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Reentry Home after Disaster Relief Work in Haiti: A Mixed Methods Study of the Reentry Process of Medical Professionals

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Reentry Home after Disaster Relief Work in Haiti: A Mixed Methods Study of the
Reentry Process of Medical Professionals

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03/09/13

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Abstract

Background and Purpose: Physical therapists and other health care workers are now playing a greater role in disaster relief work after the 2010 earthquake of Haiti. Many of the volunteers were prepared for the work they did while abroad. What they failed to prepare themselves for was re-entry upon their return home. Little information is available on the challenges of returning home after the intense experience of volunteering in Haiti. The purpose of this mixed methods study was to investigate the re-entry process of health care providers, including physical therapists, who participated in relief work in Haiti.

Methods: A total of 90 participants completed the Professional Quality of Life (ProQOL) survey and 15 participants chose to participate in a phenomenological interview. The ProQOL was used to assess the level of compassion satisfaction, burnout, and secondary traumatic stress, experienced by participants upon their return home. The ProQOL provided a general sense of the challenges of re-entry while the interviews provided a deep description of the experience. The interview transcripts were analyzed using the descriptive approach described by Giorgi (1975, 1997) and Dahlberg, Drew, and Nyström (2002). This process involved a whole-parts-whole type of holistic examination of the interview texts until the constituents of the experience were revealed.

Results: Descriptive statistics revealed our study population had low levels of secondary traumatic stress and burnout, and high levels of compassion satisfaction compared to the normal range. Chronbach's alpha was statistically significant ($p < .001$) for each of these three variables, indicating that the ProQOL tool had high internal consistency. The

essence of re-entry home was signified by constituents including (a) personal challenges, (b) family challenges, (c) professional challenges, and (d) creative coping strategies, to deal with the challenges of re-entry.

Conclusion(s): Several common themes emerged amongst participants in regard to their return home experiences. By understanding the experience of re-entry after serving in disaster relief work, we can better anticipate the support needed for those who engage in this work.

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The undersigned certify that they have read, and recommended approval of the research project entitled...

Re-entry Home After Disaster Relief Work in Haiti

submitted by

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in partial fulfillment of the requirements for the Doctor of Physical Therapy Program at
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Reentry Home after Disaster Relief Work in Haiti: A Mixed Methods Study of the Reentry Process of Medical Professionals

A 7.0 magnitude earthquake struck Port-au-Prince, Haiti on January 12th 2010, resulting in devastating damage that decimated the city's infrastructure, killed 230,000 people, injured 300,000 and left more than 1.5 million people homeless.^{1,2} The epicenter of the earthquake was only 10 miles away from Port-au-Prince, the underdeveloped and over congested Haitian Capital that contained a population of 2.8 million people.² The earthquake destroyed over 1300 schools and more than 50 health centers and resulted in a collective amount of damages that exceeded 7.8 billion dollars.^{1,2} Humanitarian relief efforts were difficult, as the main port was closed, roads contained debris, and electrical and communication systems were destroyed. The earthquake in Haiti has been described as one of the most destructive natural disasters in history and further compounded the dire state of poverty that the country was already living in.² Prior to the earthquake, the unemployment rate of Haiti was 70-80%; 55% of the people made less than \$1.25 per day; 58% of the population did not have access to clean water and the amount of food produced in the country was less than half of what was necessary to sustain the country's population of 9 million people.^{2,3} To aid with disaster relief following the earthquake, the United Nations (UN) launched humanitarian relief efforts. Many non-governmental organizations (NGOs) such as churches, schools, and professional organizations assembled teams of volunteers to send to Haiti to assist in relief efforts.

The types of injuries sustained by Haitian people included spinal cord injuries, traumatic brain injuries, nerve injuries, crush injuries, amputations, and trauma induced pain

injuries requiring immediate medical assistance.⁴ Injuries were addressed by physicians, nurses, prosthetists, occupational therapists, and physical therapists, all of whom are integral members of the disaster relief team. Physical therapists and other health care workers are now playing a greater role in disaster relief work, especially since the earthquake in Haiti. The physical therapy profession encourages physical therapists to practice altruism, compassion, social responsibility, and professional duty.⁵ The earthquake crisis in Haiti was an opportunity for physical therapists to follow through on the core values of the profession. The American Physical Therapy Association (APTA) professional website contains resources that direct physical therapists to how they can volunteer in Haiti, thus encouraging therapists to use their expertise in helping Haitian people affected by the earthquake.

Physical therapists are imperative in treating patients with musculoskeletal and neuromuscular impairments and have become a part of the health care emergency response team, working alongside physicians, nurses, occupational therapists and physician assistants.⁶ Acutely, physical therapists helped Haitian workers with triage, splinting fractures, and educated patients on crutch walking. Therapists also cared for patients with amputations, contractures, external fixation devices, and provided wound care. As a result of crush injuries, many patients developed foot drop or required amputations. Patients were fitted with prosthetic limbs, therefore, gait training with prostheses and orthoses were important primary activities of physical therapists. Patient education was extremely important in Haiti as most Haitians had not been exposed to rehabilitation therapy. Therapists educated patients about the importance of using

exercise to move their bodies after being injured and how to continue to use a limb even though it had been injured.⁴ Once physical therapists were onsite, they were able to mobilize people and make tremendous physical and mental improvements in patients by working on general mobility skills. Physical therapy increased Haitian patient independence, quality of life, and confidence.^{4,6}

Many healthcare professionals who participated in international relief work were prepared for the work they would be doing while abroad. However, they failed to prepare themselves for the reentry into their everyday lives at home upon their return. Professionals reported experiences of negative psychological effects during the reentry phase and after disaster relief work, such as compassion fatigue, burnout, and secondary traumatic stress. There has been some suggestion in the literature that debriefing sessions, before and after relief work, may mitigate adverse psychological effects of reentry and disaster relief work.⁷ Although there is a limited amount of literature that exists regarding physical therapists and their reentry experiences, there is literature on the reentry experiences of migrants, military personnel, students who studied abroad, and rescue workers.⁸⁻¹³ The experiences of these groups of people can be integrated and looked at as a whole, as these individuals were all away from home for an extended period of time. Experiences included immersion into another culture, witnessing primary trauma, and experiencing secondary trauma (such as hearing stories of trauma and suffering from a first-hand witness).

In summary, many physical therapists and other health care providers provided their services to those in need after the 2010 earthquake in Haiti. Little has been documented

in the literature regarding the experience of the health care professionals in Haiti. Even less information is available on the challenges of returning home after the intense experience of volunteering in Haiti. The purpose of this study is to investigate the reentry process of health care providers, including physical therapists, who participated in relief work in Haiti. Our research questions are as follows:

1. What is the return experience of physical therapists and other health care providers who have volunteered in Haiti?
2. What is the degree of compassion fatigue experienced by these health care workers upon their return home from Haiti?
3. What is the degree of secondary PTSD experienced by these health care workers upon their return home from Haiti?
4. What is the degree of burnout experienced by these health care workers upon their return home?

Chapter II: Review of Relevant Research

The purpose of this chapter is to summarize and analyze relevant literature which describes the issues related to the reentry home phase after health-care workers provided disaster relief services in Haiti. The literature discussed will include the topic of reentry itself as well as the challenges involved in the reentry process. Issues such as compassion fatigue, secondary trauma in the form of post traumatic stress disorder (PTSD), and burnout among the workers will be discussed. Assessment tools, such as the Professional Quality of Life (ProQOL) Scale, have been used to measure the degree of difficulty in returning home in other populations such as migrant workers, military service personnel, and students involved in study abroad programs. There is minimal literature available regarding these types of experiences of healthcare workers specifically volunteering in Haiti. However, it is possible to infer from the reentry experiences of others what reentry may be like for physical therapists and other healthcare workers.

Reentry

Hertz (1984) wondered what would “happen to returning residents in their home environment after they have spent a prolonged period of time away from home and their own culture”.^{13(p.59)} *Reverse* culture shock is experienced when migrants return home and attempt to re-enter their previous lives after having been gone for an extended period of time even if a few weeks. Even though people return to their home, they may feel a sense of loss as they unconsciously begin to identify with the culture and people of the country to which they had migrated. The reentry experience of disaster relief workers in Haiti may be magnified compared to the experience of migrants. Workers directly helped

people and developed close bonds with those who were suffering in traumatic and stressful environments. At home, workers were privileged to return to their regular lives where there was plenty of food, running water, shelter, and the assumption of safety. Further, migrant workers who tried to immediately apply their experiences to their home environment, were not seen favorably.¹³ Migrants felt rejected, abandoned and betrayed by former colleagues, who may now view the person as an intruder as opposed to a fellow citizen returning home. As volunteers in Haiti, health care workers were forced to be creative in their treatment approaches as there were limited supplies, language barriers, and a diverse health care team comprised of people from all over the world. As volunteers helped patients, they gained insights and different perspectives that when brought back home and integrated into their lives and careers, could potentially have been a source of turmoil for them. Consequently, poor reentry adjustment results in disturbances in three major areas: cognitive function, affective abilities, and value systems. A person may demonstrate disorientation, emotional detachment, and disillusionment.¹³

The experience of migrant workers is echoed by military personnel returning from combat. "Military personnel experience the stress of being in a foreign land, spending endless hours in a miserable work environment, which is then punctuated by moments of transcendental terror and unimaginable, horrific destruction of human life and property."^{10(p.491)} Military service members may not be able to transition well back into civilian society because of mental disorders, physical disabilities, or cultural dissonance that has developed as a result of their service. Although physical therapists and other

health care volunteers in Haiti were not directly in a war zone, they were in an unpredictable environment and witnesses to deep human suffering and grief. Additionally, the collective mindset of military members (the importance of honor, courage, loyalty, integrity, commitment, peacefulness, restraint and obedience) may engender feelings of being “inherent[ly] anti-civilian” upon reentry into civilian society. Because of the collective mindset of military personnel, service members have a higher risk of returning with maladaptive coping symptoms such as PTSD, anxiety disorders, major depression, and alcohol abuse.¹⁴ Health care workers may identify with the collective mindset of military personnel because of the intimate shared experiences amongst the health care team. They may feel like the only people who understand and support them are other health care professionals who had the same traumatic experiences. Thus, health care professionals may also be at a higher risk of developing maladaptive coping symptoms.

In comparison, college students re-entering their lives after study abroad experiences reported feeling rejected and unsupported by family and friends they thought were their support systems. Students also developed a new feeling of “being different” from others around them upon returning home, perhaps because of their abroad experience and new values or beliefs they developed while having that experience.¹⁵ Students experienced reverse culture shock and difficulties with the reentry process as a result of comparisons they made between their old culture and the new perspective. Disparities between values and beliefs were often developed while studying in another country.^{15,16} These conflicting perspectives caused turmoil within students, and lead to

increased levels of stress and anxiety.

Similarly, health care workers who volunteered in Haiti were immersed in a disaster zone and a new, unfamiliar culture. These workers faced a new Haitian culture and the new professional culture of engaging in disaster relief work in hospitals staffed by volunteers, foreigners from other countries as well as Haitian professionals. Due to the lack of supplies and clinics, health care professionals could not follow the same protocols that they adhered to in their home countries. Many health care professionals may have developed new attitudes and beliefs. When returning home, it is possible they encountered challenges in reconciling their old belief system with their new one, leading to negative psychological feelings.

Behaviors associated with a difficult reentry experience include emotional withdrawal, displacement, depression, anxiety, self-recrimination, acting out, projection on to family members, tendency to over-control a situation or to give up, aggressive behavior, avoidance, isolation, and somatization.¹³ The professional quality of life of physical therapists and health care workers may begin to be negatively affected by their experiences in Haiti and their experiences upon returning home to their normal lives if these behaviors are adapted. Professionals who are exposed to traumatic stressors, for example, health care workers that provided disaster relief services in Haiti after the devastating earthquake, were likely to experience elements of compassion fatigue, secondary traumatic stress, and burnout. These three elements are directly assessed by the ProQOL as contributing to professional quality of life. There is a strong potential for physical therapists and health care workers who volunteered in Haiti to develop

characteristics of these constructs. The following sections will define and discuss these constructs more in depth.

Burnout

Burnout is defined as having three common characteristics: Emotional exhaustion, depersonalization, and low feelings of personal accomplishment.^{8,17-19} It is a factor that has been analyzed in several studies and worker burnout has been shown to be a causal factor in decreased patient quality of care upon reentry.^{17,19-22} Although burnout has been studied in military treatment, humanitarian aid, and various healthcare settings, there has been little mention in the literature in the area of reentry.^{8,17-21} It is important to consider the role of burnout in the literature if it is indeed a part of the reentry experience.

Risk factors for burnout are important to identify so that burnout can be prevented or relieved. Positive risk factors include emotional exhaustion, depersonalization, and low feelings of personal accomplishment.¹⁹ Other positive risk factors for burnout include working excessive hours, being female, prolonged fatigue, and having a lower level of emotional intelligence.^{8,23} Emotional intelligence is defined as the ability to understand, regulate, and use one's emotions as well as understanding the emotions of others.²⁰ Struggling to manage alone, self-sacrificing, setting unattainable goals, distancing the self, and showing signs of falling apart have been reported by co-workers as signs of impending burnout.²¹ Negative risk factors are those that decrease the risk of burnout. A greater sense of personal accomplishment, feeling appreciated by patients, and feelings that the individual is providing a unique and valuable service have all been shown to decrease the risk for burnout.⁸ Having a greater number of years of experience

and having social support influence a sense of personal accomplishment.⁸

There are several sources that contribute to feelings of burnout. Constant levels of high stress and frustration are related to burnout as well as a difference between what an employee and organization believe or value. Increasing levels of high demand in the workplace leading to prolonged fatigue can contribute to high levels of stress resulting in burnout.^{21,24,25} Support has been shown to be related to degrees of burnout in the workplace. Social and organizational support were significantly related to low emotional exhaustion and less depersonalization, whereas spiritual support was related to a decrease in all three characteristics of burnout.¹⁸ Increasing levels of support to individuals at risk for burnout may aid in reducing both feelings and consequences of burnout.

The consequences of burnout are numerous and are greatly affecting the healthcare workers ability to provide high quality care. Consequences can be manifested physically, emotionally, and cognitively. Physically, burnout can lead to decreased energy needed to complete a task, fatigue, weakness, muscle pain, heart palpitations, sleep disturbances, and irritability.^{19,23} There are many emotional consequences of burnout including emotional depletion, decreased motivation, apathy towards work, feeling inadequate, instability in emotional regulation, and low morale.^{17,19} Cognitive consequences of burnout are also evident and include no longer considering one's work as valuable or meaningful, cognitive slowness, increased medical errors, and decreased job satisfaction.^{17,19,20} Reduction in quality of care because of burnout was shown in six countries independent of cultural difference and working conditions.²² Burnout is also associated with a high job turnover and prolonged absence from work.^{17,21} Individuals

who suffer from burnout negatively affect the work place environment, including their coworkers and clients.²¹ Although there is virtually no research to be found on the association between burnout and reentry after disaster relief, it is important to analyze the prevalence of burnout and consequences of it so that professional quality of life and client quality of care can be upheld.

Compassion Satisfaction/ Compassion Fatigue

Compassion satisfaction and compassion fatigue are two related phenomena that are experienced by people working in caring or helping professions. Compassion satisfaction refers to the satisfaction derived from being able to help other people and is a protective factor that may guard against compassion fatigue and burnout.²⁶ Compassion fatigue has been defined as “a reduction in the capacity of one’s interest in bearing the suffering of others”^{27(p.57)} and, “the cost a caregiver experiences as a result of caring for others.”^{28(p.1434)} Persons who commonly develop compassion satisfaction and/or compassion fatigue are those in helping professions, which include health care workers such as nurses, physicians, physical therapists, emergency responders, firefighters, and policemen.

Compassion satisfaction can be a positive aspect of a caring professional’s work and often helps the professional cope with the extreme emotions of dealing with death, dying, trauma, illness, and injury. Compassion fatigue represents the opposite end of the spectrum and occurs when the stress of dealing with traumatic events, death, illness, and injury cumulatively influence and personally affect the caring professional in a way that makes them unable to perform their job duties to the best of their ability.

Data shows that compassion fatigue is most commonly experienced by women, which is significant in the field of physical therapy since the majority of physical therapists are females.²⁹ Professionals with more years of service have a decreased chance of developing compassion fatigue and an increased degree of compassion satisfaction, which may indicate that a mentorship program could be helpful in preventing compassion fatigue in newer employees.³⁰ Compassion fatigue may develop quickly from one particular event, or slowly develop over years and years of service as a helping professional due to being exposed to the suffering of others.³¹ It is often accompanied by burnout and secondary PTSD. Compassion fatigue and burnout are similar although burnout is associated with environmental stressors and compassion fatigue is associated with giving compassion without receiving a positive outcome.²⁷ Both burnout and compassion fatigue often lead to increased employee turnover and lower retention rates, so it is important to study these phenomena in order to reduce the negative effects on health care professionals and help them retain their careers.

Symptoms of compassion fatigue include “re-experiencing the traumatic event, intrusive thoughts, avoiding or numbing reminders of the event, sleep disturbance, irritability, anxiety, and loss of hope.”^{32(p. 4)} Health professionals affected by compassion fatigue report feeling emotionally drained and extremely distressed. Feelings of confusion, helplessness, and isolation are also present. Four factors have been described that place trauma workers at high risk for compassion fatigue: “1) Being empathetic; 2) having a history of traumatic experiences; 3) having unresolved trauma; and 4) events in which children are involved.”^{32(p.4)} Health care workers may go through progressive

stages before developing compassion fatigue. These stages include compassion discomfort, compassion stress, and finally, compassion fatigue.³³ Compassion fatigue can disrupt a person's life for several weeks or several years and be recurrent.

Compassion satisfaction and compassion fatigue have been studied overtime in health care providers such as nurses. There is little to no evidence in the literature on the incidence of compassion satisfaction and compassion fatigue in health care professionals, specifically physical therapists, re-entering their previous lives and careers after providing disaster relief physical therapy care in Haiti.

Specialized trauma training appeared to decrease compassion fatigue and burnout while increasing compassion satisfaction. Therapists who treated a high number of patients with PTSD had higher levels of compassion fatigue and burnout.³⁴ Therapists who used evidence-based practice had higher rates of compassion satisfaction and lower rates of compassion fatigue.³⁰ Clinicians who had more years of experience were more likely to experience compassion satisfaction while clinicians working with patients who had PTSD experienced a higher level of compassion fatigue.³⁰

Compassion fatigue should be addressed with health care professionals who manifest signs of compassion fatigue or those who have had experience helping in trauma situations. Education about compassion fatigue is vital for health care professionals working in a trauma related setting. Social support, self care, meditation, and therapy are all helpful in overcoming compassion fatigue.^{31,35,36} Desensitization therapy from a professional psychologist has also been suggested as a treatment for compassion fatigue. Health care professionals may also benefit from limiting their exposure to trauma related

work in order to decrease the risk of developing compassion fatigue.²⁸ High levels of social support and self-care have been shown to increase compassion satisfaction, which may act as a protective factor to decrease the risk of compassion fatigue.^{26,31,37}

Post-Traumatic Stress Disorder

According to the diagnostic criteria for PTSD from the American Psychiatric Association, PTSD must include history of exposure to a traumatic event that meets two criteria and symptoms from each of three symptom clusters: intrusive recollections, avoidant/numbing symptoms, and hyper-arousal symptoms.³⁸ Other categories included in the definition are the fifth criterion, which concerns the duration of symptoms, and a sixth, that assesses the person's ability to function.

The first criterion is a stressor, where the individual has been exposed to a traumatic event where a person has seen or experienced an event that caused or threatened harm to themselves or others.³⁸ The second condition of the first criterion is that the response to the initial traumatic experience of the person involves intense fear, helplessness, or horror. For the remaining required criteria, the person need only experience one of the described behaviors.³⁸

Secondary PTSD is synonymous with secondary traumatization, secondary stress, and vicarious traumatization. Secondary PTSD has been described as emotions, behaviors, or responses that follow indirect exposure to another person's traumatic experiences.^{14,39} The studies examined included wives of veterans, nurses, medical doctors and other emergency response teams.

Secondary post-traumatic stress disorder is diagnosed in many individuals

involved in both man-made and natural disasters including professionals, non-professionals, and those with and without previous disaster relief work experience.^{7,14,40} At the time of this study, there was no published literature available in the databases accessed regarding secondary PTSD for physical therapists working in disaster relief or in any other practice setting where traumatic experiences were a common occurrence. The lack of research including physical therapists poses a difficulty when estimating the rate at which secondary PTSD occurs and the potential impact on those physical therapists participating in disaster relief work. However, there is literature concerning other health professions and military personnel that can be used to extrapolate the incidence and prevalence of secondary PTSD in physical therapists.^{7,14,39,41,42} Those professions with current research in rates of secondary PTSD include medical doctors, trauma and emergency room nurses, medical examiners, veterans and their families, firefighters, police officers, and others.^{10,10-13,15} From review of the available literature, it is suggested that professions that have close relationships with the victims of tragedies, as physical therapists in disaster relief do, are at high risk of developing secondary PTSD.^{14,39,41,42}

Current research suggests that secondary PTSD occurs across strata of professional experience in years of work.⁷ Nearly all professionals and nonprofessionals were susceptible to secondary PTSD with exposure to other's traumatic experiences.^{7,14,40} Considering medical volunteers with both professional and disaster work experience, there were still reported cases of secondary PTSD. The professionals who participated in the study worked closely with the victims of the disaster, and in many cases were

exposed to multiple traumatic events over the course of years while others were only interviewed regarding their exposure during a brief period (less than a year).⁷ In relation to the work done by physical therapists, providing both short and long term service may lead to a greater risk for developing secondary PTSD. Even brief encounters with the suffering of victims of a natural disaster may lead to residual stressors, mental images of the disaster, or the traumatic stories of patients. Such encounters can lead to secondary PTSD after the return home for up to years after the experience.⁴²

Regardless of the methods used to assess secondary PTSD in the literature, symptoms described by the professionals and families of veterans interviewed were nearly the same. Several different methods were used to identify secondary PTSD which included interviews, surveys, or both in combination. Symptoms that were described as part of the secondary PTSD spectrum were sleep disorders, nightmares, anxiety, withdrawal, stress, depression, increased alcohol use and other behaviors.^{14,40} General feelings of helplessness, frustration, and hyper vigilance were also noted in multiple studies.⁷ Interestingly, many of the same symptoms were reported across the studies examined despite various exposure times and a diverse variety of disasters examined. Similar experiences of physical therapists during the aftermath of the earthquake in Haiti suggest that physical therapists may not be exempt from developing these same symptoms.

Conclusion

Although health care providers have been serving others in disaster relief settings, it is only recently that physical therapists have played such a large role in disaster relief

work. The limited literature thus far has focused on reentry among migrant workers, the members of the military, and students who have studied abroad. A fascination with the new roles and opportunities for physical therapists to serve on an international level has guided our research questions. The lack of literature on this phenomenon of the reentry process of health care providers such as physical therapists and others has led us to approach our research with the hope of shedding more light on this important topic. Through examining the little researched topic of reentry after disaster relief work, we hope to inform the health care professions on the challenges of returning home after an intense experience of serving in disaster relief work in Haiti. Our next chapter will discuss the methods we chose to use in order to answer our research questions presented in the introductory chapter of this paper.

Chapter III: Methods

This chapter describes the mixed methods research used in this study. Because our research questions involved discovering the issues faced by participants who provided health care services in Haiti following the 2010 earthquake, the researchers chose to use a survey. The survey allowed us to reach a wide population of healthcare providers in order to obtain a broad awareness of the issues facing the disaster relief health care workers during their reentry process of returning home after serving in Haiti. Further probing was able to occur through the phenomenological interviews used. The phenomenological interviews allowed us to gain a deep, rich description of the experience of reentry. Please see the attached Figure 1.

Subjects

After completing the Institutional Review Board (IRB) process at St. Catherine University, subjects were recruited from a variety of sources. The subjects involved in the study were recruited from Non-Governmental Organizations (NGOs) providing services in Haiti in the aftermath of the 2010 earthquake. Emails were sent to NGOs providing services in Haiti to recruit professional healthcare providers who had returned home after participating in disaster relief work in Haiti.

Inclusion criteria for the study are listed here. Participants must have spent time in Haiti participating in disaster relief work and returned home. Our target population included licensed health care providers such as physical therapists, occupational therapists, physicians, nurses, physician assistants, pharmacists, prosthetists, and orthotists who were at least 21 years of age who have volunteered in Haiti as disaster

relief workers. Both males and females were included.

Design

The research study that we conducted used a mixed-methods approach, which included a survey tool and a phenomenological interview. The PROQOL was the survey tool, which was distributed to health care providers who had volunteered in Haiti. Descriptive phenomenological methods utilizing semi-structured interviews were used to examine the reentry experience of health care providers who had provided disaster relief work in Haiti in order to obtain deep, rich descriptions of the experience.

Phenomenological research is research of a qualitative nature that examines the lived experiences of participants in order to derive meaning from these lived experiences. In this process, the researcher and others may begin to understand trends that have developed. Klappa⁴³ stated, “According to van Manen,⁴⁴ phenomenology is the study of the lifeworld or our everyday experiences and the meanings we construct from our experiences.”^(p. 33) Phenomenological research attempts to have the researcher apply meaning to the experiences of the participants by listening to their stories, with the researcher trying to set aside their own experiences or biases. There are two main assumptions in phenomenological research. The first is that humans seek meaning in their lives, and the second is that there are multiple realities that are socially constructed.⁴³

There are several terms used in phenomenological research. They include: lifeworld, existentials, essence, imaginative variation, and reduction. *Lifeworld* is a term used to describe the world in which we are already living. There are four

fundamental existential themes of lifeworld: lived space or spatiality, lived body or corporality, lived time or temporality, and human relations or relationality.^{43,44} Lived space is the space we as an individual occupy. Lived body is how our body experiences our life. Lived time is the time that we live in day to day. Finally, human relations or relationality involves how we interact with others and the relationships we have throughout our individual lives. Each person's lifeworld is influenced by their culture, geographic location, and interaction with others. *Essence* is what makes an experience what it is,⁴³ Thomas and Polio define it as, "patterns of meaning that were universal, unchanging over time, and absolute."^{45(p. 9)} *Imaginative variation* is a process, which occurs during the analysis phase of phenomenological research, which involves the researcher imagining constituents of the lived experience shared through the interview in a non-biased way so that the essence of that experience can be realized by the researcher.⁴³

Reduction, which requires the researcher to remove their beliefs and experiences from the participants' description so the researcher can hear their story with a non-biased manner, occurred prior to the interview phase of this study. The researchers participated in bracketing interviews, which is a way to perform reduction. Klappa describes bracketing as, "how the researcher strives to set aside his or her personal, subjective experience in order to remain open to the participant's description of their experience."^{43(p. 40)}

These interviews consisted of two pairs of student researchers interviewing each other about their reasons for entering into this research project, goals and expectations for

the project, challenges they foresaw in completing the project, and expected outcomes of the research study. These interviews were approximately 10 minutes long and the intent was for the researchers to learn what biases they hold regarding the phenomena of reentry experiences. Next, the researchers reflected upon these biases through a short journal entry and attempt to put these biases aside as they proceed to interview participants of the study. One challenge of a phenomenological interview is that it may not ever be possible for the interviewer to completely bracket their opinions and put their biases aside during an interview, which is why it is important to conduct bracket exercises whenever needed or journal throughout the interview process.

Instruments

For the quantitative portion of the research, the thirty item Professional Quality of Life (ProQOL) survey was used to assess compassion satisfaction and compassion fatigue. The ProQOL was designed to measure the certain psychological effects of working alongside those who have gone through traumatic experiences.²⁵ The test was originally called the Compassion Fatigue Self-Test and was designed by Charles Figley in the 1980s. Stamm added in compassion satisfaction measures in 1993 and the name changed to Professional Quality of Life.²⁵

The ProQOL was designed to assess those in helping professions such as the health care profession, social service, or police service.²⁵ Professional quality of life is defined as, “the quality one feels in relation to their work as a helper”^{25(p. 12)} and the ProQOL breaks this term down into two components: compassion satisfaction and compassion fatigue. Compassion fatigue is further broken down into burnout and

secondary trauma. Compassion satisfaction is, “the pleasure you derive from being able to do your work well.”^{25(p.12)} Compassion fatigue is defined by its two component parts, where “burnout” is a feeling of hopelessness and having a difficult time doing work well and “secondary traumatic stress” is from the secondary exposure to people who’ve experienced traumatic events.²⁵

The ProQOL is self-administered and is commonly taken and scored electronically. Questions asked in the ProQOL are scored into three different categories: compassion satisfaction, burnout, and secondary traumatic stress. Questions relating to each of these categories are spread randomly throughout the thirty questions. All thirty items were scored from one to five, with one being “never” and five being “very often.” See Appendix B for a copy of the survey.

High scores on the compassion satisfaction items indicate increased satisfaction. A high score on the burnout items indicates a higher level of burnout. On secondary traumatic stress items, higher scores indicate an increased level of this type of stress. Cutoff scores can also be given for what is considered low and high levels of any one characteristic based on the twenty fifth and seventy fifth percentiles of score distribution based on normative data.²⁵ It is important to note that although the ProQOL was not designed to be a diagnostic tool, it can be used as a guide for further psychological testing if need be.²⁵

The ProQOL measure has been used in over 100 published research papers.²⁵ Examples of the use of the ProQOL in these other studies include assessing occupational stress, assessing compassion fatigue and burnout in oncology nurses, and looking at the

relationships between compassion satisfaction, compassion fatigue, and burnout in aid workers working in war zones in Darfur.⁴⁶⁻⁴⁸ Although the ProQOL has been used in numerous studies, there has been no study that the researchers could find that looked at the specific reliability and validity scores of the tool.

Inter-scale correlations have been published, however, because there were three separate constructs measured. These were measured in an attempt to show that the three constructs are indeed distinct from each other. There was 2% shared variance between compassion fatigue and secondary traumatic stress ($r = -.23$) and 5% variance between compassion fatigue and burnout ($r = -.14$). The shared variance between the constructs of secondary traumatic stress and burnout was 34% ($r = .58$) reflecting the similar distress that carries over into both conditions.²⁵

Procedures

Non-governmental organizations that the principle researcher, worked with in Haiti were sent an invitation for their healthcare disaster relief volunteers to participate in this study. Volunteers who accepted the invitation were emailed an online link that directed them to the PROQOL survey through Qualtrics Surveys™. Prior to beginning the survey, participants read a statement that explained the purpose of this study and that contained information regarding risk, benefit, and informed consent. Participants were informed that they could stop the survey at any time without repercussion. Please see Appendix A for the statement. After reading the statement, participants decided they wanted to continue by clicking a prompt that indicated they understood the purpose of the study and were giving their consent to participate. The survey required 10 - 15 minutes

to complete. Additionally, they were asked if they would like to participate in an optional interview about their specific experiences of reentry home after participating in disaster relief work.

Participants who consented to interviews were screened by the principal researcher by telephone in order to confirm that they had disaster relief experiences in Haiti and re-entered their home country. Participants who passed this screening phase were sent an informed consent form prior to their interview. Please see Appendix A for the interview consent form. Once participants sent the informed consent form back to the principle researcher, appointments for interviews were made. Participants chose an alias in order to remain anonymous.

Informed consent was obtained per the IRB protocol. Participants were asked to return the consent form via email before interviews were conducted on Skype™. Those participants interviewed in person were asked to sign the informed consent form and were provided a copy of the form to keep for their own records. See Appendix C for the Interview Guide. The researcher who interviewed the participant then transcribed the interview within one to two weeks. After transcripts were typed, a copy was sent back to the interviewee by email to check the accuracy of the content. Any concerns by the participant were addressed by the researcher and then corrected for the final transcript to be analyzed.

Prior to interviews with participants, the principal interviewer participated in bracketing interviews in order to remove any biases and existing assumptions about disaster relief work in Haiti. The participant interviews were conducted based on the

interview guide in Appendix C. Additionally, researchers conducted interviews using the strategy of “processual consent” as established by Rosenblatt (1995).⁴⁹ Processual consent entailed decreasing the intensity of interview questions when participants appeared distressed. Interviews lasted from 45 to 60 minutes. Participants were thanked for their participation at the end of the interview. Given the possible negative emotions may have occurred during the research process, the researchers allowed the participant to not answer a question or to stop the interview at any time. Rosenblatt also describes re-framing questions in a manner that allows the participant to refuse to answer the question immediately to decrease the level of discomfort.⁴⁹ For example, pausing and taking time for silent reflection is encouraged.

Data Analysis

The interviewer transcribed the interview and the transcription of the interview was returned to the participant so they were able to read through it to make sure everything they said was transcribed accurately. This process allowed us to complete a member checking round with each participant to ensure that the researchers had transcribed the participant’s words accurately. The participants also received a phenomenological description of their experience. This description consisted of a general summary of the participant’s experience along with themes and key phrases. Participants responded by email as to whether or not the transcript and description resonated well with the essence of their experience. This process was our vertical analysis.

We then completed a horizontal analysis across all interviews to develop the common description of reentry among all participants in this study. This process

involved a description of common themes and sub-themes across all interviews. A summary of the universal themes was written up and sent to all participants for review in order to ensure dependability, credibility, and confirmability through the member checking method.

In conclusion, this study used a mixed-methods process. The researchers utilized this mixed-methods protocol of a survey and an interview because it seemed to be the best way to answer our research questions. In order to learn about the deeper issues facing health care providers as they reentered their lives back home after serving in disaster relief work in Haiti after the 2010 earthquake we included a phenomenological interview after the survey in order to obtain thick, rich descriptions of the reentry process.

Chapter IV: Results

This chapter presents the results from both the survey and the phenomenological interviews conducted for this study. The 90 participants in this survey included health professionals who were physicians (n = 9), nurses (n = 15), physical therapists (n = 40), occupational therapists (n = 5), prosthetists (n = 5), physician assistants (n = 1), pharmacists (n = 2), and others such as logistics workers and administrators (n = 13). There were 62 females and 26 males, and two participants chose not to disclose their sex. Participants were from the United States of America (n = 84), Canada (n = 3), Haiti (n = 1), Japan (n = 1), and the Netherlands (n = 1). The number of tours of service in Haiti ranged from 1 time (50 % of the participants of participants) to more than five times (8% of participants).

The average stay in Haiti for our participants was 1.96 weeks +1.47 weeks. Forty seven percent of the participants had returned home from Haiti in the last year while 53% of our participants had returned from Haiti between 12 and 18 months. Twenty four percent of our participants took time off of work after returning home. Seventy six percent of our participants returned to their normal work routines immediately after their return. Four participants were unable to return to their normal jobs due to difficulties coping with the reentry process. In terms of employment, 81% of our participants returned to their jobs while 19% did not and found new positions. A briefing session was offered for only 31% of our participants before their disaster relief work experience in Haiti. After returning home, only 27% of our participants had an opportunity for an official debriefing session provided by the host institution. Six percent of our participants

specifically sought out mental health services while the others chose to debrief through colleagues who had been to Haiti with them or others.

ProQOL Survey Quantitative Results

The mean summed score for secondary trauma across all professions was 21.04 ($M = 21.04, \pm 7.635$). According to the ProQOL tool, this score correlates with a 'low' level of secondary traumatic stress. A summed score of 22 or less indicates a 'low' level of stress. Summed scores between 23 and 41 indicate an 'average' level of secondary traumatic stress, and summed scores of 42 or greater indicate a 'high' level of secondary traumatic stress. Chronbach's alpha was .898 ($\alpha = .898$) indicating high internal consistency of the questions in the survey for secondary trauma. In other words, the questions appeared to measure what they set out to measure.

The mean summed score for burnout was 19.25 ($sd \pm 6.575$). According to the ProQOL manual, a mean score of 22 or less in the burnout questions indicates a low level of burnout, which is apparent in this data. A burnout score between 23-41 points represents an average level of burnout, and a score of 42 or more represents a high level of burnout. Chronbach's alpha was .874 ($\alpha = .874$), indicating again a high internal consistency among these questions.

The mean score for compassion satisfaction was 43.40 ($sd \pm 5.892$). According to the ProQOL tool, scores for compassion satisfaction of 22 points or less corresponds with a low level of compassion satisfaction. Scores between 23 and 41 correspond to an average amount of compassion satisfaction, and scores of over 42 correspond to a high compassion satisfaction score. Chronbach's alpha was reported as 0.931 ($\alpha = .931$), again

indicating high internal consistency among the questions in the survey.

Correlations

A mild negative relationship was found between secondary traumatic stress and compassion satisfaction which was significant with $p < .05$ ($r = -0.230, p = .042$). This finding suggests that as one's level of secondary trauma increased, the participant tended to have a slightly decreased level of compassion satisfaction with their professional roles upon their return home.

A moderate relationship was found between secondary traumatic stress and burnout ($r = 0.637, p < .001$). This finding suggests a positive correlation between a participant's level of secondary trauma and burnout. Secondary trauma induced by hearing about the stories of the Haitian patients increased the level of participant burnout also. The null hypothesis that there was no correlation between secondary trauma and burnout was rejected as $p < .001$.

Burnout and compassion satisfaction were negatively correlated with $r = -0.586$ and a p -value < 0.001 . This data suggests that as burnout increased compassion satisfaction decreased. Again the null hypothesis that burnout and compassion satisfaction had no relationship was rejected at the $p < 0.00$ level.

Qualitative Results

Fourteen participants who had taken the ProQOL also volunteered to be interviewed by the primary investigator (SK). The sample of participants interviewed included 12 females and 2 males. There was 1 participant who was a pharmacist, 1 physician, 7 physical therapists, 1 physical therapist assistant, 1 nurse, 1 occupational

therapist, 1 medical laboratory technologist, and 1 public health/community worker. Twelve participants were from the United States and 2 were from Canada. After analyzing the participants' interviews, themes of return experiences were identified and organized. A total of five larger themes emerged which included: 1) personal themes; 2) family themes; 3) professional themes; 4) creative coping strategies, and 5) reentry and debriefing suggestions made by participants. Under each main theme several smaller themes were identified. The following section will describe the themes identified based on the interviews of the participants.

Personal Themes

Personal themes were the most prevalent issues identified through participants' experiences upon return home. Participants struggled to merge new and important experiences into their identities. A question of, "Who am I?" emerged after participants had the experience of volunteering in Haiti. Multiple personal themes concerning participants' experiences with reentry home were identified, including guilt, grief, and mourning, desire to connect for support, feeling changed from the experience, loss of sense of purpose, disconnection from others, continued worry about patients in Haiti and difficulty relinquishing control, facing extravagance, perceived ignorance of society and worry about patients in Haiti.

Guilt, Grief, and Mourning. Many participants described feeling guilty upon return home for a variety of reasons. Feelings of guilt resulted from leaving behind patients, feeling like there was more work to do in Haiti, and knowing that it was impossible for their Haitian patients to escape the suffering environment in Haiti.

According to Nadia:

You spend this time helping people that are so happy with having so little. You feel sorry for them and they're suffering and you think that you . . . could never live the same way again. But it is amazing how fast you can return to [life in the U.S.]. That always makes me feel just a little bit guilty, you know?

Participants also compared the process of leaving Haiti and re-entering their home life to a process of grief and mourning. Margaret stated:

I think it is almost a mourning, and I can't think of a better word for it, because I think you need to grieve for what you have seen and experienced, and allow that process to happen at your own pace without interruptions from our daily lives that we get caught up in here [at home].

Many participants reported grieving for the deep relationships and experiences they left behind in Haiti. It was also described that the grief process took a long time for participants to work through.

Desire and craving to connect to others for support/feeling disconnected from loved ones at home. When participants returned home, many of them wanted to share their experience with friends and colleagues from home. The Haitian disaster relief experience was a life changing experience for them. They had learned so much and had so many exceptional patient experiences that they needed and wanted to share with other people. However, the participants described how difficult it was to connect with people who had not had the same experiences that they had in Haiti. Participants described how people cannot understand unless they were there to experience the situation in Haiti first hand. Rebecca discussed:

And then this part of it which maybe will help people coming back is people . . . people care but they don't. So when people would ask me, "how was Haiti?" you know, or "what did you think of your

experience?” You know, often times people would want to hear it was good, it was bad, it was life-changing, but they want a quick sound bite. And there is not a way to sum it up in a quick sound bite.

As a result, participants sought to connect to other colleagues that had served in Haiti to share stories and to help them cope with their experiences. The Haiti experience was so unique and deep that participants recounted their need to have someone with whom to connect regarding their experiences. Upon return home, support was pivotal to participants in helping them to work through the various feelings they had after their trip. An understanding was needed on behalf of family and friends because of the intense reentry experience. Kelly described:

This week I know I have been going through all the different emotions and feelings . . . the happiness, sadness, the intensity, the frustrations, the excitement, you know, all the different emotions. I just find that it’s really important to connect and be able to talk about and hopefully have people understand that there is kind of this . . . process.

Participants at times found it difficult to have meaningful relationships and connections to people who did not have the similar experience of disaster relief work. It was difficult to communicate the importance of the experience to others which resulted in feelings of disconnection upon reentry.

Feelings of changed identity from the experience. Participants described feeling changed and returning home a different person than who they were when they left for Haiti. Participants developed new perspectives as a result of their experiences in Haiti. Regarding reentry, participants needed to find a way to integrate their new perspectives and beliefs into their lives at home. Sophia shared:

Coming home is so difficult because I think you never really come home. Things at home have changed even though they are familiar. You have

changed and that can be a challenge. You see things differently because of what you have experienced and lived. But if you can move through your grieving process and yes, I think it is a grieving process that you go through . . . for the suffering the people endured and for what you witnessed and probably for yourself, because you can't help but be changed by the situation.

Most participants considered these changes to be permanent and ongoing. For the most part, the changes described were seen as positive. Participants were grateful for the experience and felt that they were changed for the better. Pam stated:

You know the whole experience of being there was one thing, but then when you are back, how has it changed you? Is it a permanent change? Or is it just temporary? And, well, it's definitely a permanent change.

Natalie commented:

I think I am constantly changing and evolving and reflecting and I don't, yeah, I don't ever think it's ever gonna be fully over.

Although the changes were considered to be positive, it was still difficult for participants to figure out where the changes belonged in their lives at home. Margaret described her challenges:

It is so difficult for me because I think that it has changed me and provided me a perspective that not many people have the opportunity to have. My priorities in life and my perspectives, my, what is true and real to me, has changed. And I think that's difficult.

Loss of sense of purpose. The work the participants took on in Haiti had a very deep meaning and purpose. Participants were volunteering their time to help those who truly had very little. It was difficult for participants to return home as they felt that their work in their home country was not as important or as life altering as the work done in Haiti. Kelly pondered:

You know, so let me look at my life compass again here and [am] I getting

as much fulfillment? Am I impacting as many people as I was when I was down in Haiti?

The Haitian people were extremely grateful and appreciative of the disaster relief work efforts. The participants were helping to greatly improve the quality of life in Haiti and to save lives, which was extremely rewarding to our participants. As professionals, our participants felt that they were needed in Haiti, that they mattered, and were able to see the impact they were making with their work. Talia stated:

When I came home, I guess I felt a little bit like, okay, now what? What do I do? I want to continue that relationship. How do I do that? I felt sadness over what I had experienced and what I saw in Haiti and the people that I met because it's kind of an overwhelming sense of powerlessness.

Facing excessiveness and extravagance. After spending time in a country surrounded by those who had very little material goods, our participants were shocked upon their return home where luxuries were abundant. They also started to see everyday items as being excessive or extravagant. Even basic needs like food and shelter were at times seen as a luxury that they didn't deserve. Small occurrences in participants' daily lives made them think about what they had experienced. Sally stated:

The first time, about a month later, after I came back, I walked into the grocery store and there was this huge display of strawberries. And for some reason, I don't know why, but I had to turn around, and just leave the grocery store. That abundance of one food - of strawberries. So I don't really, I don't know why it affected me so much. I couldn't believe the abundance that we have, and you know, the lack of things that they have. And so I don't know what struck a chord, or if I was thinking about things, or I don't know, but that was about a month after my first trip there. I walked into the grocery store, and I had the cart to go grocery shopping, and just for some reason seeing those strawberries and how many there were and how perfect everything all was, that really made me emotional at that point. And so I just kind of turned around and left and went home and did my grocery shopping another time.

Rebecca felt conflicted by dining out because of the expense associated with it when there were people in Haiti who were unable to provide for themselves. Rebecca described a dining experience upon her return home that greatly impacted her:

So I am sitting there [at a restaurant], and five dollars is what my coffee drink costs at Starbucks. And that's more than what is considered minimum wage for an entire day's worth of work in Haiti. And [my friend] took me to this nice restaurant and I'm sitting there having a hard time ordering, because what it costs for a meal here for one person would pay a nurse's salary for an entire week.

Perceived ignorance of society. After return home, many of our participants encountered behaviors and actions of people that demonstrated ignorance of events and suffering in the global community. It was challenging for participants to interact in a society where the attitudes and beliefs were very different than the new found viewpoints they had acquired. It was very difficult for our participants to see people in their country take things for granted and to have lack of appreciation for the things they had in their lives. Amelia discussed her frustration:

It's the whole essence of gratitude for what we have, and I mean there's no point in saying something to somebody who's back is really hurting, that they are bloody lucky and should be thankful that they're not lying [with a] spinal cord injury in a hospital in Haiti. You know, I can't help but think of the blessings that everybody has here, so in my own way I try to convey that to people.

Continued worry about patients in Haiti and difficulty relinquishing control:

Wonder and not knowing. It was very difficult for our participants to leave their patients in Haiti and return to their home country. The bonds that participants formed with their patients were irreplaceable and extremely important to both the patient and themselves. The participants' lives were so affected by their patients, and vice versa, that

they couldn't help but wonder about their patients after they had returned home. Rebecca described her feelings about leaving Haiti:

When I first came back from Haiti I remember a lot of the Haitians saying things like, "Don't forget me, don't forget me." I really didn't understand it and of course I'm not going to forget you. But then living down there and seeing the other side of it, because it's like every week your heart gets broken, you know. Because every week you make these 50 or 75 fabulous really close fabulous friends and then they leave and they go back to the States to live their real lives and you're still in Haiti. And, and I can't tell you the number of times that I've had to sit down [with] Haitian employees who didn't understand and they say, "these people, they love me, and they hug me, and they say they remember me, but why don't they write?" And so they're left all the time feeling like they were forgotten.

It was also hard for the participants to trust that patients would be taken care of by other volunteers after they left Haiti. Kelly said:

There's a big part of me that really misses [my colleagues in Haiti] and is wondering what is going on and how the transition was to the current workers. Is everyone [patients] being taken care of? Could I [have] done more before I left?

Some participants found themselves thinking about their patients in Haiti and how they could have helped their patients more. Amelia stated:

[Patients in Haiti] made this huge trip from wherever they live, maybe 2-3 hours [away], and you want to make sure that you make it worth their while. I tell myself how I wish I would've told [my Haitian patients] this or some other way to do such a thing to make it easier for them. These things are still going through my mind [for example] how to best help situations.

Although participants had returned home physically, it was hard for them to say that they had fully come home, as their minds and selves were sometimes still focused in Haiti.

This connection to Haiti influenced relationships at home and at work.

Family Themes

Not only did our participants have to re-enter society in their home country, they also had to re-enter into their family life as well. The sub-categories that were identified were lack of ability for significant others to relate to their experience, having a sense of disconnect, filtering experiences told to family members, and finding it helpful if there was a shared family experience in the reentry process.

Lack of ability for significant others to relate. It was challenging for our participants to talk to their families about their experience in Haiti if there wasn't anyone in their family who had shared a similar experience. It was hard for family members to relate to the participants' experiences. Most participants longed to share their experiences, but found that this was difficult to do since their perspectives were now different. Sally described this challenge:

I just had to really continuously remind myself that people here haven't seen what I saw. I mean even my husband didn't go. Even dealing with him, it was difficult on a personal level. You know? And you try to explain things to people who are close to you and talking about it and even seeing pictures and seeing things on TV. You really don't get the gist of it the same way as you would being there. And so I just really had to remind myself that this is a totally different situation and that they hadn't seen what I saw. And over time it seems to get easier but the first few months were pretty difficult.

Not only did our participants feel that it was hard for their families to understand their experience, but they also felt that their families had to adjust to who they had become. The participants felt that when they came back from Haiti, they had changed in some way. They had to come to terms with this change in themselves, but their families had to do so as well. Sophia shared:

You know, I love my family here at home, but it does take a while to

readjust to them. I am sure it is quite difficult for them to adjust to us when we come back, too. You know, they don't always know who they will get back.

Coming home to significant others was both a joyful and challenging experience.

Participants were happy to see their loved ones at home, but they also remembered their new "families" in Haiti. Paulette stated:

Of course I was glad to be back with my family. But there is still the overwhelming need to be in Haiti. And that was pretty conflicting. I thought that I should be there instead of here. You know? My family is important, but the family in Haiti needed me more.

Feelings of disconnect. Since the participants felt that their families and significant others couldn't relate to them, they felt disconnected. In this way, connecting with others was challenging. Pam said:

It's like being at war and coming home. I mean how do you describe what you see to people that have never been there? I think that they probably noticed . . . a change in me but I don't think they have an understanding of it, you know?

Our participants acknowledged that their family members couldn't understand what they had been through in Haiti. Even though others wanted to understand, they couldn't because they hadn't been to Haiti themselves and experienced what our participants had experienced. Kelly explained this concept:

I do feel that there is, I don't know, just this sort of disconnect with not a full understanding and not that [my family] doesn't want to understand what I went through. Part of it is [that] I am not sure if they will ever understand because this is my experience. You know, it is living, breathing.

Talia felt a disconnect with her family and significant other as well and found it difficult to experience this emotional distance because of her desire to share what she had been through:

I felt, especially with my mom, whom I'm really close to, and my partner. . . I wanted them to know everything about what I had experienced and the emotional part of it, too. And it was hard to, you know, to show them that without them having been there and experiencing it as well.

Filtering. Along with finding it hard for significant others to relate with their new perspectives, another challenge for our participants was the need to filter what they told their families. Most participants still tried to tell family, friends, and coworkers about their experience. Although they shared their experiences, the participants realized that they needed to withhold some parts of their stories from Haiti. Our participants tended to filter out experiences that were tragic, painful, or might cause worry. They felt that their families would not be able to handle some of the unsettling situations they had experienced. Filtering what they told their families seemed like a way to protect them from having anxiety over what the participants had actually experienced. Rebecca explained:

I started taking at least a day before I went to see my family. I would say it takes about 24 hours for a filter to kick in. You know? And so, for example, when my mom would ask me how things were in Haiti, you know [other] people would joke about doing amputations with hack saws and half a bottle of vodka, and it really wasn't that far off. She had a really hard time with that. Or I'd talked about holding a pediatric patient while they passed away, and so, well talking about something like that, it was really, really hard for my family to hear that. So I made it a point to make sure I have at least a day before I saw them so that I could turn on a filter and not share some of that stuff with them.

One of our participants kept the entire experience from her family. Natalie admitted:

My immediate family, they would, I think would have a *stroke* [speaker emphasis] if they knew that I went. Um so it's just almost better that I never told them. And so I guess I've always done things that they didn't agree with and so for me it was better . . . The only way that we could be in each other's lives was to just leave out certain details . . . And so we have this understanding that if there's things that they don't want to hear, you know, things that they would be really upset over, well, they just don't want to hear about it.

Shared family experience. Returning participants felt that those family members who shared in a similar experience would have a true understanding of what they had just gone through. If the Haitian experience was shared by others back home, it made the reentry transition easier in that there was someone to talk to who could truly understand. Examples include family members who had done relief work in Haiti and who had the experience of traveling to developing countries in the past. Margaret participated in relief work in Haiti together with her spouse, and she described her experience with reentry in a positive light because of this:

It was an amazing experience for us. It brought us together in a really deep, meaningful way, I think, there has been a really important part of the transition back is having him to share the experience. And to be able to share the times of sadness together, really that has made all the difference in the world.

Dr. Glen shared his Haiti relief work experience with his daughter. He stated:

My brother and sister and their families had been incredibly supportive. Actually my daughter had come down and spent five weeks with us working as expediter, um . . . you know, basically organizing the people and the records in the clinic and groups and contact people and just [doing] a lot of logistical work as well. So it was a wonderful experience to spend five weeks [with] my adult daughter.

Having family members who understood the challenges of the reentry process was helpful for Nadia. Her father's past traveling experiences to Haiti were helpful in her

adjustment back to life in her home country. She felt that this was because he truly understood what she was going through because he had been there himself. Nadia shared:

Thankfully I have a family who is very used to traveling also. My dad goes down to Haiti and other countries as often as I do. So, yeah, they are very, very good at listening to what all went on and after the earthquake especially, there were times that I felt . . . I just needed my space maybe to kind of process. My dad had been there also right after the earthquake and understood that.

Re-entering back into their families at home was something that was a challenge for the majority of the participants in our study. Although family interaction was at times difficult, there was still a need to share their experiences. Participants felt that stories told to family members about their experience in Haiti needed to be filtered because they were unsure that their families could handle tragic details. Having family members who had shared similar experiences was helpful in the reentry process. Having a shared experience made our participants feel that they could open up about even the unsettling details of the experience.

Professional Challenges

Although each participant volunteered in Haiti in their respective profession, reintegration back into their professional lives in their home country proved to be a challenge. Their experience in Haiti had changed them and made them rethink what was important when working in their field. In Haiti, our participants reported having increased independence to treat patients, having to be more flexible in how they treated patients, and often worked with patients more critical compared to those in their home

country, but showed a genuine appreciation for their health care. This translated into the participants having difficulty returning to their job in their home country and having compassion for their patients at home. The overarching theme of professional challenges can be broken down into four sub-themes which include compassion fatigue, burnout, frustration with their home country's health care systems, and changes in practice after return home.

Compassion fatigue. Participants reported feeling frustrated when working with patients in their home country upon return from Haiti. The frustration often stemmed from comparing these patients to those they worked with in Haiti. According to our participants, patients in their home country often did not seem grateful for their health care service whereas the Haitian people were grateful for the very little that they had. This frustration led to compassion fatigue and made working difficult. Rebecca described this challenge:

We saw patients [who] were having amputations and we are sending them home with amoxicillin and ibuprofen and they were grateful because there is everyone around them dying. They were grateful because we were saving their lives. Then you come back to the States and you have somebody who is verbally abusive to your technician because their doctor gave them Vicodin instead of Percocet for a broken toe.

Part of the frustration was also due to the amount of resources the patients in their home countries had compared to the patients in Haiti. Our participants felt patients back home took those resources for granted. Sophia stated:

Well, initially, I found the complaints of my patients to be so minuscule in comparison to my patients in Haiti. So that was hard for a few days. Um . . . You know? Some patients had complaints that they didn't like their appointments or their equipment and I am thinking, well you are just lucky

that you have a clinic and equipment.

Pam added:

Then when there are people who complain about the health care system in our city or province or our country, I just say, “You guys have no idea how lucky we are.” You know they will complain about wait times in emergency rooms and I will say, “You know what when you’re in emergency here and you’re waiting you have a comfy chair. You have a TV you could watch.” I said, “You know what? In Haiti there would be literally people on the floor and they would be happy to be there.

Burnout. Our participants described feeling burnout upon return to their jobs at home after serving in Haiti. In Haiti, participants engaged in autonomous practice where they were allowed to use their full skill set without much restriction to provide the best care possible for their patients. Upon return home, our participants felt constrained by rules and underappreciated. Natalie described the following:

[It] didn't hit me right away, but then when I came back to work at the hospital, I felt undervalued as physiotherapist. I felt like we've done so much good in Haiti and then when I came back here, it just seemed like the work that we're doing [here in Canada] in the hospital with patients we worked with, we are really not very well appreciated. I also felt like the work that we're doing back in Haiti was much more challenging because we're using [a fuller] skill set.

Participants experiencing burnout reported loss of interest in their job and felt that they were not a valued member of the health care team back home. Some participants found it helpful to take a few days off before returning to work at home after serving in Haiti. Sally shared her thoughts:

And I definitely think the next time that I went I made sure that I took a couple days off before I came back to work.

Frustration with the health care system in the United States. In Haiti, the participants were able to practice under a much more autonomous model. Our participants felt that time spent treating patients in Haiti was more patient focused than back at home. Rebecca described her experience:

Everything is very much living in the now in Haiti and that's an enticing life because everything is genuine. And you always see what [a] huge difference you are making. And I think that with health care in the United States, I think in some ways with all the paperwork and insurance and everything, we get a little more removed from patients than we wish we were and so in Haiti it was different. And so having all that one-on-one contact with patients is just amazing and I want to get back to it.

Rebecca also described the frustration of the slow process of receiving orders from MDs or other health care professionals that is required in the U.S. health care system.

Here in the United States you run across the health care professionals that really makes you want to bang your head into the wall. You know, like you are trying to help out the patients and you spend three weeks calling the doctor's office and they won't give you a refill for blood pressure medicine and you know this patient has out of control blood pressure and you want to help the patient but you don't hear back. You know, you get jerks in every profession and you get jerks in pharmacy too, but the people who choose to do something like go down and volunteer to do something after a disaster, you know even if it's a year later they choose to spend their time going down and doing something like that, they are not those jerks. If the people in your profession, or in another profession, are the ones who believe in giving back, they will believe in social responsibility. So in some ways you get to see the best side of humanity, even in those tragedies.

Rebecca spoke of the rewarding side of volunteering in disaster relief efforts, but serving with such a compassionate and talented staff while abroad can make the return-to-work life at home more challenging.

Changes in practice after return home. A positive aspect of volunteering in Haiti

was working in a different setting with fewer resources, which forced our participants to think outside the box in terms of treatment options. Kelly shared:

I would say I am [a] more creative and resourceful person [now]...I don't necessarily use all the...technology we are sometimes given in our clinics...Some person might say, 'well this machine doesn't work,' in Haiti that wasn't very uncommon...so let's come up with some other problem solving and creative way to get around this and still get the result that we are looking for.

As well as being more creative and resourceful, Amelia commented about how she hopes to integrate the treatment model she used in Haiti into her work in the United States:

My care [in Haiti] was very one-on-one, like we didn't have modalities there. . . I remember thinking that I would sort of like to switch my practice here to a little bit more of that as well, and not be so dependent on the modalities.

Serving in Haiti was an experience that changed our participants' professional lives in positive ways and in negative ways. Participants were able to learn a lot from the patients in Haiti even though they had minimal resources. Returning home to their professional practice was difficult after having the autonomy and creativity they had in Haiti compared to perceived constraints at home, including documentation, and insurance rules and regulations.

Creative Coping Themes

The participants of this study found many ways to express themselves as part of processing or coping through what they felt, saw, and cannot forget. They were able to work through their experiences by remaining connected to those they traveled with and often made use of the new relationships to process their unique difficulties coming back

to their jobs, families, and in some cases, isolation from others with experience in disaster relief work. Change inwardly was illustrated outwardly in writing in journals, essays, papers, composing, and singing songs. The transformation for some of our participants did not end in themselves by ensuring that health care in their home countries was improved. The need for self-expression and communication from the participants was manifested through journaling, social networking, creative writing and giving presentations.

Journaling. Participants journaled about their emotions as they spent time in Haiti working with the people there. They also shared expectations they had and working through the difficulties of disaster relief. For example, Frank said:

I also kept a journal while I was there... I wrote a lot about my experiences but we didn't have a lot of time... I wrote mostly about things that happened during the day and things that I was feeling during the day... the really hard cases that I saw, the things that left an impression on me.

Writing down memories of the time in Haiti on the route back to their home country after the experience was over served as a way for participants to reflect on their time there.

Natalie suggested:

I encourage people to write down a list of goals they have for the trip, expectations...and to journal while they are there...[and] on their way home to write down what they remembered and think about their lives and what they will change when they get home because...they will forget a lot of stuff. So it's kind of doing our own debriefing.

Social Networking. A common trend throughout the interviews was the

utilization of social networking to remain connected to the people that our participants formed attachments with during their time in Haiti. The portals used most frequently were Skype™ and Facebook™. Participants, Haitian colleagues, and patients shared stories, pictures, and experiences in a way that was easy for them to access. This was possible even when schedules conflicted or the bonds formed involved people from different countries. For some it deepened relationships and enriched the lives of those involved. Frank discovered that starting the communication led to more connections and sharing of experiences:

And so I did a lot of sharing through social networking. I have a couple of [photo] albums and a whole lot of people commented on them. And that led to more conversations.

Paulette described her fondness for those that she worked with by saying:

I have done some Skyping™ with one of my colleagues . . . with whom I have become extremely close to and will never let go of.

As with any contrasting experience there can be dissonance. Some of our participants found it easier to deal with this dissonance using the technology available.

Kelly shared:

You know, some days are really happy and then some days it's just transitioning back . . . and then other days it's just like lots of memories and questions of like, how is everybody down there? You know? I am really wanting to hear and talk with them to reconnect with them. And so a little bit of blogging, a little bit of journaling, and also reaching out and communicating by phone or Skype™ ...those are probably the main things I have done [at] this point.

Even years after the volunteer experience in Haiti, the groups remain in contact. The participants found satisfaction in knowing the welfare of the patients, community

members and team members with whom they formed bonds in Haiti. Pam shared:

So for a while actually I did Skype™ with the girls in the lab there because they have a computer right in their lab. And I did Skype™ with them up until probably about a year ago... But on Facebook™ I still have contact with some of the lab people.

Betsy stated:

We keep in contact through Skype™ and now they're all on Facebook™, which is great . . . I just responded to a message from a guy that I sponsored in school for six years who sent me a message this morning on Facebook™ .

Creative Outlets. To a lesser extent, a few of the people interviewed used more creative outlets to commemorate their time in Haiti and the extraordinary circumstances in which they lived, worked, and developed friendships. Our participants found deep significance in the writing and singing of songs which allowed them to cope with what happened in a personal way. Amelia stated:

I have talked about the trips with three different groups and I always use this song: "In No Ways Am I Tired." I make everybody learn and sing it, so I feel like I am raising a prayer to all my friends in the spinal cord unit [in Haiti] every time a group of us does that spiritual.

Presentations. These health care professionals took what they learned and the memories of those they cared for, and brought this compassion into their professional practice back home. Some of our participants spoke to large groups or gave presentations to colleagues and other hospital staff and administration. In particular, this strategy was a socially active way to work through the experiences in Haiti and gain deeper insight into how this changed them.

Pam explained:

So I mean I really love to talk about it because I think it helps me to understand the experience. And I think I've learned a lot more about myself after coming back from Haiti. You know the whole experience of being there was one thing but then when you are back, [you ask yourself] how has it changed you?

Formally speaking about her experiences led Natalie to become more active and responsive to the perceived flaws in the treatment and patient education back in her home country. She was able to learn from her time in Haiti the importance of giving the best care possible regardless of the circumstances. She believed in the importance of taking personal responsibility in continuing to progress the standard of care. Natalie stated:

But seriously, physically doing those presentations sort of helped me think about it and reflect. I definitely felt that there is an evolution [in physical therapy]. And so the last presentation was basically about what can you learn as a physiotherapist or as a health care worker in that environment. And then what can you bring back to our contexts here? But it helped me a lot to process the experience. I was only there for a month and so you kind of wonder well what big impact did I have over there? And so I'm sure I helped some individuals, a small number of people. I think that speaking about the experience has probably really helped many more people here [that did not go to Haiti].

Optimizing the reentry Process

A theme that emerged during the course of the interviews was that there were ideas for a better reentry experience. Our participants expressed what they would have found helpful in the reentry experience. A common theme among these ideas was being able to talk to others who had been through similar experiences in Haiti. Social media and online forums were suggested as a means of doing this. Sophia said:

I think the important thing would be to have access to someone who has also been to Haiti to talk to so you can feel like someone understands your experience. You know, it is just really hard to come down after the heightened response you live when you're in Haiti during that initial phase after the quake. So I think it is important to have time to decompress but then again I don't really know if you ever decompress and maybe we are not supposed to. I guess it would be important to have a way to share your thoughts and stories with others somehow.

Upon reentry, participants also expressed that receiving updates from the facility they worked at in Haiti were desired. People wanted to know that the facilities they had been working with were still progressing positively after they left as they still felt connected to where they had volunteered. Kelly had several ideas for an ideal reentry, and she expressed them in her interview:

I think part of [an ideal reentry] would be an online forum where people can reconnect either with people who they had worked with or others who have had a shared experience. Maybe giving them, you know . . . thank you for your time. Here's a couple of updates with what's new with our organization and our facility. For me that is helpful to know the place I spent so much time is progressing . . . you know, there are positives that are occurring at that place.

The idea of creating a more organized reentry process was a common theme that emerged in the interviews of this study. The thoughts and ideas were meant to be helpful in implementing a better reentry process for returning disaster relief participants.

In summary, this chapter presented the results from the survey and the interviews conducted for this study on the reentry experience after serving in Haiti as a disaster relief worker. The following chapter will provide a discussion linking the results to existing literature and our resonance rounds. Finally, we will integrate the physical therapy profession's core documents with the findings of the study.

Chapter V: Discussion

This chapter will discuss the results of the study and link these findings to existing literature and resonance rounds. We will also integrate the physical therapy core documents with the findings of our study. The results of this study are consistent with past literature. Debriefing is an important activity to participate in before returning home especially when facing the demands of disaster relief work (DRW). Themes identified by our participants upon return home included personal, family, and professional challenges, as well as creative ways of coping to deal with these challenges. Interviews with participants who served abroad in Haiti with disaster relief efforts, as well as the results of the ProQOL survey, have brought to light the need for a debriefing process in order to help participants overcome hardships upon return home.

When investigating the components of our phenomenological study, we found high levels of compassion satisfaction and low levels of both secondary trauma and burnout (see Table 1). Factor analysis revealed secondary trauma and burnout are two contributing components to compassion fatigue. Therefore, when levels of secondary trauma and burnout are grouped together as compassion fatigue, the levels of compassion fatigue and compassion satisfaction are at comparable levels in our participants.

These statistics mean that although our participants gained satisfaction from helping their patients, they also experienced the relatively same amount of compassion fatigue. Ideally, there should be less compassion fatigue when comparing these two characteristics because a high level of compassion fatigue may indicate more difficulty with reentry. For example, high compassion fatigue may indicate difficulty carrying out

job tasks which impacts quality patient care. If efforts could be made to reduce compassion fatigue, the process of reentry would be made easier for disaster relief workers.

An overarching question emerged from the themes that were identified from participant interviews: “Who am I?” Personal themes were largely wrapped up in personal relationships with others and reconciling one’s own identity and feelings after return home. The personal experiences of our participants echoed that of other populations who went through a reentry process. Raschio¹⁵ described the tendency of students to alter friendships in order to seek out others who had similar experiences because of a new feeling of being different from others upon their return home. This theme was also seen in our participants, as many of them claimed they had changed and that they had sought out connections with those who had similar experiences in Haiti. Further elaborating, Raschio¹⁵ explained that a primary source of inner conflict upon reentry in students resulted from new perspectives, values, and beliefs they developed while being abroad. When students returned home, their now conflicting perspectives forced them to question who they were. The participants of our current study also reported similar changes, and went as far as to say they returned home as a different person. Similar to what was reported by Raschio¹⁵, most of our participants reported that they had difficulty finding support at home, as family and friends were not able to fully understand the depth of the participants’ lived experiences. Our participants expressed an inability to connect with loved ones which consequently led them to seek out other relationships.

Many of our participants described feeling a sense of loss upon return home. This loss has been described in the literature as people begin to identify with the culture and people from which they have returned.¹³ In addition to feelings of loss, participants expressed concern about their patients in Haiti, even though the participants had returned home and were physically unable to continue to help. This inability to relinquish control has also been described in the literature.²⁷ It is suggested that this behavior is indicative of compassion fatigue, which has been described in the methods section of this paper . Therefore, one can speculate that these types of feelings resonated with our participants' upon return home from Haiti.

Although our sample population was comprised of multiple health care disciplines, there was a parallel between the participant's personal experiences and the American Physical Therapy Association's (APTA) published Core Values.⁵ Many of the participants in our study felt a continuing accountability to their patients in Haiti, and for Haiti as a society. Many participants took responsibility for changing care including helping to educate the Haitian people to set up a physical therapy program they could utilize. All of the participants in this study volunteered their special and specific skills to help the underserved area of Haiti. These professionals had a desire to put the needs of the Haitian people before their own and selflessly sacrificed time and luxuries to help those in need. Participants adopted the perspective of those living and working in Haiti, walking in solidarity with the Haitian people. Each became an advocate for the needs of Haiti with the education of the Haitian health care providers. These behaviors reflect the altruistic and compassion/caring core values of the APTA. The health care professionals

in this study demonstrated excellence and integrity; they showed an investment in the profession of physical therapy by contributing to physical therapist education in Haiti, and through their belief that physical therapy is a service that was desperately needed in Haiti. Many participants believed that volunteer and disaster relief work are the professional duty and social responsibility of their profession. Participants in our study showed great cultural competence and built collaborative relationships with Haitians and health care professionals from countries around the world. Sophia summarized her perspective on disaster relief work in Haiti as it relates to the APTA Core Values:

If you are a PT who just goes to work and then comes home to have fun, you haven't really become a PT who is called to the profession, I guess. You're just doin' a job. You are a worker bee. When you take and live the ideals or those core values of our profession, I think that is when you find your calling. Then your job or profession becomes who you are and a different setting like being in Haiti right after the earthquake helps you realize how important your role in life is.

It would be beneficial for family members and other loved ones to better understand the experience that their volunteer goes through in order to provide better support upon reentry. Another example where family support is needed for a successful reentry experience is in the United States military. The process that military families go through during reentry provides useful insight into how loved ones can help disaster relief volunteers in their reentry process. For military families, re-integration training includes education on post-combat deployment reunion stressors, stress management, conflict resolution, anger management, and listening skills.¹¹ Preparation of the family is key to having a successful reunion upon a loved one's return.¹¹ In returning from disaster relief work, having the family receive more information about potential needs upon

reentry would aid in the family's ability to support their loved one. Changes that impact families include emotional detachment, belief discrepancy, and disillusionment. Resources in these areas would help in the reentry process for disaster relief workers and their families.¹³

This experience not only affected family life but also professional life. Participants who volunteered to serve in disaster relief situations generally served in the same area as their current profession, such as physical therapy or nursing, and many found the experience impacted their professional life upon return home. Not only did participants experience symptoms of secondary traumatic stress through patient stories, but the experience also made the participants question how health care was delivered back home.

Prior to serving abroad, our participants may have held a narrow view of health care and what their professional obligations and duties were because they only lived and worked in one city, state, or country. When participants served abroad in their designated health profession, their eyes were opened to a new health care system and a new patient population. Upon return home, the participants held new or changed views of their home country's health system. Whether their perspective became more positive or negative depended on the experience and values developed from disaster relief work. Wielkiewicz¹⁶ suggested that students who returned from a study abroad experience tended to develop new beliefs and values that likely differed from their home culture. A discrepancy between their new beliefs and the beliefs of their home culture held the potential to cause stress and anxiety.

This stress and anxiety may be one of the many reasons participants struggled with returning to work immediately after serving in Haiti. Participants had difficulty showing compassion for patients upon their return home whose health concerns were much more minor compared to the health problems of the patients they had been serving in Haiti. It was difficult for the participants to put their biases aside and treat all patients equally. In the APTA Code of Ethics, principle one states, “Physical therapists shall respect the inherent dignity and all rights of individuals.⁵⁰” Physical therapists have a duty to uphold the Code of Ethics and those disaster relief workers who struggle to do so may need to seek professional help. Many participants expressed how the patients in Haiti were so much more thankful for their care, which made it easier for the participants to be compassionate and provide the best care possible for that patient.

Finally, stressful relationships were created between colleagues when one colleague served abroad and the other did not. Hertz¹³ explained that re-migrants may not be seen favorably in their home environments if they try to immediately apply their new ideas within their home setting. This application of ideas may lead to the person feeling rejected, abandoned and betrayed by former colleagues, who may now view the person as an intruder as opposed to a fellow citizen returning home. Our participants shared that some colleagues were not interested in learning about their experience, which made it difficult for the participant to return to work as they often found they needed someone to debrief with at work as memories from Haiti were triggered with daily tasks in their workplace. Educating co-workers on strategies for supporting colleagues during reentry would be beneficial.

Our participants described various coping strategies, including gallows humor and informal discussion of experiences with co-workers to process through their reentry. These coping strategies have also been reflected in the literature. For example, in departments where tragedy is common, such as in the emergency department, health care workers described the use of these techniques rather than entering into formal psychological counseling.³⁹ In an article describing the secondary traumatization of wives of soldiers, approximately half qualified for the DSM IV category of post-traumatic stress disorder but none of them reported seeking support or any formal help.⁴² Several studies suggest that seeking counseling may be one of the best ways to cope after experiencing compassion fatigue or vicarious traumatization.^{35,36,39} Many of our participants did not seek professional counseling as suggested in the literature, but instead sought support from others with similar experiences through social media such as Facebook™ and Skype.™

Specific ideas from our participants on easing the reentry process were to establish an online community board or network for returning volunteers, utilize social media (ie Facebook™, Skype™), or create optional e-mail lists to connect with other volunteers. Having a standardized way of connecting with similar volunteers would be beneficial, such as having NGOs providing optional e-mail lists or phone numbers. Establishing an online community forum for returning volunteers to express their thoughts and feelings upon reentry would also be beneficial for creating a way to reconnect. This online community could be established through a national organization such as the APTA for physical therapists. Another way of making an online community

could be through creating a private group through Facebook™ specifically for groups of returning volunteers.

Strengths and Limitations

Strengths of our mixed methods study included sample size, for both our ProQOL survey (n= 90) and our interviews (n= 15), as we were able to reach saturation with participant experiences. The participants who consented to the interview had already taken the online survey, providing thick, rich descriptions of the reentry experience. We obtained a wide variety of descriptions as a result of the various health care professionals represented amongst our participants. The investigator who interviewed the participants was experienced in phenomenological interviews, and appropriately bracketed out her experiences prior to the interviews. This investigator was not involved in the identification and analyzing of themes in order to limit bias of results.

Several limitations existed in the present study. We acknowledge that the results of this study do not apply to every disaster, and that the resulting experiences discovered are specific to this group of health care providers who served in Haiti after the earthquake of 2010. Another limitation that exists lies within our survey tool. The ProQOL demonstrated high internal consistency as evidenced by the high value we obtained for Chronbach's alpha in our data analysis. The ProQOL is meant to be administered within 30 days of the experience.²⁵ Although we asked our participants to think back to how they felt 30 days after return home, it is possible that they were unable to contain their experience to within those first 30 days.

In summary, this chapter discussed the results of our mixed methods study and its

implications for disaster relief work. Thick, rich descriptions from our interviews elaborated on our quantitative findings from the ProQOL. Parallels were drawn between the literature, the APTA's core values, and our participants' experiences. The following chapter will present conclusions regarding the process of reentry experienced by our participants.

Chapter VI: Conclusion

In conclusion, this research paper has brought to light the need for a debriefing process for those health care providers who volunteer their time to disaster relief efforts. The participants in this study were able to verbalize their challenges with the reentry process after serving in Haiti. The military and student study abroad research reports that their debriefing programs have been helpful. The debriefing for reentry after serving in Haiti was minimal if it existed. It is evident from the stories of our participants that a debriefing program would benefit those who serve in disaster relief efforts for any period of time no matter what health care profession was involved.

Compassion fatigue can be an unfortunate secondary effect of participation in disaster relief work. The results of the ProQOL survey tool revealed that disaster relief workers who participate in our study had high levels of compassion fatigue along with high compassion satisfaction. The severity and duration of this effect may be significantly reduced with proper debriefing processes or screening tools performed upon return home. A debriefing process would be highly beneficial to all health care volunteers returning from a disaster relief effort as a way to educate and monitor for those at high risk for developing compassion fatigue. The ProQOL tool may be helpful for use by organizations to predict how their volunteers are coping with their reentry to their everyday lives. It may even help those who are struggling with reentry issues to consider options for assistance such as finding a support group or seeking counseling.

Social media has become a frequently utilized resource for those returning from disaster relief work, serving as an outlet for an informal debriefing session between

colleagues who served on the same trip. Those disaster relief workers who utilize resources such as Skype™, Facebook™ or email report it is a useful and convenient way to share experiences, stories, and pictures. These tools are adequate for some, but do not fully address the needs of some returning health care workers who show signs of severe compassion fatigue, burnout and as they attempt to re-integrate into their lives in their home countries.

The processes of reentry were similar across the health care professionals who participated in this study. There are few adequate options, resources, or screening tools for the possible negative consequences of working in a disaster relief setting. There may be significant value in a pre-deployment briefing or orientation including the provision of access to those who have participated in disaster relief in the past. The ability to have some mental preparedness for the possibility of what health care workers may experience could have a substantial impact on how they deal with their emotions, thoughts, beliefs, and coping behaviors when they are in the field and during reentry home.

Upon return home some standardization of a debriefing process should be instituted throughout different organizations. A simple debrief immediately after return followed by extended follow-up even after one month, six months, or one year, would allow participants more time to process through their feelings and experiences and may permit more in-depth reflection. With extended debriefing available, participants will be able to connect and have conversations with previous disaster relief workers. The importance of having social support from other volunteers who have gone through similar experiences cannot be underestimated.

By understanding the experience of reentry after serving in disaster relief work, we can better anticipate the support needed for those who engage in this type of work. The core value of social responsibility needs to be two sided. If members of allied health professions wish to fully carry out this principle, professional organizations need to provide resources to aid in easing the reentry process.

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Table 1

Table 1 .Levels of Compassion Fatigue And Compassion Satisfaction From ProQOL.

Variable	Mean Score	Standard Deviation	Level relative to normal	Cronbach's alpha
Secondary Trauma*	21.04	7.64	Low	.90
Burnout*	19.25	6.58	Low	.87
Compassion Satisfaction	43.40	5.89	High	.93

Figure 1

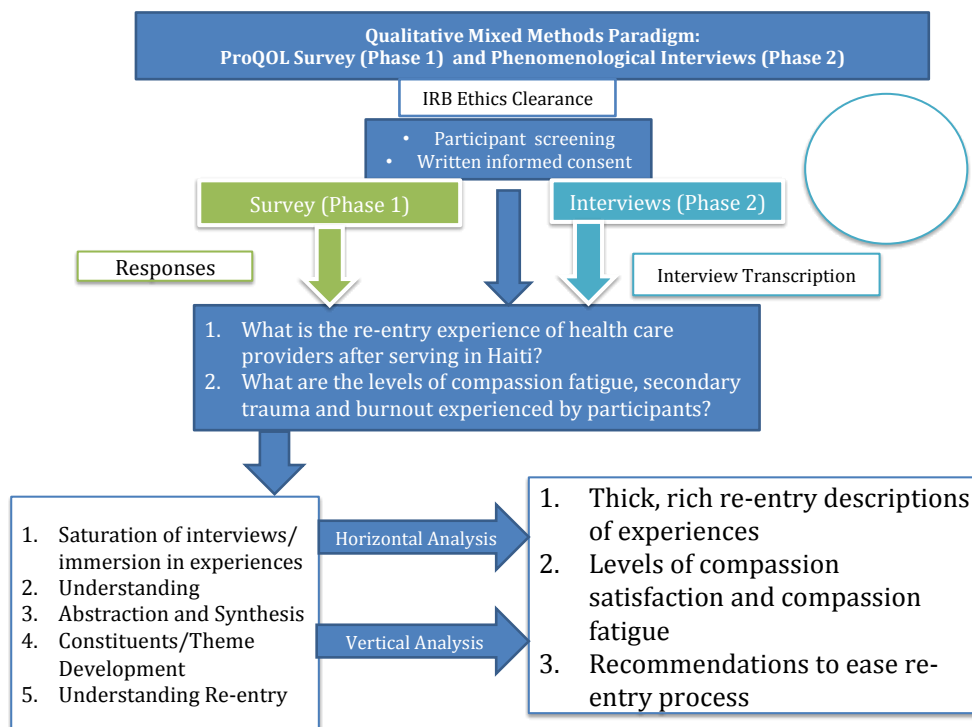


Figure 1. Qualitative mixed methods paradigm of ProQOL survey and phenomenological interviews.

Appendix A

Survey of Health Care Providers: Returning Home after Disaster Relief Work in Haiti

The following survey asks you about your role in providing disaster relief work in Haiti and your return home. The first part asks you questions about your role in Haiti and your return home. The second part of this survey asks you questions about compassion satisfaction and compassion fatigue. The entire survey should take approximately 10 minutes. By clicking on the “I agree” button implies that you agree to participate in this survey.

_____ I agree to participate in this survey.

If you would like to be interviewed about your experience, please feel free to email the lead researcher, Dr. Susan Klappa PT, PhD at sklappa@hotmail.com. We will be glad to set up a phone or skype interview which will last approximately 45- 30 minutes. An informed consent form will be emailed to you regarding the details of the interview phase of this research project.

Part I: Initial Questions

1. What is your profession?
2. How long have you practiced your profession?
3. How many times did you serve in Haiti after the earthquake?
4. How long did you serve in Haiti each time?
5. Did you take time off before returning to your job in your home country upon your return?
6. If so, how much time did you take off before returning to your normal work duties back home?

Returning Home after Disaster Relief Work in Haiti
Investigator: Dr. Susan Klappa PT, PhD 651-690-xxxx or
sgklappa@stkate.edu

Please read this document and ask any questions you may have before agreeing to be in the research study. The researcher is Dr. Susan Klappa, who is a physical therapist and associate professor in the Doctor of Physical Therapy program at St. Catherine University. Four Doctor of Physical Therapy students are also participating in this study in partial fulfillment of the requirements for their DPT Degree.

You are invited to be in a research study about the professional experience of returning home after disaster relief work in Haiti. You were selected as a possible participant because of your participation as a health care provider who has done relief work in Haiti.

Background Information:

The goal of this project will be to learn about the professional experience of health care providers as they return home after engaging in disaster relief work in Haiti. The results may help us raise awareness of the challenges and barriers that health care providers face and help inform programs to help prepare these health care providers to have a successful re-entry process.

The guiding research question is: What is the professional experience of health care providers as they return home after participating in disaster relief work in Haiti?

Procedures: You will be asked to do the following things during this study.

If you agree to be in this research study, we would ask you to do the following: Be interviewed one time in person or via the phone/Skype. The interview will take about 45 – 60 minutes and will be audio recorded. It will involve talking about your re-entry process back home after your disaster relief work experiences. We will email you a copy of the transcript and a description of your experience. We would like you to respond via email to clarify that we have indeed captured the essence of your story.

The interviews will be held at a mutually agreed upon time and location either in person, by phone or Skype call.

The only direct benefit of your involvement in this research study is that you will be allowed to share your story.*You will not be paid for participation in this study. You will not be reimbursed for travel expenses to the interviews.

Risks and Benefits of Being in the Study:

Participation in this study does not involve any physical risk. You might feel some discomfort calling to mind and discussing difficult experiences about your re-entry home after participating in relief work in Haiti. You may withdraw from the study at any time without adverse consequences. You may end the interview before completion, refuse to answer any questions, or refuse to participate in the follow-up mail or emails responses

confirming we have captured your story. You may ask that data from your interview be withdrawn from the study. After reading this consent form, we will ask you to describe your understanding of what you will be asked to do for this study. We want to be sure you understand what you will be doing.

Confidentiality:

The records of this study will be kept private. Any personal identity such as your name, place of employment will be kept confidential. In the report we write, we will not include any information that will make it possible to identify you. You may in fact choose a pseudonym for your name.

After the students' graduation, we hope to be able to publish the results of this project. Again, only pseudonyms for you, your family, or any organizational information will be used. Only the investigators and their advisor/professor will have access to the transcripts. Tapes and notes will be maintained in a locked bag during travel. The tapes, hard copies of the transcripts will be erased, and the hard copies of the transcripts will be stored in the locked desk drawer of the investigator. Hard copies of the transcripts will be shredded after 5 years.

Voluntary Nature of the Study:

You have the ultimate right to deny participating in this study or to withdraw from this study after you have agreed to participate at any time of your choice during the study. You also have the right not to answer questions posed to you by the researcher. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University. If you decide to participate, you are free to withdraw at any time without affecting those relationships.

Contacts and Questions:

You may ask any questions you have now. If you have a question at a later time, please feel free to contact Dr. Susan Klappa PT, PhD at phone number: 651-690-8131 or email at sgklappa@stkate.edu. If you would like to talk to someone other than the researcher, please feel free to contact our program director, Dr. Lisa Dutton PT, PhD at 651-690-8126. You may also contact Lynne Linder at St. Catherine University IRB via email at Lelinder@stkate.edu or by phone at 651-690-6203.

The identifying number for this project is 11-EXP-74. You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

Participant's Signature:

Participant's Printed Name:

_____ Date _____

Email:

Signature of investigator or person gaining consent:

Interviewer:

_____ Date _____

Appendix B

Part 2: Professional Quality of Life Scale (ProQOL)
 Compassion Satisfaction and Compassion Fatigue
 (PROQOL) Version 5 (2009)

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 a *[helper]*. 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 *30 days after returning home from Haiti*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I *[help]*.
- _____ 3. I get satisfaction from being able to *[help]* people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I *[help]*.
- _____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
- _____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a
 person I *[help]*.
- _____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
- _____ 10. I feel trapped by my job as a *[helper]*.
- _____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
- _____ 12. I like my work as a *[helper]*.
- _____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
- _____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. I feel worn out because of my work as a *[helper]*.
- _____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
- _____ 21. I feel overwhelmed because my case [work] load seems endless.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of

- the people I [*help*].
- _____ 24. I am proud of what I can do to [*help*].
- _____ 25. As a result of my [*helping*], I have intrusive, frightening thoughts.
- _____ 26. I feel "bogged down" by the system.
- _____ 27. I have thoughts that I am a "success" as a [*helper*].
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very caring person.
- _____ 30. I am happy that I chose to do this work.

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a nonsupportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress _____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

In this section, you will score your test and then you can compare your score to the interpretation below.

To find your score on each section, total the questions listed on the left in each section and then find your score in the table on the right of the section.

Compassion Satisfaction Scale:

- 3. _____
- 6. _____
- 12. _____
- 16. _____
- 18. _____
- 20. _____
- 22. _____
- 24. _____
- 27. _____
- 30. _____
- Total : _____

The sum of my Compassion Satisfaction questions	So My Score Equals	My Level of Compassion
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale:

- *1. ____ = ____
 *4. ____ = ____
 8. ____
 10. ____
 *15. ____ = ____
 *17. ____ = ____
 19. ____
 21. ____
 26. ____
 *29. ____ = ____

*Reverse the scores for those that are starred.

0=0, 1=5, 2=4, 3=3, 4=2, 5=1

Total : ____

The sum of my Burnout Questions	So My Score Equals	My Level of Burnout
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Trauma Scale:

2. ____
 5. ____
 7. ____

9. ____
 11. ____
 13. ____
 14. ____
 23. ____
 25. ____
 28. ____
 Total : ____

The sum of my Secondary Traumatic Stress questions	So My Score Equals	My Level of Secondary Traumatic Stress
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Appendix C

Interview Guide

Experiences of physical therapists returning home after disaster relief work in Haiti

Interview:

- Think of the time when you returned home after your disaster relief work in Haiti. Tell us about that situation:
 - Why did you decide to participate in relief work in Haiti?
 - What challenges did you experience while in Haiti?
 - What challenges did you experience after returning to your home country?
 - What barriers did you experience? Why?
 - What went well? Why?
 - What assistance did you need?
 - How has your life changed now that you are home?
 - Are there differences working with patients in Haiti versus the US?

Additional Prompts:

- I'm interested by what you just said. Can you tell me more about what you mean by "___?"
- That's a phrase I haven't heard you use yet. Can you tell me what that means?
- I want to make sure I understand you right. Can you give me an example?
- Do you recall what you meant . . . a time . . . etc?

*Questions are based on the dissertation work of Dr. Susan Klappa (2010).