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The Relationship between Compassion Fatigue and Organizational Culture

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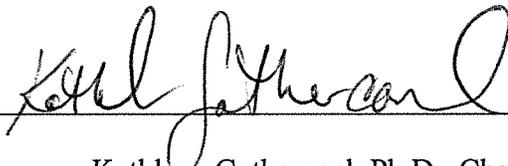Newberg, Oregon

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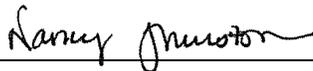The Undersigned Faculty Committee Approves the

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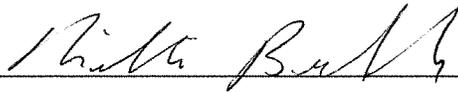Ms. Katherine M. Condrey, M.A.

The Relationship between Compassion Fatigue and Organizational Culture

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Abstract

This study examined the relationship between compassion fatigue (CF) and organizational culture in a sample of 16 organizations and 193 individual participants. Respondents completed the Professional Quality of Life Scale as well as the Organizational Culture Profile. Results of this study found an incidence rate of CF of 35-43%. Differences in CF among the organizations surveyed were due, in part, to organizational culture. Individuals who place a high value on rewards were found to be at higher risk of developing compassion fatigue. Organizations with less decisiveness and higher variability in their organizational value ratings tend to have more compassion fatigue. Finally, supportiveness in an organizational culture was found to be a strong predictor of an individual's ability to resist compassion fatigue. Important conceptual, practical, and policy reform implications are noted.

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Chapter 1

Introduction

Mental health professionals work diligently to improve the emotional wellbeing of the clients with whom they have contact. In doing so, these professionals risk their own emotional wellbeing. The long term, day-to-day contact with clients and the resulting distress puts mental health professionals at risk of their own mental health deteriorating (Newell & MacNeil, 2010). The risks are not for only mental health professionals to bear: mental health organizations can also be negatively affected by employees' chronic exposure to distressed clients. While there has been a considerable amount of research of the impact that compassion fatigue (CF) has on an individual, there has been little research done on how the organization that individuals work in affects the amount of CF that they experience. Therefore the purpose of this study is to explore how organizational culture contributes to the ability to predict individuals' CF.

Compassion Fatigue

Although we have been aware of many ways that mental health professionals can be injured by their caring for others, the field just came to understand that the process of listening to accounts of trauma can lead to trauma. This form of trauma might lead to problems that professionals have not been trained to detect in themselves, and that organizational and professional standards have not been developed to avoid.

Over the course of the last two decades, various terms have been used to identify the stress that results from helping traumatized clients. Terms used to describe this stress include

vicarious traumatization/trauma (VT; Pearlman & Saakvitne, 1995; Schauben & Frazier, 1995), secondary traumatic stress (STS), and compassion fatigue (CF; Figley, 1995). These terms have been defined numerous times in the literature (Bober & Regehr, 2006). Originating from the work of Figley (1995), the term CF has been used to identify the experiencing of emotional and physical fatigue as a result of the ongoing empathy experienced when treating suffering patients. This result is a consequence of working with people who have experienced extremely stressful events. CF occurs gradually over time (Figley, 1995). Some researchers have emphasized the socioemotional symptoms of clinicians with CF (Jenkins & Baird, 2002). Professionals experiencing CF may experience deterioration in their capacity or desire to be empathic towards clients (Elwood, Mott, Lohr, & Galovski, 2011). Stamm (2005) later conceptualizes CF as the negative effects of long-term compassion that is made up of secondary traumatic stress and burnout. He reports that compassion fatigue is the result of being vicariously exposed to traumatic material and experiencing burnout caused by long-term use of empathy.

Research has proven that higher levels of CF cause clinicians to undergo a decrease in effectiveness (Figley, 1995; Sexton, 1999). When experiencing CF, professionals run a higher risk of making poor professional judgments such as misdiagnosis, poor treatment planning, or abuse of clients. (Rudolph, Stamm, & Stamm, 1997). It is evident that adequate client care is at risk when clinicians suffer from CF as it causes professionals to experience a decrease in motivation, efficacy, and empathy. Because of these negative consequences, it can be assumed that clinicians experiencing CF will not be motivated to treat patients with adequate amounts of empathy, resulting in less effective treatment (Craig & Sprang, 2010).

In 2005, Stamm conceptualized compassion fatigue as being made up of two components. He defined compassion fatigue as being the combination of burnout and STS symptoms in an individual. Unlike burnout, compassion fatigue requires symptoms associated with STS. Likewise, unlike STS, compassion fatigue requires symptoms of burnout. These three concepts are similar yet are distinguishable.

The term STS is used to describe the development of PTSD symptoms in individuals who play a significant role in the survivor's life. Any person who is in a helping relationship with the survivor of a traumatic experience is at risk for developing STS (Figley, 1995). According to Figley (1995), the symptoms of secondary traumatic stress are the same as those of PTSD defined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013). STS and PTSD differ in only one way; in STS the affected individual does not actually experience the traumatic event rather learns about a traumatizing event that another has suffered. STS may occur after exposure to one, or multiple, traumatic narratives. It is hypothesized to occur quickly and suddenly and is a likely result of entering into a helping relationship (Figley, 1995).

Research has shown the symptoms of STS include significant disruptions in one's sense of meaning, connection, identity, and worldview as well as disruptions in one's affect tolerance, psychological needs, interpersonal relationships, and sensory memory (Pearlman & Saakvitne, 1995). These disruptions can be accompanied by emotional responses such as anger, sadness, and anxiety, and can lead to psychological numbing, denial, and distancing (McCann & Pearlman, 1990).

The second component of compassion fatigue as defined by Stamm (2005) is burnout. Stamm (2005) explains that burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing one's job effectively. Burnout is usually of gradual onset and results in the individual feeling as though his/her efforts are pointless and he/she cannot make a difference. Burnout is different from compassion fatigue as symptoms of STS are not present (Craig & Sprang, 2010).

Although Stamm (2005) defined CF as being comprised of STS and burnout, he also proposed a protective factor for those who may be vulnerable to the effects of working with traumatized individuals. Stamm (2005) proposed the compassion satisfaction can offset the effects of CF and protect individuals from experiencing negative symptoms. He defined compassion satisfaction as being the pleasure an individual feels from being able to complete his or her work effectively. This may be pleasure due to respect for colleagues, pleasure derived from helping others, or pleasure due to a sense of fulfilling a greater purpose such as one related to religious beliefs. In their quantitative and qualitative longitudinal study examining effects caregivers experience when working therapeutically with seriously traumatized people, Collins and Long (2003) found that CF and CS were negatively correlated. The more CF a therapist experiences, the less satisfaction he/she gets from his/her work within the helping field. (Collins & Long, 2003).

Unlike STS in which professionals must work with those who have suffered a traumatic event, research suggests CF is prevalent among professionals caring for people who suffer in any way. In their study measuring prevalence rates of CF, Conrad and Keller-Guenther (2006) found that almost 50% of Colorado county child protection caseworkers were at "high" or "extremely

high" risk for compassion fatigue. In addition, Wee and Myers (2002) found that within their

sample of mental health workers, 53.5% had moderate to extremely high risk of CF.

Much research has also focused on the effects that CF has on individuals. Previous

studies have found that professionals suffering from CF have episodes of sadness and depression,

sleeplessness, and general anxiety. They may also suffer from cognitive overload which causes

them to lose their ability to be objective and helpful towards clients. In serious cases,

professionals suffering from CF may sink into a deep depression, resulting in isolation of

themselves from the support of others. They may also be weighed down by dreams, nightmares,

and intrusive thoughts comparable to what their patients have experienced (Cerney, 1995).

Feelings of helplessness and loneliness (Conrad & Keller-Guenther, 2006) can also be

experienced in response to CF. In summary; CF decreases a professional's capability or interest

in holding the suffering of others. (Figley, 2002).

To summarize, research has shown that long-term exposure to traumatized individuals

can cause symptoms of burnout and STS. When these symptoms present together in an

individual, the result is compassion fatigue. What has yet to be researched is the effects of

numerous people with compassion fatigue working with one another. In studying the impact of

organizational culture on a group of employees' resulting levels of compassion fatigue, the

possibility of organizational compassion fatigue will be explored.

Organizational Culture

Organizational culture has also been defined numerous times in the literature. These

definitions tend to fall into one of two ways of conceptualizing organizational culture. First,

many choose to define organizational culture as being the norms of behavior within an

organization (Koberg & Chusmir, 1987). Secondly, others choose to define the construct as being a set of common cognitions shared by members of a social unit (O'Reilly, Chatman, & Caldwell, 1991). Erkutlu, Chafra, and Bumin (2011) attempt to integrate these by defining organizational culture as encompassing the values and norms shared by members of a social unit. Bryant (2013) reports an all-encompassing definition of organizational culture as being the beliefs, values, attitudes, behaviors, and standards shared by the individuals and groups that make up an organization. These authors all go on to suggest that an organization's values lead to normative behaviors that in turn, make up the organization's culture.

The Interaction of Compassion Fatigue and Organizational Culture

Existing findings on whether organizational characteristics predict the emergence of, or reduce, CF have been inconsistent. While few studies have examined the relationships between STS, organizational culture, and strategic information (Choi, 2011), the relationship between organizational culture and compassion fatigue is still unknown. Although much research has been done on the effects of CF on individuals, little is known about how organizational characteristics contribute to the experience of compassion fatigue in organizational members. Previous research on organizational connections to CF has primarily focused on protective factors organizations can employ (Bell, Kulkarni, & Dalton, 2003; Neumann & Gamble, 1995: Pearlman & Saakvitne, 1995; Yassen, 1995).

Townsend and Campbell (2009) found that when organizations had diffused goals, nurses were more likely to report STS. Several STS studies imply that having adequate resources, such as time, materials, space, funds, knowledge, and skills can prevent STS. For example, providing a comfortable physical work environment, such as a space with comfortable furniture (Bell et al.,

2003), private office space (Neumann & Gamble, 1995; Yassen, 1995), access to resources to help clients, and training opportunities (Pearlman & Saakvitne, 1995) might reduce negative symptoms. Interestingly, it has been hypothesized that the unhealthy dynamics of trauma victims could be transferred into the organizational culture and coworker relationships (Choi, 2011; Herman, 1992).

More knowledge about the effects of CF on organizational culture may provide managers with a better understanding of how burnout rates can be better predicted and controlled. Stamm (2005) supports this idea by suggesting that there is some relation between VT, STS, and burnout. McCann and Pearlman (1990) state that burnout may be caused by secondary traumatization that a professional cannot cope with. Research shows that workers with psychological distress reported both higher burnout and CF scores (Rossi et al., 2012). Additionally, higher levels of psychological distress will likely lead to loss of energy, commitment, and hopefulness among staff (Sexton, 1999). Furthermore, client care can be negatively affected by high levels of CF because it causes clinicians to distance from their clients (Herman, 1992).

To summarize, research contributing to an understanding of the relationship between CF and organizational culture could be of extraordinary benefit. Managers who understand the negative impacts of CF may be motivated to help protect their employees against the risks associated with chronic exposure to traumatize clients. In having knowledge about the effects of CF on organizations and implementing policies to protect their employees, organizations may save financial resources, increase compassion satisfaction, decrease burnout rates, and increase the quality of client care.

Hypothesis

The purpose of this study is to examine the relationship between CF and organizational culture. It is hypothesized that organizational culture makes a significant contribution to the ability to predict an individual's CF. When organizational culture, as defined by the mean organizational ratings, is used as a predictor, a significantly larger percentage of variance in CF will be accounted for than when using the weekly hours an employee works, the weekly hours each employee spends with patients, or an individual's organizational values.

Chapter 2

Methods

Participants

The total sample was 195 employees who represent 16 organizations. The organizations selected each had between 7 and 60 employees and all provided some type of service to clients. The organizations were selected based on the hypothesis that they would have a varied amount of compassion fatigue. This hypothesis was deduced based on the type of clients that employees come into contact with as well as the type of service that they provided. The organizations surveyed were as follows: a general psychiatric unit of an inpatient hospital; a chemical dependency unit of an inpatient hospital; an active duty military unit of an inpatient hospital; a mixed chemical dependency and chronic pain unit of an inpatient hospital; the social services department of an inpatient hospital; the culinary department of an inpatient hospital; an inpatient hospital intake department; outpatient mental health services primarily serving patients who have recently completed inpatient treatment; a medical clinic serving patient from with low socioeconomic status; a community mental health clinic; a university health and counseling center; a national bank; a fast food restaurant; a casual dining restaurant; and a fine dining restaurant. The respondent rate from the various organizations was between 40% and 100%. See Table 1 for organization specific response rates.

Table 1.

Number of Employees Surveyed Response Rates for the 16 Surveyed Organizations

Organization	Total Employees	Response Rate (%)
Inpatient general psychiatric unit	28	57.14
Inpatient chemical dependency unit	26	50.00
Inpatient active duty military unit	25	40.00
Inpatient chemical dependency and chronic pain unit	19	52.63
Inpatient social services department	21	76.19
Inpatient culinary department	7	57.14
Inpatient intake department	18	66.67
Outpatient mental health services	19	57.89
Low-SES medical clinic	57	59.65
Community mental health clinic	12	100.00
University health and counseling center	11	72.73
National Bank	7	71.43
Machine tools sales	7	71.43
Fast food restaurant	28	64.29
Casual dining restaurant	14	50.00
Fine dining restaurant	32	40.63

Instruments

> **Professional Quality of Life Scale** (ProQOL; Stamm, 2005). The ProQOL is a measure

of compassion fatigue and compassion satisfaction. The ProQOL measures compassion fatigue

by measuring both burnout and secondary stress. The ProQOL is a 30-item self-report, paper and pencil scale. The ProQOL-V contains three Subscales- Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. An individual's scores on the burnout and secondary traumatic stress scales represent his/her level of compassion fatigue. The compassion satisfaction subscale is defined as being a protective factor for the negative effects of compassion fatigue. The primary focus of this study will be the scales representing the components of compassion fatigue although the compassion satisfaction scale will be calculated and reported. The compassion satisfaction scale has a Cronbach's alpha of .88; the burnout scale has a Cronbach's alpha of .64; and the Secondary traumatic stress scale has a Cronbach's alpha of .75. The ProQOL has excellent face validity as evinced by expert witnesses utilizing this tool on multiple occasions.

Factor analysis of the ProQol was also completed by Stamm (2005) during the creation of this assessment tool. See Appendix C for a list of ProQol items by factor placement. The factor analysis resulted in individual scores for the following categories: compassion satisfaction; the pleasure derived from being able to perform work responsibilities well; burnout; associated with feelings of hopelessness and difficulties in dealing with work or in completing job duties effectively; and secondary traumatic stress; symptoms similar to post-traumatic stress disorder that result from secondary exposure to the traumatic event usually through work with traumatized individuals. Each of these scales has a mean of 50 and a standard deviation of 10. Stamm (2005) defines compassion fatigue as being a combination of secondary traumatic stress and burnout and the current study employed this definition.

Organizational Culture Profile (Abbreviated Version; OCP; Cable & Judge, 1997) The OCP is a measure of organizational culture. The OCP measures organizational culture by

assessing eight factors including: innovation; attention to detail; outcome orientation; aggressiveness; supportiveness; emphasis on rewards; team orientation; and decisiveness. The OCP is a Q-Sort of 40 items into nine categories ranging from most characteristic to least characteristic of the organization. The sort results in individuals ratings of the eight factors. The organizational culture is characterized as the mean rating for each of the eight factors across employees of that organization. The standard deviation of the employee's ratings on each factor will be used as a measure of organizational homogeneity. It is self-report, paper and pencil scale. The mean inter-item correlations for each factor ranged from 0.53 to 0.62, in other words, the items loading on each factor were moderately correlated and thus provide evidence of convergent validity at the item level. The OCP has a reported overall test-retest reliability of 0.87.

A factor analysis was completed for items on the OCP. The eight factors included the following: innovation; attention to detail; outcome orientation; aggressiveness; supportiveness; emphasis on rewards; team orientation; and decisiveness. Initially, the factor analysis completed by O'Reilly et al. (1991) was used. Due to the fact that the 1995 version of Cable and Judge's (1997) OPC used in this study had been revised to include 40 items, the initial factor analysis did not account for all of the items included in the selected version of the OCP; there was a discrepancy between items included in the two versions of the OCP that were used by Cable and Judge (1997) versus O'Reilly et al. (1991). Specifically, there were 14 items on the selected version that were not included in the factor analysis done by O'Reilly et al. (1991) and seven items included in the previous factor analysis that were not included in the selected version of the

OCP. The discrepant items were placed into factors by face validity. See Appendix B for a list of OCP items by factor placement.

Procedure

Organizational heads of 16 organizations were contacted to obtain permission to survey individual employees. They were informed of the benefits of participating in the current study such as the access to data informing them about their organizations specific culture and strengths; thus, providing them with valuable information about how to improve the overall functioning of their organization.

Each employee received a packet which included the OCP, the ProQol, a short demographic questionnaire which inquired about how long the individual had worked in the organization, the average number of hours worked per week, and the average number of hours that they are in contact with clients, patients, or guests. In addition a one-dollar bill, letter of introduction, and informed consent form was provided with the packet. Each packet took an average of 15 minutes to complete. The employees then returned the surveys to the principal investigator or their employer who then mailed the surveys to the principle investigator.

Chapter 3

Results

The study involved creating three regression equations. The first equation predicted individual participants' CF scores using the individuals' OCP ratings and demographic information. The second regression equation also predicted individual participants' CF scores using the organizational means for OCP factors in addition to how long the individual has worked in the organization, the amount of time that they spend with clients and the average number of hours that he/she works. The third regression equation predicted individual participants' CF scores using the organizational homogeny scores (i.e. SD) in addition to the predictors used in the second regression equation. The difference in R^2 for the first versus the second, and third regression equations represents the contribution of organizational culture to individual CF ratings.

Descriptive Data

The amount of organizational CS, STS, CF, and burnout differed across the organizations assessed (Table 2). The organization that experienced the most compassion satisfaction (CS) was the inpatient chemical dependency and chronic pain unit. The organization that experienced the least CS was the inpatient culinary department. The inpatient culinary department also reported the highest mean burnout (B) scores. The organization with the lowest amount of burnout was the fine dining restaurant. Additionally, the organization that reported the highest amount of secondary traumatic stress (STS) was the inpatient general psychiatric unit, while the

organization with the lowest rating of STS was the community mental health clinic. Finally, the

inpatient general psychiatric unit also reported the highest amount of CF with the community

mental health center reporting the lowest CF rating.

Not only did the various organizations report differing amounts of CF, STS, CS, and

burnout, results also indicated that they differed in their corporate culture as measured by the

mean OPC ratings of the employees working in the organization. Table 3 summarizes the mean

OPC rankings for the 16 organizations surveyed. Although there were different cultures

endorsed, the majority of the organizations reported a culture that valued either attention to detail

or team orientation. Two organizations reported a culture that emphasized innovation, one

reported a culture that emphasized supportiveness, and one organization reported a culture that

had an emphasis on rewards. Table 3 summarizes the means for 8 OPC scales for the 16

organizations surveyed.

Correlations

The correlations among individual participants' ProQOL subscale scores and individual

participants' OPC scores are summarized in Table 4.

There was a large positive correlation between compassion fatigue and STS, and between

CF and burnout which makes sense because STS and burnout are the two factors that contribute

to the overall experience of compassion fatigue. The inter-correlations among these ProQol

subscales are what we would expect given our knowledge of the contribution of STS and burnout

in determining compassion fatigue.

Table 2.

Mean ProQOL scores for the sixteen organizations

Organization	ProQOL Compassion Satisfaction		ProQOL Burnout		ProQOL Secondary Traumatic Stress		Compassion Fatigue	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
IP Gen Psych (*n* =16)	37.62	5.97	24.94	6.76	21.88	6.80	46.81	12.81
IP CD Unit (*n* =12)	39.83	4.95	24.25	4.81	20.00	3.05	44.25	6.58
IP Active Duty Unit (*n* =10)	40.10	4.75	21.70	3.27	19.90	4.65	41.60	7.06
IP CD/Pain Unit (*n* =10)	42.00	6.58	21.00	5.68	19.90	5.55	40.90	10.40
IP Social Services (*n* =16)	39.38	6.15	24.06	5.63	21.50	4.46	45.56	9.04
IP Culinary (*n* =4)	33.75	11.79	26.00	4.08	18.75	4.03	44.78	7.27
IP Intake (*n* =12)	38.17	4.15	23.75	3.44	19.33	5.14	43.08	6.84
Outpatient (*n* =11)	40.45	5.73	21.18	3.12	16.82	3.22	38.00	4.17
Medical Clinic (*n* =34)	41.32	4.93	19.53	4.47	17.94	3.72	37.47	7.15
CMH (*n* =12)	41.25	4.59	18.83	4.17	16.42	3.26	35.25	6.15
HCC (*n* =8)	39.75	4.46	20.62	3.20	18.13	5.08	38.75	7.03
National Bank (*n* =5)	39.00	6.56	22.40	6.11	19.00	3.24	41.40	7.73
Machine Sales (*n* =5)	39.40	5.59	21.80	4.15	18.20	3.11	40.00	6.89
Fast Food (*n* =18)	37.11	7.87	20.44	3.97	19.17	5.35	39.61	8.06
Casual Dining (*n* =7)	37.71	6.29	24.00	4.58	21.00	3.51	45.00	7.09
Fine Dining (*n* =13)	40.54	5.64	19.38	4.61	18.92	4.79	38.31	7.40
Total (*n* =193)	39.58	5.87	21.70	4.97	19.17	4.65	40.87	8.44

Notes to Table 2. Organization Abbreviations are as follows:

      IP Gen Psych: Inpatient general psychiatric unit; IP CD Unit: Inpatient chemical dependency unit; IP Active Duty Unit: Inpatient active duty military unit; IP CD/Pain Unit: Inpatient chemical dependency and chronic pain unit; IP Social Services: Inpatient social services department; IP Culinary: Inpatient culinary department; IP Intake: Inpatient intake department; Outpatient: Outpatient mental health services; Medical Clinic: Low SES medical clinic; CMH: Community mental health clinic; HCC: University health and counseling center; National Bank: National bank; Machine Sales: Machine tools sales; Fast Food: Fast food restaurant; Casual Dining: Casual dining restaurant ; Fine Dining: Fine dining restaurant

Correlation results also indicated that the OPC scales are orthogonal and measure separate cultural domains. The exceptions to this were scales measuring supportiveness, aggressiveness, and decisiveness. There was a negative relationship between supportiveness and aggressiveness. There was also a negative correlation between decisiveness and aggressiveness.

Only two small correlations were discovered between OPC and ProQOL scales out of thirty-two possible relationships. There was a .2 correlation between compassion fatigue and reward emphasis and a .25 correlation between STS and reward emphasis. This means that for individuals, there was no relationship between the ProQOL scores and that individual's OPC ratings. In other words, an individual's organizational values did not have much influence on the amount of CF they experienced.

Small positive correlations were found between the numbers of weekly hours worked and the weekly time spent with patients, burnout, compassion fatigue, and STS. There was no correlation between the number of hours worked, the number of hours spent with patients, and compassion satisfaction. This shows that working more hours and spending more face time with patients did not increase a person's experience of compassion satisfaction.

Table 3.

Mean OCP Rankings for 16 Organizations.

Organization	Innovation		Attention to Detail		Outcome Oriented		Aggressiveness	
	M	SD	M	SD	M	SD	M	SD
IP Gen Psych (*n* = 16)	4.51	1.07	5.52	1.02	4.98	.98	3.59	1.12
IP CD Unit (*n* = 13)	4.90	.80	5.13	1.02	4.94	.89	3.73	.89
IP Active Duty Unit (*n* = 10)	5.56	1.11	5.50	.81	5.14	1.21	3.43	.82
IP CD/Pain Unit (*n* =10)	4.68	.81	5.00	1.47	4.80	.47	3.63	.92
IP Social Services (*n* =16)	5.67	.97	5.23	.88	5.08	1.08	3.47	.74
IP Culinary (*n* = 4)	4.72	.58	6.08	.69	4.70	.74	3.38	.60
IP Intake (*n* =12)	4.96	.83	4.86	1.14	4.98	.93	3.52	1.07
Outpatient (*n* = 11)	4.58	.95	6.09	.91	5.13	1.21	3.73	1.10
Medical Clinic (*n* =34)	4.54	.81	5.60	.88	4.95	.93	3.52	.98
CMH (*n* =12)	5.14	.77	6.11	1.09	4.63	.98	3.44	1.14
HCC (*n* =8)	4.83	.59	5.83	1.36	4.83	1.23	3.28	.67
National Bank (*n* = 5)	4.87	.81	5.07	1.12	4.88	.73	4.40	1.35
Machine Sales (*n* =5)	4.91	.79	4.67	.78	4.80	.71	4.65	.89
Fast Food (*n* =18)	4.75	.63	5.37	1.19	5.21	.61	4.67	1.08
Casual Dining (*n* = 7)	4.70	.87	5.33	.84	5.26	.55	4.50	1.04
Fine Dining (*n* =13)	4.60	.74	4.64	1.08	5.40	.90	4.58	1.24

Table 3a

Mean OCP Rankings for 16 Organizations (cont.)

Organization	Supportiveness		Emphasis on Rewards		Team Orientation		Decisiveness	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
IP Gen Psych (*n* =16)	5.25	.70	5.42	.77	5.43	.68	5.17	.93
IP CD Unit (*n* =13)	5.29	.68	5.10	.98	5.43	.65	5.36	1.12
IP Active Duty Unit (*n* =10)	4.80	.69	5.10	.82	5.34	.72	5.27	.94
IP CD/Pain Unit (*n* = 10)	5.08	.77	5.00	.70	5.61	.54	5.20	1.04
IP Social Services (*n* =16)	5.49	.71	5.00	.76	5.43	.62	5.40	.87
IP Culinary (*n* =4)	4.96	.58	4.67	.27	5.43	.72	4.33	.47
IP Intake (*n* =12)	5.04	1.03	5.33	.99	5.46	.87	5.11	1.15
Outpatient (*n* =11)	4.94	.68	5.06	.66	4.96	.52	5.36	.97
Medical Clinic (*n* =34)	4.98	.60	5.02	.89	5.44	.74	5.26	1.01
CMH (*n* =12)	5.22	.97	4.58	.61	5.45	.86	5.42	.85
HCC (*n* =8)	5.10	.72	4.92	.83	5.43	.75	5.50	1.14
National Bank (*n* = 5)	4.90	1.19	5.20	1.21	5.66	1.02	5.20	1.07
Machine Sales (*n* =5)	4.93	.57	5.27	.80	5.09	.74	4.80	1.14
Fast Food (*n* =18)	5.20	.54	5.18	1.37	5.22	1.09	4.59	1.25
Casual Dining (*n* =7)	4.74	.80	5.00	.88	5.76	.75	5.19	1.00
Fine Dining (*n* =13)	4.94	.64	5.36	.87	5.45	.67	5.15	.67

Notes on Table 3. Organization Abbreviations are as follows:

IP Gen Psych: Inpatient general psychiatric unit; IP CD Unit: Inpatient chemical dependency unit; IP Active Duty Unit: Inpatient active duty military unit; IP CD/Pain Unit:

Inpatient chemical dependency and chronic pain unit; IP Social Services: Inpatient social services department; IP Culinary: Inpatient culinary department; IP Intake: Inpatient intake department; Outpatient: Outpatient mental health services; Medical Clinic: Low SES medical clinic; CMH: Community mental health clinic; HCC: University health and counseling center; National Bank: National bank; Machine Sales: Machine tools sales; Fast Food: Fast food restaurant; Casual Dining: Casual dining restaurant ; Fine Dining: Fine dining restaurant

When analyzing how the four ProQOL scales (CS, Burnout, STS and CF) were related to organizational means on the eight OPC domains (Table 5), we found that individuals had more CF if they worked for organizations that were innovative, had a reward emphasis, and had less attention to detail, as small correlations were found with these variables.

There were some interesting inter-correlations among the OPC subscales at the organizational level. For example, there was a large negative correlation between supportiveness and innovation. This means that the more supportive an organizational culture was, the less innovative it was. There was also a medium negative correlation between innovation and team orientation, indicating that when an organization's culture was high on innovation, it was low on team orientation and supportiveness. Additionally, when an organization valued attention to detail, they also were less outcome oriented, aggressive and reward focused. Finally, there was a medium correlation between decisiveness and innovation. The more decisive an organization was the more innovative their culture was.

Table 4

Correlations of CS, Burnout, STS, and CF with Individual Participant OPC Scores

	CF	Burn-out	STS	IN	AD	OO	AG	S	RE	TO	D	Weekly Hours Worked	Weekly Hours w/ Pt.'s
ProQol Burnout	.89												
ProQol STS	.87	.54											
Innovation (IN)	-.01	-.01	-.00										
Attention to Detail (AD)	.00	.03	-.03	-.06									
Outcome Oriented (OO)	-.04	-.03	-.04	-.13	-.03								
Aggressiveness (AG)	-.06	-.05	-.05	.10	-.14	.19							
Supportiveness (S)	-.07	-.09	-.04	.07	-.13	-.30	-.35						
Reward Emphasis (RE)	.21	.13	.25	-.15	-.19	.06	.11	-.13					
Team Orientation (TO)	-.02	-.07	.03	-.12	-.24	-.03	-.18	.11	.02				
Decisiveness (D)	.08	.07	.07	.06	.06	-.14	-.30	.16	-.01	-.00			
Weekly Hours Worked	.14	.13	.12	-.08	.01	-.01	-.05	-.01	-.05	-.01	.04		
Weekly Hours w/ Pt.'s	.19	.14	.21	.02	-.12	.03	.13	-.08	-.11	-.00	-.03	.7	
Months worked	-.04	-.00	-.07	-.08	-.02	.01	.05	-.06	.03	.00	-.08	.30	.06

Table 5.

Correlations of Individuals' Means on CS, Burnout, STS, and CF with Organizational Means on Eight OPC Domains.

	CS	Burn-out	STS	CF	Org IN	Org. AD	Org. OO	Org AG	Org S	Org RE	Org.TO
Org. Innovation (IN)	-.01	.11	.09	.12							
Org. Attention to Detail (AD)	.02	-.08	-.15	-.13	-.07						
Org. Outcome oriented (OO)	-.07	.01	.08	.05	-.02	-.52					
Org. Aggressiveness (AG)	-.07	-.01	.09	.04	.26	-.47	.49				
Org. Supportive (S)	-.05	.06	.05	.07	-.54	.24	-.21	-.34			
Org. Reward Emphasis (RE)	-.02	.08	.10	.10	.27	-.39	.70	.51	-.38		
Org. Team Orientation (TO)	-.01	-.03	-.13	-.09	-.38	.17	-.14	.29	.09	-.45	
Org. Decisiveness	.06	-.04	.09	.02	.39	-.07	-.12	.33	.20	.03	-.52

** Correlation is significant at the 0.01 level (2-tailed): $N = 193$.

Table 6.

Correlations of Individuals' Means on CS, Burnout, STS, and CF with Organizational Standard Deviations on Eight OPC Domains.

	CS	Burn-out	STS	CF	*SD* Org. I	*SD* Org. AD	*SD* Org. OO	*SD* Org. AG	*SD* Org. S	*SD* Org. RE	*SD* Org. TO
SD Org. Innovation (I)	.03	.19	.16	.20							
SD Org. Attention to Detail (AD)	.02	-.08	-.00	-.05	-.43						
SD Org. Outcome Oriented (OO)	.07	.01	-.05	-.02	.45	-.36					
SD Org. Aggressiveness (AG)	.01	-.13	-.07	-.11	-.02	.17	-.26				
SD Org. Supportiveness (S)	.01	.08	-.01	.04	.14	.28	.05	.28			
SD Org. Reward Emphasis (RE)	-.07	-.06	.03	-.02	-.35	.29	-.39	.31	-.13		
SD Org. Team Orientation (TO)	-.13	-.10	-.06	-.09	-.51	.22	-.38	.38	.13	.73	
SD Org. Decisiveness	-.03	-.02	-.01	-.01	-.23	.38	-.28	.01	-.01	.71	.48

When analyzing the relationship between standard deviations and OPC domains (see Table 6) we found two small relationships. There was a small relationship between CF and agreement on the culture's innovativeness. The less agreement there was about how innovative their culture, the more compassion fatigue the individuals within that organization experienced. There was also a small negative correlation between CF and aggressiveness.

There are also several correlations among the Standard Deviations of organizations' OPC scales. For example, the more consistency there was on the value placed on innovation within an organization, the less consistency was found in the values of team orientation, attention to detail, and reward emphasis. The more consistency there was within and organization on the value of aggressiveness, the more consistency there was in the values of supportiveness, reward emphasis, and team orientation. These findings are summarized in Table 6.

Multiple Regression Analysis

Three regression analyses were conducted. Each attempted to predict individual compassion fatigue. All three analyses used a simultaneous entry procedure (i.e., all of the dependent variables entered the model simultaneously and none were removed). The simultaneous entry technique allows one to examine the Beta weights to rank order contribution of every predictor. In addition to the demographic items of (tell me what they are), the predictors for the first regression analysis were the individual OPC scores, how long he/she has worked in the organization, the average number of hours that he/she works, and the average amount of time spend in direct contact with clients. The second regression analysis used all the predictors of the first regression as well as the mean score for that organization (based on the mean of the individuals in the organization who rated that domain). The third regression

included all the predictors of the second regression and the standard deviations of the ratings of each domain. The standard deviation tells the variability in ratings of that domain by all of the individuals within that organization, (i.e., how much the members of the organization agree on a value).

Regression using individual ratings of organizational culture to predict individual CF. The first regression model accounted for 7% of the variance in individual compassion fatigue, $R^2 = .067$; $p = .11$. The beta weights for the individual ratings on the OPC domains are shown in column one of Table 7. Only an individual's emphasis on rewards was found to be a significant predictor of his or her compassion fatigue.

Regression using individual ratings of organizational culture and mean scores for the organization to predict individual CF. The second regression model accounted for 18% of the variance in individual compassion fatigue, $R^2 = .179$; $p = .003$. The beta weights for the individual ratings on the OPC domains and mean scores for the organization are shown in column two of Table 7. The individual's reward emphasis continued to be a significant predictor of individual compassion fatigue. More importantly, group means on the OPC domains are significant predictors of individual compassion fatigue. The best predictors are organizational-level supportiveness followed by the organization's culture of innovation, decisiveness, attention to detail, and reward emphasis (in that order).

Table 7.

Beta Weights for Three Regression Models Predicting Individual Compassion Fatigue.

	Regression 1		Regression 2		Regression 3	
	Beta	sig	Beta	sig	Beta	sig
Innovation	.03	.70	-.03	0.69	-.04	.62
Detail	.01	.94	.05	0.57	.04	.61
Outcome Oriented	-.10	.48	-.09	0.25	-.09	.21
Aggressiveness	-.10	.25	-.11	0.19	-.09	.29
Supportiveness	-.10	.22	-.15	0.07	-.16	.05
Reward.Emphasis	.22	.00	.19	0.01	.18	.02
Team.Orientation	-.00	.70	-.04	0.56	-.04	.56
Decisiveness	.06	.45	.07	0.35	.08	.26
Org.inovation			.39	.00	1.29	.21
Org.detail			-.21	.02	1.62	.15
org.outcome			-.12	.32	1.66	.09
org.aggressiveness			.13	.22	.24	.11
org.supportive			.44	.00	-2.30	.18
org.reward.emphasis			.11	.38	-.55	.18
org.team			-.06	.52	-.52	.09
org.decisiveness			-.29	.01	.25	.23
SD.org.innovation					-.22	.26
SD.org.detail					-.69	.10
SD.org.outcome					-.59	.01
SD.org.aggressiveness					1.99	.12
SD.org.supportiveness					1.37	.21
SD.org.rewards					-2.04	.19
SD.org.team					.02	.90
SD.org.decisiveness					.02	.90

Regression using individual ratings of organizational culture, mean scores for the organization, and the consistency amongst the raters to predict individual CF. The third regression model accounted for 24% of the variance in individual compassion fatigue, $R^2 = .239$; $p = .001$. The beta weights for the individual ratings on the OPC domains, mean scores for the organization, and consistency amongst the raters are shown in column three of Table 7. Individuals' reward emphasis remained a significant predictor of individual compassion fatigue. Organizational aggressiveness was also found to be a significant predictor of individual compassion fatigue. None of the other organizational means are significant predictors.

Organizational mean OPC ratings and consistency within the organizational ratings account for 17% of the variance in individual compassion fatigue. This was determined by subtracting the variance accounted for in the first regression equation from the variance accounted for in the third regression. In other words, the demographic predictors and the individual ratings on the eight OPC domain predictors from the first regression equation were taken away and the R^2 was recalculated using the organizational means and standard deviations alone.

Chapter 4

Discussion

This study explored the relationship between organizational culture and compassion fatigue. For the purpose of this study, organizational culture was conceptualized as the mean value ratings of individuals within an organization as well as the level of agreement on those values within the organization. It was hypothesized that organizational culture would make a significant contribution to the ability to predict individual's CF. When the means and standard deviations of the OPC ratings were used as a predictor, significantly more variance of an individual's CF was accounted for than when the individuals' responses alone were used as predictors (i.e., 17% of the variance).

The interrelationship found between STS, Burnout, CF, and CS were previously proposed by Stamm in 2005. Results of this study confirm that burnout and STS are the components that most make up CF. Further, results of this study were also consistent with Stamm's (2005) and Collins and Long's (2003) findings suggesting that CS is a protective factor for CF.

In 2007, Sprang, Clark, and Whitt-Woosley found a compassion fatigue incidence rate of about 39% in a general population of mental health providers during the usual course of their professional practice. Consistently, results of this study found an incidence rate of CF of about 38%-45% among the mental health professionals surveyed. Members of organizations whose focus was not upon mental health care had an incidence rate of CF of 35%-43%. Differences

among the organizations surveyed were due, in small part, to factors such as organizational culture.

Although limited research exists on the relationship between organizational culture and compassion fatigue, results of this study were consistent with available previous research. Previous research on the relationship between organizational characteristics that predict the development of STS concluded that organizations with diffused goals are more predictive of STS in employees (Townsend & Campbell, 2009). This is consistent with results of this study which found that organizations with less decisiveness and higher variability in their organizational value ratings tended to have more CF. Additionally, previous research indicates that having adequate resources such as time, materials, space, funds, knowledge, and skills can reduce the risk of employees developing STS (Bell et al., 2003). This is similar to results of this study which indicate that the level of supportiveness in an organizational culture is a strong predictor of an individual's ability to resist CF. These results are similar given the assumption that a supportive organization is more likely to offer resources to an employee than a less supportive organization.

Implications

Implications for the conceptualization of CF, for practice, and for policy reform can be made from the current study's results. First, CF is current conceptualized as being an individual experience and is largely seen as a private matter. The results of this study indicate that the current conceptualization may be limited in that it does not take into account the community component of this phenomenon. Current results indicate that CF is not only an individual

experience but there is also a cultural or community component that has not been adequately

explored.

Second, these findings have practical implications. Various interventions within

organizations can be implemented to reduce CF in members of organizations and thus improve

employee retention and organizational spending. Early resignation and higher staff turnover

have been proposed results of secondary stress (Sexton, 1999). High levels of psychological

distress can lead to burnout which can be problematic in that it leads to high turnover. A report

from the Child Welfare Workforce Survey: State and county data and findings (Cyphers, 2001)

revealed that in 43 states, child protection caseworkers have a 22% median annual turnover rate

(Conrad & Keller-Guenther, 2006). The loss of experienced and skilled staff can demand the use

of further financial resources when training new staff members. In addition, when organizations

must replace staff with inexperienced trauma therapists, they are challenged with the fact that the

novice employees are more likely to suffer CF than more experienced professionals. These

inexperienced employees require more support and supervision than more experienced

professionals (Neumann & Gamble, 1995; Pearlman & Mac Ian, 1995).

A better understanding of the effects of CF on organizational culture may also prompt

management to require more evidence-based practices to be used by providers. Clinicians who

use evidence-based practices have the strongest efficacy in treating trauma in adults. This

efficacy causes clinicians to feel more effective. Utilizing evidence-based practices in clinical

work may affect the relationships between secondary traumatic exposure and the development of

CF. In experienced clinicians, using evidence-based practices has been found to reduce burnout

and CF, and increase CS (Craig & Sprang, 2010).

More knowledge about the harmful effects of CF on an organizational culture may result in policies to decrease it. These policies will protect organizations from costly legal suits brought against organizations. Due to the fact that CF is a severe occupational hazard, it raises damaging occupational health and safety issues in the field. This is particularly likely in circumstances in which an organization has no support systems in place to protect employees against the dangers of CF, to assist them in coping with its effects (Sexton, 1999), or to increase their experience of CS.

Initially, employees must be educated not only about the risks of compassion fatigue, but also about the individual values that can contribute to its development. Employees should be encouraged to find motivation for their work outside or external rewards. Building one's sense of accomplishment and effectiveness through internal motivations can decrease the risk of the development of compassion fatigue. Employees should seek support systems and work to remain cognoscente about successes and internal rewards gained from each member of their support group. Organizations would benefit greatly from increasing resources such as work space, supplies, sufficient time, and appropriate breaks.

Finally, this study has implications for how organizations can develop policies that will decrease the likelihood that employees will develop CF. There are many things that hospital administrators can do to influence the culture of the organizations they run. Importantly, hospital administration should seek polices that will increase supportiveness in the organization and decrease aggressiveness. These policies could include mandatory team meetings in which they offer praise to employees and acknowledge achievements. They can also implement programs in which employees recognize one another for dedication to patient care and supportive team work.

Administrators can set up support groups in which member of organizations can meet on a weekly or monthly basis to discuss struggles and successes that they have experienced.

Limitations

Limitations of this study can be found within the conceptualization and data collection stage. The first limitation stems from their being two ways in which organizational culture can be conceptualized. While this study conceptualized organizational culture as being made up of values held by the individuals in an organization, another conceptualization exists in which organizational culture is seen as being made up of behavioral aspects. Due to time constraints and study manageability, the current study only explored one conceptualization and how that related to compassion fatigue. The second limitation emerged in the data collection stage. The OCP was developed as a tool in which employees are directed to rate their organization on various values that they believe it to have. For consistency in conceptualization, this study requested that participants rate their own values rather than to hypothesize values of their organization. This may be a limitation in that results may have been impacted by this method of data collection. To control for this, the various scales were evaluated and it was found that they were in fact measuring different variables.

Building on the current research, much future research is warranted. Most obviously, future researchers may choose to replicate this study while using the behavioral conceptualization of organizational culture. Future research could also include the implementation of polices aimed at changing organizational culture and the determination of how culture was impacted and if levels of CF were altered. Future research may include

surveying organizations with varying levels of CF and exploring current polices that may be

safeguarding healthy organizational cultures.

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Appendix A: OPC Scoring

OPC items by factor placement

Factor	Items
Innovation	Adaptability
	Stability *
	Being innovative
	Risk taking
	Being rule oriented *
	Not being constrained by many rules
	Informality
	Being highly organized *
	Security of employment *
Attention to Detail	Being reflective
	Being analytical
	Paying attention to detail
Outcome Oriented	Achievement orientation
	Being results oriented
	High performance expectations
	Being calm *
	An emphasis on quality
Aggressiveness	Being quick to take advantage of opportunities
	Being competitive
	Being Aggressive

	Being socially responsible *
Supportiveness	Sharing information freely
	Fairness
	Tolerance
	Praise for good performance
	Being supportive
	Working long hours
Emphasis on rewards	Opportunities for professional growth
	High pay for good performance
	Having a good reputation
Team Orientation	Being team oriented
	Taking individual responsibility*
	Autonomy*
	Being people oriented
	Developing friends at work
	Enthusiasm for the job
	Being distinctive *
Decisiveness	Decisiveness
	Confronting conflict directly *
	Having a clear guiding philosophy

*** Asterisks represent items that are reverse scored*

Appendix B: ProQol Scoring

ProQol items by factor placement

Factor	Item
Compassion Satisfaction	I get satisfaction from being able to [help] people
	I feel invigorated after working with those I [help]
	I like my work as a [helper]
	I am pleased with how I am able to keep up with [helping] techniques and protocols
	My work makes me feel satisfied
	I have happy thoughts and feelings about those I [help] and how I could help them
	I believe I can make a difference through my work
	I am proud of what I can do to [help]
	I have thoughts that I am a "success" as a [helper]
	I am happy that I chose to do this work
Burnout	I am happy *
	I feel connected to others *
	I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help]
	I feel trapped by my job as a [helper]
	I have beliefs that sustain me *
	I am the person I always wanted to be *
	I feel worn out because of my work as a [helper]

I feel overwhelmed because my case [work] load seems endless

I feel 'bogged down' by the system

I am a very caring person *

Secondary Traumatic Stress   I am preoccupied with more than one person I [help]

I jump or am startled by unexpected sounds

I find it difficult to separate my personal life from my life as a [helper]

I think that I might have been affected by the traumatic stress of those I

[help]

Because of my [helping], I have felt "on edge' about various things

I feel depressed because of the traumatic experiences of the people I

[help/ serve]

I feel as though I am experiencing the trauma of someone I have

[helped]

I avoid certain activities or situations because they remind me of

frightening experiences of the people I [help]

As a result of my [helping], I have intrusive, frightening thoughts

I can't recall important parts of my work with trauma victims

*** Asterisk represent items that are reverse scored*

Appendix C: Curriculum Vitae

Katherine M. Condrey

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EDUCATION

Doctorate of Psychology Candidate	08/2011 to Present

George Fox University Newberg, OR

Graduate Department of Clinical Psychology: APA Accredited Institution GPA: 3.88

Masters of Clinical Psychology	08/2011 to 05/2013

George Fox University Newberg, OR

Graduate Department of Clinical Psychology: APA Accredited Institution GPA: 3.93

Bachelor of Arts, Psychology	01/2008 to 12/2010

University of Idaho Coeur d'Alene, ID Institution

GPA: 3.89

SUPERVISED CLINICAL EXPERIENCE

Psychology Resident	07/2015 to Present

Mississippi State Hospital, Whitfield, MS

- o Description: Mississippi State Hospital is a publicly funded behavioral health program of Mississippi Department of Mental Health. The hospital is located on a 350-acre campus. Mississippi State Hospital operates 476 hospital beds and is accredited by the Joint Commission. The program also includes 379 licensed nursing home beds. The program emphasizes the integration of evidence-based practice, personal and interpersonal development, and a trauma-informed, recovery-based approach to inpatient care. Residents are encouraged to approach clinical practice from a person-centered stance, to utilize current professional literature when selecting and implementing the most efficacious clinical procedures, and to objectively assess treatment outcomes. Throughout their training, residents are considered colleagues in training, and are therefore held to standards commensurate with such an advanced role. Collaborative interaction with professionals from other clinical disciplines is essential in such an interdisciplinary setting, as this promotes intellectual stimulation, mutual respect, and the necessity of a multi-faceted view of patient care. The MSH training program strives to provide residents with appropriate professional and

personal growth experiences, constructive feedback, and quality supervision in all areas of professional practice, consistent with the overarching goal of training culturally-competent psychologists who can assume professional roles in a multitude of settings.

- o Duties: Provide individual and group psychotherapy to female patient's admitting to the hospital for chemical dependency issues; facilitate DBT skills groups for adult female patients; complete administrative project which entails restructuring of a clinical service provided at MSH; Complete cognitive, projective, and personality assessments and reports; supervise a practicum student working at MSH; attend two hours of group supervision weekly; attend one hour of assessment supervision weekly; attend one hour of supervision of supervision weekly; attend all didactic presentations; provide a training on compassion fatigue and organizational culture to all psychology staff members; provide a case presentation to all psychology staff members; attend all internship committee meetings and act as Chief Resident; facilitate individual trauma treatment for patients of various ages and demographics; complete individual and group psychotherapy with patients actively psychotic and experiencing severe and persistent mental illness symptoms.

- o Supervisor: Dr. Joseph Griebler
  Contact Information: Dr. Griebler: (601) 351-8000, ext. 4929

Clinical Team- Fourth Year Oversight   09/2014 to 06/2015
George Fox University, Newberg, OR

- o Description: Each year students from the Graduate Department of Clinical Psychology are assigned to a team led by a core faculty member. Teams are composed of students from each year in the program. Clinical teams meet weekly and discuss therapy or assessment cases from practicum experiences. A fourth year students are assigned to second year students who they mentor and provide clinical oversight and supervision for.

- o Duties: Meet weekly with second year student, assist in the development of the student's clinical and assessment skills; help in the development of the student's theoretical orientation and personal style of therapy ; evaluate student's development of clinical and professional skills; provide feedback on performance across multiple domains.

- o Supervisor: Dr. Mark McMinn, Ph.D., A.B.P.P.
  Contact Information: Dr. McMinn: (503) 554-2380

Oregon State Hospital Therapist (158 hours direct patient contact, 95 hours supervision)   08/2014 to 06/2015 Oregon State Hospital, Salem, OR

- o Description: Oregon State Hospital is the primary state-run forensic psychiatric hospital in the state of Oregon. This psychiatric hospital serves patients who have been found guilty except for insanity, and those who have been deemed unfit to stand trial. All patients are under the jurisdiction of the psychiatric security review board.

- o
  Duties: Provide group and individual therapy for patients presenting with acute psychiatric diagnoses; participate in multidisciplinary treatment team meetings; complete initial psychological assessment reports; complete violence risk assessments; attend didactics on a bimonthly basis; observe forensic evaluations and psychiatric security review board hearings.

- o
  Supervisor: Dr. Timothy Connor, Psy.D.
  Contact Information: Dr. Connor: (503) 947-1064

Willamette Family Medical Center Therapist (280 hours direct patient contact, 102 hours supervision)   07/2013 to 06/2014

Willamette Family Medical Center, Salem, OR

- o
  Description: Willamette Family Medical Center is a group practice medical clinic serving low socioeconomic status patients with a variety of medical and mental health needs. The clinic serves a diverse population of patients including diversity in ethnicity, gender, age, religion, and sexual orientation. Patients work with a multidisciplinary team of medical providers, registered nurses, social workers, and psychotherapists. Psychotherapy provided at Willamette Family Medical Center is structured as both co-located, 50 minute sessions and brief behavioral health interventions.

- o
  Duties: Provide crisis interventions upon medical providers' request; provide behavioral health consultation to patients struggling with medical recommendation compliance; provide short-term therapy with patients suffering from a wide variety of mental health and behavioral health concerns; complete psycho-diagnostic and neuropsychological assessments; provide health psychology trainings for medical providers.

- o
  Supervisor: Joel Gregor, Psy.D.
  Contact Information: Dr. Gregor: (503) 554-2367

Chronic Pain Therapist (241 hours direct patient contact, 50 hours supervision)   04/2013 to 08/2013

Universal Health Services, Cedar Hills Hospital, Beaverton, OR

- o
  Description: Cedar Hill Hospital is an inpatient psychiatric and chemical dependency hospital serving adult patients with a variety of acute mental health issues including chemical dependency, chronic pain, military specific trauma, post-traumatic stress disorder, dual diagnosis, personality disorders, and severe and persistent mental illness. Patients work toward recovery with a multidisciplinary team of therapists, psychiatrists, social workers, adjunct therapists, mental health technicians, and nurses.

- o
  Duties: Provide group and individual therapy to chronic pain patients with the goal of developing holistic methods of managing pain; participate in multidisciplinary treatment team meetings; complete treatment plans and case conceptualizations; complete discharge planning including locating community resources for patients.

- ○
  Supervisors: Jon Benson, Psy.D. Mike Siegel, M.A.

  Contact Information: Dr. Benson: (360) 931-3843, Mike Siegel: (503) 381-6453

Severe Psychopathology Therapist (68 hours direct patient contact, 45 hours supervision)   01/2013 to 04/2013

Universal Health Services, Cedar Hills Hospital, Beaverton, OR

- ○
  Description: See Above

- ○
  Duties: Provide group and individual therapy for patients presenting with severe and persistent mental illness; participate in multidisciplinary treatment team meetings; complete treatment plans and case formulations; complete discharge planning including locating necessary community resources for patients.

- ○
  Supervisors: Jon Benson, Psy.D. Mike Siegel, M.A.

  Contact Information: Dr. Benson: (360) 931-3843, Mike Siegel: (503) 381-6453

Chemical Dependency Therapist (94 hours direct patient contact, 44 hours supervision)   10/2012 to 01/2013

Universal Health Services, Cedar Hills Hospital, Beaverton, OR   ○   Description: See Above

- ○
  Duties: Provide group and individual therapy for patients presenting for chemical dependency; participate in multidisciplinary treatment team meetings; complete treatment plans and case conceptualizations; assist patients in completing 12-Step work; develop relapse prevention plans with patients; complete discharge plans including assisting patients in locating community resources.

- ○
  Supervisors: Jon Benson, Psy.D. Mike Siegel, M.A.

  Contact Information: Dr. Benson: (360) 931-3843, Mike Siegel: (503) 381-6453

Assessment Center Counselor (31 hours direct patient contact, 30 hours supervision)   07/2012 to 10/2012

Universal Health Services, Cedar Hills Hospital, Beaverton, OR

- ○
  Description: See Above

- ○
  Duties: Provide crisis interventions to patients in active decompensation; complete intake evaluations for patients entering inpatient and outpatient treatment; develop initial diagnosis recommendations; provide phone interventions with potential patients; determine and provide recommendations for level of care needed.

- ○
  Supervisors: Jon Benson, Psy.D. Mike Siegel, M.A.

  Contact Information: Dr. Benson: (360) 931-3843, Mike Siegel: (503) 381-6453

Pre-Practicum (20 hours direct patient contact, 56 hours supervision)   08/2011 to 03/2012

George Fox University Graduate Department of Clinical Psychology, Newberg, OR.

○   Duties: Practice Rogerian style psychotherapy with undergraduate students; develop rapport quickly; complete treatment plans and intake interviews.

○   Supervisors: Mary Peterson, Ph.D.; Syrett Torres, M.A.

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RELEVANT EMPLOYMENT EXPERIENCE

Social Services Therapist (1,149 hours therapy provided)   3/2013 to Present

Universal Health Services, Cedar Hills Hospital, Beaverton, OR

○   Description: Cedar Hill Psychiatric Hospital is an inpatient hospital serving adult patients with a variety of acute mental health issues including chemical dependency, chronic pain, military specific trauma, post-traumatic stress disorder, and severe and persistent mental health illness. Patients work toward recovery with a multidisciplinary team of therapists, psychiatrists, and nurses.

○   Duties: Provide group and individual therapy for patients presenting with chronic pain, chemical dependency, severe and persistent mental illness, dual diagnosis, and trauma; provide group and individual therapy for active duty military patients; act as an integral part of multidisciplinary treatment team meetings; complete treatment plans and case conceptualizations; coordinate with insurance providers on behalf of patients; complete discharge plans include helping patients gain access to community resources. Additional experience includes milieu therapy.

○   Supervisors: Steven Rodgers, L.P.C., L.M.F.T.; Mario Bolivar, M.A.

Contact Information: Steven Rodgers: (503) 292-2273, Mario Bolivar: (503) 944-5000 x278

Drop-In Center Coordinator   01/2010 to 01/2011

Project Safe Place, Coeur d'Alene, Idaho

Description: Project Safe Place is a non-profit organization that serves at-risk youth. The Project Safe Place Drop-In Center provides adolescents with a safe environment during the hours after school. Adolescents are provided with mentors, case management, food, clothing, and educational groups.

○   Duties: Provide case management for twenty clients between the ages of ten-years-old and twenty-years-old; conduct intake and exit interviews; perform suicide assessments and violence risk assessments; provide guidance in employment searching; complete appropriate documentation; run educational groups; conduct staff meetings with college interns, volunteers, and staff members before each shift; head Youth Government program as Staff Advisor; preform administrative duties for food

bank; represent Project Safe Place at community meetings; assist in program development; attended weekly supervision meetings.

- ○   Supervisor: Brandi Smitherman, B.A. Psychology
Contact Information: Brandi Smitherman: (208) 676-0772

Host Home Coordinator   01/2010 to 01/2011
Project Safe Place, Coeur d'Alene, Idaho

- ○   Description: The Project Safe Place Host Home Program provides temporary sheltering for adolescents in crisis. A twenty-four hour crisis line is available for sheltering emergencies. Clients are sheltered with host home families for up to twenty-eight days. Case management is provided for clients and families to locate permanent sheltering.

- ○   Duties: Carry crisis phone two weeks out of every month; schedule crisis phone workers; perform case management; perform intake and exit interviews with clients and legal guardians; facilitate solution-oriented meetings with clients and guardians; provide assistance in finding permanent sheltering; complete appropriate documentation; attend weekly supervision meetings.

- ○   Supervisor: Brandi Smitherman, B.A. Psychology
Contact Information: Brandi Smitherman: (208) 676-0772

VOLUNTEER EXPERIENCE

Drop-In Center Youth Mentor   06/2009 to 01/2010
Project Safe Place, Coeur d'Alene, Idaho

- ○ Description: See Above

- ○   Duties: Attend Drop-In Center three days a week; mentor clients ages ten-years-old to twenty-years-old; complete weekly case management meetings with all clients; complete all necessary documentation; attended weekly supervision meetings.

- ○   Supervisor: Brandi Smitherman, B.A. Psychology
Contact Information: Brandi Smitherman: (208) 676-0772

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RESEARCH EXPERIENCE

Dissertation

Title: The Relationship Between Organizational Culture and Compassion Fatigue

Summary: The present study is designed to measure the impact of organizational culture on individual employees' experience of compassion fatigue, a combination of burnout and secondary traumatic stress. Organizational culture has been defined as an accumulation of values held by individual members of the organization. It has been hypothesized that organizational culture makes a significant contribution to the ability to predict individuals' compassion fatigue. When organizational culture is used as a predictor, a large percentage of variance in CF will be accounted for.

Chair of Committee: Kathleen Gathercoal, Ph.D.
Committee Member: Bill Buhrow, Psy.D.

Poster Presentation

Condrey, K., Jasper, L., Zarb, D., & Gathercoal, K. (April 2013). Patient satisfaction: Does staffing matter?. Poster presentation given at Oregon Psychological Association (OPA) Conference: Portland, OR

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TEACHING EXPERIENCE

The Culture of Compassion Fatigue   01/2016
Guest Lecturer
Training for Psychology Staff at Mississippi State Hospital

Introduction to Motivational Interviewing   08/2014
Guest Lecturer
Training for Therapists in an Inpatient Hospital

Introduction to Psychopathology   09/2013- 12/2013
Teacher's Assistant
Graduate Level Course at George Fox University

Cognitive Behavioral Therapy Interventions   11/2013
Guest Lecturer/ Trainer
Graduate Level Cognitive Behavioral Therapy Course at George Fox University

Mental Health in Service: Understanding Psychopathology and Self-Care   10/2013

Training Developer and Provider

Training for Non-Profit Volunteers and Staff Serving Homeless Population

Theories of Motivation and Positive Psychology   03/2013

Guest Lecturer

Undergraduate Introduction to Psychology Course at George Fox University

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EDUCATIONAL ACHIEVEMENTS

Induction into Psi Chi, the National Honors Society in Psychology   08/2010

University of Idaho, Coeur d'Alene, ID

Dean's List   Three Semesters 2009

University of Idaho, Coeur d'Alene, ID

Department of Psychology Student Representative   01/2010 to 12/2010

University of Idaho, Coeur d'Alene, ID

Associated Students of North Idaho College   Four Semesters 2007-2008

North Idaho College, Coeur d'Alene, ID

PROFESSIONAL TRAINING AND EDUCATION

Evidence-Based Treatments

"Evidence-Based Treatments for PTSD in Veteran Populations: 03/2014

Clinical and Integrative Perspectives"

Dr. Beil-Adaskin, PsyD

"Motivational Interviewing Training Workshop"   02/2013

Michael Fulop, Psy.D.

"Satori-Alternatives to Managing Aggression"   08/2012

Glenn Semrad, M.H.T.

"Mindfulness Strategies for the Christian Psychologist"   03/2012

Erica Tan, Ph.D.

Trauma

"Trauma Informed 101: Risk and Resiliency"   09/2016
Amy Baskin, Ph.D.; Barbara Fishgrab, Ph.D.

"Eye Movement Desensitization and Reprocessing (EMDR)"   09/2015
Roy Thomas, LCSW

"From Surviving to Thriving: A Comparison of Resilience Theory and Post Traumatic Growth" 09/2015
Nicole A. Simonson, MS

"ADAPT- Evidence Based Practices for Youth with Co-Occurring Disorders"   09/2015
Mona Gauthier, MS; Adrian James, MS

"Trauma and the Road to Recovery"   09/2015
Tonier "Neen" Cain

"Animal Assisted Therapy and Trauma"   09/2015
Stuart Pope, Ph.D.

"Trauma Informed Care: A Culturally Responsive Approach"   09/2015
Gloria Morrow, Ph.D.

Diversity

"Afrocentric Approaches to Clinical Practice"   1/2013
Danette C. Haynes, L.C.S.W.; Marcus Sharpe, Psy.D.

"Working with Sexual Minorities"   11/2012
Erica Tan, Ph.D.

"Working with Transgender Issues"   10/2012
Erica Tan, Ph.D

CLINICAL ASSESSMENT

Psychodiagnostic Assessment Measures Learned and Supervised In	Neuropsychological Assessment Measures Learned and Supervised In

°16 Personality Factor Questioner	°15/21-Item Test
°Adaptive Behavior Assessment System-2	°Benton Line Orientation Test'
°Beck Anxiety Inventory	°Bilateral Simultaneous Sensory Processing
°Beck Depression Inventory	°Booklet Categories Test
°Behavior Assessment System for Children-2; Parent Rating	°Boston Naming Test
°Behavior Assessment System for Children-2; Self-Report	°California Verbal Learning Test-2
°Behavior Assessment System for Children-2; Teacher Rating	°Controlled Oral Word Association
°Behavior Rating Inventory of Executive Function	°Finger-Tapping
°Brown ADD Scales	°Finger-Tip Number Writing
°Child Bipolar Questionnaire	°Grip Strength
°Childhood Autism Rating Scale-2	°Grooved Pegboard
°Conner's 3 ADHD Index Parent	°Hooper Visual Organization Test
°Conner's 3 ADHD Index Self-Report	°Medical Symptom Validity Test
°Conner's 3 ADHD Index Teacher	°Paced Auditory Serial Addition Test
°Conner's Continuous Performance Test-2	°Reitan-Indiana Aphasia Screening
°Delis-Kaplan Executive Function System	°Repeatable Battery for Assessment of Neuropsychological Status
°House Tree Person Test	°Rey-Osterrieth Complex Figure
°Million Pre-Adolescent Clinical Inventory	°Speech-Sound Perception Test
°Millon Clinical Multiaxial Inventory-3	°Tactile Finger Recognition; Seashore Rhythm
°Mini Mental Status Exam-2	°Tactual Performance Test
°Minnesota Multiphasic Personality Inventory-2	°Test of Memory Malingering
°Montreal Cognitive Assessment	°Trail Makin Test
°Personality Assessment Inventory	°Wisconsin Card Sorting Test
°Picture Vocabulary Test 4th Edition	°Wechsler Memory Scale-Fourth Edition
°Roberts-2	°Word Memory Test
°Rorschach Test	
°Scales of Independent Behavior- Revised	
°Test of Nonverbal Intelligence- 4th Edition	
°Wechsler Adult Intelligence Scale-4th Edition	
°Wechsler Individual Achievement Test	
°Wechsler Intelligence Scale for Children-4th Edition	
°Wechsler Preschool and Primary Scale of Intelligence-IV	
°Wechsler Abbreviated Scale- Second Edition	
°Wide Range Achievement Test 4th Edition	
°Wide Range Assessment of Memory and Learning-2	
°Wide Range Intelligence Test	
°Woodcock-Johnson III Test of Achievement	

PROFESSIONAL AFFILIATIONS

American Psychological Association, Student Affiliate   1/2011 to Present

REFERENCES

Joseph Griebler, Ph.D.
Director of Clinical Training
Mississippi State Hospital
(601) 351-8000, ext. 4929
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Sheila Holmes, Ph.D.
Mississippi State Hospital
Assessment Coordinator
Supervisor of Female Chemical Dependency Unit
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Dean of Student Services
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