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Professional Quality of Life: An Examination of Compassion Fatigue and Compassion  
Satisfaction in Athletic Trainers

A Thesis

Presented to the Faculty of the  
Department of Sports Medicine  
West Chester University  
West Chester, Pennsylvania

In Partial Fulfillment of the Requirements for the  
Degree of  
Master of Science

By

Tina E. Riordan, LAT, ATC

May 2020

## Dedication

This work is dedicated in the loving memory of my grandparents. I will forever be grateful for the endless support and now guidance from up above. I miss you both tremendously. I hope I am making you proud.

## Acknowledgements

To my thesis committee, thank you for your support, guidance, and insight throughout this process. Dr. Lindsey Keenan, your love and passion for this field has shown me the path for my future academic work, and for that I am forever indebted for. Emily Duckett, thank you for being my role model and having the most caring heart. People like you are few and far between. Dr. Alison Gardiner-Shires, thank you for your support both inside and outside the classroom. You have shown me the true meaning of work-life balance. The mentorship the three of you have given me during my time here has impacted me greatly.

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To my brothers and forever friends- John and Chris. Thank you for being my biggest supporters. No matter what happens in our lives, I'm glad we still have each other. "We'll be ok. Lean upon me. I'll lean upon you. We'll be ok". – Dave Matthews Band

## Abstract

**Context:** Compassion Fatigue is prevalent in many health care professions; however, prevalence in athletic trainers have not been examined. Given the high rate burnout and excessive demand placed upon those employed in athletic training profession, there is a need to examine the overall professional quality of life in order to identify compassion imbalances that may affect both patient care and personal well-being. **Methods:** A total of 293 clinically active National Athletic Trainers' Association (NATA) members (33.4% male, 66.6% female) completed a demographics questionnaire along with the Professional Quality of Life-21 (ProQOL-21) survey provided via Qualtrics online software. Descriptive statistics were used to determine the prevalence of the professional quality of life scales including compassion satisfaction and compassion fatigue, and a Pearson's Correlation was conducted to examine the relationship between these two factors. **Results:** More than half the participants (55.3%, n = 162) experienced an average level of compassion fatigue, while another 25.6% (n = 81) of participants were categorized as experiencing high compassion fatigue. Similarly, half of the participants (53.6%, n = 157) experienced average compassion satisfaction. The bivariate correlation analysis indicated a significant, negative relationship between compassion fatigue and satisfaction,  $r = -.377$ ,  $n = 293$ ,  $p = .001$ . **Conclusions:** Athletic Trainers experience average satisfaction in their clinical compassion when providing care to patients; however, compassion fatigue is also prevalent in this profession. Additional research is warranted to further investigate this relationship in athletic training and examine both prevention and causes of compassion fatigue.

**Word Count:**250

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## CHAPTER I

### INTRODUCTION

Healthcare employees embrace the caregiving responsibilities necessary to help promote the improvement, quality of life and general outcome of individuals they encounter. In certain environments, this giving nature may affect the individual personally, therefore impacting their overall quality of life both positively and negatively. When taking into consideration the positive and negative aspects of being in the healthcare field, the Professional Quality of Life (ProQOL) measure may be considered (Stamm, 2010). Examining the emotional balance of oneself, the ProQOL helps determine any reflective behaviors due to the emotional impact of ones' care-giving job.

The desire to provide care and connect with a patient serves as a driving factor of the behaviors of many health care workers. In conjunction with the desire to help, the individual experiences a sense of derived personal fulfillment of helping others. This concept can be further expressed through compassion satisfaction (CS). Although many professionals experience the positive impacts of their profession, there is a risk for the caregiver. Contrary to compassion satisfaction, the ProQOL identifies compassion fatigue (CF) as a negative component that may be experienced due to their caregiving role.

Healthcare professionals whom experience repeated exposures to personal exhaustion and depletion along with patient injury, trauma, illness, and impairment may be at a higher risk of what is known as compassion fatigue. To better understand this phenomenon, CF has been described as the "cost of caring" (C.R. Figley, 1995). Literature has determined the experiences of burnout

(BO) and secondary traumatic stress (STS) influence the caregivers experience of CF (Stamm, 2010).

Due to the giving nature of these individuals and the working environment, there may be more susceptibility to experience burnout (BO) (S. M. Mazerolle et al., 2018). This phenomenon is characterized by chronic emotional exhaustion and depletion of oneself psychologically (C. Maslach & Jackson, 1981). This emotional response may callous and dehumanize oneself and his or her ability to provide the compassionate care that was previously accomplished. This concept of job stress serves as a subcomponent of CF. Along with the negative interpersonal relationship with ones job witnessed in BO, the exposure to a patient's trauma serves as the other component of CF.

Providing aid to those who have suffered trauma can compromise the ability of the provider to accomplish quality patient care (Bride, Radey, & Figley, 2007). Involved in a care-giving occupation, health care workers frequently come into contact with individuals whom have experienced either trauma or distress. This phenomenon is identified as secondary traumatic stress (STS). This exposure to the patient's traumatic state along with the emphasis of compassionate care may deplete the workers ability to emotionally manage and cope with the situation.

As the experience of BO and STS are experienced throughout ones care-giving duties, the overall experience of CF will be further impacted. Researchers have evaluated compassion fatigue among health care professions such as nurses (Harris & Griffin, 2015; Hunsaker, Chen, Maughan, & Heaston, 2015; Mangoulia, Fildissis, Koukia, Alevizopoulos, & Katostaras, 2011), mental health workers (Fiona Cocker & Nerida Joss, 2016), social workers (Gregory, 2015), physical therapists (Klappa SG, 2015), and many more. Studies have shown that across health care provider

groups, the average levels experienced are average levels of CF and high levels of CS (Cavanagh et al., 2019).

The demands placed upon an athletic trainer, both personally and professionally are evident through previous research. Known for their multi-variability in roles, athletic trainers provide medical services for multiple teams, attention to individual patients, clinical care, administrative responsibilities, and, often, teaching or student supervision (S. M. Mazerolle et al., 2018). Due to this working environment, athletic trainers may be more prone to experience burnout. Established in early literature, it was shown that time commitment, low salary, limited advancement, and administrative and coaching conflicts influenced burnout and an athletic trainers decision to leave the profession (Capel, 1986).

Along with the experience of BO, athletic trainers also witness traumatic events. Within the athletic training profession, one study by Estock and Simon (2018) examined the prevalence of catastrophic events among athletic trainers. Through this study it was concluded that more than half of the participants reported providing care to an athlete whom was exposed to a catastrophic event (Estock & Simon, 2018) It is through this working environment of high demands and traumatic events that an athletic trainer may experience both the positive and negative aspects of being a first responder in the healthcare field.

### *Purpose of the Study*

The purpose of this study is to examine the overall professional quality of life within the athletic training profession. As part of the healthcare profession, athletic trainers utilize their knowledge and skills to improve the quality of life of others, with the possible consequence of affecting their own quality of life. Specifically, compassion fatigue is prevalent in many health care professions, however prevalence in athletic trainers has not yet been examined. Given the

high rate of burnout and the high demand placed upon those employed in the athletic training profession, there is a need to examine the overall professional quality of life, in order to identify compassion imbalances that may affect both patient care and personal well-being.

### *Research Questions*

1. What is the prevalence of compassion fatigue in athletic trainers?
2. What is the prevalence of compassion satisfaction in athletic trainers?
3. What is the relationship between compassion fatigue and years of athletic training experience in clinically-active athletic trainers?
4. Is there a difference in the components of the Professional Quality of Life between athletic training settings?
5. Is there a relationship between compassion fatigue and compassion satisfaction in athletic trainers?

### *Hypotheses*

1. Athletic trainers experience a moderate level of compassion fatigue.
2. Athletic trainers experience a high level of compassion satisfaction.
3. There is a positive relationship between compassion fatigue and years of athletic training experience in clinically-active athletic trainers.
4. There will be a difference in compassion fatigue between athletic training settings.
5. There is a negative relationship between compassion fatigue and compassion satisfaction in athletic trainers.

### *Assumptions*

1. It was assumed that each participant provided honest and truthful answers to all questions in the survey.
2. The collected responses accurately reflect the individual's perception of his or her professional quality of life

### *Limitations*

The following factors may have generated an impact on the outcomes of this study

1. This study was limited to athletic trainers who maintained an active NATA membership. Consequently, this does not represent the true population of athletic trainers in totality.
2. The ProQOL-21 measurement tool has been under-utilized in the research field; therefore it may showcase a different reliability measure compared to previously used measurement tools.
3. The online survey-based response may not represent a fair depiction of the selected representative sample.

### *Operational Definitions:*

1. Professional Quality of Life- “the quality one feels as a result of their work as a helper” (Stamm, 2010, p. 8)
2. Compassion Satisfaction- “the pleasure you derive from being able to do your work” (Stamm, 2010, p. 12)
3. Compassion Fatigue – “The negative aspect of our work as helpers” (Stamm, 2010, p. 21)

4. Burnout- A psychological syndrome of exhaustion, cynicism and inefficacy, which is experienced in response to chronic job stressors (C. Maslach & Leiter, 2007)
5. Secondary Traumatic Stress- “work-related, secondary exposure to extremely stressful events” (Stamm, 2010, p. 13)

*Significance of Study:*

Currently, there are many studies focusing on the concept of Professional Quality of Life within other health care professions. However, further use of the measurement tool (ProQOL-21) utilized in this study is needed, in order to establish its reliability across multiple other health care professions. Results of the study may be used to help further promote and advocate the field of athletic training. With no available literature, athletic trainers have limited awareness of ProQOL compared to other professions. This study will serve as a start to the growing body of knowledge of this phenomenon in the athletic training profession. Further, these findings may serve as a foundation to help build upon prevention strategies, management protocol and a treatment plan for compassion fatigue.

## CHAPTER II

### REVIEW OF THE LITERATURE

#### *Professional Quality of Life*

Within the workforce, individuals offer skills to accomplish tasks and improve the working environment he or she is in. Many employees begin to experience negative and positive impacts due to the job and the work it entails. Entities who provide their skills in a helping matter have been shown to experience these negative and positive impacts more frequently (Stamm, 2005). In order to better understand this phenomenon, the professional quality of life can be considered.

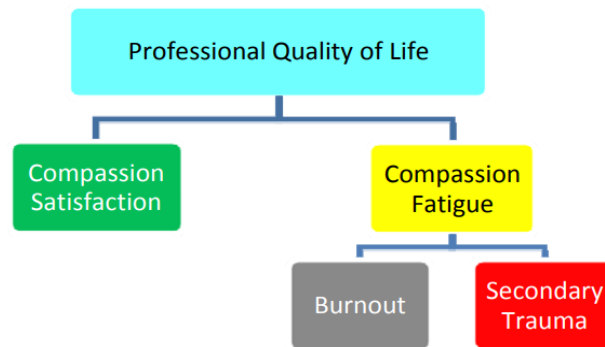


Figure 1: Diagram of Professional Quality of Life (Stamm, 2010)

Defined as “the quality one feels in relation to their work as helper” (Stamm, 2010, p. 8), the professional quality of life takes into consideration the aspects of those who experience an unfortunate illness, trauma, or suffering due to providing care-giving efforts to others. This concept provides efforts into showcasing an understanding of improving the ability to help the patient, along with balancing the needs of oneself. (Stamm, 2010).



The utilization of this ProQOL concept encompasses the importance of compassion and its effect on the helper. This phenomenon is developed by two components, compassion satisfaction (CS) and compassion fatigue (CF). Compassion fatigue is further comprised of subscales consisting of burnout and secondary trauma (Stamm, 2010). It is important to note that the ProQOL is important for both the individual providing care and the recipient, as there is a balance of care (Todaro-Franceschi, 2013). The foundation of the Professional Quality of Life concept can be further depicted in Figure 1.

Due to the complexity of the ProQOL concept, a theoretical path analysis can be utilized to examine contributing factors to the positive and negative outcomes of care giving. The three environments identified are work environment, client/person helped environment, and the personal environment (Stamm, 2010). These three environments will contribute to the care givers' overall CS and CF (Stamm, 2010). The framework of this analysis is represented in Figure 2.

The theoretical path analysis further explains the complex relationship between CS and CF. This illustration (Figure 2) allows the understanding that one may experience both CS and CF due to the three contributing factors. For example, a care giver may experience CF due to the contribution of a poor working environment, however despite the poor working environment, the individual could experience CS due to their positive experience of helping others (Stamm, 2010).

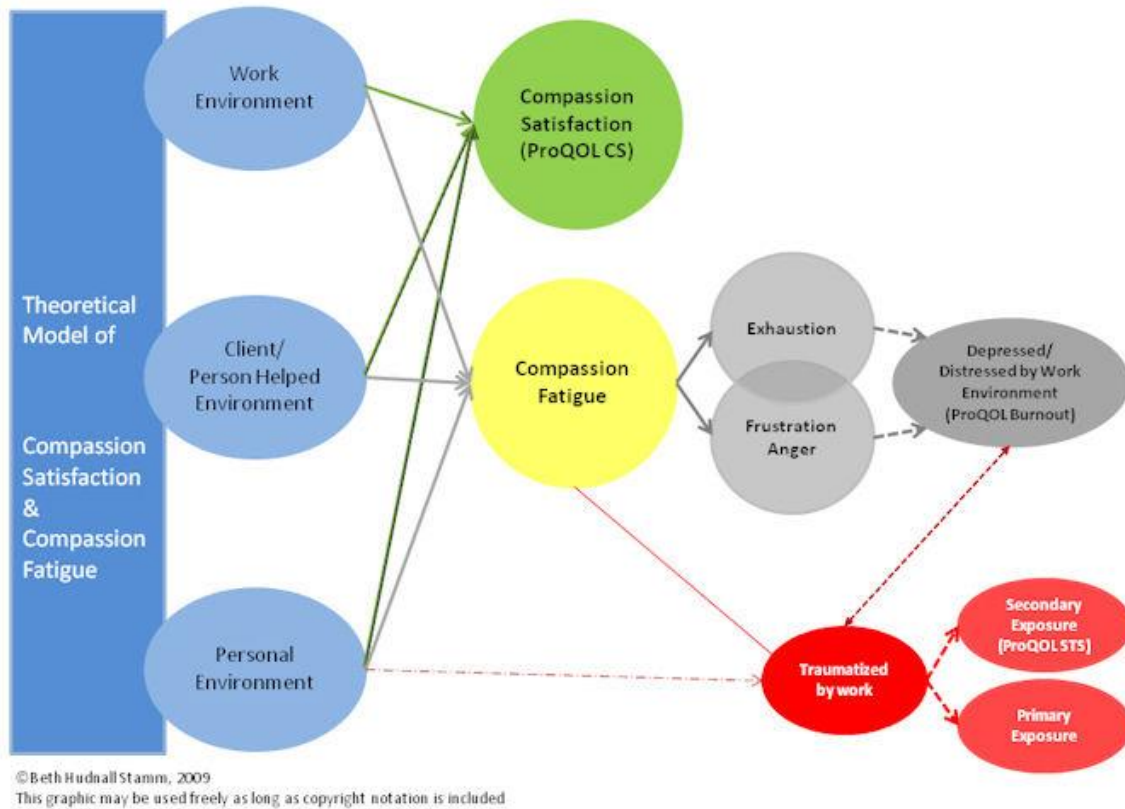


Figure 2. The Theoretical Model of Compassion Satisfaction and Compassion Fatigue (Stamm, 2010)

### *Compassion*

The utilization of the professional quality of life concept allows an attempt to balance the negative and positive aspects of these roles, which entails the foundation of compassion satisfaction and compassion fatigue. Compassion is defined as “a virtuous response that seeks to address the suffering and needs of a person through relational understanding and action” (Sinclair et al., 2016, p. 19). This characteristic lies at the core of the meaning of human existence, as this gift from within is deep rooted within an individual (Himmelfarb, 2001).

This concept is further is marked by three elements: (1) noticing another’s suffering, (2) emotionally feeling and connecting through perspective and empathy, and (3) reacting through

active attempts to alleviate the suffering (Kanov et al., 2004; Way & Tracy, 2012). A more recent study concluded that compassion is further involved by a total of five elements: recognizing suffering in another individual, understanding the common humanity of suffering, feeling emotionally connected with the person who is suffering, tolerating difficult feelings that may arise, and being motivated to help the affected person (Strauss et al., 2016)

### *Compassion in Health Care*

Compassion serves as an evident keystone to the healthcare profession and the broad array of environments that it encompasses. The first principle of the American Medical Association Code of Ethics state “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights” (Riddick, 2003, p. 9). Individuals typically embark in the caregiving field because compassion is individually deep rooted within (Yoder, 2010). Healthcare professionals embody the skillset and commitment to relieve suffering through their compassionate response.

Further exploring this key concept of compassion in clinical care, the compassion model can be considered (Sinclair et al., 2016). In 2016, a qualitative analysis through the use of semi-structured interviews brought forth seven categories that serve as the first empirically based clinical model of compassion (Sinclair et al., 2016). The elements of these yielded categories can be seen in Figure 3. The relationship between each category and the contained themes provides further insight into the foundation of patient-clinician relationships and the values of quality care.

Categories	Themes	Sub-themes
Virtues	Genuineness	
	Love	
	Openness	
	Honest	
	Authenticity	
	Care	
	Understanding	
	Tolerance	
	Kindness	
	Acceptance	
Relational Space	Patient awareness	
	Engaged caregiving	
Virtuous Response	Knowing the person	
	Person as a priority	
	Beneficence	
Seeking to Understand	Seeking to understand the person	
	Seeking to understand the person's needs	
Relational Communicating	Demeanor	Non-verbal
		Tone
		Outlook
		Intent
	Affect	Expressed Affect
		Attentive stance
	Behaviors	Physical displays of caring
		Listening and supportive words
		Showing respect
	Engagement	Acknowledgment of the person and the situation
		Attentive
		Dialogue
	Compassion related needs	Physical comfort
Spiritual		
Emotional		
Disease and Treatment		
Family		
Financial		
Timely		
Action		
Patient Reported Outcomes	Alleviates suffering	
	Enhances wellbeing	
	Enhances care	

Figure 3. Elements of Compassion (Sinclair et al., 2016)

### *Compassion Satisfaction*

The concept of compassion satisfaction (CS) is further elaborated as the positive aspect of working as a helper (Stamm, 2010). These intrinsic benefits further enhance the care a helper may provide. A health care employee's inclination to provide help to an individual in turn serves as a sense of pleasure to oneself personally due to their work (Stamm, 2010). This positive outlook about one's work effectiveness helps impact one's level of compassion satisfaction (Stamm, 2010). Along with the positive feelings of one's work, the ability to help others, and the impact of one's work can impact CS (Stamm, 2010). Within the health care field, compassion satisfaction may be an overlooked attribute to a strong patient and clinician relationship.

Those whom embark in the health care field select this path due to the desire and passion of helping another individual. According to previous studies, "The core competence for all care providers and all care giving is the capacity for and the ability to develop empathy" (LaRowe, 2005, p. 11). A valuable service is provided when being the care taker of someone's health and can be viewed as "sense of fulfillment derived from seeing clients suffer less and watching them transform from the role of victim to survivor" (Radey & Figley, 2007, p. 208).

An individual may experience personal fulfillment of being able to offer care. However, this positive influence may present with contrary effects (CF) despite personal fulfillment. Previous research has shown that increased levels of compassion satisfaction promoted lower levels of the components of compassion fatigue (Ray, Wong, White, & Heaslip, 2013; Thieleman & Cacciatore, 2014). This concept serves a counterbalance to the negative effects experienced through the CF component.

## *Compassion Fatigue*

In contrast to compassion satisfaction, compassion fatigue (CF) is also a term utilized in many medical professions. First introduced in the nursing field (Joinson, 1992), the prevalence of this term has increased throughout many health care professionals. Within the early stages of understanding, the term was further defined as the loss of the “ability to nurture due to repeatedly caring for patients in life-altering or life threatening situations” (Joinson, 1992, p. 121). This concept was further developed by Figley (1995) and was focused on the emotional impact of caregivers in the trauma setting (C.R. Figley, 1995). Due to increased knowledge, CF accompanies various interpretations and definitions since being originally established.

As further research was conducted, two distinctive components of CF were identified (Stamm, 2010). Compassion fatigue can be described through two components: secondary traumatic stress and burnout. Secondary traumatic stress takes into consideration exposure to patients whom experienced traumatic events, while burnout is associated with altered negative emotions due ones’ work (Stamm, 2010).

Compassion fatigue was originally considered as an interchangeable term with secondary traumatic stress (STS) and vicarious trauma (C.R. Figley, 1995), however through increased research, these terms have been separated and are no longer recommended to being used synonymously (Stamm, 2010). For the purpose of this research, STS and compassion fatigue will not be viewed as the same phenomenon and both will be used independently.

Further investigating CF, burnout (BO) played a large factor in the development of this phenomenon (C.R. Figley, 1995). This state of physical, emotional and emotional exhaustion has been shown to present itself through long-term emotionally impacting situations (Malach-Pines,

2005). In addition to these experiences of depersonalization, BO has shown to impact ones sense of personal accomplishment and discourage the employee within the work setting (C. Maslach & Jackson, 1981). This in turn, may influence ones level of personal fulfillment and level of CS.

Since then CF has advanced into definitions that provide a greater understanding. Compassion fatigue is considered “the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients, the use of self, and the exposure to stress” (Coetzee & Klopper, 2010, p. 237). This emotional and spiritual exhaustion leads to an insidious decline in the individuals aspiration and capability to care for other individuals (McHolm, 2006). These caring individuals may sacrifice their own personal well-being in order to aid those whom are suffering (Bride et al., 2007).

Often referred to as “the cost of caring”(C.R. Figley, 1995), this state of CF is often caused by taking on emotionally the suffering of others. Four factors that further play a role in the contribution of compassion fatigue are poor self-care, previous unresolved trauma, inability of refusal to control work stressors, and a lack of satisfaction for the work (C.R. Figley, 1995).

Symptoms that can arise from compassion fatigue include emotional responses such as emotional and physical exhaustion, despair, depersonalization, grief, anger, high stress, reduced ability to be empathetic and compassionate, and a decreased sense of personal accomplishment (Newell & MacNeil, 2010; Stamm, 2010; Tehrani, 2007). As per the Compassion Stress and Fatigue Model (C. R. Figley, 2002), an identification of variables were determined and the role they play on compassion fatigue. The 10 variables can be seen in Figure 4.

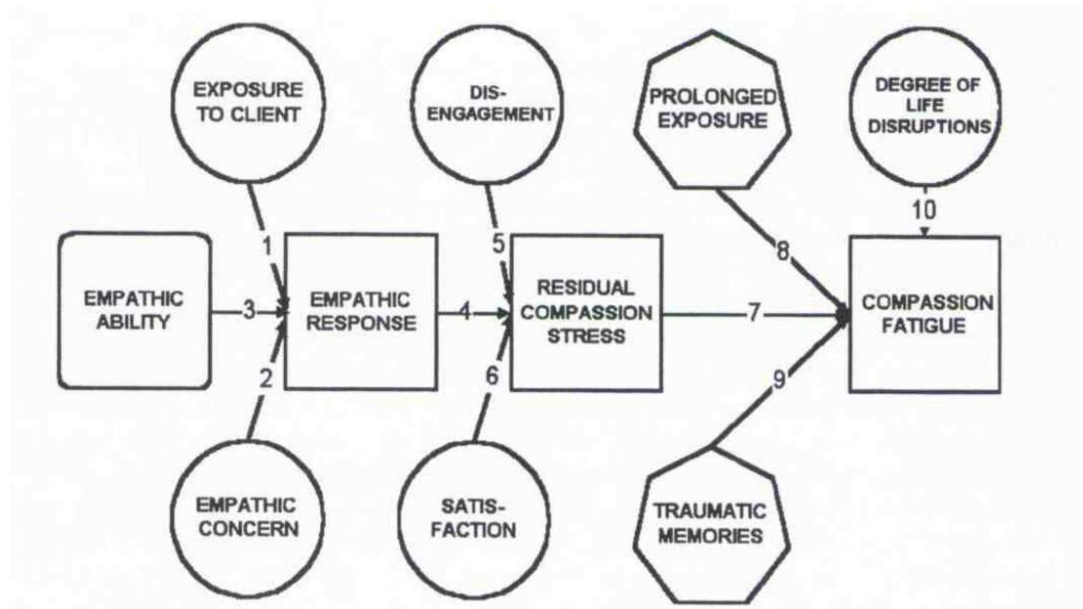


Figure 4. Compassion Stress and Fatigue Model

### *Compassion Fatigue in Health Care Professionals*

As described above, CF develops from repeated care to an individual who is experiencing a sense of traumatic injury or suffering along with emotional depletion. In regards to this definition, many individuals involved in the health care field can experience CF due to the empathy they display. One's role in the health care field is to provide care and support to those who are suffering in a demanding environment; however, this role may cause someone to fall victim to their compassionate personality.

The concept of compassion fatigue is further explained by one of the original researchers of the phenomenon by expressing, the emotional connection encountered by some within the helping profession (C.R. Figley, 1995). Elaborated in a personal manner, Dr. Charles Figley (1995) states “We have not been directly exposed to the trauma scene, but we hear the story told with such intensity, or we hear similar stories so often, or we have the gift and curse of extreme



empathy and we suffer. We feel the feelings of our clients. We experience their fears. We dream their dreams. Eventually, we lose a certain spark of optimism, humor and hope. We tire. We aren't sick, but we aren't ourselves" (C.R. Figley, 1995). Compassion fatigue begins to erode on an individual's personal self and his or her ability to serve their care giving skills.

### *Compassion Fatigue in Nurses*

Compassion Fatigue has been explored in various professions; however, an abundance of studies is seen within the nursing profession. Originally brought to the attention of the health care field, Joinson (1992) showcased that due to those conditions a realization was made that the care givers ability to nurture was at risk and compromised (Joinson, 1992). Within the nursing profession compassion fatigue has been described as "a state of significant depletion or exhaustion of the nurse's store of compassion, resulting from repeated activation over time of empathic and sympathetic responses to pain and distress in patients and loved ones"(Pembroke, 2016, p. 120).

Compassion fatigue has been known to result from increased emotional giving over time, given by the nurse to the patient, that ultimately causes an incapability to maintain a well balance of empathy and objectivity (Aycock & Boyle, 2009). This physical, emotional, and spiritual imbalance causes an individual to personally fatigue and lose his or her ability to experience joy and provide the quality of care previously given (Worley, 2005). It has been shown that if there is no identification and treatment of this imbalance, this will in turn perpetually alter the capability to provide compassionate care (Coetzee & Klopper, 2010). This decrease in personal well-being and work quality serves as a concern within the health care profession as it suggests a decrease in quality of patient care.

## *Compassion Fatigue in Athletic Trainers*

Athletic Trainers encompass many different roles within the healthcare profession while providing patient care for a single patient within a long duration. Similar to those in other health care professions, athletic trainers showcase a tendency of self-sacrifice in regards to their well-being when taking care of others. The profession of athletic training is established through a field concerned with the health, care and safety of the athlete (Prentice, 2003). Further serving as the cornerstone of the profession, compassion is evident within the National Athletic Trainers' Association (NATA) Code of Ethics. Compassion is described in the first principles of ethical behavior as "members shall practice with compassion, respecting the rights, wellbeing, and dignity of others" (NATA, 2019).

The professional membership association, National Athletic Trainers' Association is an established entity within the athletic training profession. Dictating the month of March as National Athletic Training month, the NATA utilizes this celebration as a way to help increase awareness about the profession and to show gratitude towards those who carry the board certification. In efforts to impact knowledge of the profession, the released slogan of March 2018 was "Compassionate Care for All". Presenting the public with the understanding of the role of an athletic trainer, they also were able to present the underlying but epitomized compassion that one showcases within this role.

In many environments, the athletic trainer typically holds the main responsibility of the delivery of care and the well-being of the patients. This role, responsibility, and impact an athletic trainer has renders concern of their personal well-being in regards to compassion fatigue. While there is an increased awareness of compassion fatigue and information provided within

the literature(De La Rosa, Webb-Murphy, Fesperman, & Johnston, 2018), there is a lack of research in regards to compassion fatigue within the athletic training profession.

### *Secondary Traumatic Stress*

Secondary traumatic stress (STS) serves in conjunction with burnout (BO) to creates the foundation of the compassion fatigue phenomenon. Trauma can be experienced through a stressful response both in a primary and secondary exposure (C.R. Figley, 1995). Secondary traumatic stress is "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person" (C.R. Figley, 1995, p. 7). This can be experienced through intrusive imagery, avoidance, distressing emotions, cognitive changes, hyperarousal and functional impairment (C.R. Figley, 1995).

Although the individual did not directly experienced the trauma, through exposure to the conversation or physical evidence of the event repercussions, this can impact an individual's well-being. Absorbing the emotional weight of the trauma patient can further lead to impacting a decline in one-self personally. This prolonged exposure to the trauma and loss experienced by a patient may cause an integration of these emotions to the personal emotions of the giver (Bush, 2009).

### *Secondary Traumatic Stress in Athletic Trainers'*

Within the athletic environment, athletic trainers are normally the first responder to an athlete's injury. Experiencing and working closely with these injured athletes, athletic trainers often witness the consequences of the trauma (Estock & Simon, 2018). Established within the major practice domains of athletic training, immediate and emergency care serves as a priority

within the profession (Prentice, 2003). Further, guidelines are discussed in position statements through the National Athletic Trainers' Association (NATA) to help recommend management of traumatic events. These statements include guidelines of preventing sudden death (Casa et al., 2012), emergency planning (Andersen, Courson, Kleiner, & McLoda, 2002), managing acute cervical spine injuries (Swartz et al., 2009), exertional heat illness (Casa et al., 2015), concussions (Broglia et al., 2014), and disqualifying conditions (Conley et al., 2014).

During a recent reporting year (2017), the National Center for Catastrophic Sport Injury Research (NCCSIR) presented findings of a 20% increase of catastrophic athletic events compared to the 2015/2016 reporting year (NCCSIR, 2017). Further investigating, Estock (2018) concluded athletic trainers who offered care to athletes in traumatic situation were impacted personally. It was found that these athletic trainers had an increased likelihood of experiencing a lack of personal accomplishment and emotion-oriented behaviors (Estock & Simon, 2018). This study also produced findings that athletic trainers who were exposed to a catastrophic event were likely to experience higher levels of a syndrome known as burnout.

### *Burnout*

Serving as a common reaction of many people in today's society, stress can function as a trigger of adverse physical and emotional responses. To further express this phenomenon, the burnout syndrome has been established. First elaborated on in 1974 by Freudenberger, the decline of personal motivation and overall patient care began to become noticed within his own office staff (Freudenberger, 1974).

Common elements that were found to be considered to be the core symptoms of burnout are as follows: (1) there is a predominance of dysphoric symptoms such as mental or emotional

exhaustion, fatigue and depression. (2) The emphasis is on mental and behavioral symptoms more than physical ones. (3) Burnout symptoms are work-related. (4) The symptoms manifest themselves in “normal” persons who did not suffer from psychopathology before. (5) Decreased effectiveness and work performance occur because of negative attitudes and behaviors (C. Maslach & Schaufeli, 1993).

Since first elaborated multidimensional syndrome was then further developed into being comprised of three parts: emotional exhaustion, depersonalization and decreased personal accomplishment in order to help further delineate the term (C. Maslach & Jackson, 1981). Emotional exhaustion takes into consideration the individuals reaction to the stressors the job encompasses. This stimulates one to emotionally and cognitively distanced from his or her work, as a way to cope with the work overload that is experienced (C. Maslach, Schaufeli, & Leiter, 2001). Describing the interpersonal response of the chronic stress a helper experiences, depersonalization or cynicism, showcases the detachment between client and patient relationships. This will greatly impact their ability to build the client-patient bond and trust. In turn, the concept of decreased personal accomplishment describes the self-evaluation response where an individual will judge the quality of work that they previously experienced enjoyment from (C. Maslach et al., 2001)

To further investigate the role of burnout in regards to ones working environment, six categorical areas can be referred to: workload, control, reward, community, fairness, and values (C. Maslach & Leiter, 2007). Within the working environment, individuals whom partake in a people-oriented profession may showcase increased risk to burnout (C. Maslach & Goldberg, 1998). This may be due to the idea that care-giving occupations hold a tendency to be selfless and put ones needs before those of their own (C. Maslach & Goldberg, 1998). These individuals

have also been shown to participate in an increased amount of work hours to go exhaust all abilities to help a client (C. Maslach & Goldberg, 1998).

Stemmed from the giving nature, health care providers may experience burnout that is facilitated through overload, prolonged stress and feelings of be undervalued and underappreciated within their work environment (S. M. Mazerolle et al., 2018). To further identify the foundation of burnout it was shown, “psychological stress is a perceived imbalance between environmental demands and one’s coping resources, whereas burnout is a state of mental weariness, emotional exhaustion, negative or cynical attitudes toward people and a low level of job satisfaction” (Giacobbi Jr, 2009, p. 370).

This unrelenting experience of emotional exhaustion may lead to a calloused mind that could interfere with one’s personal well-being and relationship with patients. Although many occupations experience this phenomenon, those whom partake in a helping profession are more susceptible (Gieck, Brown, & Shank, 1982) This is problematic for health care employees as it impacts their ability to cultivate the compassionate and supportive bond with the individuals around them.

### *Burnout in Athletic Training*

Though some individuals in all health care professions may experience the burnout syndrome, it has been shown that each profession must be thought as individually in regards to the potential levels of burnout (Cooper, Dewe, & O'Driscoll, 2001). One of the first studies of burnout within the athletic training profession was evaluated in the 1980’s. It was determined then that athletic trainers experienced six major areas of stressors that influenced what was known as then as “burnout syndrome” (Gieck et al., 1982).

Defined by the National Athletic Trainers' Association, athletic trainers are considered "highly qualified, multi-skilled healthcare professionals" (NATA, 2019). Certified athletic trainers (AT's) encounter multiple roles within their profession. Through this role there is a collaboration with physicians to provide prevention, emergency care, clinical diagnosis, therapeutic interventions and rehabilitation or injuries and medical conditions(NATA, 2019).

Commonly seen in a "traditional" athletic setting (e.g. high school, college, university, professional), athletic trainers are also employed in physician offices, physical therapy clinics, industrial, hospitals, military settings, public service and many more (NATA, 2019). Within the traditional setting, athletic trainers are considered to serve as a critical link between athletics and medical community(Anderson, 2000). The athletic trainer serves as primary guidance to the athlete in regards to the direction of appropriate medical treatment (Schenck, 1997).

As a health care professional, athletic trainers prioritize the care of their athletes, similarly to other professions in the sports medicine field. A study supported the conclusion that athletic trainers provide the same level of value, outcomes, and patient satisfaction as seen in physical therapists (Albohm, 2001). However, cultivating a unique environment compared other sports medicine professionals, athletic trainers face many confounding factors that impact their ability to provide care.

This priority may be seen in addition to long work hours, continuing into their personal lives well after the work day is done. This level of involvement seen within the profession can present with highly stressful working environments along with emotionally impacting the individual which may potentially lead to early burnout (C. Maslach, & Jackson, S.E. , 1996). It was identified that committed time, low salary, poor working conditions, limited opportunities

for career advancement, and conflicts with coworkers also played a role into this negative experience within the profession (Capel, 1986).

Early research of the examination of burnout among athletic training identified the stressors that athletic trainers experience. These include: (1) The requirement to give emotionally without considering their personal well-being, (2) The stressful nature of the profession, (3) Multiple occurrences of overworking, (4) Environment that requires multiple decisions to be made and a maintenance of a difficult schedule, (5) Gender indifferences, (6) Inconsistency of what athletic trainers are allowed to do and what they are educated to do (Gieck et al., 1982)

In the work place, athletic trainers perform a wide variety of roles. This may include a wide variety of medical coverage for numerous teams, individual attention to athletes, clinical care, administrative responsibilities, and teaching or student supervision.

Along with performing the role of a caregiver, athletic trainers also serve other roles such as a parent, spouse, caregiver, employee, and homemaker (S. M. Mazerolle, 2005). This further provided the concept of work-life balance. The attempt to balance these roles together in both their professional and personal lives, a conflict of blending of these two environments does impose a demand on him or herself. It was shown that those whom establish a better work-life balance were able to prevent experiences of burnout (Kania, Meyer, & Ebersole, 2009).



## CHAPTER III

### METHODS

The purpose of this study was to examine the overall professional quality of life among certified athletic trainers (ATs). The data collected from the study was used to determine the prevalence of the two subscales of compassion satisfaction and compassion fatigue. The discussion of this chapter will be presented under the following headings: a) research design, b) participants, c) measures and instrumentation, d) general procedures, and e) analysis of data.

#### *Research Design*

A cross sectional quantitative research design was used to examine the outcome scores of compassion satisfaction and compassion fatigue in clinically employed athletic trainers. Independent variables included sex, age, race, level of education, employment setting, and years of experience as a certified athletic trainer. Dependent variables included scales of compassion satisfaction and compassion fatigue scores measured by the ProQOL-21.

#### *Participants*

For the purpose of this study, 3,000 certified athletic trainer participants were randomly selected from the National Athletic Trainers' Association (NATA) Research and Education Foundation (REF) membership database. The sample of participants who were solicited were individuals whom possessed an active membership with the NATA. This professional membership association maintains a database of individual members whom hold a certification

of athletic training and others who support the profession. A set of eligibility requirements were further structured. Eligible NATA member participants for this study included individuals whom were certified as an athletic trainer by the Board of Certification (BOC), working as a clinical athletic trainer. There were no restrictions placed upon gender, age, years of experience, or education level.

A list of names and email addresses for the 3,000 eligible participants was obtained through the National Athletic Trainers' Association public database and the Research Survey Request Application Form. The formal application included the following information: The title, purpose, and desired population of the proposed study, the institution where research was being conducted, and funding source of the study and the length of data collection. Documents consisting of a copy of the informed consent form, cover letter/email to survey audience, and Institutional Review Board (IRB) application and approval were also submitted (Appendix A). After the NATA research committee approval confirmation of this study, email addresses utilized through this membership were filtered by the NATA based on eligibility requirements to adhere to the inclusion requirements listed above.

Prior to the commencement of this study, the following procedures were reviewed and approved by the Institutional Review Board (IRB) at West Chester University of PA, for the protection of human subjects.

### *Measures and Instrumentation*

This study was comprised of two parts: a demographic questionnaire and the ProQOL-21 survey. Due to the preponderance in the literature, these two components were utilized to determine the outcomes of the study.

## Demographics

The first presented section of the utilized survey contained basic background information of each participant in order to collect demographic information of the athletic trainers. The information collected in this section included the respondents' age, sex, race, highest level of education, employment setting, years of experience and employment status (full time, part time, per diem).

## Professional Quality of Life Assessment

As individuals whom experienced compassion fatigue became more apparent within the literature, several standardized measurements were developed to assess this phenomenon through previous research. The ProQOL-21 measure was the assessment tool utilized in the present study. This quantitative assessment tool has been developed from past assessment instruments. This section will include the information and background regarding the primary tool utilized for this study.

Several versions of the ProQOL have been utilized in research studies in order to further investigate the components of an individual's professional quality of life. The Compassion Fatigue Self Test (CFST) is considered one of the first standardized measurements in which it assessed to subscales of compassion fatigue and burnout (Figley 1995). This instrument consisted of 40 items divided into two subscales: compassion fatigue and burnout. Continuing the concept of the CFST, the Compassion Fatigue Scale – Revised (CFS-R) was developed (Gentry, Baranowsky, Dunning, & Figley, 2002). However, this measurement had no report of reliability or validity (Gentry et al., 2002), along with numerous underlying issues through a psychometric study of the CFS-R (Adams, Boscarino, & Figley, 2006). The original CFST was

revised with an addition of “positively oriented questions paralleling the negative orientation of the compassion fatigue items” (Bride et al., 2007, p. 156). This measurement subsequently included three subscales: compassion fatigue, burnout, and compassion satisfaction. This concept of a positive aspect to compassion was further investigated in the ProQOL-5 (Stamm, 2005). All scales including the CFST, CFS-R, and ProQOL utilized the subscale of compassion fatigue in conjunction with secondary traumatic stress.

Compassion fatigue is further classified into two separate aspect consisting of Burnout (BO) and Secondary Traumatic Stress (STS) (Stamm, 2010). Within the measurement manual, information that identifies the obstacles separating burnout and secondary/vicarious trauma can be found, as they each hold a unique characteristic psychometrically and therefore should not be combined (Stamm, 2005). It is stated that this tool has established construct validity within the published literature (Stamm, 2010), however this remains uncited. Further data supporting the validity of this assessment tool has not been presented in the literature.

Due to the lack of validity of the ProQOL-5 found within the literature, a Rasch analysis procedure was completed by Heritage et al. (2018) to further investigate the construct validity. Through this Rasch measurement, there is an important placed “on whether the data collected from an instrument’s items provides an invariant representation of underlying ability or trait of interest” (Heritage, Rees, & Hegney, 2018, p. 3)

### The ProQOL-21

The Professional Quality of Life Scale-21 (ProQOL-21) is a revised version of Professional Quality of Life Scale (ProQOL). Based on a Rasch analysis procedure of the three

proposed ProQOL scales seen in the ProQOL-5 (Stamm, 2010) an alternative measure was created. The ProQOL-21 (Heritage et al., 2018), is comprised of a 21 item survey (Appendix E).

After completing the Rasch analysis, Heritage et al. (2018) concluded that, although support for the relevance of the ProQOL-5 was found, the burnout and secondary traumatic stress scales did not demonstrate appropriate measurement properties. (Heritage et al., 2018). This led to the combination of the burnout and secondary traumatic stress subscales to form a distinctive robust measure of compassion fatigue. Recoding, scoring and normed scores were provided for this singular measure. (Heritage et al., 2018).

It was determined through examining the monotonicity of the item response categories that revisions should be made through guidelines of category collapsing (Heritage et al., 2018). A 5 point Likert scale is utilized to score each item (1= Never, 2= Almost Never, 3= Sometimes, 4= Often, 5= Very Often), however each question was specifically calculated to represent any bias for differential item functioning and the potential mis-fitting items. This measure utilizes the cut-points presented in the ProQOL-5 (Stamm, 2010), while taking into consideration the item/scoring differences. These cut-points for compassion satisfaction include: Low (below the 25<sup>th</sup> percentile): 21 and below, Average (between the 25<sup>th</sup> and 75<sup>th</sup> percentile): 22-30, and High (above 75<sup>th</sup> percentile): 31 and above. The cut points for compassion fatigue include: Low: 16 and below, Average 17-25, and High: 26 and above.

The ProQOL-21 also utilizes the instructions described in the ProQOL-5 (Stamm, 2010). These instructions direct the respondent consider each of the presented questions about themselves and his or her current work situation. The selected responses should reflect the frequency of the specified questions within in the last 30 days. Further, the ProQOL-21 tool,

allows for word substitution for specified bracketed words in the survey. This allows to better specify the specific work context (Stamm, 2010). For the purpose of this study, word substitutions were used by inserting “athletic trainer” where specified for modifications.

### *General Procedures*

After gaining IRB approval, 3,000 eligible clinically working athletic trainers were invited via the NATA email data base to participate in this study. For data collection purposes, only one survey collection window was utilized. This consisted of a 4 week duration between the dates of 11/19/2019 – 12/17/2019. During the two week mark of the collection window, a follow up reminder email was distributed to the individuals whom received the first invitation email.

These emails included the initial email invitation to participate in the study (Appendix C). Information provided to the randomly selected individual included the purpose of the study, and a link to the web-page for the survey.

Each survey was administered using the web-based software system, Qualtrics. Upon the start of the comprised survey, an initial page cover letter was included. This initial page elucidated the instructions of the survey along with a participant informed consent (Appendix D). Participants could either electronically consent or opt out of the study. There was no compensation offered to individuals whom were solicited to participate in this study.

### *Data Analysis*

The statistical analysis of the received data was conducted using Statistics Program for Social Sciences Version 22.0 (SPSS). Data from the Qualtrics survey software was exported and imported into SPSS. Prior to importing the collected data, responses were removed if the participant failed to complete all questions within the ProQOL-21 survey.

Descriptive statistics were calculated based on collected demographic information which included means, medians, modes, frequencies and standard deviation. The computed demographic data consisted of the respondents' age, sex, ethnicity, highest level of education, employment setting, and employment status. Information regarding how each research question was analyzed can be located in Table 3.1.

Table 3.1

*Data Analysis*

<b>Research Question</b>	<b>Data Analysis</b>
What is the prevalence of compassion fatigue in athletic trainers?	Descriptive Statistics were computed to assess frequencies and percentages of athletic trainers in each scoring of compassion fatigue (low, average, and high).
What is the prevalence of compassion satisfaction in athletic trainers?	Descriptive Statistics were computed to assess frequencies and percentages of athletic trainers in each scoring of compassion fatigue (low, average, and high).
What is the relationship between compassion fatigue and years of athletic training experience in clinically-active athletic trainers?	A Pearson's correlation was completed to examine the relationship between total compassion fatigue scores and years of experience.
Is there a difference in the components of the Professional Quality of Life between athletic training settings?	A one-way ANOVA was completed to examine the ProQOL-21 mean scores between athletic training settings.
Is there a relationship between compassion fatigue and compassion satisfaction in athletic trainers?	A Pearson's correlation was completed to examine the relationship between the total compassion fatigue and compassion satisfaction scores.

## CHAPTER IV

### RESULTS

This study was conducted to examine the professional quality of life among clinically working athletic trainers utilizing the Professional Quality of Life -21 (ProQOL-21) survey tool. This chapter will be presented in the following sections: Participant demographics, Professional Quality of Life scores, and research questions.

#### *Participant Demographics*

Three thousand surveys were emailed to members of the NATA whom identified as a certified athletic trainer within the clinical field. A total of 2,999 (99.9%) emails were successfully delivered. At the cessation of the four-week response period, a total of N=323 (10.8% response rate) individuals participated and submitted a survey through the Qualtrics system. However, 29 (9.0%) participants provided incomplete data and were eliminated from the final analysis. The final data set consisted of 293 (9.8%) surveys, which were analyzed using statistical analysis. The participants' full demographics obtained through this study are shown in Tables 4.1 through 4.5.

Descriptive statistics were computed for all demographic variables included in the survey measurement. As previously noted in the discussion of participants, data consisting of 293 individuals whom successfully participated in the Qualtrics survey was analyzed. The participants' full demographics are shown in Tables 4.1 through 4.5. Ages of participants ranged from 22-84 years, with a mean age of 33.08 9.21; however, 37 (12.6%) of individuals did not



wish to identify their age. More than half of the participants ages ranged from 26-35 years (62.9%, n = 184). Table 4.2 presented the average age groups that participated in this study.

Table 4.1

*Gender Demographics*

<b>Gender</b>	<b>N</b>	<b>Frequency (%)</b>
Female	195	66.6
Male	98	33.4

Table 4.2

*Age Groups*

<b>Age (Years)</b>	<b>N</b>	<b>Frequency (%)</b>
20-30	113	38.6
31-40	117	39.9
41-50	4	1.4
Above 50	22	7.5

Table 4.3

*Ethnicity/Race of Participants*

<b>Ethnicity</b>	<b>N</b>	<b>Frequency (%)</b>
White	257	87.7
Black or African American	12	4.1
Multiracial	16	5.4
Asian or Asian Indian	4	1.4
Hispanic, Latino, or Spanish	4	1.4

Table 4.4

*Employment Status*

<b>Employment Status</b>	<b>N</b>	<b>Frequency (%)</b>
Full Time	258	88.1
Part Time	30	10.2
Unemployed	5	1.7

Table 4.5

*Years of Experience*

<b>Experience (Years)</b>	<b>N</b>	<b>Frequency (%)</b>
1-5	84	28.6
6-10	140	47.8
11-20	46	15.6
21+	23	7.4

The sample predominately specified having a further advanced degree (74.1%, n = 217). A total of 75 (25.6%) participants reported having bachelor’s degrees, 210 participants (71.7%) reported having master’s degrees, with the remaining 7 (2.4%) of participants reporting having doctoral degrees. One (0.3%) participant did not report the highest degree earned.

More than half of the participants reported working in the secondary school setting (53.9%, n = 158). Professional sports setting (n = 10, 3.4%) and College/University setting (n = 62, 21.2%) were combined to comprise an Elite Athletics category consisting of a total of 24.6% (n = 72) respondents’. These settings were combined for purposes of statistical analyses. Due to the low numeric value of participants in the professional setting (n= 10, 3.4%), and the most similarity of work setting compared to college/university work settings, these settings were combined for analyses. Other employment settings included clinic and hospital (12.6%, n = 37), and non-traditional setting (8.9%, n = 26).

*Professional Quality of Life Scores*

Mean ProQOL -21 scores were calculated based on the total scores of the assessment tool. The total scores of the compassion satisfaction component ranged from 12-36 with a median total score of 26.44. The total scores of the compassion fatigue component ranged from 11-39 with a median total score of 22.19. The total compassion satisfaction score presented in this study was

26.44±5.453. The total compassion fatigue score resulted as 22.19 ± 5.958. Distributions of both of the components of the Professional Quality of Life Scores can be seen in Figures 5-6.

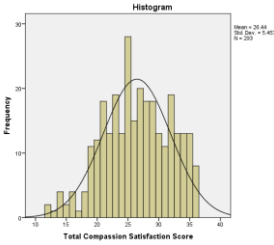


Figure 5. Distribution of Total Compassion Satisfaction Score

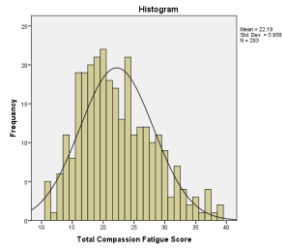


Figure 6. Distribution of Total Compassion Fatigue Score

### *Research Questions*

#### Research Question 1

*What is the prevalence of compassion fatigue in athletic trainers?*

Descriptive statistics were calculated for the subscale score of compassion fatigue (CF) through the ProQOL – 21 in this study. Possible scores for the compassion fatigue component range from 11-39. As per the cut off scores of compassion fatigue within the literature, percentiles were based as follows: Low (below the 25<sup>th</sup> percentile): 16 and below, Average (between the 25<sup>th</sup> and 75<sup>th</sup> percentile): 17-25, and High (above 75<sup>th</sup> percentile): 26 and above. Based on the these cut

off scores of low, average and high compassion fatigue, descriptive statistics including frequencies and percentages for each range can be found in Table 4.6.

Table 4.6

*Prevalence of Compassion Fatigue in Athletic Trainers*

<b>Levels</b>	<b>N</b>	<b>Frequency (%)</b>
Low	50	17.1
Average	162	55.3
High	81	27.6

Research Question 2

*What is the prevalence of compassion satisfaction in athletic trainers?*

Descriptive statistics were also calculated for the subscale score of compassion satisfaction (CS) through the ProQOL – 21 in this study. Possible scores for the compassion satisfaction component could consist of a range from 12-36. As per the cut off scores of compassion satisfaction within the literature, percentiles were based as follows: : Low (below the 25<sup>th</sup> percentile): 21 and below, Average (between the 25<sup>th</sup> and 75<sup>th</sup> percentile): 22-30, and High (above 75<sup>th</sup> percentile): 31 and above (Stamm, 2010). Based on the cut off scores for low, average and high compassion satisfaction, Table 4.7 describes the frequencies and percentages of athletic trainer participants in each range.

Table 4.7

*Prevalence of Compassion Satisfaction in Athletic Trainers*

<b>Levels</b>	<b>N</b>	<b>Frequency (%)</b>
Low	59	20.1
Average	157	53.6
High	77	26.3

### Research Question 3

*What is the relationship between compassion fatigue and years of athletic training experience in clinically-active athletic trainers?*

A bivariate Pearson's correlation analysis was conducted between the respondents' overall compassion fatigue scores and the years the participants have worked in the athletic training profession. The relationship between these two variables showcased a significant, weak, negative correlation,  $r = -.126$ ,  $n = 293$ ,  $p = .032$ .

### Research Question 4

*Is there a difference in the components of the Professional Quality of Life between athletic training settings?*

A one-way ANOVA showed that the components of compassion satisfaction is not statistically different between athletic training settings,  $F(3, 289) = .484$ ,  $p = .694$ . A T-3 post-hoc test was completed due to the unequal variances across groups. In addition, this did not showcase a significant difference between athletic training settings, Levene's  $F(3, 289) = .513$ ,  $p = .674$ .

A one-way ANOVA showed that the components of compassion fatigue was statistically different between athletic training settings,  $F(3, 289) = 2.870$ ,  $p = .037$ . However, when completing the post-hoc test, there was not a significant difference found between compassion fatigue scores and athletic training settings. A T-3 post-hoc test was completed due to the unequal variances across groups. Levene's  $F(3, 289) = .447$ ,  $p = .720$ .

The mean scores of both compassion satisfaction and compassion fatigue scores among settings can be found in Table 4.8 and Table 4.9.

Table 4.8

*Compassion Satisfaction Mean Scores within Settings*

<b>Setting</b>	<b>Mean CS Score</b>
Elite Athletics	25.99
Secondary Schools	26.70
Clinic / Hospital	26.73
Non Traditional	25.69

Table 4.9

*Compassion Fatigue Mean Scores within Settings*

<b>Setting</b>	<b>Mean CS Score</b>
Elite Athletics	22.43
Secondary Schools	22.84
Clinic / Hospital	20.24
Non Traditional	20.35

Research Question 5

*Is there a relationship between compassion satisfaction and compassion fatigue scores?*

A bivariate Pearson's correlation analysis was conducted between the respondents' overall total compassion fatigue scores and total compassion satisfaction scores. The relationship between these two variables indicated a significant, moderate, negative linear relationship variables,  $r = -.377$ ,  $n = 293$ ,  $p = .001$ .

## CHAPTER V

### DISCUSSION AND CONCLUSIONS

This chapter discusses the study's key findings and implications, limitations, and future considerations of the Professional Quality of Life phenomenon within clinically-active athletic trainers.

#### *Purpose*

The purpose of this study was to examine the components of the professional quality of life in the athletic training profession. The Professional Quality of Life -21 (ProQOL-21) measurement was utilized as the assessment tool to accomplish the study purpose. A sample of 293 certified NATA member clinically-active athletic trainers provided data that were utilized in this research.

#### *Key Findings and Implications*

To the authors' knowledge, this research is the first study examining the professional quality of life in athletic trainers. Several findings emerged in this study that may serve as a foundation to future ProQOL research within ATs. Through previous research discussed in the literature review combined with the findings from this study it is evident that ATs experience both components of this phenomenon. More than two-thirds of the participants (87.4%) identified themselves as "White" in this study. This finding mirrors the ethnicity demographics of the National Athletic Trainers' Association (NATA) membership statistics (Association,



2018). This further depicts the high likelihood that the participant population was accurately represented. With the use of the participant responses, a total of five research questions were utilized in this study to explore the professional quality of life among athletic trainers.

### *Research Question 1*

For research question 1, descriptive statistics were calculated for the subscale score of compassion fatigue (CF) through the ProQOL – 21 order to examine the prevalence of compassion fatigue. Although compassion fatigue has been shown to have been experienced in many different healthcare professionals, no literature has explored compassion fatigue within the athletic training profession.

The majority of total scores of the compassion fatigue component fell within the average level (55.3%, n = 162); however, a large number (27.6%, n = 81) fell into the level of high compassion fatigue. This renders the possible indication that athletic trainers (ATs) do experience compassion fatigue and may present with a potential risk of falling into the high-level category based on percentages within this study.

Athletic trainers' are expected to be compassionate and aware of the emotions of the athlete or patient (Raab, Wolfe, Gould, & Piland, 2011). In addition, ATs are expected to take into consideration the well-being of their athletes, both in the present moment and long term. Through conducted interviews with ATs, one study explored the key components of quality athletic trainers. According to the participants, there was a total of five constructs that impacted the quality characteristics including: ability to care, showcase of commitment and integrity, value and professional knowledge, and effective communication (Raab et al., 2011). One participant in the study completed by Raab (2011) stated “athletes need to know you care for them not only now, but that you are thinking about them long term. What is the effect of this decision going to have

today or tomorrow or this weekend but also a year, 5, 10, or 15 years from now” (Raab et al., 2011, p. 676).

As expressed in the literature, athletic trainers may have experienced a loss of the original compassion and excitement that influenced their decision to join the profession initially (Hendrix, Acevedo, & Hebert, 2000). Although a large portion of the participants (27.6%, n = 81) presented with a high level of compassion fatigue, the majority fell within the average level (55.3%, n = 162). This is consistent with other health care professions seen within the literature in which the majority of health care professionals experience average compassion fatigue (De La Rosa et al., 2018).

### *Research Question 2*

The second variable examined in this study was compassion satisfaction in clinically-active athletic trainers. Descriptive statistics were calculated for the subscale score of the the ProQOL-21 in order to examine the prevalence of compassion satisfaction. The main findings indicated that more than half of the participants (53.6%, n = 157) experienced average levels of CS. This is consistent with ProQOL literature findings in which the majority of health care professions showcase average levels of CS (De La Rosa et al., 2018). This finding yields the conversation of the true joy ATs experience serving as a caregiver to athletes and patients. This average level of CS seen within this completed study can be compared to a study done by Barret et al. (2002) who used a different measurement tool to calculate job satisfaction within ATs working in a Division I setting. Those findings concluded overall job satisfaction of ATs (Barrett, Gillentine, Lamberth, & Daughtrey, 2002), which is similar to the results found within this current study. Barrett et al. (2002) utilized descriptive survey research to identify the perceptions of ATs job satisfaction

within the Division I athletic environment. This study examined satisfaction and other variables through the Job Satisfaction Survey (JSS). The other nine variables consisted of : (1) pay, (2) promotion, (3) supervision, (4) fringe benefits, (5) contingent rewards, (6) job conditions, (7) co-workers, (8) communication, and (9) nature of work. It was concluded that ATs presented with higher overall job satisfaction scores compared to that of the total American sample mean when made in comparison (Barrett et al., 2002).

It has been shown that ATs typically enter the profession due to their high attraction to sports and their desire to help people (Mensch & Mitchell, 2008). Further exploring why ATs experience job satisfaction, Eason et al (2015) found that ATs who were outgoing, felt that time spent at work was rewarding, and felt appreciated by others presented with influences to one's job satisfaction (Eason, Mazerolle, Monsma, & Mensch, 2015). Our findings within this study help further possibly indicate that the individuals who are clinically active within the profession facilitate increased levels of job satisfaction.

### *Research Question 3*

An important relationship that was evaluated in this study was between the total compassion fatigue score and years of athletic training experience of clinically-active athletic trainers. A bivariate correlation analysis revealed a significant, weak, negative relationship with these variables. As years of experience increase, overall levels of compassion fatigue may decrease. This is consistent with other findings among other health care professions (Adams et al., 2006; F. Cocker & N. Joss, 2016; Salmond, Ames, Kamienski, Watkins, & Holly, 2017) among social workers and those in the nursing profession.

A possible explanation for the negative relationship between compassion fatigue and years of experience in ATS could be that as an athletic trainer increases their experience in the field, the

experience of compassion satisfaction becomes more evident. Due to the inverse relationship found within this study, this theory can be inferred. Within the athletic training profession, the longevity of careers has been seen to be impacted, as many athletic trainers leave the profession (Kahanov & Eberman, 2011). Those whom stay in the profession long enough to obtain many of years of experience can be considered ATs whom truly enjoy their job therefore helping to combat any factors that influence compassion fatigue.

Athletic trainers in this study with many years of experience and high compassion satisfaction could have also stayed within the profession, however changed the employment setting in which they work. For example, within the early stages of one's career, an athletic trainer may experience compassion fatigue due to their personal experience within that setting. Noticing the personal toll this may be taking on them, they may decide to switch settings to cultivate an environment that did not impact them as personally, which then in turn may combat experiences of compassion fatigue.

Our findings are overall consistent with current literature, as original studies discussed that the experience of burnout typically occurs about one year after an employee begins working at an institution (Freudenberger, 1974). This was showcased within the athletic training profession in previous literature, in which it was determined that younger ATs were more likely to experience burnout (Campbell, Miller, & Robinson, 1985); however, this was not seen within the collegiate athletic population. Utilizing a cross-sectional survey, Kania et al. (2009) assessed demographics and burnout measurement scores to identify any characteristics that may play a role in burnout among collegiate level ATs. This study showcased that higher levels of burnout was found within ATs with more than five years of experience.

When examining burnout among psychologists, one study concluded that more than one-third of the participants reported high levels of burnout (Ackerley, Burnell, Holder, & Kurdek, 1988). The majority of participants who experienced burnout were low-income, young individuals whom were new to the start of his or her career (Ackerley et al., 1988). Factors that influence younger professional burnout could be due to a lack of formal training and awareness of workplace stressors during the educational learning experience (Kania et al., 2009). Mazzerole et al. (2012) discussed the lack of awareness athletic training students have of burnout therefore impacting their experience of burnout within their early career (S. Mazerolle, Gavin, Pitney, Casa, & Burton, 2012) Newly certified ATs tend to experience an adaptation to management of professional responsibilities along with personal commitments (S. Mazerolle et al., 2012)

#### *Research Question 4*

A one-way ANOVA showed that compassion fatigue scores in clinically-active ATs were significantly different across settings. However, when examining the Post Hoc Test, there were no significant findings. This was determined to be due to the fact that there is an unequal distribution of sizes of participants in the AT setting categories the Post Hoc testing. To observe compassion satisfaction, a one-way ANOVA established that compassion satisfaction scores in clinically-active ATs were not significantly different across settings. Therefore we accept the null hypothesis that there is no significant difference of CS between AT employment settings. However, unequal distribution also may have impacted this calculation.

The majority of the participants (53.9%,  $n = 158$ ) were employed in the secondary school setting. The remainder of participants were not equally distributed across the other settings; therefore no statistically significant differences between groups were able to be described.

However, it is worth noting and discussing the mean scores and level measurements of CF and CS of ATs in the various settings described in the study.

Within this study it was hypothesized that there would be a difference in compassion fatigue among athletic training settings. A total of 122 (38.2%) of participants in this study experienced high levels of CF across all settings. When observing the cross tabulation of CF levels and AT settings, the highest number of participants ( $n = 79$ ) were employed in the secondary school setting and experienced average compassion fatigue.

Although there was an unequal distribution of group sizes, it was expected to see that the clinic/hospital and non-traditional employment AT settings experienced the lowest amount of participants within the high CF level. Both of these employment settings also presented with lower mean scores compared to those of the elite athletics or secondary school settings. This could be due to the clinic/hospital and non-traditional settings cultivate a quality working environment that may combat the experience of BO and STS. Giacobbi (2009) examined the prevalence of AT occupational burnout across settings through the use of a demographics questionnaire, the Stress Appraisal Measure (SAM), Maslach Burnout Inventory (MBI), Occupational Engagement Survey (OES), along with additional surveys to examine other influential factors of BO. The results of this study showed that ATs employed in the college/university or secondary school setting scored higher than individuals in the clinic or industrial settings (Giacobbi Jr, 2009).

Similar to the findings of CF levels among settings, the majority of participants when analyzing CS levels among settings were employed in the secondary school setting and experienced high levels of CS. Although the unequal group distribution impacting statistical analysis outcomes, this finding has been shown in the literature (Pitney, 2010). Exploring the

professional role commitment among secondary school ATs, Pitney (2010) found four common themes through interview interpretation. These four themes consist of: professional responsibility, rewards, respect, and rejuvenation. It was further established that those employed in the secondary school setting felt a great deal of responsibility towards the athletes. Analysis presented that secondary school ATs experienced a positive feelings of their work due to both intrinsic and extrinsic rewards established through satisfaction, validation and respect (Pitney, 2010).

#### *Research Question 5*

The final association that was examined was the relationship between the two components of professional quality of life; compassion satisfaction and compassion fatigue. The results of this study indicated a significant, moderate, negative linear relationship between these two variables. It is no surprise that there was a negative relationship between CF and CS in this study, as these two constructs essentially contradict each other (Stamm, 2010). This result indicates there is an inverse relationship between CF and CS; for example, based on these results it is unlikely ATs will experience high CF and high CS levels, through the correlation between these two variables was moderate and may be influenced by numerous factors. Some of these influential factors described in the discussion above, may include setting, years of experience, and potentially other demographics that were not analyzed for the scope of this study such as age, race, and gender of the ATs.

This inverse relationship has been seen in the literature among other health care professions. It was shows that these had an opposite effect on each other, and emphasis on directing an increase in CS may also lead to a decrease in CF(Fahey & Glasofer, 2016). This

finding can help further showcase the need for prevention methods that encompass emphasis on decreasing the experience of compassion fatigue, or increasing the experience of compassion satisfaction. This study specifically showed that high compassion fatigue was experienced among athletic trainers. If this level was able to be sustained throughout a long term duration, this may further decrease the experience of compassion fatigue that an athletic trainer will experience when caring for their athletes/patients.

### *Limitations*

This study had a few limitations that may have influenced the outcome of results and are worth noting for future research. The sample size that was utilized in this study was low. The timing of the data collection (11/19/2019- 12/17/2019) may have served as a contributing factor to the low response rate (10.8%) and small participant sample size (n = 293). As per the injury rates conducted through the High School Sports-Related Injury Surveillance Study, fall season showcased the highest number of injuries during the 2018-2019 school year (Comstock & Pierpoint, 2020). This time frame serves as cross-over season between many collegiate and secondary school settings. With the increase of injury rate and the possible higher demand of working hours, those most vulnerable to compassion fatigue may have not completed the survey due to the likelihood of the individuals being unable to contend with additional tasks (Puig et al., 2012). Individuals who possibly may have scored within the high level of CF may be less likely to voluntarily participate in the study.

The low response rate proved difficult when conducting analyses, as it may have contributed to the unequal distributions between groups. This also restricts the ability to make



assumptions about a population in totality. The data of the total participants (n = 293) may not be representative of the athletic training profession as a whole.

In addition, the data collection period may have potentially affected results due to the specified time frame of the ProQOL-21 instructions. Prior to beginning the ProQOL-21 survey, the participant is instructed to consider each of the presented questions about themselves and his or her current work situation. The selected responses should reflect the frequency of the specified questions within in the last 30 days. It is very likely that experiences of CS and CF is temporal and changes over time and due to certain situations. This study found that ATs experience average levels of both CS and CF, however this may change based on time frame.

Another limitation in this study was utilizing a newly established assessment tool for the components of the Professional Quality of Life among athletic trainers. The lack of research utilizing this tool serves as a limitation, as there was not a cemented foundation to the measurement and still renders the need for further application within research. Although there was a lack of this ProQOL-21 tool within the literature, it held the highest validity compared to other measures, as to why it was utilized for this study.

### *Future Considerations*

Future research should be conducted to further validate the ProQOL measurement tool, ideally within the athletic training profession. Although the assessment tool applied in this study (ProQOL-21) was validated through the Rasch Analysis, it has not been utilized in many other literature studies. This may be due to this being a newly developed tool. Further investigation into the ProQOL-21 and the findings among other healthcare professions will create a respected database of the professional quality of life components.

Another proposition for future research would be to conduct a longitudinal study over the course of athletic trainers' careers to examine the long-term development of the professional quality of life components. This would provide a different outlook on this phenomenon and the analysis of compassion fatigue and compassion satisfaction, to determine how these factors may evolve over time. Correlating factors that may impact this long-term development could be analyzed and eventually implemented into a prevention plan for athletic trainers to utilize throughout their careers.

Future research could also utilize a mixed methods approach to help better understand one's personal experiences with this concept. By incorporating qualitative research such as interviews of athletic trainers, this could provide a greater in-depth understanding of the feelings athletic trainers may be experiencing in regards to the components of the professional quality of life. Mixed methods research has shown to be beneficial in sports medicine research because it is a multifaceted and versatile based field. (Kay & Kucera, 2018). This would serve as further insight into the positive and negative aspects athletic trainers experience within their caregiving role. This may also bring attention to mitigate possible red-flags that could impact those whom are on the verge of leaving the profession. Research with intervention programs and techniques to combat compassion fatigue in the athletic training profession is also warranted.

There is a further need for more evenly distributed participants across settings, age groups, and across years of experience when examining the ProQOL among athletic trainers. A solution to this would be conducting a study with a larger number of intended subjects. Even distributions among the participants will allow further powerful parametric statistical tests to be calculated. The lack of uniformity among participants within this study may impact the replicability of results compared to future studies.

Finally, an addition of other demographics may be warranted as this further information may establish a better understanding as to why athletic trainers experience average levels of CF and high levels of CS. The addition of these supplemental questions could consist of: the number of witnessed traumatic events, use of self-care strategies, relationship status, and whether they are a parent to a child.

### *Conclusions*

The goal of this present study was to examine the overall professional quality of life of athletic trainers. We are able to demonstrate that athletic trainers do experience both compassion satisfaction and compassion fatigue due to their caregiving role. Overall, the experience of average compassion satisfaction and average compassion fatigue was mainly seen within this population sample.

To the author's knowledge, this is the first attempt to examine the professional quality of life components among athletic trainers. Previous literature has examined this phenomenon in multiple other health care professions; however, there is no published research on compassion satisfaction nor compassion fatigue in the athletic training profession. This is surprising given the paucity of research on burnout in athletic trainers for several decades (Capel, 1986; Hendrix et al., 2000; Kania et al., 2009; Oglesby, Gallucci, & Wynveen, 2020). Our results showcased that athletic trainers hold their ability to help their athletes/patients as a high priority (compassion satisfaction), however do experience the negative side effect of offering this care (compassion fatigue). Until these constructs are further examined, athletic trainers will likely continue to experience a possible imbalance between CF and CS, and may not receive the proper care needed as valued members of the health care team.

A unique aspect that speaks to the athletic training profession and the flaws of dedicating one's life to their work can be seen from the results of this study. The overall finding of decreased levels of CF as one gains experience in their career yields the conversation of suggesting recommendations to experience these decreased levels within the early beginning of one's career. These decrease levels of CF and increase levels of CS should be maintained throughout ones career, not specifically within the later portion of one's career, in order to achieve the most optimal outcome of ProQOL.

Further examining how these positive and negative components of professional quality of life are experienced among athletic trainers could create awareness of the confounding factors that may contribute to compassion fatigue and compassion satisfaction. Specifically examining this phenomenon within the athletic training profession will further establish a framework for athletic trainers specifically compared to other researched health care professionals. Future research may have the opportunity to enhance the positive aspects of athletic trainers' ability to care, and minimize the negative effects that may be experienced through this profession. Continuing to examine the professional quality of life in athletic trainers has the potential to further solidify the value athletic trainers have as a health care professionals and positively impact the quality of both the care given, and the care-giver as a whole.

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Appendix A: IRB Approval



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West Chester, PA 19383 | 610-436-3557 | www.wcupa.edu

**Protocol ID # 20191022A**  
*This Protocol ID number must be used in all communications about this project with the IRB.*

TO: Tina Riordan  
FROM: Nicole M. Cattano, Ph.D.  
Co-Chair, WCU Institutional Review Board (IRB)  
DATE: 10/21/2019

**Project Title: Professional Quality of Life: An Examination of Compassion Fatigue and Compassion Satisfaction in Athletic Trainers**  
**Date of Approval: 10/21/2019**

**Expedited Approval**

This protocol has been approved under the new updated 45 CFR 46 common rule that went in to effect January 21, 2019. As a result, this project will not require continuing review. Any revisions to this protocol that are needed will require approval by the WCU IRB. Upon completion of the project, you are expected to submit appropriate closure documentation. Please see [www.wcupa.edu/research/irb.aspx](http://www.wcupa.edu/research/irb.aspx) for more information.

**Any adverse reaction by a research subject is to be reported immediately through the Office of Research and Sponsored Programs via email at [irb@wcupa.edu](mailto:irb@wcupa.edu).**

**Signature:**

A handwritten signature in black ink, appearing to read 'Nicole M. Cattano'.

Co-Chair of WCU IRB

WCU Institutional Review Board (IRB)  
IORG#: IORG0004242  
IRB#: IRB00005030  
FWA#: FWA00014155

## Appendix B: Survey Request Form Application

Submission #173



Published on NATA (<https://www.nata.org>)

[Home \(/\)](#) > [Research Survey Request \(/research-survey-request\)](#) > Submission #173

**Name of Primary Investigator** Tina E. Riordan

**District** 2

**Email** [tina.e.riordan16@gmail.com](mailto:tina.e.riordan16@gmail.com)

**Title of Study** Professional Quality of Life: An Examination of Compassion Fatigue and Compassion Satisfaction in Athletic Trainers

**Purpose Statement**

The purpose of this study is to examine the overall professional quality of life within the athletic training profession. As part of the healthcare profession, athletic trainers utilize their knowledge and skills to improve the quality of life of others, with the possibility of affecting their own quality of life. Specifically, compassion fatigue and satisfaction has been found to be prevalent in many health care professions, however, prevalence in athletic trainers has not been examined. Given the high rate of burnout and the high demand placed upon those employed in the athletic training profession, there is a need to examine the overall professional quality of life in order to identify compassion imbalances that may affect both patient care and personal well-being.

**Institution where Research is Being Conducted** West Chester University of PA

**Funding Source of Study** Lindsey Keenan's Department of Sports Medicine faculty development fund

**Length of Data Collection Period** 4 weeks

**Informed Consent Form** [consent\\_form.docx](https://www.nata.org/sites/default/files/webform/consent_form_10.docx) ([https://www.nata.org/sites/default/files/webform/consent\\_form\\_10.docx](https://www.nata.org/sites/default/files/webform/consent_form_10.docx))

**Institutional Review Board application** [irb\\_application.docx](https://www.nata.org/sites/default/files/webform/irb_application_5.docx)  
([https://www.nata.org/sites/default/files/webform/irb\\_application\\_5.docx](https://www.nata.org/sites/default/files/webform/irb_application_5.docx))

**Institutional Review Board approval** [irb\\_approval.docx](https://www.nata.org/sites/default/files/webform/irb_approval_22.docx)  
([https://www.nata.org/sites/default/files/webform/irb\\_approval\\_22.docx](https://www.nata.org/sites/default/files/webform/irb_approval_22.docx))

**Description and Target Number of desired survey audience**

A total of 3,000 subjects

The sample of participants who are solicited are individuals who possess an active membership with the NATA.

Eligible NATA member participants for this study will include individuals certified as an athletic trainer by the Board of Certification (BOC), working in the CLINICAL setting as an athletic trainer.

**Target date to begin survey** Tue, 2019-10-29

**Cover Letter/Email to survey audience** [email\\_to\\_audience.docx](https://www.nata.org/sites/default/files/webform/email_to_audience.docx)  
([https://www.nata.org/sites/default/files/webform/email\\_to\\_audience.docx](https://www.nata.org/sites/default/files/webform/email_to_audience.docx))

**Is this considered a "High Risk" Survey?** No



## Appendix C: Survey Invitation Email

### SURVEY INVITATION EMAIL

Dear Certified Athletic Trainer,

My name is Tina Riordan and I am a graduate student at West Chester University of PA. I am inviting you to participate in a research study examining **compassion fatigue and satisfaction in athletic trainers** for my Master's thesis, under the direction of Dr. Lindsey Keenan, in the Department of Sports Medicine.

The results of this study aim to examine compassion fatigue and create awareness of the “cost of caring” within athletic training. This concept has not yet been published in regard to athletic trainers; however, it has been examined in numerous other health care professions.

Participation in this study is voluntary and you can withdraw at any time. The West Chester University of PA Institutional Review Board has approved this study. If you are interested in participating in this study, please click on the link below to access the informed consent document and complete the survey. The survey should take approximately less than 10 minutes to complete.

Link to survey:

[https://wcupa.co1.qualtrics.com/jfe/form/SV\\_eyUCySHDKNZu7Zz](https://wcupa.co1.qualtrics.com/jfe/form/SV_eyUCySHDKNZu7Zz)

Or copy and paste the URL below into your internet browser:

[https://wcupa.co1.qualtrics.com/jfe/form/SV\\_eyUCySHDKNZu7Zz](https://wcupa.co1.qualtrics.com/jfe/form/SV_eyUCySHDKNZu7Zz)

If you have any further questions regarding this study, please contact Tina Riordan, [TR917714@wcupa.edu](mailto:TR917714@wcupa.edu) or Dr. Lindsey Keenan, [LKeenan@wcupa.edu](mailto:LKeenan@wcupa.edu).

Thank you for your kind consideration,  
Tina E. Riordan, LAT, ATC

## CONSENT FORM TO TAKE PART IN A HUMAN RESEARCH STUDY

### **Project Title: Professional Quality of Life: An Examination of Compassion Fatigue and Compassion Satisfaction Among Athletic Trainers**

**Investigator(s):** Tina Riordan, LAT, ATC; Lindsey Keenan, PhD, LAT, ATC

*Project Overview:* The participation in this research project is voluntary. This study is being done by Tina Riordan, LAT, ATC as part of their Master's Thesis. The purpose of this study is to examine the overall professional quality of life of athletic trainers.

Your participation will take less than 10 minutes to:

- Read and sign the Consent Form
- Complete the survey questionnaire
- Submit the survey questionnaire

There is a small risk of participating in this study. This survey may cause participants to become more aware of their emotional state.

None of the questions will ask identifying information. This study will be confidential and anonymous. At the end of the survey, both the crisis hotline and ATs Care contact information will be given.

There are no direct benefits to you as a participant. However, this study may help better understand the negative and positive aspects of caregiving as an athletic trainer.

If you would like to take part, West Chester University requires that you agree and sign this consent form. You may ask Tina Riordan, LAT, ATC any questions to help you understand this study. If you do not want to be a part of this study, it will not impact any services from West Chester University. If you choose to be a part of this study, you have the right to stop being a part of the study at any time.

#### **1. What is the purpose of this study?**

- To examine the overall professional quality of life of athletic trainers

**2. If you decide to be a part of this study, you will be asked to do the following:**

- Read and sign the Consent Form
- Complete the survey questionnaire
- Submit the survey questionnaire
- This study will take less than 10 minutes of your time.

**3. Are there any experimental medical treatments?**

- No

**4. Is there any risk to me?**

- By completing this survey you may become more aware of your emotional state.
- If you experience discomfort, you have the right to stop at any time.
  
- If you become upset and wish to speak with someone, you may speak with:
  - Crisis Textline: Text HOME to 741741
  - ATs Care: <https://forms.nata.org/ats-care-contact>

**5. Is there any benefit to me?**

- There are no direct benefits to you as a participant.
- This study may help better understand compassion satisfaction and fatigue in athletic trainers

**6. How will you protect my privacy?**

Participation in this study is anonymous.

No questions will ask identifying information.

All survey data will be saved on a password protected Qualtrics account hosted by the co-investigators.

Records will be stored in a password protected computer.

Records will be destroyed 5 years after study completion.

Only Tina Riordan, LAT, ATC, Lindsey Keenan, PhD, LAT, ATC and the IRB will have access to your anonymous responses.

**7. Do I get paid to take part in this study?**

No

**8. Who do I contact in case of research related injury?**

If you have any questions about this study please contact:

Primary Investigator: Tina Riordan, LAT, ATC at 508-942-4427 or [TR917714@wcupa.edu](mailto:TR917714@wcupa.edu)

Secondary Investigator: Lindsey Keenan, PhD, LAT, ATC at 610-436-2753 or [lkeenan@wcupa.edu](mailto:lkeenan@wcupa.edu)

For any questions about your rights in this research study, contact the ORSP at 610-436-3557.

**9. Will this data be used in the future?**

This data will not be used for any future studies outside of this research study.

I, \_\_\_\_\_ (your name), have read this form and I understand  
the statements in this form.

I know that if I am uncomfortable with this study I can stop at any time. I know that it is not possible to know all possible risks in a study, and I think that reasonable safety measures have been taken to decrease any risk.

By clicking **I CONSENT**, you give permission and consent to take part in this research study.

This project has been approved by the West Chester University Institutional Review Board for the Protection of Human Subjects. Approval Dates: \_\_\_\_\_

I consent

I do not consent

Appendix E: Demographics and ProQOL-21 Survey

**Demographics and ProQOL-21 Survey**

**What is your age?**

▼ 18 ... 90

**To which gender do you identify as?**

- Male
- Female
- Transgender Female
- Transgender Male ‘
- Other \_\_\_\_\_

**What is your race or ethnicity? (Select all that apply)**

- White
- Black or African American
- Hispanic, Latino, or Spanish
- Asian or Asian Indian
- American Indian or Alaska Native
- Middle Eastern or North African
- 2+ Races / Mixed Race
- Some other race or ethnicity (please specify) \_\_\_\_\_

**What is your highest earned degree?**

- Bachelor’s (BA, BS, etc.)
- Master’s (MA, MS, etc.)
- Academic Doctorate (PhD, EdD, etc.)
- Clinical Doctorate (DAT, DHSc, etc.)

**In which setting do you predominately practice as athletic trainer?**

- Professional Sports
- College / University
- Secondary Schools
- Clinic
- Hospital
- Education / Academia
- Amateur / Recreational / Youth Sports
- Military / Law Enforcement / Government
- Performing Arts
- Health/Fitness / Performance Enhancement
- Occupational Health/Industrial
- Independent Contractor
- Business / Sales / Marketing
- Unemployed
- Other (please describe) \_\_\_\_\_

**What is your current employment status?**

- Employed full-time (40+ hours a week)
- Employed part time (less than 40 hours a week)
- Unemployed

**How many years of athletic training experience do you have?**

▼ Less than 1 year ... 65

*When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as an athletic trainer. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.*

	Never	Almost Never	Sometimes	Often	Very Often
1. I feel “bogged down” by the system. (ProQOL-21_1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I feel overwhelmed because my case load seems endless. (ProQOL-21_2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I feel worn out because of my work as an athletic trainer. (ProQOL-21_3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I avoid certain activities or situations because they remind me of frightening experiences of the people I help. (ProQOL-21_4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I feel trapped by my job as an athletic trainer. (ProQOL-21_5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Because of my helping, I have felt “on edge” about various things. (ProQOL-21_6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I think that I might have been affected by the traumatic stress of those I help. (ProQOL-21_7)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

<p>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help. (ProQOL-21_8)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>9. I feel as though I am experiencing the trauma of someone I have helped. (ProQOL-21_9)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>10. As a result of helping, I have intrusive, frightening thoughts. (ProQOL-21_10)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>11. I feel depressed because of the traumatic experience of the people I help. (ProQOL-21_11)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Almost Never	Sometimes	Often	Very Often
<p>12. I am happy that I chose to do this work. (ProQOL-21_12)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>13. I get satisfaction from being able to help people. (ProQOL-21_13)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>14. I believe I can make a difference through my work. (ProQOL-21_14)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>15. I am pleased with how I am able to keep up with helping techniques and protocols. (ProQOL-21_15)</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



<p>16. I have happy thoughts and feelings about those I help and how I could help them. (ProQOL-21_16)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>17. I am proud of what I can do to help. (ProQOL-21_17)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>18. My work makes me feel satisfied. (ProQOL-21_18)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>19. I feel invigorated after working with those I help. (ProQOL-21_19)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>20. I like my work as an athletic trainer. (ProQOL-21_20)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>
<p>21. I have thoughts that I am a “success” as an athletic trainer. (ProQOL-21_21)</p>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>

Thank You for participating in this survey!

If you become upset and wish to speak with someone, you may speak with:

Crisis Textline : Text HOME to 741741

ATs Care: <https://forms.nata.org/ats-care-contact>