Exploring Professional Quality of Life among Therapeutic Recreation Professionals working in Long-Term Care Homes

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Abstract

Professional Quality of life (PQoL) is described as the quality one feels in relation to being a helping professional, and incorporates both positive and negative aspects (e.g., compassion fatigue and compassion satisfaction) (Stamm, 2010). To date, concepts within the PQoL framework have not been fully explored within LTC, nor have they been explored from the perspective of therapeutic recreation professionals. To fill this gap, this narrative inquiry explored the stories of Professional Quality of Life among four TR practitioners working in LTC homes within the Greater Toronto Area. Narrative accounts describe the complexities, tensions and variations in describing experiences of PQoL among TR practitioners working in LTC homes. Key patterns and plotlines emerged revealing six narrative threads: *experiences that fuel the soul and ignite TR spirit; experiences of seeking out opportunities for challenge and change; experiences in encountering professional tensions in TR practice; experiences in developing professional valour as a TR advocate; experiences of the workplace that shape PQoL;* and *re-imagining practice to foster PQoL*. This study provided space for TR practitioners to share their stories surrounding phenomena within the PQoL framework. I offer personal, practical and social justifications of this narrative inquiry to facilitate future conversations in understanding PQoL to assist helping professionals along their professional journey.

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Do not stand by and weep,
I'm not here, I'm not a sleep
I really did not die so do not cry
I'm the sparkle in my granddaughter's eye
-George Patrick Kennedy

Dedication

I dedicate this research to my grandparents - Jacqueline and George Kennedy.

I also dedicate this thesis to the four wonderful TR practitioners who shared their stories with me - *Rose, Isabel, Louise and Leah.* You are true leaders in the field of TR. Thank you for opening your hearts and sharing your beautiful stories with me.

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Prologue: My Narrative Beginning

After graduating with my undergraduate degree in Recreation and Leisure Studies from Brock University in 2012, I worked as a Recreation Assistant in a long-term care (LTC) home in Toronto. I thought I was on cloud nine. I worked close to home, in my field, with the population I desired, but over time, reality set in. I started to feel that my programs were dumping grounds for residents when they were not receiving medical or occupational care. I also came to the realization that there was not enough time in my day to get everything done, including new admission assessments, creating and planning my activity calendar, and balancing the programming on my floors to whole home programs such as church service, bingo, entertainment, dinner groups, and breakfast club. I also regularly assisted with resident meal times, documented programs and completed the Minimum Data Set (MDS) and care plans, and attended care conferences and other general meetings. At that time, I also signed up to be the new Outings Co-ordinator, and offer new and exciting trips into the community for residents. This meant that I needed to allocate time in my already crammed day to plan and organize these outings as well as any administrative work that went along with it. I began to bring work home on my days off. I did research on appropriate venues, risk analysis on accessibility, and created lists and forms from home so that it would not take away time spent with residents. My job tasks really started to pile up.

It wasn't until my mother was diagnosed with ovarian cancer that I really noticed how unsettling caring can be at times. When I thought that my own mother was on the verge of death, caring for others became emotionally challenging. I found myself making mistakes at work like forgetting when my MDS was due or mixing up dates for outings. I

was constantly frustrated and even started to not want to go in to work. I found sometimes that my interactions with residents would make me cry.

When I first started my role, I thought I could handle 48 residents' care plans and aid in their leisure and recreation endeavours, but when stress became unbearable in my life, I found it hard to manage everything, including self-care. I felt guilty not being with or taking care of my mom when I was with residents, and then when I was with my mom, I often thought about what I needed to do at work. I did not understand why I was unable to cope, why I was so tired all the time and why my professional life was being compromised. I felt ashamed as a TR professional that I was unable to help myself and have work-life balance.

I did some web searches on stress in health care and found terms such as *compassion fatigue* and *burnout* within the nursing and trauma literature. I filled out an online professional quality of life self-test which determined that I had high levels of burnout and compassion fatigue. I noticed that these terms and experiences were not well documented in the therapeutic recreation literature and I wondered why.

My experience in learning to navigate through stress tells me that being a helping professional, specifically a TR professional, is more complex than I originally thought. I started to ask myself whether others might feel the way I did. How did other practitioners view professional quality of life? Why was this not discussed in the TR literature? These questions led me back to school. I thought that I could use my own experiences as a starting point to explore TR practice in LTC.

Chapter One: Introduction

Long-term care (LTC) homes are a part of the health care system that provides 24-hour medical and non-medical services for individuals with progressive and chronic illness who are no longer able to function independently in their own home (Banerjee, 2007; Canadian Healthcare Association, 2009; LTC Innovation Expert Panel, 2012). Licensed under the Ontario LTC Homes Act (2007), the provincial government regulates the standards and policies for services in all LTC homes (Armstrong & Banerjee, 2009). In the province of Ontario, there are over 600 LTC homes (LTC Innovation Expert Panel, 2012). This sector employs 16,000 full- and part-time staff work in Ontario LTC homes, including nurses and physicians, administrators, and members of allied health teams (e.g., therapeutic recreation, occupational therapy, physiotherapy, social work, and chaplains) (LTC Innovative Expert Panel, 2012).

Research surrounding the culture of working in LTC homes shows growing systemic workplace issues including managing and dealing with continuing and complex health conditions (Barbosa, Nolan, Sousa, & Figueiredo, 2014; Broadaty, Draper, Low, 2003; Buhr & White, 2007; Duffy, Oyebode & Allen, 2009; Zwijsen et al., 2015), time constraints related to duties and expectations (Broadaty, Draper, Low, 2003; McGilton, Boscart & Brown, 2014), and high caseloads and lack of support related to staffing levels (Barbosa, Nolan, Sousa, & Figueiredo, 2014; Choi, Flyn & Aiken, 2011; Duffy, et al., 2009). In fact, the Ontario Health Coalition (2008) provides context to some of the systemic issues of the work environment in LTC homes:

> Crushing workloads, stress, inadequate supports, lack of control, a punitive culture, rationing of supplies, and inadequate resources have contributed to conditions that are creating harm to residents, stress and undue financial burden families, and exacerbated staffing shortages across the sector. (p.4)

This suggests that the LTC care sector is plagued with many obstacles which contribute to increasing stress levels for staff (as well as family and residents) and ultimately leads to a debilitating work environment and overall quality of life as a helping professional.

The Professional Quality of Life (PQoL) framework is valuable in understanding one's feelings in relation to their work as a helping professional (Stamm, 2010; Todaro-Franceschi, 2013). This framework is comprised of the following core concepts: *compassion satisfaction*, the positive experiences related to being a helpful professional, while *compassion fatigue* is understood as the combination of *burnout* and *secondary stress* (Stamm, 2010). Todaro-Franceschi (2013) describes these concepts as the "good, the bad and the ugly of professional quality of life" (p. 5). Research indicates that the prevalence of compassion fatigue among helping professionals in healthcare ranges between 40-80% (Mathieu, 2012), and stems from the high caseloads, long hours, job dynamics including challenging demands of responding to the patients' needs who have experiences trauma or are suffering, over identifying with patients, lack of support, poor self-care and the inability to cope as a professional (Austin et al., 2013; Mathieu, 2012; Melvin, 2012; Sabo; 2011).

Building a Rationale for talking about PQoL in TR

Therapeutic recreation (TR) professionals are among the members of allied health professionals working in LTC homes. Anderson and Heyne (2012) define TR as:

> the purposeful and careful facilitation of quality leisure experiences and the development of personal and environmental strengths, which lead to greater well-being for people who, due to illness, disability or other life circumstances, need individualized assistance in achieving their goals and dreams. (p.40)

TR professionals build on existing skills, strengths, capacities, and interests of their clients while using leisure as its catalyst or teaching method (Anderson & Heyne, 2012; Hood & Carruthers, 2013). TR practitioners do not seek to "cure" or fix individuals, rather to help discover resources to help improve quality of life. Leisure is meant to support past roles, find a sense of normalcy by provide a sense of hope in sustaining personal identity especially for those living with dementia (Genoe & Dupuis, 2011).

Within the field of TR, limited research has explored professional challenges, complexities and tensions in day-to-day experiences and the ensuing implications on the well-being of TR practitioners (see Briscoe, 2012; Hall & Mark, 2015; Hebblethwaite, 2013; Hutchison, 2009; LeBlanc & Singleton, 2008). Additionally, although studies have examined burnout and job satisfaction from the perspectives of frontline staff in LTC, the voices of TR professionals are missing. According to LeBlanc and Singleton (2008) as a collective, practitioners and academics need to be aware of the complexities in TR practice specifically addressing how workplace cultures and societal assumptions impact the day-to-day decision-making of therapeutic recreation professionals. It is important to understand the on-going tensions in healthcare, the emotional impact of being a caring professional and its implications on practice. Only then can we finally begin to discuss how to better support practitioners.

My motivation in conducting this research was derived from my own personal and professional journey. In my own practice, I often questioned whether I should/could separate my work life from my personal life. I asked myself what I found most meaningful in my role as a TR professional in LTC, what it was about working in a LTC home that I found so stressful and how was I still able to go to work despite the

challenges I faced? Through this research, I wanted to know how other practitioners address these questions and how they describe PQoL within the LTC environment.

Overview of the Study

The purpose of this narrative inquiry was to explore the everyday stories that shape PQoL among TR professionals working in Ontario LTC homes. I inquired into the stories of *compassion satisfaction* related to the positive moments such accomplishments, passion, joy and inspiration in working in LTC but also explored *compassion fatigue* known as the negative experiences related to the work environment, emotional stress, overwhelming interactions with residents, family and staff. My questions included:

1. *What kinds of positive practice lived experiences shape Professional Quality of Life for TR professionals?*
2. *What kinds of stressful and vulnerable practice lived experiences shape Professional Quality of Life?*
3. *What do these stories reveal about Professional Quality of Life in LTC homes?*

Using an interpretive methodology, narrative inquiry (Clandinin, 2013) allowed me to explore many experiences using stories from the perspective of four TR practitioners working in different LTC homes across the Greater Toronto Area (GTA). Narrative inquiry is "an approach to study human lives conceived as a way of honoring lived experiences as a source of important knowledge and understanding" (Clandinin, 2013, p. 17). For me, narrative inquiry was a flexible and descriptive methodology that symbolized a journey between a participant and myself, to explore a phenomenon without trying to find a solution (Clandinin, 2013). My data collection involved meeting separately with each practitioner on two occasions. The first interaction focused on understanding and discussing PQoL. The second interaction involved reflecting on two

kinds of lived experiences that the participants wrote as a narrative artifact. We also discussed how their practice and understanding of PQoL has changed over the years as well as their future hopes and dreams for TR in LTC.

Chapter 2 further explores the LTC landscape, literature surrounding concepts within the PQoL framework while addressing the tensions experienced by TR practitioners. Stamm's (2010) Compassion Satisfaction-Compassion Fatigue Model was used to help frame this research to explore into PQoL and is also highlighted in Chapter 2. Chapter 3 explores my process for data collection and analysis, which involved using Connolly and Clandinin's (1990) analytic tool of broadening, burrowing and re-storying as well as remaining committed to the three-dimensional narrative framework (Clandinin, 2013). In the first level of analysis, I share 4 narrative accounts of the participants - *Rose, Isabel, Louise* and *Leah* in Chapter four. In Chapter 5 I look across their stories for plot lines and patterns offering a broader awareness to what the stories revealed as narrative threads that emerged about PQoL in LTC homes (Clandinin, 2013). Chapter 6 presents a weaving of findings and literature in order to highlight significant findings and present future directions. Finally, my learning, knowing, who I became and my re-telling, is found in the epilogue.

Chapter Two: Review of Literature

LTC homes have been likened to assembly lines or being ‘factory-like’ as they provide bare bones level of care focusing on tasks and routines (Daly & Szebehely, 2012; MacDonald, 2006; McGilton, et al., 2014; Ontario Health Collation, 2008; Wilson & Davis, 2009). Related to the long-standing alliance with the biomedical model of care, the effectiveness in LTC homes is primarily measured in speed and quantity of tasks performed (Armstrong & Banerjee, 2009). As a result of high caseloads and managing complex health conditions, this model of care contributes to feelings of time urgency in providing care on the part of staff (Barbosa, Nolan, Sousa, & Figueiredo, 2014; Daly & Szebehely, 2012).

Studies acknowledge that workload and time pressure contribute to stress and burnout in staff of LTC homes. McGilton et al. (2014) found that staff turnover in LTC homes was linked to workplace conditions including leadership style and type of relationships among the team influencing job satisfaction. Anderson (2008) indicated that turnover can be related to lower levels of job satisfaction which is more common among younger care professionals. A study examining job satisfaction found that negative interaction and poor relationships among co-workers predicted job dissatisfaction (Ejaz, Noelker, Menne & Bagaka, 2008). In a qualitative study conducted by Barbosa et al. (2014), personal care providers shared how they often felt unappreciated or unacknowledged by their managers. McGilton et al. (2014) support this finding as participants in their study highlighted how managers expect frontline staff to "give more time, energy...with little to no acknowledgement by management" (p. 923).

Research suggests that some LTC homes focus on organizational needs at the expense of supporting the emotional needs of frontline staff (Barbosa et al., 2014). Morrison and Korol (2014) found that staff perceive the work environment to have unrealistic expectations between clinical documentation and meeting the needs of the residents. Furthermore, inadequate resources are frequently mentioned as constraints for staff working in LTC homes. This includes financial constraints including being underfunded, having unrealistic budgets, rigid standards and rules related to tasks, poor staff to resident ratios, and a lack of support from management (McGilton, et al., 2014). Estabrooks et al. (2015) conducted a study among nursing care aides in Manitoba, Alberta and Saskatchewan in which they too found that frontline staff have moderate to high burnout linked to limited resources and an inability to meet the complex health and social needs of residents. Researchers found that cynicism was higher among LTC homes that were medium to large and privately owned. However, despite the moderate to high levels of burnout, care aides reported having high levels of job efficacy. This research suggests that job satisfaction and high levels of burnout can co-exist, and as a result, these constructs do not have to be considered polarized.

Research also supports the relationship between the positive aspects of the work environment and one's sense of job satisfaction. Research has demonstrated that meaningful relationships are formed between frontline staff, residents and their family members described as being family like bonds (Marcella & Kelly, 2015; Moss, Moss, Rubinstein & Black, 2003; Wilson & Davis, 2008). Relationships with residents and family members have been linked to a nurses' sense of meaning and purpose (McGilton et al., 2014; Moss et al., 2003). One study explained that connecting, relating and

experiencing emotional reciprocity with the residents are key contributors to remaining working in LTC (Moss et al., 2003). Moss et al. (2003) explained that emotional attachment, intimacy, obligation and compassion were the central themes surrounding the development of family-like bonds with residents. These connections appear to be central to one's satisfaction in the role they play to help those who are frail, dependant or who feel powerless (Moss et al). Other positive contributions that help staff remain working in LTC homes include relationships among co-workers and receiving educational and learning opportunities (Barbosa et al., 2014; McGilton et al., 2014).

Demographic changes in LTC.

Over the past several years, significant health care needs and demographic changes have shifted the landscape of LTC homes (Ontario LTC Association, 2014). Over one million Canadians are expected to be living with dementia by 2038 (Alzheimer Society of Canada, 2010). Research suggests that older adults moving into LTC homes are more physically challenging, and have more chronic and continuing complex needs compared to past generations (Armstrong & Daly, 2004; Banerjee, 2007; Barbosa et al., 2014; Brazil, Maitland, Walker & Curtis, 2013; Doupe et al., 2012; Estabrooks, Squires, Carleton, Cummings & Norton, 2015; Ontario LTC Association, 2014; Rai, 2010). One of the major challenges facing front line staff is managing responsive behaviours of individuals living with dementia. Responsive behaviours can include agitation, wandering, repetitive questions, confusion, restlessness, verbal outbursts, being resistive to care, and sexually inappropriate behaviour (Brazil et al., 2013; Buhr & White, 2007). A cross-sectional study examined burnout among care staff working with individuals with dementia. Researchers found 68.6 % of staff indicated they were emotionally

exhausted, 42% indicated feelings of depersonalization and 24.5% felt less accomplished in their role (Duffy et al., 2009). Research shows that staff need more support to help manage these responsive behaviours and complex concurrent mental health conditions that significantly influence staff stress and strain (Barbosa et al., 2014).

Additionally, higher numbers of young people living with severe disabilities are moving into LTC homes. Residents, some as young as 37 years of age, are moving into LTC homes (Brazil et al., 2013) because they are unable to access the proper level of care they need to live independently in their community (Ontario Health Coalition, 2008). These demographic changes not only take a toll on the healthcare system, but also on the well-being of frontline staff providing care in LTC (Barbosa et al., 2014; Estabrooks et al., 2015).

Professional Landscape of TR in Ontario

The job title, education requirements, and qualifications of a TR professional are inconsistent across the field. From personal experience, there are many job titles used to describe recreation staff in LTC homes, including activity aide, activity director aide, activation assistant, activation therapist and programs aid, programs assistant, recreation assistant, recreationist, life enrichment therapist or aide. The widespread job titles reflect the fact that TR is a non-regulated health profession.

In addition to having no standardized title for TR staff, there is also no standard professional qualification for TR professionals. In Ontario, it is recommended that TR professionals acquire either R/TRO designation or CTRS credential (TRO, 2014). Therapeutic Recreation Ontario (TRO) has established a voluntary designation "R/TRO" to promote a level of minimum competency to practice as a TR professional in Ontario

(TRO, 2014). The National Council for Therapeutic Recreation Certification (NCTRC) established the Certified Therapeutic Recreation Specialist (CTRS®) credential based on educational courses taken in TR, internship requirements as well as successful completion of a professional exam to display minimum competencies to practice as a recreation professional (NCTRC, 2014). To work in LTC homes, neither designation is required but R/TRO is suggested.

Although the Government of Ontario (2007) has established the minimum standard for TR professionals in LTC homes, practitioners with varying levels of education can practice in LTC. According to the Long-Term Care Homes Act (2007), staff providing recreation and social activity must have:

> a post-secondary diploma or degree in recreation and leisure studies, TR, *kinesiology or other related field* from a community college or university, or be enrolled in a community college or university diploma or degree in such field having at least one-year experience working in a health care setting. (p. 2-42) (italics added for emphasis)

Although the purpose of this research is not to examine the educational or experience disparities among recreation staff in LTC homes, this could be frustrating when competing against other practitioners who do not have formal TR training. This too may impact PQoL at a broader level.

Other Tensions in TR Practice

A common dispute addressed in the literature of TR is the on-going tension of working within a biomedical model that focuses on a deficits approach to care (Briscoe & Arai, 2015; Heyne & Anderson, 2012; Hebblethwaite, 2013). This model focuses on a laundry list of limitations linked to obligations in following rigid schedules (Heyne & Anderson, 2012; Hebblethwaite, 2013) such as priorities on body care and activities of

daily living (Heyne & Anderson, 2012; Wiserma & Pedlar, 2008). Hebblethwaite (2013) explains that practitioners find this model restricting yet she suggests that TR professionals are trailblazers by working to find a balance between relationship-centred practice within a biomedical environment.

Compared to other allied health professionals, the relationship between TR practitioners and a participant appears to be unique (Lansfield, 2010). Wiersma and Pedlar (2008) argue that TR professionals provide a more supportive relationship rather than a functional or task-oriented relationship. This is also echoed in Lansfield's (2010) study which found that TR professionals focused on enjoyable experiences rather than medical functions or tasks. Lansfield (2010) indicated that recreation therapists get to know residents differently by tap into other dimensions of what it means to be human. This enables TR professionals to honour relationship-centred care by not always focusing on the medical aspects of an individual (Briscoe, 2012; Lansfield, 2010). Hutchinson (2009) argues TR professionals walk a fine line with respect to engaging in therapeutic relationships, where at times professionals find themselves in unhealthy circumstances from spending a lot of time with those they serve, and over-identifying ourselves with them. Some evidence acknowledges the tensions within TR practice such as building and supporting, and sustaining therapeutic relationships (Briscoe, 2012; Hall & Mark, 2015) as well as implications on ethical boundaries and navigating through power (Briscoe, 2012; Hutchinson, 2009; Sylvester, 2002).

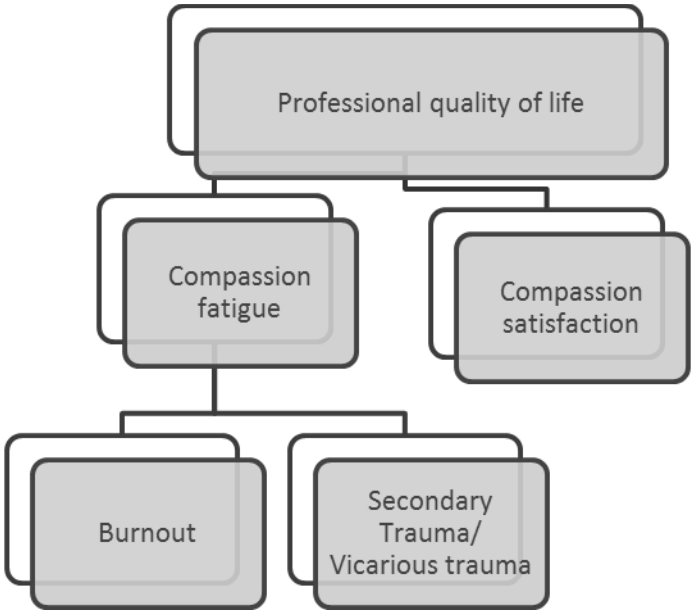
Briscoe (2012) explored the challenging interactions that occur within therapeutic relationships. Themes presented in this dissertation were vulnerability, push-pull dynamics related to connections, disconnections, even reconnections and power within

relationships (Briscoe, 2012). Within this research some narratives revealed conflict within the therapeutic relationship that could be precursors to compassion fatigue or even burnout, if not addressed. Her research started an important conversation related to navigating power through the professional practice challenges using relational theory. She addressed the need to provide space to discuss experiences of vulnerability within therapeutic relationships. Hall and Mark (2015) who participated in Briscoe's study highlighted that TR professionals can experience moments of doubt, concern, challenge and second guessing themselves within the context of therapeutic relationships. Researchers would agree that these moments could be indicative of compassion fatigue or burnout (Adams, Figley & Boscarino, 2008; Austin et al., 2009: 2013; Showalter, 2010; Stamm, 2010). Briscoe and Arai (2015) are the first authors to address the application and the need to reflect on compassion fatigue and burnout in TR practice.

Professional Quality of Life

Stamm (2010) developed the theoretical framework that depicts the contributions of both negative and positive aspects of PQoL. This framework is divided into two main concepts: *compassion fatigue* and *compassion satisfaction* (Stamm, 2010) (see Figure 1). Stamm (2010) and Adams et al. (2006) explain that compassion fatigue can be further broken down into two components, *secondary stress* and *burnout*. Three subscales are used to determine one's PQoL that includes secondary trauma, burnout and compassion satisfaction (Stamm, 2010).

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



Compassion satisfaction.

Compassion satisfaction is described as the sense of fulfillment one receives in connecting with patients by providing comfort or helping alleviate pain and suffering (Coetzee & Klopper, 2010; Stamm, 2010). Kelly, Runge and Spencer (2015) indicated that nurses who experience high levels of compassion satisfaction score significantly lower levels of compassion fatigue. As a result, this research suggested that meaningful recognition and finding energizing moments in practice, feelings of worth and value can increase compassion satisfaction to help overcome compassion fatigue. These authors also indicated a link between compassion satisfaction, retention and quality of work-life.

Compassion fatigue.

Compassion fatigue (CF) was first introduced as a nursing phenomenon by Joinson (1992) who defined compassion fatigue as a loss in being able to remain connected to those who are suffering. Since then, other researchers have investigated this

phenomenon among helping professionals, such as Charles Figley, a well-known researcher who has rooted CF in traumatology. Figley (2002) defines CF as:

> a state of tension and preoccupation with traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders persistent arousal (e.g. anxiety) associated with the patient. It is a function of bearing witness to the suffering of others. (p. 1435)

Compassion fatigue (CF) goes beyond the everyday stress in providing care, with researchers cautioning that CF is the 'cost or consequences of caring work' a form of occupational stress (Figley, 2002; Melvin, 2012; Sabo, 2006).

There are many symptoms that describe the behavioural, physical, emotional, intellectual, and even spiritual domains of compassion fatigue (Bush, 2009; Coetzee & Klopper, 2010; Figley, 2002; Showalter, 2010). Some examples include depleting energy levels leading to depression, anxiety, feelings of guilt, shame, fear, feelings related to failure or ineffectiveness, inability to concentrate, impaired clinical judgement, and loss of meaning and purpose towards work (Adams, Figley, & Boscarino, 2008; Austin et al., 2009: 2013; Boyle, 2011; Coetzee & Klopper, 2010; Melvin, 2012; Mathieu, 2012; Sabo, 2011; Showalter, 2010; Stamm, 2010). Stamm (2010) refers compassion fatigue to be a combination of burnout and secondary stress.

Burnout.

Described as a stress phenomenon, *burnout* is the exposure to prolonged chronic stress that unfolds gradually (Barker, 2012). Austin (2009) describes stress as feeling like one is drowning whereas burnout feels like there is no more energy left in one's tank. Burnout is then seen as an emotional and mental state that has psychological consequences, such as low energy and irritability, and physical manifestations such as headaches or gastrointestinal problems (Barker, 2012). Burnout has been suggested to

combine extrinsic, individual and intrinsic contributions among health care workers (Sanchez, Mahamoudi, Camonin & Novella, 2015). Extrinsic contributions relate to the work environment, such as having less time to complete tasks and increased workload (Sanchez et al., 2015). Individual contributions include personality, gender, inexperience, and limited social support (Sanchez et al., 2015). Intrinsic contributions relate to poor training, poor communication between team members, and conflicts in the workplace (Sanchez et al.). Sabo (2011) argues that some professionals may become burnt-out if there is a mismatch between personal values with an organization's vision and values. Burnout reflects the long-term effects of being distressed compared to compassion fatigue.

Burnout has only slightly been addressed within the literature of TR (Austin, 2009; 2011; Bedini, Williams & Thompson, 1995). Austin (2011) cautioned that "good professionals burnout" (p. 64) as they are the ones who seem to put their heart and soul into their work. Bedini, Williams, and Thompson (1995) found a positive relationship between burnout and role stress, and role conflict among TR professionals. This study found that caseloads were perceived to be the most stressful part of their job. Dupuis et al. (2005) indicated that practitioners working in LTC had a wide range of caseloads – from 93.5 to in some cases, as many as 510 residents. On average, a recreation staff member is responsible for 27.4 residents. This suggests inadequate ratios of recreation staff to the number of residents in LTC homes. In Ontario for therapeutic recreation professionals, there is variability in the number residents on a practitioners' caseload. There are no standards for caseloads for TR practitioners working in LTC.

Secondary trauma / vicarious trauma.

Secondary trauma, a subcomponent of compassion fatigue, is defined as a state of exhaustion and dysfunction in biological, psychological and social aspects of life that appear from recollections of traumatic memories and are similar symptoms associated with post-traumatic stress disorder (Coestzee & Klopper 2010; Sabo, 2006). According to Stamm (2010) secondary trauma could involve difficulty sleeping after hearing stories about extreme or traumatic life events. Stamm continues that secondary trauma is similar to vicarious trauma (VT) however it is identified as a primary exposure to trauma. Vicarious trauma is experienced when a practitioner's cognitive processing alters their sense of meaning, identity and world view (Bush, 2009; Sabo, 2011). Sabo (2006) argues that compassion fatigue is more reflective of the lived experience of the cost of caring working with clients who are in pain, suffering or traumatized rather than vicarious or secondary trauma. Showalter (2010) too adds that compassion fatigue impacts our ability to be fully present when providing care. Therefore, it is the relational elements that hold therapeutic relationships together is what makes helping professionals most vulnerable to experiencing compassion fatigue, vicarious trauma, secondary trauma (Bush, 2009).

Exposure to work-related trauma in LTC.

Research has also suggested that working under stressful conditions as well as being near human suffering and vulnerability exposes professionals to great emotional risk (Austin, et al., 2013). The very reason that draws helping professionals to want to help alleviate people's suffering is what makes professionals most susceptible to emotional turmoil, stress, and strain (Austin et al., 2013; Bush, 2009; Boscarino, Adams, & Figley, 2010; Melvin, 2012; Sabo, 2006, 2011). Fredrickson (2009) indicates that our

negative experiences can have a downward spiral effect that restricts our outlook, which in turn can spill over into other facets of our lives (e.g., personal health and wellness, and relationships with others). These negative experiences or emotions can indeed impact our sense of PQoL. Yet, Fredrickson's research also reminds us that positive emotions can help buffer negative experiences, leading to a broadening and building of our psychological resources that enable us to bounce back during stressful times in our lives (Fredrickson, 2009).

A reality of working in LTC homes and palliative care is being in the constant presence of declining health and death of residents. This can expose staff to primary and secondary sources of trauma. Frontline staff appear to endure a greater sense of loss and emotional struggle working in a high mortality settings due to exposure to pain, suffering and death (Anderson & Gaugler, 2007; Anderson, 2008; Marcella & Lou Kelley, 2015). Although compassion fatigue in LTC has not been fully addressed, related concepts such as grief, disenfranchised grief and burnout have been explored.

Grief, which has been described as a universal yet individual experience is the "emotional, psychological and physical loss, most commonly encountered following the death of someone significant" (Anderson & Gaugler, 2007 p. 301). Marchella and Lou Kelly (2015) found that grief is complex with many factors contributing to the management and acceptance of death. Within their study, an important contributing factor was the work environment. When death is silenced or hidden and no formal debriefing regarding a resident's death is provided to staff, it can significantly impact one's ability to cope with grief (Marchella & Lou Kelly, 2015). Research suggests that frontline staff find it difficult to deal with grief and emotional burden when nothing is in

place to help support them (Marcella & Lou Kelley, 2015). Repeated exposure to painful deaths can lead to lower levels of job satisfaction for staff (Jenull & Brunner, 2008).

Although the therapeutic relationship can be a source of pain, research suggests that the family-like bonds have the potential to help balance disenfranchised grief so that grief can be embraced and professionals' suffering can be validated (Moss et al., 2003). Anderson (2008) suggested that personal growth can be experienced during grief reflecting the importance of celebrating the relationship between residents and staff members.

Personal characteristics.

Personal characteristics have been shown to influence the negative and positive aspects of PQoL. These characteristics include: gender, marital status, full time or part time status, salary, education, emotional intelligence, previous exposure to trauma, one's ability to cope, and number of years in the field (Ejaz et al., 2008; Kelly, Runge & Spencer, 2015; Zeindner, Harder, Matthews & Roberts, 2013). For instance, Rai (2010) found that females generally have higher stress levels compared to males who work in LTC. Additionally, it was found that age of the care professionals, and lower levels of reciprocity at work played a role in predicting burnout (Duffy, et al., 2009). Moss et al. (2003) explain that personal experience related to family and residents' deaths are sometimes interrelated. It was indicated that practitioners can become callous even in their own personal experiences related to death. Jenull and Brunner (2008) would agree as they propose that this can lead to difficulty in separating private life from work life. Another study also illustrated that those staff who are paid higher minimum starting rate are more likely to have higher job satisfaction (Ejaz et al., 2008). Kelley et al. (2015)

found that nurses within the millennia generation (21 - 33 years of age) are more prone to develop compassion fatigue and burnout compared to more seasoned professionals because more seasoned staff have developed coping strategies and know how to navigate through the system.

Chapter Three: Methodology

"There is no greater agony than bearing an untold story inside you" - Maya Angelou

In this chapter, I provide an explanation of narrative inquiry, along with outlining the theoretical underpinnings and assumptions of this methodology. I describe the research design, including recruitment, interview process, and data collection and analysis. Further I address ethical considerations and describe the criteria for judging a narrative inquiry.

Narrative Inquiry

Within the interpretive paradigm, narrative inquiry uses stories to narrate the unfolding of significant aspects one's life or events to generate meaning through understanding emotions and perceptions within social contexts (Chase, 2005). Narrative inquiry engages in a relational way of knowing through *telling, re-telling and re-living* lived experiences (Clandinin, 2013 p. 14) allowing participants and researchers to develop a strong connection through a journey of togetherness (Clandinin, 2007). Narrative inquiry is a thoughtful exploration into experience which "is viewed narratively and necessitates considerations of relational knowing and being, attention to the artistry of and within experience, and sensitivity to the overlapping stories that bring people together in research relationships" (Cain, Estefan & Clandinin, 2013, p. 584). Narrative inquiry therefore explores experiences through shared storytelling (Clandinin & Connolly, 2000).

Narrative inquiry begins and ends with ordinary lived experiences (Caine, Estefan & Clandinin, 2013; Clandinin, 2013). Human experiences are highly complex and subjective shaped across time and place and space (Caine et al, 2013). As a result, it is

important to examine the social context of who participants are interacting with in relation to the situations that are unfolding (Clandinin & Connelly, 2000; Clandinin, 2013; Pinnegar & Daynes, 2007). Narratives are socially constructed (Clandinin & Rosiek, 2007), uncovering multiple ways of knowing based on experience (Clandinin, 2013; Caine et al., 2013). This emphasises that experience is highly personal and contextual where narrative inquirers have an experiential starting (Pinnegar & Daynes, 2007). Researchers believe that narratives reveal what has happened and what we know (Clandinin, 2013; Kim, 2016) by examining social, cultural and institutional influences based on knowledge gained from previous experience (Clandinin, 2013). In this vein, stories too are the phenomenon under study (Clandinin, 2013) while capturing complexities and nuances in lived experiences (Brisco & Arai, 2015; Clandinin, 2013).

The epistemological and ontological commitments for narrative inquiry are rooted within John Dewey's pragmatic theory of experience, interaction and continuity and on his concept of situation (Caine, Estefan & Clandinin, 2013; Clandinin, 2013; Clandinin & Connolly, 2000). Experiences and relationships are also central for engaging in a narrative inquiry (Caine & Estefan, 2011; Clandinin & Connelly, 2000). Caine and Estefan (2011) explain that for narrative inquirers reality is relational, temporal and continuous as stories are fragments of lived experiences and are only partial understandings (Clandinin, 2013). As a recreation therapist who firmly focuses on experience who uses stories to connect and develop strong relationships within my own practice, narrative inquiry was a well-suited methodology for this research.

Thinking narratively: The three-dimensional commonplaces.

To help think narratively, it is important to keep in mind the fundamental features from Dewey's philosophy of experience (Clandinin, 2013). This understanding of viewing experience has influenced Clandinin and Connelly (2000) in developing the three-dimensional commonplaces – temporality, sociality and place or series of places (Clandinin, 2013). This framework allows researchers to reflect backwards and forwards (past and future), inward (emotions, hopes, dreams) and outward (environmental contexts), related to places where stories can be found (Clandinin & Connolly, 2000; Clandinin & Rosiek, 2007).

Based on Dewey's notion of *continuity*- where experiences have a build- up effect over time (Clandinin, 2013; Kim, 2016) is linked to the dimension of temporality. *Temporality* refers to the interaction between *past and present events and emotions* that can influence the unfolding of future events that impact future actions (Clandinin & Connelly 2000; Clandinin, 2013). The second-dimension *interaction* – is the interplay and connection between situation, social influences and personal inner feelings and emotions (Clandinin, 2013; Clandinin & Rosiek, 2007; Kim, 2016). This is related to *sociality* which refers to context or situations related to factors or relationships with people (Clandinin & Rosiek, 2007) such as "cultural, social, institutional, familial, and linguistic narratives"(Clandinin, 2013, p.40). This dimension also attends to the relationship between researcher and participant (Clandinin, 2013). The final dimension known as *place is* linked to *situation*- where experiences are taking place (Clandinin, 2013; Clandinin & Rosiek, 2007; Kim, 2016). This refers to the physical and geographical boundaries and situations where experiences physically occur known as the

landscape (Clandinin). Interview questions for this research were developed keep this framework in mind. All three dimensions were interwoven throughout the research process to help capture the complex and multiple experiences (Clandinin) that can inform PQoL.

Relational Ethics in Narrative Research.

Narrative inquiry is known as a relational methodology (Clandinin, 2013). As the researcher, it was my main responsibility to outline the parameters of this research to establish entry and our relationship throughout this process (Clandinin, 2013). It is imperative as researcher to show respect, mutual understanding and ensure ethical practices are maintained during and after the research is complete (Clandinin, 2013). My relationship with my participants lasted about a year.

Ethical approval was received from the Research Ethics Board (REB) at Brock University in May of 2016. Upon receiving an email confirmation from each participant who showed an interest in this study, I sent them a letter of invitation (Appendix B) and consent letter (Appendix C) to outline the research and our relationship. Before beginning the interview process, each participant read and signed the letter of consent outlining the risks and benefits for engaging in this research. Each participant created pseudonyms for their fictional character and for the LTC home where they practice protecting their identity. Josselson (2007) suggested keeping a codebook to help the primary researcher identify who has which pseudonym and to double-check changes from the original data.

As a researcher, it was imperative to attend to the participants' emotional and psychological needs. This means ensuring confidentiality, and reminding them that at any time during our time together they can withdrawal from participating in this research.

Before asking participants to share with me their stories of stress, or conflict within practice during the interview, I told them that if they feel uncomfortable at any time to let me know and we can end the interview. I also provided a list of resources that participants can use in the event they experience emotional discomfort (Appendix F). All participants were given an honorarium as a thank you for their valued time, and effort in engaging in this research. I reviewed all documents several times to make sure that participants' personal information or any identifiers were not on the final document. I asked each participant to look over the verbatim transcript via email and provide me with feedback if changes needed to be made. Participants reviewed their narrative account offering feedback and changes to language and were asked to see if their stories fit within each narrative thread. The transcripts and interim texts were stored on my password-protected computer. My supervisor, participants and myself are the only ones who viewed the original transcripts. All field texts (e.g., journals, observations, printed copies of the interviews) were stored in a locked cabinet in my home. Audio recordings were destroyed once all interviews were finished being transcribed.

Research Design and Consideration

I inquired into the professional lives of four participants over the course of a year. Field texts were collected from participant interviews, their artifact in story form, my field notes, and my reflective journal. I outline here my journey engaging in narrative inquiry.

Negotiating Relationships: Seeking participants.

I began negotiating relationships by asking the Communications Coordinator of Therapeutic Recreation Ontario (TRO) to share the details of my research on social

media and advertise my recruitment poster with their members (Appendix A). Potential participants interested in this study were asked to email me or my supervisor. Once someone contacted me, I forwarded a letter of invitation which outlined the details of my study (see Appendix B). I also used the membership directory to reach out to practitioners who were listed as working in LTC homes in the GTA (Greater Toronto Area) and who met my inclusion criteria:

a) Participants must be working full-time in LTC as a recreation therapist or assistant (showing consistent engagement in one facility)
b) Participants must be a member of TRO, holding R/TRO or CTRS credential (most job descriptions in Ontario suggest Recreation Therapists hold their R/TRO and or CTRS)
c) Participants must have at least 3 years of practice experience as a TR professional in LTC home specifically (in order to have ample experience to pull from when sharing stories)
d) Participants must be practicing in the Greater Toronto Area (for researcher convenience).

To ensure participants would be a good fit for this research I arranged a phone call with each of the potential participants where I discussed the parameters of the research and shared my experiences about why I was interested in this topic.

Pilot Interviews.

Before engaging in the interview process, I conducted two pilot interviews to help me practice for my interviews with professionals. Doody and Doody (2015) suggest that pilot interviews allow researchers to gain confidence in conducting an interview. This also assists the researcher in identify changes in wording, phrasing and provide an opportunity to develop prompting or probing skills to get in-depth lived experiences. Based on my experiences in the pilot interviews and reflecting with my academic supervisor, the phrasing of some questions was modified and probing questions were developed for use in the interview guide. I revised my questions using more open-ended

phrasing such as: "*Tell me about an experience that you found to be very stressful, or what brought you joy in your practice*". Follow up questions included: "*Where did this experience take place, who were you with, can you tell more about that, how does this experience contribute to your sense of PQoL?*" I found these questions useful to stay in line with the three commonplaces for narrative inquiry and allowed for elaboration of details related to their lived experiences. I learned that it is important to focus on how the question is asked to get meaningful and descriptive responses.

Data Collection: Multiple Field Texts

I chose to conduct two in-depth face-to-face interviews (lasting between 60 and 90 minutes) with four participants, had them engage in creating two narrative artifacts, wrote personal observations, and engaged in my own reflective journal which allowed me to understand my thoughts and emotions throughout this journey. Data collection started in June of 2016 and finished in September 2016.

Interview 1: Discussing PQoL.

Before each interview, I emailed my interview guide to the participant (see Appendix D) to allow an opportunity to reflect in advance and ensure transparency. I began each interview with sharing my story first to make them feel at ease. By sharing my stories participants could identify with the concepts within the PQoL framework. I focused this interview on what brought participants into the field, how they described PQoL and explored what a typical and atypical day looked like in order to better understand the complexity of their role as a recreation therapist. I also asked questions related to three positive and negative experiences that have influenced their PQoL. I

prompted participants to share the kinds of emotions they experience with residents, co-workers, and family on any given day.

At the end of the interview, I provided a handout (See Appendix G) to help participants develop their narratives. Participants were asked to write two experiences in the form of a story, and bring them to our second interview to discuss with me. These artifacts helped to prompt stories of significant times, events and people (Clandinin, 2013; Clandinin & Connelly, 2000). According to Kim (2016), artifacts such as writing stories can further aid in the story-telling process. Clandinin and Connolly (2000) explain that writing stories is a form of reflection on past experiences to engage in further dialogue based on the participants telling and knowing. Participants emailed me their narratives prior to their second interview which allow me an opportunity to generate probing questions related to the narratives. I transcribed the first interview and reviewed it in-depth before scheduling the second interview with each participant.

Interview 2: Reflecting on positive and negative kinds PQoL experiences.

At the start of the second interview, I asked follow-up questions from the previous interview in order to solicit more detail and clarification of my interpretation of their lived experiences. We then moved on to reflecting on the two narratives (artifacts), and considered how one's sense of PQoL has changed over their career. I also asked a 'miracle question' looking to draw out their hopes and dreams for the future of TR in LTC (See Appendix E). I spent most of this second interview unpacking or unloading their struggles and successes while critically reflecting how practitioners make meaning of experiences offering knowledge found within TR relationships and practice (Briscoe & Arai, 2015). Fragments from their artifact appear in their narrative accounts (Chapter 4)

and in the findings chapter (Chapter 5). The gap between first and second interviews ranged between 4-6 weeks based on the schedule of the practitioners.

Observations as field texts.

I wrote observations after each interview where I considered and acknowledged hesitancy in body language, tone of voice, incongruence in quotes, the atmosphere of the interview, and documented questions based on the responses for further inquiry. I used these notes to help prompt follow-up discussions to clarify any misunderstandings or new perspectives.

Engaging in reflexive journaling.

Reflexivity helps produce depth of knowledge by processing the meaning of the researchers' experiences during the research process (Kim, 2016). I kept a reflexive journal which allowed me to understand my thoughts and emotions throughout this journey. In my entries, I wrote about what I learned from participants, how I thought our interactions went, and highlighted the sensitive and emotional stories they shared with me. I also wrote about how these stories impacted me as a practitioner and researcher. I asked myself questions like: *what did I learn from their stories; how do I relate or not relate to these experiences; what does it mean to be with my participants; how do I maintain personal and professional integrity as I write and be with my participants; what personal thoughts, feelings or actions have changed throughout this process; who am I in this narrative inquiry and how might have I influenced their responses?* Journaling continued as I analysed the data and worked in the field. This journal supported acted as a check in and allowed me to continue to be self-reflective of my own practice both the positive and negative aspects in being a helping professional.

Data Analysis: Field Texts to Interim text to Research texts

The most challenging aspect of this research was representing and interpreting participants' voices which can be a very messy and lengthy process (Hunter, 2010). Each interview was audio- taped and transcribed verbatim lasting approximately sixty minutes in length. After listening to each audio recording, I jotted down notes and reflected after I finished transcribing each interview. I made sure to notice changes in tone, emotions revealed, and cross-checked with my observations when participants paused in conversation. I used two levels of analysis – first, I developed narrative accounts (interim texts) to represent their unique experiences and describe how their Professional Quality of Life has unfolded (see Chapter 4). I then created narrative threads (plotlines/ summarizing multiple storylines) (see Chapter 5). In the final research texts (chapter 6), I return to the personal, social and practical justification (Clandinin, 2013).

In the first level of analysis, after transcribing each of the interviews individually, I began developing their narrative accounts of each practitioner. To assist with this process, I used the analytic tool of *broadening, burrowing and storying* based on Connolly and Clandinin's (1990) work as cited by (Kim, 2016). *Broadening* includes putting each participant's stories in order, making notes on their values, what brought them into the field of TR, how they described TR, the culture of their work environment, caseload, and how they managed their professional work life. *Burrowing* focuses on specifics such as emotions, and describes how participants have come to their understandings and dilemmas related to PQoL (Connolly & Clandinin, 1990; Kim, 2016). *Storying* captures transitions and what occurs over time (Connolly & Clandinin, 1990) with the following questions used to assist storying: *what is the meaning of the event?*

and *how might s/he create a new story of self which changes the meaning of the event, its description, and its significance for the larger life story the person may be trying to live?* During this stage, I came to create new stories, such as narrating an ordinary day and a TR job description based on my participants' data (see Chapter 4). The narrative threads also demonstrate storying-describing changes, and reveal bigger picture understandings.

Further, I used the three-dimensional narrative inquiry framework to develop the narrative accounts in this first level of analysis (Clandinin, 2013; Clandinin & Connelly, 2000). To address *temporality,* I share significant past experiences that brought Rose, Isabel, Louise and Leah into the field of TR, describe how they perceive TR in LTC and positive and negative experiences related to PQoL. To address *sociality,* I looked at the relationships participants had with their residents, co-workers as well as with me. I also described the kinds of emotions, feelings ad actions from these relationships (Clandinin, 2013). Lastly, I highlight their reflections, values, intentions and purpose as a TR and how they manage work-life balance over the course of their career. To address place, I examined where participants lived experiences were unfolding especially within their work environment.

In the second level of analysis, I used the broadening tool with the aim of generating overarching themes (Clandinin, 2013). The narrative threads were primarily based on the second interview discussing their artifact revealing a deeper and broader awareness of experiences (Clandinin, 2013) of the positive and negative kinds of lived experiences that shape PQoL in LTC. I focused on analyzing the two stories they brought to the second interview as well their hopes and dreams for TR based on the miracle question. I listened to each audio recording multiple times, read and re-read the

transcriptions and reviewed my field notes to get a better sense of the meaning their lived experiences. I made notes on based on the similarities and differences across their experiences. I used direct quotes and fragments of their stories to accurately convey their understanding and interpretations. I also integrated what I noticed, and some of my reflections within the narrative threads. The narrative threads were sent to each of the participants where I asked them if they could see themselves within each thread and if I captured the meaning of their experiences within each thread. Finally, chapter 6 represents the main findings across their stories illuminating social, environmental and personal contexts that shape PQOL in working in LTC.

Trustworthiness in Narratives

Trustworthiness in narratives is often questioned in relation to its legitimacy in presenting forms of truth (Duff & Bell, 2002; Hunter, 2010). Clandinin and Connelly (2000) explain that good quality narratives display “adequacy, authenticity and plausibility” (p. 185). I align with Clandinin’s (2013) understanding that narrative inquiry does not seek to generalize lived experiences but rather offers multiple ranges and representations of lived experiences. Narrative inquirers understand that participant stories are viewed as recollections, not exact duplications of original experiences (Duff & Bell, 2002; Clandinin, 2013). Trustworthiness of narratives is found in the "detail, rich, temporally unfolding, narrative accounts as they represent the lived and told experiences of the participants and the researcher" (p.206).

Central to judging worthiness in narrative inquiry is keeping with conceptual, ontological and epistemological commitments (Caine, Estefan & Clandinin, 2013; Clandinin, 2013). Clandinin (2013) offers twelve touchstone considerations to help judge

the quality of narrative inquiry. These include: "*relational responsibilities; in the midst; negotiation of relationships; narrative beginnings; negotiating entry in the field; moving from field texts to interim and final research texts; representing narratives of experiences in ways that show temporality, sociality, and place; relational response communities; justification - personal, practical, social; attentive to multiple audiences; commitment to understanding lives in motion*" (Clandinin, 2013, p. 212).

Throughout this chapter I have already explained how I was attentive to most of these touchstones. Below are the remaining touchstones.

- *Representing narrative of experience in ways that temporality, sociality and place* can be found in chapters 4, 5 and 6.
- *Relational response communities*: throughout this process I remained connected with my supervisor and committee to provide dialogue and feedback for on-going concerns and ensure thoughtfulness and believability as I wrote the narrative accounts and threads.
- *Justification:* can be found in chapters 1 and 2. I also re-visit this in chapter 6.
- *Attentive to multiple audiences:* while writing this research, I considered multiple perspectives including TR educators, practitioners, researchers, and the LTC system. I outline implications for multiple audiences in chapter 6.
- *Commitment to lives in motion*: this research provides a glimpse into the lives of four practitioners. Their stories revealed how PQoL is a fluid construct that changes over time based on place and interaction with people. Although it is a subjective and a personal understanding, some key aspects are universal. It is important to note we (practitioners and I) are still developing PQoL after our

interactions. Keeping in mind there is no final story or no solution (Clandinin, 2013). PQoL will always be changing based on experiences and will continue to change outside of this research context.

This chapter provided a detailed layout of the research design and methodology to understand PQoL of TR professionals working in LTC homes. In the next chapter, I narrate an ordinary day from the perspective of a TR practitioner and introduce the four participants - *Rose, Isabel, Louise* and *Leah*.

Chapter Four: Narrating a Typical day and Meeting the Four participants

During the first interview, participants shared a typical day in LTC. Their stories described the fullness of their days, while providing context to their physical landscape. Participants found their work environment to be challenging – whether that was the result of the structure of the calendar, fitting programs between meal times and how fast paced the days are in LTC – but their stories of stress were often juxtaposed with experiences of fulfilment and how time would fly by. These typical days revealed the many events and situations that could shape the professional landscape of a TR practitioner. I composed a narrative story to highlight tensions, dilemmas and common challenges facing TR practitioners each day based on their situations and language used. Participants' text is included in italics. Further, I created a job description highlighting the disconnection to what is expected and what occurs from the perspectives of a therapeutic recreation professional.

Lastly, in this chapter I tell the stories of four participants *Rose, Isabel, Louise and Leah* sharing their narrative accounts. Clandinin (2013) considers narrative accounts as interim texts revealing the multiple unfolding perspectives of PQoL. Each shared with me a yearning to help people and make a positive impact on those they serve. They all brought a unique perspective of what it was like to be a TR in LTC while also providing me a glimpse into each as an individual. Most TR practitioners connected PQoL to finding work life balance.

Narrating a Typical Day in LTC - Perspective of a TR

The recreation therapist enters through the LTC home doors taking a long deep breath as she begins developing the long check list in her mind of all the items that need

to be completed before she goes home. Once at her desk, she begins checking emails, phone messages and the 24-hour report. She *then moves on to updating all the orientations boards on her home areas, delivering newspapers, and completing any documentation missed from the night before*. As she walks onto the home area to assist with meals, she intervenes between two residents who are arguing. She thinks to herself: *I don't know why I am even there [...], is this a part of the job? No, it is not what I signed up for but it is not going to change.*

Between helping with meals and working around personal care, at least four TR programs need to find their way into the day. These programs can include structured and unstructured small group and large group programming or even one to ones. However, other moments creep in throwing the day's plans out the window. A family member, other staff and or residents will grab her attention and need her to *put out fires*. As this is going on, *residents will ask you to grab their favourite pink sweater"* or *will need you help them find their missing car keys, purse or even need you to take them to the washroom because other staff refuse to take them.* Hearing this, the Personal Support Worker (PSW) calls out from across the hall: *we just finished toileting him/her*.

Meanwhile, the recreation therapist realizes she is now late for her own program and residents are waiting outside the activity room. She quickly collects resources needed for the program and helps residents get settled. As she finishes the program, and starts assisting residents back to their rooms, a voice over the intercom says – 'recreation therapist please report to the family care conference on the 2nd floor'.

While in the care conference, families voice how they feel that their father has not attended each and every recreation program offered on the calendar. The recreation

therapist shares how the initial and ongoing assessments and evaluations determine that their father is not the best fit for some programs based on their needs, abilities and interest. As the family becomes upset making it seem like the TR department does nothing for their loved one, the recreation therapist begins thinking internally: *we are not a cruise ship here*. Family then suggest that management should offer more group programs as they perceive large events to be most beneficial and therapeutic. As the recreation therapist walks away from this situation (feeling depleted after trying to educate and justify her actions), she remembers she still needs to lead two more programs and help her co-worker prepare for the outing later this afternoon.

As the day comes to an end, she remembers *documentation should have been in there [in the day] and you can see what falls through the way-side when you are running around trying to put out fires all day. Then you get a call into your manager's office, hey so and so's paperwork is overdue* ... She then stops to think: I *knew that I forgot about it as I was running around".* Then as she tries to leave for the night, *a resident is trying to follow her home and does not want [her] to leave. The resident has been reasonable when she tells her I should go and feed my cat and walk my dog. But, like it is still hard to see someone be very upset at the end of your shift …screaming that they wanted to go home, throwing their walker into the window. And you know she is just the sweetest, sweetest person who just really gets bad sun-downing at night. It's hard to see how she is earlier in the day to how they are later on in the day and to see the amount of turmoil they are in and you can't let them go home and you have to try.* She thinks to herself: *like am I the only one who can talk to this person.* The *feeling of guilt* sets in as she tries to leave for home and *the resident continues to call out for help*. Making her way to her car,

way past the time of her shift has ended she re-plays the many events and the kinds of emotions that were experienced during the day thinking to herself I survived another day...then she wonders, did I even have my lunch today!?

The figure below (Figure 1.1 Job description for Recreation Therapist in LTC) is made from the voices of participant's. The job description along the left-hand column is adapted from an existing positing. The job description along the right-hand column are based on interactions with my four participants (their words are italicised).

Figure 1.1: Job Description for Recreation Therapist in LTC	
Composite Posting	**Interpretive Posting**
The Recreation Therapist is responsible for assessing, planning, implementing and evaluating various physical, educational, emotional, social, intellectual, spiritual and leisure interests based on needs of the residents.	The Recreation Therapist will focus on large groups with no assessments required. Will take direction from family members, other staff with no education in TR and management. The successful candidate will be responsible for other undesirable jobs and responsibilities that other staff do not want to complete.
Required Qualifications (but not limited to):	
• University degree in Recreation/ Leisure, Gerontology, and or a degree in Health Sciences with a post-graduate degree in TR, from a recognized university or equivalent education and experience • 3 years' experience in LTC Setting • Experience with Point Click Care, and or MDS RAI coding and Activity Pro for accurate documentation • Member in good standing with TRO and in the process of registration	• University or College Degree in games • No experience in LTC • Knowledge of and delivery of programs such as *Bingo, colouring pages, Connect Four and big events* • Demonstrate effective time management by being in two places at once • Properly document the efficacy of practice or engage in self-reflective practices on a regular basis without having adequate time in your day
Key Skills and Responsibilities (but not limited to):	
• Provides recreation therapy activities including outings in accordance with established policy, resident plan of care and within the scope of practice • Develops and sustains a plan of care to meet the residents assessed needs based on individual strengths, needs and interest of residents to establish importance and direction of TR intervention • Ensures that thorough evaluation of assessments, intervention plans, program development and program delivery is consistently being completed to ensure efficacy of recreation services • Complete proper documentation using MDS/ RAI, Activity Pro; observes facilitation of activities, engages in reflective practice to ensure appropriate and thorough programming is taking place	• "*Put out fires*" such as resident conflict, staff conflict, sun-downing. • Act as "*the scapegoat*" when residents are bored or experience responsive behaviours • Be willing to experience grief, loss, burnout, and moments of discomfort while at work or at home • Be "*on stage*" and/or have the personality of an "*energizer bunny*" • Identify with waking up in the middle of night to think about work • Appreciate small moments that help you come through the doors every day • "*Advocate for TR and be assertive*" to help you navigate through challenging situations with residents, family and co-workers

Meeting Rose

Rose and I met in the beginning of June and again in July of 2016. As I listened to Rose, I noticed how soft spoken, genuine in nature, and someone who displayed her feelings and opinions openly and honestly. At times, she would use humour to help narrate her experiences. Rose showed enthusiasm for this research during our initial phone call by saying: *"it is about time our profession started having conversations regarding Professional Quality of Life in LTC"*. Although Rose came across as nervous for example in her hand movements and tone of voice, her depth and openness of her stories was undeniable. I also found Rose to be reflective, easy going, considerate, and compassionate. For Rose, engaging in her own leisure helped her step back from tough experiences. Every week Rose plays basketball to de-stress and makes it a habit to have quality family time. Rose eloquently summed up PQoL: *"I think it [PQoL] does draw from your passion, love for the field and love for the clients who you work with...and that's what makes you come back every day"*.

Rose is the TR Supervisor at Lake House Care Community (pseudonym) and has been in this role for over two years. Rose also oversees five full- and part-time Recreation Assistants and four casual Recreation staff. She described the caseload ratio for TR to be about 1:60 (1 staff for every 60 residents), which in her opinion was extremely high. Rose found the field of TR after considering nursing and social work. Rose graduated with a University degree in Therapeutic Recreation. She also holds both designations of CTRS and R/TRO. She drives over an hour to get to work each day. Rose stated that for her, the field of TR "*felt like a calling"*.

> *When I was going through high school, I thought 'okay maybe I will be a social worker or a nurse'. And then I thought to myself okay on the nursing side - of all the clinical, life and death decisions - I don't really know if that was for me. And then social worker and seeing the lowest of situations with people...I don't know if that is something that would really fit me. And then I had a Great Aunt who was in a nursing home and I saw the calendar and all the programs and thought this is great, I could be in health-care but I can kind of be on the positive swing of things which was important to me.*

When I asked Rose to provide me with five words that describe the role of a TR in LTC she used: "*family", "Ministry"* (referring to the institutional guidelines and restrictions), *"fun", "passion"*, and "*many hats"* because TRs tend to juggle other roles outside their professional scope of practice. When we focused our attention on her positive practice experiences, she referred to these stories as "*moments of victory*" where she has done something for her residents that can stretch beyond the eight-hour work day. The common thread in her positive lived experiences was being able to provide special moments for residents like outings or honouring their contributions at their facilities art gallery. When we discussed stressful situations in practice, Rose shared a story of when a resident sustained a minor injury due to a fall on an outing where residents went fishing. Although it was a minor bump on a resident's head, when Rose returned to the home, she felt that management was giving into a culture of fear overshadowing the great conversations and memories had by residents. She told me how management suggested that next time she should inspect each chair before a resident sits down on an outing. She made me laugh when she stated, "*I'm not Goldilocks and will sit on all the chairs to see if this one is just right!?"* She went on to share a story of an irate family member who frequently believed that TR staff were purposely not including her mother in programs. Rose shared how much this situation weighed on her, weeks after the encounter:

> I had probably thought about this situation for weeks afterwards. It just chews at you because you know as much as you try and tell them ‘oh you know, here is ActivityPro [participation tracking software that provides statistics] and actually here are the programs your mom is involved in'. Like this resident seriously goes to everything. I am telling you, everything! It is tough when someone is trying to question your care for their family member and your integrity as a professional when you [want] to just look at them and say ‘look we do so much for mom’! I can totally understand why the family would be eye rolling at some of these things I am listing but in my heart of hearts I know this is the reality and we do a lot of things for your mom. It is heartbreaking when someone thinks that you are not ...and we are in one of those professions where it's like we are not making millions of dollars here and how do you say that to a family member!?And I can guarantee you [that for] 99% of the people who are in this profession, money wasn’t really a factor of why they got into it because that would not be a very smart choice.

Rose, like most TRs, try to balance the emotional demands of families and the reality of what she can do with the number of staff and limited resources for programs.

Meeting Isabel

Isabel and I met at her facility twice in the month of July 2016. Isabel had been a Recreation Therapist at Hedgewood Homes (pseudonym) for over 10 years and holds an R/TRO designation. She is very optimistic and happy about her career choice. The Recreation team with whom she works regularly engages in self-reflective practices to learn and grow from their experiences. Isabel shared her background of how she came to practice TR in LTC. She explained:

> I knew I wanted a career in helping people and loved the idea of working in health-care. Then, when I learned about this program called Recreation Therapy, I choose to apply to University…[and I luckily got in]. I really enjoyed the classes; [they] really resonated with me and Hedgewood Homes was my first placement that was actually TR-related. And then it kind of all fell into place because… I loved it. It was the first job I had where I wasn't looking at the clock, or waiting to go home. Everything was just in the moment and I just really enjoyed working in the field. After I graduated from university, Hedgewood Homes had an opening so I started off as a Recreation Therapy Assistant and then some openings came up for a Recreation Therapist. I have enjoyed every minute of it.

I asked Isabel to elaborate more on the university classes that resonated with her and she explained how eye opening it was to learn more about assessing barriers and finding ways to provide accessibility. She noted: "*in [one] class I realized how many barriers there are and I can definitely see that even in my work now and when we go on outings. It is so difficult for my residents to get around in a wheelchair".* For Isabel, it is important to identify the barriers residents face so that she can find ways to modify the environment or the activity to provide meaningful leisure experiences.

At first, Isabel was taken back when I asked her to describe Professional Quality as she is used to viewing exploring quality of life from the perspective of residents. Isabel shared an experience that pushed her outside of her comfort zone: *"During my first sing-along I felt so embarrassed. It was then I learned [that] to be a recreation therapist [means] having those almost humiliating moments and just learning to go with it and accept it and be like, this is what I have to do sometimes".* Isabel told me how she felt self-conscious and embarrassed when singing and dancing in front of residents. She laughed as she told me how it felt like a solo act having her residents watch her. Isabel then drew my attention to a recent memory of a sing-along that she facilitated with a new resident who she described as very quiet. To her astonishment, when a song came on during the program, he began to sing and yelled out to another resident: *"this is my favourite song too".* Isabel indicated how thrilled she was to notice the connections he had made with the music and other residents.

As we moved onto discussing moments of challenge and stress in practice that could resemble compassion fatigue or burnout, Isabel remained positive. She shared instances of receiving insulting feedback from a co-worker because of a difference of

opinion, and another related to the interpersonal dynamics with family members. She also talked about the hardships related to managing responsive behaviours of residents who are no longer able to communicate. Isabel discussed the impact these experiences used to have on her. However, despite the challenges that could occur in her day Isabel reflected:

> I feel like after work though, no one is perfect. So sometimes you are just tired or exhausted and so you are not going to always be your pleasant self when you want to go to bed. I think I can take more of the pleasant stuff home though to be honest.

She indicated that it took her time to get to this reflective place as recreation therapist. Isabel acknowledged that it was when she was first starting out that she felt the most burnout. I realized that being able to reach residents in a positive way brings Isabel the most joy as a recreation therapist. She told me that she feels "*there is always something every day that is joyful*" and those moments help buffer feeling burnt out. Isabel spoke and wrote about the importance of human connection as an integral part of being a TR practitioner in LTC. This reflected in the word selection she used to describe the role of a TR in LTC: *"provider, quality, meaningful, enjoyment and empathy"*. These words also appeared to be grounded in her personal sense of PQoL.

Isabel attributes her positive view of PQoL to her work culture. She spoke highly of staff on the home areas as well as members of the Recreation team. She explained how team members are like "*family*". Isabel explained how remarkable it is to walk through the home areas doors and have staff welcome her by saying hello, the residents missed you and make her feel like she belongs and is a valued and respected member of the team. Isabel also pointed out the importance of working collaboratively, not feel drained and having opportunities to attend workshops and professional development to support her sense of PQoL.

Meeting Louise

Louise and I met in the community first in July and then again in August of 2016. Louise has been working at Southtown Homes (pseudonym) for three years. Louise is quick-witted and, at times, full of sarcasm. For example, at one point during our interview, Louise stared into my eyes with such conviction and stated: *"What I actually do every day is put out fires. I am a firefighter extinguisher".* Louise often used humor to help her narrate her experiences, and spoke more about the negative aspects of her work environment.

She initially started studying biology in hopes of becoming a veterinarian but it was a family members' lived experience of schizoaffective disorder that sparked her curiosity in becoming a Recreation Therapist. For Louise, the field of TR was an opportunity to help others to incorporate positive leisure experiences in their lives. She began studying recreation and leisure studies at the college level and went on pursue a degree in TR. Upon completing her CTRS internship, Louise worked with individuals with mental illness in the community, but then turned to LTC because of the availability of jobs. The following is a fragment of her journey into LTC with a brief glimpse into her personal and professional landscape at Southtown Homes.

> *I was let go from my mental health job, my contract was not renewed. So, I was living in London and came back to where my family was in the GTA and the quickest job I could get was in Long Term Care. I still remember my former co-worker from mental health saying 'I don't think you are going to fit in into LTC I don't see you there'. And I am going 'oh okay'... um so like I said when I had the interview, I don't even think I really prepared for it very much. I was just kind of like 'well I'll work there for a while and then I will hopefully find a different job' just because I guess the stereotypes I had of working in long term care at the time was like, you know, it is with older people, you are not going to be doing much. Coming from a mental health background, I was running psycho-education groups [and] there was quite a bit of interacting every day. I thought once I got into LTC there would be very little interaction with the residents just because of*

> *their cognitive ability…and you know a lot of residents can be non-verbal. I also thought I was going to be bored, but that changed! I seriously remember when I was first working at Southtown being in the elevator and putting my head against the wall and going okay this is what I am doing because it was just such a different working style than what I was used to from my previous job.*

This was a significant change for Louise working with a different population, and feeling unsure of the kinds of recreation and leisure interventions for this population. Over time, her view of working in LTC has changed:

> *I noticed when I started I had very little quality of life. I wanted to get out of LTC as quickly as possible because I could not imagine any growth in this field. And then I got to know the residents more and more, [and] got to be more in a recreation therapist role…because when I was a casual staff member at the beginning, I wasn't doing assessments...So now that I am more regularly employed and I know the residents, I know what my role is ...and I think my quality of life is better.*

Now, she can put forward her own ideas into planning of the calendar to better match resident needs and interests. She also indicated how being more involved on committees and receiving additional training and education has helped her overcome some of her initial insecurities. Louise learned to overcome her own misconceptions of working with seniors, understanding more about the role of TR in LTC, and conquering her internal monologue of "*what am I doing here?".*

Louise emphasized in her narratives how everything seemed to fall onto the recreation department. As a result, she landed on following five words; *"fire extinguisher, superwoman, energizer bunny, odd job task completer [changed from B*tch jobs]",* and ended by saying we are "*the heart of the home".*

When we moved onto negative experiences, I gathered that all Louise wants is for management to recognize how stressful it is to work in LTC and for staff to work together. The narrative threads in Louise's stories were interpersonal conflict. She finds

that staff tend to remain loyal to their routines and do not understand her perspective as a TR practitioner. She shared *"I feel I do not have anyone on my team who gets me or who share the same point of view... and I just sometimes want to vent without repercussions".* Later in the second interview, she told me that the LTC sector needs to do a better job in supporting mental health days - more than just a poster on the wall indicating here is a helpline. She shared how it is perceived that if you take a mental health day, you are considered "*lazy"*.

Like other participants, Louise focused on the positive moments with residents. She identified how challenging it was to separate herself work when she is on her own time- She goes onto describe how she focuses on the little things that she can do that will support quality of life for her residents. Here she says:

> *On a more positive light I … feel a lot of us care a lot. For instance, one of my residents really likes Johnny Cash and there was a Johnny Cash show starting at 9 pm on a Saturday and it is too late for that person. So, I recorded it. I will put it on for them in the afternoon later on in the week and he will enjoy it. Instead of looking for his keys to the car, or wanting to go to the bank, he and others will just sit, enjoy and watch. And it is just a little thing that we can do. We are the heart, and we are constantly thinking about work. And it's not healthy for work life balance but you know!? I find when I am at a library and I see a DVD that I'm like oh I think the residents will really like this.*

Louise also described for me how amazing it feels to come onto her home area and have residents greet her. It makes her feel valued to know that residents are excited to spend their day with her in the programs she has planned. She shared how at times she has had to fight to get residents on an outing, for example to a Blue Jays game. Louise shared a story of how staff sometime appear rigid about a residents' toileting schedule suggesting that some residents should not attend outings. Louise told me that she advocates to get residents to those programs regardless of their routine. She explained

how rewarding it is to see residents at a Blue Jays game cheering, laughing and enjoying themselves. She indicated how experiences like these make the struggle with her co-workers worth it in the end.

To help her find balance after a busy day, Louise uses creative modalities such as music and art as well as enjoys walking her dog. She also told me how she begins her day with a cup of tea. She also enjoys the processes of cooking and gardening which she brings to the work place. She made me laugh when she described how she must put reminders in her Google calendar in CAPITALS letting her know "IT'S TIME TO GO FOR A RUN!" She is very grateful for her partner who is her personal cheerleader and with whom she enjoys debriefing her day over a glass of wine.

Meeting Leah

Leah and I met at her facility twice in September of 2016. Leah had the most experience in LTC with almost 13 years. Leah is married and has one child. She is a coach in her home for Gentle Persuasive Approach (GPA) to Dementia Care. GPA is a course that teaches techniques for frontline staff on how to approach and react to challenging behaviours. Leah is a well-seasoned practitioner, articulate, diplomatic yet unapologetic in challenging the status quo when advocating for the best interest of her TR department and residents. She can be forward and is willing to take risks to make her voice heard. For instance, she told me how in the past she has invited herself to meetings when she felt she should have been included. Leah holds both CTRS and R/TRO designations.

When I initially contacted Leah, she held a dual role of Manager of the Recreation Department and therapist, with a caseload of 30 residents, however since then, Leah let

go of her frontline role for her own PQoL. Leah indicated she can now focus on supporting the TR department more and act as a mentor for her staff. In addition to Leah, Escarpment Residence (pseudonym) has 4 full-time staff, 3 part-time and 3 casual staff for 210 residents where the average ratio is 1 staff to approximately 60 residents. Leah explained that the home has been on a journey to build a strong work culture focusing on inter-professional collaboration and providing high quality services. Leah spoke passionately about her facility and being a strong advocate for the field of TR. To help her find balance, Leah enjoys fitness, and sports - plays competitive volleyball, enjoys being outdoors and makes family time a priority. She indicated these experiences make her a better employee, mother and partner. At Escarpment Residence, her team engages in team building exercises to strength their ability to support each together. She also indicated that she has participated in research previously but was excited that this research highlights the voices of the practitioners of Recreation Therapists working in LTC.

Leah did not initially begin in TR; in fact, she started in Kinesiology/ Physical Education aspiring to be more in the physical rehab side of helping people. After her first year in university, she realized that this path was not in line with what she truly wanted:

> *I looked at other options and I just by chance came across the program of TR. I did some investigation and talked to the people at the university and thought okay I think I am going to apply. It is still working with people, it is still in the health-care field and it is using modalities and interventions that I love, so I thought let's see. So, I got in and enjoyed the program [and] really became passionate about recreation therapy and I think what really solidified it for me was [academic fieldwork] … getting out into the field, working with other practitioners and getting a feel of what kind of care environment I wanted and to maybe focus my attention on it. I have always loved older adults so that I think that is kind of where…I felt that, that might be where I wanted to end up long term.... So, that is where my passion started. I loved older adults [and] had great relationships with*

> *them, and my own grandparents I just think it was the right fit. And here I am 12 years later.*

When asked to describe some key words associated with being a TR in LTC, Leah used the words *"many hats, facilitator, advocate, mentor and relationships".* She highlighted how:

> *building those relationships are the best part of my job and seeing that therapeutic relationship develop and see that resident trust you and believe in what you are doing and seeing those results - small or large. I think that gives you the most joy and satisfaction, hearing that feedback as well from the residents and family members.*

Leah told me she won an award based on service excellence within her organization. To her surprise two of the nominations came from residents. She explained how exciting that experience was for her and how she still has a copy of the nomination letters written by those residents. She went on to explain:

> *From a professional recognition perspective that was something that I have never forgotten. Another experience that is small but to me it is not the large grandiose aspects that are the most important. But over the years, I have gotten thank you cards from residents who I have worked with, thanking me about trivial little things and it is like wow it does not take much to make them feel good or as a valued person. And here I am getting a thank you note for doing something very small so those kinds of things hold a lot of weight for my professional quality of life or even just the 'thank you I had so much fun'. Or you know you don't realize how important you are to us and things like that you hear and that solidifies the whole piece of professional quality of life: that you are not doing this to get the notes or the thank you but the fact that what you are doing is having an impact and a benefit to these residents and that they feel empowered enough to say something back to you.*

As we talked more, Leah explained how my story with my mother resonated with her. She shared how her parents, who lived in a LTC home, passed away recently. Leah related to the difficulty in being a double duty care provider both at work and outside of work. She even considered leaving LTC because of how much her work experiences was connected to her personal experiences in caring for her parents in LTC. She went on to

discuss other examples that have caused her anxiety. First, she mentioned a story related to the sudden loss of a resident and the kinds of emotions associated with that experience. She also acknowledged how family members can have unreasonable expectations and highlighted the importance of advocating for matching TR programs with interests and abilities of residents. Leah reminded me that as a TR practitioner in LTC:

> *You are on stage every day. You must create that excitement and that desire to engage in programs and generate those smiles and laughter. It is exhausting; it is, when you think about it. And creating fun for your residents every day when you are not feeling it, it is hard to draw that out and if you have a day where your residents are really quiet, digging deep into those creative juices to try and figure out how we can get more people engaged, and talking, or completing a task. It is a constant thing, and you feel like you are constantly going.*

Over the years, Leah indicated how she has developed a strong sense of PQoL. Below, Leah explains to me her key "pieces" for PQoL.

> *You need to feel good about walking through that door; knowing you are valued, respected, appreciated, heard, but the other piece to it is more of the resident focused. Seeing that the services you are managing or providing is making a difference, that you are setting goals for the client groups you are working with and you are seeing positive change whether it is small change or large change. So, whether it is you are hearing [about] the change or seeing it but in long term care also hearing the positives and constructive feedback because to me it also supports professional quality of life too. How do you get better unless you get that feedback? The dialoguing just from the client group you serve and the families you serve but also your manager as well, and I think if you are not getting that regular dialogue happening with respect to your supervisor, it is hard to get that feel, that you feel good about your quality of life working here. So, it is a balance - a bit of everything that sort of supports those feelings, I think it is huge. This is the best culture I have worked in that supports professional quality of life knowing that I am going into a cultural environment that I want to be in that supports my career. Like if you do not have a positive culture how do you feel good about doing what you do every day, right? So that ties in to the value and other piece to it is being allowed to voice your opinions, being allowed to develop and grow and being allowed share that with your team.*

Here, Leah speaks to the important aspects that support a positive culture/ work environment for her and knowing she is making a difference offers meaning and

fulfillment that supports her overall quality of work life. All participants acknowledged needed to feel respected, valued and heard. Leah, like Isabel gave a similar narrative related to needing a positive work culture to support PQoL.

This chapter focused on building a narrative for an ordinary day and reconstructing the voices of participants and experiences through contrasting job descriptions. The job description offers assumptions, perceptions and common misunderstandings regarding the daily tasks of a recreation therapist. Further, these two representations offer insight into the professional landscape and inner world as recreation therapist in LTC. Further, this chapter conveyed the energy and personality of each practitioner for readers. Their stories highlight what brought them into the field, how they describe the role of TR in LTC, perceptions of their work environment, how they manage professional work life balance because of changes over the years. It was clear when looking across their experiences, a central thread among their negative experiences was the interactions with others and the role of their work climate. What appeared to be different or unique was how they each internalize their work environment. When describing positive lived experiences, all participants shared that being with residents brought them the most joy and satisfaction. Further, they addressed how important it was to make a small impact to someone's day. The next chapter focuses on the second level of analysis digging deeper to look across their lived experiences revealing narrative threads.

Chapter Five: Narrative Threads

While the previous chapter provided individual accounts of my participants' professional journeys and their understandings of PQoL, this chapter reveals *narrative threads*, the patterns and plotlines across field texts (Clandinin, 2013). In this chapter, I compare their positive and negative kinds of lived experiences that have shaped their PQoL. From the perspective of these four practitioners, PQoL was linked to feelings experienced in relation to those with whom they work, tied in with the daily irritations with colleagues and professional challenges that often go unresolved as well as tensions experienced between their personal philosophy of TR and workplace culture. Further, their stories revealed new knowledge gained about themselves as professionals that helped shape their professional quality of life. Here, I do not seek to generalize experiences of PQoL as changes can occur over time where their experiences are snapshots and may not be the same as other practitioners (Clandinin, 2007).

Experiences that fuel the soul and ignite TR spirit

In the conversations with participants, I heard many stories that provide each practitioner with satisfaction, confidence, joy and purpose. It was clear these experiences with their residents while in a therapeutic recreation program or during a one to one had shaped who they are as a practitioner. Participants told me how much they loved their job and being with their residents. *Experiences that fuel the soul and ignite a TR spirit* describes the bi-directional connection with their residents. In witnessing residents experience joy by making them feel alive inside not only helped confirm the need and existence for a TR practitioner but it provided them with joy and a sense of purposeful action. More importantly, these small yet significant experiences nurtured their

motivation and energized their passion for TR. *Experiences of Moments that Fuel the Soul* appeared to be the wellspring to their internal rewards and professional energy that aligned and tapped into their TR philosophy – *igniting their TR spirit*.

For example, Rose spoke about an experience working as a casual recreation therapist in a LTC home. She described in her narrative how she perceived a female resident to be aimless, and wandering the secure home area. Rose attempted to facilitate doll therapy, but the first attempt was unsuccessful. She followed her intuition by re-attempting the program by changing her approach which seemed to be more effective. Rose describes how this experience contributed to her sense of PQoL:

> *I think for me just knowing that when you take a moment to really see the resident and see a need for them and help them makes such a difference. Because it makes me want to come back to work and see how is that resident doing - is it working for them? And you just feel really accomplished in your work when something like this happens. I also find it makes you happy with your work and makes you feel satisfied and you want to come back and maybe move on to the next person and it gives you purpose and meaning in your day. And it is not just running a random program; this is a therapy that you implemented that is working.*

In sharing this experience with me, Rose continued to explain how there are many moments like this in her practice that make her feel amazing. She stated:

> *I kind of feel empowered by the fact that our job allows you to provide these opportunities for people. I think these are some of the things people hope for in a job but I feel like sometimes in TR we are kind of naturally fortunate to experience.*

For Rose, this example reinforced that TR is more than just a game, or activity; there is meaning behind each intervention she puts in place. Rose described how this experience gave her a full body experience where it extended beyond her shift providing her with a significant contribution to the resident's quality of life. For Rose, providing meaning and finding a need for a resident within a leisure context fueled her TR spirit to want to move onto other residents and challenges.

Isabel's memorable moment took place during an reminiscing group that help solidify her purpose as a TR practitioner. She wrote how residents with late-stage dementia can appear to be drowsy and confused during a program, making it a challenge to engage residents in meaningful conversation. Yet to Isabel's surprise, the story during the reminiscing group had resonated greatly with her participants. She shared:

> *Seeing that they grasped the emotion of the story and everything, I thought, 'okay I am not just doing nothing here' and when I am doing these groups, I am reaching out to them with their emotions and they are stimulated. Because when their eyes are closed you wonder 'are they stimulated whatsoever'? And ...it just gave me validation for what I do. I feel I have more meaning in my programs, and I feel I am reaching them even though sometimes it is not as visible as you think. I even remind other people, just because their eyes are closed, it does not mean they are not getting something out of it or paying attention. So, I will still bring them to groups even though it appears they are still sleeping, where they are just not communicating. So, just knowing even though when you think it is end-stage dementia, they are still in there, and they still whether you believe in a soul or spirit where you are still reaching them on some sort of human level. So, keep them included and know that it is not for no reason to bring them to a music group. So, when I do bring them to a group and not see a reaction, it is just may not as visible.*

She wrote in her narrative that when she looked up after finishing the story, she saw tears in residents' eyes and they were smiling and nodding as they remembered moments of excitement and joy with their families during Christmas. As Isabel described this story she told me she will always remember this experience, especially when she is feeling burnt out. This experience was a reminder for her to focus on the small moments that help her make her feel confident as a practitioner. Isabel could take her residents back to a place when they were happy and experiencing joy with their family during Christmas. During the second interview, she reminded me that this story was the exemplar experience from the first interview to help describe the role of TR in LTC. As a

result, this story is significantly interwoven with her TR philosophy that fueled her existence as a practitioner igniting her TR spirit of *providing quality, meaning and human connection*.

Louise narrated an experience during a program when she was preparing jams and preserves with residents for the Christmas Bazaar. Louise told me that a co-worker expressed concerns that residents were being permitted to use knives and stand over the stove. Louise acknowledged the safety risks and concerns but trusted her decision to enable residents to engage in this process. Louise wrote in her narrative:

> *Residents who don't normally say much in programs and those who sit in their rooms were involved in the program. They were talking about what they used to preserve, the jars they used, how their mother and their grandmothers would preserve and shared their favourite recipes. There were smiles, and although it was hot because of all the boiling water and different components on the stove but the time flew by! It was reminiscent of memories that I have just before Christmas in baking things with my own mother and many of the residents I think felt the same.*

As she continued, she described how TR is about creating positive moments for residents. She shared:

> *As much as it is nice to feel appreciated for all the hard work you do, it also goes back to what we learned in school about creating positive moments. And it is not just keeping them busy; it is not just about getting their hearts pumping in a noodle ball game. It is connecting with them and understanding them, and learning from them. It is a holistic thing, we try to do our best we can within the constraints that we have in LTC.*

For professionals or families who do not have a TR lens, it is easy to only see the activity and goal of keeping residents "busy". However, Louise and the other three participants stressed that they are more than that, it is a holistic. It was obvious to me that Louise's TR spirit is being able to connect with residents in a meaningful way and being able to learn from them too.

Leah told me of a resident on her caseload with complex mental health-related challenges. She indicated that he had a persistent need to be in her office asking to help or look for something to do. Leah shared how she and the team developed roles for him in the home. For instance, they asked him to be the night security guard ensuring unnecessary lights were turned off, and that staff doors were closed and locked. She also described how he would MC large events ad thrived in public speaking. Before he passed away he had completed over 3000 hours of volunteer service. Leah stated:

> *I think we could help him to the extent that his companion would send notes, would come visit, [and] send emails [that] what you are doing is amazing. She said we had just transformed him into this person who I do not even recognize in a good way. The issues he was experiencing at home he was no longer experiencing here. He built friendships, I mean even though the experience was exhausting work, and I could never get any admin work done with him because he would sit where you are being like I have a problem. So, I mean I never leave on time anyways but he would keep me longer. It was really exciting to see the transformations in him making it all worthwhile.*

For Leah, this experience provided her with satisfaction in being able to transform "*a lost soul into a new human being who is thriving and happy".* She mentioned how he had a long-lasting impact on everyone at the home. Leah mentioned how challenging his case was and knowing that her ideas and creativity worked for him. Leah thrives in these situations which help build her confidence and willingness to try similar strategies on others. Leah's TR spirit is being able to see and notice the positive changes within her residents through the relationships she can form.

What became evident was their strong connection and meaning they received from the relationships with their residents. Being with their residents gave them the most joy and satisfaction. Todaro-Fransceschi (2013) suggests that experiencing joy is linked to the phenomenon of compassion satisfaction or the "good" elements in one's PQoL. I

was drawn to Todaro-Franceschi (2013) who highlighted the importance of connectedness in helping feed purposeful action. She also refers to these as "*aha moments*" known as situations that come together to re-affirm one's sense of purpose. Participants indicated that their moments of joy or "*aha moments*" helped sustain their beliefs about the field and about themselves as a competent practitioner. These heartfelt moments shared by the practitioners, provide a glimpse into their philosophy as a recreation therapist and the influence in future actions. It was clear to me that these were more than just positive lived experiences; these experiences fueled their souls by giving them momentum to carry on with their purpose and calling as a TR practitioner which in turn, ignited their TR sprit to influence future actions with other residents.

Experiences of seeking out opportunities for challenge and change in TR practice

As they shared their positive and negative kind of lived experiences with me, participants suggested that status quo programming is not acceptable in their practice. As the participants reflected on their experiences with me over the course of their career, they revealed how important being challenged and having opportunities for growth were important to them over all sense of PQoL. Participants wanted to be develop as a practitioner in hopes of better serving their residents. Participants thrived when their days were busy and when they were engaged with their strengths as a practitioner. *Experiences of seeking out opportunities for challenge and change in TR practices* describes their longing to do better and be better personally and professionally.

For example, Isabel shared how being a part of operational planning meetings, attending workshops, engaging in team development, attending conferences and teaming up with other allied health professions on co- facilitated programs contributes to being

challenged and her willingness to change her programming as builds her confidence as a TR practitioner. Isabel too appreciates collaborative learning. Here she speaks to the role of change over the course of her career (bolded text emphasizes my argument).

> *I think with time that you become more confident in programs you are running and become more creative and open to trying new things, well for me anyways. I mean some people are the complete opposite where they get into a routine and they are stuck in their ways and do not want to change whereas I feel more confident to take on those* ***challenges*** *as I have gone [on] in my career whereas before I would likely have been more stuck in my ways or follow the same routine versus* ***trying something new****. So, confidence is something in my career, [pause] independence because when I started out I was a recreation therapy assistant here so, now I am a recreation therapist I have my own home area and I get to have more freedom and flexibility to do programs [I] want to.*

She went onto describe *"it's important to stay fresh [as a practitioner], and always look for* ***new opportunities*** *is important…And I think it is important to* ***change*** *your programs".* Isabel has a vested interest in exploring ways to change and improve leisure experiences for the residents for her own growth as a practitioner. She told me *"I will often reflect back to a time when I was feeling less confident and can now see how far I have come in my professional development".* Isabel reflected and noticed the growth and development as a practitioner throughout her career which was an important aspect to her PQoL. It was in between her stories of tension and satisfaction I noticed her need for challenge and change.

Louise described herself as a *"lifelong learner.* Her aim is to improve her knowledge and skills and competencies as a TR practitioner by learning from her experiences and attending additional education on how to better support individuals living with Dementia. During our conversations, she mentioned examples of additional education such as Montessori approaches to dementia care as well as GPA. As she

reflected on her experiences, she shared. "*I think it is [about] growing as an individual and learning more about yourself in being able to set [Professional] boundaries".* Louise struggled with her environment due to lack of team cohesion and lack of motivation from other team members to want to do better. Throughout our conversations she compared herself and programming to others in the department. She hopes that her programing and success with residents would inspire others to try new things.

Leah was the strongest advocate for growth and development as a TR practitioner. She told me how TR in LTC is a "*growth and development kind of process"* related to understanding PQoL. She emphasized how experiences will challenge you but help you change how you practice as a TR practitioner in understanding what you want from this career. She revealed how this learning about challenge and change helped her understand her strengths: *"utilizing my own creativity and feeling pushed in a positive way and excited about coming up with ideas that are going to eventually help people get better…supports my PQoL absolutely".* As mentioned previously, Leah thrives on challenge and is willing to change her practice based on feedback from others to improve her practice as a professional.

Each practitioner shared how different experiences of challenge and change shaped their becoming as a confident and competent TR practitioner. In turn, this contributed to feeling a sense of reward and feeling good about their quality of life as a professional.

Experiences of encountering professional tensions that threaten PQoL in TR practice

Participants shared various obstacles and tensions related to their professional quality of life. These stories came from the conversations of negative and stressful lived experiences. Experiences of encountering professional tensions that threaten PQoL were related to *role ambiguity, feeling devalued, guilt, doubt, and feeling misunderstood.* Practitioners also indicated how they have trouble in separating work from home as this is the perceived expectation in LTC. These challenges left a lingering impact threatening their sense of PQoL as they would reoccur across different situations but would often go unresolved. Their experiences challenged their energy, motivation, sense of being as a TR practitioner, and over all purpose as a TR practitioner.

Rose shared with me her emotional tensions in witnessing and hearing someone's life situation related to a new illness. The event took place at a day program where she was interning. A man had recently experienced a stroke, and could not recall the last time he experienced any joy. Rose wrote how this experience "*left me with a heavy heart and made me look at life differently"*. This man who was accompanied by his wife who had divulged personal information related to their relationship and the significant change to his life due to his new illness. As she re- told this story, she mentioned how in that moment she thought to herself: "*I am useless… I couldn't even support them after they disclosed such a personal and emotional story with me".* As she reflected with me she shared how:

> *this reminds me about being new to the field; how I thought it was going to be all these victories. I am going to be doing this and it worked and they are happy with the things I am providing them and then kind of brings back the feeling of okay it doesn't always go smooth every time and you are going to feel useless at times*

> *when someone has this big life moment and you are not always able to help with that.*

This experience was a reminder for her that the field of TR is not always full of pleasant experiences. This was Rose's first encounter in the field in witnessing and hearing someone's life story related to illness and disability. Rose described why she chooses to focus on this lived experience with me:

> *To this day, I often meet people whose lives have changed dramatically because of illness. It is heartbreaking and feels unfair, although we know this is just the reality of life. It does not erase the fact [that] awful things happen...I do like to try and keep in mind that I am here to help and will try to do that in whatever way possible.*

Rose explained how she often remembers this experience when she completes the initial assessments in LTC. Although it causes her emotional tension in hearing a difficult life situation she has learned how to not let her personal feelings of the situation get in the way of being able to help those who she serves.

Isabel's shared an experience that most practitioners could relate to when a family member of a resident displays unrealistic expectations to their parents' activity levels. She told me how distressing this dilemma can be feeling as if she is *"hitting a wall'':*

> *So, it's a power struggle with the family but also a power struggle with the disease and not knowing what is happening or what is helping them. And dementia is a struggle and sometimes it is even hard for the nurses to know why they are acting out. It could be delirium, and just a lot of mysteries of the disease.*

When I followed-up with Isabel and asked her what she meant by power struggle, she stated: *"power struggle is trying to work with the family to create that balance of helping that patient as much as possible and building that therapeutic relationship"*. Isabel explained that *"at the end of the day it should be about the patient, which again is that power struggle too you are trying to advocate for that patient but you also have to meet those other demands. So that is a hard reality".* Isabel also discussed with me how she

bases her decision making on her assessments as well as on the interests, and wants of her residents. However, families sometimes disregard what the resident wants - causing a professional dilemma when Isabel knows her residents does not wish to attend programs. She went on to explain how experiences related to power struggles with family members instill a sense of doubt by prompting her to question her knowledge and judgement as a TR practitioner. In her narrative, Isabel shared her interpretation of this experience: "*it does bring on compassion fatigue because the families make me question myself whether I am doing enough for their family member, when at the same time, I have 60 residents I also have to attend to".*

Louise appeared to be constantly challenged with the perpetual misunderstanding of the TR role in LTC. In our initial meeting, she stated: "*when I first started, I was handed colouring pages by the other recreation staff saying, 'here you go and grab some residents'.* Later, she stated: "*Sorry [but] I didn't go to school to play checkers, or take a class on bingo or Connect Four, but I am sure that is what everyone thinks, that we went to school to learn all these different games*". Louise mentioned how this leaves her feeling devalued and frustrated with the lack of understanding in the role of TR in LTC.

In Louise's narrative, she shared a story that took place a few days prior to our meeting. As Louise was trying to gather 60 residents for a special dinner event outside on a hot humid summers' day, she was working short staffed. Prior to the event, she provided a list of attendees to the nursing staff on each of the home areas, but, the list was not communicated to all the team members. As a result, a resident who was on the list had just taken a shower and staff members dressed her in a nightgown. Louise was met with resistance from other co-workers when she attempted to advocate for this resident to

attend the program. Louise told me it got to the point where her manager had to get involved. In the end, the resident attended the event and had an enjoyable time singing and dancing to the music. The following is an excerpt from Louise's narrative:

> *The emotions of frustration, disappointment and thoughts that I should have talked to staff earlier, even though that wasn't really my job and I was busy leading up to that event. These feelings lingered for more than a day. I thought about how I could have handled the situation better and I was angry that once again nursing staff didn't appreciate how we were trying to put on something special for the residents. They just wanted to get the same old dinner on the table and rush residents off to bed as quickly as possible.*

As the story unfolded in the interview, Louise indicated how she frequently supports her inter-professional team members, but does not feel it is reciprocated. Louise highlighted many times throughout our time together how the conflict within her work environment has impacted her mentally, physically and emotionally. Louise told me *"it's hard when you are trying to do your best and you realize that others do not care that I am here for the residents".* Louise went on explained to me how she wonders if these experiences will ever change as they appear to be frequent within her work environment.

Leah shared an experience that made her consider *'packing her bags'*. By chance, Leah learned from a co-worker that her organization was taking part in leadership development workshops to help break down departmental silos and establish a culture of inter-departmental collaboration; however, Leah and her recreation department were not included to these in-services. Here, Leah explains how insulted she felt by not being involved:

> *I was in complete shock, as you can imagine. So, after feelings of anger, frustration and all those emotions you go through and of being devalued, you start to question - 'well maybe I should pack my bags and see you later, I do not want to be part of this anymore'. [But then] I realized I had to take a step back, take a few days [to] process what happened and then the end result was me going*

> *to my boss [and] confronting her about this - you know why was I not made of aware of these things? I manage staff and then I find out about this through one of my colleagues. Why was I not included? Her response was that she felt my department was not perceived as being one of those silos which - kudos to my department and myself, but it doesn't take away from the fact that I felt blindsided, devalued or excluded.*

Leah explained how this experience felt like "*slap in the face as a professional*". As she continued reflecting on this story with me she went on to describe how *"there are days that I still do question my continued commitment and find that at times I do get defensive [about] the ongoing need to justify what we do as an allied health profession to maintain that respect amongst registered nurses".* Leah also reflected: "I *have come to realize that human relationships are very complex particularly in the work environment when 99% of them are women*". Here she spoke to the relational or personality dynamics when working in a female dominated environment.

Other tensions addressed within our conversations were related expectations in LTC and the constant struggle suggesting working in LTC is a never-ending work day. Leah reminded me that *"as a recreation therapist is not a 9-5 job and you are working evening and weekends when really that guilt is there when you should be with your family".* Leah also addressed expectations as a manager in her home: *"work is not going to stop past 5pm and some people love and thrive on that… you are always on call even when you are not on the schedule at least in my organization, they expect you to work from home".* Rose would agree as she explained the expectation as a manager: *" if you are not home thinking about work then you are not someone who is committed to your job or if you are not coming in 30 minutes early or leaving an hour later you not seen as a team member and that's just the role".* Louise also identified how she finds it difficult to not think about residents outside of the work environment for example: "*when you are at*

a garden centre on Sunday morning and they have tomatoes, plants or flowers for $1.44 and you might think I could probably bring these into work which is what I did this morning".

These experiences have left a profound impact on their sense of being as a TR practitioner. Many of these stories shed light into the complex professional tensions that could manifest as burnout, compassion fatigue, moral distress or coarseness in the work place. What was similar among their experiences was the discomfort that these experiences left as helping professional. While no job is perceived as stress-free, these practitioners shared encounters that indeed threatened or stifled their sense of PQoL as these experiences seem to never get resolved. The following thread is an extension of their professional tensions highlighting what they gained from some of their tensions.

Experiences in developing professional valour as a TR advocate

Linked to the negative kinds of lived experiences, participants shared the learning and value they received from their negative practice situations. Within their stories, participants used metaphors of "*battles", "wars"* and *"victories"*. Each openly shared stories of fighting against the system/environment, toxic relational dynamics, their willingness to challenge the status quo, the client mix and health challenges and some discussed being plagued by their own internal dialogue. To find inner strength, each participant had struggled with negative lived experiences. Their stories highlighted how experiences in *developing Professional Valour as an advocate for TR that* built professional confidence in standing up for themselves, and voicing the wishes on behalf of their residents. Moreover, participants highlighted how reflecting on their experiences

helped them learn from their setbacks. Each participant demonstrated self-awareness and the ability to recognize when situations were getting the best of them.

Linked to the negative experience shared in the previous thread, Rose described how hearing and seeing human vulnerability in working with individuals with disabilities can be emotionally painful at times. She found:

> *[This was a really] heavy experience for me and so hard to know what is the right thing [to say in that moment] because you could say to someone oh it's okay it happens all the time and all these things and then someone could say well actually it doesn't happen to me all the time, or you could go the route of that's awful I am so sorry you are experiencing this right now and make them feel worse about it. Having someone [my supervisor] who has had similar experiences, [like this one] so whether that was a coping thing for me or not to help me but, having someone there and be there for them [the couple] but to then give me a moment was huge. That is what brought me back to [the idea that] you are there to help them and although this is so sad and you feel awful for them but quit thinking about your feelings and get back to helping them and then move forward.*

As I inquired more into overcoming her own feelings, she revealed to me the importance of embracing empathy and learning how to better approach her interactions with empathy. Instead of fearing "*traumatic stories*" and letting them impact her both professionally and personally, she decided to grow from this experience. Rose built up professional strength by learning to not let her own emotions impact situations while in practice. She told me how easy it is *to get caught up* in these experiences impacting her ability to be a professional and help them move forward. Rose's ability to step back and recognize that although sharing space with human vulnerability is frightening helped her overcome difficult situations.

Other participants learned to develop professional valour by advocating for residents. For example, Isabel shared stories with me about educating families and co-workers about her role as a TR practitioner. She told me: *"it can get bad sometimes when*

I get told 'oh that group is not big enough' but I do not let it affect me as much anymore". Rather she learned to communicate and advocate for residents by providing quality experiences.

Louise developed professional valour differently based on her experiences in a work environment which she perceived to lack team cohesion and perpetuates incivility among co-workers. Louise described how often co- workers *"stab others in the back"*. Rather than communicating to each other, co- workers will go directly to management. Louise told me how she tends to internalize her experiences more deeply as an introvert but she has learned how to work with her co-workers otherwise *"it's a constant struggle".* She told me how she found courage in speaking up for her needs:

> *I also have [learned] to communicate when I am banging my head up against the wall to my team and to my partner and if it is something that keeps happening you do have to bring it up and again in a professional manner when you must figure out some sort of solution.*

Multiple times Louise mentioned the importance of being more assertive. She said: *"I literally have to stand my ground" when talking to other staff. Louise told me how she often* feels outnumbered by the nursing staff. For Louise, her sources of stress are out of her control such as co-workers' attitudes and the health care system. Another example of Louise learning to stand up for herself and for her residents is found in her narrative account related to the resistance she sometimes received in bringing residents to a Blue Jay's baseball game.

Like Louise who found courage in speaking up, Leah learned to not give up when she feels devalued. In a humble but firm tone, she stated:

> *I am not giving into the lack of understanding of TR in LTC… I will continue to be a strong advocate of TR and not let one-person bully or take advantage of me…and continue the great work that we had achieved with the department*

> *[recreation]at that point. I was not ready to give up on that, we had some great things happening in the home and we had built a reputation around our service in the community and I was not ready to let one moment shut me down.*

She too shared how this experience taught her to "*stand my ground*":

> *I am here to serve the residents and yes, that means working as a team player, having those dialogues but at the end of the day I know what is valuable and somebody who lacks the insights and understanding [of TR], devalues you that is their choice to do it. I have [learned] to stand my ground.*

Leah told me it is important to develop assertiveness within the LTC environment and not be afraid to have your voice heard. She cautioned me in making sure to put residents at the centre of the conversations. Here, she offered me advice that speaks to her willingness to challenge the status quo and be a strong advocate. She explained:

> *Don't be afraid to educate, advocate and to be around those tables. Be sure that you are absolutely sure about working in long term care before you commit to being in this health care environment and knowing that you will get some resistance and knowing how to stand up for that. Even though the level of credentials does not need to be CTRS, R/TRO I am a strong supporter of that. [It] does not matter what health care environment you are working in. I think those credentials mean something and as long as you are able to back it up you hopefully will be seen as a valued member of the team. I would hope that would be the case. But be a strong person, emotionally, and be willing to give more than you would in another health care environment. I think in Long Term Care the expectation is that you give more than perhaps other places. But I would also recommend there are so many rewards and valuable experiences you can take away that will help you in your professional journey. Have standards but be flexible and be aware of what you want to achieve as a professional in long term care and be assertive.*

It was through her professional tensions of being afraid and feeling silenced where she gained the courage to invite herself to be around conversations and advocate for TR. Leah reflected that her experiences made her realize what was important to her and understand more about her own strengths as a practitioner. She offered me advice in relation to growth and development:

> *And do not be afraid to try new things and think outside of the box and do not worry if someone says you are nuts or crazy, just do it. I think the more experience you have with behaviours in long term care or before coming to long term care will only help you and gaining mental health experience, as you know from working in Long- term -care.*

Each practitioner developed courage differently, learning to speak their knowledge and understanding as a TR practitioner and learn ways to cope with the LTC environment. What was similar amongst their stories was learning to voice their concerns by speaking up in different ways for themselves or for their residents. Their challenges provided them with gaining a new perspective by learning how to navigate through future experiences. What struck me was how they found their inner strength to overcome the setbacks they faced. Their stories demonstrated how strong-willed, bold, and dedicated they are as practitioners. The practitioners acknowledge that they may not be winning the "*war*" necessarily, but they are strategic in choosing the battles they are willing to take on. I began to consider how these 'aspects' in overcoming their tensions and building valour as a recreation therapist provided them with an armor that supports them during their ' battles' to help them return to their job every day.

Experiences of the work place that shape PQoL

Embedded in participants' stories were the *experiences of the work place that shape PQoL.* As participants reflected with me, the dominant plotline across most of their stories illustrated how complex and challenging it can be to work in a LTC environment. These sentiments were also addressed in their narrative accounts, the story of an ordinary day and the interpretive job description found in chapter four. What also emerged was the contrasting perspectives of LTC landscapes among the four TR practitioners and the implications on their sense of PQoL.

Rose discussed with me restrictions related to the guidelines by the Ministry of Health and Long-Term Care, having high caseloads, and how management does not always understand or fully support TR initiatives. When she shared with me her hopes and dreams in LTC she mentioned how she wants to background noise of management and families would disappear. She also indicated how those extra tasks and responsibilities that are outside of the scope of TR would no longer be present. Like Louise, Rose discussed how unwanted tasks seem to fall onto the Recreation department. She also shared how she felt that some staff were just there for a paycheque.

Louise revealed that her work environment has made her consider quitting multiple times. She seems to have the most troubling work environment which impacts her ability to cope. At the most basic level, she would like to be treated with respect and be acknowledged by other staff. She addressed how relationships within her setting feel like high school all over again where she wondered *"why do I even bother helping other staff when it is not reciprocated?".* Jokingly she mentioned how she wished everyone could just come together and "*sing kumbaya".* Her experiences of the work place were related to the perceived dysfunction among teams and co- workers as well as the pace in which all staff need to uphold.

In comparison, Isabel and Leah shared glimpses into a counter-story (Clandinin, 2013) of what a positive work place could look and feel like. They shared stories related to pleasant workplace experiences which reflected a more positive PQoL. Isabel stated: "I *am lucky I have support and I do have a good team*" as she described her co-workers to be friendly and welcoming whenever she encounters them. She went on to describe *"well, my work culture we are like family, we talk about everything, we are able to*

communicate about our problems... I feel comfortable talking about these things … we are very compassionate. Hedgewood Homes provides Isabel with an opportunity to form meaningful relationships with not just residents, but co-workers too. After reflecting on the course of her career, she described how rewarding it is to share the positive aspects of her work place.

> *You really feel like there is a community here too and that we are all here just supporting each other…which is another reason why it's so great to come into work every day... but I have only been at Hedgewood … we built such great friendships and just talking about work is a good feeling and rewarding!*

Leah also shared a glimpse into the influences of a positive work culture. She explained to me that *"if you don't have that positive work culture how can you feel good about what you are doing every day?"* For Leah, a positive work culture supports her feeling good about coming through those doors every day. Leah enjoys her work place as it supports her creativity, input and working collaboratively to offer quality services in LTC.

It was clear throughout my time with these four participants how their perception of their work landscape shaped their overall PQoL. As mentioned previously in chapter four - all participants addressed how fast paced the environment is, and how high their caseloads are. Yet, having a positive work community among colleagues seemed to help buffer some of the other stress they experienced in their day. Having a positive work culture helped TR practitioners walk through those doors every day.

Re-Imagining TR Practice to foster PQoL

During the final interview, I asked practitioners a miracle question getting them to consider what LTC might look like and feel like without experiencing tensions. *Re-*

Imagining Practice to Foster PQoL highlights the practitioners hope and dreams for the future of TR in LTC. This thread speaks to the bigger tensions that connect to the findings, including the physical environment, hum of the home and changes participants would like to see from a systems perspective more specifically more funding, resources and more staff. Practitioners also shared having more respect for the TR profession and more space and time to reflect on challenging moments in practice.

As Rose considered future possibilities, she envisioned that upper management and families would be more supportive of initiatives from the TR department. She also indicated having more financial resources to better support family members needs wishing that: "*each person would have their own recreation therapist".* She went on to describe how TR in LTC could be more focused on resident outcomes by way providing more last wishes kinds of programming for residents. She stated:

> *So, if I came into work and didn't have to think about them [tensions], I could come in and say this resident's dream is to go to a golf course right now [and] I would love to have a rec. staff take them and be able to have those moments and continue to build on their goals and their dreams.*

Rose explained how this unable to occur due to staff numbers and trying to support her entire facility. Rose beamed with excitement as she explained how she wishes TR could be a contracted position much like physiotherapy, massage therapy and dentistry in LTC. As she stated:

> *They [physio, and contracted services] have their own organization who comes into the home and does their job and obviously, they have to follow rules and regulations and are self-governed and then they do their documentation and report on things. Where I feel rec within LTC can't. It's funny, there is a part in your job description where it's like 'other duties as assigned' - we try to have a concept of oh that is not my job right because at the end of the day we are here to help the resident and it is a team effort and I get that and you don't want to be that person that is like, 'well that is not my job' but you do want to say that*

> *because I actually can't do my job because you are making me do these other things and duties that have nothing to do with what is actually important.*

Rose hopes that one-day TR will become a regulated health profession so that job descriptions and job tasks become clearer and prevent role ambiguity. Rose, like the other participants, acknowledged how much these *'other jobs as assigned'* impacted their ability to do their job effectively.

Unlike the other participants, Isabel pointed out that not much would change in her 're-imagined LTC' scenario because of her existing sense of freedom/autonomy and positive work environment. However, in a re-imagined practice, she would no longer experience self-doubt:

> *because when I talked about the power struggle and the doubt I sometimes think well, do they need me here? As a career and especially with the aging population, sometimes job security can be a little more stressful so taking out all those worries and you really know that everything you are doing is great, people respect you and families love everything that you are doing. I would feel relieved and just really good without those struggles and stress for sure. I do feel that I have enough flexibility where I would not change my practice too much... and if the power struggle was gone then I wouldn't have some of those hard conversations in the family conferences because as much as they do have these expectations, it is impossible for their family member to recover or improve.*

Louise spoke at great length about all the changes she hopes to see in LTC:

> *We would have more budget and [they would tell me] you are pretty good at your job and forget this union stuff and having seniority linked to pay, you are awesome and let's just give you a raise now'! I would probably [also] be asked to completely re-do the schedule [and do] what works for the residents.*

In an ideal world, she could re-organize the home areas based on interests and abilities. She mentioned again how she would like management to appreciate staff more and acknowledge how hard the job can be and what TR professionals do:

> *so, appreciating the bare basics; knowing what my job is and knowing what a Certified Therapeutic Recreation Specialist does and what I went to school for ... You know BSO [Behavioural Support Ontario] on a miracle day would have a Recreation therapist on it. And work in collaboration and we would talk about interventions and work with the nurses, PSWs, RT and management to understand what the triggers are, and what the intervention plan is and have family involved.*

She went on to explain:

> *The system must do better. In mental health like I said before we had compassion fatigue training, we had work life balance seminars and gyms accessible to us we were encouraged through emails and meetings about our own health where we can't help others until we have helped ourselves and so now I don't see that here. I mean I see posters on the wall and hey if you are in trouble oh here is a helpline but aside from the management team giving you candy or the odd Zumba class during the year at nurses week, um do I see them promote quality… and like there are constantly so many people going on sick leave and in mental health it was so much more accepted to be like yes, I need a mental health day and in long term care if you say you need a sick day or a mental health day you are considered lazy, like get to your job, so, it is a systematic thing in LTC.*

This speaks to the social and practical justification for this research specifically looking at the LTC landscape and how it needs to better support frontline line staff including recreation therapists. More opportunities for education on compassion fatigue, work life balance and supporting mental health days is clearly needed in LTC.

Leah highlighted most of what the other practitioners addressed - having fewer restrictions on guidelines, more bucket list/ final wish initiatives, more vehicles for community outings, and more respect and understanding for what TR brings to the table. Thinking about how TR would be different in LTC, she stated:

> *We would absolutely be facilitating true TR every day in the home...we would be following the TR model to a "T". We would be absolutely solely needs-based, individualized, we would not feel the pressures from the family [and] nursing 'oh you need to be doing on this terrace' or 'bring so and so this program'. Families would understand and appreciate the value of what we are trying to do for their family member. I think we could create a different picture of TR in LTC.*

Leah hopes that TR in LTC would be significantly different than how it is currently where there could be more recreation therapists to support residents in meaningful leisure. She also mentioned how she would be able to create more personalized care plans as they appear *"institutional and generic".* She also mentioned that the job title would be 'recreation therapist' and not 'activity aid'.

This thread has implications on future directions related to supporting frontline staff in LTC. Therapeutic recreation professionals want to be taken more seriously and want to be more evidence or outcomes based however are unable to demonstrate this due to being consumed by other jobs tasks that fall outside of their scope of practice.

In this chapter, I discussed the narrative threads that were apparent across participants' stories. Their narratives revealed the diversity in experiences that can shape PQoL along one's career. Their experiences were indicative of cycles shift between experiencing tensions to experiences joy and compassion satisfaction.

These story fragments provide glimpses into who each is as a practitioner, their beliefs about TR in LTC and the many twists and turns that can occur throughout one's journey in LTC. More importantly, their stories revealed the importance of being able to reflect on moments of tension, passion that help shape their perceptions of PQoL. They revealed the importance of learning what their own needs are as professionals to keep them grounded and able to keep fighting on behalf of their residents. Additionally, they shared with me what they learned from each of their experiences, how they gained new professional knowledge in changing future actions such as how to approach relationships within LTC. Further, in this chapter I described the kinds of positive and negative lived

experiences shaping PQoL. In the next chapter, I will describe what their stories reveal about PQoL by returning to personal, practical, and social justifications for this research.

Chapter 6: Making Sense of PQoL in LTC

This narrative inquiry explored into the experiences of PQoL from the perspective of TR practitioners working in LTC. Their stories revealed a journey in learning to overcome tension, setbacks and experiencing meaningful moments with residents. Their stories reflected multiple understandings and perspectives that have shaped professional quality of life as a TR practitioner. Each practitioner identified and shared pivotal moments both good and bad in their career that shifted or impacted their perspective on PQoL. It is important to note that when each of the practitioners first started out, they all identified with experiencing more moments of burnout. In this chapter, I answer the final research question: what do these stories reveal about PQoL in working in LTC homes?

Based on participant's stories, I constructed puzzle pieces that reflected important aspects of PQoL. These pieces were constructed by using the three-dimensional commonplaces - temporality, sociality, and place - outlined by Clandinin (2013). As I continued to step back and look at a broader level of the key pieces to PQoL, I began to consolidate and infuse their perspectives together revealing the juxtaposition between harmony / disharmony within the LTC environment (*relationships*), institutional lens / TR lens (place*/ situations*) and sense of fulfilment and devalued (*personal*) as a TR practitioner regarding PQoL.

Lastly, this chapter is the final research texts where I revisit the personal, social and practical justification while offering future directions for understanding PQoL and TR practice in LTC. Clandinin (2013) suggests that there is no one way to represent the final research text. She makes it clear that final research texts do not seek a final answer. Rather, texts are intended to engage audiences to re- think and re- imagine ways to

practice and ways we can relate to others (Clandinin, 2013). As the reader, it is important to keep in mind that these findings can co-exist and be blended together shaping PQoL.

Harmony / Disharmony within Relationships and the LTC Environment

Throughout each of the four participant's stories it was apparent the role of relationships within the LTC setting in shaping PQoL either negatively or positively. The notion of harmony and disharmony within relationships and the LTC environment speaks to the complexity in working with people and for people. Each participant shared the importance of communication, working collaboratively, getting along with others and being able to work towards common goals. Yet at the same time, they shared experiences that cause a sense of disharmony related to co- worker conflict, power struggles with families and tensions from the relationships with residents.

Research has linked job satisfaction to organizational culture and the kinds of relationships within a workplace. For example, Chamberlain, Hoben, Squires and Estabrooks (2016) has linked aspects of organizational culture within LTC homes such as leadership, support from co-workers, social capital and sharing ideas to having higher job satisfaction. In the present study, it was not surprising that TR practitioners strived to have a sense of harmony with co-workers, wanted to collaborate or create a sense of community due to our deep roots in developing relationships and working within a collaborative lens (Hebblethwaite, 2013). Chu, Wodchin and McGilton (2014) suggest that LTC homes need to focus on strong leadership and build strong communication practices among team members to support job satisfaction and decrease turnover. Their study indicated that poor leadership and poor communication has implications on the kinds of relationships within organizations. Further, Tyler and Parker (2011) found that

high functioning teams within positive work cultures are more likely to have more positive attitudes towards co-workers. Further, Tyler and Parker (2011) suggested having good teamwork, a manager that supports staff and who demonstrates positive behaviour, improves attitudes of employees by fostering open communication and allows co-workers to respect each other's points of view. These findings align with participants' attitudes of co-workers and working together as a team that fosters collaboration and communication as well as perceiving the work place as a community provides a sense of harmony within relationships in LTC.

There is growing interest in the role of spirituality in the workplace and its contribution to producing positive outcomes such as organizational performance (Houghton, Neck & Krishnakumar, 2016; Pirkola, Rantakokko & Suhonen, 2016). Workplace spirituality is conceptualized as a complex phenomenon on an individual, group and organizational level linking to inner life, meaningful work and sense of community for a greater sense of purpose (Houghton, et al., 2016; Pirkola, et al., 2016). By developing strong relationships with co-workers, creating meaningful interactions with residents and a having a sense of community within their work environment TR practitioners felt a sense of harmony.

All four participants also experienced a sense of harmony within relationships with residents. Connecting with residents and being in their presence provided TR practitioners with the most joy and satisfaction. They recognized the bi-directional connection between themselves and residents. Within these moments, practitioners could see, hear and feel fulfillment, joy, meaning, and satisfaction in the work they do every day. This will be further elaborated on in the section on fulfilment.

In contrast, TR practitioners also shared glimpses of disharmony with respect to relationships with residents that resembled compassion fatigue or burnout due to power struggles with families and dynamics with co- workers that resemble incivility in the work place. As a result, disharmony was evident within their negative practice lived experiences as a TR practice.

Since the act of caring is described as "difficult and messy" (Sylvester, 2002, p.325) compassion fatigue lies in the kinds of relationships with self, residents, their families and the system (Austin et al., 2013). As noted by Briscoe and Arai (2015), spaces within relationships are often multifaceted, at times conflicting due to power within institutionalized care. Showalter (2010) suggests that these experiences related to dynamics can cause blurred professional boundaries causes a sense of disharmony. This study revealed some examples of how therapeutic relationships can be a source of tension and stress with the lingering feeling of emotional tension such as guilt (Austin et al., 2009; 2013; Sabo, 2011). Some practitioners even revealed how these experiences challenged their ability to remain professional while in the presence of vulnerability.

Although these four participants periodically experience disharmony or tensions in relationships with residents, and their stories however revealed a strong commitment to their inner calling (Sylvester, 2002; 2009). Sylvester (2009) cautions practitioners as they can lose their way when their external compass deviates from their internal orientation. Austin et al. (2013) suggests that compassion fatigue is a relational phenomenon that occurs where a practitioner may lose his/her connection to their past as a helping professional. Although my participants could relate to experiencing compassion fatigue and shared moments that might resemble losing their way, what was interesting was how

they found their way back in re-connecting the relationship with themselves. Here I suggest they found an inner harmony; being self-aware, and turning inwardly allowed them to find ways to bounce back. This is further addressed in the implications section stressing the importance of self-reflection.

Louise experienced the greatest sense of disharmony with her co-workers. She spoke of workplace bullying, experiencing a lack of respect among co- workers and an environment that appears to be demoralizing. Leah too spoke to conflict with her former manager who frequently made her feel belittled, bullied and left out. These experiences are suggestive of experiencing incivility in the workplace and tension within interpersonal conduct (Anderson & Pearson, 1999; Vagharseyyedin, 2015). Incivility or negative workplace behaviour can be witnessed, experienced or even instigated impacting psychological safety (Schilpzand, De Pater & Amir Erez, 2016). Lack of team cohesion, respect or basic acknowledgement as well as not feeling included impacted participants' sense of harmony at work. Moreover, some participants revealed how a lack of support from colleagues, especially management, influenced their job satisfaction (Willese, De Jonge, Smit, Visser, Depla & Pot, 2014).

The significance that harmony and disharmony plays in one's sense of PQoL is rooted in the interpersonal or social contexts with co-workers, residents and family members. Based on the patterns of the four participants' stories, it was clear that strong, positive and healthy co-worker relationships are the *glue* to finding harmony in the workplace and a key piece to PQoL. Alternately, tensions in these relationships can cause a sense of disharmony which subsequently shaped one's outlook on professional practice (and their future with the organization)**.**

Institutional Lens / TR Lens

This study revealed some of the ongoing tensions within TR philosophy and working in an institutional environment (Briscoe & Arai, 2015). Based on the participants' stories it was clear how the culture or model of care of the home shaped their experiences and perspective on PQoL. Their stories provided glimpses into how LTC home still continue to focus on tasks are inflexible routines around bathing, eating, sleeping and when other things can happen (Banerjee, et al., 2015) such as leisure engagement. Research has indicated that environments that focus on tasks and routines frontline staff are more likely to have a lower job satisfaction (Edvardsson et al., 2011).

Participants in this study acknowledge fighting against the system of LTC such as justifying small groups, trying to work within routines and strict regulations. Compassion fatigue and burnout have been suggested to develop among employees when fighting against the system and as well as managing institutional demands. It is important to note though the TR lens is counter to the bio- medical model. In fact, the TR lens supports focus a holistic, strengths based, relationship and person-centred lens (see Briscoe, 2012; Hebblethwaite, 2013; Hood & Carruthers, 2013). For example, having big groups where every resident is in attendance even when it does not match their interest and skill level goes against everything a TR believes in and stands for as a professional. Having to quantify the experience of leisure, challenges the value (Hebblethwaite, 2013) and lens of a TR practitioner. Narrating a typical day and the job description also spoke to the challenges they face in working in an institutional setting. However, their stories further demonstrate that TR practitioners Yet again, research is demonstrating how TR

practitioners continue to move farther away from medical and institutional models (Briscoe, 2012).

When working within this institutional lens and fighting for their TR philosophy the participants revealed how they had to learn assertiveness to make their voices heard and know. They challenged other health care professionals when advocating for their resident's wishes, misunderstanding in the role of TR. They demonstrated courage and commitment. Sylvester (2009) suggests that this is a valuable and needed characteristic for a TR practitioner to possess.

Assertiveness appears to be a common professional characteristic among these practitioners in being able to share their lens and understanding. This research provides additional context of how the environment might contribute to TR practitioners not at ease philosophy due to their work environment (e.g., Hebblethwaite, 2013).

Some practitioners mentioned the fact that TR practitioners are not regulated and how this has impacted their PQoL. While regulation is outside of the scope of this research, what became evident were the socio-political tensions within LTC in not being a regulated professional. Being regulated as a profession could influence future TR practice in LTC such as caseloads, more TR practitioners, number of residents in programs, and the kind of programs being offered. Further research might want to look into the role of regulation on professional quality of life among health care professionals.

Sense of fulfilled and feeling devalued as a TR practitioner in LTC.

The most important aspect of PQoL for a TR practitioner was the personal fulfilment in finding meaning, purpose and experiencing joy. For each of the participants, their fulfilment and experiencing joy came was while in the presence residents. In

noticing the positive impact, they had on their residents' quality of life they could experience a sense of accomplishment and internal reward. This supported their love of the field and re-affirmed their journey as a TR practitioner by giving them a sense of accomplishment and pride. Moreover, they indicated how important their relationships with residents gave them energy and determination to continue in helping others. It was clear how each practitioner cherished the relationships with residents, which in turn inspired them to come to work every day (Carpenter & Thompson, 2008). This study produced similar findings to Carpenter and Thompson (2008) who highlighted that human connection coupled with a strong desire to make a difference can help nurture passion and fulfilment in LTC.

Research also supports how personal achievement, accomplishment and personal efficacy significantly contribute to job satisfaction (Chamberlain et al., 2016). Participants in this study indicated how meaningful experiences within their work environment provided them with energy and gave them motivation to carry on in their helping role (Bjerrefaard, Haslam, Mewse & Morton, 2017). These experiences are linked to help form their identity as a helping professional by feeling good about the contributions they make to their organization and residents (Bjerrefaard, et al., 2017).

Moreover, fulfilment and re-affirming of purposeful action supports spirituality in the workplace. Pirkola et al. (2016) suggests that co-workers need to feel a sense of alignment with the organizations' values in conjunction with what they can provide the organization can contribute to a sense of fulfilment. Leah emphasized how it was important that her work culture be in line with her values and what she wants to contribute to the world. Isabel, Leah and Rose could find alignment with their values and

those of their organizations. Todaro-Franceschi (2013) states that finding meaning and a sense of alignment in day to day experiences helps sustain a professional journey. She argues that spiritual aspects of caring and a sense of existence connects to a sense of belonging within the universe.

Participant narratives also revealed that TR practitioners experience the most joy in applying their skills, interests and knowledge towards programming and being with residents giving them a strong sense of fulfilment. Practitioners told me how happy they are when with residents and being at work. Todaro-Franceschi (2013) suggests the act of caring and experiences that re- affirm professional purpose contribute to helping professionals feeling fulfilled. Moreover, Todaro-Franceschi (2013) links happiness at work to Csikszentmihalyi's notion of optimal experience or the concept of flow. As mentioned, participants enjoyed being challenged and learning new things. Leah stated how she received fulfilment in utilizing her creativity and overcoming challenging situations. Both Rose and Louise enjoyed researching programing ideas and going through the process of trying. These experiences too contributed to their satisfaction.

Yet at the same time, practitioners shared tensions in finding their own worthiness and value (Edvardsson et al., 2011). As noted in Briscoe and Arai (2015), literature points out that recreation therapists continue to feel under- or de-valued when working within an institutionalized setting. Like Hebblethwaite (2013), TR practitioners sometimes feel under attack in having to demonstrate their value on different levels. Louise and Leah indicated how feeling devalued caused them to consider leaving their organization. Todaro-Franceschi (2013) suggests that feeling devalued can lead to depersonalization

linked to the concept of burnout. She too suggests that feeling devalued can stem from an inability to experience fulfillment or effective as a professional.

Practitioners within this study indicated how when they first started in LTC their role was not clearly defined. All practitioners indicated how management, family and other allied health care professionals do not full understand the role of a TR practitioner within the LTC setting. Their stories indicated how societal assumptions of TR and work place culture impacts not only their day- to day decision making (LeBlanc & Singleton, 2008) and in turn contributes to their PQoL. Having to constantly justify and advocate for their contribution to the organization left some practitioners disheartened and exhausted. These four TR practitioners held their role in high regard but when staff perceive their role to *"just be fun and games"* it causes an uneasiness about their significance and role in the home.

Participants in this study shared how they complete many duties outside of the TR scope limiting their ability to do their job effectively. Being taken away from their actual role as a TR practitioner caused tensions impacted their professional quality of life. It was clear how role ambiguity and conflict appears to cause internal conflict influencing their PQoL. Rai (2010) found that role conflict and stress contributes to emotional exhaustion linked to burnout. Being a TR practitioner in LTC was more to them than just a job; it was this strong sense of connection they felt in relation to those they serve. Feelings of fulfilment were often juxtaposed with feeling devalued as a competent practitioner.

Implications

This research study contributes to the growing body of literature around the phenomena within the Professional Quality of Life framework, the need to continue self-

reflective practices in health care, and spirituality in the work place. Here I offer implications based on the findings and literature that supports these findings.

This study aligns with the hermeneutic phenomenological study on compassion fatigue by Austin et al. (2013) who suggest that a professional journey is filled with many cycles. They compared compassion fatigue to winter time -freezing cold and numbing related to relationships with self and others. But they also suggest that health care professionals can experience joy and hope within their practice. I suggest that compassion satisfaction or experiences that fuel the soul could resemble summer time where practitioners can witness and feel the beauty of their profession and accomplishments with residents. Despite all the tensions that were shared in this research, it was still clear to me how much they love what they do and are committed to their residents. They demonstrated the ability to experience joy and passion and purpose despite the challenges they face. All though some of these tensions do not get solved they do not let them impact their practice and interactions with residents. The participants in this study were open to new possibilities and had a willingness to learn and grow. Spring time is often characterized as a sense of renewal an opportunity for growth by planting the seeds of change. Fall is a time when climate becomes cooler where we need to prepare for survival of the winter harsh climates. During this season, we celebrate thanksgiving. Practitioners could then practice gratitude reflecting on all the wonderful memories and experiences that summer time brought them in their practice. Having these reminders in a memory box can help buffer when compassion fatigue or winter time begins again. This transition period would also be a good time to remember to practice self-care and continue to engage in self-reflective practices.

Future research should continue to explore the experiences of PQoL among TR practitioners as our voices are missing within the literature. Research could therefore explore how other TR practitioners working in different settings describe PQoL in TR practice. Are stories of practitioners working in LTC similar or different to those working in other health care settings? How do other TR practitioners find work life-balance in other settings? This could utilize a multiple case study mixed methods approach by using Stamm (2010) PQoL scale and engaging in focus groups to share their understanding of the results. Although this research was only from the perspective of female practitioners, I recognize that men who are recreation therapists in LTC may have a different perception or journey all-together. I recommend further research should look at gaining a men's perspective of PQoL in LTC.

Practitioners, managers and administrators could benefit from using Stamm's (2010) PQoL scale as a starting point to evaluate either personal or collective levels of burnout, compassion fatigue and compassion satisfaction. This tool could help prompt further reflection when frontline staff are struggling as well as help identify further action based on their results. This could include help workplaces identify further training on stress management or trauma, or finding professional balance. It was this scale that prompted my own journey into exploring my experiences and why I selected it to use as the conceptual basis for this research.

Tyler and Parker (2011) emphasize that positive organizational cultures provide better quality of care for residents, but also better quality of life among frontline staff. Research on the culture change movement indicates that this philosophy of care has implications on quality of work life for frontline staff. As a result, further research should

then investigate PQoL among frontline staff who work in LTC facilities that endorse the culture change movement as they may have a unique perspective on PQoL. What do these organizations do that better support PQoL in LTC?

This narrative inquiry opened space for TR practitioners working in LTC homes to dialogue about their personal experiences that have shaped their sense of PQoL. My participants indicated how they did not have enough time in their day to unpack or reflect on these moments with team members. These findings connect with Briscoe and Arai (2015) who argue that TR practitioners rarely engage in self- reflective practices in exploring possibilities within therapeutic relationships including compassion fatigue. Further, Briscoe and Arai suggest that to help TR practitioners counteract feelings of compassion fatigue, we must come together as a collective to strengthen connections and voices of practitioners. Sharing our stories with others such as co-workers or other TR practitioners over a cup of coffee can help us cope and learn ways to move forward. Based on the feedback and debriefing with participants, they expressed their enjoyment in engaging in self-reflective practices and having the opportunity to share their experiences without having criticism from their places of employment. In fact, at the end of the first interview Rose stated "*I feel like I just had a session [therapy] ...we should be doing more of this [self- reflective practices] this was very therapeutic for me.* Leah stated: "*I really enjoyed being part this research and it felt really good doing self-reflecting- a much needed exercise. It really made me think about what is important to me as a professional working in the field and what I envision the future to look like".*

It is important to continue collaborative conversations around Professional Quality of Life as a TR practitioner through self- reflective practices. Austin et al., (2013)

suggest that self-awareness through stories help health care professionals acquire and sustain values and process the kinds of emotions health care professionals' experience. Todaro-Franceschi (2013) highlighted how narrative storytelling is a useful practice in identifying turning points in actions, behaviours and feelings. Gilbert (2010) adds that self -reflective practices help identify personal emotions related therapeutic relationships, offers insight into how practitioners contribute to moments in practice, and help consider implications on self-care related stress, burnout and compassion fatigue. Further, she links self-reflective practices in assisting practitioners to be more fully present or in the moment with clients. She offers some questions that are a useful guide to start self-reflective journaling. She provided the following questions; how are you feeling, what choices did and will you make because of your feelings, does anything stand out to you, what patterns do you see about yourself, how are feeling about the choices (professional actions) you are making? (Gilbert, 2010, p. 307). Todaro-Franseschi (2013) suggests that health care professionals need to be able to identify the good that occurs in one's day. This can help contribute to a sense of wellbeing and wholeness as a professional. In doing this she suggests how this builds up experiencing joy in practice.

Practitioners might want to consider the following questions to assist in self-reflection on PQoL; what does professional quality of life mean to me? What occurred today that made me feel good? What do I need to feel good about my role as a TR? When was the last time I experienced joy, and satisfaction at work? Who was I with and where was I? What contributed to experiencing joy? Where can I experience more of this? How do I engage in my own strengths at work? How do I envision the future of TR practice my professional quality of life?

Louise reminded me that the system of LTC needs to do a better job in offering more workshops on work life balance, compassion fatigue, burnout and mental health training and self-reflection as a helping professional. Louise indicated that asking for a mental health day or wanting to talk about the issues at work is perceived as being lazy and shared to share her tensions. This is in line with Showalter (2010) who argued health care professionals experience fear in expressing concerns related to their job. Showalter also indicated the need for meetings and debriefs among helping professionals to explore feelings of emotional pain within organizations.

Moreover, Showalter (2010) points out that organizations inadequately support frontline staff mainly due to the management team who lacks of experience in sitting with heavy experiences such as witnessing intense complex family dynamics, being with those who experience sever disability and trauma or even witness patients die (Showalter, 2010). Based on the feedback from these participants, these kinds of conversations need to be better supported in the LTC environment and among TR practitioner. Mental health days are also needed to be more accepted in organizations so that frontline staff are able to provide better care for those they serve. I agree with Boyle (2011) who suggests that organizations should provide on-site counselling, support groups for staff, debriefing sessions, and attention to spiritual needs of frontline staff. Based on the literature review provided in chapter 2, LTC environments are struggling to support Professional Quality of Life among their frontline staff. In addition, conferences at the national and provincial level for TR professionals are an ideal setting to provide spaces for self- reflection in relation to compassion fatigue, burnout, moral distress, compassion satisfaction or Professional Quality of Life in general. TR organizations need to do a better job in

supporting their members through professional tensions by providing sessions that support these kinds of initiatives.

Building on the finding of this research on harmony and spirituality in the work place, future research in therapeutic recreation could continue to explore opportunities for spiritual connection, purposeful action within organizations to support compassion satisfaction. How are TR practitioners able to find ways to experience joy or a sense of harmony every day? These considerations have not been explored in the TR literature. I also began to wonder about the ethical and moral implications of TR practice (Sylvester, 2002; 2009) when experiencing compassion fatigue and moral distress. Based on the suggestions of Sylvester (2009) how do TR practitioners restore the heart of professionalism when experiencing moral distress or compassion fatigue? What steps or initiatives exist that support organizations in helping restore a sense of harmony in the work place? How are TR practitioners able to find their way back to their internal calling after experiencing compassion fatigue? How can TR practitioners experience personal and professional growth when experiencing ethical and moral dilemmas?

Finally, I share personal implications in relation to my own tensions with PQoL. In the reflection below, I narrate how I began to view PQoL as a personal journey full of twists and turns that teach us valuable lessons along our way. Clandinin (2013) claims for that for narrative inquirers, "we write to learn" (p. 206) and this journey taught me more than I could have imagined.

As I was traveling homeward from meeting with Isabel at Hedgewood Homes, I was prompted to record my impressions of the interview on my phone while being stuck in traffic on Highway 401. While being at a standstill, it hit me; there was a connection between the stresses of being caught in traffic and the tensions in the working life of a TR practitioner. I began to imagine how a highway could represent a professional journey. I then considered how depending on the time of day, traffic could be heavier, lighter or the

road conditions might be not as ideal due climate or construction. I remembered how my participants all got on the "TR highway" at different ramps and appeared to be at different places in their careers. While thinking about their experiences of setbacks, compassion fatigue and burnout I started to compare a practitioner to cars getting a flat tire, running out of gas, needing a tune-up, hitting a bump in the road or even worse, spinning out of control and getting into an accident. For me, I started associating going to work as a helping professional to getting into your car every day. It is a risk, yet, we continue to do it. We know we cannot control traffic and realizing that accidents are bound to happen. When stuck in traffic, we unfortunately have no choice but to sit and wait for it to subside; in due time, this too shall pass.

I considered my interaction with Isabel who had such a positive mindset towards her PQoL. This made me focus on what is going well on my drive home. She reminded me to enjoy the journey. So, I choose to sit back, relax and enjoy the drive back home by listening to country music as I soaked in the sunshine. I was not in any hurry to get to my destination, and did not want to let trivial experiences get in the way of enjoying the rest of this day. This reflection was a reminder that I am the driver in my car and I can control my own reality. It was clear that I was letting the outer world impact my inner world.

In my epilogue, I share further insight into my learning and knowing, and the personal shifts that I experienced while inquiring into the stories of other practitioners. I also offer what I learned from each of the practitioners that I hope to always keep me with me in my TR journey. Their stories helped me through difficult times while I experienced distress at work. I learned the importance of turning inward and reflecting on my own stories to help me grow and fight for what I want as a professional.

Conclusions

In this study, I presented the stories and voices of four TR practitioners who described their perspective Professional Quality of Life while working in LTC homes. I shared their narrative accounts, revealing their journeys into TR practice in LTC, and the pivotal moments that both positively and negatively influenced their PQoL. I offered some insight into how they negotiate and have learned to overcome their challenges. Although these challenges have not gone away, they are still able to remain committed to

themselves and to those they serve. They demonstrated self-awareness, determination and the ability to grow despite the turmoil and disharmony they experienced (sometimes daily). I shared how they turned inwardly and connected with others to help them through their challenges.

Epilogue - Owning my Journey

"*In a very powerful way, owning this story allowed me to claim who I am as a researcher and establish my voice*." Brene Brown

In this epilogue, I share what I learned as a researcher and as a practitioner. The above quote was taken from a book called the *Gift of Imperfection* (Brown, 2010) that I turned to, to help me overcome my own feelings of inadequacy, looking to re-gain my personal strength and courage to finish this research. For the longest time, I have suffered from my own internal monologue of 'I'm not good enough', 'this is not good enough', and 'what am I really doing here?' - not only as a graduate student but also as a TR practitioner. I did not feel at ease as a Masters student - feeling insignificant, sometimes stupid, and very small as a qualitative researcher in a graduate class that predominately preached about quantitative research. I felt so out of place - still do at times.

These feelings and experiences as well as others led me to not feel like myself, lacking energy, passion, drive, and enthusiasm. In fact, I felt depleted, and lost. It was as if I was trapped in someone else's body. When I first started writing my proposal, I was working part-time twice a week which helped me re-build my career and gave me that human connection with residents I missed. The company I work for saw something in me and asked me to be a part of their Behavioural Support Ontario (BSO) team in October 2016. I began working two-part times lines considered full-time all the while still working towards completing this research. As my work hours increased, I began to witness experiences similar ones to those of my participants. My writing became less of a priority and so did my own self-care. I also found myself over identifying with my participants' experiences, clouding my ability to narrate objectively. Needing to step back from my research was hard, but it was necessary. It was in the slowing down and letting things happen, that I felt more authentic in my writing and where I learned the most.

I know this is not the end of my learning, but rather a chapter in my book of life. Throughout this experience, I noticed how I am not alone in struggling with (un)worthiness - my participants did too. I have learned each day brings new challenges - some harder than the last but we need to pick ourselves up and keep trying. This journey re-ignited my passion for lifelong learning. I have learned to embrace vulnerability; to be okay with sitting with difficult emotions and learning not to fight when you are stuck in quicksand. Each of my participants taught me something that I hope I keep with me for the rest of my career, especially when I feel I am trapped.

Rose reminds me to look at the bigger picture of experiences. She turned to vulnerability to try and help her be a more compassionate and empathetic practitioner. She also reminds me to remember why I want to help in the first place and to always remember those small moments in practice.

Isabel taught me to find the joy in every day. This has changed my outlook and how I end my day. She also taught me to find ways to embrace every moment with residents even if it means I get embarrassed. For me, Isabel embodies her TR philosophy and as a result she reminds me to advocate for and educate others on what matches my values, beliefs and approach as a TR practitioner. I am grateful for her insight and her reminder to focus on the experience with residents and the connection you have with them.

Louise reminds me that success as a practitioner does not depend on someone (a coworkers) getting out of the way. Success is determined by the interactions we have with residents and what is meaningful for me. It is important to look back on our experiences to remind ourselves why we do this! She also reminded me to use more of my strengths at work where I see more dancing and celebrating in LTC!

Leah embodies the kind of manager and mentor I hope to be one day. She has learned how to navigate through those hard conversations with co-workers and refuses to shy away from having her voice silenced. I hope to carry with me her spirit and willingness to take chances, make mistakes and to learn and grow from them. She also reminds me that our professional quality of life is constantly evolving. She also highlighted how we need to feel comfortable walking through the doors of LTC every day and when we don't, then we really need to re-evaluate what we truly want.

For me, owning my story means being confident enough to share and be willing to learn from my mistakes and challenges. I have realized that my experiences are my best teacher. I have learned what I am able to tolerate intellectually, emotionally, and physically as a researcher and practitioner. I have also had to learn to let go of the things that I cannot control. I have learned when it is appropriate (and not appropriate) to voice my concerns and read situations when it is most needed to advocate. I was naive to believe that everything would magically fall into place with my research, my career and that everything would turn out as planned. For me, Professional Quality of Life will be a life long journey - continuing to figure out what is important for me to have as a helping professional and knowing or using the resources that can support me through the bumps in the road. I know burnout and compassion fatigue are inevitable. I will likely experience these tensions in my practice again, but this time I can handle them more effectively. However, I also realize that if I am unable to experience joy or satisfaction in the work I do, it might be time to move on.

I hope that the field of TR continues to embrace vulnerability in its practice and that practitioners are willing to share their rich stories so we may continue to learn from them. I also hope that practitioners will persist in their journey as trailblazers by demonstrating and advocating for their innovative ideas and unique perspectives. Lastly, I have learned that just
because I had a few "bad chapters" doesn't mean my story is over. As a proud Brock Badger, I will always remember to Surgite! ...continue to push on as my participants have exemplified.

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Appendix A: Recruitment Advertisement

TR PROFESSIONALS IN LTC HOMES NEEDED FOR RESEARCH EXPLORING PROFESSIONAL QUALITY OF LIFE

I am looking for three volunteers to take part in a study titled: *Exploring Professional Quality of Life among Therapeutic Recreation Professionals working in Long Term Care homes.*

This research is looking to capture the complexity and nuances within TR practice in LTC homes.

Your participation would involve two individually one-hour interviews. In advance of the first interview, I will ask you to bring along a story, a photo or poem that represents an experience related to Professional Quality of Life.

In appreciation of your time, you will receive *a $50.00 gift card to Starbucks*

For more information about this study or to participate in this study, please contact:

Jenna Johnstone, Graduate student
Department of Recreation and Leisure Studies,
Brock University
jj08tp@brocku.ca

or

Dr. Colleen Whyte, Supervisor
Department of Recreation and Leisure Studies,
Brock University
cwhyte@brocku.ca

Appendix B: Letter of Invitation

Project title: Exploring Professional Quality of Life among Therapeutic Recreation Professionals working in Long Term Care homes.

Dear Participant**:**

My name is Jenna Johnstone and I am a graduate student in the Department of Recreation and Leisure Studies. I am writing to you to invite you to participate in a research project as part of my graduate degree at Brock University under the supervision of Dr. Colleen Whyte. The title of this project is: Exploring Professional Quality of Life among Therapeutic Recreation Professionals working in Long Term Care Homes. The purpose of this letter is to inform you of my research and your role as a participant. The purpose of my study is to explore the lived experiences of professional quality of life. It is my hope that t this research will begin to find ways to support a positive work environment in the LTC sector.

Criteria to be considered a participant includes:

- Must be a full time Recreation therapist or assistant
- Must be a member of TRO who holds an R/TRO or CTRS designation.
- Must have at least three years' experience working in a LTC home.
- Must be working in Greater Toronto Area.

Your participation in this project would involve:

- Speaking with the researcher over a course of a few months. Each conversation will take approximately **60 minutes.** The first conversation will be conducted in a confidential location and time of your convenience. The second interview will be done on the phone.
- I ask that you bring a representation of an experience either a photo or a story of working in LTC.
- After each conversation, I will provide a verbatim transcript for you to review and look over to ensure that I have captured your experiences related to your story.
- The second interview will be used to reflect on Professional Quality of Life throughout their career, clarify anything related to Professional Quality of Life in LTC, and gain an understanding of strategies used to help balance professional and personal quality of life.

As a participant, you will receive a $50 Starbucks gift card as an honorarium for agreeing to participant in this study.

I would like to **audio record** our conversations so we can better understand your personal experiences and have an accurate record. All audio recordings collected during this study and hard copies of transcripts will be stored in a secure research room at Brock University. After data have been collected and analyzed, the audio files will be deleted.

All other hard copy files that may be used for participant information purposes will be destroyed. Electronic data will be retained indefinitely in a secure location for possible future data analysis. An executive summary of the results of this study will be available to all participants once all the data has been analyzed

If you decide to take part in this study, I will be asking you to sign a letter formally stating your consent to participate. **Participation in this study is voluntary** and you may choose not to participate. You may decline to answer any of the interview questions if you so wish. Further, you may decide to withdraw from this study at any time without any negative consequences by advising us. Information gathered throughout this study will be kept **confidential** and will only be accessed by myself and my advisor, Colleen Whyte. Your name will not appear in any thesis or report resulting from this study, however, with your permission anonymous quotations and stories may be used using a pseudonym.

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board [XXX-XX]. However, the final decision about participation is yours. Any comments or concerns can be addressed to the Brock University Research Ethics Officer (905-688-5550 ext. 3035, reb@brocku.ca).

I very much look forward to speaking with you and thank you in advance for your assistance in this project.

Jenna Johnstone, BRLS, CTRS
Master's Candidate
Department of Recreation and Leisure Studies
Brock University

Appendix C: Informed Consent

Project Title: Exploring Professional Quality of Life among TR professionals working in Long Term Care homes.

Student Principle Investigators: Jenna Johnstone, Department of Recreation and Leisure Studies Brock University, (416) 948 7062, jj08tp@brocku.ca

Faculty Supervisor: Dr. Colleen Whyte, Department: Recreation and Leisure Studies, Brock University, (905) 688-5550 ext. 3124, cwhyte@brocku.ca

Dear Participant,
Below outlines what is involved, the benefits and risk followed with information regarding confidentiality. Your signature is required indicating you understand the parameters of this study.

What is involved? You will be asked to participate in three interviews, each approximately an hour in length. All three interviews will be recorded on a digital recorder. First interview involves background information, and inviting you to share the positive experience and how this relates to Professional Quality of Life. The second interview will surround the two experiences around the tough stuff in practice. The last interview is to really reflect on Professional Quality of Life and understand strategies that help you find balance between Professional and Personal Quality of Life. Lastly, you will have the opportunity to review the transcripts from the interviews to ensure your language and voice is present. You will be provided a copy of the final representations of the narratives.

Benefits and Risk: Participation in this research provides each participate with a $15 Starbucks gift card as a token of my appreciation for your involvement for participating in this study. Exploring Professional Quality of Life as a TR professional working in LTC has not been examined in academic research. As a result, possible benefits of participating in this study include contributing to the body of knowledge surrounding burnout, compassion fatigue and compassion satisfaction. Moreover, the insights gained from these narratives will provide a deeper understanding of what it is like being a TR professional working in LTC. This research is not anticipated to be harmful in anyway, however, sharing personal stories related to stress and trauma to someone who is foreign can be discomforting. This may be a psychological risk associated to stress and trauma from being a helping professional in LTC. In effort to minimize the risks the interview questions will be provided prior to each interview. Your questions are welcomed during all stages of the research process. Should you experience emotional distress as a result of the interview process, you will be encouraged to seek services through an agency listed on an attached information handout.

Confidentiality: Any information that is obtained in connection with this study linked with you will remain confidential. You will be asked to provide a pseudonym, which will

be used to code all data, and used in the analysis of this research. Anything related to this research including your identification linking you to the pseudonym will be kept in a locked file in my supervisor's office and all information will be destroyed two month after the research has been completed.

Consent: I understand that I may withdraw my consent at any time without penalty by advising the researcher. I have read the information presented in the information letter about a study being conducted by Jenna Johnstone, of the Department of Recreation and Leisure Studies at Brock University. I have had the opportunity to ask any questions related to this study, to receive satisfactory answers to my questions, and ask any additional questions. I am aware that the interview will be audio-taped and that excerpts from the interview may be included in the thesis and/or publications to come from this research, with the understanding that the quotations will be anonymous. Further, I understand this project has been reviewed by, and received ethics clearance through the Research Ethics Office at Brock University [XX-XXX]. I have been informed that if I have any comments or concerns about my rights as a research participant, I can contact the Research Ethics Office at (905) 688-5550 ext. 3035, reb@brocku.ca.

With full knowledge of all foregoing, I agree, of my own free will, to participate in this study.

Participant Name: _____ Participant Signature: _____

Witness Name: _____ Witness Signature: _____

Date: _____

Appendix D: Interview Guiding #1: Discussing Professional Quality of Life

Introduction

1. What experiences led you to become a TR professional in LTC? (Probes: how did you become a TR in LTC, how long have you been working in LTC? Why LTC?)
2. Can you tell me about the LTC home where you work? (Probes: for profit or not-for-profit? Number of residents on your caseload? Number of residents in the home? Culture of the home?)

Professional Quality of Life

1. How would you describe Professional Quality of Life in LTC? What does this mean to you?
2. Can you think of 5 words that describe your role as a TR practitioner in LTC?
    a. Can you tell me a story that describes that adjective?
3. How would you describe a typical day working in LTC? How would you describe an atypical (out of the ordinary) day at work?
4. Can you share three moments that have brought you joy as a TR practitioner in LTC?
    a. What do you find most meaningful about these experiences?
    b. At the end of a great day, how do you feel? How do these feelings carry over into your personal and/or home life?
5. Can you share three moments that have brought you great stress as a TR practitioner in LTC?
    a. What do you find most memorable about these experiences? (Probes: for example, increasing caseloads? Anything related to residents? Families? Workplace culture?)
    b. At the end of a stressful day, how do you feel? How do these feelings carry over into your personal and/or home life?
6. Can you tell me about any strategies you use to support a well-balanced professional quality of life?

Conclusion

1. We are now at the end of the interview, is there anything else you'd like to add? Do you have any questions for me as we end our time together?

Appendix E: Interview Guide #2: Reflecting on artifact

Artifact

1. Can you tell me about the narrative you wrote on compassion fatigue? (Probe: How did you choose to tell this particular story? What did you take away from this experience? How did you cope with this situation? How has this experience changed you? Your practice?)
2. In what ways does the experience represented in your artifact contribute to your sense of Professional Quality of Life? (Probes: Has PQoL changed for you over the years?)
3. Can you tell me about the narrative you wrote on compassion satisfaction? (Probe: How did you choose to tell this particular story? What did you take away from this experience? How has this experience changed you? Your practice?)
4. In what ways does the experience represented in your artifact contribute to your sense of Professional Quality of Life? (Probes: Has PQoL changed for you over the years?)

Professional Quality of life over the course of one's career

1. Thinking back over your career as a TR practitioner in LTC, how has your sense of Professional Quality of Life changed?
2. I want you to imagine that tonight as you sleep, all the tensions and challenges in LTC would no longer be present when you go into work tomorrow. How would your experience in TR practice be different now? (Probes: What might that feel like? How might LTC look like?)
3. Do you have anything else you would like to add?

Appendix F: Resources for Workplace Grief Counsellors in the GTA

Organization	Phone number	Services
GriefNet www.griefnet.org Website GriefNet.org		Internet community of persons dealing with grief, death, and major loss. Over 50 e-mail support groups and two web sites available
408 help hotline	Call **416 408 4357** to reach our 24/7 crisis line.	Providing a confidential help-line service available 24 hours a day to persons in emotional distress
Hospice Association of Ontario	416-304-1477	
C.O.P.E.S (Community Of People Extending Support)	416-767-6793	Offers bereavement follow-up four times per year for six weeks at a time. No charge to attend.

Appendix G: Reflections on Professional Quality of Life

Please reflect on and write two stories/ experiences related to compassion satisfaction and compassion fatigue related to being a Therapeutic Recreation Professional working in a Long- Term Care (LTC) home. The stories should be at least 1000 words (approximately 2 pages double spaced). Think about how they align with the definitions of compassion satisfaction, burnout and compassion fatigue. What emotions do you remember experiencing? what aid these emotions do for your professional quality of life? How long did these emotions last? Did these emotions lead you to do/ say/ think anything?

Compassion Fatigue: *is an experience of accumulated stress usually from being in close proximity to those who are suffering, in pain or have experienced trauma. Related to the engagements with clients.*
***Burnout**: has three main components: emotional exhaustion, cynicism and personal efficacy related to the work environment and associated with high caseloads.*

Think about what is it about working in LTC that you find so stressful or hard? What are the tensions/ challenges you have faced as a TR practitioner in LTC? Describe an experience that relates to one of these tensions or challenges.

- Personal: feeling frustrated angry, de-valued.
- Organizational: caseload, funding, not enough staff, residents on the home area, co-workers.
- Professional: Documentation, programs, relationships with residents, complex conditions, and family.

Compassion Satisfaction*: is the positivity and gratification one receives in being in a helping role. This can include moments of satisfaction, pride, joy, being fully engaged with what you are doing.*

Think about a moment(s) that provide you with a sense meaning and fulfillment in your role - describe what happened.

- Personal: feeling effective, confident, full engaged, mission and values are in harmony.
- Organizational: co-workers, work environment,
- Professional: helping a resident overcoming barriers, overcoming a challenging situation with a resident

Writing the narratives

Who were the main characters in the story? What events led to these experiences? What emotions/ events occurred as a result of this experience?

Beginning - situate us with the sights, sounds, characters, location

Middle - describe what happened/ the event and the emotions

End - the lingering impact of the experience has on you? what do you do at the end of the day to put some of these vulnerable and difficult situations away before you go home?

At our next interview, we will talk more about your narratives - don't worry if it's a working progress!