive. To help families understand their child's developmental milestones, or things that most children can do by a certain age (CDC, 2020b), developmental and behavioral screenings are offered to each family. Care coordinators guide families through the screenings, score them, and review the results with the family. Any developmental concerns that are presented can lead to great stress within the family as a result of their inability to access resources, secure quality service providers, or seek support from the professional community (Kalek, 2008). These needs and demands (Kalek, 2008) greatly contribute to increased communication and established relationships between the family and their care coordinator. Parenting a child with developmental disabilities can negatively affect a parents' well-being (Cummings, 1976) and may lead to depression, anxiety, and low self-esteem as a result of the subsequent stress (Kalek, 2008). The stress faced by parents of children with developmental disabilities results from the need for specialized care, children's developmental milestones not being achieved at appropriate ages, and worrying about the child's future (Akkok, 1996). Stress may also be experienced as a result of concerns securing quality service providers and seeking support (Boyd, 2002). Boyd (2002) states that social support is a large factor that has been shown to alleviate parental stress related to parenting a child with a disability. He further explains that

this social support may include formal services from professional-based organizations (Boyd, 2002). The HMG system care coordinators are responsible for providing this support to families that the program serves.

With limited research on compassion fatigue in the care coordinator profession, a case study focusing on compassion fatigue among HMG care coordinators will help add to the existing literature on compassion fatigue in helping professions. The researcher intends to explore the perceptions of the prevalence and impact of the condition within HMG care coordinators who work directly with families by collecting data through a questionnaire and subsequent interviews. This chapter will provide a general overview of the forthcoming study, including the problem statement, purpose, research questions, framework, limitations, and a definition of terms.

Statement of the Problem

In helping and caring professions, individuals often open their hearts and minds to those they serve (Francoise, 2015). However, this empathy makes helpers and caregivers vulnerable to being strongly affected or distressed by their work and therefore susceptible to compassion fatigue (Francoise, 2015). Existing research and literature on compassion fatigue examine the phenomena in a variety of professions including medical professionals, mental health counselors, social workers, and first responders (Turgoose & Maddox, 2017). Despite the research on compassion fatigue in a variety of helping professions, there is a major gap in the literature on compassion fatigue in the care coordination field. Therefore, the researcher conducted a case study to explore the impact of compassion fatigue among HMG care coordinators. Considering the negative consequences that are associated with compassion fatigue, the quality and efficiency of care that is provided to clients are at risk (Cesta, 2018; Upton, 2018).

Purpose of the Study

The purpose of this mixed methods case study was to explore the perceptions of the prevalence and impact of compassion fatigue among HMG care coordinators in the United States. HMG care coordinators serve children and families by providing free developmental and behavioral screenings, child development information and parent education, and referrals to local services and supports (Therriault et al., 2020). To serve children and families in their communities, HMG care coordinators listen to family stories, collect sensitive information and data, and answer any questions or concerns that a caregiver may have about their child's development (Therriault et al., 2020). The compassionate care, empathy, and support that care coordinators provide to their clients (Monterio, Arnold, Locke, Steinhorn, & Shanske, 2016; Werdhani et al., 2018) can lead to negative consequences for the empathizer (Hansen et al., 2018). The occupational stress experienced as a negative consequence of compassionate care is also known as compassion fatigue (Killian, 2008). As a result of the nature of their work, HMG care coordinators are susceptible to compassion fatigue (R. Gabriel, personal communication, June 21, 2020). Exploring the incidence and impact of the compassion fatigue phenomena among the HMG care coordinators has provided insight into the professional and personal effects it has on care coordinators, in addition to the quality and efficiency of care that care coordinators provide to their clients.

Research Questions

Despite the vast existing literature that explores compassion fatigue in helping and caring professions, the lack of research on compassion fatigue among care coordinators provides an opportunity for further exploration. This sequential explanatory mixed methods study aims to fill a gap in the compassion fatigue research by exploring the perceptions of the prevalence and

impact of compassion fatigue among care coordinators. The following research questions guided this study:

1. What are Help Me Grow (HMG) care coordinators, located in the United States, perceptions of the prevalence of compassion fatigue among HMG care coordinators?
2. How do HMG care coordinators perceive the effect of compassion fatigue among themselves professionally and personally?

Conceptual Framework

A conceptual framework presents an integrated way of looking at a problem within a study (Adom, Hussein, & Adu-Agyem, 2018). It describes the relationship between the main concepts of the study by linking concepts, empirical research, and important theories (Adom et al., 2018). The researcher developed the conceptual framework for this study as a way to specify and define the concepts with the problem being addressed by considering the topical research, personal interest, and theoretical framework.

The topical research on compassion fatigue supports the idea that it is an occupational hazard; a state of different forms of exhaustion that is dependent on a caring relationship that results in a loss of coping ability (Day & Anderson, 2011). The majority of the existing literature on compassion fatigue explores its symptoms and effects on helping and caring professions. The research also finds that symptoms associated with compassion fatigue can affect an individual's professional or personal life and may lead to burnout (Sprang, Clark, & Whitt-Woosley, 2007).

The researcher is personally interested in the topic of compassion fatigue due to their professional role as the statewide director of an HMG state affiliate. In this role, it is the researcher's responsibility to ensure that the system is being implemented appropriately and efficiently throughout the state and that quality care is being provided to children and families.

The negative effects that accompany compassion fatigue may negatively impact the compassionate care that HMG care coordinators provide to children and families (Sprang et al., 2007; R. Gabriel, personal communication, June 21, 2020).

The theoretical frameworks for this study are Figley's (1995) compassion fatigue theory and Stamm's (2010) professional quality of life theory. Through these theoretical concepts, this study aims to explore the perceptions of compassion fatigue among care coordinators throughout the national HMG system. Compassion fatigue theory, which was used as this study's theoretical foundation, was initially proposed by Figley (1982) and was used throughout his academic work on traumatology. Figley (2002) defined compassion fatigue as the tension, preoccupation, and lack of empathy a formal caregiver experiences from witnessing the suffering of a client who has experienced or suffered from trauma. This theory describes emotional, mental, and physical symptoms experienced by helping professionals by virtue of their profession (Stamm, 1995). The professional quality of life theory (Stamm, 2010) explores the well-being of helpers within the workplace, centered on positive (compassion satisfaction) and negative (compassion fatigue) aspects or sense about their work. Stamm's (2010) compassion fatigue concept can be broken up into two parts- burnout and secondary trauma.

Assumptions, Limitations, and Scope

There are several assumptions that could have potentially influenced this research study. During the data collection process, the researcher worked under the assumption that the participants responded honestly and candidly. Additionally, the researcher worked under the assumption that the study's participants only participated to support the researcher's purpose in conducting the study, as opposed to participating for reasons such as impressing their supervisor or earning a potential raise or bonus from their employer.

Additionally, this study had limitations that must also be considered. One limitation to this study was the timeframe in which it was conducted. Because this study took place amid the COVID-19 pandemic (Masonbrink & Hurley, 2020; Saberi, 2020), the results may not be a fair representation of the professional and personal effects of compassion fatigue among HMG care coordinators experienced on a regular basis. The COVID-19 pandemic is affecting the work of telephone support services with callers, the types of problems that their callers are facing, and how they are able to respond to and meet the needs of those calling (Fisher et al., 2020). This could have potentially skewed the professional and personal experiences that HMG care coordinators experience, as well as the experiences that the children and families they serve. Another limitation to this study may have been the researcher's association with the program of focus. While deemed credible as a result of their "training, experience, track record, status, and presentation of self" (Patton, 1999, p. 1190), the researcher's association with the program of focus may have prevented questionnaire respondents and interview participants from being truthful with their responses.

The researcher ensured this study's credibility through a variety of strategies including remaining engaged with the study participants during the interviews and data triangulation (Korstjens & Moser, 2018). The researcher actively listened and conversed during the open-ended interviews to foster a rapport with the participants, which encouraged them to be open and share their feelings (Korstjens & Moser, 2018).

To avoid bias and ensure credibility, dependability, and validity in the interviews, the questions were field-tested by a non-study participant (McGrath, Palmgren, & Liljedahl, 2019). This ensured that the questionnaire and interview questions were easily understood and appropriate to the study. Another method the researcher used to ensure credibility and validity is

by providing all interview respondents an opportunity to member check and edit, clarify, elaborate their own words from the narratives after the interview (Carlson, 2010). The interview transcriptions were offered to each participant with the option of member checking. Participant feedback was taken into consideration and any requested redactions were made.

Significance of the Study

There are several layers of significance to knowing the potential impact compassion fatigue has on an individual. Care coordinators are susceptible to compassion fatigue due to the nature of their work being based on compassion care (Monterio et al., 2016). Compassionate care addresses the emotional and psychosocial aspects of the patient or client experience and their need for human connections and relationships (Monterio et al., 2016). Compassionate care is vital in making sure that individuals feel comfortable, safe, and heard (Burnell, 2009). Compassion fatigue can lead to a reduced capacity to show compassionate care (Labib, 2015) by affecting one's professional ability to form effective and therapeutic relationships with their clients (Sheppard, 2014; Sprang et al., 2007).

Staff experiencing suffering from compassion fatigue may receive support from their place of employment or program affiliation (Condrey, 2015). This means administrators or program supporters may find it beneficial to have knowledge about the effects of compassion fatigue and how it affects their staff (Condrey, 2015). Without support, care and helping professionals are likely to exhibit negative symptoms that may affect their work performance (Figley, 2002; Upton, 2018). While each staff member has a personal responsibility to take care of their individual needs, organizations have an ethical responsibility to create healthy work environments for their staff (Madden et al., 2012). Staff need leaders that support them and create the conditions in which their well-being is valued (Welford & Langmead, 2015). By

addressing and showing an understanding and respect of the compassion fatigue their staff are experiencing, program administrators can show support to their staff and help meet their needs.

Definition of Key Terms

This section defines certain key terms that are relative to the study topic and will be used throughout this paper. These definitions are fluid and will be added to throughout the study.

Burnout. Burnout is a component of compassion fatigue, characterized by feelings of hopelessness and difficulty dealing with work or in doing your job effectively (Stamm, 2010).

Care Coordination. Care coordination is a process that links or facilitates children and their families to appropriate services and resources in a coordinated effort to maximize the potential of the children (AAP, 1999).

Compassion. Compassion is a “virtuous and intentional response to know a person, to discern their needs and ameliorate their suffering through relational understanding and action” (Sinclair et al., 2018, p. 1).

Compassion Fatigue. Compassion fatigue is the term used to describe behavior and emotions experienced occupational stress experienced as a result of helping or working with people who have experienced trauma or extremely stressful events in their lives (Kapoulitsas & Corcoran, 2015).

Compassionate Care. Compassionate care is the relationship-based care and emotional connection between a professional and their patient or client (Upton, 2018).

Compassion Satisfaction. Compassion satisfaction is a positive effect and/or improvement on a provider’s pleasure, personal growth, and well-being, especially when working with traumatized individuals (Craig & Sprang, 2010).

Empathy. Empathy is the ability to understand and share other people's emotions and feelings (Cuff, Brown, Taylor, & Howat, 2016).

Help Me Grow (HMG). HMG is a program, serving as a system model, which promotes cross-sector collaboration by leveraging existing resources to build comprehensive and effective early childhood systems in local communities (Therriault et al., 2020).

Professional Quality of Life. Professional quality of life is the internal sense that helpers feel about their work, including both positive and negative aspects (Stamm, 2010).

Professional Quality of Life Questionnaire (ProQOL). ProQOL is a questionnaire that attempts to contribute to better understanding a professional's quality of life, or the quality one feels in relation to their work as a helper, by addressing the negative (compassion fatigue, burnout, secondary trauma) and positive (compassion satisfaction) effects (Stamm, 2010).

Secondary Traumatic Stress. Secondary traumatic stress is a natural, work-related consequence of caring for another person that has experienced trauma (Bride, Hatcher, & Humble, 2009).

Self-Care. Self-care is a "multidimensional, multifaceted process of purposeful engagement in strategies that promote healthy functioning and enhance well-being" (Miller, Donohue-Dioh, Niu, & Shalash, 2018, p. 138).

Vicarious Traumatization. Vicarious traumatization is a slow, progressive result of stress through seeing or hearing other people's stories traumatic events, which may affect the way workers perceive situations (Gentry, 2002).

Conclusion

In conclusion, this chapter provides an introduction to the study, including background information on the topic and concepts that were explored. The purpose of this study was to

determine the perceptions of the prevalence and impact of compassion fatigue among care coordinators within the HMG system throughout the United States. By utilizing a mixed methods case study research design, the researcher explored the perceptions of the prevalence and impact of compassion fatigue among HMG care coordinators at a variety of locations throughout the United States as a result of the compassionate care they provide. Chapter 2 will provide a traditional-narrative review of the existing literature and academic resources on the compassion fatigue topic, including empirical and theoretical scholarly work.

CHAPTER 2: LITERATURE REVIEW

Compassion fatigue, or the occupational stress experienced as a negative consequence of compassionate care, is often experienced in helping or caring professions (Killian, 2008).

Working with children and families who are experiencing fear, pain, and suffering can have significant effects on the professionals assisting them (Geoffrion et al., 2016). Untreated symptoms of compassion fatigue “can lead to burnout, poor job performance, physical and mental health problems, and chaos in professional and personal lives” (Otte, 2018, para. 3).

The forthcoming literature review is a traditional-narrative review that utilizes a combination of academic resources, including empirical and theoretical scholarly work, to investigate compassion fatigue and associated conditions (such as burnout, secondary traumatic stress, and compassion satisfaction). The review also examines a variety of research methods including qualitative, quantitative, and mixed methods to provide a comprehensive background and interpretation of the topic at hand.

The focus of study in this case study is a condition known as compassion fatigue, which is generally defined by behavioral, emotional, or physical reactions or symptoms of working with people who have experienced trauma or extremely stressful events in their lives (Figley, 1995; Kapoulitsas & Corcoran, 2015). Compassion fatigue is considered a negative aspect affecting one’s professional quality of life (Stamm, 2010). This review will also examine burnout and secondary trauma and elements of compassion fatigue, along with compassion satisfaction, the positive aspect of one’s quality of life (Stamm, 2010). Specifically, the topic of compassion fatigue among care coordinators was examined. Care coordinators link or facilitate appropriate services and resources for children and their families in a coordinated effort to maximize the potential of the children (AAP, 1999).

Organization of Chapter

A comprehensive literature review was completed to evaluate existing literature, identify experts and key figures, and determine methodologies used in past studies. The forthcoming literature review begins with an introduction to the relevant terminology, providing definitions based on current literature. A selective review of the literature will address the history/background of compassion fatigue (measures, effects, treatment, risk/protective factors), care coordinators, compassion fatigue in varying professions and fields (healthcare and crisis centers/call specialists), related conditions (burnout, secondary traumatization, compassion satisfaction, empathy), and the coronavirus (COVID-19) pandemic.

Conceptual Framework

A conceptual framework guides the path of a research study and offers the foundation for establishing its credibility (Adom et al., 2018). It accentuates the reasons why a research topic is worth studying by linking concepts, empirical research, and important theories (Adom et al., 2018). The researcher developed the conceptual framework for this study as a way to specify and define the concepts with the problem being addressed. Empirical and theoretical scholarly work that document compassion fatigue supports the idea that it is an occupational hazard; a state of different forms of exhaustion that is dependent on a caring relationship with a loss of coping ability (Day & Anderson, 2011). An overwhelming majority of the robust existing literature on compassion fatigue is focused on helping professions such as social workers, mental health counselors, nurses, doctors, emergency services workers, etc. (Turgoose & Maddox, 2017). The topical research on the subject supports the idea and provides evidence of the existence of exhaustion amongst caring and helping professionals (Turgoose & Maddox, 2017). Symptoms associated with compassion fatigue can affect a professional's ability to form effective and

therapeutic relationships with their clients, interfere with their personal life, and may lead to burnout (Sprang et al., 2007).

As the statewide director of a state Help Me Grow program, this researcher has witnessed compassion fatigue first-hand within program staff resulting from care coordinators providing relationship-based care, which often takes a toll on their energy and emotional capacity (R. Gabriel, personal communication, June 21, 2020). Connecting with care coordinators through the centralized telephone access point can be a daunting and intimidating step for families seeking help with child development and/or basic needs (R. Gabriel, personal communication, June 21, 2020). It is the statewide director's responsibility to ensure that the system is being implemented appropriately and efficiently throughout the state. If the program care coordinators are experiencing compassion fatigue, the quality of care they provide to families in their communities could potentially diminish (R. Gabriel, personal communication, June 21, 2020).

Theoretical Framework

A theoretical framework is critical to this study, as it served as its foundation, structure, and support (Grant & Osanloo, 2014). Merriam and Tisdell (2016) proposed that a theoretical framework serves as the researcher's lens, and "conceptual basis for understanding, analyzing, and designing ways to investigate a problem" (Grant & Osanloo, 2014, p. 16). The theories that shaped and provided the framework for this study are Figley's compassion fatigue framework (1995) and the professional quality of life theory (Stamm, 2010). These theories functioned as the foundation from which the knowledge was developed for this research study (Grant & Osanloo, 2014).

Compassion Fatigue Theory

Compassion fatigue can be defined as the tension, preoccupation, and lack of empathy a formal caregiver experiences from witnessing the suffering of a client who has experienced trauma (Figley, 2002). Figley's (1995) compassion fatigue framework focuses on empathy and exposure, recognizing that caregivers who are repeatedly exposed to trauma and suffering and respond with empathy are susceptible to compassion fatigue (Figley, 1995). This theory is based on the idea that compassion, empathy, and emotions are critical in working with individuals who are suffering and can impact a caregiver's personal and emotional lives (Figley, 1995; Romeo-Ratliff, 2014).

Strengths and weakness of compassion fatigue theory. The most significant strength of the compassion fatigue theory is that it brings attention to the changes and symptoms that an individual experiences as a result of secondary exposure to trauma or suffering. While Joinson (1992) originally identified the compassion fatigue phenomenon as having "lost the ability to nurture" (p. 119), Figley's (1995) compassion fatigue theory became a replacement for occupational stress outcomes related to caring professions (Coetzee & Laschinger, 2018). This term has brought attention to the negative aspects of working in the helping and caring field and has provided opportunities for researchers to study and contribute to Joinson (1992) and Figley's (1995, 2002) literature.

In contrast, Figley's (1995) compassion fatigue theory has "both conceptual and methodological limitations" (Coetzee & Laschinger, 2018, p. 4). Coetzee and Laschinger (2018) describe the most conflicting limitation of the theory as empathy. Figley (1995, 2002) recognizes that empathy is necessary to form therapeutic relationships and care and is the main antecedent of compassion fatigue, though researchers argue that not all empathic and caring individuals

inevitably experience compassion fatigue (Coetzee & Laschinger, 2018). The model does not clearly describe the conceptualization of empathy on which the theory is based (Sabo, 2011). Additionally, since Figley's (1995, 2002) pioneering research on compassion fatigue, others have found limitations to its "binary dimension" (Coetzee & Laschinger, 2018, p. 7). Others have begun questioning the lack of consideration to the interaction of the various influencing factors (Sabo, 2011) of compassion fatigue, and "core constructs of compassion and fatigue" (Coetzee & Laschinger, 2018, p. 5) in its definition.

Professional Quality of Life Theory

In addition to Figley's (1995) compassion fatigue framework, Stamm's professional quality of life theory (2010) guides this study. Professional quality of life is the quality and internal sense that helpers feel about their work, as influenced by the positive and negative aspects of doing that work (CVT, 2019; Stamm, 2010). These aspects of their work have an impact on their work environment, experience, and how they engage within the environment (Bernstein Chernoff, 2016).

The professional quality of life theory (Stamm, 2010) explores the well-being of helpers within the workplace, centered on positive and negative aspects or sense about their work. It describes how the client, work, and personal environments of the helper contribute to either a positive (compassion satisfaction) or a negative (compassion fatigue) outcome of helping others. In this model, Stamm (2010) divides the compassion fatigue concept into two parts--burnout and secondary trauma.

Strengths and weaknesses of professional quality of life theory. The strengths of the professional quality of life theory provides strong support for this study. The model strongly considers both the antecedents and the outcomes of one's work situation. The ProQOL measure

(Appendix A) includes questions related to the client environment, caregiver's environment, and work environment (Coetzee & Laschinger, 2018), along with both negative and positive potential outcomes.

While the professional quality of life theory will serve as a solid foundation for this study, Coetzee and Laschinger (2018) acknowledge the theory's weaknesses. The model successfully describes compassion fatigue as a combination of burnout and secondary traumatic stress, however this perspective blurs "the conceptual boundaries of compassion fatigue (Coetzee & Laschinger, 2018, p. 6). Additionally, Stamm's (2010) model does not describe or provide a background or reasoning for the onset or cause of the outcomes of one's professional life, including the individual's environment that may protect or increase the chance of development of compassion fatigue (Coetzee & Laschinger, 2018).

Topics of Study

With careful consideration of the purpose of this study, the researcher will review the current literature and research on the main topics of study. The researcher studied the perceptions of the prevalence and impact of compassion fatigue among Help Me Grow (HMG) care coordinators nationwide. Therefore, this review will examine HMG, compassion fatigue, caring with empathy, care coordination, compassion fatigue in varying populations, and Coronavirus (COVID-19).

Help Me Grow (HMG)

HMG is a program, serving as a system model, which promotes cross-sector collaboration by leveraging existing resources to build comprehensive and effective early childhood systems in local communities (Therriault et al., 2020). The HMG system first launched in New England in 1997 and expanded nationwide in 2002. In 2019, 31 states were

affiliates of the HMG National Network and received ongoing technical assistance from the HMG National Center to implement the HMG model and diffuse innovative system enhancements (Therriault et al., 2020).

The system model consists of four cooperative and interdependent core components--a centralized access point, family and community outreach, child health care provider outreach, and data collection (Therriault et al., 2020). Through the implementation of the four core components, the mission of HMG is to promote children's healthy development and support early detection of developmental delays, referrals, and linkage to community-based services to ensure all children can grow and thrive to their full potential (Cornell et al., 2018; Cornell et al., 2019).

The program's care coordinators serve as case managers that interact directly with children and families through the centralized access point, assisting them in getting the help they need (Therriault et al., 2020). Many of these HMG care coordinators throughout the United States work within the 2-1-1 social services information and referral systems (Mullen et al., 2016). United Way Worldwide and the Alliance for Information and Referral Systems (AIRS) report that each year, 2-1-1 call specialists connect 15 million vulnerable populations, including "socioeconomically, disadvantaged, uninsured/underinsured callers" to social and health resources within their communities (Mullen et al., 2016, p. i10), covering 93% of US communities (Mullen et al., 2016). These resources may include rent and utility assistance, healthcare referrals, crisis and emergency services, and case management (United Way Worldwide, 2020). Individuals can call 2-1-1 from any cell phone or landline and speak privately and confidentially with a live, specially trained service professional 24/7 (United Way Worldwide, 2020).

HMG care coordinators, within the 2-1-1 and United Way agencies and otherwise, provide developmental and behavioral screenings to families, free of charge, and can make referrals to local services based on the screening results (Help Me Grow Florida, 2020). In addition to providing child development information and referrals, program care coordinators can connect families to social services for basic and essential human needs such as food, clothing, shelters/housing, disaster relief, employment supports, veteran affairs, etc. (United Way Worldwide, 2020). Care coordinators work with families from their initial contact with HMG, until they are successfully connected to local community services, thus establishing relationships with the families in their care along the way (Therriault et al., 2020). In addition to providing information and referrals (Therriault et al., 2020), care coordinators provide empathy and support (Werdhani et al., 2018) as they listen to family stories, collect sensitive information and data, and address any questions or concerns families may have (Therriault et al., 2020). Feeling empathy for those in need can lead to negative consequences as a result of the costs involved (Hansen et al., 2018).

Each year, the HMG National Center develops, administers, and collects data from a Fidelity Assessment (FA) tool. The FA is a self-report study that measures the fidelity of the HMG system and ensures alignment of the system model across all HMG communities by determining levels for each HMG affiliate's core component implementation (Cornell et al., 2019; Therriault et al., 2020). To do this, the FA asks questions regarding the implementation of each of the four core components. The HMG National Center organizes the information submitted and categorizes sites with respect to their activities and implementation progress into three levels, (a) *Exploration* (refers to affiliates that have implemented none of the activities within the core component), (b) *Installation* (refers to affiliates that have implemented at least

one activity within the core component, or (c) *Implementation* (refers to affiliates that have implemented all activities within the core component) (Therriault et al., 2020). Each core component is scored individually, with the lowest-scoring component as the overall classification (Therriault et al., 2020).

Compassion Fatigue

The literature on compassion fatigue has increased in recent years, but the compassion fatigue term was first introduced by Joinson (1992). Joinson (1992) described it as the unique form of burnout nurses experience from working with patients that are suffering or experiencing trauma. Joinson (1992) recognized that nurses were experiencing emotional and physical symptoms from their jobs including exhaustion, illnesses, forgetfulness, and decreased attention span. These symptoms often lead to feelings of helplessness, apathy, and anger (Joinson, 1992). Building on Joinson's (1992) idea, Figley (2002) later defined the term as the tension, preoccupation, and lack of empathy a formal caregiver experiences from witnessing the suffering of a client who has experienced trauma. Commonly referred to as the "cost of caring" (Boyle, 2015) and "caring too much" (Yoder, 2010), compassion fatigue is characterized as a natural outcome of working involving caring for others, that may result in deep physical and emotional exhaustion, along with a change in empathy. Compassionate care is the emotional connection (Upton, 2018) and relationship-based care (Ehrlich et al., 2012) that is provided.

Figley (1995) determined three main categories of compassion fatigue responses or symptoms that professionals caring for or helping others may experience. These categories include (a) psychological distress, including sadness or depressive emotions, nightmares or negative images, sleep difficulties, headaches, gastrointestinal suffering, obsessive behaviors, physiological symptoms of palpitations and hyperventilation, and/or impairment of daily

activities, (b) a shift in cognition, (c) relational disturbances which could present itself as distancing or detaching from one's loved ones (Figley, 1995).

With the goal of creating healthy and helpful caregivers, researchers have studied compassion fatigue in working professionals (Adams, Boscarino, & Figley, 2006; Bilaye-Benibo, 2019; Hunt, Denieffe, & Gooney, 2019; Sheppard, 2014) by learning more about the condition and methods of increasing their resiliency and improving their helping behaviors (Newsome, Waldo, & Gruszka, 2012). Much of the literature on compassion fatigue shares similar findings, concluding that individuals in helping or caring professions do, in fact, experience compassion fatigue and classify it to be an occupational hazard (Showalter, 2010). Showalter (2010) notes that compassion fatigue is “prevalent across all spectrums of the helping professions and is flourishing” (p. 239). While the relevant research most often explores the condition in nursing and healthcare settings, recent literature studies compassion fatigue in a variety of other backgrounds and professional settings including social work (Kapoulitsas & Corcoran, 2015), mental health professionals (Turgoose & Maddox, 2017), and family caregivers (Lynch & Lobo, 2012). The research discussed thus far has examined helping and caring professionals that tend to patients face-to-face, although some research on compassion fatigue examines care provided using alternative methods of communication such as via telephone (Meischke et al., 2018; Kitchingman, Caputi, Woodward, Wilson, & Wilson, 2018a). Despite the various populations and variables that the literature presents, common conclusions may still be drawn regarding the effects of compassion fatigue and the cost of caring.

Measures of compassion fatigue. Various measurement instruments have been utilized to assess compassion fatigue and its associated symptoms. Figley (1995) introduced the Compassion Fatigue Self-Test (CFST) to measure the level of risk an individual might have to

develop compassion fatigue (Nimmo & Huggard, 2013). Improvements were made to the CFST psychometrics and were reintroduced and renamed as the Professional Quality of Life measure (ProQOL). As a revision of Figley's (1995) CFST, the ProQOL is a conceptual model that sheds insight into an individual's professional quality of life, or the quality that one feels in relation to their work as a helper, especially in those who help others that experience suffering and trauma (Stamm, 2010).

The ProQOL instrument addresses compassion fatigue by assessment of both negative (compassion fatigue, burnout, secondary trauma) and positive (compassion satisfaction) effects (Stamm, 2010). These conceptual components are demonstrated in the instrument as three subscales, including compassion satisfaction, burnout, and compassion fatigue/secondary traumatic stress (Stamm, 2010). Each subscale (compassion satisfaction, burnout, and secondary traumatic stress) is scored independently based on the questionnaires scoring methods. The scores on the individual scales reveal the person's responses on each of the constructs but reviewing the combination of scores helps to provide insight on what the person is truly experiencing (Stamm, 2010).

Effects of compassion fatigue. Research conducted to examine the effects that helping victims of trauma and suffering has on their caregivers or helpers has shown that symptoms of compassion fatigue have been proven to mimic those of PTSD (Figley, 2002; Baum, Rahav, & Sharon, 2014). Figley (2002) reported symptoms may be cognitive, emotional, behavioral, spiritual, relational, somatic, or affecting work performance. Professionals in a variety of disciplines have reported psychological symptoms as a result of their helping responsibilities, including dissociation, anxiety, distressing dreams, sleep disturbances, social withdrawal (Figley,

2002; Nelson-Gardell & Harris, 2003). Physical symptoms that have been reported include headaches, increased heart rate, dizziness, shock, or sweating (Figley, 2002).

When helpers or caregivers experience compassion fatigue, they may no longer be able to function effectively due to its overwhelming nature and intensity of symptoms. These symptoms may lead to reduced standards of care and work performance (Upton, 2018). Some examples of these symptoms include low morale, low motivation, avoiding tasks, apathy, negativity, and absenteeism (Figley, 2002). If these symptoms are not addressed, qualified and experiencing caring professionals may choose to leave their positions or the field, “leaving the community services sector depleted and placing vulnerable people at greater risk” (Hopwood, Schutte, & Loi, 2018, p. 344).

Additionally, the literature on compassion fatigue supports the idea that there is a strong correlation between the well-being of staff and their clients/patients’ well-being or care (Showalter, 2010; Cocker & Joss, 2016; Newsome et al., 2012). Bush (2009) asserts that burnout and compassion fatigue can cause feelings of failure and exhaustion which can lead to a lack of empathy and decreased efficacy and also impacts the quality of care that patients or clients receive. Therefore, the symptoms that helpers and caregivers experience as a result of their indirect trauma experiences are important warning signs that need to be addressed and/or treated.

When compassion fatigue becomes widespread within a workplace environment, the organization suffers as a whole (CFAP, 2020). The negative impact that compassion fatigue has on workers causes subsequent costs to their employers (Adimando, 2018). Roles at all levels within organizations require interactions with those that care or help (Figley, 1995; Sprang et al., 2007). Pfifferling and Gilley (1999) note that workers experiencing compassion fatigue are less satisfied with their jobs, experience less joy, and feel as though they have failed at their jobs.

Organization-related consequences caused by compassion fatigue in staff include a decrease in job satisfaction and decreased employee engagement (Adimando, 2018). Coffman, Gonzalez-Molina, and Gopal found that, with decreased employee disengagement, organizations are more likely to see an “increased use of sick days, decreased productivity, and decreased staff retention” (as cited in Adimando, 2018, p. 305). Compassion fatigue has also been found to cause changes in job performance, including poor professional judgment, and an increase in work-related errors/mistakes (Upton, 2018). These negative consequences can contribute to significant costs for an organization, but are avoidable (Adimando, 2018).

Treatment of compassion fatigue. In addition to making attempts to better understand the prevalence and impact of compassion fatigue and associated conditions, researchers have started studying how the conditions of compassion fatigue can be treated. While preventing compassion fatigue is critical to ensuring the utmost care for patients and clients, research suggests that the prevalence of compassion fatigue is proving to be inevitable for those in the helping and caring professions (Cramond, Fletcher, & Rehan, 2017). Therefore, understanding methods to manage and treat compassion fatigue is equally as important. Babbel (2012) notes that in order to reduce compassion fatigue, it is important to treat or improve the feelings that result from interactions with the traumatized patients/clients, instead of simply focusing on combatting the symptoms. While the majority of research on this topic has been in one discipline, specifically healthcare (Berger, Polivka, Smoot, & Owens, 2015; Cocker & Joss, 2016; Hooper, Craig, Janvrin, Wesel, & Reimels, 2010; Sheppard, 2014), the literature surrounding the treatment and management of compassion fatigue, secondary traumatic stress, and burnout share similar strategies, including resiliency, self-compassion, mindfulness, and self-care (Al Barmawi et al., 2018; Adimando, 2018; Miller et al., 2018).

With the realization that professionals must protect themselves from the compassion fatigue phenomena, research has found various successful strategies for coping and treating the condition (Miller et al., 2018). Despite the stress and emotional exhaustion that helping people experiencing trauma presents, it is important that professionals stay present and empathetic in their work (Francoise, 2015). Simple strategies to feel energized rather than drained by working with those who are suffering include reflecting on one's own past experiences with difficult circumstances, enhancing resiliency, setting emotional boundaries, learning new skills and discovering a purpose behind their work (Kearney, Weininger, Vachon, Harrison, & Mount, 2009).

Resiliency. Early research previously considered resilience to be a personality trait, though it has recently been redefined and better understood to be a psychological response to adversity that involves personal growth and newly developed insight to help deal with challenges (Kapoulitsas & Corcoran, 2015). Resilience is important to managing stress, making it a significant factor in coping with compassion fatigue. Research overwhelmingly supports the idea that lower compassion fatigue and burnout is associated with higher levels of compassion satisfaction and resilience (Kapoulitsas & Corcoran, 2015). This is because a helper with an increased sense of resilience may be able to thrive under high levels of stress. Kinman and Grant (2011) found that resilience can offset the negative effects of stress in the workplace, especially among workers that deal with challenging situations (as cited in Kapoulitsas & Corcoran, 2015).

Self-Compassion. Literature related to the treatment of compassion fatigue and associated conditions largely discuss compassion in different manners. Self-compassion can be defined as “being kind and understanding towards oneself” during painful times or situations of failure “rather than being harshly self-critical” (Neff, 2003, p. 23). Self-compassion activities

may include relaxation, exercise, meditation, developing self-acceptance, and kind self-talk (Barratt, 2017). With research suggesting that self-compassion is linked to psychological well-being (Beaumont, Durkin, Hollins Martin, & Carson, 2016), individuals may be able to respond to their feelings of suffering with a sense of “warmth, connection, and concern” instead of “reacting with self-criticism and self-judgment” (Delaney, 2018, p. 3). People exhibiting self-compassion can better cope with symptoms of stress and have greater emotional resilience; therefore, they are at less risk of compassion fatigue and burnout and are better able to cope with these conditions (Beaumont et. al., 2016). When studying compassion fatigue in nurses, Delaney (2018) found benefits in a self-compassion intervention on compassion fatigue and resilience, concluding that providing nurses with on the job support that can be utilized during the caregiving process, as opposed to after the event.

Mindfulness and self-care. Mindfulness is an important aspect of self-compassion (Barratt, 2017). Defined as “non-judgmental awareness of the present moment”, mindfulness can promote a sense of inner peace, calmness, and mental space (Barratt, 2017, p. 64). Newsome et al. (2012) make the claim that mindfulness is an important form of self-care. According to Mathieu (2007), improved self-care is “the cornerstone of compassion fatigue prevention” (p. 4). Studies have shown that self-care techniques, both psychological and physical, may not only reduce vulnerability to the secondary stress and compassion fatigue but may help treat the condition as well (Adimando, 2018; Christopher & Maris, 2010). Some other self-care activities may include exercising, getting rest, thinking about things in a meaningful way, practicing gratitude, looking for the good in things, and living in the present (Pooler, Wolfer, & Freeman, 2014). Not only may these strategies help improve one’s work life, but they will also likely improve all aspects of their life.

Organizational support. While self-care is crucial in decreasing compassion fatigue in one's self, organizational leaders can ensure a positive culture within the workplace by developing, implementing, and following through with "programs, policies, and procedures that prevent, lessen, and treat the effects of compassion fatigue" (Handran, 2013, p. 10). When compassion fatigue is experienced within an organization, the healing process takes time, patience, and commitment (CFAP, 2020). Organization leadership and management can support their employees by engaging in reflective supervision, managing caseload sizes, and providing adequate allowed time off (Handran, 2013; Mathieu, 2007). They can also work towards developing a supportive work environment that will encourage regular breaks, mental health days, peer support, assessing and changing workloads, improved access to further professional development, and opportunities for staff to safely discuss the impact of their work (Mathieu, 2007; Turgoose, Glover, Barker, & Maddox, 2017). Some organizations may implement prevention programs, which are believed to help improve helpers' compassion satisfaction and reduce the risks for developing compassion fatigue (Stamm, 2010). Not only do these organizational programs positively impact workers' well-being, but they demonstrate that the organizations have formally addressed the potential negative consequences their workers may experience (Stamm, 2010).

Educational programs and interventions. The literature demonstrates that there have been efforts to explore how organizations may positively impact an employee's work environment and compassion satisfaction (Mathieu, 2007). The literature provides insight into organizational strategies and interventions to help treat compassion fatigue and burnout, and their effectiveness and levels of success. Koeske and Koeske (1993) report that emotional exhaustion should be the focus of any interventions because it "represents the essence of

burnout” (as cited in Craig & Sprang, 2010). Strategies including peer support and trauma-specific training initiatives have been found to be successful in addressing burnout and helping support the idea that organizations making an effort to provide professional development opportunities for their staff has more benefits than just increasing their knowledge (Craig & Sprang, 2010). In addition to informative training on trauma support, resiliency support programs can help protect professionals from occupational stress and burnout (Hopwood et al., 2018).

Research supports the idea that educational programs and interventions are effective, though most of these researched interventions focus on nurses and healthcare providers. An intervention study found that by increasing nurses’ knowledge and practice of self-care and mindfulness, their stress levels were reduced and their levels of compassion fatigue decreased (Abernathy & Martin, 2019). In the study, nurses were taught mindfulness-based techniques and were asked to meditate before their shifts, with noticeable changes after one month of these practices. A study conducted with healthcare professionals indicated that providing self-care education to healthcare providers was beneficial to their compassion satisfaction and burnout over time (Klein, Riggenbach-Hays, Sollenberger, Harney, & McGarvey, 2018).

Risk and protective factors of compassion fatigue. Studies have found several risks and protective factors that are associated with the components of professional quality of life (compassion fatigue, burnout, compassion satisfaction) (Haber, Palgi, Hamama-Raz, Shrira, & Ben-Ezra, 2013). These factors contribute to determining why compassion fatigue exists and what may contribute to compassion fatigue (risk factors) or helps prevent it (protective factors) (Child and Family Services Reviews, n.d.). These studies provide insight as to why certain individuals or populations are more or less likely to experience compassion fatigue.

Risk factors. Since the negative consequences of compassion fatigue have the potential to be detrimental to those helping and those being helped (Al Barmawi et al., 2018; Killian, 2008), it has become evident amongst researchers that there is a need to determine any risk factors that may affect an individual's vulnerability to it (Craig & Sprang, 2010; de Figuerido, Yetwin, Sherer, Radzik, & Iverson, 2014). While research has investigated these risk factors and their prevalence, findings are inconsistent (Craig & Sprang, 2010). Despite the inconsistency, a review of the literature suggests that the most prevalent risk factor for compassion fatigue and secondary traumatic stress is a history of personal trauma (de Figuerido et al., 2014). Specifically, Nelson-Gardell and Harris (2003) studied child welfare workers and found that childhood treatment poses the greatest risk, including emotional abuse or neglect.

Researchers de Figuerido et al. (2014) noted the risk factors that were relevant to their study on perceptions of compassion fatigue, compassion satisfaction, and burnout among clinical providers. From their review of the literature, they found that there were certain risk factors for providers, including, "younger age, female gender, greater caseload, higher number of traumatized clients on caseload, personal history of trauma, occupational stress, and working in inpatient settings," (de Figuerido et al., 2014, p. 287). An additional review of the literature presented additional risk factors, such as individuals who have experienced personal trauma/loss (Baird & Kracen, 2006; Chaverri, 2011), are highly dedicated and have high demand for personal competence (Killian, 2008; Figley, 2002), and lack social support and comprehensive trauma training (Killian, 2008; Mathieu, 2012).

Protective factors. While risk factors increase the likelihood of an individual experiencing the conditions, protective factors do the opposite by protecting against compassion fatigue and increasing compassion satisfaction. There is significant research on compassion

fatigue, secondary traumatic stress, and burnout, but there is a lack of research on protective factors that may alleviate the onset of the conditions. Some protective factors against compassion fatigue and burnout include an individual's perception of their knowledge and information obtained to assist their clients, increasing their levels of efficacy (Adams et. al., 2006). In their study on clinical providers working with traumatized youth (de Figueiredo et al., 2014) concluded that additional protective factors against compassion fatigue that may lead to compassion satisfaction include training, education, and supervision on trauma victimization.

Related conditions. The exploration of compassion fatigue should also include exploration into its associated conditions. There are a number of conditions that are similar to compassion fatigue “in that they can create feelings of helplessness, loneliness, anxiety and depression” (Conrad & Kellar-Guenther, 2006, p. 1073). The following section explores the negative aspects of an individual's professional quality of life (including burnout and secondary traumatic stress), and positive aspects (including compassion satisfaction) (Stamm, 2010).

Burnout. Before the idea of compassion fatigue was introduced to the nursing and helping professions, overworked workers were known to suffer from burnout (Lizano, 2015). Now, burnout is known to be a component of compassion fatigue (Stamm, 2010). Burnout is a result of workplace dysfunction, overload, stress, and exhaustion over an extended period of time (Gallagher, 2013; Potter et al., 2010). It is associated with feelings of hopelessness and difficulty dealing with work or in doing one's job effectively (Stamm, 2010). These negative feelings usually have a gradual onset, typically caused by a very high workload or a non-supportive work environment (Stamm, 2010).

A common inquiry proposed by the research questions whether compassion fatigue arises from burnout, or if it is influenced in some way by burnout (Ledoux, 2015). Joinson (1992)

categorized compassion fatigue as a “unique form” of burnout, specifically affecting people in caregiving professions (p. 116). Compassion fatigue typically results from putting high levels of energy and compassion towards the relationship with a client who is suffering over an extended period of time (Gallagher, 2013; McHolm, 2006). The main distinction between the two concepts is that burnout occurs as a result of stress from the work environment, while compassion fatigue comes from working with specific types of clients. A worker that is experiencing burnout is more susceptible to compassion fatigue (Gentry, Baranowsky, & Dunning, 2002). Even though the two concepts are different, they are ambiguously defined and definitely overlap. Compassion fatigue and burnout can manifest similarly and often coexist.

Burnout amongst employees in any workplace setting has a large impact on themselves, and often on others. Maslach, Jackson, and Leiter (1997) report that burnout is associated with high rates of employee absenteeism which results in organizations being financially strained due to losses in work production and the need to recruit, hire, and train new staff. Ducharme, Mello, Roman, Knudsen, and Johnson (2007) noticed a negative impact on the satisfaction of clients/patients and an increase in the number of individuals that drop out of treatment. When studying burnout amongst counselors, populations that have been reported to be more susceptible to burnout include counselors with Type A personalities, are young in age, of the male gender, and are unmarried with high levels of education (Perkins & Sprang, 2013).

Research on burnout in professionals has been studied in a few different fields. Kim and Stoner (2008) studied burnout in social and child welfare workers, finding that they are susceptible to a high risk of burnout due to the nature of their work, organizational and job duties stress, and large workloads. Multiple studies have determined that between 40-60% of healthcare professionals experience some form of burnout during their careers (Delaney, 2018). A study

conducted by Perkins and Sprang (2013) used the ProQOL scale to examine compassion fatigue, burnout, and compassion satisfaction in groups of substance abuse counselors. The qualitative study found that out of twenty participants, five scored high for compassion satisfaction, three scored high for burnout, and nine scored high for compassion fatigue (Perkins & Sprang, 2013).

Secondary traumatic stress (STS) and vicarious traumatization. Some academics refer to compassion fatigue as “secondary” or “vicarious” trauma. Though some scholars, such as Gallagher (2013), consider compassion fatigue to be the same as secondary and vicarious traumatization, other researchers explain that the three concepts are different. Supporting this idea, a study conducted by Adams et al. (2006) found that secondary traumatic stress could be categorized as a model or element of compassion fatigue, along with burnout. STS is related to vicarious traumatization, as they share similar characteristics and effects.

While both secondary traumatic stress and vicarious trauma are effects of exposure to trauma, the literature explains that they occur as a result of different situations. Secondary traumatic stress occurs when one is directly exposed to the traumatic events of others, causing those to be overwhelmed by secondary exposure (Gentry, 2002). The literature explains that the secondary traumatic stress was originally used to describe how symptoms of trauma may be contagious between family members, but that the term became later known as a natural, work-related consequence of caring for another person that has experienced trauma (Bride et al., 2009; Stamm, 2010). Huggard, Stamm, & Pearlman (2013) have more recently recognized the condition occurring due to fear of a threat to one’s safety. The Secondary Traumatic Stress Scale (STSS) was developed to assess the frequency of negative consequences that people working with traumatized people experience by measuring PTSD symptoms, intrusion, avoidance, and arousal (Bride et. al., 2009). Using the STSS, a study found that nurses experiencing secondary

traumatic stress exhibited symptoms such as difficulty sleeping, intrusive thoughts, irritability, emotional numbing, avoidance of people and places, and detachment from others (Quinal, Harford, & Rutledge, 2009).

Conversely, vicarious trauma occurs as a result of stress through seeing or hearing other people's stories traumatic events, which may affect the way workers perceive situations (Gentry, 2002). Developing compassion fatigue is not sudden, instead, it is a cumulative process that progresses over time (Mathieu, 2007). Vicarious trauma can be caused by repeatedly hearing stories of trauma or stressful events (CVT, 2018). Two tools may be used to measure vicarious trauma. The Traumatic Stress Institute Belief Scale measures levels of disruption in certain personal characteristics and psychological areas (Nimmo & Huggard, 2013). The Traumatic Stress Institute Life Events Checklist aims to identify the added vulnerability that a professional might have due to personal trauma they may have experienced in the past (Nimmo & Huggard, 2013).

Compassion satisfaction. In contrast, while the previously defined terms focus on the negative consequences of helping others, compassion satisfaction is a more positive effect. Craig and Sprang (2010) define compassion satisfaction as a positive effect and/or improvement on a provider's pleasure, personal growth, and well-being, especially when working with traumatized individuals. More simply, it is "the positive feelings about people's ability to help" (Stamm, 2010, p. 8). While people in helping and caring professions may experience the negative effects of their work helping others, they may gain pleasure and satisfaction from making a difference in other people's lives (Stamm, 2010). The adaptive nature of compassion satisfaction makes it comparable to resilience (Russell & Brickell, 2015).

Some of the positive effects that compassion satisfaction may have on a helping professional include increased energy and insight, heightened performance, a positive attitude towards work, and increased motivation to help and serve (Kulkarni, Bell, & Hartman, 2013). The literature suggests that compassion satisfaction may protect against compassion fatigue and reduce burnout (de Figuerido et. al., 2014). When Pooler et al. (2014) studied the workforce of social workers, it was determined that increased levels of compassion satisfaction allow them to “vicariously benefit from their clients’ improved functioning, personal growth, or therapeutic gains as they share the positive outcomes and feelings of empowerment, energy, and exhilaration,” (as cited in Wagaman et al., 2015, p. 203).

Caring with Empathy

With the strong connection that helping professionals have with their patients or clients, strong empathic connections are built as well. People in caring professions often provide emotional support, or empathy (Adams et al., 2006). Empathy is the ability to understand and share other people’s emotions and feelings (Cuff et al., 2016). The role of empathy in these connections is crucial, as it plays a large role in increasing the likelihood of helping others, altruism, ethical behaviors, and maintaining interpersonal relationships (Mottaghi, Poursheikhali, & Shameli, 2019). In his research on compassion fatigue and secondary traumatic stress, Figley (1995) theorized that a significant factor in a caregiver’s cause of secondary traumatic stress is their level of empathy. He also proposed that the more empathetic professionals are towards those they are helping, the more likely they are to experience emotional distress and compassion fatigue as a secondary traumatic stress response (Turgoose et al., 2017). This works in reverse as well; compassion fatigue can cause a decreased ability to provide compassion and empathy to those an individual works with (Turgoose et al., 2017). The difference between compassion and

empathy are that compassion leads to a desire to act on behalf of others, whereas empathy does not entice one to act (Armstrong, 2011). Research shows that levels of empathy are not linear; they can change over time (Llewellyn, 2009). While a professional may begin a client relationship with high levels of empathy and compassion, an increased level of compassion fatigue may lead to a gradual reduction in empathy (Mathieu, 2007).

A study conducted by de Figuerido et al. (2014) examined perceptions of compassion fatigue, compassion satisfaction, and burnout in providers of different disciplines that serve traumatized youth. The findings suggest that youth workers providing professional interventions or supportive care for at-risk children may be particularly susceptible to distress (de Figuerido et al., 2014). Working with children, one of the most vulnerable populations, can deepen a helper's empathy and motivate them to successfully help those they are working with. Another study that examined empathy, compassion fatigue, guilt, and secondary traumatic stress in nurses found a close association between guilt and empathy, along with links between empathy and symptoms of compassion fatigue (Mottaghi et al., 2019). The authors also reported that having high levels of empathy may explain 77% of the nurse's compassion fatigue through feelings of guilt and secondary traumatic stress (Mottaghi et al., 2019).

Care Coordination

Care coordination is defined as a process that links or facilitates children and their families to appropriate services and resources in a coordinated effort to maximize the potential of those being served (AAP, 1999). Care coordinators, also known as health navigators or care managers, work with and guide a collaborative effort of services that is driven by the needs of patients and families for assistance and community supports (Au et al., 2018; AAP, 2014). These services may include “systems coordination, information and referral, family support and

resources” (Dunst & Bruder, 2002, p. 367). To fully address the needs of the children and families they serve, care coordinators must link and refer families to social services for basic needs, such as housing and education (Au et al., 2018).

Care coordinators play a critical role in the collaboration or integration of services, and their work has been shown to be strongly associated with improved patient outcomes in integrated models (Au et al., 2018). Successful care coordination addresses all needs that a child might have including “health, education, early child care, early intervention, nutrition, mental/behavioral/emotional health and social services” (AAP, 2014, p. e1452), and has been found to produce positive outcomes for children and families (Ufer, Moore, Hawkins, Gembel, Entwistle, & Hoffman, 2018). However, when failures in care coordination occur, the quality of care provided to children and families can be adversely affected (Cesta, 2018).

Much of the literature on care coordination discusses it in the context of healthcare, nursing or hospital case management (Cesta, 2018; Simpson, Farr-Wharton, & Reddy, 2020). In medical health settings, care coordination services connect families and children to needed resources to optimize a child’s health status (AAP, 1999). It has been found to be an important aspect of healthcare by ensuring that patients’ needs and preferences are understood and addressed, and effectively communicated to all providers involved in the patient’s care (National Priorities Partnership, 2008).

Care coordination for children and youth often requires relationship coordination, defined as task integration through communication and relationships (AAP, 2014). Relational coordination values the quality of communication and the quality of relationships between families, patients/clients, providers, and partners (AAP, 2014). Care coordination models that are centered around early intervention, connect families and children with needed resources to

address the child's developmental concerns or delays, and optimize the child's health (Ideishi et al., 2010). These early intervention models focus on family-focused coordinated care (Ideishi et al., 2010).

A study conducted by Au et al. (2018) examined burnout risk and job satisfaction reported by care coordinators. The study showed that while their work was stressful, care coordinators were found to have a low risk of burnout and low levels of emotional exhaustion as a result of "high levels of job satisfaction, perceived job support, and personal accomplishment, and low levels of disconnection from participants" (Au et al., 2018, p. S250). The study also found that care coordinators working in integrated systems felt a sense of accomplishment and satisfaction, connected with the people they serve, and a strong sense of achievement (Au et al., 2018). Additionally, care coordinators who felt supported in their jobs experienced less emotional exhaustion and greater personal accomplishment and job satisfaction (Au et al., 2018). Au et al. (2018) acknowledged that further research on care coordinator burnout will help better support the work that they do, which may lead to better participant outcomes.

Compassion Fatigue in Varying Populations

The major literature on compassion fatigue in helping professions examines its symptoms and impact in healthcare settings. Some of these professions include trauma treatment therapists (Craig & Sprang, 2010), social workers (Adams et al., 2006), mental health professionals (Turgoose & Maddox, 2017), and first responders (Pietrantonio & Prati, 2008). The forthcoming review will examine compassion fatigue in healthcare (with a focus on the nursing field) and crisis centers/call specialists.

Healthcare. A review of studies suggested that the compassion fatigue phenomenon has a high prevalence among health workers. Being a healthcare provider "is the perfect compassion

fatigue formula” (Ashfaq, 2015, p. 287). Caring for patients, especially those with chronic illness or are terminally ill, can be a stressful and emotionally draining experience (Ashfaq, 2015). The compassion and empathy that healthcare professionals provide to their patients to help ease suffering can be costly to their well-being, therefore impacting the quality and safety of patient care (Cavanagh et al., 2019; Cocker & Joss, 2016; Okoli et al., 2020; Smart et al., 2014).

Compassion fatigue in nurses and other healthcare workers may affect their quality of work and personal lives (Kashani, Eliasson, Chrosniak, & Vernalis, 2010). Within healthcare organizations, professionals experiencing compassion fatigue may experience burnout, apathy, a desire to quit, decreased productivity, staff turnover, and an increase in mistakes (Berger et al., 2015; Upton, 2018).

Numerous studies have been conducted to examine compassion fatigue within healthcare providers, including nurses, Intensive Care Unit medical staff (van Mol, Kompanje, Benoit, Bakker, & Nijkamp, 2015), emergency medicine workers (Dasan, Gohil, Cornelius, & Taylor, 2014), pediatric healthcare providers (Meadors, Lamson, Swanson, White, & Sira, 2009) and cancer healthcare professionals (Hunt et al., 2019). The Compassion Fatigue Awareness Project reports that 25–50% of healthcare workers experience some form of compassion fatigue (as cited in Sikorski, 2013).

Nursing field. Joinson (1992) introduced the concept of compassion fatigue when she observed that nurses had appeared to lose their “ability to nurture” (p. 119) as a result of burnout. Since Joinson’s (1992) original research on compassion fatigue, further research has been conducted to better understand the prevalence and impact of compassion fatigue in that profession. A number of studies have acknowledged the likelihood of nurses being vulnerable victims of compassion fatigue due to their responsibility to provide compassionate care to “sick,

wounded, traumatized, and weak patients” in their care (Coetzee & Klopper, 2010, p. 235; Hooper et al., 2010).

The National Survey of the Work of Health of Nurses (Shields & Wilkins, 2006) found that about one fifth of nurses reported that their mental health affected their ability to do their nursing job, were experiencing high job strain, and thought that the quality of care had deteriorated. A study conducted in oncology nurses showed that they felt as they have become pessimistic and less sympathetic towards their patients (Potter et al., 2010). Coetzee and Klopper (2010) found that identifying and recognizing compassion fatigue within oneself is essential for nurses to combat the effects. According to Hooper et al. (2010), compassion fatigue within nurses concludes that further research must be conducted to “provide education about the symptoms, prevention, and treatment of compassion fatigue” (p. 421).

Crisis centers/call specialists. While the majority of literature on compassion fatigue features research on healthcare providers and social workers, the evidence and impact of the conditions in the telephone crisis support field has been researched as well. While helpers and caregivers in registered professional roles may experience negative consequences as a result of their work with their patients and clients, research shows that telephone crisis support workers are especially vulnerable to experiencing compassion fatigue, secondary traumatic stress, and burnout. In positions where they are constantly providing support for people who are in distress, they must listen empathically, remain calm amongst the callers’ distress, and provide information and referrals to services that may further assist them (Kitchingman, Wilson, Woodward, Caputi, & Wilson, 2018c). The empathic communication they engage in with their callers is critical to developing a connection that will not only provide emotional support for the caller but will also provide them with the assistance that they need.

While some experts have suggested that since call specialists do not provide support face-to-face and provide support on a short-term basis, they are not vulnerable to the same distresses of professionals that do (Kitchingman, Wilson, Caputi, Wilson, & Woodward, 2018b). But the research suggests otherwise, reflecting that telephone crisis support workers are, in fact, vulnerable to “symptoms of vicarious traumatization, stress, burnout, and psychiatric disorders” (Kitchingman et al., 2018b, p. 13), which impacts the delivery of the care they provide.

Coronavirus (COVID-19)

Thompson and Rasmussen (2020) reported that COVID-19 has become a global public health crisis with a drastic impact on daily life, including health, humanitarian, and socio-economic threats. Due to the current relevance and level of emergency of COVID-19, research and literature on the pandemic is slowly emerging. Research has already been published on the effect of COVID-19 on children and families, along with service providers, and the impact has been found to be drastic and ever-changing (Fisher et al., 2020; Matthewson, Tiplady, Gerakios, Foley, & Murphy, 2020; Prime, Wade, & Browne, 2020; Stark, White, Rotter, & Basu, 2020; Wilke, Howard, & Pop, 2020).

Impact on children and families. The COVID-19 pandemic has threatened the well-being of children and families by the subsequent social disruption to aspects of everyday life (Prime et al., 2020, p. 631). Children and families have been exceptionally vulnerable due to the increased demands on parents which has resulted in a rise in parenting stress and children’s emotional distress (Stark et al., 2020). Statistics Canada (2020) reports about one third of families feel anxious as a result of COVID-19 (as cited in Prime et al., 2020).

Parents are facing challenges related to “financial insecurity, caregiving burden, and confinement-resulted stress (e.g., crowding, changes to structure, and routine)” (Prime et al.,

2020, p. 631), and children have experienced a “lack of socialization, skill-based learning, social support, and reduced physical activity” (Stark et al., 2020). An estimated 1.38 billion children are out of school or childcare, restricting their access to group activities, team sports, or playgrounds (Cluver et al., 2020). Parents and caregivers are attempting to work remotely or unable to work, while caring for children at home indefinitely (Culver et al., 2020). Additionally, many families are grieving the loss of loved ones, as the Centers for Disease Control and Prevention (2020a) reports that there have been more than 56,000 fatalities in the United States alone.

In families with children with special needs, preexisting family stress has been exacerbated by a lack of access to services that their children usually receive (Fisher et al., 2020). Child development experts have recognized the strain that COVID-19 has placed on the early identification children of with developmental delays (US Official News, 2020). Barnett (2020) acknowledged that schools and childcare providers have significant roles in the early detection and identification of developmental delays in children and for linking parents to local services and supports (US Official News, 2020). With schools and childcare centers closed as a result of the COVID-19 pandemic, many children who need developmental screenings may be missed (Barnett, 2020, as cited in US Official News, 2020).

Impact on service providers. In addition to children and families, the COVID-19 pandemic has led to unprecedented challenges for service providers that work with vulnerable children and families (Wilke et al., 2020). Services in child health care and social services have been disrupted, or “sidelined” (Sinha, Bennett, & Taylor-Robinson, 2020, p. 1). Some of these services include “acute services for life threatening illnesses, outpatient services for chronic conditions, child protection services guarding against abuse and neglect, and preventative

services that support early years development, routine checks, and immunizations” (Sinha et al., 2020, p. 1).

School closures and social distancing measures related to the coronavirus pandemic have interrupted “educational trajectories” (Sinha et al., 2020, p. 1) and have impacted nearly 60 million students from critical educational and health resources (Masonbrink & Hurley, 2020). These school closures pose an imminent threat to child health and wellbeing (Masonbrink & Hurley, 2020). School officials have recognized that students who are already at a disadvantage (i.e. struggling academically, lack access to technically needed to learn remotely, parents cannot afford to stay at home with children, etc.) are most affected by school closures (Rubin, 2020). Additionally, school closures as a result to COVID-19 have interrupted support that schools can typically provide (Rubin, 2020). Specifically, Rubin (2020) notes that without schools open, there is a lack of access to the identification and interventions of “child and adolescent physical or sexual abuse, substance abuse, depression, and suicidal ideation” (p. 534).

COVID-19 has influenced the work of telephone peer support services in their work with callers, the types of problems that their callers are facing, and how they are able to respond and meet the needs of those calling (Fisher et al., 2020). With the goal of helping people navigate the resources needed to continue their day-to-day activities and receive needed services and supports, these peer supporters have been impacted by the availability of resources, which is making their responsibilities to serve their callers more challenging (Fisher et al., 2020).

Conclusion

The literature reviewed, studies, and research articles discussed provide important background information related to the current research problem. While there has been significant research conducted on compassion fatigue in the nursing field and in counseling professions,

there is a lack of literature of the condition in other helping professions. With such limited research on compassion fatigue among care coordinators, a study on compassion fatigue within the Help Me Grow system will help fill that gap.

The compassion fatigue concept was originally introduced as an observed consequence of nurses serving patients experiencing suffering and trauma (Joinson, 1992). The term was later determined to be applicable to other helping professions, defined as “the cost of caring” (Boyle, 2015) and characterized by deep physical and emotional exhaustion, changing the level of empathy that a helper shows their patients or clients. Studies that have been conducted on compassion fatigue and its impact in certain professions have concluded that it is, in fact, a prevalent issue in helping professions. This finding makes this study even more critical for staff within the HMG system.

With the literature demonstrating different ways that compassion fatigue is characterized and how its associated conditions and symptoms are often confused, interchanged, and understood inconsistently, some generalizations can be made about each that will be used to guide this study. Other conditions related to compassion fatigue, including burnout, vicarious traumatization, and secondary traumatic stress, each describe the consequences that people experience as a result of working with trauma survivors or those who are suffering. They also share similar exhibited symptoms. Other related terms, such as empathy and compassion satisfaction, are more positive feelings and characteristics regarding helping others.

The effects of compassion fatigue on the professionals experiencing the condition may negatively impact the individual and the clients they serve (Lynch & Lobo, 2012). Compassion fatigue can cause a decreased ability to provide compassion and empathy to those an individual works with, and decrease one’s compassion satisfaction. Additionally, these helping

professionals may experience cognitive, emotional, behavioral, or somatic symptoms (Figley, 2002). If HMG care coordinators lack empathy or compassion satisfaction, or experience any other physical or emotional systems, the quality of care they are able to provide will diminish (Cesta, 2018).

This chapter reviewed literature on the main topics of this research study. With little literature on compassion fatigue among care coordinators, recognizing and attempting to fill this gap will contribute to the existing empirical research on the topics. As demonstrated in the upcoming chapters, this particular study explored the perceptions of the compassion fatigue phenomena and will allow HMG to better understand compassion fatigue among the system's care coordinators. Chapter 3 will describe the methodology and research design that this study utilized to answer the research questions.

CHAPTER 3: METHODOLOGY

This study utilized an explanatory sequential mixed methods design that combined quantitative and qualitative data collection methods. The research questions that guided the study in exploring the perceptions of the impact and prevalence of compassion fatigue among Help Me Grow (HMG) care coordinators were influenced by a gap in the literature on compassion fatigue case study research in care coordinator positions. A questionnaire helped determine the occurrence of compassion fatigue in care coordinators within HMG, a nationally recognized community-based system model which promotes cross-sector collaboration by leveraging existing resources to build comprehensive and effective early childhood systems (Therriault et al., 2020). To understand if and how HMG care coordinators are personally and professionally affected by compassion fatigue as a result of the nature of their work, conducting interviews to speak with care coordinators presented a direct approach (Creswell, 2009) and allowed for extensive interaction (Wong, 2008) that encouraged them to share their stories.

This chapter gives full descriptions of the research methodology that was used in this study. This includes a review of the study's research design and research questions. Additionally, the chapter will describe the population and sample, along with data collection and analysis methods.

Purpose of the Study

The purpose of this mixed methods study was to explore the perceptions of the impact and prevalence of compassion fatigue among HMG care coordinators. Care coordinators are susceptible to compassion fatigue due to the nature of their work being provision of compassion care (Monterio et al., 2016), which is vital in making sure that individuals feel comfortable, safe, and heard (Burnell, 2009). Care coordinators provide empathy and support (Werdhani et al.,

2018) as they listen to family stories, collect sensitive information and data, and address any questions or concerns families may have (Therriault et al., 2020). Feeling empathy for those in need can lead to negative consequences for the one who empathizes, resulting in emotional exhaustion (Hansen et al., 2018). This occupational stress, experienced as a negative consequence of compassionate care, is also known as compassion fatigue (Killian, 2008).

Research Questions and Design

To develop research questions and the study design, the topic of focus was considered. This study focused on compassion fatigue, the behavioral, emotional, or physical reactions or symptoms of working with people who have experienced trauma or extreme stressful events in their lives (Figley, 1995; Kapoulitsas & Corcoran, 2015). To determine the impact and prevalence of compassion fatigue in HMG care coordinators that assist children and families by providing information and referrals, the researcher asked the following questions:

1. What are Help Me Grow (HMG) care coordinators, located in the United States, perceptions of the prevalence of compassion fatigue within HMG care coordinators?
2. How do HMG care coordinators perceive the effect of compassion fatigue among themselves professionally and personally?

The researcher utilized a mixed methods case study research approach to address the study's purpose and research questions (Guetterman & Fetters, 2018). Integrating both quantitative and qualitative research allowed the researcher to gain an understanding of compassion fatigue within its context through a variety of data sources. More specifically, the study utilized an explanatory sequential mixed methods design in which quantitative data was collected first, followed by qualitative data collection as a way to explain the results of the quantitative data (Guetterman & Fetters, 2018). In this study, quantitative data was collected

through a questionnaire that determined the prevalence of compassion fatigue and was analyzed using numeric data for description (Creswell, 2013b). Qualitative data was collected through interviews that provided in-depth information about the attitudes and behaviors of care coordinators and will be presented narratively to tell the participants' stories.

By utilizing a case study research approach, the researcher explored the compassion fatigue phenomenon among care coordinators in the HMG system nationally “through detailed, in-depth data collection involving multiple sources of information” (Creswell, 2013a, p. 97). A case study allowed the research questions of “how” the direct services provided by HMG care coordinators affect their quality of life to be answered, with the contextual conditions in mind (Baxter & Jack, 2008).

Site Information and Population

This study did not have a physical site. To study compassion fatigue within HMG care coordinators, the population for this study consisted of care coordinators that are affiliated with an HMG system. These HMG care coordinators are distributed throughout the United States, with 104 HMG systems operating in 31 states (Therriault et al., 2020).

Participants

The participant pool for this study was determined by the results of the 2020 standardized HMG Fidelity Assessment (FA) and the eligibility criteria set by the researcher. To explore compassion fatigue among care coordinators in HMG systems throughout the United States, participants in this study must have been associated with an HMG affiliate state or system that scored at an *Installation* or *Implementation* level of implementation for their CAP based on the 2020 FAs. Study participants were also required to work as an HMG care coordinator, or

perform similar duties such as offering developmental screenings, providing information and referrals, or providing care coordination or case management services.

Based on the 2019 FA results, this study had a potential participant pool of 89 care coordinators. This number was determined by the total number of HMG affiliate systems that completed the FA and scored in the *Installation* or *Implementation* phases for their CAP component (Therriault et al., 2020), with an estimated participation at least one care coordinator from each eligible HMG system.

Sampling Method

A purposive sampling method (Saldana, 2013) was used for this mixed methods study to help fulfill the study's purpose. Purposive sampling refers to producing a sample that can be assumed to represent the population (Lavrakas, 2008). It allows researchers to make generalizations from the sample that is being studied to a larger population (Lavrakas, 2008). Utilizing this sampling method allowed the researcher to select specific individuals that can purposefully inform and aid in the understanding of compassion fatigue (Creswell, 2013a). By selecting a sample of HMG care coordinators, the study allowed the researcher to make generalizations to a larger population of care coordinators within HMG or care coordinators in other fields/programs.

Bachman and Schutt (2011) describe three guidelines for selecting participants for purposive sampling. Participants must be knowledgeable about the subject or phenomenon that is being studied, willing to participate in the study, and represent a range of points of view (Bachman & Schutt, 2011). Inviting HMG care coordinators throughout the United States to participate in this research study complied with these guidelines and allowed the researcher to explore compassion fatigue in this population.

Instrumentation and Data Collection Procedures

Utilizing a sequential mixed methods research approach, both qualitative and quantitative data were collected to address the study's research questions. Quantitative data for this study were collected through a questionnaire to estimate the prevalence of compassion fatigue and to provide the sampling frame for subsequent participant interview questions (Appendix B) aimed at describing the impact that compassion fatigue has on the participants. The questionnaire was used as an instrument to recruit participant volunteers for the open-ended interviews, which served as this study's qualitative data collection method. Questionnaires can provide evidence of patterns, while qualitative interviews can gather in-depth insight on the attitudes, thoughts, and actions of the participants (Kendall, 2008).

Following receipt of permission to access HMG's FA data (Appendix C & Appendix D) and after having received IRB approval, collection of data commenced. The HMG National Center used the private FA data to determine which affiliate site was eligible to participate in the study (based on their level of implementation for their CAP). HMG National then contacted the program leads at each of the eligible sites via email, requesting permission to share the FA data and contact information with the researcher and offering an opportunity for the HMG system to opt-out of the data sharing if they choose. Once the opt-out period closed, HMG National shared the FA data and contact information with the researcher, noting which HMG affiliate sites scored at the *Installation* and *Implementation* levels of their CAPs (Appendix E). The researcher sent a recruitment email (using a work email address) (Appendix F) to each of the eligible sites that agreed to have the researcher follow-up with them, inviting them to participate in the research study. The recruitment email described the researcher's study topic and purpose, the activities that participation in this research study would entail, and a link to complete the questionnaire,

noting that the questionnaire would become unavailable nine days later. The documents attached in the email included the researcher's resume and informed consent forms for the survey/questionnaire (Appendix G) and subsequent interviews (Appendix H). These informed consent forms included the project purpose and participant eligibility, responsibilities, rights, and potential risks and benefits. The informed consent forms also described participant privacy and confidentiality, explaining that all questionnaires may be completed anonymously, but participants that agree to participate in a follow-up interview will no longer be anonymous and will be required to enter their names and contact information. It also explained that pseudonyms would be assigned using the first letter of their first name and a random name generator on the internet to ensure that their identity was kept strictly confidential. The researcher requested that the program leads forward the invitation email to those that meet the participant eligibility criteria.

Questionnaire

The recruitment email that the researcher sent to program leads to be forwarded to their care coordinators included a link to the ProQOL questionnaire in REDCap. The questionnaire was set to expire in REDCap seven business days after the recruitment email was sent. The first question of the questionnaire in REDCap included reiterated the study's participant rights and consent information (Appendix I). Before respondents were able to complete the questionnaire, they were required to give consent to participate in the study. Once consent was given, they could proceed. The ProQOL questionnaire (Stamm, 2010) was used to determine the prevalence or occurrence of compassion fatigue within study participants. The ProQOL questionnaire is a conceptual model that attempts to contribute to better understanding a professional's quality of life, which can be defined as the quality one feels in relation to their work as a helper (Stamm,

2010). Compassion fatigue is considered a negative aspect of one's professional quality of life (Stamm, 2010). As a precautionary measure, the "Permission to Use the ProQOL" form was submitted to the ProQOL office at the Center for Victims of Torture (CVT). Permission was granted upon submission via email (Appendix J).

The ProQOL questionnaire is formatted as 30 statements designed to self-report how frequently each item was experienced in the past 30 days (Bride, Radey, & Figley, 2007). These statements are to be rated by the respondent using a 5-item Likert scale (1 = never, 2 = rarely, 3 = sometimes, 4 = often, 5 = very often) (Bride et al., 2007).

The ProQOL instrument addresses compassion fatigue by assessment of both negative (compassion fatigue, burnout, secondary trauma) and positive (compassion satisfaction) experiences (Stamm, 2010). These conceptual components are demonstrated in the instrument as three sub-scales (Figure 1), including burnout and secondary trauma (which make up compassion fatigue), and compassion satisfaction (Stamm, 2010). In order to determine the prevalence of compassion fatigue within participants, the questionnaire scores from the burnout and secondary traumatic stress scales were specifically examined to determine if compassion fatigue is prevalent. The questionnaire scores were kept in the researcher's University of New England password-protected Google Drive for confidentiality until the dissertation was defended. Results of the compassion satisfaction subscale served as complementary data to help answer the study's research questions.

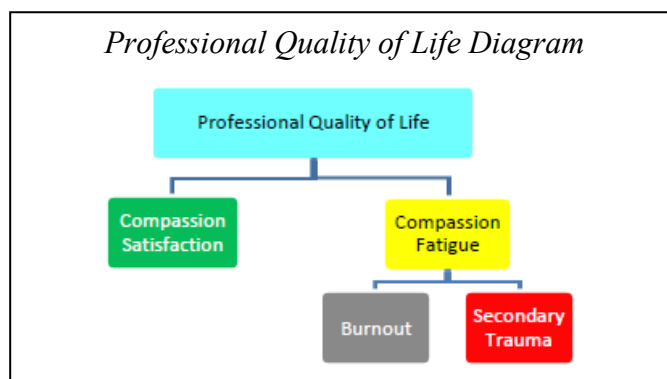


Figure 1. Diagram of Professional Quality of Life (Stamm, 2010)

The ProQOL questionnaires were distributed through an online REDCap survey, which allowed participants to enter data for themselves. The ProQOL questionnaire was reformatted from its original paper version into a virtual format in REDCap. Following instructions from the Center for Victims of Torture (2019), no changes were made other than replacing “[helper]” with a more specific term, care coordinator. The REDCap software distributed, collected, and managed the online questionnaires. Responses through the REDCap link were collected anonymously. Participants that agreed to participate in a follow-up interview were no longer anonymous and were required to enter their names and contact information, but pseudonyms were assigned and their identity was kept strictly confidential. All questionnaire responses are stored securely within REDCap’s encrypted database servers, which back-up regularly. All REDCap data records relevant to this study were deleted by the researcher upon the successful dissertation defense.

Interviews

The ProQOL questionnaire served as the recruitment process for the interviews. Upon completion of the questionnaire, participants had an opportunity to volunteer for a 15-30-minute follow-up interview. To incentivize participation in follow-up interviews, the researcher offered

a \$25 Amazon gift card to the first eight interview participants upon completion of the interview. The questionnaires did not ask for participant contact information unless they selected that they were interested in a follow-up interview. If the questionnaire respondent was interested in participating in a follow-up interview, their participation was no longer anonymous and they were asked to provide their name and contact information. Once the questionnaire responses were submitted, the researcher accessed the data, including names and contact information, through REDCap. At this time, the researcher contacted the volunteer participants using the contact information provided by the questionnaire respondent (phone number and/or email address) to email the participant to schedule an interview.

Following Creswell's (2013a) recommendation of interviewing up to 10 participants for qualitative research, the researcher interviewed the first eight questionnaire respondents that agreed to volunteer for a follow-up interview. This number represents 10% of the potential participant pool based on the total number of HMG affiliate systems that completed the 2019 FA (89 HMG systems) and scored in the *Installation* or *Implementation* phases for their CAP component, with an estimated participation at least one care coordinator from each eligible HMG system. Lopez and Whitehead (2013) note that small samples are manageable in qualitative research due to the high quality data that can be generated from each single participant. To incentivize participation in follow-up interviews, the researcher offered a \$25 Amazon gift card to the ten interview participants upon completion of the interview. If more than eight participants volunteer, they were to be notified via email that the interview spots had been filled but that their contact information would be kept safely secured.

Crabtree and Miller (2012) explain that interviews provide opportunities for participants to tell their stories. In this study, the researcher conducted semi-structured interviews with open-

ended questions to allow for flexibility, rapport with the interviewees, and active listening (Silverman, 2006). Both structured and semi-structured interviews provided rigidity that would prevent information that participants may potentially share (Silverman, 2006). Open-ended questions also allowed for a conversational interview, as the researcher actively listened to participants and responded with follow-up questions (Korstjens & Moser, 2018).

Each interview lasted between 15 and 30 minutes and was digitally recorded using the Zoom teleconference program. Zoom is an online software that allows for users to host or join online meetings, trainings, webinars, conference rooms, chats, etc. (Zoom Video Communications, 2020). The researcher conducted the online recorded interviews in an office setting after workhours to ensure strong internet connectivity and a quiet and private environment. The participants participated in the Zoom interview in a location of their choosing away from public view. The interview responses were transcribed into a Microsoft Word document using the Rev.com online transcription service to transcribe the interview responses from an oral language to a written language for further analysis. The Zoom audio recordings of the participant interviews, along with the Rev.com transcripts, were stored securely in the researcher's University of New England password-protected Google Drive until the dissertation has been defended.

Field Test

A field test was conducted prior to the study to ensure credibility, dependability, validity, and risk level (McGrath et al., 2019). A field test is important in confirming that the data collection tools or methods successfully gather the information it was designed to gather (Roberts, 2010), and provides an opportunity for the researcher to “explore language, the clarity of the questions, and aspects of active listening” (McGrath et al., 2019, p. 1003). An individual

who met the research study eligibility criteria and would not be participating in the study was invited to participate in the field test via email. Once the participant agreed, the researcher set-up a Zoom teleconference call to test out the interview questions.

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When pretesting an instrument, Roberts (2010) recommends looking for understandable instructions, adequate answers, clear wording, irrelevant questions, length, and convenience. The field test volunteer reviewed the interview questions and shared their feedback with the researcher via email. The field test participant found one of the interview questions to be unclear and a bit confusing, which made it difficult for them to respond to. Once the researcher received feedback from the field test participant, the interview questions were revised to simplify the language to make the questions clearer. All field test documents, including signed consent form, audio recording, and transcriptions, were securely stored in a password-protected Google Drive until the researcher’s dissertation had been successfully defended.

Data Analysis

This data analysis process included organizing and arranging the questionnaire responses, scoring the questionnaire subscales, and transcribing the recorded interviews to increase the

understanding of compassion fatigue within HMG care coordinators. Each subscale/section (compassion satisfaction, burnout, and secondary traumatic stress) scores are calculated uniquely (Stamm, 2010). The sum of the compassion satisfaction questions was totaled by adding up the scores to the associated questions (Stamm, 2010). The sum of the burnout and secondary traumatic stress questions were each totaled by reversing the scores of the associated questions (Stamm, 2010). Once the sum of the questions is calculated, the key for each subscale was used to determine the level of each subscale (Stamm, 2010). Scores in the higher range on the compassion satisfaction subscale (10 items) indicated the respondent is experiencing better professional satisfaction from their position and their ability to be an effective caregiver in their jobs (Stamm, 2010). Higher scores on burnout and secondary traumatic stress subscales (10 items each) indicated that the respondent is at higher risk for compassion fatigue (Stamm, 2010).

Once questionnaires were completed and subsequent interviews were conducted, the interview recordings responses were transcribed using the Rev.com software from oral language to written language. The transcriptions were offered to each interview participant via email with the option of member checking to ensure validity and credibility, and to avoid misinterpretation (Merriam & Tisdell, 2016). Once the transcriptions were member checked by each participant, the researcher de-identified them to protect the participants' identity (The Qualitative Data Repository, 2020) and assigned a pseudonym based on the first letter of their first name using a random name generator on the internet. De-identifying data is the process of detecting identifiers, or personal information, that directly or indirectly point to a person and deleting those identifiers from the data to break the linkage to real world identities (Kayaalp, 2007). The de-identified transcripts were coded and categorized to determine any patterns, themes, and/or categories from the data (Creswell, 2009). The researcher used *in vivo coding*, assigning words

or phrases from language taken directly from participant responses, in quotes (Saldana, 2013). Once the researcher identified the codes, statements that fit into each category/theme were highlighted and explained in memo form (Ford, 2014). The analytic memo served as the researcher's documentation and reflection of the coding processes used, code choices, and patterns and themes (Saldana, 2013).

Limitations of the Research Design

This mixed methods case study research design has limitations that must be considered. While a mixed methods research approach allows researchers to collect rich and comprehensive data, this can increase the complexity of evaluations (Wisdom & Creswell, 2013). The integration of quantitative and qualitative data can be challenging to plan and collect, and the subsequent data analysis process can be challenging for many researchers (Wisdom & Creswell, 2013). Wisdom and Creswell (2013) also note that a mixed methods approach can be more labor intensive for researchers and require more resources and time than single method studies.

The reliance on cross-sectional data in this study, or a one-time measurement (Setia, 2016), may also be considered a limitation. With the questionnaire being completed at one point in time, the data only reflect the compassion satisfaction and compassion fatigue (Stamm, 2010) that is experienced when the questionnaire is completed. Future studies would benefit from a longitudinal design, which would allow for ongoing research over an extended period of time (Epstein, 2002, as cited in Koro-Ljungberg & Bussing, 2013).

The ProQOL questionnaire that was used to collect quantitative data on the prevalence of compassion fatigue utilizes a Likert scale (Stamm, 2010), which could also be considered a limitation to this research design. A Likert scale is a set of declarative statements followed by ordered response options that is used to measure a person's attitudes, beliefs, or opinions about

something (Allen, 2017). The ProQOL Likert rating scale is a 5-point design rating the frequency of the statement, ranging from “never” to “very often” (Stamm, 2010). Likert scales have been found to show potential bias (Gunderman & Chan, 2013). In a study by Ogden and Lo (2011), Likert scales were found to highlight “the role of participant’s frame of reference and indicate how questions can be interpreted in different ways according to what is salient to the individual” (p. 360). Gunderman and Chan (2013) also noted that respondents may feel limited by the 5-points in their response and that they may need an option between the response ranges offered. In the ProQOL questionnaire, respondents may need an option somewhere between “never”, “rarely”, “sometimes”, “often”, and “very often” (Stamm, 2010). The Likert scale’s limited response options also contribute to the “central tendency bias” (Gunderman & Chan, 2013, p. 1467) and may fail to measure the respondents’ true attitudes (Allen, 2017).

The forthcoming section will review methods the researcher utilized to enhance the quality and trustworthiness of the data analysis (Korstjens and Moser, 2018). This includes strategies for ensuring credibility, member checking, transferability, dependability, and confirmability.

Credibility

In order to ensure this study’s credibility and “truth value” or truth of the research findings, Korstjens and Moser (2018) suggest “prolonged engagement, persistent observation, triangulation and member check” (p. 121) as strategies to ensure credibility. These strategies will require conducting different activities. To ensure prolonged engagement, the researcher exercised patience during the participant interviews, and conversed with participants with follow-up questions (Korstjens & Moser, 2018). By investing sufficient time into the open-ended interviews, the researcher was able to build trust and become familiar with the setting and

context which helped participants feel comfortable and open to sharing their personal experiences (Korstjens & Moser, 2018). Data triangulation was conducted by the multiple methods of data collection in this study, or method triangulation (Korstjens & Moser, 2018).

The credibility of the researcher should also be considered in any research study. The trustworthiness of the data is tied directly to the trustworthiness of the researcher who does the collecting and analyzing (Patton, 1999). The researcher's credibility is "dependent on training, experience, track record, status, and presentation of self" (Patton, 1999, p. 1190). The curriculum and program implementation of the University of New England's Doctorate of Education program has prepared this study's researcher for conducting the study, collecting data, and analyzing the data to draw conclusions. An additional factor to consider in the researcher's credibility is the potential biases. Separation between a study's researcher and the process and final product are inevitable (Galdas, 2017). With the researcher's personal interest in the study topic, biases may present themselves through researcher or participant biases. The researcher is associated with the same program as the participants (HMG care coordinators). This may affect the willingness and ability for participants to be vulnerable when sharing their experiences. Therefore, an open-ended interview structure was used to allow for the establishment of a rapport between the researcher and participants, active listening, and thoughtful in-depth responses (Silverman, 2006; Patton, 2002; Creswell, 2013a). The researcher avoided bias through data collection, specifically in the interviews. The interview questions were field tested by a non-study participant to ensure credibility, dependability, validity, and risk level (McGrath et al., 2019). The researcher conducted open-ended interviews without leading questions and wording to avoid the influence of participant responses (Smith & Noble, 2014).

Member Checking Procedures

Lincoln and Guba (1985) suggest that member checking is a crucial step in establishing credibility. Once the participant interviews were transcribed and coded, the interpreted themes and patterns were member checked, or approved, by the participant to ensure validity and credibility, and to avoid misinterpretation (Creswell, 2009; Merriam & Tisdell, 2016). Curtin and Fossey (2007) note that member checking is helpful in verifying that the data collected aligns with the participant's experiences that they shared in the interview. In this study, all interview respondents were given an opportunity to member check and edit, clarify, or elaborate their own words from the narratives (Carlson, 2010). The transcribed responses were offered to each interview participant with the option of member checking to ensure the researcher has accurately reported their stories. The researcher sent the transcriptions to the participant by email or a link to the password-protected Google Drive where the transcriptions will be uploaded. Participant feedback will be noted within the transcription.

Transferability

Transferability of this study is important due to the lack of research on compassion fatigue in the care coordination profession. When analyzing and reporting the findings of this study, the researcher will present the information in a way that allows the reader to determine if the study or findings are transferable, or applicable, to their own settings (Korstjens & Moser, 2018). To do this, the researcher wrote the report with full descriptions of behaviors, experiences and context so an outside reader will recognize the significance of the content (Korstjens & Moser, 2018).

Dependability and Confirmability

Korstjens and Moser (2018) define dependability and confirmability as describing the research steps and events through the duration of the study, from development to reporting the findings. These records are kept throughout the study as a research path, or an audit trail (Korstjens & Moser, 2018) with the purpose of the ability of another researcher to follow the decisions made throughout the study (Thomas & Magilvy, 2011). The researcher used a digital document kept in Microsoft Word as the audit trail for this study.

Confirmability occurs when credibility, transferability, and dependability have been established (Thomas & Magilvy, 2011). Within the confirmability criteria, reflexivity provides an opportunity for the researcher to become self-aware and reflective about the activities conducted throughout the study, including data collection, analysis and interpretation (Korstjens & Moser, 2018). Through reflective notetaking, the researcher can reflect on if and how their assumptions, beliefs, biases, and perceptions affect the research (Korstjens & Moser, 2018; Thomas & Magilvy, 2011). Reflective research will help the researcher develop confirmability through the discovery of new insights, allowing the reader to trust in the “conduct credibility of findings and applicability of the study” (Thomas & Magilvy, 2011, p. 154).

Ethical Issues in the Study

Approval for the research protocol was obtained from University of New England’s (UNE) Institutional Review Board (IRB) to allow for ethically responsible research. The researcher completed the Collaborative Institutional Training Initiative (CITI) Ethics Training for Research with Human Subjects and Research Ethics and Compliance (Appendix K). Through these courses, the researcher is educated on the ethical principles included in the Belmont Report

that UNE is guided by, including respect for persons, beneficence, and justice (Office for Human Research Protections, 2016).

Creswell (2013a) recognizes that ethical issues can arise throughout each phase of the research process. The care coordinators within the HMG program were selected as the study focus with the approval and vested interest of HMG National. The researcher was responsive to the needs and feelings of the study participants, as their potential experiences with compassion fatigue could be sensitive and make them a potentially vulnerable population (Creswell, 2013a). Since this research study involved participants that are employed, the researcher was mindful of their work responsibilities and aimed to disrupt as little as possible (Creswell, 2013a). The data and evidence collected are guaranteed by the researcher to not be falsified and to be reported honestly (Creswell, 2013a).

Each participant received a consent letter for both methods of data collection explaining how human subjects will be protected. The letter reviewed the purpose of the study and an identification of researchers, research procedures, the time required, the risks and benefits involved, research subject rights, confidentiality, participation and withdrawal, and contact information for questions about the study. Participants were required to give consent via REDCap before the questionnaire began and were given an opportunity to give verbal consent at the beginning of the interview.

Conclusion and Summary

Prior literature describes compassion fatigue as a complex phenomenon in helping professions. While research on the topic is plentiful, there are still many areas in which research does not exist. This study will contribute to the existing literature by examining compassion fatigue among care coordinators, specifically within the HMG system. This mixed methods case

study research design explored the perceptions of the prevalence and impact of compassion fatigue within HMG care coordinators as a result of their compassionate care their work requires them to provide to children and families. Through the use of a questionnaire and participant interviews, the impact and prevalence of compassion fatigue among HMG care coordinators was determined. The researcher took appropriate measures to ensure this study's credibility. With the goal of addressing a gap in the literature on compassion fatigue in the care coordination profession, the results of this study provides important findings to inform those interested in compassion fatigue in helping professions and care coordinators.

CHAPTER 4: RESULTS

The purpose of this explanatory sequential mixed methods case study was to explore the perceptions of the impact and prevalence of compassion fatigue among Help Me Grow (HMG) care coordinators. This research study is intended to fill the current gap that exists in the literature on compassion fatigue among care coordinators by focusing on care coordinators within the HMG system. Care coordination is a process of coordinated and collaborated care aimed to link or facilitate people to needed services and resources (AAP, 1999; Au et al., 2018). HMG care coordinators within the HMG system help children and families navigate through the early detection and intervention process and connect them to local services (Cornell et al., 2018). Working with children and families who are experiencing fear, pain, and suffering, as HMG care coordinators do, can have significant effects on these professionals assisting them and may contribute to the development of compassion fatigue (Branch & Klinkenberg, 2015; Geoffrion et al., 2016).

Supported by existing research and literature that provides evidence of exhaustion amongst caring and helping professionals, Figley's (1995) compassion fatigue theory and Stamm's (2010) professional quality of life theory served as an underlying structure aimed to frame this study (Merriam & Tisdell, 2016). With these frameworks in mind, this research study was guided by the following research questions:

1. What are Help Me Grow (HMG) care coordinators, located in the United States, perceptions of the prevalence of compassion fatigue within HMG care coordinators?
2. How do HMG care coordinators perceive the effect of compassion fatigue among themselves professionally and personally?

The population for this study consisted of care coordinators that are affiliated with an HMG system. During the 2020 year, there were 111 HMG systems operating in 29 states (C. Therriault, personal communication, January 18, 2021). One hundred HMG systems in the United States completed the 2020 FA, as reported by HMG National (C. Therriault, personal communication, January 14, 2021) (Appendix E). Of those hundred systems, 98 were found to be eligible for the research study based on the researcher's eligibility criteria. There were 9 HMG systems that opted out of sharing their FA results with the researcher. Additionally, one HMG system (that reflects 21 HMG systems within) was still pending approval at the time that the opt-out period ended so care coordinators from that system were unable to participate. This left a total of 68 HMG systems in the United States that were eligible and interested in participating in the research study. This determined the potential participant pool to be 68 HMG systems, with an estimate of at least one care coordinator from each eligible HMG system participating.

This mixed methods study utilized questionnaires and interviews as data collection methods. Using email addresses provided by HMG National, a recruitment email was sent by the researcher to each HMG program lead with a link to the ProQOL questionnaire in REDCap. Program leads were asked to forward the recruitment emails to their care coordinators. There were a total of 23 participants that volunteered to participate in a follow-up interview, which is 57% of the total number of survey respondents ($n = 40$). The researcher scheduled interviews with the first eight volunteers through their preferred method of communication (phone, email, or text), as noted in their questionnaire submission. Interview dates and times were scheduled using a free online appointment scheduling software, Calendly.com (Calendly.com, 2021). The researcher emailed each volunteer a Calendly link, followed by a calendar invitation and Zoom call information after a time slot was selected. The interview volunteers that were not included in

the first eight volunteers were notified via their preferred method of communication that the interview spots had been filled but that their contact information would be kept safely secured.

The focus of this chapter is the quantitative and qualitative data collection process for this study and explains the analysis methods that were used to interpret and understand the data. The chapter concludes with a presentation of study results. These results helped to identify the prevalence and impact of compassion fatigue among HMG care coordinators.

Analysis Method

Quantitative and qualitative data analysis were both required for this sequential mixed methods study. A sequential mixed methods research design utilizes quantitative data collection first, followed by the collection of qualitative data as a way to explain the results of the quantitative data (Guetterman & Fetters, 2018). To begin an analysis of quantitative data, questionnaire responses were calculated using the ProQOL scoring guide (Stamm, 2010). Stamm's (2010) questionnaire scoring protocol requires each subscale (compassion satisfaction, burnout, and secondary traumatic stress) to be scored individually, and then combined for further analysis. While each ProQOL subscale reflects how an individual is experiencing each of the conditions, Stamm (2010) acknowledged parallels between various levels of each component of a professional's quality of life. Therefore, the researcher examined the combinations of levels of compassion satisfaction, burnout, and secondary traumatic stress among HMG care coordinators.

To analyze this study's qualitative data, *in vivo* coding was used to identify words or phrases from the actual language the participant used in their interview (Saldana, 2013). These codes were used to determine categories and themes. The researcher also maintained an analytic memo throughout the data collection and analysis process. The analytic memo, also known as a

researcher's journal (Saldana, 2013), served as method of reflection and thoughts about the interview responses or how the collected data addressed the study's research questions.

To explore compassion fatigue among care coordinators in HMG systems throughout the United States, the researcher recruited HMG care coordinators to complete ProQOL questionnaires and participate in semi structured interviews. Participants in this study must have been associated with an HMG affiliate state or system that scored at an *Installation* or *Implementation* level of implementation for their CAP based on the 2020 FAs, and work as, or perform similar duties as, an HMG care coordinator. With a contact list provided by HMG National, links to the ProQOL questionnaire were distributed via email to all eligible HMG program leads for their care coordinators to complete. Once the questionnaire availability window closed and all interviews were conducted, the researcher began analyzing the collected data. The combination of surveys and interview data created a description that sheds light on the occurrence and impact that compassion fatigue has on HMG care coordinators.

Quantitative Data Analysis

Quantitative data for this research study was collected via the ProQOL questionnaire. The ProQOL instrument is a self-test that addresses compassion fatigue by assessment of both negative (compassion fatigue, burnout, secondary trauma) and positive (compassion satisfaction) experiences (Stamm, 2010). The ProQOL questionnaire was distributed, collected, and managed through REDCap. The questionnaire link was sent through a recruitment email to 68 HMG sites throughout the United States that were found to be eligible for this research study. Once the questionnaire submission period ended, the researcher reviewed all questionnaire submissions through the *Record Status Dashboard* in REDCap. The REDCap software automatically assigned each questionnaire submission a numerical Record ID. While there were 68 eligible

HMG sites in the United States being invited to participate in the study with an estimated one care coordinator at each site, there was a resulting total of 41 questionnaire respondents. One participant submitted a record although they did not provide consent and therefore did not complete the questionnaire. As a result, there were a total of 40 questionnaire respondents and submissions, with an overall response rate of 58.8% ($n = 40$), which is more than the average survey response rate of between 20-30% (Qualtrics, n.d.).

The researcher exported all raw data from REDCap into a Microsoft Excel document which organized all questionnaire submission data into one spreadsheet. The raw data included all Record ID numbers (as assigned by REDCap), time stamps, and itemized responses, including consent fields and the 30 ProQOL statement responses. To further organize the data and begin scoring each questionnaire scale, the researcher prepared a spreadsheet (Appendix L) with hidden formulas that would allow for the addition of scale scores and the reversal of certain itemized responses. The researcher copied and pasted the ProQOL itemized responses from the REDCap data export spreadsheet into the new scoring spreadsheet, transposing the data to be reformatted as vertically instead of horizontally.

Following Stamm's (2010) ProQOL questionnaire scoring protocols, individual scale scores were summed for compassion fatigue (including burnout and secondary traumatic stress scales) and compassion satisfaction. Within the scoring spreadsheet, numerical responses to ProQOL item numbers 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 (Appendix A) were summed to determine levels of compassion satisfaction. Responses to item numbers 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 (Appendix A) were summed to determine levels of burnout, with responses for item numbers 1, 4, 15, 17, and 29 (Appendix A) being scored reversely, as required by the scoring guide [(1 = 5) (2 = 4) (3 = 3) (4 = 2) (5 = 1)] (Stamm, 2010). Lastly, responses to item

numbers 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 (Appendix A) were summed to determine levels of secondary traumatic stress.

Stamm (2010) explains that a few specific scores within the burnout scale must be reversed because scientifically, the measure is more effective when the “questions are asked in a positive way” though they can shed more insight “about their negative form” (p. 71). To reverse the scores for item numbers 1, 4, 15, 17, and 29, the researcher used a reverse scoring formula within the Microsoft Excel spreadsheet. Since the ProQOL questionnaire utilizes a 5-point Likert scale with five response options, the formula [$x = 6 - (\text{original numerical response})$]. This formula allowed the designated scores to be automatically reversed each time a questionnaire respondent’s response scores were copied, pasted, and transposed into the new scoring spreadsheet.

Once all participant question responses were calculated and scored according to Stamm’s (2010) ProQOL scoring guide, levels of compassion satisfaction, burnout, and secondary traumatic stress were identified (Appendix L). On each scale, per Stamm’s (2010) ProQOL scoring guide, a sum of ≤ 22 indicates a ‘low’ risk or level of each condition (Stamm, 2010). Per Stamm’s (2010) ProQOL scoring guide, a sum between 23 and 41 indicates an ‘average’ risk or level of each condition (Stamm, 2010). Lastly, per Stamm’s (2010) ProQOL scoring guide, a sum of ≥ 42 indicates a ‘high’ risk or level of each condition (Stamm, 2010).

After the three individual ProQOL scales were scored for each participant questionnaire response, a further examination of the combination of ProQOL scale scores for each respondent was conducted. While scores on individual scales shed insight on a person’s responses on each of the ProQOL statements, a review of the combination of scores for each respondent helps provide a more detailed picture of what the individual is experiencing (Stamm, 2010).

Qualitative Data Analysis

Of the 40 ProQOL participant questionnaire responses that were submitted through REDCap, 60% of respondents volunteered for a follow-up interview ($n = 24$). Following Creswell's (2013a) recommendation for interviewing up to 10 participants for qualitative research, the first eight volunteers were interviewed. This number was determined as a representation of 10% of the potential participant pool based on the total number of HMG affiliate systems that completed the 2019 FA (89 HMG systems) and scored in the *Installation* or *Implementation* phases for their CAP component, with an estimated participation at least one care coordinator from each eligible HMG system. Upon completion of the interview and member check, one participant chose to opt-out of the interview portion. The participant did not feel as though she communicated her thoughts well once she member checked the transcription. Subsequently, the first participant volunteer that was next to respond to recruitment was contacted via email to schedule an interview. Two interview participants added additional notes within the Word document of their interview transcription to elaborate on thoughts they expressed during the interview. Once the questionnaire window closed and all eight interviews were conducted, the remaining 15 interview volunteers were contacted via their preferred method of contact and notified that the interview spots had been filled but that their contact information would be kept safely secured in a password-protected Google Drive until the researcher's dissertation had been successfully defended.

Semi-structured interviews with open-ended questions were conducted and recorded via Zoom. The researcher conducted the eight interviews in an office setting after work hours to ensure strong internet connectivity and a quiet and private environment. The participants participated in the Zoom interview in a location of their choosing away from public view. The

researcher asked questions related to the participant's experience as an HMG care coordinator and their experience with compassion fatigue (Appendix B), if any. After the eight participant interviews were conducted, the recorded participant responses were transcribed by Rev.com into individual Microsoft Word documents. Each participant received a copy of the interview transcription via email for member checking. The researcher gave each interview participant 48 hours to complete their member check and noted that if a response was not received by the set date and time, the researcher would move forward under the assumption that the participant had no feedback to report. Once all member checks were complete, the eight interview transcriptions were de-identified. The researcher removed all mentions of locations, persons mentioned or identified, and programs/agencies to ensure confidentiality.

After all interviews were conducted, transcribed, member checked, and de-identified, the researcher read through each transcription multiple times. Following Creswell's (2014) recommendation, the first read through helped this researcher to develop a sense of the data overall. Following the initial read-throughs, the coding process resulted in the organization of data into identified categories as influenced by the study's theoretical frameworks; Figley's (1995) compassion fatigue theory and Stamm's (2010) professional quality of life theory. Interview transcripts were each coded using *in vivo* coding which uses the participants' exact words placed in quotation marks (Saldana, 2013). To do this, the researcher highlighted and added comments with *in vivo* codes directly into the de-identified interview transcripts formatted in Microsoft Word.

The *in vivo* codes were further organized into emergent themes. These themes were developed with consideration to this study's purpose and interview questions and demonstrated the perceived prevalence and impact of compassion fatigue among HMG care coordinators. A

total of 42 codes were clustered into seven key themes that included (a) developing relationships and establishing trust with families, (b) love of being a care coordinator, (c) empathy and compassion required, (d) communication skills required, (e) physical and emotional symptoms, (f) struggle to establish boundaries, and (g) self-care and external support as coping strategies. Once the researcher identified codes and themes, they were highlighted and explained in memo form (Ford, 2014). The analytic memo served as the researcher's documentation and reflection of the coding processes used, code choices, and patterns and themes (Saldana, 2013).

Emergent Themes

Once the quantitative and qualitative data had been collected and analyzed, the researcher sought any themes, patterns, or categories in the data to help determine study findings. A thorough examination of all data collected allowed for the determination of emerging themes supported by this study's results. The following provides an overview of themes from ProQOL questionnaire scores and interview transcripts with specific excerpts used to further illustrate each theme presented.

Questionnaire Themes/Patterns. ProQOL questionnaire responses and scores were analyzed to detect any themes or patterns. When the results of all respondents ($n = 40$) were aggregated, 70% of HMG care coordinators scored high for compassion satisfaction, while no HMG care coordinators were at high risk for burnout or secondary traumatic stress (Figure 2). Participants that reported high levels of compassion satisfaction ($n = 28$) also reported either low or average levels of burnout or secondary traumatic stress (Figure 2).

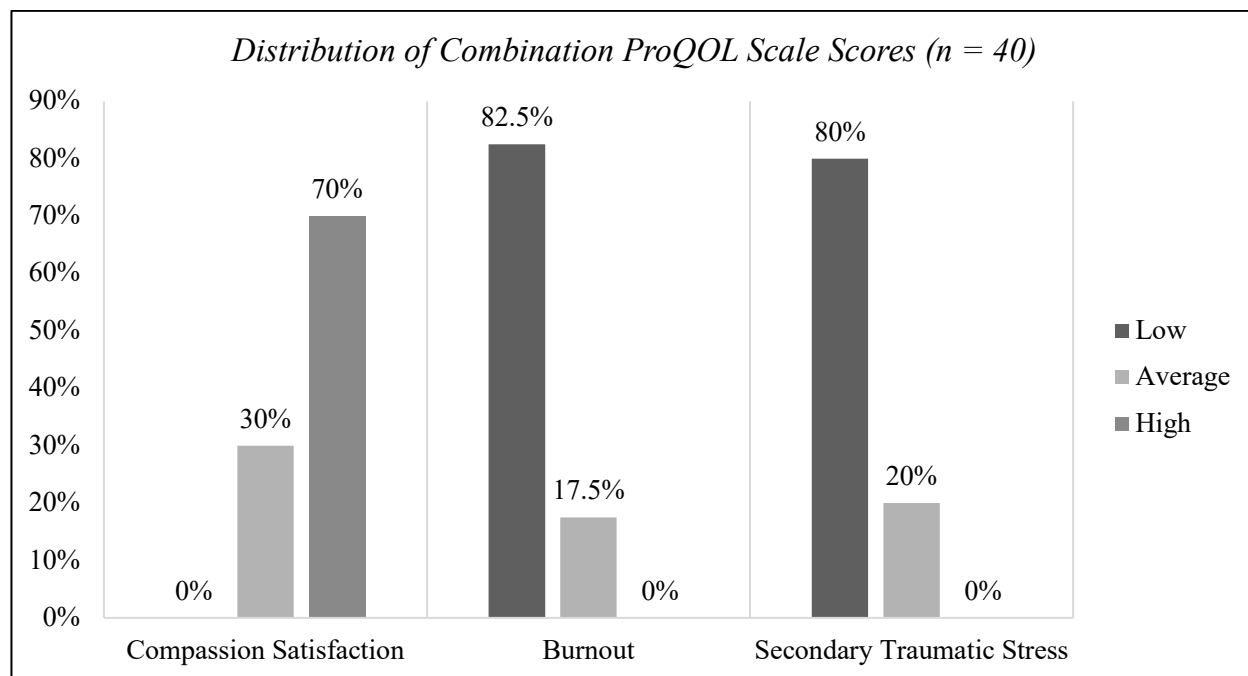


Figure 2. Distribution of Combination ProQOL Scale Scores (n = 40)

REDCap produced a statistics report that reflected itemized ProQOL questionnaire responses. The itemized responses were combined into one table for a stronger data analysis (Appendix M). For a further analysis of the individualized responses, specific ProQOL statements that help provide a generalized idea of the respondent's professional quality of life were determined. Specifically, ProQOL statement numbers 3, 7, 12, 18, 19, 21, 22, 24, 29, and 30 were of interest due to their straightforward language regarding how the participant feels about their work as an HMG care coordinator (Table 1).

Table 1

Frequency Distribution of ProQOL Itemized Responses (N = 40), n (%)

ProQOL Item #	ProQOL Statement	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
3	I get satisfaction from being able to help people or families.	0 (0%)	0 (0%)	1 (2.5%)	5 (12.5%)	34 (85%)
7	I find it difficult to separate my personal life from my life as a care coordinator.	7 (17.5%)	24 (60%)	5 (12.5%)	3 (7.5%)	1 (2.5%)
12	I like my work as a care coordinator.	0 (0%)	0 (0%)	1 (2.5%)	18 (45%)	21 (52.5%)
18	My work makes me feel satisfied.	0 (0%)	0 (0%)	6 (15%)	27 (67.5%)	7 (17.5%)
19	I feel worn out because of my work as a care coordinator.	6 (15%)	19 (47.5%)	11 (27.5%)	3 (7.5%)	1 (2.5%)
21	I feel overwhelmed because my case load seems endless.	9 (22.5%)	12 (30%)	14 (35%)	2 (5%)	3 (7.5%)
22	I believe I can make a difference through my work.	0 (0%)	0 (0%)	6 (15%)	19 (47.5%)	15 (37.5%)
24	I am proud of what I can do as a care coordinator.	0 (0%)	0 (0%)	3 (7.5%)	14 (35%)	23 (57.5%)
29	I am a very caring person.	0 (0%)	0 (0%)	1 (2.5%)	12 (30%)	27 (67.5%)
30	I am happy that I chose to do this work.	0 (0%)	0 (0%)	3 (7.5%)	10 (25%)	27 (67.5%)

As seen in the distribution of specific ProQOL itemized responses (Table 1), the majority of respondents reported that they like their work as HMG care coordinators (item #12, $n = 21$, 52.5%) and are proud of what they can do as care coordinators (item #24, $n = 23$, 57.5%). Additionally, the majority of respondents noted that they get satisfaction from being able to help families ($n = 34$, 85%) and feel they can make a difference through their work (item #22, $n = 19$, 47.5%). When reviewing ProQOL items that speak to an individual's personal traits, 67.5% ($n = 27$) of respondents self-reported that they are caring people (item #29) and are happy they chose to do this work (item #30). When examining specific items that reflect negative aspects of one's professional quality of life, the majority of responses reported rarely feeling worn out because of their work as HMG care coordinators (item #19, $n = 19$, 47.5%) but sometimes feel overwhelmed by endless caseloads (item #21, $n = 14$, 35%).

Interview Themes. After the participants' interview responses were transcribed and coding was completed, the *in vivo* codes were organized into emergent themes for clearer organization and to analyze the data within the context of this study's research questions. The participant's narratives captured stories, experiences, and complexities associated with their

work as HMG care coordinators. Participants identified a range of professional and personal challenges that affect their professional qualities of life. Seven key themes emerged from the qualitative data including (a) developing relationships and establishing trust with families, (b) love of being a care coordinator, (c) empathy and compassion required, (d) communication skills required, (e) physical and emotional symptoms, (f) struggle to establish boundaries, and (g) self-care and external support as coping strategies.

Developing relationships and establishing trust with families. A theme emerged regarding the care and services that the participants, as care coordinators, provide to the families they serve. All eight of the participants reported the significance of strong relationships/rappports and the establishment of trust between themselves, as care coordinators, and their clients. Emily explained, “So establishing that relationship, that rapport with them is also, I think, another skill. Having that trust so that you can develop that, so that they feel comfortable asking for support.” Jana finds that in her position as a care coordinator,

I feel that every time that I speak with a caregiver, I feel we’ve connected in some way, especially based on the conversations that we have as I’m doing the intake. I very much feel I connect with each client that I serve.

Love of being a care coordinator. All eight participants reported that they love and enjoy their jobs as care coordinators within the HMG system. Participants (Allison, Emily, and Kacey) shared that they find their jobs to be rewarding. Kacey explained, “I feel like it’s making a difference, so I feel good about it. I love it.” Carrie explained the reasoning for her enjoyment of being a care coordinator, specifying that it is the “interaction with the families” that she enjoys the most.

Empathy and compassion required. All eight participants reported that having empathy and compassion is required to be an effective care coordinator. Participants (Carrie, Isabella, Jana, and Kacey) each reported that they consider themselves to be empathic and compassionate individuals, which led them into their positions as care coordinators. Jana explained that empathy is critical in her job as a care coordinator because, “we are the support of Help Me Grow and we support the families in any way possible, sometimes even emotionally.”

Communication skills required. All interview participants agreed that an HMG care coordinator must communicate well to share sensitive information with their clients. Emily and Katie shared that communication is critical in reviewing information with families. Emily and Allison detailed that listening skills are important, as well, including “knowing what to listen for” (Emily), “reading people” (Katie), and “reading between the lines” (Allison).

Physical and emotional symptoms. When asked about symptoms of compassion fatigue that they may experience as a result of the work they do, all eight participants identified either physical and/or emotional symptoms that have impacted them personally. Jana, Isabella, Allison, and Carrie reported that they each experience physical symptoms. Isabella shared that when she feels stressed or overwhelmed, she gets headaches. All eight participants described forms of emotional symptoms that they experience, including frustration, anxiety, lack of ability to be fully present, detachment, and being emotionally tired.

Struggle to establish boundaries. A theme emerged related to difficulty establishing emotional and physical boundaries, as an affect or impact of the work they do. Participants (Kacey, Isabella, Carrie, and Jana) reported that while they try to separate themselves from their work and their clients, it is a struggle. When discussing her role as a care coordinator, Kacey explained that, “It's not a job that necessarily is easily left at the front door, so to speak, because

it does kind of pull on your heartstrings a lot.” Participants (Kacey, Emily, Patricia, Isabella, Allison, and Katie) also shared the struggle to establish boundaries during the COVID-19 pandemic when working from home. Kacey found that it is difficult to establish boundaries because, “it's your work environment and your home environment.”

Self-care and external support as coping strategies. A theme emerged regarding engaging in self-care and seeking external support as coping strategies. Jana, Allison, Emily, Isabella, and Carrie shared self-care strategies including exercise, relaxing at home, watching movies. Jana reminds herself that she needs to help herself first before she can help her clients. Emily practices “a lot of self-reflection” and “breathing techniques”. Isabella, Carrie, and Jana also reported seeking external support from friends, family, and colleagues. Jana shared that talking to her colleagues daily is helpful, while Carrie relies on her friends for fun and to take her mind off of work.

Presentation of Results

Data for this study were collected using a mixed methods approach. Results from this study’s quantitative data were collected from ProQOL questionnaire responses and are presented in the forthcoming section. A presentation of the qualitative data follows, with participant responses and a demonstration of the thematic connection to specific interview questions.

Questionnaire Results

The distribution of the individual ProQOL scale scores including compassion satisfaction, burnout, and secondary traumatic stress were determined (Table 2). On the compassion satisfaction scale, 0% of participant responses were found to have low levels ($n = 0$), 30% had average levels ($n = 12$), and 70% were at high levels ($n = 28$). On the burnout scale, 82.5% of participant responses were found to have low risk ($n = 33$), 17.5% had average risk

($n = 7$), and 0% were at high risk ($n = 0$). On the secondary traumatic stress scale, 80% of participant responses were found to have low risk ($n = 32$), 20% had average risk ($n = 8$), and no participants were found to have reported high risk of secondary traumatic stress.

Table 2

Frequency of Individual ProQOL Scale Scores

	Compassion Satisfaction, n (%)	Burnout, n (%)	Secondary Traumatic Stress, n (%)
Low	0 (0%)	33 (82.5%)	32 (80%)
Average	12 (30%)	7 (17.5%)	8 (20%)
High	28 (70%)	0 (0%)	0 (0%)

Note: N = 40

With a potential of 27 different combinations of compassion satisfaction, burnout, and secondary traumatic stress levels, this study yielded 8 combinations of levels (Table 3). The most common level combination was high in compassion satisfaction, low in burnout, and low in secondary traumatic stress and was found in 50% ($n = 20$) of questionnaire respondents. The next most occurring combination of scale scores was average in compassion satisfaction, and low in both burnout and secondary traumatic stress, experienced by 20% ($n = 8$) of participant responses.

Table 3

Frequency of Combination ProQOL Scale Scores

Compassion Satisfaction	Burnout	Secondary Traumatic Stress	n = x
High	Low	Low	n = 20
Average	Low	Low	n = 8
High	Low	Average	n = 4
High	Average	Average	n = 2
Average	Average	Average	n = 2
Average	Average	Low	n = 2
High	Low	Low	n = 1
High	Average	Low	n = 1

Interview Results

During the interview data collection process, participant's narratives provided in-depth insight into the perceptions of their work as HMG care coordinators. The identified themes of developing relationships and establishing trust with families; love of being a care coordinator; empathy and compassion required; communication skills required; physical and emotional symptoms; struggle to establish boundaries; and self-care and external support as coping strategies are presented below in relation to the study's interview questions.

Developing relationships and establishing trust with families. This theme was connected to interview question #2, "What are your main duties/responsibilities as a care coordinator?" Jana felt as though care coordinators are the support of HMG, while program managers or directors are the face of HMG. Jana further explained that as a care coordinator, she is the connection between the family and HMG. She detailed,

My main responsibilities are making connections with families to make sure, number one, we get connected on a personal level to some degree, make them feel warm and welcome, tell them about Help Me Grow, provide resources, follow up at least three times to make sure, number one, that they were able to use the resources and that they were able to get connected.

Allison said that care coordinators 'must be available' to not only provide direct services to the family, but to 'support' and 'uplift' them. Carrie and Jana acknowledged the way that families feel when they connect with HMG. Carrie explained, "Families just feel more at ease. It's comforting to talk to someone that you know cares. It just alleviates that stress a little bit." Jana explained, "And once they hear from Help Me Grow, I can totally hear anxiety leave their persona."

Emily found that “it’s hard not to get too close or too attached” to the families she works with. She also recognized that forming these personal relationships with families can make it challenging to separate her personal life from the care coordination services she provides. She stated, “So, with building that trust and that relationship, you talk about maybe your own things that you go through as a parent, or having kids, you find those similarities or things that you can relate with.”

Jana and Emily shared that routine follow-ups or check-ins are also important when thinking about relationships and rapport between care coordinators and their clients. When asked if families appreciate the check-ins as a follow-up, Jana responded “Absolutely. Absolutely. Again, I think that solidifies or helps that parent-engagement that is such an integral part of HMG and the care coordinator’s job.” Jana also explained, “a lot of times parents just want that positive reinforcement after they’ve been connected to resources, just maybe a check-in. So I do one or two more check-ins and then I close the case.”

Emily explained that following-up with families is her favorite part about her work as a care coordinator,

So for me, that's the best part, is doing a follow-up with them also to see how are those materials working out for them. And if it's also seeing an improvement in their child's development or the parents are just excited to see that progress with their child development. So for me, it's really rewarding.

Love of being a care coordinator. This theme was connected to interview question #3, “How do you feel about your work as a care coordinator?” Multiple participants used the word ‘rewarding’ to describe how they feel about their work as care coordinators (Emily, Kacey, and Allison). Emily noted that she really enjoys her job and finds it rewarding, continuing to explain

that she receives joy from providing direct services and helping families, and following up with them to ensure that they get the help they need. Kacey shared she feels good about the care coordination services she provides to her children and family clients because “it’s making a difference”. Patricia explained, “It makes me feel good when I know that I’ve helped the family, I’ve truly helped them and get them what they need for their families.” Allison stated, “It’s super rewarding to be able to talk to a family that is having a question or a concern and getting them linked up to that service.”

Isabella shared her love for her job, even with all care coordination services at her HMG affiliate site being provided to families over the phone versus in person. She explained, “I really enjoy it. I think I get pride in knowing that a family is connected, especially those that have been struggling before they called us.”

Emily reported that she enjoys her job, but further explained her favorite part of her job as a care coordinator,

Oh, I enjoy it a lot. I really... For me, that's the best part of it is that direct service that I'm providing, whether it's a phone call or an email and then seeing the little, little kids also, because they enjoy coming to the events as much as the parents.

Empathy and compassion required. This theme was connected to interview question #4, “What do you find to be the most important characteristic or quality of a care coordinator?”

Isabella explained,

Empathy, I would say, is really important, especially in those families that call in or are really frustrated more because they’ve come across a lot of barriers. And at this point, to a lot of families, we’re their last hope of not knowing what else to do, where to go.

Isabella continued to explain that sometimes it can be helpful to utilize empathy by putting herself in her client's shoes to show "understanding" and "compassion",

Sometimes if parents seem frustrated, it's not that they're frustrated towards us, but more towards... all the barriers that they've come, everything going on. So, I think in that sense, you have to be really empathetic and just knowing that a family's not being a certain way towards you. And not that they necessarily are, but you can sense their frustration sometimes.

Participants (Carrie, Isabella, Jana, and Kacey) noted that they consider themselves to be empathic and compassionate people, which is why they got into the human services field and love what they do. Isabella shared, "I think I'm, in general, a very empathetic person." Carrie reported, "I'm such a caring individual, I kind of just naturally take the weight on of other people. I just genuinely care. You have to care, you have to empathize, you have to be understanding." Jana reflected and shared that she believes she has the ability to "put a parent at ease".

Allison shared her thoughts on why individuals may get into the care coordination position,

Because you get into that field to help, right? You have that heart bone that's maybe a little bigger than other people in other fields where you really want to be the change, right? You want to be able to help those families.

Communication skills required. This theme was connected to interview question #4, "What do you find to be the most important characteristic or quality of a care coordinator?" Emily explained that since sensitive information is being shared between the care coordinator

and the family, as a care coordinator she must be mindful of how this information is communicated to them. Emily explained,

I think that information that we're wanting to share with the families need to be in a way that they're going to understand. And so I think reviewing the information with them so that that piece of communication is, how do we communicate this information in a way that they will understand?

Allison, Emily, and Katie identified listening as a skill required by care coordinators.

Allison and Emily noted that while it is important to listen to a family's story to help assess their needs and provide assistance, "some families just like to talk" (Allison); therefore, they must aim to be a "reflective" or "active" listener (Emily). As a reflective listener, Emily asks herself, "What do I need to look out for? What am I listening for?" While strong listening skills was commonly reported to be an important characteristic or quality of a care coordinator, Allison specified that a care coordinator must learn to read between the lines and know what to listen for. Allison further explained,

Well, you have to be a good listener. That to me is super important because all of our work is done virtually over the phone. And so oftentimes, you have to really be paying attention to what somebody is saying on the other line of that phone call, because we're not able to read their body language. We're not able to see those other important pieces of communication, it's all about listening. And so it's super important that you're cued in and that you're asking the right questions to help get to the end of the story of what you're needing to help the family with.

Emily has found that professional development trainings has helped her improve her care coordination services. She shared, "I think it has helped me because maybe I hadn't been very

good listener before, or I hadn't been taking my time to really understand what the family is needing or what they're asking, you know?"

Physical and emotional symptoms. This theme was connected to interview question #12, "What types of symptoms of compassion fatigue do you experience, if any?" Half of the interview participants (Jana, Isabella, Allison, and Carrie) reported experiencing physical symptoms in the form of headaches and achiness. All participants reported feeling tired at the end of the day. When asked if they were referring to physical or emotional tiredness, participants shared that both were experienced, though Emily reiterated the emotional exhaustion she feels, "I would say other than that, just feeling really drained at the end of the day. And just exhausted, tired mentally. Not so much wanting to take a nap, but... I just can't think about anything else."

Seven of eight interview participants (Carrie, Katie, Jana, Kacey, Isabella, Emily, and Allison) identified and described feeling strong emotions as a result of their work with children and families. Emily stated that the reason why she experiences emotional impacts as a result of the care coordination service she provides is "because I think when you're helping them or you're working with them, you give a little bit of yourself." When asked how compassion fatigue affects her ability to do her job, Kacey clarified that although she feels like she can still do her job, she experiences emotional impacts, "It doesn't necessarily cause me to not be able to do my job. I think it causes me to not be fully present or it causes more anxiety." Katie also went into detail about how compassion fatigue affects her ability to do her job, explaining,

I think at some point you either become detached and it's routine and you may not work as hard as you should because you know it's the same thing over and over and over again and you don't feel like you're making a difference. You get kind of detached from it. You

have to step back from it and recognize that you did help that one person, you did help that one person. The next person has the same problem; you can still help that person.

Carrie has worked as an HMG care coordinator in her county at two different organizing entities. She explained that the most challenging parts of her job as a care coordinator is “probably the emotional draining part”. Carrie described her experience working with a family that was seeking assistance for their child’s development and behavior but had not yet been successful in getting professional help. The parent was “upset and emotional”, which “definitely takes a toll on you”.

Isabella and Allison both shared that it can be frustrating when they try to help families to the best of their ability, but for one reason or another, they are not able to do so. Isabella explained, “So, that’s a little frustrating for me. I think it kind of stresses me out or it just makes me a little upset. I won’t show that to the family.” Furthermore, Allison explained, “It’s not just jumping in and hearing these family stories and just feeling that overwhelmed feeling of not being able to help and just wanting to give that 110%.”

Struggle to establish boundaries. This theme was connected to interview question #12, “What types of symptoms of compassion fatigue do you experience, if any?” Participants (Isabella, Carrie, Jana, and Kacey) shared that the nature of their work and the emotional exhaustion that they feel elicits a struggle of establishing and maintaining emotional boundaries between work and home, and the services they provide. Isabella explained,

So as much as you try to separate yourself when you're in this type of position, any type of position like this, like you said, firefighters, anything, it's really hard to separate yourself as much as you like to think that you do.

Carrie reiterated the toll that her work can take on an individual and shared her experience and struggles in separating her work life from her home life,

I think it's draining. It's emotionally draining. You go home and you think about it, and it's one of those things are constantly on your mind. And that's draining in itself. So you now have the thought just recurring and recurring.

Jana detailed a story about an experience in which she stayed at work late one evening because she was on the phone helping a family. When she arrived at home, her husband was upset that she had stayed late. She continued to share, "And don't you know, that evening we got into a huge fight. And it wasn't even him. It was me, it was me, I was fatigued. And it kind of overflowed until the morning." That being said, Jana continued by stating that she tries to maintain a solid work/life balance,

I work very hard, Alexandra, to separate the two. When I'm in the building, that's my job. But those two 15-minute breaks and that 30-minute lunch break, that's Jana, and that's mine. And I try not to mix my job in that hour that I have for myself each day.

Kacey described her difficulty in separating her professional and personal life due to the impact of the COVID-19 global pandemic. Six participants (Kacey, Emily, Patricia, Isabella, Allison, and Katie) reported that they are currently working from home. Kacey has found it difficult to work from home and maintain both physical and emotional boundaries, stating that,

There's less of a boundary of, this is work and this is home. And so it has been harder then, to switch off that, 'I'm not care coordinating right now. I don't have to worry about this. I've done everything that I can do'. Because you're kind of just in your environment already, it's your work environment and your home environment. So I think that that does play, even more now, a part of that.

Emily also shared her experience working from home, acknowledging that working from home during the COVID-19 pandemic impacted her work-life balance,

So, I think that definitely has impacted me just, I know that I know I'm going to work from home, I'm going to be here 24/7. So how do I transition from being a mom, a parent to now working [from home]?

Self-care and external support as coping strategies. This theme was connected to interview question #13, "How do you deal with these symptoms and help manage the impact of compassion fatigue both professional and personally?" Half of the interview participants (Emily, Carrie, Jana, and Allison) reported that they practice self-care as a way to mitigate the impact of compassion fatigue on their professional and personal lives. Emily shared that her coping mechanisms to deal with any stress or challenges is relaxing at home and watching movies that will help her not to think about work or the clients she serves. Allison described her self-care strategy,

So, it's having that, knowing when I just need to go home and disconnect, and just sit on my couch and not do anything versus having that energy to keep doing stuff after work, because you have to know when it's enough and you just need to recharge a little bit.

Two participants shared that they use exercise, either 'walking' (Jana) or 'jogging' (Emily), as a way to relieve stress and practice self-care, while oppositely, Allison shared that she is an emotional eater and finds herself eating food at home or on a fast food run. Three respondents (Isabella, Carrie, and Jana) reported that support from colleagues and loved ones help them cope with the stressors of their daily work lives. Isabella finds that talking to her colleagues every day helps. Jana confides in friends to discuss her work and the work stressors

that she faces. Carried shared that she enjoys unwinding and relaxing with her loved ones and finds herself “lucky to have some awesome people in my life.”

During the interview, Kacey expressed a strong opinion that self-care is not encouraged as much as it should be for people in helping and caring professions,

And I think finding a balance of self-care and helping is not something that is talked about often. I think maybe now more in the world that we live in, but previous I think that maybe we don't utilize self-care as much as we need to because we feel like it's selfish. Just the helping type people want to help. They don't really necessarily always think that helping themselves is the first option. So I would say that that would be my opinion why it happens more.

Of interest was that once Kacey member-checked her interview transcription, she added a comment with additional thoughts to her interview response,

I would also add that when helping or caring is our career, I think we also feel that much more responsibility to it. Caring for someone is not something you can just turn off like a switch. Emotions are real and unless we have learning through therapy or reading how to manage them, they can be overwhelming.

Additional observations. In addition to the seven themes that were discovered as a result of analyzing, interpreting, and *in vivo* coding qualitative data collected from the interviews, two additional observations of significance were made.

Compassion fatigue in former professional position. Allison and Jana shared that they had experienced compassion fatigue or burnout in previous professional positions, which has helped them avoid experiencing it as HMG care coordinators. Jana shared that she was a special education teacher for eighteen years and did not practice self-care in that position. Jana also

shared that she chose to leave that job because she was really struggling. Once she began working at a new organization as an HMG care coordinator, she realized what had happened to her,

I burned out because I didn't practice self-care. In my job now, I recognize the total importance of self-care. So, I don't really struggle with burnout, Alexandra. I make sure that when I work, I do take my breaks. I don't allow fatigue to affect me because previously it did. And I left my most favorite job that I ever had in my life.

When asked to describe her knowledge of or experience with compassion fatigue, Allison explained,

Not in this role. I have come from a more intensive case management programs, working with a tougher demographic, and working with staff that definitely would have more of that, even myself, you find that balance, right?... And so I think because I have that history and understand that balance more, and working with families that that's not necessarily, in this role, something that happens frequently for myself.

Impact of COVID-19. When study participants were asked interview question #8 “In your opinion, how has COVID-19 impacted your day-to-day activities as a care coordinator?” responses were varied. Six participants (Kacey, Emily, Patricia, Isabella, Allison, and Katie) reported that they are currently working from home due to the COVID-19 pandemic, and Kacey iterated that it is hard to establish and maintain boundaries when your home serves as both your home and workplace. Additionally, Kacey and Patricia shared that they are serving families virtually instead of face-to-face. Kacey further explained,

As a person who likes to be in person, it is a little bit frustrating at times to not have eyes on kids or eyes on a family. Or to even just be able to look someone in their eyes and say,

"I know it's difficult, but it's going to be okay" or, "We're going to get your child the help they need." That part of it, I would say is probably, in my opinion, a negative thing.

Jana and Isabella have noticed that families have shifted their priorities and are now more focused on receiving assistance accessing basic needs and human services. Carrie noted that she has seen an increase in interactions. She is "getting a lot more questions, more inquiries."

Isabella explained, "a lot of families have a lot of other stuff going on" and are preoccupied. Jana detailed,

And because of COVID, I think there's all of these external stresses that we're all bringing to the table already. And so, there is that feeling of helplessness for families, because there's not the solutions to help them when they're like, my kids need to be in preschool, they can't go to preschool. They have all of these external things. It's just this, you feel sometimes powerless to help, but working through that.

Despite the challenges that participants presented as a result of the COVID-19 pandemic, Jana acknowledged a positive effect, sharing "So I feel that despite the negative impacts of COVID, I feel a positive thing is that they can reach out to Help Me Grow and we can bring light to an uncomfortable situation."

Summary

Both quantitative and qualitative data that was collected during this research study were presented in this chapter. A sequential mixed methods research design was utilized to gather rich, in-depth data to supplement the quantitative data collected through the ProQOL questionnaires. The quantitative data collected through the ProQOL questionnaire was focused on shedding insight to this study's first research question regarding the prevalence of compassion fatigue in HMG care coordinators. The subsequent qualitative data collected through semi-structured,

open-ended interviews attempted to address this study's second research question regarding the perceptions of the impact that compassion fatigue has on HMG care coordinators. While both data collection methods and processes provided substantial data on the compassion fatigue that study participants may or may not be experiencing, data collected from the ProQOL indicates that most participants are at low risk for compassion fatigue, contradicting the data collected from the interview responses reported by participants. The forthcoming chapter will present an overview of this study's methodology, data analysis, and findings, drawing conclusions from the collected data.

CHAPTER 5: CONCLUSION

To help fill the literature gap of compassion fatigue in care coordinators, a case study was conducted to determine the perceptions of the prevalence and impact of compassion fatigue among care coordinators within the Help Me Grow (HMG) system. While this study did not have a physical site, the population for this study consisted of care coordinators that are affiliated with an HMG system in the United States. HMG is a system model that utilizes existing resources to build comprehensive and effective early childhood systems in local communities (Therriault et al., 2020). Study participants were also required to be affiliated with HMG systems that had scored in the *Installation* or *Implementation* phases for their Centralized Access Point (CAP) component on the 2020 HMG National Fidelity Assessments (FA).

An explanatory sequential mixed methods design was used in this study. Quantitative data were collected through use of the Professional Quality of Life questionnaire (ProQOL), which helped determine the prevalence of compassion fatigue among HMG care coordinators. The ProQOL questionnaire served as a recruitment method and the quantitative data for subsequent qualitative data collection, while semi-structured interviews were conducted with open-ended questions to help explore the impact that compassion fatigue has on the participants, the HMG care coordinators.

A summary of the study's findings and conclusions drawn from the data collection and analysis is presented in this chapter. An interpretation of the study's findings will be reviewed, followed by a discussion of the implications, recommendations for action, and recommendations for further research.

Interpretation of Findings

The purpose of this study was to explore the perceptions of the impact and prevalence of compassion fatigue among HMG care coordinators in the United States. Guided by Figley's (1995) compassion fatigue theory and Stamm's (2010) professional quality of life theory, two research questions served as the basis for exploration:

1. What are HMG care coordinators, located in the United States, perceptions of the prevalence of compassion fatigue within HMG care coordinators?
2. How do HMG care coordinators perceive the effect of compassion fatigue among themselves professionally and personally?

This study's first research question was explored through quantitative data while the second research question was explored through qualitative data. This case study's findings will be presented with interpretation of quantitative findings first, followed by qualitative findings adhering to a sequential mixed methods research design in which quantitative data are collected first, followed by qualitative data as a way to explain the results of the quantitative data (Guetterman & Fetters, 2018).

Quantitative Questionnaire Findings

The distribution of the individual ProQOL scale scores including compassion satisfaction, burnout, and secondary traumatic stress were calculated and assigned either low, average, or high levels of each based on the ProQOL scoring rubric (Stamm, 2010). All participants in this study were found to have either average (30% of participants, $n = 12$) or high (70% of participants, $n = 28$) levels of compassion satisfaction. No participants were found to have low levels of compassion satisfaction. All participants, however, were found to have either low (82.5% of participants, $n = 33$) or average (17.5% of participants, $n = 7$) risk of burnout.

Additionally, all participants were found to have either low (80% of participants) or average (20% of participants) levels of secondary traumatic stress. No participant scored as high risk of burnout or secondary traumatic stress.

The study's first research question, "What are Help Me Grow (HMG) care coordinators, located in the United States, perceptions of the prevalence of compassion fatigue within HMG care coordinators?" was answered through the collection and analysis of quantitative data. The quantitative results indicated that all participants (n = 40) were not experiencing compassion fatigue as a result of the nature of their work at the time this study was conducted. The ProQOL instrument used in this study to address this research question examined the negative effects of indirect trauma exposure, such as compassion fatigue (secondary traumatic stress and burnout), while taking into account the role that compassion satisfaction plays in decreasing these harmful effects (Gonzalez, Burnett, Helm, & Edwards, 2019). Stamm (2010) noted that the combination of an individual's ProQOL scores better reflects what the person is experiencing, since the compassion satisfaction acts as a "moderator/mediator" (Pittman, 2016, p. 19) between the burnout and secondary traumatic stress subscales.

No participants in this study were found to be at high risk for compassion fatigue, which includes burnout and secondary traumatic stress, which means that the participants have not experienced the gradual onset of negative feelings associated with their work. With low risk of burnout, these participants are not feeling hopeless or struggling to do their work or serve families effectively. With low risk of secondary traumatic stress, the participants reportedly are not experiencing what Stamm (2010, p. 17) refers to as "work-related, secondary exposure to extremely or traumatically stressful events."

The lack of compassion fatigue experienced by participants as reported through the ProQOL questionnaires may be partially attributed to the high or average levels of compassion satisfaction that were also reported. Compassion satisfaction is considered a counterbalance to compassion fatigue, including burnout and secondary traumatic stress, and plays a role in decreasing its harmful effects (Stamm, 2002; Stamm, 2010). All of the study's participants were found to experience average or high levels of compassion satisfaction, with the majority (70% of participants, $n = 28$) experiencing high levels. Based on Stamm's (2010) ProQOL questionnaire scale definitions and scores, high levels of compassion satisfaction are a result of professional satisfaction from their positions. This demonstrates that the participants, HMG care coordinators, feel a great satisfaction related to their ability to being effective caregivers.

A detailed analysis of the 10-individual ProQOL statement responses on the compassion satisfaction subscale support the high levels of compassion satisfaction reported by study participants. Responses for the 10 compassion satisfaction ProQOL subscale statements (item numbers 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30) demonstrate an overall satisfaction among the study participants with their positions as HMG care coordinators. According to their ProQOL statement responses, 97.5% ($n = 39$) of participants like their work as HMG care coordinators. Additionally, 97.5% ($n = 39$) of participants find satisfaction from being able to help people or families, and 85% ($n = 34$) find satisfaction specifically from their work. Study participants were found to be proud of what they can do as care coordinators (92.5% of participants, $n = 37$) and are happy that they chose to do this work (92.5% of participants, $n = 37$). These positive perceptions of their work as HMG care coordinators serve as an explanation and justification for the high levels of compassion satisfaction scored through the ProQOL questionnaires.

In addition to the individual ProQOL subscale scores, the combination of ProQOL scores (including scores for compassion satisfaction, burnout, and secondary traumatic stress) for study participants were determined. Stamm (2010) explains that the combination of ProQOL scores better reflects what individuals are experiencing. Findings of the questionnaire yielded eight combinations of scale scores, with 50% of participants ($n = 20$) scoring high in compassion satisfaction, low in burnout, and low in secondary traumatic stress (Table 2). More specifically, 70% of participants ($n = 28$) had high levels of compassion satisfaction, 82.5% of participants ($n = 33$) had low levels of burnout, and 80% of participants ($n = 32$) had low levels of secondary traumatic stress (Figure 3).

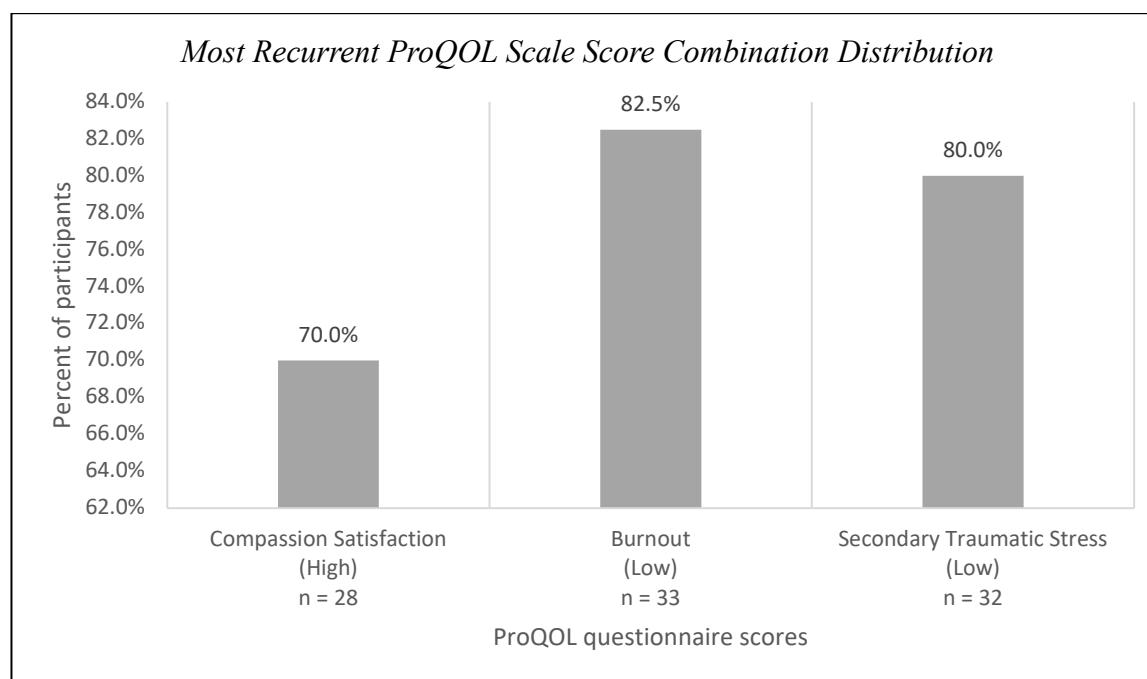


Figure 3. Most Recurrent ProQOL Scale Score Combination Distribution

Stamm (2010) suggests that combinations of high compassion satisfaction and average to low compassion fatigue are “the most positive result” of an individual’s professional quality of life (p. 22). These participants, as HMG care coordinators, do not feel “bogged down” (Stamm, 2010, p. 22) by the HMG system or their employing organization. Stamm (2010) notes that

individuals with high compassion satisfaction and low compassion fatigue, including 50% of this study's participants (n = 20), receive "positive reinforcement from their work" (Stamm, 2010, p. 22). Additionally, Stamm (2010) suggests that individuals who score high in compassion satisfaction and low in compassion fatigue are typically liked by the clients they serve.

Qualitative Interview Findings

This study's second research question, "How do HMG care coordinators perceive the effect of compassion fatigue among themselves professionally and personally?" was addressed qualitatively through participant interview responses. Qualitative interviews were conducted to explore the impact that compassion fatigue has on the participants through thirteen open-ended questions. The qualitative results suggested that study participants experience symptoms of and are affected by compassion fatigue, despite scoring for low levels of compassion fatigue on the ProQOL questionnaire. Seven key themes emerged from participant interview responses to five of the interview questions (question numbers 2, 3, 4, 12, 13). These themes include (a) developing relationships and establishing trust with families, (b) love of being a care coordinator, (c) empathy and compassion required, (d) communication skills required, (e) physical and emotional symptom, (f) struggle to establish boundaries, and (g) self-care and external support as coping strategies.

Developing relationships and establishing trust with families. The theme of developing relationships and trust with families was woven throughout each participant interview. This theme is supported by literature on care coordination that states that relationship-based care is a significant component to effective care coordination (Monterio et al., 2016). All eight study participants shared that one of the main duties or responsibilities of their roles as care coordinators is connecting with the families they serve. When Kacey was asked about how she

feels about her job as a care coordinator, she responded, “I love it. Absolutely love it. It’s a great opportunity to connect with families and build relationships.” Additionally, all participants spoke positively about the emotional connections they share with the families they serve and reported that these connections are developed by providing empathy and compassionate care. Kacey went on to explain,

That's what I think what really is important in terms of supporting a family is to make sure you have the care coordination relationship with the families. So, when they're in between questionnaires or they run into a problem, they know they can call somebody they already know and trust. I think that's great. I just love what I do.

Emily explained that it can be hard not to become too close or emotionally attached to the families they work with, which she thinks contributes to compassion fatigue experienced by helping or caring professionals. She also shared that she finds herself over-identifying with families she works with and has a hard time separating her personal life from her care coordination services. Emily went on to explain that she often shares personal information and experiences about her life as a way to bond and establish trust with the family she is working with. She stated,

So, with building that trust and that relationship, you talk about maybe your own things that you go through as a parent, or having kids, you find those similarities or things that you can relate with, with the parents that you're working with. So, for me, it's like, “oh yeah, I understand that” or, “oh yes, that's happened to me”. So, you try to find something that you can relate to so that they trust the work that you're doing is going to really support them and help them. And so, for me, it's that attachment piece I think I get. I think it's that attachment.

Love of being a care coordinator. Supporting the quantitative data from item #12 of the ProQOL questionnaire, the study's participants' love of being a care coordinator was also reiterated through the qualitative data. All eight interview participants expressed that they "love and enjoy" their jobs as care coordinators within the HMG system. Isabella shared, "It just makes me happy knowing how much we help, even though we're not seeing them in person. I think that would be the hard part. But I do enjoy my job as a care coordinator." Specifically, participants (Emily, Kacey, and Allison) found their work to be rewarding. Allison went into more detail, sharing that "just talking about the concerns is oftentimes helpful, but when you find out that families are able to get successfully connected and those needs met, it's, of course, very rewarding."

Empathy and compassion required. Four study participants (Carrie, Isabella, Jana, and Kacey) self-reported that they find themselves to be compassionate and empathetic people. Allison expressed the idea that individuals in helping or caring professions, including herself, have a "heart bone" larger than others that allows them to empathize and want to help families they work with. Isabella explained that care coordinators must be empathetic towards the families they work with to help make them comfortable and foster a trusting relationship, more notably in families that feel helpless or frustrated.

Individuals who are strongly empathetic and provide compassion to clients regularly may be most at risk for compassion fatigue (Showalter, 2010; Craig & Sprang, 2010). Jana shared that she considered herself to be an empathetic person, and explained,

So, to me, compassion fatigue happens very, I want to say slowly and without knowledge, because someone who has the ability to be compassionate, doesn't recognize the amount of energy it takes to provide compassion to many people.

Existing literature supports the impact of compassion fatigue that HMG care coordinators reported in their participant interviews. Their reported impact of compassion fatigue does not align with the responses in the ProQOL questionnaire results that reflected low levels of risk of burnout and secondary traumatic stress.

Communication skills required. All participants agreed that communications skills are required in their positions as HMG care coordinators. Because sensitive information is shared between parties, Emily and Allison expressed that both verbal and listening skills are important in reviewing information with clients to make them feel comfortable. Kalek (2008) notes that many parents react to news that they perceive to be negative about their child's development with shock and denial. Emily explained that communication skills specific to their roles as care coordinators is important and shared an anecdote,

I always worry that when I'm talking to a mom about their kids' development, I'm going to say something wrong or something that'll offend them. I try to be careful with my words and try not to make it seem like their kid has a problem.

Supporting Emily's anecdote, Katie shared, "Sometimes we talk about some hard topics, ya know? And it's important to know how to address them in a way that won't like, scare or worry them."

Physical and emotional symptoms. Descriptive findings from participant interviews provide evidence to suggest that HMG care coordinators are experiencing the impact of compassion fatigue, including physical and emotional symptoms. Physical symptoms that Isabella and Jana reported include headaches, achiness, and physical exhaustion. Participants also discussed the heavy emotional drain of working with children and families who are seeking HMG services. The narratives shared by study participants revealed the emotional stress or

fatigue of helping children and families who are experiencing stress or trauma, aligning with Figley's (1995) definition of compassion fatigue. Participants reported emotional symptoms such as anxiety (Kacey), the lack of ability to remain present (Katie and Allison), emotional exhaustion (Carrie, Jana, and Emily), and detachment (Katie). Katie explained that compassion fatigue has affected her ability to do her job working as an HMG care coordinator. She has found herself sometimes becoming detached from the family or situation and having to take a "step back from it and recognize that you did help that one person".

Struggle to establish boundaries. Participants (Jana, Kacey, Carrie, Isabella) reported struggling to set professional and personal boundaries and to maintain a strong work/life balance. Emotional stress experienced by individuals in the workplace is often brought home, causing a negative influence on personal relationships and "chaos in professional and personal lives" (Otte, 2018; Wentzel, 2019, para. 3). Jana explained that while she tries to maintain a solid work/life balance, she often ends up bringing the emotional strain from her work into the home. She continued by providing an anecdote about a day when she was emotionally drained from work and as a result, got into an argument with her partner. She recognized that she was fatigued and that her fatigue had "overflowed until the morning" leading to the argument.

Participants (Kacey, Emily, Patricia, Isabella, Allison, and Katie) shared that the current COVID-19 pandemic has intensified the struggle to establish physical boundaries. The COVID-19 pandemic has rapidly caused drastic changes in workplace conditions, and can potentially cause tension "between the professional, familial, and social dimensions of our lives" (Couch, O'Sullivan, & Malatzky, 2020, p. 273). With some of the participants (Kacey, Emily, Patricia, Isabella, Allison, and Katie) working from home, they have found it hard to establish physical boundaries between their work and home lives. Kacey explained that the challenge she faces

working from home is that “there's less of a boundary of, this is work and this is home”. She went on to explain that it is challenging working in the same space that she lives.

Self-care and external support as coping strategies. The participants’ responses in the interviews also provided insight into how HMG care coordinators cope with the negative impacts of their work. The use of self-care and external support was found to be a common theme that was reported during the participants’ interviews. Showalter (2010) reported that despite the exhaustion that helping or caring professionals may feel, they typically continue giving and showing compassion to their clients and neglect self-care. However, in this study, the majority of participants (Emily, Carrie, Jana, Allison, Isabella, and Kacey) shared how they cope with the stress and exhaustion of their work through the use of self-care and support from loved ones.

The importance of self-care has been repeated throughout the literature review and further reinforced in the qualitative data from this study. Participants reported treating or coping with their compassion fatigue by using self-care strategies. Emily found that practicing self-care has helped cope with work stress, including “a lot of self-reflection” and “breathing techniques”. A self-care activity that was reported by both Jana and Emily during interviews was exercise, which has been found to improve one’s mood (Xie et al., 2020). Existing research supports the idea that practicing self-care can enhance one’s compassion satisfaction and decrease burnout and compassion fatigue (Alkema, Linton, and Davies, 2008). This sequential mixed methods study’s findings are further evidence of this idea. Study participants reported low levels of compassion fatigue and high levels of compassion satisfaction on their ProQOL questionnaire responses. The use of self-care reported by interview participants as a strategy to help cope with exhaustion from work partially explains the lack of compassion fatigue reported in the quantitative ProQOL questionnaire findings.

Showalter (2010) reported that despite the exhaustion that helping or caring professionals may feel, they typically continue giving and showing compassion to their clients and neglect self-care. However, in this study, half of the interview participants (n = 4) shared how they cope with the stress and exhaustion of their work using self-care and support from loved ones. Jana explained the importance of self-care,

But again, if you are not taking care of your emotional needs, you are going to burn out very quickly, because emotionality, there's not an unlimited amount. There's a limited amount of emotionality. And sometimes it's not always plentiful. So, it's important that you refill your cup daily.

External social support. Another coping mechanism reported by study participants was external social support, which is critical in combatting compassion fatigue (Killian, 2008). Participants (Isabella, Carrie, and Jana) reported finding solace in support from their loved ones, including family, friends, and colleagues. While Isabella stated, “I talk to my colleagues every day. I think that’s what helps”, Carrie and Jana cope with support from their friends. The participants’ active engagement in receiving social and external support as a way to cope with work stressors helps explain the low levels of compassion fatigue reported from the ProQOL surveys. Carrie reported that she gets together with the “awesome people” in her life to “unwind”, and she further explained this as, “We have food, we have games, we laugh and it just takes away from the week that we just had at work”.

Unexpected Findings

All study participants (n = 40) reported low levels or risk of burnout and secondary traumatic stress according to the ProQOL questionnaire results, which therefore prepared the researcher for interviews with the expectation that participants would not report experiencing any

negative effects from compassion fatigue. However contrary to the researcher's expectations based on the quantitative questionnaire results, the interviewees told a different story. The overall findings for this study provide evidence that although the ProQOL questionnaire results showed that the participants, all HMG care coordinators, do not have high levels or risk of compassion fatigue, they seem to be experiencing the impacts of compassion fatigue as defined in the existing literature.

Researchers have found that compassion satisfaction, along with coping strategies such as self-care, support, etc., counterbalances the risk of compassion fatigue (Cetrano et al., 2017). Therefore, despite clear evidence of felt symptoms of compassion fatigue among HMG care coordinator participants, the high levels of compassion satisfaction experienced may have served as a buffer to protect the care coordinators from extreme expressions of compassion fatigue. With 70% (n = 28) of this study's participants experiencing high levels of compassion satisfaction and no levels or risk of burnout or secondary traumatic stress, the negative correlation between compassion fatigue and compassion satisfaction (Cetrano et al., 2017) is consistent with this study's results.

Another potential explanation of the differences in this study's quantitative and qualitative data is the ProQOL questionnaire itself, including the questionnaire's 30 statements and its validity. Each study participant may have interpreted the ProQOL statements differently or may not have had a full understanding of what it was asking. The ProQOL manual does not include explanations of questionnaire items or definitions to words used in the ProQOL language, such as "trauma" (Stamm, 2010). This may have caused participants to respond in a way that may not accurately reflect their experience in relation to the question.

Implications

Findings from this study have practical implications for a variety of stakeholders, including the HMG National Center and organizations that administer the HMG program. The HMG National Center provides technical assistance and professional development opportunities to local HMG systems in the United States regularly, but these opportunities are typically related to the direct work (duties/responsibilities) that HMG staff do (R. Gabriel, personal communication, November 16, 2020). The HMG National Center could potentially utilize this study's findings to have knowledge about the effects of compassion fatigue and how it affects program care coordinators as a way to support local HMG systems.

A second implication of this study is similar to the first in that this study's results can help business, agency, or organizational leaders better understand what their staff are experiencing. In addition to the HMG National Center providing well-being support to system staff, the agency or organizations where the HMG care coordinators are employed may be interested to learn more about their employees' professional qualities of life. Although people have the personal responsibility to take care of their individual needs, organizations have an ethical responsibility to support their staff and create healthy work environments and conditions for their staff (Madden et al., 2012).

A third implication of this study stems from the lack of current research or literature on compassion fatigue among care coordinators. While this case study explored compassion fatigue among care coordinators with the HMG system, the findings may be applicable to other care coordination positions, programs, or agencies. Case managers and social workers have similar general job duties as care coordinators (AAP, 2014), so the findings of this study may be helpful for researchers focusing on professionals in those fields. With such little existing research on

compassion fatigue among care coordinators, the findings may bring awareness to the lived experiences of care coordinators and how the negative and positive aspects of their work affect them.

Recommendations for Action

The results, findings, and implications from this study prompted a significant recommendation for action. It is recommended that organizations associated with HMG in the United States, including organizations/agencies that administer local HMG systems and the HMG National Center, utilize this study's findings to acknowledge and address the effects of compassion fatigue and how it affects program HMG care coordinators. Jana, a study participant, explained that her agency coordinates mandatory professional development trainings to maintain staff certifications, but they also provide quarterly self-care in-service trainings, which she finds to be helpful.

They bring in a community agency. One time we had an agency come in and train us about just taking that 15-minute break that we have and doing stretching or listening to calming music. We also are required to do self-care daily. It's an integral part of staying fresh and staying mentally aware of fatigue, I suppose.

Two participants (Carrie and Isabella) shared that their agencies provide training opportunities, but nothing related to compassion fatigue, self-care, or their well-being. Isabella expressed the importance of trainings to help maintain staff well-being, sharing,

But I do think that, even above professionally, as someone who is directly connected to families is that the self-care, the outside, that personal time into the development, because it will pile on top of you quickly.

With the COVID-19 pandemic placing increasing demands, stress, and anxiety on people (Stark et al., 2020), it is recommended that organizations provide additional well-being support for staff to help cope with its effects. Workers are experiencing increasing caseloads, staff shortages and changes in needed services, in addition to the COVID-19 stressors they are experiencing at home that they bring into the workplace.

The importance of organizational support of staff well-being is reiterated through existing research finding that compassion fatigue protective factors employed in the workplace, including training, education, and supervision on trauma victimization, can help lead to compassion satisfaction (de Figueiredo et al., 2014; Condrey, 2015). Organizations should support their staff's well-being because it demonstrates that the organizations have formally addressed the potential negative consequences their workers may experience from compassion fatigue (Stamm, 2010). As a way to support local HMG systems in the United States, local organizations and the HMG National Center can provide opportunities and/or implement policies to protect their employees against compassion fatigue.

Recommendations for Further Research

Due to the difference in this study's quantitative and qualitative results, it is recommended that further research be conducted on the same population to gain a more accurate understanding of the impact that compassion fatigue has on their professional and personal well-being. Said recommendations include a longitudinal case study, an exploration of the impact of an HMG system's centralized access point (CAP) on their HMG care coordinators, and measuring client satisfaction as a way to determine the impact compassion fatigue has on the quality of care provided.

A second recommendation is that a similar study on compassion fatigue among HMG care coordinators be conducted with more than one data collection period. This study was conducted at a single point in time, but a longitudinal case study, in which data is collected more than one time (Koro-Ljungberg & Bussing, 2013), could be helpful in obtaining a more accurate reflection of the prevalence and impact of compassion fatigue among HMG care coordinators. The researcher of this case study conducted data collection at one point of time, and therefore did not explore the changes HMG care coordinators' experience over time, nor give a better idea of the prevalence of compassion on a regular basis without the data from an additional collection.

Additionally, further research could be conducted on the impact of an HMG system's CAP on their HMG care coordinators. HMG care coordinators throughout the United States work within a variety of different organizations and utilize different CAPs as a portal of entry for families to connect with HMG. Study participants reported a variety of reasons as to why families contact or are connected to HMG ranging from concerns about their child's development, to access to basic needs or human services. HMG CAPs may include, but are not limited to, 2-1-1 helplines and specialized early childhood helplines (Therriault et al., 2020). Due to the diverse populations that these CAPs serve, of interest would be a study exploring the impact of an HMG care coordinator's CAP on their levels or risk of compassion fatigue. Findings from this study could add to the existing literature on trauma and contribute to the little existing research on trauma or compassion fatigue in care coordinators.

A final recommendation for further research includes measuring client satisfaction or successful connections to services to explore the impact that compassion fatigue has on the quality of care that families are provided by HMG care coordinators. Findings from this study's participants' interviews presented evidence that HMG care coordinators are experiencing

emotional symptoms of compassion fatigue, including feeling drained, frustrated, overwhelmed, and/or detached. Experiencing these symptoms could potentially decrease the compassionate care and empathy that HMG care coordinators may be able to provide to their clients (Bush, 2009). Therefore, it is recommended that further research should be conducted using data collection methods that would help assess a client's customer satisfaction, in addition to compassion fatigue measures, such as the ProQOL.

Conclusions

In an effort to explore the perceptions of the prevalence and impact of compassion fatigue among HMG care coordinators, a sequential explanatory mixed methods research design was used to collect data. Figley's (1995) compassion fatigue theory and Stamm's (2010) professional quality of life theory served as the guiding framework of this study, with the knowledge that compassion fatigue can have negative consequences for a worker's professional quality of life. Compassion fatigue is the result of helping or caring professionals exerting high energy and compassion over a prolonged period of time to individuals who are suffering or may have experienced trauma (McHolm, 2006). While differences between the quantitative and qualitative data were found, this study provided evidence that compassion fatigue symptoms are being experienced by HMG care coordinators. The literature on symptoms of compassion fatigue directly aligns with the symptoms experienced by HMG care coordinators as an impact of compassion fatigue on their professional and personal lives.

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Appendix A

Professional Quality of Life (ProQOL) Questionnaire: Version 5

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.					
_____ 2.					
_____ 3.					
_____ 4.					
_____ 5.					
_____ 6.					
_____ 7.					
_____ 8.					
_____ 9.					
_____ 10.					
_____ 11.					
_____ 12.					
_____ 13.					
_____ 14.					
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_____ 20.					
_____ 21.					
_____ 22.					
_____ 23.					
_____ 24.					
_____ 25.					
_____ 26.					
_____ 27.					
_____ 28.					
_____ 29.					
_____ 30.					

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

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 them 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	And my Compassion Satisfaction level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

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

You Wrote	Change to	the effects of helping when you are not happy so you reverse the score
	5	
2	4	
3	3	
4	2	
5	1	

- *1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	And my Burnout level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

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. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	And my Secondary Traumatic Stress level is
22 or less	Low
Between 23 and 41	Moderate
42 or more	High

Appendix B

Interview Protocol: Semi-Structured Interview Questions

Opening statement:

Thank you so much for agreeing to participate in this interview. know that you're very busy so I appreciate you taking the time to meet with me and have this conversation. This interview is being recorded. If I have your permission to record, please verbally state "yes".

As I have mentioned, I hope to better understand the perceptions of the prevalence and impact of compassion fatigue among HMG care coordinators. Compassion fatigue is the term used to describe exhaustion from helping or working with people who have experienced trauma or extremely stressful events in their lives.

Your participation in this interview is voluntary and you are free to withdraw from this research study at any time, for any reason. This interview is confidential, and all recordings and transcriptions will be safely secured in a password-protected Google Drive. A pseudonym will be assigned to replace all references to you and your HMG affiliate site or backbone agency to protect your identity. None of the responses will be connected to identifying information. If I have your continued consent, please verbally state "yes".

And last but not least... Upon completion of this interview, you will receive a \$25 Amazon gift card via email for your participation in this study. Do you have any questions?

Research Question: How do HMG care coordinators perceive the effect of compassion fatigue both professionally and personally?

Background:

1. In your own words, please explain what Help Me Grow is?
2. What are your main duties/responsibilities as a care coordinator?
3. How do you feel about your work as a care coordinator?
4. What do you find to be the most important characteristic or quality of a care coordinator?
5. What training/professional development do you or your team participate in to better support families?
6. In your opinion, what would you say are the most common reasons that families/caregivers contact HMG?

7. How many times do you typically follow-up with a family after initial contact and referrals have been made?
8. In your opinion, how has COVID-19 impacted your day-to-day activities as a care coordinator?

Compassion Fatigue:

9. Please describe your knowledge of /experience with compassion fatigue.
10. Why do you think people in the 'helping' or 'caring' professions experience compassion fatigue or burnout?
11. How does compassion fatigue affect your ability to do your job?
12. What types of symptoms of compassion fatigue do you experience, if any?
13. How do you deal with these symptoms and help manage the impact of compassion fatigue both professionally and personally?

Appendix C

Permission Request for Participant Contact Information

Alexandra Goldberg

From: Alexandra Goldberg <agoldberg@thechildrensforum.com>
Sent: Wednesday, October 28, 2020 3:11:14 PM
To: Therriault, Cassandra
Cc: Martini-Carvell, Kimberly; agoldberg3@une.edu
Subject: Research study permission request

STOP! Use caution when opening EXTERNAL emails from known or trusted senders. Do not open attachments or click on links from unsolicited messages.

Good afternoon Kimberly and Cassandra,

Thank you for your support as I begin my dissertation journey. I am writing to request permission to obtain data from Help Me Grow National to support my proposed research study [upon approval from the University of New England (UNE) Institutional Review Board (IRB)]. Specifically, I am requesting a list of program sites and contact information of HMG systems that scored in the Installation and Implementation levels of HMG affiliation according to the 2020 Fidelity Assessment results.

I am conducting a research study designed to explore compassion fatigue within Help Me Grow care coordinators throughout the United States. Please see the information below.

Project Title: Compassion Fatigue in Help Me Grow Care Coordinators: A Case Study

Principal Investigator(s): Alexandra Goldberg, Doctor of Education in Educational Leadership Student, University of New England

Problem: The problem being considered in this study is the potential impact that compassion fatigue has on care coordinators that link or facilitate appropriate services and resources for children and their families in a coordinated effort to maximize the potential of the children. Any compassion fatigue experienced may pose a risk to the quality and efficiency of care that is provided to clients.

Purpose: The purpose of this qualitative exploratory case study is to understand the perceptions of the prevalence and impact of compassion fatigue among Help Me Grow care coordinators throughout the United States.

Method of Study: Quantitative data for this study will be collected through a questionnaire to explore the prevalence of compassion fatigue and to provide the sampling frame for subsequent participant interviews aimed at describing the impact that compassion fatigue has on the participants.

Benefits to HMG Care Coordinators: Participating in this study will allow Help Me Grow care coordinators an opportunity to explore and give detailed consideration to their current work situation, both positive and negative. The questionnaire and/or interview will allow participants to determine if the compassion provided to those they serve has an impact on their professional and/or personal lives.

Proposed Project Period: The research proposed research period is from January 4, 2021 to March 15, 2021.

Participation: All participants will be required to provide consent to participate. All participants will be informed of the purpose of the research and I will be responsible to obtain consent from each participant. Participants will be informed that their participation is completely voluntary and may discontinue participation at any time.

All questionnaires will be anonymous. If participants agree to volunteer for a follow-up interview, they will no longer be anonymous and will be asked for their name and contact information. A pseudonym will then be assigned to protect their identity.

Participant Eligibility:

- Participants must work as a Help Me Grow care coordinator (*or perform similar duties such as offering developmental screenings, providing information and referrals, or providing care coordination or case management services*)
- Participants must be associated with a Help Me Grow affiliate state or system that scored at a "Installation" or "Implementation" level of Help Me Grow Centralized Access Point implementation based on the 2019 (or 2020) Fidelity Assessments.

How will participant privacy be protected?

- Each participant will be assigned a pseudonym to protect their anonymity and remove any individual identifiers from the research and its findings.
- All data will be kept safely-secured in a password-protected Google Drive and will be deleted upon the researchers successful dissertation defense.
- All data will be kept confidential and only available to those involved in the research study [the researcher, the researcher's dissertation committee, and UNE's IRB.

Once approval from UNE's IRB has been received, I will notify you so we can move forward. Please let me know if you have any questions.

Thank you again!

Sincerely,

Alexandra Goldberg, M.Ed.

Statewide Director, Help Me Grow Florida

CDC's "Learn the Signs. Act Early." Ambassador to Florida



1211 Governors Square Blvd., Suite 200

Tallahassee, FL 32301

T: (850) 487-6307 | F: (850) 201-6960



Connecticut Children's Confidentiality Notice

Appendix D

Permission for Participant Contact Information



November 3, 2020

Kimberly Martini-Carvell, MA

*Executive Director
Help Me Grow National Center
Connecticut Children's Medical
Center*



*An Equal Opportunity
Employer*

282 Washington Street
Hartford, Connecticut 06106

Telephone:
(860) 837-6217
E-mail:
KMartini@connecticutchildrens.org

www.HelpMeGrowNational.org

To Whom It May Concern,

Please accept this letter as a formal letter of support from the Help Me Grow (HMG) National Center to Principal Investigator, Alexandra Goldberg, for the study, *Compassion Fatigue in Help Me Grow Care Coordinators: A Case Study*. The HMG National Center will grant this study access to a list of affiliates within the National Network that are in Installation or Full Implementation of the HMG Core Component: Centralized Access Point, identified by the 2020 Help Me Grow Fidelity Assessment. The National Center will provide a two-week opt out period to affiliates who qualify for this study based on the requirements in the study proposal. During this time, if an affiliate would prefer not to participate in this study, they will not be included moving forward. The name of each system and their contact information will be provided to the Principal Investigator following the opt out period. In addition, the Principal Investigator has permission to use the Help Me Grow name and past Building Impact Annual Reports to further support this study.

Help Me Grow is a system model that utilizes and builds on existing resources in order to develop and enhance a comprehensive approach to early childhood system-building in any given community so that all young children can thrive. Successful implementation of the Help Me Grow model requires communities to identify existing resources, think creatively about how to make the most of existing opportunities, and build a coalition to work collaboratively toward a shared agenda. The Help Me Grow National Network is comprised on over 100 early childhood comprehensive systems in 31 states.

Please do not hesitate to reach out if you need further information.

Sincerely,

Kimberly Martini-Carvell

Appendix E

HMG National data

Alexandra Goldberg

From: Therriault, Cassandra <CTherriault@connecticutchildrens.org>
Sent: Thursday, January 14, 2021 9:11 AM
To: Alexandra Goldberg
Cc: Cornell, Erin
Subject: Eligible HMG Systems
Attachments: Eligible HMG Systems_Care Coordination Sudy_AGoldberg_14 Jan 21.xlsx

Hi Alexandra,

I hope you are well! I have pulled together the materials you need for your study! An overview is below:

- 100 HMG systems took Fidelity in 2020
- 98 HMG systems were eligible base on your criteria of (CAP in installation or Full Implementation)
- 9 HMG systems opted out of the study at this time
- 1 HMG system is still pending approval from their backbone organization (this statewide system reflects 21 HMGs each with their own CAP)

Remaining eligible = 68 HMG systems

You will notice on the first tab of the excel sheet I have highlighted 13 HMG systems in red. These systems are currently in installation of the HMG CAP but as a reminder to be in installation you only need to have 1 of the 4 key activities accomplished. None of the 13 have a CAP at this time or have recently established their CAP but do not currently have care coordinators to take calls. I am not sure if it would be a good use of your time to outreach to them if they don't have the staff currently to participate in your survey. Just wanted to put this on your radar!

Lastly, as you know the current full implementation affiliates take a substantially shorter assessment each year that serves as an update on their system rather than a full model overview. You will notice that very few of the CAP questions in the FA are in the SA. This means that I don't have the most up to date data on number of CCs or where the CAP is located, etc for theses affiliates so you may consider asking in your interviews if you need that data for the analysis.

Please let me know if you need anything else! We are looking forward to connecting on your major findings and would love to stay in the loop with how the process is going.

Best,
Cassie

****Connecticut Children's Confidentiality Notice****

This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the intended recipient, or an employee or agent responsible for delivering the message to the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message, including any attachments.

Appendix F

Invitation to Participate/Recruitment Email

Alexandra Goldberg

From: Alexandra Goldberg
Sent: Thursday, January 14, 2021 9:33 AM
Cc: agoldberg3@une.edu
Subject: HMG Care Coordinator survey
Attachments: A. Goldberg Resume.pdf; UNE Participant Consent-survey.pdf; UNE Participant Consent-interview.pdf

Importance: High

Good morning,

Thank you for allowing the HMG National Center to share your 2020 Fidelity Assessment results and contact information with me. Your HMG affiliate site was found to be eligible for participation in my research study due to scoring at an "Installation" or "Implementation" level of your Centralized Access Point implementation.

In addition to my role as the Statewide Director of Help Me Grow Florida, I am also a Doctor of Education student at the University of New England. My dissertation topic is "*Compassion Fatigue in Help Me Grow Care Coordinators: A Case Study*". My interest in this topic is a result of my three years working in the Help Me Grow Florida system and my personal observations of the impact that working with children and families in this capacity may have on staff.

I am looking for Help Me Grow care coordinators (or those that fill a similar role) to participate in my dissertation research. **Participants must work as a Help Me Grow care coordinator (or perform similar duties such as offering developmental screenings, providing information and referrals, or providing care coordination or case management services).** Further explanation of my study and participant rights can be found on the consent forms attached.

Participants will be asked to:

- **Complete a short questionnaire** about their experience as a HMG care coordinator
 - Will take no longer than 5 minutes to complete
- **If interested, participate in a follow-up interview**
 - Interviews should take 15-30 minutes via Zoom (audio or video)
 - The first 8 questionnaire respondents that agree to participate in a follow-up interview will receive a \$25 Amazon gift card upon completion of the interview.

Please share this email with your care coordinators, or those that fill a similar role.

The questionnaire will be available through **Friday, January 22** through this link: <https://redcap.une.edu/redcap/surveys/?s=D99YTAHHT3>

Thank you in advance for your participation in my research study.

Sincerely,

Alexandra Goldberg, M.Ed.

Statewide Director, Help Me Grow Florida
 CDC's "Learn the Signs. Act Early." Ambassador to Florida



1211 Governors Square Blvd., Suite 200
 Tallahassee, FL 32301
 T: (850) 487-6307 | F: (850) 201-6960



Appendix G

Survey with Informed Consent

**UNIVERSITY OF NEW ENGLAND
CONSENT FOR PARTICIPATION
IN ANONYMOUS SURVEY RESEARCH**

Project Title: Compassion Fatigue in Help Me Grow Care Coordinators: A Case Study

Principal Investigator(s): Alexandra Goldberg, Doctor of Education in Educational Leadership Student, University of New England

Introduction:

- Please read this form. The purpose of this form is to give you information about this research study.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete.

Why is this research study being done?

The purpose of this study is to understand the perceptions of the prevalence and impact of compassion fatigue among Help Me Grow care coordinators throughout the United States.

Who will be in this study?

- Participants must work as a Help Me Grow care coordinator (*or perform similar duties such as offering developmental screenings, providing information and referrals, or providing care coordination or case management services*)
- Participants must be associated with a Help Me Grow affiliate state or system that scored at an “Installation” or “Implementation” level of Help Me Grow Centralized Access Point implementation based on the 2020 Fidelity Assessments.

What will I be asked to do?

- Participants will be asked to complete a questionnaire that will explore their current work situations, both positive and negative.
 - The questionnaire contains 30 statements and uses a 1-5 Likert scale
 - The questionnaire will take no longer than 10 minutes to complete
- Participant will be invited to participate in a 15-30-minute interview.

What are the possible risks of taking part in this study?

Participating in this study will allow Help Me Grow care coordinators an opportunity to explore, give detailed consideration to, and bring awareness to their current work situation, both positive and negative, that may not be otherwise considered.

What are the possible benefits of taking part in this study?

Participating in this study will allow Help Me Grow care coordinators an opportunity to explore and give detailed consideration to their current work situation, both positive and negative. The questionnaire will allow you to determine if the compassion you provide for those that you serve has an impact on you.

What will it cost me?

There are no costs associated with the participation in this study.

How will my privacy be protected?

- The questionnaire is anonymous, unless the participant wishes to volunteer for a follow-up interview. At this time, the participant will no longer be anonymous, but a pseudonym will be assigned to each participant to protect the participant's identity.
- Questionnaire responses will be kept confidential and stored securely in an electronic format with password protection, and only available to those involved in the research study (the researcher, the researcher's dissertation committee, and the University of New England's Institutional Review Board)

How will my questionnaire data be kept confidential?

- The questionnaire is anonymous, unless the participant wishes to volunteer for a follow-up interview. At this time, the participant will no longer be anonymous, but a pseudonym will be assigned to each participant to protect the participant's identity.
- Questionnaire responses will be kept confidential and stored securely in an electronic format with password protection, and only available to those involved in the research study (the researcher, the researcher's dissertation committee, and the University of New England's Institutional Review Board)

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University of New England.
- If you choose not to participate, there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.

What other options do I have?

- You may choose not to participate.

Whom may I contact with questions?

- The researcher conducting this study is Alexandra Goldberg. For more questions or information concerning this study, you may contact her at (305) 613-4200 or agoldberg3@une.edu.

- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Jacqueline Lookabaugh, Ed.D. at jlookabaugh@une.edu.
- If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

Will I receive a copy of this consent form?

You may print and keep a copy of this consent form.

Appendix H

Interview with Informed Consent

UNIVERSITY OF NEW ENGLAND

CONSENT FOR PARTICIPATION

IN INTERVIEW RESEARCH

Project Title: Compassion Fatigue in Help Me Grow Care Coordinators: A Case Study

Principal Investigator(s): Alexandra Goldberg, Doctor of Education in Educational Leadership Student, University of New England

Introduction:

- Please read this form. The purpose of this form is to give you information about this research study.
- You are encouraged to ask any questions that you may have about this study, now, during or after the project is complete.
- Your participation is voluntary.

Why is this research study being done?

The purpose of this study is to understand the perceptions of the prevalence and impact of compassion fatigue among Help Me Grow care coordinators throughout the United States.

Who will be in this study?

- Participants must work as a Help Me Grow care coordinator (*or perform similar duties such as offering developmental screenings, providing information and referrals, or providing care coordination or case management services*)
- Participants must be associated with a Help Me Grow affiliate state or system that scored at an "Installation" or "Implementation" level of Help Me Grow Centralized Access Point implementation based on the 2019 Fidelity Assessments.

What will I be asked to do?

- If a questionnaire respondent reports that they are interested in participating in a follow-up interview, the researcher will contact the volunteer to schedule an interview.
- Interviews will be between 15-30 minutes.
- Interviews will be recorded using a teleconference software, such as Zoom.

What are the possible risks of taking part in this study?

Participating in this study will allow Help Me Grow care coordinators an opportunity to explore, give detailed consideration to, and bring awareness to their current work situation, both positive and negative, that may not be otherwise considered.

What are the possible benefits of taking part in this study?

Participating in this study will allow Help Me Grow care coordinators an opportunity to explore and give detailed consideration to their current work situation, both positive and negative. The questionnaire will allow you to determine if the compassion you provide for those that you serve has an impact on you.

What will it cost me?

There are no costs associated with the participation in this study.

How will my privacy be protected?

- Interview recordings and transcriptions will be kept confidential and stored securely in a stored in an electronic format with password protection, and only available to those involved in the research study (the researcher, the researcher's dissertation committee, and the University of New England's Institutional Review Board)
- Each participant will be assigned a pseudonym to further remove any individual identifiers from the research and its findings

How will my interview data be kept confidential?

- Interview recordings and transcriptions will be kept confidential and stored securely in a stored in an electronic format with password protection, and only available to those involved in the research study (the researcher, the researcher's dissertation committee, and the University of New England's Institutional Review Board)
- Each participant will be assigned a pseudonym to further remove any individual identifiers from the research and its findings

What are my rights as a research participant?

- Your participation is voluntary. Your decision to participate will have no impact on your current or future relations with the University of New England.
- If you choose not to participate there is no penalty to you and you will not lose any benefits that you are otherwise entitled to receive.
- You are free to withdraw from this research study at any time, for any reason.

What other options do I have?

- You may choose not to participate.

Whom may I contact with questions?

- The researcher conducting this study is Alexandra Goldberg. For more questions or more information concerning this study, you may contact her at (305) 613-4200 or agoldberg3@une.edu.
- If you choose to participate in this research study and believe you may have suffered a research related injury, please contact Jacqueline Lookabaugh, Ed.D. at jlookabaugh@une.edu.

- If you have any questions or concerns about your rights as a research subject, you may call Mary Bachman DeSilva, Sc.D., Chair of the UNE Institutional Review Board at (207) 221-4567 or irb@une.edu.

Will I receive a copy of this consent form?

- You may print and keep a copy of this consent form.

Appendix I

Professional Quality of Life (ProQOL) Scale in REDCAP

Confidential

Page 1

Professional Quality of Life Scale (ProQOL)

As a Help Me Grow care coordinator, you are directly involved in your client's 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 someone who helps families and children in your community. 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.

CONSENT: Please provide your consent to participate in this study before completing this survey. Yes No

"I understand the description of this research and the risks and benefits associated with my participation as a research subject, as explained in the initial email. I agree to take part in the research and do so voluntarily."

Your participation is voluntary. You are free to withdraw from this research study at any time, for any reason. All questionnaire responses are anonymous, will be kept confidential, and will be securely stored in a password-protected Google Drive.

At the end of the survey, you will be presented with an option to participate in a 15-20 min. follow-up interview about your experience as a HMG care coordinator. At that point, you will no longer be anonymous, but your identity will be kept strictly confidential and only available to those involved in the research study (the researcher, the researcher's dissertation committee, and the University of New England's Institutional Review Board).

	(1) Never	(2) Rarely	(3) Sometimes	(4) Often	(5) Very Often
1 I am happy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 I am preoccupied with more than one person (or family) I help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 I get satisfaction from being able to help people (or families).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 I feel connected to others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 I jump or am startled by unexpected sounds.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 I feel invigorated after working with those I help.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 I find it difficult to separate my personal life from my life as a care coordinator.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 I am not as productive at work because I am losing sleep over traumatic experiences of a person (or family) I help,	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9					

Confidential

Page 2

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|----|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | I think that I might have been affected by the traumatic stress of those I help. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10 | I feel trapped by my job as a care coordinator. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11 | Because of my helping, I have felt "on edge" about various things. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12 | I like my work as a care coordinator. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13 | I feel depressed because of the traumatic experiences of the people (or families) I help. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14 | I feel as though I am experiencing the trauma of someone (or families) I have helped. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15 | I have beliefs that sustain me. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 16 | I am pleased with how I am able to keep up with care coordination techniques and protocols. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17 | I am the person I always wanted to be. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18 | My work makes me feel satisfied. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 19 | I feel worn out because of my work as a care coordinator. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 20 | I have happy thoughts and feelings about those I help and how I could help them. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 21 | I feel overwhelmed because my case load seems endless. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 22 | I believe I can make a difference through my work. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 23 | I avoid certain activities or situations because they remind me of frightening experiences of the people (or families) I help. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 24 | I am proud of what I can do as a care coordinator. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 25 | As a result of my care coordination services, I have intrusive, frightening thoughts. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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Confidential

Page 3

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|----|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | I feel "bogged down" by the system. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 27 | I have thoughts that I am a "success" as a care coordinator. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 28 | I can't recall important parts of my work with trauma victims. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 29 | I am a very caring person. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 30 | I am happy that I chose to do this work. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Are you interested in participating in a 15-30 minute individual interview to discuss your role as a HMG care coordinator? Select "yes" to enter your contact information.

- Yes
 No

The first 8 questionnaire respondents agree to participate in a follow-up interview will receive a \$25 Amazon gift card upon completion of the interview.

The interview will be recorded via Zoom (audio or video). Your participation in this interview is entirely voluntary. By entering your contact information, please understand that your answers are no longer anonymous at this point, but will be kept confidential. A pseudonym will be used to protect your identity and none of the responses will be connected to identifying information.

Participant name:

Participant phone number:

Participant email address:


What is your preferred method of communication to schedule an interview?


- Text
 Phone call
 E-mail

Appendix J

Permission to use Professional Quality of Life (ProQOL) questionnaire

Permission to Use ProQOL 📎 1 ▾

 ProQOL Office <noreply@surveygizmo.com>
Sun 11/8/2020 2:07 PM
To: Alexandra Goldberg

 PermissionToUseProQOL.pdf
19 KB

Thank you for your interest in the ProQOL.

The ProQOL measure may be freely copied and used, without individualized permission from the ProQOL office, as long as:

- (a) You credit The Center for Victims of Torture and provide a link to www.ProQOL.org;
- (b) It is not sold; and
- (c) No changes are made, other than creating or using a translation, and/or replacing "[helper]" with a more specific term such as "nurse."

Because you have agreed that your use of the ProQOL follows the above criteria, the ProQOL Office at the Center for Victims of Torture grants you permission to use the ProQOL. Your recorded request is attached here as a PDF.

If you have any questions or comments, you can contact us at proqol@cvt.org. Note that unfortunately our capacity is quite limited, as this is a volunteer-run effort, but we will do what we can to respond within a couple of weeks.



Thank you!

The ProQOL Office
at The Center for Victims of Torture
proqol@cvt.org

Reply | Forward

Appendix K

CITI Certifications

		Completion Date	01-Aug-2020
		Expiration Date	31-Jul-2024
		Record ID	37606240

This is to certify that:

Alexandra Goldberg


Has completed the following CITI Program course:

Human Research	(Curriculum Group)
Social & Behavioral Research Investigators	(Course Learner Group)
1 - Basic Course	(Stage)


Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

University of New England


 Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w699b3fcd-093d-4ed6-908a-9d9a84e7e01a-37606240

		Completion Date	03-Aug-2020
		Expiration Date	02-Aug-2024
		Record ID	37606242

This is to certify that:

Alexandra Goldberg


Has completed the following CITI Program course:

Conflict of Interest mini-course	(Curriculum Group)
Conflict of Interest	(Course Learner Group)
1 - Stage 1	(Stage)

Not valid for renewal of certification through CME. Do not use for TransCelerate mutual recognition (see Completion Report).

Under requirements set by:

University of New England


 Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?wf205e74b-6db1-4049-af76-d7e74ab0a49d-37606242

Appendix M

Frequency Distribution of Itemized ProQOL Questionnaire Responses

ProQOL Item #	ProQOL Statement	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
1	I am happy.	0 (0%)	0 (0%)	6 (15%)	22 (55%)	12 (30%)
2	I am preoccupied with more than one person (or family) I help.	2 (5%)	8 (20%)	10 (25%)	12 (30%)	8 (20%)
3	I get satisfaction from being able to help people or families.	0 (0%)	0 (0%)	1 (2.5%)	5 (12.5%)	34 (85%)
4	I feel connected to others.	0 (0%)	0 (0%)	8 (20%)	22 (55%)	10 (25%)
5	I jump or am startled by unexpected sounds.	2 (5%)	15 (37.5%)	13 (32.5%)	8 (20%)	2 (5%)
6	I feel invigorated after working with those I [help].	0 (0%)	0 (0%)	6 (15%)	19 (47.5%)	15 (37.5%)
7	I find it difficult to separate my personal life from my life as a care coordinator.	7 (17.5%)	24 (60%)	5 (12.5%)	3 (7.5%)	1 (2.5%)
8	I am not as productive at work because I am losing sleep over traumatic experiences of a person (or family) I help.	25 (62.5%)	10 (25%)	5 (12.5%)	0 (0%)	0 (0%)
9	I think that I might have been affected by the traumatic stress of those I help.	20 (50%)	14 (35%)	6 (15%)	0 (0%)	0 (0%)
10	I feel trapped by my job as a care coordinator.	25 (62.5%)	10 (25%)	2 (5%)	3 (7.5%)	0 (0%)
11	Because of my helping, I have felt "on edge" about various things.	19 (47.5%)	17 (42.5%)	3 (7.5%)	0 (0%)	1 (2.5%)
12	I like my work as a care coordinator.	0 (0%)	0 (0%)	1 (2.5%)	18 (45%)	21 (52.5%)
13	I feel depressed because of the traumatic experiences of the people (or families) I help.	24 (60%)	10 (25%)	6 (15%)	0 (0%)	0 (0%)
14	I feel as though I am experiencing the trauma of someone (or families) I have helped.	25 (62.5%)	12 (30%)	3 (7.5%)	0 (0%)	0 (0%)
15	I have beliefs that sustain me.	0 (0%)	2 (5%)	5 (12.5%)	17 (42.5%)	16 (40%)
16	I am pleased with how I am able to keep up with care coordination techniques and protocols.	0 (0%)	1 (2.5%)	7 (17.5%)	18 (45%)	14 (35%)
17	I am the person I always wanted to be.	1 (2.5%)	2 (5%)	11 (27.5%)	20 (50%)	6 (15%)
18	My work makes me feel satisfied.	0 (0%)	0 (0%)	6 (15%)	27 (67.5%)	7 (17.5%)
19	I feel worn out because of my work as a care coordinator.	6 (15%)	19 (47.5%)	11 (27.5%)	3 (7.5%)	1 (2.5%)
20	I have happy thoughts and feelings about those I help and how I could help them.	1 (2.5%)	0 (0%)	5 (12.5%)	22 (55%)	12 (30%)
21	I feel overwhelmed because my case load seems endless.	9 (22.5%)	12 (30%)	14 (35%)	2 (5%)	3 (7.5%)
22	I believe I can make a difference through my work.	0 (0%)	0 (0%)	6 (15%)	19 (47.5%)	15 (37.5%)
23	I avoid certain activities or situations because they remind me of frightening experiences of the people (or families) I help.	31 (77.5%)	7 (17.5%)	2 (5%)	0 (0%)	0 (0%)
24	I am proud of what I can do as a care coordinator.	0 (0%)	0 (0%)	3 (7.5%)	14 (35%)	23 (57.5%)
25	As a result of my care coordination services, I have intrusive, frightening thoughts.	32 (80%)	8 (20%)	0 (0%)	0 (0%)	0 (0%)
26	I feel "bogged down" by the system.	6 (15%)	18 (45%)	11 (27.5%)	4 (10%)	1 (2.5%)
27	I have thoughts that I am a "success" as a care coordinator.	1 (2.5%)	2 (5%)	15 (37.5%)	17 (42.5%)	5 (12.5%)
28	I can't recall important parts of my work with trauma victims.	19 (47.5%)	16 (40%)	5 (12.5%)	0 (0%)	0 (0%)
29	I am a very caring person.	0 (0%)	0 (0%)	1 (2.5%)	12 (30%)	27 (67.5%)
30	I am happy that I chose to do this work.	0 (0%)	0 (0%)	3 (7.5%)	10 (25%)	27 (67.5%)