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Original Articles

One Cannot Pour From an Empty Cup: Compassion Fatigue, Burnout, Compassion Satisfaction, and Coping Among Child Life Specialists

Lisa Lagos, MS[1], Amy M. Claridge, PhD, LMFT[2][a], Katy Tenhulzen, MS, CCLS[2]

[1] Central Washington University, [2] Department of Child Development and Family Science, Central Washington University

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Objective:
Child life specialists provide support across various medical units and are frequently exposed to high-intensity, stressful, or traumatic situations. As such, they are at risk of developing burnout and compassion fatigue; however, limited research has examined the relationship between professional well-being of child life specialists and use of coping strategies. The present study examined professional quality of life, including compassion satisfaction, compassion fatigue, and burnout.
Method:
This survey used responses from 196 child life specialists across the United States and Canada to examine whether professional quality of life varied based on reported coping strategies, frequency of supervision and consultation, or hospital units on which participants worked.
Results:
Results revealed use of avoidant coping strategies was associated with lower likelihood of compassion satisfaction and higher risk of compassion fatigue and burnout. On the other hand, more frequent consultation with colleagues was associated with higher likelihood of compassion satisfaction. Child life specialists who worked in hematology/oncology units reported higher risk of compassion fatigue than those on other medical units.
Conclusion:
This study provided several implications for practice to enhance child life specialists' professional quality of life. Researchers should consider qualitative studies to better understand the professional quality of life of child life specialists in order to improve the delivery of quality, family-centered care.
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Helping professionals will ideally experience professional quality of life characterized by high levels of positive emotions associated with compassion satisfaction and low levels of negative emotions associated with compassion fatigue and burnout (El-Shafei et al., 2017). However, child life specialists support patients around issues of grief, loss, and trauma, and the challenging nature of this work may threaten their professional quality of life (Fisackerly et al., 2016; Munn et al., 1996). Child life specialists are at risk of burnout due to factors such as high workload, inadequate compensation, lack of respect and understanding of the child life role by other medical professionals, and difficulty finding work/life balance (Hoelscher & Ravert, 2021).

The current study examined the experiences of compassion satisfaction, compassion fatigue, and burnout among child life specialists and whether coping strategies or specific aspects of the work environment contributed to child life specialists' reported professional quality of life.

Professional Quality of Life

According to Kelly et al. (2015), the experience of compassion fatigue combines two factors of professional well-

a amy.claridge@cwu.edu

being: secondary trauma and burnout. Secondary trauma refers to negative feelings which result from supporting people experiencing suffering (Stamm, 2010). Burnout is a result of physical and mental exhaustion caused by stress (Maslach & Jackson, 1981) and is characterized by fatigue, inability to cope, reduced psychological ability to "give," a negative or cynical attitude towards patients, and a negative perception of one's job performance and abilities. Burnout can result in depersonalization of patients and family members and lower-quality patient care (Bridgeman et al., 2018). Despite their synergistic relationship, compassion fatigue and burnout have unique symptomology (Sorenson et al., 2016). Symptoms of compassion fatigue may include sleep disturbances, isolation and loss of morale, depression, reduced self-worth, low cognitive performance, and cynicism (The American Institute of Stress, 2017). Compassion fatigue tends to be more serious and pervasive than burnout and can be associated with long-term negative outcomes such as reduced empathy, reduced sense of control and safety, hopelessness, and indulging in binge eating and substance use (Portnoy, 2011). Meadors et al. (2010) found that compassion fatigue was significantly related to post-traumatic stress disorder for pediatric healthcare professionals.

In contrast to burnout and compassion fatigue, compassion satisfaction, or the degree to which a professional feels they are successfully accomplishing their job and the fulfillment associated with their work (Conrad & Kellar-Guenther, 2006; Stamm, 2002), may help mitigate the experience of burnout, secondary trauma, and compassion fatigue (Harr, 2013; Meadors et al., 2010).

Compassion Fatigue in Helping Professions

Existing research has examined professional quality of life of helping professionals in multiple fields. Among mental health counselors, exposure to trauma from clients contributed to development of compassion fatigue (I. Thompson et al., 2014). Flannelly et al. (2005) found that among disaster relief workers, prolonged exposure to trauma victims was directly correlated with compassion fatigue. Nurses are more likely than other professionals to develop compassion fatigue and have higher risk for illness related to stressors such as end-of-life care and observing patients' suffering, particularly on critical care units (van Mol et al., 2015; Von Rueden et al., 2010). Similarly, nurses from oncology units tend to report more job dissatisfaction and mental and emotional exhaustion (Potter et al., 2010), and those who feel isolated, overloaded, and underappreciated are at higher risk for compassion fatigue (Medland et al., 2004).

Hospital social workers face similar demands as child life specialists, juggling large caseloads and providing practical and emotional support to families in crisis. Zimmerman & Dabelko (2007) suggested the multifaceted roles and responsibilities of hospital social workers and exposure to stress and trauma may contribute to the risk of compassion fatigue. Emotionally charged interactions with children and lack of support from other hospital staff increased this risk for pediatric oncology social workers (Yi et al., 2018). Taken together, helping professionals in healthcare settings may be at particular risk for negative outcomes because of their exposure to stressful and emotional situations which may be exacerbated by perceived lack of support or appreciation in their work environment.

Compassion Fatigue in Child Life

Similar to nurses, medical social workers, and mental health counselors, child life specialists work in high stress environments with possible exposure to trauma, and such working conditions can result in experiences of job dissatisfaction, burnout, and compassion fatigue (R. H. Thompson et al., 2018). Though they face many emotional burdens, such as providing end-of-life care (Shuck et al., 2013), there is limited research on compassion fatigue among child life specialists. Studies have examined child life specialists' experience of burnout in general (e.g., Hoelscher & Ravert, 2021; Holloway & Wallinga, 1990), and two recent studies have examined compassion fatigue more specifically. In a study of child life specialists, 75% were found to be at risk for developing compassion fatigue or burnout (Brinson, 2012). Fisackerly et al. (2016) found that child life specialists were at similar risk of compassion fatigue as other helping professionals, with higher risk for compassion fatigue for those who worked on hematology/oncology or intensive care units than among those who worked in emergency departments.

The stressful nature of a child life specialist's day-to-day work may be mediated by certain protective factors. Munn et al. (1996) found supervision to be a protective factor against job-related stress and dissatisfaction. Similarly, Fisackerly et al. (2016) found child life specialists were at lower risk of compassion fatigue when they had a supportive work environment with opportunities to debrief with colleagues after a patient death. Therefore, supportive work environments may serve as a mediating factor against the risk of burnout and compassion fatigue (Hoelscher & Ravert, 2021).

The current study aimed to build on this research (Brinson, 2012; Fisackerly et al., 2016) by examining child life specialists' risk for compassion fatigue, burnout, and compassion satisfaction in relation to coping strategies, frequency of consultation with colleagues, and supervision.

Coping Strategies and Compassion Fatigue

Individuals engage in coping strategies to control or ease stressful experiences (El-Shafei et al., 2018), and the type of coping used may impact the likelihood of experiencing compassion fatigue, burnout, and compassion satisfaction. The approach-avoidance coping model details two categories of coping strategies (Roth & Cohen, 1986). Approach coping strategies include seeking information and being proactive about dealing with the stressor whereas avoidance coping is characterized by the tendency to avoid or ignore the stressor to reduce negative emotional responses. Approach coping may involve acceptance, optimism, positive reframing, and planning, whereas avoidance coping may include denial, self-blame, and distraction. Individuals

may oscillate between approach and avoidant strategies, and while both can serve a beneficial purpose, benefits of avoidance strategies tend to be short-lived and over time may contribute to negative outcomes. On the other hand, approach coping strategies tend to be associated with long-term benefits related to well-being and processing trauma but may contribute to greater distress in the short-term. Amstadter & Vernon (2008) reported that use of approach coping strategies after a traumatic exposure was positively correlated with long-term improvements in daily functioning. Similarly, approach coping was associated with positive well-being and post-traumatic growth among police officers (Arble et al., 2018). On the other hand, use of avoidant strategies have been associated with psychopathology (Amstadter & Vernon, 2008), more substance use, and poorer overall well-being (Arble et al., 2018; Arble & Arnetz, 2016).

Previous literature has mostly focused on the relationship between coping strategies and burnout, and there is less research on approach and avoidance coping in relation to compassion satisfaction or compassion fatigue. Among critical care nurses in Jordanian hospitals, approach coping strategies were associated with more compassion satisfaction and less compassion fatigue, whereas avoidance coping strategies were associated with more compassion fatigue (Al Barmawi et al., 2019). Similarly, Brinson (2012) suggested use of approach coping strategies may help restructure child life specialists' appraisal of stressful situations and prevent compassion fatigue.

Current Study

The present study aimed to examine professional quality of life of child life specialists and explore whether there was an association between the degree to which child life specialists used different coping strategies and their risk for compassion satisfaction, compassion fatigue, and burnout. The second aim of this study was to determine whether the experience of compassion satisfaction, compassion fatigue, or burnout varied by frequency of consultation with colleagues or supervisors. The final aim was to determine whether associations between coping strategies and professional quality of life varied by medical unit.

Method

Participants and Procedures

This study used a convenience sample of Certified Child Life Specialists who worked in pediatric settings across the United States and Canada. The study protocols were approved by the institutional review board at the authors' institution. A cross-sectional survey design was used to minimize participant burden and recruit a large sample of child life specialists across North America. Participants were recruited through the Association for Child Life Professionals (ACLP) forum, announcements on social media (e.g., Child Life Facebook groups), and snowball sampling methods. The recruitment script was posted three times on the ACLP forum and eight times on social media, and it included a request for participants to share the opportunity with colleagues. The response rate is unknown because it is not clear how many potential participants viewed the recruitment script. After agreeing to participate, participants completed an online, anonymous survey in Qualtrics including questions about participants' demographic characteristics, hospital work environment, professional quality of life, and coping strategies. Data collection took place during the COVID-19 pandemic; therefore, reports of stress and coping may have been compounded by factors related to the pandemic.

Measures

Demographic Characteristics

Participants reported their age, race and ethnicity, gender, and educational attainment as well as a series of details about their employment (i.e., years of experience, number of labor hours per week, and employment status).

Hospital Work Environment

Participants responded to a multiple response question identifying the type of unit on which they provide their services: oncology/hematology, emergency department, PICU, NICU, specialty inpatient, outpatient, radiology, and other. Participants were able to select multiple units, if applicable, and were asked a follow up question where they indicated the unit where they worked the majority of the time and for how long. Participants responded to two questions regarding frequency of clinical supervision by a child life specialist and their frequency of consultation with other medical professionals at their organization. Both questions used a 5-point scale from 1 = "Never" to 5 = "Very often."

Professional Quality of Life

To measure professional quality of life, participants completed the Professional Quality of Life-5 (ProQOL-5; Stamm, 2005), which measures three aspects of professional quality of life: compassion satisfaction, burnout, and secondary traumatic stress (i.e., compassion fatigue). For each condition, the measure indicates potential risk rather than prevalence (Stamm, 2010). The ProQOL-5 includes 30 items that assess the positive and negative experiences of working in an environment of high stress in the last 30 days (e.g., "I can't recall important parts of my work with trauma victims" and "my work makes me feel satisfied"). This study used an author-developed subset of 25 items from the original measure. Participants responded to each item using a 5-point Likert scale from 1 = "Never" to 5 = "Very Often." Subscale scores for compassion satisfaction (CS), compassion fatigue (CF), and burnout (BO) were created by averaging subscale items such that higher scores indicated greater risk of CS, CF, and BO (CS: $\alpha = .81$; CF: $\alpha = .86$; BO: $\alpha = .81$).

Coping Strategies

To assess the degree of use of coping strategies, participants completed 21 items from the Brief COPE inventory (Carver, 1997) about their responses to stress in the last

30 days. The measure has been used extensively in medical research both in terms of patient and provider coping (e.g., McMeekin et al., 2017; Rahman et al., 2021). Avoidant Coping (9 items) was characterized by denial, substance abuse, venting, behavioral disengagement, self-distraction, and self-blame (e.g., "I've been turning to work or other activities to take my mind off things"). Approach Coping (12 items) included items related to active coping, positive reframing, planning, acceptance, seeking emotional support, and seeking instrumental support (e.g., "I've been concentrating my efforts on doing something about the situation I'm in"). Participants responded to each item using a semantic differential scale from 1 = "I haven't been doing this at all" to 5 = "I've been doing this a lot." Subscales demonstrated strong internal consistency in the current study (Avoidant: $\alpha = .76$; Approach: $\alpha = .88$).

Data Analysis Strategy

Analyses were conducted in SPSS v. 27 (IBM Corporation, 2020). Descriptive statistics were conducted to describe the distributions of demographic characteristics of the participants and variables of interest, including the professional quality of life scales.

In order to examine the first study aim, a series of correlation analyses were conducted between coping strategies and professional quality of life scales. To address the second study aim, correlations were conducted to determine if professional quality of life subscales were related to reported frequency of reported consultation and supervision. A series of t-tests were conducted to determine if professional quality of life subscale scores were different based on medical unit (e.g., those who work on Hematology/Oncology versus those who do not). Finally, to assess the last aim, an analysis of moderation was conducted using a series of correlations between coping strategies and professional quality of life subscales, separately for each medical unit. Pearson correlation (r) values were calculated separately for those who work in each unit (e.g., hematology/oncology) versus those who do not work in the unit and then compared using Fisher's Z tests (Arnold, 1982), yielding six Fisher's Z values for each medical unit examined as a moderator. Significant Fisher's Z tests indicated the medical unit moderated the correlation.

Results

Participants' Characteristics

This study included 196 Certified Child Life Specialists (Table 1). The sample was primarily female (n = 195, 99.5%) and White (n = 177, 90.3%). Participants ranged in age from 24 to 71 years old (M = 35.40, SD = 9.95), and over half (n = 104, 53.1%) had a Master's degree. Most participants reported working on an outpatient unit (n = 81, 14.8%), PICU (n = 76, 14.0%), or emergency unit (n = 73, 13.2%). Over half of participants (n = 105, 53.6%) reported they were the only child life specialist working on their unit, and 27.0% (n = 53) reported working in a hospital which employed 20 or more child life specialists. About half of the participants reported they "never" receive supervision from another child life specialist (n = 100, 51.3%), and half (n = 97, 49.5%) reported receiving clinical consultations "somewhat" or "very often."

Professional Quality of Life and Coping Strategies among Child Life Specialists

On average, child life specialists reported higher likelihood of compassion satisfaction (M = 4.23, SD = 0.54) than risk for burnout (M = 2.29, SD = 0.62) or compassion fatigue (M = 2.18, SD = 0.70). Likelihood of compassion satisfaction was significantly higher than both risk of burnout ($t(195) = -25.37$, $p < .001$) and compassion fatigue ($t(195) = -25.37$, $p < .001$), and risk of burnout was significantly higher than compassion fatigue ($t(195) = -2.66$, $p < .01$).

Correlations were conducted between the degree to which child life specialists used different coping strategies and their professional quality of life (Table 2). Avoidant coping was correlated with lower likelihood of compassion satisfaction ($r = -.30$, $p < .01$) and higher risk of burnout ($r = .55$, $p < .01$) and compassion fatigue ($r = .52$, $p < .01$). Approach coping was associated with higher likelihood of both compassion satisfaction ($r = .15$, $p < .05$) and compassion fatigue ($r = .15$, $p < .05$) but not related to burnout.

When coping subscales were analyzed, various avoidant coping strategies were associated with professional quality of life, but none as consistently as *venting*. *Venting*, an avoidant coping strategy, was associated with lower likelihood of compassion satisfaction ($r = - .18$, $p < .05$) and higher risk of burnout ($r = .33$, $p < .001$) and compassion fatigue ($r = .32$, $p < .001$). On the other hand, approach coping strategies such as use of active coping, relying on emotional support and reframing were each associated with higher likelihood of compassion satisfaction but not significantly associated with risk of compassion fatigue or burnout. *Planning* was positively associated with risk of burnout ($r = .24$, $p < .01$) and compassion fatigue ($r = .24$, $p < .01$).

Differences Based on Work Context

A series of t-tests were used to analyze differences in professional quality of life based on medical unit (Table 3). Participants who worked in hematology/oncology units reported higher levels of compassion fatigue (M = 18.87, SD = 5.37) than those who did not (M = 16.84, SD = 5.67; $t(194) = -2.306$, $p < .05$). There were no statistically significant differences in risk of compassion fatigue, burnout, or compassion satisfaction among the rest of the units.

Correlations revealed a significant positive association between frequency of consultation from colleagues and likelihood of compassion satisfaction ($r = .17$, $p < .05$), but consultation was not associated with burnout or compassion fatigue. Frequency of supervision by a child life specialist was not associated with risk of compassion satisfaction, compassion fatigue, or burnout.

Moderation Analyses

A series of correlation analyses revealed working in the hematology/oncology unit moderated the association be-

Table 1. Demographic characteristics of sample (N = 196)

	n (%)
Gender	
Female	195 (99.5%)
Other	1 (0.5%)
Education	
Bachelor's Degree	89 (45.4%)
Master's Degree	104 (53.1%)
Doctorate	3 (1.5%)
Years of Experience	
0-2 years	38 (19.4%)
3-5 years	48 (24.5%)
6-10 years	38 (19.4%)
11-15 years	36 (18.4%)
16-20 years	14 (7.1%)
20+	22 (11.2%)
Race	
White	177 (90.3%)
Black	4 (2.0%)
Asian	4 (2.0%)
Multiracial	7 (3.6%)
Other	4 (2.0%)
Ethnicity	
Latina	12 (6.1%)
Not Latina	183 (93.4%)
Employment Status	
Full Time	173 (88.3%)
Part-time	17 (8.7%)
Supplemental/On-Call	3 (1.5%)
Other	3 (1.5%)

tween avoidant coping and compassion satisfaction such that among those who did not work on the oncology unit there was a moderate association between avoidant coping and lower likelihood of compassion satisfaction (r = -.39, p < .01), but there was no association among those who did work on the unit (r = -.06, p = .650). The difference between the correlations was statistically significant (Z = 2.159, p < .01). The hematology/oncology units also moderated the association between approach coping and likelihood of compassion satisfaction (Z = 2.64, p < .01). Among those who worked in hematology/oncology there was a moderate positive association between approach coping and likelihood of compassion satisfaction (r = .45, p < .01) but no association among those who did not work on the unit (r = .05, p = .574). Hematology/oncology units also moderated the association between approach coping and risk of burnout (Z = -2.09, p < .01) such that among those who worked on the oncology unit there was a weak association between approach coping and lower risk of burnout (r = -.26, p = .05), but there was no association among those who did not work on the unit (r = .075, p = .383).

Discussion

Child life specialists are frequently exposed to high-intensity, stressful, or traumatic situations and are at risk of developing emotional burnout and compassion fatigue (Brinson, 2012; Fisackerly et al., 2016). Child life specialists in the current study reported similar risk levels of burnout as nurses in other studies (Potter et al., 2010) but higher likelihood of experiencing compassion fatigue and compassion satisfaction. Conrad & Kellar-Guenther (2006) found a similar trend for child protection workers who were at high risk for compassion fatigue but also reported high compassion satisfaction. They suggested this could result from an intrinsic motivation to pursue the job as one's calling and thus find satisfaction advocating for children while at the same time experiencing compassion fatigue due to the emotionally demanding nature of the job. Likewise, child life specialists tend to express strong intrinsic motivation and value in their work despite the challenging nature of the profession, and Meadors et al. (2010) found they experience higher satisfaction in their work than other health care professionals.

Table 2. Correlates of Coping Strategies and Means (SD) of Study Variables.

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
1. Compassion Satisfaction	___														
2. Burnout	-.68***	___													
3. Compassion Fatigue	-.33***	.61***	___												
4. Approach Coping	.15*	-.02	.15*	___											
5. Active Coping	.25***	-.12	.03	.20**	___										
6. Emotional Support	.18*	-.13	.09	.77**	.39***	___									
7. Informational Support	-.02	.08	.14	.78***	.31***	.66***	___								
8. Positive Reframing	.33***	-.27***	-.08	.70***	.55***	.50***	.37***	___							
9. Planning	-.06	.24***	.24***	.78***	.52***	.39***	.52***	.43***	___						
10. Acceptance	.04	.07	.18**	.67***	.26**	.18*	.48***	.26***	.51***	___					
11. Avoidant Coping	-.30***	.55***	.52***	.40***	.20***	.18*	.39***	.09	.45***	.37***	___				
12. Self-distraction	-.03	.19**	.29***	.45***	.33***	.29***	.34***	.20***	.38***	.44***	.68***	___			
13. Denial	-.09	.31***	.31***	.13	.11	-.01	.12	.07	.16*	.09	.62***	.28***	___		
14. Venting	-.18*	.33***	.32***	.48***	.22***	.33***	.49***	.21***	.42***	.40***	.70***	.28***	.29**	___	
15. Self-blame	-.38***	.55***	.45***	.17*	.045	.01	.22*	-.07	.33***	.15*	.75***	.34***	.30***	.37***	___
Mean (SD)	33.85 (4.40)	20.63 (5.57)	17.44 (5.66)	40.91 (8.51)	6.63 (1.77)	7.17 (1.95)	6.63 (2.14)	7.08 (1.79)	6.43 (2.12)	6.97 (1.87)	22.04 (5.81)	6.58 (1.94)	3.10 (1.50)	5.70 (1.92)	4.77 (2.09)

Note. ǂ p < .10. * p < .05. ** p < .01. *** p < .001

Table 3. Professional Quality of Life (ProQOL-5) Scores based on Medical Unit

Medical Unit	Total Sample	Compassion Satisfaction			Burnout			Compassion Fatigue		
	%(*n*)	*M(SD)*	*t*	p-value	*M(SD)*	*t*	p-value	*M(SD)*	*t*	p-value
Oncology/Hematology			-.56	.575		-.32	.748		-2.31*	.022
Yes	29.08% (57)	34.12 (4.01)			20.82 (5.41)			18.88 (5.37)		
No	70.91% (139)	33.73 (4.56)			20.54 (5.64)			16.85 (5.68)		
Emergency Department			-.20	.845		-.73	.805		-1.86‡	.064
Yes	32.14% (63)	33.94 (4.37)			21.05 (5.71)			18.52 (5.93)		
No	67.85% (133)	33.80 (4.43)			20.43 (5.51)			16.92 (5.46)		
PICU			-.75	.452		-1.13	.225		-1.12	.266
Yes	35.71% (70)	34.14 (3.69)			21.23(4.58)			18.04 (5.29)		
No	64.28% (126)	33.68 (4.75)			20.29 (6.03)			17.10 (5.84)		
NICU			.86	.392		.53	.596		.20	.840
Yes	18.87% (37)	34.41(4.18)			20.19 (4.70)			17.27 (5.21)		
No	81.12% (159)	33.72 (4.45)			20.73 (5.76)			17.48 (5.77)		
Specialty Inpatient			1.48	.141		-1.80‡	.073		-.73	.468
Yes	22.95% (45)	33.00 (5.28)			21.93 (6.04)			17.98 (5.47)		
No	77.04% (151)	34.10 (4.08)			20.24 (5.37)			17.28 (5.71)		
Radiology			-.93	.355		-.30	.764		-.29	.769
Yes	21.42% (42)	34.40 (4.04)			20.86 (5.46)			17.67 (5.82)		
No	78.57% (154)	33.69 (4.49)			20.56 (5.61)			17.38 (5.63)		
Outpatient			-.78	.436		.85	.397		.38	.707
Yes	37.75% (74)	34.16 (4.64)			20.18 (6.15)			17.24 (5.96)		
No	62.24% (122)	33.66 (4.25)			20.90 (5.19)			17.56 (5.48)		
General Pediatrics			-.21	.833		1.00	.320		.51	.614
Yes	15.81% (31)	34.00 (3.83)			19.71 (4.08)			16.97 (5.47)		
No	84.18% (165)	33.82 (4.51)			20.80 (5.80)			17.53 (5.70)		

Note. ‡ $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$

Participants' reported use of approach coping strategies, particularly active coping, emotional support, and reframing, were associated with higher likelihood of compassion satisfaction but not associated with risk of compassion fatigue or burnout. Overall, approach coping was positively associated with likelihood of compassion satisfaction, and *acceptance* and *planning* were positively associated with compassion fatigue. Acceptance strategies included statements such as "I've been learning to live with [hardship at work]" and may suggest that helping professionals experiencing apathy or disengagement, often associated with compassion fatigue, may feel a lack of control or energy to change aspects of their work they find draining. Likewise, failed attempts to control situations by excessive planning may increase risk of compassion fatigue.

Child life specialists who reported more avoidant coping tended to report lower likelihood of compassion satisfaction and higher risk of burnout and compassion fatigue. This was particularly true of venting, although other avoidant strategies including distraction, self-blame, and denial were positively correlated with risk of burnout and compassion fatigue. This suggests avoidant strategies may not be as effective as approach strategies in promoting professional quality of life for child life specialists, which supports previous literature specific to coping with trauma (Arble et al., 2018; Arble & Arnetz, 2016; I. Thompson et al., 2014). Conversely, burnout or compassion fatigue might lead professionals to use avoidant coping strategies such as venting or self-blame.

The current study revealed significant positive correlations between frequency of consultation with colleagues and both compassion satisfaction and use of approach coping. Seeking support from a multidisciplinary team may serve as a protective factor and source of effective coping. This corresponds with findings from Hoelscher and Ravert's (2021) study on burnout in child life, which found that positive relationships with others on the medical team were protective against emotional exhaustion.

Hematology/Oncology Unit

Consistent with Fisackerly et al.'s (2016) findings, the current study found that child life specialists who worked in hematology/oncology had a higher risk for compassion fatigue than those who did not work on the unit. Among child life specialists on the hematology/oncology unit, there was a positive association between approach coping and likelihood of compassion satisfaction and a negative association between approach coping and risk of burnout. Taken together, the use of approach coping seems especially important among child life specialists in the hematology/oncology unit. Further research should investigate the unique stressors on various units and the efficacy of specific coping strategies for each.

Limitations

Although these findings have implications for the child life field, the study is not without limitations. The sample was relatively small and mostly homogenous in terms of race and gender, which largely reflects the lack of diversity in the child life profession. This study only targeted Certified Child Life Specialists currently in practice, therefore not accounting for retired professionals or those who may have left the field due to compassion fatigue or burnout. The study took place during the COVID-19 pandemic, which may have influenced reports of stressors and coping. Another limitation of this study was assessment of consultation and supervision using single-item measures that may have been subject to idiosyncratic variation (Schutt, 2012). Future studies should assess multiple dimensions of consultation and supervision. Finally, the authors used a subset of the ProQOL measure to assess professional quality of life, which could have contributed to impaired reliability or validity of the measure and makes comparisons with previous studies more challenging.

Implications for Practice and Future Research

Despite the limitations, the current study has significant implications for the field of child life. Implementing education that focuses on professional well-being, effectively managing stress, and using approach coping strategies will promote improved professional quality of life for child life specialists. Mentorship programs to increase opportunities for debriefing and reflective practice may be particularly important for child life specialists who do not have access to formal supervision. Previous studies indicate lack of regular access to supervision is a risk factor for compassion fatigue (Killian, 2008), yet about half the participants in this study reported never receiving supervision from another child life specialist.

Supervision, support from colleagues, and other professional consultation opportunities may serve as potential areas of intervention to address compassion fatigue and burnout. Future qualitative studies should further explore child life specialists' perceptions related to the amount and quality of supervision they receive, allowing for greater understanding of the risk for and experience of compassion fatigue and burnout among child life specialists and possible protective factors that may promote compassion satisfaction. Ultimately, prioritizing professional quality of life for child life specialists promotes longevity in the field and delivery of high-quality, family-centered care.

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