

EXPLORING COMPASSION FATIGUE AMONG MENTAL HEALTH PROVIDERS
IN COMMUNITY-BASED OUTPATIENT ORGANIZATIONS

by

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As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Misty A. McGillem entitled “Exploring Compassion Fatigue Among Mental Health Providers in Community-Based Outpatient Organizations” and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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SIGNED: Misty A. McGillem

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ABSTRACT

Background: Providing care to individuals with multifaceted mental health needs can be very demanding and in turn leave mental health professionals at an increased risk for compassion fatigue (CF). Comprised of Burnout (BO), Secondary Traumatic Stress (STS), and a lack of Compassion Satisfaction (CS), CF is the state of exhaustion and dysfunction, emotionally, biologically, and physiologically, due to prolonged exposure to compassion stress. CF can leave healthcare providers at an increased risk for experiencing their own health issues, contributing to tardiness and absenteeism, as well as increasing the risks for such adverse effects as clinical and medication errors, poor treatment planning, and decreased patient satisfaction.

Purpose: The purpose of this paper is to identify the risk factors for CF and describe the perceptions of CF among outpatient mental health providers employed in urban community-based mental health outpatient organization.

Method and Sampling: A qualitative descriptive study design utilizing two focus groups, each having four participants was conducted to assess outpatient mental health providers' perceptions of CF. Purposeful sampling of current providers in two community-based mental health outpatient organizations was performed to protect the privacy and enhance the comfort of each participant as they discussed elements of CF

Findings: Five themes were identified from the focus group analysis: the participant's perceived definition of CF, participant perceptions of prevalence of CF in the mental health setting, participant perceptions regarding the triggers, perceived participant causes of CF, and self-care practices. These results reflect data collected in a mental health setting however, the findings are consistent with current research contributed from other specialties.

Conclusion: Personal descriptions of the experiences and insights of these providers expand the current CF literature and will contribute to the development of quality improvement projects committed to reducing compassion fatigue among outpatient mental health providers.

Keywords: compassion fatigue, burnout, secondary traumatic stress, compassion satisfaction, mental health providers

INTRODUCTION

The attribute of *caring* is at the core of any quality health care system and is a critical component of the inter-personal relationship between patient and health care provider. This very important attribute can sometimes come with an unfortunate cost – compassion fatigue. Compassion is our innate ability to not only see but feel the pain and suffering of others. Caring requires resilience as the accumulation of compassion stress over time can lead to harmful physical and emotional results, for the health care staff and the patient. Unresolved compassion stress puts health care staff at risk for developing *compassion fatigue*. Compassion fatigue, or CF, is described as the state at which providing care brings more distress than satisfaction and can affect the quality of care provided to the patient (Sheppard, 2014). Next some background information on CF will be offered followed by a description of the local problem. The purpose of this project, methods used to conduct this project, project limitations and final conclusions and implications for future research will be presented.

Background Knowledge

Compassion fatigue was a term first coined to describe burnout experienced by healthcare professionals (Ray, Wong, White, & Heaslip, 2013). In 1992, Carla Joinson noticed that nursing professionals increasingly had “lost their ability to nurture” and called this compassion fatigue (p. 116). With the development of the Compassion Fatigue Model by Figley (2001) and various attempts at a more comprehensive definition over the years, this simple term continues to expand. For the purpose of this paper, the definition of CF that will be used is that it is the “loss of satisfaction that comes from doing one’s job well, or job-related distress that outweighs job satisfaction” (Sheppard, 2016, para 2). This definition is conceptualized through the Professional Quality of Life (ProQOL) model as a loss of compassion satisfaction (CS), or the positive

attributes of the job, contrasted by increased burnout (BO) and secondary traumatic stress (STS), or the negative aspects of the job (Stamm, 2010; Ray, Wong, White, & Heaslip, 2013; Sheppard, 2014).

Figley (2001) recognized that some healthcare providers could experience significant suffering by their patients yet maintain their compassionate natures without getting emotionally overwhelmed. This is because these individuals continued to experience a sense of satisfaction and achievement which in turn “balanced out” the negative aspects of caring for those suffering (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). CS is basically defined as the positive emotion associated with caring and the “ability to receive gratification from caregiving” (Simon, Pryce, Roff, & Klemmack, 2006, p. 6; Smart et al., 2014). Therefore, in comparison to CF, CS is a healthier more pleasant state and may decrease the risk for CF (Sheppard, 2014).

Per Leiter and Maslach (2004) Burnout (BO) is a “psychological syndrome that involves a prolonged response to chronic interpersonal stressors on the job” and does not directly correlate to traumatic incident exposure (p. 93). Burnout is cumulative, gradually developing over time and progressively getting worse as an individual remains involved in emotionally demanding situations in their work environment over long periods of time (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Sheppard, 2014). Stressors that contribute to CF can include non-supportive work settings, higher caseloads, and too few resources (Ray, Wong, White, & Heaslip, 2013). Constant illnesses, absenteeism, fatigue, cynicism, disillusionment, anger, and difficulties sleeping are just a few of the symptoms of BO (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010). Burnout can also leave the healthcare provider feeling helpless and hopeless, thereby reducing their sense of accomplishment (Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010).

Unlike BO, STS is event-related and the exposure to traumatic events can cause sleep disturbances, disturbing images, and avoidance (Stamm, 2012). Healthcare providers, especially those that specialize in the treatment of trauma must find ways to cope with another individual's stories of suffering while remaining aware of their own emotions of fear, horror, and powerlessness (Stamm, 2012). Working with others' trauma increases the risk of experiencing a change in one's own psychological functioning (Simpson & Starkey, 2006). Additional responses healthcare providers may have to STS may include feelings of guilt, grief, detachment, and rage (Simpson & Starkey, 2006).

Local Problem

Problems such as clinical and medication errors, poor treatment planning, and poor judgment may contribute to CF (Rossi et al., 2012). Ineffective patient care (a result of CF) results in poor patient outcomes and strategies to effectively address CF have yet to be developed (Hooper et al., 2010). Informal discussions with a variety of mental health providers in the Tucson inspired me to explore and validate both the risks and experience of CF among local mental health providers. Common themes in these discussions with MH providers were; mental exhaustion, lack of purpose and joy, and frustration with healthcare facility systems (unrealistic organizational and patient expectations) (McGillem, 2015). The concerns expressed by the MH providers are all terms relevant to CF, specifically BO. There are no current processes in place within the local outpatient organization to address the experience of CF or the risk factors associated with CF (McGillem, 2015).

Outpatient mental health care is provided by a variety of disciplines such as case management, social work, nursing, psychology, and psychiatry (Ray, Wong, White, & Heaslip, 2013). Providing care to individuals with multifaceted mental health needs can be very

demanding and in turn leave mental health professionals, to include psychiatric mental health nurse practitioners, at an increased risk for CF (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012). The adverse psychological impacts CF has on health care providers increases the potential for negative interpersonal interactions, not only between staff, but also between patients and their families (Flarity, Gentry, & Mesnikoff, 2013).

Intended Improvement

The purpose of this study is to describe mental health provider's experiences with CF. Describing their experiences will help improve identification of the specific psychological and physical impacts of CF among these mental health providers, as well as outcomes of unresolved CF. This project aims to provide insight on the provider perceptions of CF; the triggers and events that contribute to CF, the prevalence of CF as perceived by the providers, and provider coping strategies. The findings from this project will offer a foundation for quality improvement in the outpatient mental health setting and improve CS for present and future advance practice nurses within the mental health field.

Study Question

What are the experiences and risk factors of compassion fatigue (CF) among mental health providers employed in an urban community-based mental health outpatient organization?

METHODS

Design

A qualitative descriptive study design utilizing two focus groups was conducted to describe CF among outpatient mental health providers. Over the last two decades, focus groups have been utilized more frequently within health care research (Rabiee, 2004). This type of qualitative data collection is appropriate for identifying the attitudes, feelings and beliefs of

interview participants (Sandelowski 2010). I observed the attitudes surrounding the experience of CF as expressed by the mental health providers, therefore, there were no variables to manipulate (Sandelowski, 2010). The findings from this qualitative descriptive project will help stimulate ideas that can be used to reduce CF and enhance CS within mental health outpatient clinic provider (Polit & Beck, 2012).

Plan-Do-Study-Act (PDSA) Cycle

The framework that guided this study was the Plan-Do-Study-Act, or PDSA, method (Figure 1) (Deming Institute, 2016). This simple cycle consists of four stages and is a practical, supportive tool for gaining valuable knowledge and testing quality improvement projects on a small-scale (Taylor et al., 2013).



FIGURE 1. PDSA (Plan-Do-Study-Act) Cycle (Deming Institute, 2016)

The “Plan” step begins the cycle by identifying the purpose of the study and defining how the study will be put into action (Deming Institute, 2016). The purpose of this project was to assess provider’s perceptions of CF. The study was put into action by the planning of the focus group interviews which included selecting outpatient MH clinical sites, days, and times, as the plan for recruitment of participants. This was followed by the “Do” step in which the

components of the “plan” are implemented (Deming Institute, 2016). In this stage, the participants were recruited, the focus groups were conducted, and data analysis began. The “Study” step is the third piece of the cycle and allows the researcher to monitor the outcomes for trends (Deming Institute, 2016). This phase involved data analysis and the compilation of project results. Finally, the “Act” step ends the cycle and requires integration of learned insights alongside the development of practice recommendations that are based on project findings.

Ethical Considerations

To ensure appropriate steps were taken to protect and safeguard the privacy of the participants, approval from the University of Arizona College of Nursing Institutional Review Board (IRB) “Determination of Human Subjects Form” was obtained prior to conducting this study. The three components that were addressed included *respect for persons*, *beneficence*, and *justice* (U.S. Department of Health and Human Services [USDHHS], 1979).

Respect for Persons

Respect for persons is the notion that individuals should be treated autonomously, and that they are entitled to protection if they have diminished autonomy, such as in the case of children or prisoners (USDHHS, 1979). Respect for persons requires that participants in human subject research enter the research voluntarily and that they be made aware that they can withdraw from the study at any time (USDHHS, 1979; Polit & Beck, 2012). The participants in this study were made aware of their right to participate voluntarily and withdraw at any time by way of the IRB Disclaimer Statement found in Appendix A. The use of this disclaimer statement ensured they did not feel forced or coerced into participating.

Beneficence

The second ethical principle, beneficence, requires researchers to protect individuals from harm by maximizing the anticipated benefits and minimizing the risk of harm (USDHHS, 1979). One risk that I foresaw was that the participants of my project, the outpatient mental health providers, might be concerned about their privacy and how the information they provided during the focus interview groups would be used. I practiced beneficence by explaining how I would protect their identity and store the information collected during my research project. I also explained that the data collected will be used for future research projects that may help identify possible interventions that prevent compassion fatigue in the outpatient setting.

Justice

In the last basic ethical principle of justice, the benefits and burdens of research must be distributed fairly (USDHHS, 1979). This essentially means that the participants who undertake the burden of research must be equally likely to benefit from the research. My project identified factors that increase the incidence and risks for compassion fatigue in the outpatient mental health setting, as told by the providers. My goal is to inform future research and suggest interventions that may be used to prevent compassion fatigue, thus benefitting current and future outpatient mental health providers.

Setting

The setting for this project was two local urban non-profit mental health organizations in Tucson, AZ both consisting of several different outpatient clinics. Each focus group was held at noon during a routinely scheduled providers' meeting located in the conference rooms at two of the clinics, one from each organization. Use of the conference room and holding the focus

groups during their providers' meeting allowed for greater convenience for the providers and increased participation. Both focus groups were comprised of 4 participants each.

Participants

The primary purpose of a focus group is to understand and explain the beliefs that influence the overall attitude of a group of individuals (Rabiee, 2004). Per Rabiee (2004), this technique selects these individuals because they are a purposeful sampling of a specific population. Since one of the unique aspects of a focus group is the ability to generate data based on the collaboration of the group's interactions, careful selection of participants was accomplished to ensure the members felt comfortable with engaging in discussion with one another (Rabiee, 2004). Recruitment occurred through in-person announcements in which I met with the medical directors at each of the two local Tucson community-based mental health outpatient organizations. The participants for each focus group were enlisted from a pre-existing group of mental health providers within each of these organizations. This allowed for the participants to already be acquainted and provided the trust necessary to build upon each other's comments regarding the possibly sensitive and personal issue of CF (Kitzinger, 1994).

Data Collection

The main source of data in this study was retrieved via two focus groups, each consisting of four participants (n=8). A demographic survey was completed by each participant at the beginning of the group (Appendix B). Each focus group was guided by asking the providers open-ended questions regarding their feelings about CF. The three-item questionnaire used to conduct the focus groups is included in Appendix C. The groups were audio-recorded and I kept a reflective journal to recall non-verbal communication conveyed by the participants. The observational notes, which consisted of things such as the participant's interactions and body

language portrayed contributed valuable elements that enriched the data analysis process. The digitally recorded audio was destroyed immediately upon being transcribed into word format and all collected data will be kept for six years in a password protected computer at my residence to maintain confidentiality.

Data Analysis

Throughout each phase of a qualitative study, researchers must overcome the daunting duties of how to collect, store, organize, retrieve, analyze, and give meaning to the material obtained during their research (Johnson, Dunlap, & Benoit, 2010). The first task was to compile and review demographic data recorded on the participant's surveys. The audio recordings were transcribed into an electronic Word document, each line numbered for ease of analysis of explicitly reoccurring elements (DeSantis & Ugarriza, 2000). These reoccurring elements were then clustered into groups based on their similarity to extract the emerging themes that best explain the CF experiences of the providers (DeSantis & Ugarriza, 2000). These themes were confirmed by the observational notes, as the observational notes were consistent with the themes expressed by participants.

Credibility, or the believability of the study, was accomplished by way of a process called member checking (Polit & Beck, 2012). At the end of each focus group discussion, notes were reviewed and discussed with the participants, allowing them the opportunity to clarify and/or confirm the information. The interpretation of the data was shared with the providers to ensure the themes that emerged properly represent their beliefs regarding CF in the mental health outpatient setting.

This project used a data-driven approach in which the transcribed data was read and reread, noting keywords, trends, and themes *prior* to any analysis taking place (Namey, Guest,

Thairu, & Johnson, 2007). This approach is considered to have greater validity as it is more flexible and open to theme discovery not previously considered (Namey, Guest, Thairu, & Johnson, 2007). Five themes resulted: the participant's perceived definition of CF, what they believe the prevalence is in the mental health setting, their attitudes regarding the triggers, what they feel the symptoms and effects of CF are, and what their self-practices are, if they exist.

FINDINGS

Demographics

A total of four providers participated at each of the two focus groups, one focus group was offered at each outpatient MH organization. Table 1 lists the descriptive statistics. A clear majority of the community-based outpatient mental health providers that participated in the focus groups were male (62.5%). Approximately 50% of the sample are between the ages of 56 to 65, and have 15 or more years' experience within the mental health field.

TABLE 1. *Demographics*

Characteristic	Range	n	%
Gender	Male	5	62.5
	Female	3	37.5
Age range	25-35	3	37.5
	36-45	0	-
	46-55	2	12.5
	56-65	3	50
Title	MD	4	50
	NP	3	37.5
	PA	1	12.5
Length of employment in mental health field (Yrs. in MH)	< 6 yrs.	2	25
	6-10 yrs.	4	12.5
	11-15 yrs.	1	12.5
	> 15 yrs.	3	50
Length of employment at current organization	< 6 yrs.	4	50
	6-10 yrs.	0	-
	11-15 yrs.	1	12.5
	> 15 yrs.	3	37.5

TABLE 1 - *Continued*

Characteristic	Range	<i>n</i>	%
Days worked per week	1-3	0	-
	4	6	87.5
	5	2	12.5
Hours worked per week	< 30 hrs.	1	12.5
	30-40 hrs.	5	75
	> 40 hrs.	2	12.5
Total patient caseload (Pt Caseload)	< 200 pts.	0	-
	200-500 pts.	4	50
	> 500 pts.	4	50

Perceptions

Definitions

The participants' perceptions of CF are displayed in Table 2. All the participants had a basic knowledge of CF. However, nearly all the participants did not know that CF was comprised of BO, STS, and a lack of CS. Most the participants defined CF as BO. Some of the definitions per the participants included: "I thought it was accumulated work stress," "It's when work is emotionally draining," "When I start to empathize less," "Isn't it another way of saying I 'checked out'?"

TABLE 2. *Participants' Definitions*

Perceived Definitions of CF	Response	<i>n</i>	%
Basic knowledge of CF	Yes	8	100
	No	0	-
Comprised of all three: BO, STS, and lack of CS	Yes	1	12.5
	No	7	87.5
Thought CF was BO specifically	Yes	5	62.5
	No	3	37.5

Prevalence

The four participants with the smallest patient caseloads ranging between 200-500 all work at the same organization which allots 30 minutes for patient follow-up appointments. For this

study, this organization will from here on out be referred to as Organization A. The second organization, Organization B, however, has higher patient caseloads and only allows for 20-minute patient follow-up appointments, requiring more patients to be seen in a day. All the providers at Organization A only work four days per week, whereas two of the four at Organization B work five days per week while the other two only work four. Overall, the participants employed at Organization A reported lower levels of CF. This finding might suggest that clinical settings that have smaller patient caseloads for each provider and allow for longer patient visit times may decrease CF among their outpatient MH providers.

Triggers

Triggers of CF may be things that increase stress levels for providers in their work settings. The main trigger for all participants was “unrealistic expectations.” from organizational leadership or other staff members. Other common CF triggers included “difficult patients,” “logistical and technical difficulties,” and “work place environment.”

“Yesterday I was double-booked for three different appointments and out of the six patients, I had never seen four of them!”

“Everyone saying “I need this....and more, and more, and more.”

“Clients have an unending list of needs and they’re expecting us to fix everything wrong with them, their health, and their lives.”

The key triggers of CF were directly related to inconsistencies in organizational structure, unrealistic clinical expectations of MH providers by organizational leadership and overwhelming and unrealistic patient expectations. These findings indicate the importance of fair and reasonable work environments that support safe and realistic clinical practice structures in the outpatient MH setting. These findings also indicate the need to develop or introduce coping

strategies or interpersonal approaches (motivational interviewing and limit setting strategies) for MH providers to learn how to cope with the overwhelming demands of patient expectations.

Symptoms and Effects of Compassion Fatigue

All participants agreed that the “emotional exhaustion” of CF can lead to negative physical and psychological effects for the MH provider as well as negative patient outcomes. A common finding was that patient care is “always good” but that the care can and does tend to decline as this “exhaustion” increases. The most common physical and psychological symptoms that were derived from the focus groups include: sleep deprivation, nightmares, increased sickness, headaches, crying, and fatigue (Table 3). One participant said when they’re feeling tired or frustrated, they tend to slam their fists onto their desk and curse. The most common effects of these physical and psychological symptoms were “calling out sick” and “becoming more disconnected with the patients.” A few participants could share situations in which their patients mentioned the “disconnection” to them during their appointments. Other providers stated that the patient’s perceptions of such disconnected interactions are made indirectly conveyed when the patient’s request to “switch providers.”

TABLE 3. *Reported Compassion Fatigue (CF) Symptoms*

Compassion Fatigue Symptoms	Response	<i>n</i>	%
Sleep deprivation		4	50
Nightmares		2	25
Increased sickness		3	37.5
Headaches		7	87.5
Crying		4	50
Fatigue		6	75

Practices of Self-Care

All participants agreed that to stay balanced, they must be more mindful and recognize that they can’t take care of anyone else until they take care of themselves first. All but one

participant believed they practiced frequent self-care. The one participant that was unable to give examples of self-care reports moderate to high levels of CF.

“I don’t have energy to do anything once I get home...I’m tired all the time.”

The most common example of self-care practiced was “exercise” of various types. The second most common self-care practice was “spending time with friends/family,” followed by “eating well” and “traveling.” Other practices mentioned were “getting massages,” “getting manicures and/or pedicures,” and “shopping.”

The subject of traveling brought up lengthy communication at Organization B as to whether the organizations allow the participants to take vacation, and how hard it is to get it approved.

“I think that’s a huge thing...your employer, any employer, really doesn’t want you to take a vacation, and that’s a problem.”

“When I’m taking a couple of days off at the end of the month, I have to be on-call...that’s not ‘time off’.”

DISCUSSION

The findings of this study describe mental health provider’s experiences with CF and are consistent with literature that identify the triggers of CF, the physical and emotional symptoms associated with CF, and that self-care practices increase CS. Per Morse and colleagues (2012), mental health professionals are at an increased risk for CF due to the care they provide to individuals with multifaceted mental health needs. The aim of this project was to explore the experience of outpatient community-based mental health provider’s perceptions of CF. The qualitative descriptive design of this study accomplished this goal and has provided clear data on the provider’s perceptions of CF. The participants in this study (n=8) are at an increased risk for

CF and openly discussed their thoughts on CF during the focus group discussion. All participants demonstrated expressiveness and full engagement in the focus groups. An objective observation of the behaviors of participants during and after the focus groups demonstrated that the focus groups were also therapeutic and beneficial as evidenced by the expressiveness and appreciation participants offered after each focus group session. The data obtained offers solid implications for the development of future quality improvement strategies and research. Future projects will target the identification of CF, the reduction of CF and the design of healthier outpatient mental health settings that will ensure greater support and a more realistic work environment thereby promoting greater CS among outpatient MH providers in outpatient MH settings.

Definition

Coetzee and Klopper (2010) defined *compassion fatigue* (CF) as “the end result of a progressive and cumulative process that is caused by prolonged and intense contact with patients, the use of self, and exposure to stress” (p. 237). CF is therefore considered to be that limit where an individual can no longer provide effective compassionate and empathetic care due to over-disbursement of personal compassionate energy. All eight participants could express what CF means to them utilizing similar concepts to the above definition and many often used the term “emotional exhaustion.” The most notable concern demonstrated in a review of current literature was the differentiation in what the term CF truly entails. This study confirmed the misperception of the concept of CF among the project participants. Only one of the eight participants were aware that CF is comprised of BO, STS, and a lack of CS.

Prevalence

Per Green, Albanese, Shapiro, and Aarons (2014), role overload has been found to be most associated with increased emotional exhaustion and BO. This was seen in this study as

Organization A (with the smaller caseloads, longer patient appointment times, and no more than a four-day work week). These participants expressed they comprised all the elements of CF and participants in organization A demonstrated greatest consistency in the belief that they had symptoms of CF. A clear majority of participants in both organizations agree that 20 minute appointments are too brief and diminish the quality of patient care.

Triggers

The participants in this study believe unrealistic expectations from the healthcare administrators, working with a difficult population (patients with complex mental health needs), and unrealistic or demanding work place environments were the main triggers of CF within the outpatient mental health setting. This supports the findings by Flarity, Gentry, and Mesnikoff (2013), which indicate factors such as high patient acuity, unrealistic expectations from administration and patients, and low workplace morale were the greatest contributors to CF in emergency department nurses. Also, per Morse et al. (2012), the challenge of providing care to individuals with complex mental health needs can place mental health professionals at an increased risk for CF.

Symptoms and Effects of Compassion Fatigue

Healthcare providers who experience CF are at an increased risk for experiencing negative health outcomes, poor job performance, increased mistakes and medication errors, and are more likely to leave their profession (Hooper et al., 2010). All participants agreed that CF can negatively affect quality patient care, albeit minimally. Participants admit that healthcare providers tend to give less time and maybe don't listen as well as they could when they are more "emotionally exhausted."

The findings in this study also substantiated research indicating CF promotes the development of psychological and emotional symptoms in emergency room nurses (Flarity, Gentry, & Mesnikoff, 2013; Wentzel & Brysiewicz, 2014). A few of the psychological and emotional symptoms reported include increased sickness, insomnia, and crying. These findings are also in line with the study conducted by Wentzel and Brysiewicz (2014) indicating that individuals experiencing CF may display symptoms of disconnection, intolerance, depression, and a pure lack of compassion and empathy to those they care for.

Practices of Self-Care

In 1995, Dr. Charles Figley noted that there were providers that could experience CF yet remain emotionally balanced and not become overwhelmed (Harrison & Westwood, 2009). This is the concept of *compassion satisfaction* (CS), and in contrast to CF, it is that sense of pleasure a healthcare provider gets from performing his or her role (Hooper et al., 2010; Sheppard, 2014). The purpose and meaning derived from their work as a caregiver is a positive “balancing out” of the negative aspects in caring for troubled and traumatized individuals (Hooper et al., 2010). Participants believed that good self-care practices allowed them to not become overwhelmed with the constant triggers of CF within the mental health setting. The Professional Quality of Life (ProQOL) framework suggests that providers must first identify their own personal experiences and triggers so that they are better able to recognize their own limitations and/or coping abilities (Levenson et al., 2005; Stamm, 2010). All providers agreed that this awareness is necessary to allow them to be cognizant of their own vulnerabilities within this setting and that by practicing good self-care, they can improve their own resiliency.

Study Limitations

Interpretation of this study's findings are limited by a several factors. First, the generalizability of this study's findings is limited. This project focused on determining the perceptions of CF in a small sample size of eight community-based outpatient mental health providers. Another major limitation may be the response bias. The responses given by the participants may not be representative of the mental health providers that did not participate within each of the organizations. Those that refused to participate may have higher CF than those that did participate. Also, because of the design of this project, the data may be representative of what type of day the participant was having when the focus group took place. Other limitations may be that this project did not include other potentially relevant variables such as stressors outside the work environment and patient acuity levels. Despite these limitations however, this project highlights the importance of CF awareness among mental health providers and identifies areas for future research within the outpatient mental health setting.

RECOMMENDATIONS FOR PRACTICE

Current evidence shows that CF, being comprised of BO, STS, and a lack of CS, can have adverse effects on provider's performance, morale, and staff retention (Schwam, 1998). Despite the prevalence and negative effects of CF, minimal attention has been focused on preventing CF among mental health professionals. This project specifically calls attention to the attitudes and beliefs of the community-based outpatient mental health provider regarding their perception of CF. This is an area of study where there is currently limited information. Sharing the results of this study invites all stakeholders and mental health care administrators to consider the risk of CF in the community-based outpatient mental health providers and to seek out methods to prevent and reduce CF for their organizations, their patients, and their community.

Recommendations for Mental Health Providers

Research for CF prevention has shown that most interventions focus on changing the individual by improving coping skills. Most of these interventions fall into the Cognitive Behavioral Therapy (CBT) category. These can include education, cognitive restructuring, communication skills training, and muscle relaxation (Morse et al., 2012). Assessment of such interventions on an individual level have shown to be effective in reducing CF, targeting “emotional exhaustion” specifically (Morse et al., 2012).

There have also been research studies showing that an emerging set of strategies incorporating methods derived from spiritual practices (i.e., meditation and mindfulness), are even more effective than simply improving coping skills alone (Morse et al., 2012). In 2009, Krasner and colleagues developed a program for CF prevention that incorporated mindfulness practices, as well as appreciative inquiry and narrative journaling. Although this program was targeted toward primary care providers, the results demonstrated significant reduction in all facets of CF (Krasner et al., 2009). The critical elements that were included in the Krasner program included copings skills to improve the enhancement of the individual’s sense of meaning and purpose using techniques such as meditation (Krasner et al., 2009).

Recommendations for Organizations

Many researchers have suggested “organizational” factors are antecedents to the development of CF, and BO among health care providers (Morse et al., 2012). These findings offer the opportunity for health care administrators to create healthier outpatient MH clinical settings by recognizing ways in which they might address the reduction of CF among their providers. One such intervention suggested includes increasing social supports and communication with leadership. In this project, participants at Organization A believed that

having *weekly* provider meetings reduced the level of CF by allowing the participants to come together often to communicate their frustrations with the patients and the organization.

Decreasing patient caseload, giving longer appointment times, and promoting self-care within the organization's culture, were recommended organizational changes that may help reduce and even prevent CF for all staff (Morse et al., 2012).

Conclusion

Although there have been several research studies conducted on CF, there is a great lack of research regarding the prevalence, the provider experience and risk factors that contribute to the development of CF among outpatient MH providers who work in community-based outpatient mental health settings. Consequently, this project contributes an important initial piece so that we may begin to fill a gap that deserves increased consideration. By offering insights on the experiences CF among outpatient MH providers, we offer evidence to existing CF literature and the findings from this project will contribute to the development of targeted quality improvement projects committed to reducing compassion fatigue in outpatient mental health providers.

APPENDIX A:
IRB DISCLAIMER STATEMENT

Compassion Fatigue Among Mental Health Providers in Outpatient Organizations

Misty A. McGillem

The purpose of this study is to describe mental health provider's experiences with compassion fatigue. Describing these experiences will help to identify physical and emotional effects of compassion fatigue among mental health providers working in outpatient settings. This study will also provide greater awareness of physical and emotional outcomes of unresolved compassion fatigue. This project aims to provide insight on the provider's perceptions of compassion fatigue, specifically the triggers and events, prevalence, and what is done to combat compassion fatigue to minimize adverse physical and emotional effects while increasing compassion satisfaction among health providers in the mental health field.

If you choose to participate in this study, you will be asked to attend a focus group session and openly discuss your perceptions and experiences related to compassion fatigue. The focus group session will last approximately 1 hour and include 4-6 participants. The focus group session will occur in a private conference room at the outpatient clinic. The interviews will be recorded using a digital audio recorder and will be transcribed into a word format for analysis. The principal investigator will also take handwritten observational notes during the session, making important nonverbal observations. You will be asked to complete an anonymous demographic questionnaire to collect information about your gender, age, ethnicity, years of experience as a provider, length of time working in mental health, length of time working in your current organization, and your current caseload. Your participation is voluntary, and you may refuse or discontinue participation in this study at any time. By agreeing to participate in this interview you agree to have your responses used for research purposes. During the focus group interview, you can choose not to answer any of the questions that the researcher poses. During the research project's data collection, analysis, and dissemination, your name and identifying information will not be disclosed. You will be given a pseudonym in the interview transcription to ensure anonymity. Your responses will be kept confidential and all data collected will be destroyed once reviewed and analyzed by the principal investigator and her advisor.

By participating, you do not give up any personal or legal rights you may have as a participant in this study. An Institutional Review Board at the University of Arizona reviewed this research project and found it to be acceptable, per applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research. For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints, you may contact the Human Subjects Protection Program at 520-621-3515 or online at:

<http://rgw.arizona.edu/compliance/human-subjects-protection-program>

For questions or concerns about the study you may contact Misty McGillem, BSN, RN, DNP Candidate at 520-468-9844 or via email at mmcgillem@email.arizona.edu.

APPENDIX B:
DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

The information in this questionnaire will be used for study purposes only and all your answers are private; they will be seen by no one else other than this researcher. By answering the questions, you are agreeing to let me use your information in this study. Thank you for your time and completing this questionnaire.

1. Gender?

Male _____

Female _____

2. Age: _____

3. What is your ethnicity _____

4. Title (MD, NP, PA, DO, etc) _____

5. Education _____

6. Length of employment at current location _____

7. Length of employment within the mental health field _____

8. Days worked per week _____

9. Hours worked per day _____

10. Patient caseload _____

APPENDIX C:
FOCUS GROUP QUESTIONS

Focus Group Questions

I am interested in how you perceive compassion fatigue.

- a. What does *compassion fatigue* mean to you?
- b. *Burnout? Secondary Traumatic stress? Compassion Satisfaction?*
- c. Were you aware that CF is actually comprised of all three components - BO, STS, and CS?
- d. Knowing this, what are some triggers or events of compassion fatigue?
- e. What are some of the physical and emotional symptoms of CF?

I am interested in the prevalence of compassion fatigue within this setting.

- a. Do you believe you currently suffer from CF? In what ways?
- b. Do you feel you have ever suffered from CF while practicing in mental health?
- c. How would you rate your threshold for CF – low, moderate, high?
- d. How would you rate your patient care – poor, fair, good, excellent?
- e. How do you feel your patient's perceive your interactions?

I am interested in how you combat compassion fatigue.

- a. What are your hobbies/interests?
- b. How often do you exercise?
- c. When was the last time you had a vacation and how often do you take time off?
- d. How do you practice self-care?

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