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Workplace Relationships and Professional Burnout Among Certified Child Life Specialists

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ABSTRACT

Certified Child Life Specialists (CCLS) work within a complex medical system, comprised of multiple interpersonal relationships including those with their immediate supervisors, peers, and non-child life medical staff. The job demands of a CCLS often place them in situations that involve high levels of stress and anxiety, placing them at risk for burnout and job turnover. This study examined which types of work relationships are associated with levels of burnout. The study included a sample of CCLS (n = 214) working a minimum of 20 hours a week in clinical settings in the United States. Participants completed an online survey containing the Caplan Social Support Instrument, the Maslach's Burnout Inventory, and an open-ended question related to burnout. Multiple linear regression was used to identify factors associated with burnout. Having a positive relationship with one's direct supervisor, a positive relationship with peers, or positive relationships with non-child life medical staff were associated with lower rates of burnout. Age, years of experience, exposure to trauma and bereavement, and exposure to chronic or terminal illness were not found to be significant predictors of burnout. Qualitative analysis identified additional stressors that participants considered contributors to burnout including compensation, workload, and respect and understanding of the child life role by other medical professionals.

Child life specialists occupy an important role within the world of pediatric health care. Since 1922, child life specialists have been present in children's hospitals and on pediatric units providing psychosocial care and support for children and their families in the medical environment (Wheelwright, 2018). The Association of Child Life Professionals (ACLP) has over 5,000 registered members made up of child life managers, specialists, and students across the world (ACLP, 2018). Certified Child Life Specialists (CCLS) focus on allowing children to maintain steady development during a stressful experience and support the whole child during a medical experience, including their emotional and social needs (ACLP, 2018; Holloway & Wallinga, 1990).

Research has shown that child life services are perceived by patients, families, and medical staff to improve the medical experience for pediatric patients (Duda, 2018; Tyson et al., 2014). Other benefits noted in these studies include shortened hospital visits and reduced amounts of pain, fear, and anxiety experienced by children during medical procedures. The work that child life specialists do often requires them to become emotionally engaged with patients and families during medical experiences, exposing them to others' strong emotions, stress, or trauma (ACLP, 2018; Figley, 1995; Krog, 2016).

Certified Child Life Specialists and other health care workers are at high risk for experiencing negative effects from their work environment. Research on caregiving professions similar to child life have found that this exposure to emotionally charged interactions

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puts them at a high risk for experiencing job stress and may be harmful to their psychological well-being (Figley, 1995). Burnout is a psychological condition that occurs primarily in caring professions and is characterized by long-term emotional exhaustion and decreased interest in one's work (Embriaco et al., 2007; Maslach et al., 1996; Munn et al., 1996). Burnout often occurs due to demanding interpersonal situations, psychological strain, and chronic stress (Krog, 2016; Meadors et al., 2009). Symptoms of burnout include irritability, emotional instability, rigidity in relationships with coworkers, and eating and sleeping problems (Embriaco et al., 2007). Those experiencing burnout tend to have lower job satisfaction, higher job turnover, and a lowered level of job performance (Embriaco et al., 2007; Fisackerly et al., 2016; Holloway & Wallinga, 1990).

A child life specialist's unique position within a complex health care system places them at high risk for experiencing burnout. A CCLS engages in multiple interpersonal relationships throughout the day with patients and families, fellow child life staff, and clinical staff members. Involvement with people is a known source of burnout, but something that a CCLS is unable to remove from their work (Holloway & Wallinga, 1990). The role of a child life specialist requires them to be present with patients and staff during moments of high stress and emotion.

Due to daily tasks and job characteristics, over half of child life specialists are found to be at risk for developing burnout, a similar rate to other human service professions (Brinson, 2012; Fisackerly, 2017). Feelings of burnout are in turn related to the professional's intention to leave a job and high turnover rates (Fisackerly, 2017; Fisackerly et al. 2016; Maslach et al., 1996). Additionally, experiences of burnout and high turnover in the medical field are associated with a decreased quality of care and safety for patients, and increased medical errors (Embriaco et al., 2007; Hall et al., 2016). It is important to understand the phenomena of burnout among child life specialists to decrease job turnover and increase quality of care for all pediatric patients and families.

Social Relationships and Burnout Among Health Care Workers

Research suggests that social support can play an important protective role in preventing burnout among health care workers. A low level of support from supervisors and colleagues is associated with job dissatisfaction and stress, two indicators of burnout (Caplan et al., 1975). For professions with similar work environments and caseloads as a child life specialist, the quality of relationships with coworkers has repeatedly showed to be a protective factor against burnout and similar symptoms (Abualrub, 2004; Embriaco et al., 2007; Lee et al., 2010; Purpora & Blegen, 2015; Rollins et al., 2018; Roomaney et al., 2017; Sun et al., 2017). For a child life specialist, healthy relationships at work are positively associated with professional well-being and negatively associated with job dissatisfaction, intention to leave a job, compassion fatigue (lowered ability to experience empathy following repeated exposures to emotional situations without proper coping or processing skills), stress, and burnout (Fisackerly et al., 2016; Holloway & Wallinga, 1990; Krog, 2016; Munn et al., 1996). The current study attempted to replicate those findings, while further distinguishing which specific types of support seem to be most important to avoid burnout.

This relationship between social support and burnout has been attributed to multiple positive benefits within the workplace, including less conflicts between colleagues and a higher likelihood of relying on coworkers in times of stress (Abualrub, 2004; Shirey, 2004). At least one program was able to improve burnout and job turnover levels of varying health care workers by improving the supportive work environment through randomized implementation of the Civility, Respect, and Engagement in the Workplace initiative (CREW). The CREW initiative consisted of facilitated sessions over the course of six months that focused on interactions between staff (Leiter et al, 2011).

Positive social support in the workplace is beneficial to the overall care provided by a hospital. With lower levels of burnout and job turnover, quality of care for patients is positively impacted (Abualrub, 2004). Some have suggested that high levels of support within the health care workplace may be able to counteract the emotional labor (the work of regulating one's own emotions during interactions with patients and families experiencing high emotions) of caregiving professions (Fisackerly et al., 2016). These findings suggest that higher levels of social support will be associated with lower levels of burnout. The current study tests the hypothesis that positive supervisor, peer, and medical co-worker relationships will be associated with lower levels of burnout among child life specialists.

Methods

Participants and Data Collection

This study was approved by the Institutional Review Board at the University of Missouri. Data was collected from a web-based survey completed by a randomly selected sample of Certified Child Life Specialists that reside in the United States. These child life specialists were invited to participate through email once selected. Participants received an email containing a link to an information and consent form, assuring participants of confidentiality and voluntary participation, and a follow-up email one week later. Participants were allowed to continue with the survey after confirming certified status and working more than 20 hours a week in a clinical position.

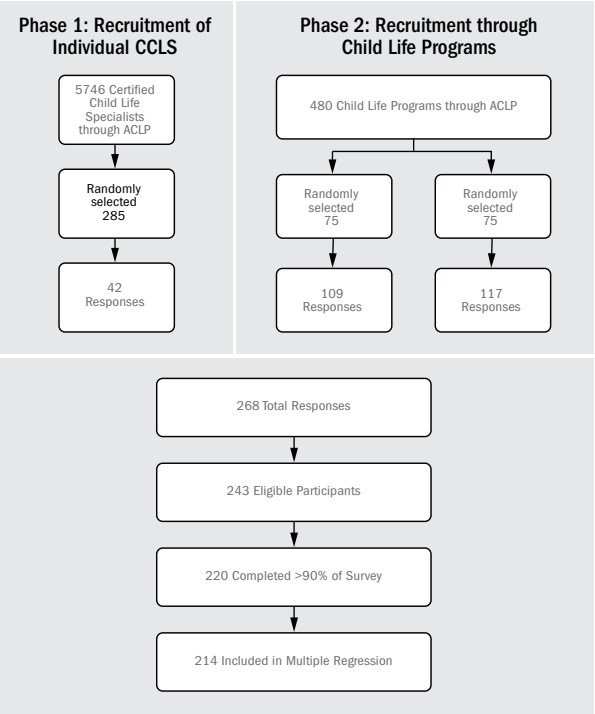

Figure 1 *Participant Selection*

Figure 1 outlines the recruitment strategy. A goal of collecting 200 completed survey responses was set. Step one of the sampling procedure involved randomly selecting 285 participants from the complete list of ACLP members (5,746 child life professionals and students). From that initial email sent to 285 participants, 42 responses were collected. Since this attempt resulted in fewer than the goal number of completed surveys, recruitment then continued with two waves of 75 randomly selected child life programs from the complete list of child life programs (480) on the Association of Child Life Professionals website. The first round collected 109 individual responses and the second round collected 117 individual responses. Of the 268 total collected responses, 243 participants met the following minimum eligibility requirement of working more than 20 clinical hours a week as a Certified Child Life Specialist (students and non-practicing specialists were excluded from this study). The final sample included the 220 eligible respondents; however, six of those participants reported not having a peer child life specialist or being a one-person child life team, and thus those data were excluded from the multiple regression analysis due to their lack of peer support scores.

Sample and Measures

Demographics. Demographic information was collected from participants and included: gender, ethnicity, country of employment, highest level of education (i.e., BA, MS, and PhD), size of organization (i.e., small 0-99 pediatric beds, medium 100-499 pediatric beds, and large 500+ pediatric beds), and the nature of their direct supervisor (i.e., CCLS, nursing, family services, and other). Participants also reported on their age, number of years working as a CCLS, the percentage of their work hours exposed to patients involved in a trauma or bereavement, and their exposure to patients with a terminal or chronic illness.

Burnout. The Maslach Burnout Inventory Human Services Survey for Medical Personnel (MBI-HSS, MP) is a questionnaire designed to measure a participant's level of burnout and has been widely used in research on health professionals (Embriaco et al., 2007; Guidroz et al., 2012; Holloway & Wallinga, 1990; Knox et al., 2018; Munn et al., 1996; Ofei-Dodoo et al., 2018; Spence Laschinger et al., 2009; Sun et al., 2017). The measure includes 22 questions that ask how often the respondent experiences various indicators of burnout (e.g., "I feel emotionally drained from my work" and "I don't really care what happens to some patients"). Respondents answer using a Likert scale from 0 = "Never," to 6 = "Every day." The measure includes three subscales: emotional exhaustion (7 items), depersonalization (7 items), and personal accomplishment (8 items).

The choice to utilize the MBI-HSS (MP) stemmed from its ability to accurately assess a participant's level of burnout syndrome (BOS) specifically based on the work context, as opposed to other measures that include personal life or outside factors (Fisackerly et

al., 2016; Knox et al., 2018; Van Mol et al., 2015). One strength of the MBI-HSS (MP) is that participants report on the degree they experience symptoms of burnout, rather than relying on the term "burnout" in items (Knox et al., 2018). Additionally, the use of the MBI-HSS (MP) allows comparison with previous studies utilizing the MBI-HSS (MP) with professions like child life.

The present study used the score for emotional exhaustion as the outcome measure of burnout (rather than depersonalization and personal accomplishment) for conceptual and empirical reasons. Scholars have argued that the measure for emotional exhaustion substantially represents the notion of "burnout" more than the measures for personal accomplishment and depersonalization (Embriaco et al., 2007; Guidroz et al., 2012; Munn et al., 1996; Spence Laschinger et al., 2009). Emotional exhaustion is the result of interpersonal conflict, chronic stress, and emotional burden at work and is exhibited through a lack of energy or interest in one's work (Fisackerly et al., 2016; Guidroz et al., 2012; Maslach & Leiter, 2017; Munn et al., 1996). Being emotionally exhausted leads to depersonalization and a decreased sense of personal accomplishment (Embriaco et al., 2007; Maslach et al., 1996). Emotional exhaustion specifically has been linked to lowered job satisfaction and increased intention to leave a job (Guidroz et al., 2012; Spence Laschinger et al., 2009).

Previous research using the MBI-HSS (MP) demonstrated satisfactory reliability and validity of the instrument, with Cronbach's alpha for the three subscales ranging from $\alpha = 0.69$ to $\alpha = 0.95$, and with a test-retest reliability of 0.95 (Maslach et al., 1996; Loera et al., 2014; Montiel-Company et al., 2016; Sun et al., 2017). In the present study, Cronbach's alpha for emotional exhaustion was 0.88. A sum score of 27 or over on the emotional exhaustion subscale indicates a high level of emotional exhaustion, a sum score of 17-26 on the emotional exhaustion subscale indicates a moderate level, and a sum score of 16 or under indicates a low level of emotional exhaustion (Maslach et al., 1996).

Relationships. The Caplan Social Support Instrument (CSSI) (Caplan et al., 1975) was used to measure the strength of the participants relationship with their supervisor, peer CCLS, and non-child life medical staff. The CSSI was chosen based on its ability to compare different workplace relationships on the same scale, and its focus on the interpersonal nature of the relationship. Participants responded to four questions for each of the three relationship domains, on a Likert scale of 1 (not at all), to 4 (very much). A score of 0 indicates "don't have any such person." For each of the domains, questions include: "How much does each of these people go out of their way to do things to make your work life easier for you?"; "How easy is it to talk with each of the following people?"; "How much can each of these people be relied on when things get tough at work?"; and "How much is each of the following people willing to listen to your personal problems?" Scores were averaged to create individual mean response scores for supervisor, peers, and coworkers, with a higher score representing higher levels of perceived social support from that domain. Responses of "don't have any such person" for a subscale resulted in a score of 0 and were categorized as missing data, for that category.

Prior research utilizing the CSSI has found Cronbach's alpha scores ranging from $\alpha = 0.63$ - 0.93 on the measure (Caplan et al., 1975; Kovach et al., 2009). In the present study, Cronbach's alpha for supervisor relationship was 0.86, for CCLS peer relationships it was 0.92, and 0.83 for non-child life medical staff.

Qualitative. Participants were asked to provide a short answer to the following question: "What do you feel is the single strongest cause of worker burnout among Certified Child Life Specialists?" This exploratory question was asked to explore CCLS's views toward burnout and to assess how social relationship and other factors not included in this study are perceived as contributors to burnout.

Data Analysis

Data were exported from Qualtrics as a CSV (comma separated value) file and imported into R studio for analysis. Descriptive statistics were calculated for participant demographic variables. Multiple linear regression was used to regress burnout scores on demographic and relationship quality variables. Listwise deletion was used in analysis, resulting in the exclusion of six cases who did not have CCLS peers, and therefore had missing peer support scores. Predictor variables included age, years of experience, percent of work hours spent with trauma or bereavement patients, percent of work hours spent with chronic or terminally ill patients, and overall social support. Prior to analysis, distributions and regression models were

assessed for normality, including tests for discrepancy and leverage of participants, a Shapiro-Wilks test, a Breush-Pagan test, and a Durbin-Watson test.

Text responses to the open-ended item regarding causes of CCLS burnout were imported into Microsoft Excel for content analysis. In the analysis, the respondent's entire textual response was considered as the unit of analysis. The analysis procedure involved the following steps: (a) reading all responses to become familiar with the contents, (b) reviewing responses case by case to generate a preliminary set of potential themes, (c) identifying the final set of themes, and (d) coding each response into the appropriate theme. In 19 cases (8%), the response could fit into two of the themes. In these cases, the researcher coded by weighting the themes within the response. Thus, an exhaustive and mutually exclusive set of themes were identified.

Table 1 *Participant Demographics*

Characteristic	Frequency	Percent
Which gender identity do you most identify with?		
Male	5	2.3
Female	215	97.7
Please specify your ethnicity: check all that apply		
White	191	86.8
White, Black, or African American	2	0.9
White, Black, or African American, prefer not to answer	1	0.5
White, Native Hawaiian, or Pacific Islander	1	0.5
White, Hispanic, or Latino	3	1.4
White, prefer not to answer	3	1.4
Black or African American	4	1.7
Asian	4	1.7
Asian, Hispanic, or Latino	1	0.5
Hispanic or Latino	5	2.3
Other/Prefer not to respond	5	2.3
What is the highest level of education you have completed?		
Bachelor's degree	113	51.4
Master's degree	105	47.6
PhD	1	0.5
Prefer not to respond	1	0.5
What is the size of your hospital based on pediatric capacities?		
Small (0-99 beds)	77	35
Medium (100-499 beds)	111	50.5
Large (500+ beds)	29	13.1
Other/Prefer not to respond	3	1.4
What is the occupation of your direct supervisor?		
Certified Child Life Specialist (CCLS)	172	78.2
Nursing Profession (RN, LPN, etc.)	32	14.5
Family Services Coordinator	1	0.5
Not Listed	14	6.3
Prefer not to respond	1	0.5
In which country are you currently employed?		
United States	220	100

Results

Descriptive Analysis

Participants in this study identified primarily as white (86.9%) and female (97.7%), which is consistent with participant demographics in prior CCLS studies (Fisackerly et al., 2016; Holloway & Wallinga, 1990; Munn et al., 1996). Study participants indicated working in a combination of small (35%), medium (50.5%), and large (13.1%) hospitals in the United States. On average, participants spent around half of their time (47.2%) with chronically ill patients and around a quarter of their time (23.0%) with trauma patients or bereavements. The majority of participants (78.2%) are supervised by a CCLS. Participant's average perceived social support score with supervisors was 3.2, with their peer CCLS it was 3.7, and with non-child life medical staff it was 3.1. On average, participants reported a moderate level of burnout (M= 25.0, score over 27 is high) according to MBI-HSS (MP) criteria. This level is high compared to previous studies of CCLS emotional exhaustion using the measure, which reported average scores of 18.06 (Holloway & Wallinga, 1990) and 19.2 (Munn et al.,1996). Detailed frequencies and percentages for all categorical variables are presented in Table 1, and descriptive statistics for all continuous variables are in Table 2.

Table 2 *Participant Characteristics*

Variable	Mean	Median	Standard Deviation
Age	33.6	30.5	9.0
Years as a CCLS?	8.7	6.0	7.8
Percent of time with trauma patients/ bereavements?	23.0	15.0	22.6
Percent of time with patients chronically/terminally ill?	47.2	40.5	32.0
Overall Social Support	3.3	3.4	0.4
Supervisor	3.2	3.5	0.8
Peer CCLS	3.7	4.0	0.5
Non-CCLs Medical Staff	3.1	3.3	0.7
Emotional Exhaustion	25.0	24.0	8.9

Table 3 *Correlations Between Demographic Variables, Social Scores, and Emotional Exhaustion*

Measure	1	2	3	4	5	5a	5b	5c
1. Age	---							
2. Years CCLS	0.885**	---						
3. Trauma/Bereavements	-0.024	0.023	---					
4. Chronic/Terminally Ill	0.094	0.089	0.126	---				
5. Social Support	0.008	0.116	0.096	0.053	---			
5a. Supervisor	0.002	0.011	0.105	-0.006	0.722**	---		
5b. Peer	-0.047	0.024	-0.083	0.009	0.527**	0.121	---	
5c. Medical Staff	0.082	0.215**	0.076	0.099	0.640**	0.119	0.085	---
8. EE	-0.091	-0.092	-0.0001	0.089	-0.398**	-0.317**	-0.217**	-0.221**

* = p-value < .05 ** = p-value < .01 n=220 for all calculations not including "Social Support" or "Peer"

Trauma/Bereavement = percent of work hours interacting with trauma patients or bereavements

Chronic/Terminal = percent of work hours interacting with chronic or terminally ill patients

Social Support = Combined average relationship score with supervisor, peer CCLSs, and non-child life medical staff

EE = Emotional Exhaustion

Quantitative Analysis

Bivariate correlations between all variables are presented in Table 3. Participants who had more experience as a CCLS reported better relationships with medical staff $r(218)=0.215$, $p<.01$. Emotional exhaustion scores were not significantly correlated with age, $r(218)=-0.091$, $p>.05$; years working as a CCLS, $r(218)=-0.092$, $p>.05$; interactions with chronic or terminal illness, $r(218)=-0.0001$, $p>.05$; or interactions with traumas and bereavements, $r(218)=-0.089$, $p>.05$. Overall, positive social support was negatively correlated with emotional exhaustion, $r(212)=-.398$, $p<.01$. A positive relationship with one's supervisor, $r(212)=-.317$, $p<.01$; peer CCLSs, $r(212)=-.217$, $p<.01$; and non-child life medical staff, $r(212)=-.221$, $p<.01$ were associated with a lower level of emotional exhaustion.

Table 4 *Multiple Regression Model – Social Relationships and Emotional Exhaustion (Burnout)*

Model	R2	Unstandardized		Standardized	t value
		b	St. Error	β	
Model	.157				
(Constant)		60.88	6.93		8.78**
Age		-0.23	0.14	-0.22	-1.62
Years as a CCLS		0.18	0.17	0.15	1.10
Trauma/ Bereavement		0.001	0.03	0.003	0.05
Chronic/ Terminal		0.03	0.02	0.11	1.78
Supervisor		-3.23	0.77	-0.27	-4.18**
Peer		-3.30	1.17	-0.18	-2.82**
Medical		-2.80	0.92	0.20	-3.04**

** p<.001, other p-values not significant at .05 level

Trauma/Bereavement = percent of work hours interacting with trauma patients or bereavements

Chronic/Terminal = percent of work hours interacting with chronic or terminally ill patients

Social Support = Combined average score of relationship with supervisor, peer CCLSs, and non-child life medical staff

Multiple linear regression analysis results are presented in Table 4. The model, which included demographic predictive factors (i.e., age, years of experience, interactions with traumas/bereavements, and interactions with chronic/terminally ill patients) and social relationships predictive factors (with supervisors, peer CCLSs, and medical staff) was significant, $F(7, 206) = 6.651$, $p < .001$ and represented a small but significant effect (R2adj = 0.157), accounting for 15.7% of the variance in emotional exhaustion. Diagnostic tests for influential cases and assumption testing for multicollinearity, normality, homoskedasticity, and independence of error were deemed satisfactory. Results of the regression indicated that supervisor relationship, $t(206) = -4.18$, $p < .001$; peer CCLS relationships, $t(206) = -2.82$, $p < .001$; and non-child life medical staff relationships, $t(206) = -3.04$, $p < .001$ significantly predicted emotional exhaustion while controlling for other variables. Based on beta weights, supervisor relationship ($\beta = -0.27$) had the strongest association with emotional exhaustion, with an expected 0.27 de-

crease in emotional exhaustion for every one standard deviation increase, while controlling for the other social relationships. Relationship with peers (β = -0.18) and medical staff (β = -0.20) had smaller and similar influences with a 0.18 and 0.20 decrease in emotional exhaustion for every one standard deviation increase in the respective variable, while controlling for the other variables in the model.

An additional independent sample t-test was conducted to test for possible differences in emotional exhaustion between those whose direct supervisor is a CCLS and those whose direct supervisor is from another discipline. Results of the t-test, $t(225) = -0.417$, $p>.05$, $d=3.74$ indicated that levels of emotional exhaustion did not differ significantly between those who were directly supervised by a CCLS (M =24.78, SD =9.24) and those with a supervisor from another profession (M =25.37, SD =7.86).

Qualitative Analysis

Directed content analysis (see Table 6) was used to code and group responses to the open-ended question by common themes (Hsieh & Shannon, 2005). Six themes were identified: 1) workload and compensation, 2) lack of respect or understanding, 3) emotional burden and compassion fatigue, 4) lack of support, 5) poor work-life balance, and 6) job ambiguity.

Participants citing workload and compensation as a cause of burnout (31% of respondents) reported feeling that they had a poor patient-to-CCLS ratio and were not receiving the appropriate salary for their work. Many participants also reported needing more child life specialists on their staff to meet patient needs. The second-highest reported perceived cause of worker burnout (22% of respondents) was coded as lack of respect or understanding for the child life profession by other staff in the hospital. Participants

Table 6 *Thematic Correlation: Common Causes of Burnout Reported by Child Life Specialists*

Theme	Description	#(%)	Examples
Workload and Compensation	Responses related to being understaffed, being unfairly/poorly compensated for work and education level, having high level of patient to CCLS ratio	68 (31%)	Poor CCLS to patient ratios
			Over worked and under paid wearing too many hats
			Low compensation in relation to the number of patients we see daily and the work we do
			Increased workload with no increase in staffing
Lack of Respect or Understanding	Responses related to needing to advocate for the CCLS profession to other medical staff or families, feeling unvalued by hospital administration or other medical professions	48 (22%)	Lack of respect from other medical providers
			Other team members not understanding or respecting the profession
			Lack of respect from hospital administration
			Repetitive advocating for what the CCLS can do
Emotional Burden and Compassion Fatigue	Responses related to the emotional burden and toll of caring for sick children and their families, interactions with high acuity patients such as bereavements/traumas and the chronic patient population	39 (18%)	Having to deal with sad/difficult situations at work (abuse, child deaths, etc.)
			Emotional weight of the work of CCLSs
			Compassion fatigue
			Emotional labor
Lack of support	Responses related to the lack of support from the child life manager, team members, or ACLP	29 (13%)	Managers that are not supportive
			Not being supported by management, staff, ACLP
			Not being supported by boss/peers
Poor work-life balance	Responses related to the personal inability to care for one's feelings of burnout – as supported by either the individual or the institution	29 (13%)	Not enough self-care, either personally or the institution does not allow for it
			Lack of work-life balance and boundaries
			Failing to maintain appropriate boundaries
Job Ambiguity	Responses related to being unsure of boundaries of job title	5 (2%)	Job ambiguity
			Juggling multiple responsibilities beyond patient care
Other		1 (<1%)	Unkindness to healthcare workers

Note: Participants response to the question: What do you feel is the single strongest cause of worker burnout among CCLSs? (n = 219).

reported having to consistently advocate for the child life profession and often receiving pushback from medical staff. Likewise, participants reported feeling a lack of recognition from administration, medical providers, and other health care disciplines for their work. A smaller proportion of responses (18%) reported feeling an emotional burden or compassion fatigue from working with difficult cases. Slightly smaller groups of respondents were coded as feeling a lack of support (13%) and having a poor work-life balance (13%). Additionally, a small group of respondents were coded as struggling with job ambiguity (2%).

Discussion

The purpose of this study was to examine the connection between burnout and child life specialists' relationships with different individuals. Results from this study support the initial hypothesis that positive supervisor, peer child life specialists, and medical co-worker relationships are associated with lower levels of burnout among child life specialists.

Relationships and Burnout Levels

Positive relationships with one's supervisor, a peer CCLS, and with non-child life medical staff each had significant positive associations with lower levels of emotional exhaustion (while controlling for potential influence of age, years of experience, and interactions with traumas, bereavements, and chronic or terminally ill patients).

Reporting a high quality relationship with one's direct supervisor was found to have the strongest association with low burnout and emotional exhaustion, with relationships with peer CCLSs and medical staff having smaller but similar associations. These findings are congruent with several studies regarding burnout in the health care field and the influence of the supervisor relationship (Brinson, 2012; Munn et al., 1996). Additionally, participants rated their relationships with a peer CCLS (M = 3.68, SD = 0.50) as more supportive on average than with their supervisor or medical team. Levels of burnout did not depend on whether one's direct supervisor was a CCLS versus another profession.

In open-ended responses, participants described what they considered to be causes of burnout among child life specialists. Lack of compensation and having a large workload were seen as particularly problematic. Participants also frequently reported concern regarding a lack of respect or understanding of child life by other hospital staff. Other burnout causes were the emotional burden of the child life profession, feeling a lack of support from co-workers, and seeing child life as having a poor sense of work-life balance.

Importantly, although a lack of support related to social relationships in the workplace was cited as burnout cause, it was mentioned significantly less often than the other three top-cited themes. This finding implies that the Caplan Social Support Instrument used for this study is relevant but cannot fully capture all factors influencing the degree of burnout that a CCLS experiences. This qualitative analysis suggests that additional research into causes of child life burnout might focus on the impact of compensation and workload, respect from other professionals in the health care field, compassion fatigue, or co-worker relationships.

Limitations

There were several identified limitations to this study. Of the original 243 respondents, 23 survey respondents (9.5%) were not included in analysis due to not completing over 90% of the survey. Although this represents a small portion of the total sample, it is possible that these participants were unique, for example in terms of their duties, support, and burnout. Additionally, participants in the study reported a moderate level of emotional exhaustion, with an average score for each social relationship category above three on a scale of one to four. It is possible that the study respondents are those who are not experiencing the highest levels of burnout or work stress, as they had the time and ability to complete the survey. Future studies might try alternate methods to increase levels of survey completion and assure a representative sample. The regression analysis only accounted for 15% of the variance. Future research studies should aim to determine what factors could account for the remainder of the variance among emotional exhaustion scores. Additionally, six of the respondents who completed the survey were one-person CCLS teams. Future research could explore whether relationships and burnout are different among these types of programs. Despite these limitations, the findings have important implications for the child life profession.

Implications and Significance of Study

The proposed study aimed to examine the association between worker burnout and workplace relationships among Certified Child Life Specialists. Because health care workers are at high risk to experience burnout due to their job demands and work environments, patients are then at risk of receiving less than optimal care. Pediatric patients and their families come to hospitals at a time of high anxiety in their life and are relying on the support from a child life specialist to support and guide them through the experience. In order to provide the best possible care to these patients, it is important to recognize what may be amplifying experiences of burnout.

Findings from this study have the potential to influence interventions targeting workplace social relationships among child life specialists or similar health care professions. Based on results, supervisors of child life programs appear to have a particularly strong impact on their employee's levels of burnout, highlighting the need for competent and caring supervisors. This finding may indicate a need for management training or additional certification for supervisors of child life programs on ways to support and recognize staff burnout, along with regular evaluations of the level of support received, to ensure child life specialists' needs are being adequately met. Findings suggest that supervisor support alone is not sufficient to eliminate the effects of burnout, which indicates that finding ways to establish and maintain strong relationships with peer child life specialists and other medical staff may also be important.

Responses to the open-ended question suggest additional areas of future research and attention. The common perception that being overworked, understaffed, and under-compensated leads to burnout suggests a need for hospitals to re-evaluate workload and compensation in relation to the benefits they provide to the institution. Also, given that lack of respect and understanding of the child life profession by other medical staff was a commonly cited cause of burnout, training for CCLS and their supervisors should include advocacy for the child life profession to other medical teams and to administrative boards. Responses suggest a need for more general education for various medical staff on the child life profession and how to utilize them as a resource within pediatric health care settings.

Results from this study may influence future programming or coursework for both certified child life specialists and their managers. The Association of Child Life Professionals may be one governing body to take responsibility for the burnout of the profession's members, offering continued education seminars and professional development units focused on reducing causes of burnout for child life specialists. These sessions should focus on education and support for managers of child life teams, as results from this study suggest that child life specialists who feel more supported by their managers experience less burnout. This education should empower child life managers to be better able to reduce additional causes of burnout as reported by child life specialists in this study. These may include teaching managers ways to advocate for their profession in terms of increased funding or adding more positions to reduce feelings of being overworked or unfairly compensated. Additional seminars may focus on advocacy to medical boards and institutions on the value of child life specialists to reduce feelings of their staff being misunderstood or undervalued by the institution. Following sessions may educate both managers and child life specialists on role boundaries for child life specialists to reduce feelings of job ambiguity, reflection and support following intense patient situations to reduce emotional burden, and continued support for maintaining a healthy work-life balance. These educational topics may lead to lowered burnout through targeting of specific concerns voiced by child life professionals, and by strengthening the relationship between child life specialists and their managers.

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