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THE EMOTIONAL COST OF CARING: COMPASSION FATIGUE
EXPERIENCED BY NURSE STAFF ON AN INPATIENT
GERIATRIC BEHAVIORAL HEALTH UNIT

By

SUSAN A. CAMPBELL

Submitted to the Faculty of the Graduate College of
Arkansas Tech University
in partial fulfillment of the requirements
for the degree of
MASTER OF SCIENCE IN NURSING
May 2017

Permission

Title: The Emotional Cost of Caring: Compassion Fatigue Experienced by Nurse Staff on an Inpatient Geriatric Behavioral Health Unit

Program: Nursing

Degree: Master of Science in Nursing

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Abstract

Purpose: Research studies on the prevalence of compassion fatigue (CF) in nursing have been conducted in various clinical settings. There has been limited empirical research conducted on nurses working within the geriatric behavioral health setting, which can present increased nursing challenges related to the chronic health problems of aging coupled with acute behavioral health crises. The purpose of this quantitative, descriptive research study was to identify the prevalence of CF in RN and LPN staff within an inpatient geriatric behavioral health unit setting in two comparably sized hospitals.

Design/Methods: An electronic survey design (consisting of demographics and the ProQOL v. 5 survey tool) was used to collect data from a convenience sample of inpatient geriatric behavioral health nurses in two mid-sized rural hospitals in Arkansas. A total of 18 patient care nurses voluntarily completed the survey measuring their professional quality of life (compassion satisfaction, burnout, and secondary traumatic stress). Data analysis was conducted via the ProQOL v. 5 scoring and interpretation tools.

Findings: The inpatient geriatric behavioral health nurses' survey results showed predominately high levels of compassion satisfaction, low levels of burnout, and secondary traumatic stress associated with their work. Therefore, based on this unexpected trio of results, the sample groups of nurses as a whole did not display the characteristics associated with experiencing CF. Further, this study showed the average length in years as a nurse was longer than the average length of years as a nurse within the geriatric behavioral health setting.

Conclusions: The results of this study indicated it was possible to work as a nurse in a highly stressful environment such as inpatient geriatric behavioral health and have a low risk of developing CF.

Implications/Recommendations: A more in-depth study on inpatient geriatric behavioral health nurses would be beneficial in determining how nurses working within the acute geriatric behavioral health setting do not experience CF. Improved recognition of CF among inpatient geriatric behavioral health nurses may prevent emotional exhaustion and help identify interventions that will help nurses remain caring nurses.

Keywords: burnout, compassion fatigue, compassion satisfaction, geriatric behavioral health, geriatric nursing, nursing, secondary traumatic stress

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Chapter I: Introduction

Focus of Inquiry

According to the Institute of Medicine (2008), the geriatric population in the United States (U. S.) is projected to double in the next two decades to greater than 70 million representing the fastest growing segment of the U. S. population (Barba, Hu, & Efird, 2012). Around 50 million Americans provide care for older adults in the form of financial and emotional support to at least one of their parents (Sweet, Drum, Ericson, Gutierrez, & Martensen, 2014). This increasing older adult population has resulted in an even greater demand for nurses in the geriatric acute care settings as well as in the community setting. It is not uncommon for patients in an inpatient geriatric behavioral health unit to have experienced depression, dementia, and agitation in addition to a myriad of pre-existing or ongoing health problems (King, 2012). Cheong (2004) claimed approximately 80% of geriatric patients in a nursing home setting experienced agitated behaviors that lead to an increased risk for compassion fatigue (CF) in caregivers from the continuous exposure to this behavior (as cited in King, 2012, p. 33). McHolm (2006) defined CF as the “emotional, physical, social, and spiritual exhaustion that overtakes a person, causing a pervasive decline in his or her desire, ability, and energy to feel and care for others” (as cited in Clifford, 2014, p. 54).

CF has been identified as affecting people who work in helping professions with traumatized populations such as teachers, doctors, nurses, veterinarians, police, social workers, pastoral care workers, first responders, correctional officers, etc. (Zeidner, Hadar, Matthews, & Roberts, 2013). Nurses can be vulnerable to CF because they tend to patients under the caregiver role as partners instead of just observers when delivering

healthcare to their patients (Boyle, 2011). Perry, Toffner, Merrick, and Dalton (2011) described the development of CF in caregivers as the unconscious absorption of the traumatic feelings from being exposed to the traumatic events of those in their care. Therefore, nurses are more vulnerable to CF from the connectedness caregiver role in caring for their patients (Henry, 2014).

In the healthcare organizations, CF has contributed to an increase in the turnover of staff, sick day consumption, and a reduction of productivity. Ultimately, this type of behavior can lead to an increase of patient safety risks and patient dissatisfaction (Hegney et al., 2013). Additionally, CF could negatively affect nursing retention amidst a nursing shortage which is predicted to reach one million by the year 2020 in the U. S. (Burtson & Stichler, 2010). Many affected nurses may choose to leave the profession of nursing altogether, thus contributing to an ever-increasing nursing shortage (Schroeter, 2014). The result could lead to higher healthcare costs associated with recruiting and re-educating nurses to function competently in highly specialized patient care areas.

Barba, Hu, and Efird (2012) claimed the benefits of increased knowledge related to CF in geriatric behavioral health nurses coupled with administrative leadership and support, could potentially lead to the modification of hospital practice environments. However, failure to recognize the impact of CF on nurses working in geriatrics and taking steps to reduce CF could further impact the availability of competent nursing staff that can provide high quality care to meet the specific needs of the ever increasing older adult population (King, 2012). A focused study specifically targeting nurses who provide care for the geriatric population will not only provide clues to the identification of CF

causes and risk factors, but can contribute to the limited knowledge of the existence and susceptibility of CF in nurses caring for patients in the geriatric settings.

Need and Background for the Study

Compassion encompasses a motivational and emotional state that is characterized by a desire to alleviate distress and suffering through nurse caring that exudes kindness and warmth (McConnell, 2015). According to Morrison and Korol (2014), nurses can be repeatedly exposed to the traumatic events and pain of their clients. Nurses continually give of themselves through the innate capacity to nurture and alleviate the suffering of others by taking the distress experienced by their patients on as their own (Morrison & Korol, 2014). Nurses may often neglect to care for themselves, while intensely committing to following their calling of caring for others (Barkin, 2007). King (2012) claimed nurses who continually neglect to care for themselves without re-charging, may develop burnout (BO), which may ultimately lead to the development of CF. Sabo (2011) claimed burnout in caregivers occurs gradually as a response to negative work environment factors such as high workloads and feelings of being unable to accomplish work goals (Perry et al., 2011). Tellie (2008) described burnout as a gradual emotional exhaustion (manifested in the caregiver as a diminished ability to care for the self or others) from work triggers that can be relieved with time away from the workplace. Whereas, CF typically onsets more rapidly and manifests in the caregiver as the inability to care for the self or others (Tellie, 2008).

The provision of nursing care to geriatric behavioral health patients can be more stressful and challenging because of the complex physical and psychological needs of the aging patient population (King, 2012). In addition to the complex physical health

problems as a progression of aging, geriatric behavioral health patients may also suffer from heightened forms of agitation from diagnoses such as depression, dementia, Alzheimer' disease, organic brain syndrome, communication disorders, and post-traumatic stress disorder (PTSD) from re-living past events such as war veteran's or a previous stressful occupation (Hiskey, 2012). Moreover, many older people lack much or all of their family social support system due to death (Hiskey, 2012). Nurses who care for geriatric behavioral health patients that exhibit repeated out-of-control behaviors may experience increased caregiver distress, which can lead to increased levels of stress, BO, and CF if nurses repeatedly do not take the time to care for themselves (Hiskey, 2012).

CF is a unique form of BO that affects professionals in the helping role of caregiving (Joinson, 1992). BO is a commonly used and accepted term when referring to affected providers in the healthcare environment (Tellie, 2008). In many healthcare organizations, CF can be reluctantly discussed or identified relatable to the stigma surrounding the fear and shame from colleagues upon recognition of self-impairment from CF (Hiskey, 2012; Johnson et al., 2011). Figley first described CF in 1995, then later psychosocially conceptualized as the 'loss of the ability to nurture' by Joinson in 1992 from a study of BO among emergency room nurses (Sabo, 2011). Joinson (1992) claimed nurses will experience CF at some point in their careers related to the nature of the nursing profession. Boyle (2011) posited the need for increased understanding and awareness of CF within caregiving professions conjoined with prevention and management plans and policies to prevent, anticipate, and manage CF effectively. The development of a plan to improve understanding and awareness of CF in nursing began by describing CF followed by distinguishing CF from other commonly interchanged

terms such as BO, secondary traumatic stress disorder (STSD), vicarious trauma, and others (Aycock & Boyle, 2009). The resultant effects of CF on nurses can be far-reaching for the affected nurse including the nurse's family, patients, and the healthcare organization. CF can affect the personal-professional life balance of nurses when they are not able to emotionally decompress or able to perform optimal self-care for themselves (Morrison & Korol, 2014).

Physical, emotional, spiritual, and intellectual effects may be evident in nurses who experience CF. Physical impairments may cause the CF affected nurse to exhibit possible work behaviors of increased tardiness or absenteeism. Also, the rate of errors in patient care such as in documentation or medication administration, cynicism, and more critical of other team members (Douglas, 2010). Physical effects of CF may include increased heart rate, inability to sleep, fatigue, increased susceptibility to infection, self-medication, unexplained body aches, and gastrointestinal issues (Aycock & Boyle, 2009). The emotional effects of the CF affected nurse may include feeling emotionally overwhelmed, irritable, poor enthusiasm, feelings of isolation or desensitization, and decreased self-worth (Coatzee & Klopper, 2010). Examples of spiritual effects may include doubting beliefs or value systems, withdrawing from fellowship, or believing that a major life change is necessary such as divorce, relocation, or career change (Aycock & Boyle, 2009). Intellectual effects of nurses experiencing CF may involve boredom, decreased attention span, and impaired concentration ability (Coatzee & Klopper, 2010). The presence of symptoms in the nurse may lead to the definitive diagnosis of CF.

Regrettably, while significant emphasis exists on empirical research of CF in nurses over the last two decades, a definitive definition of CF has not been established

leaving an increasingly important need to clarify further and delineate the concept of CF in nurses. The importance of early detection of the identifying characteristics and circumstances that lead to CF in nurses is an important need in addition to defining the occurrence of CF in the realm of the profession of nursing. Nurses have the responsibility to provide safe competent care to their patients with compassion (Douglas, 2010). Nurses who experience CF are emotionally and likely physically unable to provide optimal care effectively to their patients (Morrison & Korol, 2014). The delivery of patient care without caring can damage the very purpose of nursing in the realm of healthcare which is to create a caring environment conducive to healing (Douglas, 2010). The optimal goal would be to implement interventions aimed at prevention and early recognition of CF in nurses before it can impact the nurses' ability to self-care. This in turn affects the nurses' ability to provide competent, compassionate patient care.

Assumptions

Nurses who work in geriatric behavioral health settings often develop an emotional bond with the patients they care for as many of these patients often have complex long-term needs while suffering ongoing emotional trauma from the effects of aging (Passos, Sequeria, & Fernandes, 2012). This emotional bond can potentially lead to increased incidences of emotional distress for nurses related to the ongoing complex long-term chronic care needs of the older adult population (Barba, Hu, & Efird, 2012). The provision of care to the older population often encompasses end-of-life care which further increases the occurrence of emotional distress for nurses repeatedly exposed to this environment over long periods of time (Wenzel, Shaha, Klimmek, & Krumm, 2011). It was assumed that all nurses within the study do not have the same amount of

experience providing care for the geriatric behavioral health patients identified in the study. However, it was also assumed that the nurses working on the geriatric behavioral health unit has provided direct care to a geriatric patient. An assumption exists that a RN or LPN on the geriatric behavioral health unit may or may not experience CF differently. Assumedly, complete anonymity is a key factor in the ability to provide honest answers to the online survey accessible by the participant during their choice of time within the study timeframe.

Statement of the Problem

Nurses repeatedly give unconditional care to their patients, often without re-charging themselves, while repeatedly experiencing the pain, trauma, and suffering of their patients. The repeated exposure to the traumatic experiences of patients and not taking time for emotional and physical self-awareness can lead to the consequential problem of development of CF in nurses. The lack of early prevention, recognition, and intervention implementation of measures to prevent and manage CF can lead to the development of CF in nurses. Nurses who experience CF could affect healthcare organizations outcomes through lost productivity, decreased nurse retention, and diminished patient care excellence. Current research studies on the prevalence of CF, in nursing, have been focused on such settings as the emergency room, general psychiatry, oncology, critical care, hospice, pediatrics, and even within the military settings. However, there has been limited empirical research conducted on nurses who care for patients specifically in the geriatric population. A study of the prevalence of CF in nurses who care for the aging population within an inpatient psychiatric setting focused specifically on geriatrics can be a valuable addition to existing research.

Purpose of the Study

The purpose of this quantitative, descriptive research study was to identify the prevalence of CF in RN and LPN staff within an inpatient geriatric behavioral health unit setting in two comparably sized hospitals. The ProQOL v. 5 survey was used to measure CF in the voluntary study participants. The ProQOL v. 5 survey determines whether these geriatric behavioral health nurses experience the identified characteristics of CF. Recognizing the prevalence of CF experienced by the profession of nursing has the potential to increase awareness of CF, while potentially leading to the development of educational and supportive services to aid in the prevention and management of nurses experiencing CF.

Research Question

Do nurses experience CF on an inpatient geriatric behavioral health unit?

Limitations

Limitations of the study included generalizability due to the small sample size $N=18$. However, the sample consisted of nurses from two comparably-sized inpatient geriatric behavioral health units from two rural hospitals in Arkansas, which may potentially offset the small sample size. Demographic data that was not collected included the number of hours each nurse works per week and working part-time versus full-time. This data could impact the prevalence of CF from decreased time spent caring for the identified patient population. Study participant data were collected during a three-week timeframe versus collection during multiple timeframes. The study sample of inpatient geriatric behavioral health nurses may reflect a limitation in that the study results may not apply to nursing populations in other specialized or generalized areas.

Definition of Terms

Burnout stems from Freudenberger (1974), which defines a person's psychological health in the workplace with symptomatology examples representing a gradual inclination to indifference, cynicism, reduced personal accomplishments, and uncaring attitudes (Hayes, 2013). Measured within the study is the risk for burnout via the Professional Quality of Life Version 5 (ProQOL v.5) survey tool through the frequency of occurrence of the negative attributes associated with the provision of care to others. Higher scores of negative attributes reflect greater risks for burnout occurrences.

Compassion represents the emotional capacity and desire to help relieve the suffering of others through the giving of self-empathy/sympathy. In addition, compassion is ranked in numerous philosophies as a great virtue while being considered among the greatest of virtues in all major religious mores (Douglas, 2010). The frequency of incidence of positive caring attributes noted within the ProQOL v.5 survey study reveals the measurement of compassion.

Compassion Fatigue refers to the negative feelings of caregivers of being overwhelmed to the point of fearing the work of caregiving associated with providing care to clients who have experienced traumatic or extreme stressors (Stamm, 2010). Within the ProQOL v.5 survey used in the study, the two scales of BO and secondary traumatic stress signify the measure of CF.

Compassion Satisfaction encompasses the personal satisfaction a caregiver feels when able to perform in his/her role well (Stamm, 2010). The overall score of the positive, caring attributes of the ProQOL v.5 survey tool reflect a measure of compassion satisfaction for the participants of the study.

Empathy is being considerate of a situation from a patient's point of view which is achieved by actively listening and conveying understanding to the patient (Groves, 2014). Within the ProQOL v.5 survey, the incidence of empathy is measured by the frequency of occurrence of sympathetic attributes.

Geriatric Behavioral Health is a field of study which involves the diagnosis and treatment of the mental health older adults (Duke University School of Medicine, 2004-2015).

Health Promotion Behaviors refers to the adoption and promotion of behaviors aimed at self-care such as healthy living, exercise, adequate rest/relaxation, expressing emotions, and seeking supportive measures (Collins & Long, 2003).

Inpatient Geriatric Behavioral Health Unit refers to secure inpatient units in hospitals that provide acute comprehensive psychiatric evaluation and treatment for geriatric patients 50-60 years and older with all types of psychiatric illnesses.

Licensed Practical and Registered Nurses are licensed professionals guided by the scope and standards of practice by their respective state boards of nursing. Professional nurses within this study perform their roles in the domains of transferer of knowledge, scientist, educator, practitioner, leader, and in the less spoken of role of supporting patients and caregivers through fear, pain, and loss (Douglas, 2010). The nurses within the study represented the sample population of licensed professional healthcare providers who work within the identified inpatient geriatric behavioral health setting.

Secondary Traumatic Stress reflects an emotional response to distress or trauma defined by Stamm (2010) as the negative behaviors and emotions experienced by the caregiver from being exposed to client's traumatic experiences (Sheppard, 2014). This term is

often used interchangeably with the term CF in the literature. Secondary traumatic stress is measured within the study by noting the incidence frequency from the ProQOL v.5 survey, of the negative experiences of nurses associated with constant exposure to the physical or emotional suffering of others.

Vicarious Traumatization is a concept that was first introduced by McCann & Pearlman (1990), as a theoretical framework to aid in the understanding of the distressing and complex effects of therapists who work with victims of trauma (as cited in Collins & Long, 2003, p. 418). This term is often used interchangeably in literature with CF and secondary traumatic stress disorder.

Summary

This quantitative, descriptive research study was conducted to identify the prevalence of CF in nurses working within the inpatient geriatric behavioral health setting of two mid-sized rural hospitals. The prevalence of CF will be measured via the ProQOL v. 5 survey. The prevention and recognition of CF in nurses is becoming increasingly important with the projected increase in the older population with complex physical and psychological needs coupled with the ever-increasing need to retain competent compassionate nurses with the ability to provide quality care. Recognizing the prevalence of CF can be used to describe the associated emotional cost of the caring effects on the nurses themselves, their friends, family, colleagues, in the healthcare organizations where they work, and ultimately the very patients for whom they provide care. In essence, the importance of identifying CF in geriatric behavioral health nurses is of utmost importance especially during a shortage of nurses and a large scale of aging adults.

Chapter II: Literature Review

Introduction

This chapter begins with the discussion of the Modeling and Role Modeling (MRM) Theory that presents a sound theoretical conceptual framework for this study. The literature review will follow the introduction of the MRM Theory, which examines empirical research studies related to the effects of CF in nursing in three key areas. The three areas consist of a presentation and discussion of the research to better understand and define CF, the prevalence of CF within the profession of nursing, and research-based strategies that can be employed to aid in the prevention and management of CF in nursing.

Conceptual Framework

The aim of this study is to determine if nurses who care for hospitalized GBH patients are likely to experience CF relative to the commonly identified characteristics within the ProQOL version 5 realm as described by Stamm (2010). A sound theoretical framework is important to assist in building a comprehensive body of knowledge on which to serve as a model for the sample, hypotheses, and results of a research study (currentnursing.com, 2012).

In 1983, the MRM middle-range nursing theory was developed by Erickson, Tomlin, & Swain, 2013. It encompasses the synthesis of concepts from Maslow's Theory of Hierarchy of Needs, Seyle and Lazarus's General Adaptation Syndrome, Piaget's Theory of cognitive Development, and Erikson's Theory of Psychosocial Stages (Petiprin, 2016). According to Petiprin (2016), the benefits of the MRM theory enabled nurses to deliver focused nurturing and respectful care to clients while honoring and

understanding the uniqueness of each individual to assist in the achievement of optimal well-being. The Modeling and Role Modeling Theory (MRM) can serve as an effective theoretical perspective and conceptual framework for stress mediation applicable to both the individualized self-care level and at the organizational level. Therefore, the resultant stress mediation constructs in the form of evidence-based interventions, can be employed at the individual (self-care) or organizational level of nursing practice for the prevention, recognition, and management of CF.

According to Erikson, Tomlin, and Swain (2013), the MRM theory was based on the client's world perception and adaptability to stressors while considering a self-care based model of nursing. This was accomplished through the processes of Modeling and Role Modeling. The process of Modeling refers to developing an understanding of the clients world through or from the clients own unique perspective of stress adaptation. The healthcare organization and those in the environment of CF affected nurses would utilize this process in the development of understanding and image of the affected nurse's perspective of their world. The process of Role Modeling encompasses the planning and implementation of unique nursing interventions. These nursing interventions are aimed at nurturance with unconditional acceptance of the individual to promote, attain, and maintain health. Unconditional acceptance by who validates the client as the expert in regards to the best way to achieve optimal self-care (Petiprin, 2016).

Erickson et al. (2013) posited, MRM theory application is accomplished through three roles of nursing: (1) facilitation; (2) nurturance; and (3) unconditional acceptance. Facilitation is accomplished by assisting the CF affected nurse in taking steps toward health attainment through the provision of necessary information and resources for the

prevention and management of CF. From the organizational and/or personal level facilitation of information and resources, the CF affected nurse can self-choose the best course of action to reduce stressors and employ adaptation strategies. Basic needs must be met before personal growth can occur (Burtson & Stichler, 2010). Henry (2014) claimed the availability of a confidential organizational employee assistance program (EAP) represents one example of a great place for the CF affected nurse to seek guidance on the self-management of CF, which leads to the next theoretical nursing role of nurturing.

Nurturing is the process of care and comfort provision to the CF affected nurse (Petiprin, 2016). Nurses generally nurture others prior to seeking or self-nurturing themselves in their attempt of trying to meet the needs of all the people in their environment. Over time, this constant giving of self without replenishment can lead to self-deficits manifesting as CF from a combination of emotional, spiritual, and physical depletion. This equates to apathy in the affected nurse's environment from the physical distress and emotional pain (Coetzee & Klopper, 2010).

The nurse is unconditionally accepted just as he/she is in the third step of the three main roles of the MRM theory of nursing model (Erickson et al., 2013). According to Petiprin (2016), unconditional acceptance reflects holism wherein people represent the sum of their parts in functioning consciously and unconsciously as one unit. This dynamic, equally important interaction with one another encompasses the mind, spirit, emotion, and body as one unit that controls and affects the interactions with others (Petiprin, 2016).

The MRM theory defines five goals of nursing interventions which include: (1) to build trust; (2) to promote positive orientation of the client; (3) to promote the client's control; (4) to promote and affirm the client's strengths; and (5) to set health-directed mutual goals (Erickson et al., 2013). The MRM theory can be used as a nursing model to aid in the development of sound evidence-based interventions aimed at social support on both the professional and personal level for the CF affected nurse. Optimal interventions must include tactics to form trust, promote positivity, provide and encourage self-management. These interventions must be tailored to meet the nurse's strengths, and incorporate mutual health promotion goals (Petiprin, 2016).

For the CF affected nurse, adequate social support is inherent in the provision of personal and professional resources directed at self-care, well-being, self-worth, and stress management (Lombardo & Eyre, 2011). Zangaro and Soeken (2007) cited job stress as the strongest predictor of nurses' intent to leave because of job dissatisfaction (as cited in Paris & Terhaar, 2011, p. 1). Additional causes for nurse job stress in the hospital setting were work schedules, patient acuity, poor nurse-physician interactions, new technology, staff shortages, lack of meal or non-meal breaks, and evolving new technology (Barkin, 2007). Contrastingly, a healthy practice environment with engaged nurses who employ the use of sound evidence-based interventions in their practice, represent favorable nurse-staffing levels as well as optimal possible favorable patient outcomes (Aycock & Boyle, 2009; Paris & Terhaar, 2011).

Current ongoing economic constraints in the arena of the healthcare environment, continues to trickle down to manifest as increasing demands and complexities on patient care. Healthcare organizations must maintain financial viability while balancing patient

advocacy and patient satisfaction (Douglas, 2010). More of the focus has moved to the care of the patient within the community setting, thus leaving the sickest of the sick patients in the acute care hospital environment. Regardless of the healthcare setting, more emotional stress has been placed on caregiver's in the role of nursing attributable to the economy and the increased longevity of the aging population. Without attention to self-care needs, the increased emotional stress experienced by nurses can influence empathy to change to apathy, which may indicate the progression of burnout to CF. With the aid of the MRM theory as a conceptual framework, healthcare organizations and nurses should seek and develop a model of self-care health promotion aimed at recognition, prevention, and management of stress-related desensitization. This could ultimately lead to the culmination of CF in the presence of inadequate intervention.

Review of the Literature

The literature review will address three areas of research related to CF in nursing. In the first section, research related to understanding and defining CF will be addressed. In the second section, there will be a discussion on the prevalence of CF within the profession of nursing. Finally, the last section will focus on research-based strategies that can be employed to aid in the prevention and management of CF in nursing.

CF is a concept that was first recognized over twenty-five years ago. In existing literature, the term CF, is often used interchangeably with other terms such as secondary traumatic stress disorder (STS), vicarious victimization, and even burnout (BO) (Sabo, 2011). Regardless of the term used, CF represents the loss of the ability to care, or apathy, by those in the helping or caregiver roles (Coetzee & Klopper, 2010).

Boyle (2011) claimed that compassion towards others involves emotional feelings by the caregiver guided at removing the pain and suffering of those in their care. CF is referred to as the cost of caring being attributed to the repeated suffering, pain, and trauma of others resulting in a psychic exhaustion state (Boyle, 2011). The literature shows the common characteristics of CF which depict physical, emotional, social, and spiritual effects on nurses regardless of the setting. This includes specialized areas such as end-of-life care or in a generalized area that involves repeated exposure to the trauma, pain and suffering of others (Coetzee & Klopper, 2010). Sabo (2011) found nurses who work in some specialty practice areas (such as mental health, intensive care, pediatrics, and oncology) have been found to be more vulnerable to emotional stress in the workplace. The same holds true for a lack of organizational support for nurses at the bedside in the provision of care and in the provision of personal/professional resources to prevent and manage CF in nurses, which can ultimately lead to a healthy life balance (Groves, 2014; Schroeter, 2014).

Delineating Compassion Fatigue

In any research study, defining the problem area in its current state is the crucial first step. In this research study, describing the most current concepts of CF are important as there is a continuing gap in existing literature of a formally recognized definition of CF. This lack of clarity adds to the use of the concept interchangeably with other similar yet different terms such as BO, STS, and vicarious traumatization (Boyle, 2011). Three research articles will be presented to exemplify the most current delineation of CF as it is commonly utilized today. The first presentation represents a concept

analysis that remains applicable today even though the information was first presented in 2010. The second research study represents a systematic literature review to define CF from a military perspective. The third research study presents the results of a qualitative study of the perceptions of clinical oncology nurses in Canada. Those results were used to define CF.

Coetzee and Kloppe's (2010) concept analysis focused on relating, exploring, and clarifying CF within the realm of nursing to enable nurses in identifying and combating the effects of CF on nursing practice. The Walker and Avant (2005) method was used as the concept analysis framework (as cited in Coetzee & Kloppe, 2010, p. 235). Data collection involved dictionary, journal, book, theses, and dissertations sources for the timeframe beginning in 1992 (CF first introduced) to 2007. Articles were excluded related to natural disasters and war situations.

The end result of CF stems from a cumulative and progressive three-step process from stress exposure caused by the use of self in intense, prolonged, and continuous patient contact (Coetzee & Kloppe, 2010). Each process entails physical, emotional, social, spiritual, and intellectual effects on the affected nurse. Compassion discomfort is the first step which is viewed as temporary and can be relieved by self-rest. This step entails the effects of weariness, decreased enthusiasm and ability, desensitization, inability to aid, decreased perception, and increasing inattention. Compassion stress is the second step, where the nurse has decreased endurance levels and increased stress levels. Effects of this step on the affected nurse are portrayed as reduced work output and performance, loss of strength and endurance, increased physical ailment complaints, irritability, feeling emotionally overwhelmed, unable to share in suffering, lack of

spiritual awareness, inability to concentrate, and boredom. Unrelieved compassion stress will ultimately lead to the final step of CF. Nurses with CF display the inability to recover where the expenditure of energy outstrips the restorative process. Empirical indicators of nurses in the CF state showed the effects of BO, total lack of energy, accident-proneness, apathy, breakdown symptomatology, strong desire to quit, indifferent, callous, unresponsiveness, impaired judgement, introspection disinterest, and disorderliness (Coatzee & Klopper, 2010).

The resultant practice implications showed the importance of effacing CF in its early stages to attempt self-restoration to a compassionately functioning nurse before it is too late. Coatzee and Klopper (2010) stressed the importance of informing nurses regarding the causes and risk factors that lead to CF development. Recommendations included the development of peer support networks while supporting the use of employee assistance programs. Education concerning CF prevention, risk factors, and causes should begin with nursing students to assist in recognizing CF in the nursing environment, as well as knowing how to avert the occurrence of CF later when functioning as an employed compassionate nurse. Research suggestions entailed the development of a reliable accurate measure for CF in addition to CF theory development for the practice of nursing that could potentially be utilized in other general human service professions (Coatzee & Klopper, 2010).

Peterson-Owen and Wanzer (2014) performed an integrative review within military healthcare teams with the purpose of delineating a uniform definition of CF that could be applied to optimal recognition and development of interventions to prevent and manage CF in the environment of military healthcare. This study was conducted due to

the ongoing lack of recognition of a universally accepted definition for CF. The systematic review for the study involved searching five databases for studies comprised of CF in military healthcare providers during the years comprised of 2009 to 2013. The conceptual framework for systematic integrative review data analysis was Bibb and Wanzer's (2008) identifying, organizing, and synthesizing (IOS) approach. Bandura's (1997) Social Cognitive Theory was used as the model of theory to serve as the underpinning to why CF can occur in this population setting while the development of a universal CF definition can assist with the future development of CF interventions. The hierarchy of evidence rating system by Fineout-Overholt et al. (2010) was used in the study to rate data from highest to weakest literature commonalities and gaps in military healthcare teams. Inclusion and exclusion criteria resulted in 18 articles for integrative review (Peterson-Owen & Wanzer, 2014).

The results indicated the lack of a consistent conceptual definition of CF with the continued interchangeable use of terms, perceptions, and ideas. Thirty concept terms resulted from the descriptions of CF phenomena, which were then categorized into seven main themes as a result of latent content analysis. These themes were identified as: "(1) occupational hazard, (2) psychological distress, (3) sense of helplessness, (4) fear, (5) loss of purpose, (6) empathy, and (7) inability to recognize own needs" (Peterson-Owen & Wanzer, 2014, p. 6). The two most common themes of psychological distress and occupational hazard were descriptively linked to over 75% of the reviewed literature. Thus, these two themes were identified as vital in describing CF, while the remaining five themes added to the CF definition significance.

Peterson-Owen and Wanzer (2014) further described the seven identified themes. Occupational hazard was described as a risk to mental or physical well-being as an element of caregiving professions with repeated exposure to trauma. Further occupational hazard stemmed from the relationship that developed between nurses and patients wherein the nurse empathized with the patient's suffering, as if the nurse was actually in the combat zone. The highly stressful and chaotic work environment represents the third component of the occupational hazard. Psychological distress was defined as the negative emotional state which included symptoms of anxiety and depression. The repeated exposure to the medical and psychological trauma experience of patients were often found to have long-lasting effects on caregivers. Empathy in military healthcare providers was described as being able to respond with compassion to the emotions of patients. Lack of empathy was associated with being unable to provide effective treatment. In contrast, too much empathy was associated with giving too much of the self which could lead to CF. The sense of helplessness related to the caregivers' feelings of weakness, dependence, and utter helplessness in handling emotional situations. Fear is described as a concept wherein a perceived threat is triggered by an emotion. This aspect of CF is associated with the caregiver internalizing the negative feelings of patient trauma, which may lead the affected nurse to believe it is his/her own trauma experience. The theme of loss of purpose described when the caregiver feels the lack of a purpose in life. The inability to recognize one's own emotional and physical needs occurs after repeated exposure to increased unrelieved stress. The proposed definition describes CF as an occupational hazard with the defining attributes of fear, empathy, sense of helplessness, inability to recognize the need of self, and loss of

purpose that all result in causing psychological distress (Peterson-Owen & Wanzer, 2014). Peterson-Owen and Wanzer (2014) posited a clear CF definition is paramount in preventing and managing CF. Additionally, a standard CF definition can lead to improvements in the well-being of healthcare providers through the promotion of healthy work environments where clinical errors could be reduced, quality of care could be improved, and team member retention could be supported (Peterson-Owen & Wanzer, 2014).

Many patients in an acute GBH environment often suffer dementia and other behavioral disorders. Many of these patients may revert to re-living traumatic events in their younger lives. For example, this may equate to serving in wars, police departments, concentration camps, slavery, state mental hospitals, or suffering immense physical and/or psychological trauma in their youth or early adulthood lives. Physically, patients in acute GBH settings may have concomitant trauma injuries from falls, a myriad of other potential health problems, and even possibly from self-inflicted trauma. Nurses within the acute GBH environment may potentially be at an increased risk related to the repeated exposure of the previous traumas experienced by this patient population. Moreover, acute care GBH patients are often in their final stage of life which further adds to nurse exposure to stress in this environment. With limited studies on the experience of CF in nurses who care for this client population, studies on military healthcare teams could potentially be helpful to caregivers of acute GBH patients.

Perry, Toffner, Merrick, and Dalton (2011) conducted a descriptive exploratory qualitative study with the goal of forming a conceptual CF definition from the occupational experiences of clinical oncology nurses in Canada. The purpose of their

study was to determine the perceptions of CF by clinical oncology RN's in Canada. The study participants ($N=19$) were selected with the inclusion criteria consisting of having experienced CF as defined by LaRowe (2005), English or French communication ability, internet access, and current employment as a clinical oncology nurse. The online questionnaire was in a narrative format comprised of narrative descriptions of participants' personal experience with CF. Resultant data was analyzed by reading and re-reading of participant responses by the research team which led to the formation of five major themes: (1) defining CF, (2) causes of CF, (3) factors that worsen CF, (4) outcomes of CF, and (5) circumstances that lessen CF (Perry et al., 2011).

In-depth descriptions of the five themes were presented by Perry et al. (2011). In theme one, participants defined CF while reporting a lack of knowledge of the term or meaning of CF. Theme two presented the causes of CF to be related to lack of support, lack of time or ability to deliver high quality care, and again a lack of knowledge regarding CF. The lack of support stemmed from the onset of CF from administration, peers, and colleagues from other disciplines. The time limitations to deliver high quality care was attributed to the feeling of not enough time to develop a strong connection with the patient and his/her family. The deficient CF knowledge was viewed by the nurses as a cause of CF. They felt as if they had known more about experiencing CF prior to CF development, they could have prevented and/or managed CF sooner (Perry et al., 2011).

In theme three, Perry et al. (2011) reported that respondents described factors that worsened CF as excessive emotional attachment and involvement, inability to ease suffering, and co-existing emotional and physical stresses. Nurses felt in a heightened CF state with feelings of helplessness to relieve the suffering of patient's. Home-life

stressors contributed to feeling of increased levels of CF. The emotional connection or bond between nurses and their patients and families can be severely impaired. Theme four presents the outcomes of CF as nurses considering leaving the profession, personal relationships negatively affected, and intense fatigue. One of the respondents felt CF was responsible for her divorce. Several respondents felt that changing nursing roles would not stop the CF (Perry et al., 2011).

Perry et al. (2011) report theme five represents factors responsible for lessening the effects of CF such as work-life balance, colleague support, acknowledgement, connecting with others, and experience and maturity. Work-life balance or self-care was important to manage stress while aiding with keeping a perspective to prevent feeling overwhelmed. Colleague support provided feelings of teamwork and caring towards each other. Coaching was described as being important especially in the prevention of CF in newer nurses. Acknowledgement comes in many forms to show appreciation such as smiles, positive words or encouragement, thank you cards, and other notes of appreciation. Connecting with others represented the bond between the nurse, patient, and family. This connectedness was reported as minimizing or preventive of CF. The gaining of work experience and maturity over time helped nurses to learn interventions and techniques that helped and alleviate patient suffering, while making themselves less vulnerable to CF (Perry et al., 2011).

Implications of the study reported that all respondents found a way to cope with CF. The importance of more education was stressed as preventing and recognizing early risk for CF for optimal management of CF. The development of programs for mentorship, role models, and preceptorship geared toward management and discussion of

difficult patient situations was important in promoting teamwork while providing collegial support. Most importantly, feelings of helplessness or aloneness were identified as common risk factors for CF development. The promotion of an environmental culture of banding together to manage patient suffering as a supportive team, can decrease CF tendencies. Finally, Perry et al. (2011) recommended further research in addressing emotional involvement in the arenas of nursing orientation and ongoing professional development. The relevance of the aforementioned study to nurses who care for any patient population such as inpatient GBH patients is important, as the study shows how a conceptual definition of CF can be formed from the lived experiences of clinical nurses who are repeatedly exposed to suffering of others.

The research literature indicated the definitive need for further research regarding a more universal conceptual representation of the defining characteristics and risk factors associated with CF for all areas of those in helping professions. Commonalities for CF exist in the three presented studies (Coatzee & Klopper, 2010; Perry et al., 2011; & Peterson-Owen & Wanzer, 2014). CF represents caregiver stress as the end result of repeated exposure to internalizing the suffering of others with a lack in the ability to maintain an effective life-work balance (Perry et al., 2011). The promotion of a professional cultural change for CF prevention and management dialogue is important to facilitate the concept of togetherness and collegial support, instead of suffering silently in the inability to deliver compassionate care from feelings of despair and hopelessness. A study on the prevalence of CF in the arena of nurses who deliver care in the highly specialized area of inpatient GBH represents a significant addition to existing empirical research.

Prevalence of Compassion Fatigue in Nursing

Over the last seven years, the prevalence of CF in nursing has received more attention in empirical research studies for a myriad of reasons. The importance of attracting and keeping highly-skilled experienced nurses has become increasingly important for healthcare organizations to survive in the current trend of closer scrutiny. A few of the reasons can be attributed to the rising nursing shortage, quest for Magnet recognition, increased focus on evidence-based care provision, and ongoing economic constraints. This has become increasingly dependent on core measure/quality indicator compliance to receive reimbursement for care, as well as encourage patients to select such care (Wenzel et al., 2011; Burtson & Stichler, 2010; Potter et al., 2010; and Paris & Terhaar, 2011). CF in nursing was first thought to be more prevalent in specialized high-stress care areas such as emergency rooms, critical care, hospice care, and oncology units (Lombardo & Eyre, 2011). Empirical research studies in CF and CS in acute care nurses have begun to emerge and discern the prevalence of CF and CS as occurring in other patient care environments such as medical-surgical units, critical care areas, across other patient care areas in a healthcare organization, and even in the educational setting. According to Stamm (2010) CF represented the negative aspects of a person's professional quality of life (ProQOL) whereas CS represents the positive aspects of the person's ProQOL in which an adequate balance is needed for optimal work-life balance to occur.

A research study by Kelly, Runge, and Spencer (2015) proposed to discover and report the prevalence of CF and CS in acute care nurses across multiple specialty areas in the setting of a large hospital. In the study, CF is the term used to designate the

combination of STS and burnout. STS represents the anxiety, pressure, and other feelings of negativity that are possible from caring for patients who have experienced direct trauma exposure. Stamm (2010) claimed the term of “secondary” refers to not experiencing the traumatic event first-hand, which accounts for the relationship that occurs when the caregiver interacts with the suffering of the patient. The continuous, prolonged, and intense nurse/patient contact interaction of the patient’s going through stressful life changes can potentially lead to CF formation in nurses (Coetzee & Klopper, 2010; Stamm, 2010). Maslach, Schaufeli, & Leiter (2001) contended BO is comprised of three paradigms: (1) diminishing one’s personal accomplishments, (2) depersonalization, and (3) emotional exhaustion (Kelly et al., 2015).

Kelly et al. (2015) performed a cross-sectional, quantitative, survey research study to assess CS and CF over a 3-week period in May 2013, in the setting of a 700-bed, Magnet recognized, quaternary care teaching hospital in the southwestern U.S. The sample for the voluntary research study consisted of 491 per diem, part-time, or full-time direct care RN’s on their representative patient care unit for at least three months. Exclusion criteria were nurses who worked in outpatient settings or worked in education, leadership, or advance care roles. Demographic information of the respondents represented a mean age of 39.3 years, 11.3 average years of nursing experience, a mean of six years of tenure on units, a mean average of 36.3 hours worked per week, 88.6% were female, 93.1% worked full-time, and 60.7% worked day shift. Education demographic characteristics showed 3.9% at the diploma level, 39.3% at the associate level, 53.2% at bachelor’s level, and 3.7% at master’s or higher degrees. DAISY award recognition had been received by 25.3% of the nurses. According to Kelly et al. (2015),

the DAISY award is a formal recognition awarded to nurses for their extraordinary contributions within the profession of nursing. The percentage of nurses who reported they were highly satisfied was 77.1%, while 14.9% of nurses indicated the intent to leave their current position within the next year (Kelly et al., 2015).

The electronic survey, completed by secure non-identifiable email, consisted of the aforementioned demographic data, the Professional Quality of Life Scale (ProQOL v. 5; Stamm, 2010), and questions derived from the investigators which asked respondents about their work status, job satisfaction, intent to leave their current position within the next year, receipt of meaningful recognition (DAISY award), and about their professional backgrounds. Results were reported above. Reminders emails were sent to participants on days 7, 14, and 21 of the survey. At the close of the survey respondents were directed to a secure email address obtained immediately after survey completion to register to win in a raffle drawing for an electronic tablet. The response rate was 35% and respondents represented 25 hospital units, which were not specifically listed in the study (Kelly et al, 2015).

Data analysis was accomplished by assigning frequencies to the demographic data. The ProQOL subscales for burnout, STS, and CS, were reverse scored and averaged. The age demographic was further divided into three generational categories: Millennials represented age 21-33, “Generation X” represented age 34-49 years, and “Baby Boomers” represented age 50-65 years. ProQOL score differences between specialties and generations were analyzed using analysis of variance (ANOVA). Regression analysis was performed on individual nurse characteristics and ProQOL subscale scores. Univariate analysis was initially employed to determine significance of

nurse demographics, intent to leave, and satisfaction on the three outcome variables of BO, STS, and CS separately (Kelly et al., 2015).

The results indicated that nurses in the study were in the normal range for CS and BO while the lower range represented the risk for STS. Respondents who had received a DAISY nomination were in the range of lower risk of CF and higher CS. Unique differences were noted in the age and experience range of nurses. The “Millennial” generation nurses were more likely at risk for burnout and STS and lower levels of CS than the other two generational counterparts. The study found the nurses with longer experience reported higher CF and lower CS (Kelly et al., 2015).

The study concluded that nurses will continue to feel the burden with the continued rise in the complexity of healthcare leading to decreased CS and increased CF (Kelly et al., 2015). Further, the study showed that meaningful recognition is important to increase satisfaction while decreasing the risk for CF. Alarming, the study found younger nurses may potentially leave their position or the profession of nursing altogether from the prevalence of experiencing STS and BO. Study implications included the recommendation of healthcare organizations to promote the quality of their workforce and nurse retention through actively addressing CS and CF in nurses from all nursing arenas (Kelly et al., 2015).

Sacco, Ciurzynski, Harvey, and Ingersoll (2015) performed a cross-sectional study to determine the prevalence of CS and CF in intensive care unit (ICU) nurses in adult, neonatal, and pediatric critical care settings in a 739-bed tertiary care Magnet-designated academic hospital in western New York in late 2010. The secondary aim was to determine if certain demographics and organizational characteristics potentially

affected CS and CF in this sample nursing arena. The nursing sample consisted of full-time, part-time, or per diem clinical RN's and LPN's working in one of nine targeted units. The nine targeted units consisted of mixed-acuity units (general care, progressive care, or intensive care patients in the same unit) and single-acuity units (only ICU patients). The units consisted of three adult ICU's (medical, surgical, and cardiovascular), three adult mixed progressive care and ICU's (PCU's; 1 medical and 2 surgical), one pediatric ICU (PICU), one mixed-acuity pediatric unit (general care patients, ICU, and PCU), and one neonatal ICU (NICU). Demographic data ascertained included educational level, age, sex, acuity, change in nursing management, unit, and major systems change.

Respondents were asked to voluntarily complete an anonymous survey which consisted of demographics and the ProQOL v. 5 questionnaire. Participants were directed to access the survey via an external secure link provided to them via inter-organizational email. Nurses were sent a reminder email two weeks later. Nurses could receive a \$2.50 beverage coupon certificate from an accessible platform upon survey completion. Data was analyzed using SPSS, version 17.0 software. The response rate was 38% or 221. The highest percentages (30%) of nurses were neonatal nurses with pediatric ICU's being the next highest (16%). The majority of respondents were female (94.6%) while 71% had bachelor's degrees. The results showed critical care nurses scored within the average range for all three subscales which showed a balance in the positive and negative aspects of the ProQOL. This reflected positively for the organization as differences between units were not significant thus, reflecting the appearance of a healthy work milieu. The most significant finding was that nurses 50

years and older reflected higher CS scores with lower STS and burnout scores than did younger nurses. This may signify older nurses are more equipped to handle critical care nursing challenges from life and professional experiences (Sacco et al., 2015). Lower CS scores were found in nurses with bachelor's degrees. A suggested explanation for this was perhaps these nurses were transitioning in and just finishing their degree, or were in pursuance of a higher degree (Sacco et al., 2015). The study lists significant differences in the CS and CF scores for male nurses although the data was not included. Men represented five percent of respondents which was presented as needing a further study with a larger sample of men to determine the degree of significance.

Sacco et al., (2015) reported concerning system or organizational factors where nurses reported lower CS scores and higher BO scores if they worked on a unit that had a managerial change within the last year. This suggested CS is greater with more stable and/or supportive leadership. The single-acuity units scored better than the mixed-acuity units. However, the mixed-acuity units were new units started within the year of the study which was reported to possibly explaining the result significance.

The research study concluded by stating how a CS and CF assessment can be used to show the existence of a positive work environment. A suggestion was made to perform a future study on the relationship between organizational structure and work characteristics to determine the relative significance of the CS and CF results as determined within the study. Lastly, the day-to-day patient acuity levels were suggested as possibly affecting the outcomes of the study which suggested implementing interventions aimed at modifying factors that could remove obstacles to influence nurses in this arena (Sacco et al., 2015).

Smart et al. (2013) conducted a cross-sectional survey study of 139 healthcare providers including physicians, clinical nurses, and certified nursing assistants (CNA's), working in ICU's, emergency department (ED), the float pool, and the general medical-surgical unit of a 250-bed Magnet-designated community-owned hospital in the northwestern U. S. The primary purpose of the study was to determine the prevalence of CS and CF within the organization, while identifying factors to improve the professional quality of life aspects. The survey consisted of the ProQOL v. 5 questionnaire, along with demographic, environmental, and health behavior questions to determine the relationships between areas such as shift rotations, sleep habits, marital status, years in the profession, and education level. The overall response rate was 54.9% with nurses representing the majority of respondents.

The survey was self-administered in a paper or online format depending on respondent preference. One month was allowed for survey timeframe, while the researchers made weekly rounds on the participating units to collect surveys and invite participation during August 2010. The resultant data was analyzed via the SPSS version 17.0 software, while ANOVA was used to determine group mean scores of ProQOL scores by work unit. The majority of respondents (63.3%) were RN's who worked less than 40 hours per week (85.5%) with a spouse or partner in the home (77%). The units with higher participation were the ED (31.3%) and the float pool (30.6%). The average length of experience in their profession was 12.2 years and the mean length of time employed within the organizations was 7.2 years. The reported rate of aerobic physical activity three to four times/week was 33.3% while 43.5% reported exercise one to two

times/week. The average hours of sleep per night were 6.5 to 7 hours (43.3%) (Smart et al., 2013).

The study findings suggested respondents from ICU and ED experienced significantly less BO than those on the general medical unit. Overall, the study found an average of more favorable scores for BO, STS, and CS. Study participants who worked the night shift reported lower CS and higher BO scores. Study limitations included a small sample size, 96% Caucasian, with the majority of surveys completed at work. In comparing the surveys completed outside of work with the surveys completed in the organization, it was determined the at-home completed surveys reflected slightly higher BO and lower CS scores. Smart et al. (2013) concluded the ICU environment may condition healthcare providers toward experiencing less factors that contributed to CF. Future research is recommended for strategies to increase rest and sleep. Organizational efforts aimed at strengthening the professional quality of life for healthcare providers will likely help in bearing the weight of suffering of their patients (Smart et al., 2013).

Sheppard (2014), a psychiatric mental health nurse practitioner, was concerned about the number of nurses leaving the profession soon after obtaining a terminal degree, as well as an increase in the amount of patients in mental health practice who self-identified as former nurses. This led to the conduction of a concept development study with the goal of increased understanding and recognition of CF in nurses. The field phase of the qualitative study involved phenomenological interviews of 16 RN's in a level-1 trauma center. Every qualitative interview began with the same open-ended question: "What can you tell me about CF?" (Sheppard, 2014, p. 58). Additional questions were guided from respondent responses to clarify, query, or prompt feelings

connected with the descriptive answers. The ascertained responses mirrored similar descriptions of ProQOL concept model proposals. Participants reported BO and STS experiences which resulted in lower CS. Interestingly, none of the participants believed BO contributed to experiencing CF as BO was equated as being accepted as the norm. Thematic analysis led to the discovery of four additional trepidations: (1) life is unfair, (2) endless suffering, (3) unable to let go and, (4) wanting support but pushing away (Sheppard, 2014). The belief that life is unfair equates to feeling that negative things happen to innocent or good people more frequently, whereas people who do not take care of themselves appear to keep receiving more chances at life. The theme of endless suffering, involved feeling powerless to help those with repeated suffering, causing feelings of loss in hope. The theme of unable to let go, described the continued emotional attachment for some patients that lead nurses to skip lunch, stay late, call to check on the patient on days off, or the feeling of emotionally working 24/7. Participants described wanting to talk to someone with concerns of experiencing CF, but felt doing such would be stigmatizing or shameful. Sheppard (2014) concluded further research was needed to develop a new concept model for CF in nursing.

Additionally, Sheppard (2014) found that many of the participants stated a desire to become nurse practitioners in an attempt to escape further emotional draining. This led Sheppard (2014) to the conduction of a second study with the purpose of determining if nurse practitioner students experienced CF. Fifty-nine second year doctor of nursing practice students were voluntarily surveyed utilizing the ProQOL model concept guide. Additionally, respondents were asked to partake in a 10-week program that consisted of weekly completion of learning modules via internet. The modules consisted of learning

about CF triggers, symptoms, mindfulness, and protective factors (Sheppard, 2014). Participants were also asked to maintain a weekly journal to record emotional trigger responses.

Strikingly, the study results showed moderate to high levels of STS (74%) and burnout (81%). At the same time, participants showed moderate to high levels of CS (71%). None of the participants withdrew from the study early, even though they were advised they could withdraw at any time. Moreover, participants were asked to write in their journals a minimum of three paragraphs per week. Yet, the majority of participants were writing one to two pages halfway through the program. Coincidentally, the graphic detail of the journals reflected the thematic descriptions provided by the nurses in the first study. The study did not mention if the nursing students were employed in patient care areas, which may potentially have affected the study results. Again, Sheppard (2014) recommended the development of a reformulated concept model for CF, as well as the implementation of strategies to eliminate the stigma surrounding recognizing and seeking help for CF emotions.

The research literature indicated the prevalence of CF in nursing varies in all units of nursing instead of existing primarily in specialty areas where exposure to traumatic events of patients would be expected to be greater. The prevalence of the existence of CF in younger generation nurses is troubling, especially with the aging workforce and projected ever-increasing nursing shortage. The stigma surrounding CF continues to be a problem as reported in the literature. It is imperative for healthcare organizations to implement education and interventions aimed at the prevention and management of CF in

nursing for the immediate and future impetus of enabling optimal self-care in nurses to be able to provide the very best patient care.

Prevention and Management of Compassion Fatigue in Nursing

Over the recent few years, there has been a marked increase in research dedicated to the prevention and management of traumatic stress that can ultimately lead to the formation of CF, if not effectively identified and managed prior to CF development (Potter et al., 2010). Identification and implementation of self-care educational and work support strategies should be employed in the work environment to help foster a decrease in the emotional cost of caring that may result in emotional and physical exhaustion leading to CF and BO in nurses (Aycock & Boyle, 2009). In an era of increased healthcare organizational scrutiny, the delivery of compassionate care is paramount for the healthcare provider whether at the bedside or at the organizational level.

Hunsaker, Chen, Maughan, and Heaston (2015) conducted a descriptive study aimed at two goals. The first study purpose was to identify the prevalence of CF, BO, and CS in ED nurses throughout the U. S. The second purpose of the study was to determine work-related and demographic components that lead to the development of CF, CS, and BO in this area of nursing. One thousand Emergency Nurses Association (ENA) members were mailed surveys to achieve purposive sampling of RN's who worked in a clinical role at least eight hours per week for a year or more in an ED setting. The final sample was comprised of 278 ED nurses with a response rate of 28%. The survey tool was the ProQOL v. 5 questionnaire. Demographic characteristics were collected which included shift worked (12 hour or 77.2%) sex (87.4% female), ethnicity (89.2% white), marital status (married, 68.3%), age (mean 44 years), educational level (diploma level,

30.9%, bachelor's degree, 49.3%, and MSN/doctoral degree 19.8%), length of time as an ED nurse (mean 13.01 years), and length of time working as a nurse (1 to 48 years, mean 17.58 years). Data analysis was accomplished through the use of SPSS, version 21.0 software with ANOVA employed for the demographic data analysis.

The results of the study determined 65.9% of the ED nurses were in the low level of CF, 54.1% were in the average level of BO, and 56.8% were in the average level of CS. Moreover, it was discovered that older nurses had higher CS levels while younger nurses had higher BO scores. No significant differences were found between male and female nurses. In addition, no significant differences were reported in regards to CF when examining the educational levels of the nurses. However, it was noted that higher CS and lower BO levels were more prominent in nurses with MSN/doctoral degrees than diploma or bachelor's level nurses. Nurses who worked 12 hour shifts had higher burnout and lower CS scores than nurses working 8 or 10 hour shifts. Higher levels of CS and lower levels of CF and BO were reported in nurses with the perception of managerial support.

Therefore, Hunsaker et al. (2015) recommended formal mentorship pairing of newer nurses with more established nurses, hiring more experienced nurses with higher educational backgrounds, utilizing shorter shift lengths, and more involved managerial support to influence a positive work environment to lead to more satisfied nurses. Positive professional managerial support cognizant of nurses at higher risk for CF and BO are imperative in creating a successful, strong, supportive, and compassionate professional practice environment for nurses in order to retain and recruit caring, knowledgeable, and experienced nurses (Hunsaker et al., 2015).

The study limitations were a small sample size with a low response rate. There was also the possibility that perspective respondents may have chosen not to participate if they felt the topic was not pertinent to them. The results may not have been generalizable to all ED nurses as a number of nurses were not members of the ENA. Another limitation was the study data was measured at one point in time, which may not accurately reflect CF perceptions over time related to changing work related conditions. Hunsaker et al. (2015) suggested further research is needed to develop programs to help nurses care for difficult patients, examine coping strategies to prevent and manage CF and BO. Further recommendations include determining if older more experienced nurses in other areas of nursing could be the key in mentoring newer younger nurses in strategies to prevent BO and CF. This could be done through teaching them how to improve their quality of life-work balance at home and in the professional practice environment (Hunsaker et al., 2015).

Berg, Harshbarger, Ahlers-Schmidt, and Lippoldt (2016) performed a qualitative study using a focus group to collect data to identify coping strategies, related stress triggers, and measure CF in a trauma team at a Midwestern Level 1 trauma center. The 12 participants included a trauma surgeon, social worker, physical therapist, three physician assistants, and six nurses. Eighty-three percent of the sample group was Caucasian, 16.7% Hispanic/Latino, 66.7% were female, 50% were nurses, and 83.3% were over 40 years old. Three assessment tools were used to conduct the study. The first measurement tool consisted of the Holmes-Rahe Life and Stress Inventory (Holmes & Rahe, 1967) which consists of a 43-item scale used to measure how illness is affected by stressful life events. The second measuring tool was the ProQOL (Stamm, 2010) which

measures CF, CS, and burnout. The focused interviews were 1.5 hours in length conducted by a trained facilitator. Voluntary participants were asked about CS, CF, STS, self-care coping mechanisms, STS education, and availability of organizational resources. Due to the sensitive nature of the content, a chaplain was available following the focused-group interviews for possible debriefing needs. Demographic data collection consisted of items related to sex, ethnicity, age, professional expertise, and religion. After the study was completed, data was summarized using frequencies (percentages) for categorical data while means (standard deviation) was used to summarize interval data.

The results indicated 58.3% stated no substantial problems in the Holmes-Rahe Life and Stress Inventory while 41.7% reported stress levels as mild. There were no reports of major or moderate stress. Concerning the individual ProQOL, 25% indicated moderate BO while 33.3% scored a combination of high BO and low CS. Seventy-five percent of respondents indicated high STS (25%) or moderate STS (50%). Regarding the group ProQOL scores, 16.7% were reflected at high risk for BO, nearly half (42%) were identified as being in the risk category, and 25% were identified as feeling useless in the job, overwhelmed, or distressed. The study did not list the scores separated into the different professions.

The transcription analysis listed positive aspects of being on the trauma team as prideful, cohesive, and striving for perfection. Respondents identified geriatric and pediatric abuse trauma victims as stress triggers. Trauma's involving multiple family members (especially if several family members died) and the perception of failure as a cohesive team were further identified as stress triggers by the participants. A variety of physical and emotional stress symptoms were reported by the group such as flashback

memories of graphically disturbing trauma cases that went horribly or exceptionally well, nightmares, and re-assessing clinical decisions. Hypervigilance of children, self, or family members were reported by the participating trauma team members. Respondents reported the occurrence of CF was infrequent. However, there were several differences identified in the stress coping strategies of respondents. Respondent's stated formal education regarding stressful coping strategies were non-existent. The majority of participants reported an awareness of organizational options, but felt unwilling or uncomfortable to utilize these services. Interestingly, participants did not identify any recommendations or suggestions for the organization to improve or facilitate organizational stress management services (Berg et al., 2016).

Berg et al. (2016) recommended eight strategies aimed at stress coping and management. The first strategy is to recognize and accept that CF and BO exist in professions that involve traumatic situations. Suggestions included delegating a champion to provide team education for setting professional behavior boundaries and to accept that it is normal to experience patient care-related stress. The second intervention involved education on self-recognition of symptoms of BO and CF. Discreet annual self-evaluation was recommended with an ideal suggested reminder occurring around annual employee evaluation time. The third strategy can be accomplished through teamwork in the embodiment of professional stress relief coping skills. Examples were aimed at alleviating CF through professional social support and positive co-worker relationships. Further, teach employees to recognize they are not alone in their distress and to take part in self-soothing activities. The fourth recommended strategy involved leadership wherein social support should be made a priority for leadership development.

Supervisors with strong supportive working relationships have been associated with higher job satisfaction in personnel.

The fifth stress coping strategy suggested engaging in coping management conversations during regular group/individual meetings as a routine occurrence instead of waiting to respond after an unprofessional behavior occurrence or crisis incidence. It is important to have a professional in CF management available as well as utilizing caution in the possibility of triggering a stress response during conversation. Awareness of personnel who are especially silent, or do not participate in conversation can signify possible correlation with CF. Non-judgmental discussion is vitally important in conversations. The sixth strategy involved being proactive in active high-crisis traumatic event interventional response, such as in a geriatric or pediatric abuse patient death. The seventh strategy entailed focusing on the positive outcomes of patient care such as discussing patient encounters that were successful. Finally, the eighth recommendation suggested screening and hiring individuals who exhibit natural strong coping personality traits (Berg et al., 2016).

Limitations of the study were described as generalizability as of the qualitative nature and the perspectives of a Level 1 trauma team may not mirror perspectives across other healthcare provider disciplines. The study concluded a few important points. CF and burnout can be identified as real and existing instead of representing complex literature concepts. A needs assessment for education, surveillance, and/or intervention can be accomplished through simple measurement tools. Lastly, it is imperative to proactively self-prevent and manage CF and burnout through the creation of a culture of professional supportiveness, acceptance, and acknowledgement (Berg et al., 2016).

Van Sant and Patterson (2013) conducted a naturalist qualitative research study to determine the emotional connectedness between psychiatric nurses and their patients on the Child/Adolescent Mental Health Acute Inpatient Unit, Residential Substance Abuse Unit, Adult Mental Health Inpatient Unit, and Access Center within a mid-Atlantic region community hospital in the U. S. The specific goal of the researcher was to study the interaction between the nurse's self and the raw emotional pain of the patients. The patients on the units encompassed children, adolescents, and adults with psychiatric disorders (with and without co-existing substance abuse) who were experiencing high emotional pain levels with resultant crises. The study participants consisted of 12 nurses from the various units. In addition, a staffing shortage of nurses was noted as being in occurrence at the time of the study, which may have added to the challenging interpersonal relationships. The 12 participating RN's had daily experience in connecting with the emotional pain of the patients. The duration of employment on the units was at least one year with varied experience in psychiatric nursing for 1.5 to 28 years. Two of the participants were male while ten of the participants were female.

Data collection consisted of semi-structured interviews, unstructured interactions, and participant observation until data saturation was achieved. The majority of interviews were conducted outside of the nurses' unit. Resultant data was analyzed by an unnamed computer system to result in a model of connecting. Trustworthiness, dependability, confirmability, and transferability were described as obtained. The study results indicated the nurses connected with the emotional pain of patients in the psychiatric setting both with and without energy imbalance and/or depletion. The resultant themes consisted of: (1) the influencing factors, (2) the decision point to connect

or not to connect, (3) the steps of the process, with or without self-protection, defined as getting to where the patient is, identifying with the patient, giving of the self, carrying the patient's pain, getting out without suffering patient's pain, having absorbed the patient's pain, and the triggering of one's own pain; and (4) the outcomes.

The first theme described influencing factors that inhibited or facilitated the connectedness between the patient and the nurse. These factors were influenced by the nurse's experience of time of connectedness, personal health, innate ability, intra/interpersonal processes, spiritual/philosophical beliefs, knowledge, and personal/professional experience. The influence of connectedness was also dependent upon the patient's, such as those that projected a need for love or were victimized were more easily connected to, versus patients who exhibited anti-social or violent traits. All of the nurses in the study identified with patients with and without self-protection.

The influencing factors led to the second theme wherein nurses experienced a decision point of connecting or not connecting to the patient. The initial decision appeared to have been a subconscious one which later evolved into a conscious choice. These experiences were described as physically, energetically, emotionally, and intellectually associating with the patient's pain with and/or without self-protection. Many of the nurses described feeling as if they had to place themselves in the patient's emotional pain to be able to connect with the patient to help them. The emotional connections or experiences were described as positive and negative energies.

In the third theme or step, participants described self-awareness or the giving of self. This was described as being constantly present throughout each theme of the process. This step in the process was akin to mothering through the provision of

unconditional love, attentive listening, self-disclosure, offering of self-presence, problem solving, projecting a positive healing energy, and offering the use of the grove technique. The grove technique consisted of visualization of images of safe places to release negative energies. The nurses stated that they often had to remind themselves of self-awareness and self-releasing in that it was about the patient and not themselves.

The fourth theme or step involved outcomes or the act of leaving the associations with the patient's emotional pain identified as getting out of the emotional, cognitive, physical, and energetic connectedness between the patient and the self (nurse). During this step, nurses could have triggered pain from their own personal painful issues and carried pain which was identified as carrying the patient's pain through the four previously described emotional connections. The nurses could also have absorbed pain which describes the nurse self-absorbing the patient's pain and leaving the connection with no pain if concentration occurred for self-protection. The nurse's decision to emotionally connect or not connect with patients led to positive and negative outcomes regardless of connecting or not. Positive outcomes were associated with self-replenishing/refilling and self-satisfying pain releasing methods. Participants with a higher number of these methods reported more immediate and greater professional and personal outcomes. Negative outcomes were demarcated as the professional or personal results of the connection as self-damaging. The employment of self-protection techniques resulted in less intense negative outcomes. The forms of self-damage described when using self-protection included: feeling physically and emotionally drained, loss of sleep, the experience of stress, self-neglect, the forever feeling of pain in one's body unless emotional processing occurs, and feelings of prolonged sadness. The

damages to the self that occurred without the use of self-protection included: ineffective work completion, migraine headaches, taking pain home, feelings of over-involvement, fear of having to quit nursing altogether, emotional distancing, and BO (Van Sant & Patterson, 2013).

For the study participants, key facilitators emerged as releasing and refilling behaviors which enabled the ability to work through much of the initial negative connecting outcomes. Emotional self-pain was released through common techniques such as: reflecting, processing patient connections with others, physical activity, patient advocacy, crying, and spiritual interventions. Less common self-release of pain techniques was identified as: seeking sanctuary, meditation, channeling negative energy back to the earth, and body work. Specific refilling method examples consisted of: seeking fun, pleasure, and enjoyment; exercising; relaxing through sleep and creativity; and the obtainment of further knowledge (Van Sant & Patterson, 2013).

The implications for practice from the study were numerous. The study participants described ways to emotionally connect and disconnect effectively with the emotional pain of patient's in the psychiatric setting. Self-awareness, self-protection, and empowered decision making were described by the participants as ways to emerge with minimal self-destruction to enhance future professional and personal growth and effectiveness. All of the steps or themes identified within the emerging model allowed the psychiatric nurses' unique application within the provision of evidence-based psychiatric nursing care. The finding of an appropriate balance between connecting or withdrawing from the psychiatric patient's emotional pain was described as especially important for the caregiver to be self-aware of when to stop the giving of self to prevent

burnout and progression to CF. Finally, future research is suggested in other settings to determine if the identified model can have similar positive implications for nurses, patients, and the profession of nursing as a whole (Van Sant & Patterson, 2013).

The research literature indicated several measures that healthcare organizations can employ to prevent and manage the existence of CF in nursing. The three research articles evaluated in this section provided support for an array of techniques aimed at combating CF in nursing, which will ultimately increase the provision of compassionate care at the patient's bedside (Berg et al., 2016; Hunsaker et al., 2015; & Van Sant & Patterson, 2013). In the first study, sound leadership, shorter shifts, a positive work environment, and mentorship were suggested to combat CF in nursing (Hunsaker et al., 2015). This was suggested as paramount for newer nurses to promote growth, retention, and longevity in the profession of nursing (Hunsaker et al., 2015). The second study presented eight stress coping strategies to prevent and manage CF in nurses such as organizational and self-care interventions to prevent, recognize, and manage CF and BO (Berg et al., 2016). The third empirical research study described four resultant themes that emerged from a study of nurses who provide care to patients in the mental health arena (Van Sant & Patterson, 2013). The themes show how behavioral health nurses connect or choose to not connect emotionally with behavioral health patients to self-prevent or self-protect themselves from CF development or further CF deterioration.

Literature Review Summary

Global demand for nurses continues to grow in relation to the increased advances in diagnosing and management of patient health issues (Wenzel et al., 2011). In addition, medical advancements coupled with health promotion of enhanced self-care have resulted

in an ever-increasing geriatric population. A study of the prevalence of CF in nurses who care for GBH patients in an inpatient setting would be a valuable addition to the current literature. There have been many changes in the prevention, recognition, and management of CF in nursing since the term was first recognized over twenty-five years ago. The last seven years have represented an explosion of related empirical research studies on the topic of CF and other related interchangeably used terms such as BO and STS in the arena of nurses who provide care to patients at the bedside.

First and foremost, the ultimate goal for any healthcare organization is to avoid the ultimate cost of caring for nurses who give of themselves until they can give no more. Nurses must possess self-compassion in order to be able to provide compassionate care to others (McConnell, 2015). Understanding the effects of caring for patients on professional nurses is healthcare management and the nurses' responsibility. The analysis of the prevalence of CF and BO represents the crucial first step for any healthcare organization to determine the appropriate interventions and programs to implement for CF prevention and management in nursing. It is important for the healthcare provider to understand and possess the concept of CF in the way that defines the term within the organization as there is not a universally accepted definition of CF. Optimal self-care is the key to managing CF. The healthcare organization should seek and implement the best evidence-based techniques and programs aimed at providing nurses with the necessary resources to self-care for themselves.

A compassionate nurse is contagious in that he/she cultivates self-compassion while spreading an atmosphere of positivity to other's in the organization's environment such as other staff and patients. There are many available websites that offer

interventions in the form of coping strategies to prevent and/or manage CF such as the American Psychological Association website (www.apa.org) or the American Institute of Stress website at www.stress.org. McConnell (2015) suggested nurses' practice the STOOOP technique for oneself whether in the provision of patient care or outside of the organization when facing time constraints. The technique is practiced by **s**topping, **t**aking a breath, **o**bserving (what are you doing, feeling, or thinking? Are these things judgmental, harsh, critical, or kind?), **o**ptions (What would be a compassionate/kinder choice of words or action right now?), and **p**roceed by implementing the more compassionate previously chosen action (McConnell, 2015). By focusing on the development and delivery of compassion, this could lead to long-term compassion which in turn would greatly build walls to deter the development and spread of CF.

Application of the MRM theory model by the healthcare organization as a conceptual framework would enhance while easing the process of implementing effective strategies aimed at prevention, recognition, and management of CF in nurses. It is important for the techniques to represent the organization level, management level, and at the self-care level of nurses. This would ultimately represent a huge step in the ability to provide the very best care to the organization's population it serves. In addition, the promotion of a positive work environment coupled with sound leadership could lead to the attraction and retention of nurses capable of providing compassionate care.

Chapter III: Methodology

Introduction

This chapter provides an overview of the research methods applied in this study to determine if registered nurses and licensed practical nurses on an inpatient geriatric behavioral health (GBH) unit experience CF. Specifically targeted within this chapter were the research study design, study setting, sample population, the protection of human subjects, instrumentation, data collection methods, and analysis of the collected data.

Research Design

The following research question was addressed in this study:

1. Do nurses experience CF on an inpatient geriatric behavioral health unit?

A quantitative, non-experimental descriptive research design study was conducted to determine if nurses who work on an inpatient geriatric behavioral health unit experience CF. The recognition of CF has become more prevalent within the profession of nursing in the provision of patient care. Stamm (2010) described CF as the negative aspects of the professional quality of life caused by repeated exposure to patient-related trauma or suffering without taking adequate measures to recharge the self. Joinson (1992) described CF as likely linked to occur in nurses in any healthcare setting (Peterson-Owen & Wanzer, 2014). The current empirical literature focuses on identifying CF in nurses working within the areas of oncology, critical care, emergency room, military, and in generalized patient care areas. The inpatient GBH setting represents an area of nursing susceptible to CF. Due to the limited empirical research on the effects of CF on nurses working within the specialized area of the inpatient geriatric behavioral health setting, a quantitative, descriptive research design was used that has

been utilized in hundreds of previous research studies worldwide on the prevalence of CF in nurses working within a variety of other care settings.

The Professional Quality of Life (ProQOL v. 5) survey, developed by Beth Hudnall Stamm, was used in this study to determine if nurses experience CF within the inpatient GBH setting. The survey measures both the positive Compassion Satisfaction (CS) and the negative (CF) aspects of the participant's ProQOL (Stamm, 2010). The ProQOL v. 5 survey has been utilized as a measuring instrument in hundreds of studies worldwide as a way to measure the negative effects of exposure to traumatic stress (Stamm, 2010). The ProQOL v. 5 study was utilized for this study on the prevalence of CF in nurses working within the inpatient geriatric behavioral health setting because of the ease of administration to both individuals and groups and it is the most commonly used measure for CF (Stamm, 2010). Moreover, Stamm (2010) claimed the ProQOL v. 5 represents worthy construct validity and reliability with over 200 published papers, greater than 100,000 internet articles.

Setting

The setting of this quantitative research study took place in two inpatient GBH units located in two mid-sized rural hospitals in Arkansas. The two settings were categorized as *Hospital A* and *Hospital B* for data collection. *Hospital A* is a 90 bed non-profit community owned hospital located in Northwest Arkansas. The inpatient GBH unit of *Hospital A* is a 20 bed unit, providing psychiatric healthcare to patients 55 years of age and older. The average length of stay on the inpatient geriatric unit is 12 to 14 days. Patients on the unit are diagnosed with acute psychiatric symptoms that require 24-hour acute care inpatient treatment (Johnson Regional Medical Center, n. d.).

Hospital B is a 268 bed non-profit community owned hospital located in the central region of northern Arkansas. The inpatient GBH unit of *Hospital B* is a 19 bed unit, providing interdisciplinary care to patients with emotional and physical needs to patients 50 years and older (Baxter Regional Medical Center, 2013-2016).

Population/Sample

The population of interest was all RN's and LPN's working within the inpatient GBH units of the two hospitals. At the time of this study, there were seven RN's and four LPN's working within the inpatient GBH unit of *Hospital A* and there were 12 RN's and three LPN's working within the inpatient GBH unit of *Hospital B*.

The sample procedure for this study was a convenience sampling of nurses on the inpatient GBH units of both hospitals. The participants were recruited on a voluntary basis with informed consent obtained prior to participation in the research study. The inclusion criteria for this sample included being either a RN or LPN working on an inpatient GBH unit and having cared directly with acute GBH patients. A total of 26 nurses were invited to participate in the study which consisted of them completing a self-completion survey after informed consent was obtained. *Hospital A* consisted of inviting a total of 11 possible nurses, which included seven RN's and four LPN's. *Hospital B* consisted of inviting a total of 15 possible nurses, which included 12 RN's and three LPN's. A total of 18 of 26 (69%) nurses participated in the study which represented 14 RN's (74%) and four LPN's (57%). Eight (73%) nurses participated in the study from *Hospital A*, which represented seven RN's (100%) and one LPN (25%). Ten nurses (67%) participated in the study from *Hospital B*, which represented seven RN's (58%) and three LPN's (100%).

Human Subjects

The process of going through institutional review for the protection of human subjects began with the primary investigator (PI) completing the application for review of human participants' research. The completed application was sent to the Arkansas Tech University Institutional Review Board (IRB) along with the research study framework, participant research invitation (see Appendix A), informed consent statement (see Appendix B), and copy of the ProQOL v. 5 survey questionnaire (see Appendix C) utilized for this research study. The IRB application contained specifically detailed information regarding the purpose and objectives of the research study, the comprehensive consent process, data collection methods, and the recording and dissemination of findings. The IRB application was approved on May 12, 2016, by the IRB committee and survey distribution began on September 13, 2016 and concluded on October 4, 2016. Research study participation was voluntary with attempted paramount anonymity and confidentiality.

Demographic information was gathered regarding age, gender, length of years as a nurse, length of years as a GBH nurse, RN or LPN, and whether the participant worked at *Hospital A* or *Hospital B*. The study participants were invited to voluntarily participate in the research study via identical scripting for both hospitals. *Hospital A* participants were invited by a printed copy of the study participant invitation provided to inpatient GBH unit nurses by the Nurse Leader of the unit. Next, the Nurse Leader handed out a copy of the study participation invitation which contained the hyperlink to the study. The healthcare organization did not have individualized interorganizational email for many of the employees, which included the inpatient GBH unit nurses. The inpatient GBH unit

nurses from *Hospital B* were invited to partake in the research study via interorganizational email with the same identical study participation invitation which contained the hyperlink to the study. The hyperlink directly connected participants to the QuestionPro website where the participants agreed to informed consent prior to progressing to the survey questionnaire which consisted of the ProQOL v. 5 survey and the aforementioned demographic data questions. Participants were re-directed out of the survey if they voluntarily chose to exit the survey prior to informed consent agreement and/or at any time during the survey. In addition, within the electronic communication, if the participants had any questions or concerns, they were provided with contact names, numbers, and hyperlinks to information for the PI, ATU Nursing Thesis Chair, ATU-IRB Chair, and guidance for emotional discomfort from the American Psychological Association's Help Center or from the American Counseling Association.

The collected research study data were grouped and aggregated together to represent overall findings reported as *Hospital A* and *Hospital B* survey data results. The PI and the ATU Thesis Chair are the only people with direct password protected access via personal computer to the initial study findings, which were aggregated and documented as group (*Hospital A* or *Hospital B*) research study results. This data will only be shared as group (*Hospital A* or *Hospital B*) findings within the study. The entire raw survey data will be password protected and stored within the personal computer, which is also password protected and external USB drive with data was secured in a locked cabinet in the home office of the PI. Data will be kept for a period of up to two years.

Instrumentation

Beth Hudnall Stamm's Professional Quality of Life Scale (ProQOL) version 5 (2010) was used to measure the ProQOL of the inpatient GBH nurses who participated in this study. A set of demographic questions were included at the end of the survey which were developed by the researcher. The demographic questions included information about the participatory nurses' age, gender, length of years as a nurse, length of years as a geriatric behavioral health nurse, RN or LPN, and whether the participant worked at *Hospital A* or *Hospital B*. For individuals who work with those who have experienced tremendously stressful events, the ProQOL is the most commonly used measure for over twenty years (Stamm, 2010). According to Stamm (2010), the ProQOL was originally developed in the late 1980's by Charles Figley and was called the Compassion Fatigue Self Test. In 1988, Figley and Stamm collaborated on the measure. The measure was changed to the Compassion Satisfaction and Fatigue Test in 1993, when Stamm added the Compassion Satisfaction concept (Stamm, 2010). In the early 1990's, there were several versions of the measure by Figley and Stamm, then version's changed to Stamm and Figley (Stamm, 2010). In the late 1990's, the measure became entirely Stamm's with a final change to the ProQOL measure (Stamm, 2010). The ProQOL v. 5 survey is available in over twelve languages with translation of other languages available upon request (Stamm, 2010).

Permission to utilize the ProQOL v. 5 measure was obtained through the www.ProQOL.org website by completing a Permission Request form. The permission to use request was completed by the PI on February 24, 2016. The survey is credited with permission to be used and copied freely as long as (a) the author is credited, (b) no

changes are made, and (c) it is not sold (Stamm, 2010). In this study, Stamm (2010) posited the ProQOL v. 5 scale measures the quality of how the participant (nurse) feels in regards to his/her career as a helper (nurse). Nurses work in helping professions and respond to patients' crises that may occur at the bedside, community, national, and even international settings. The nurse's quality of life is influenced by both the positive (CS) and the negative (CF) aspects of his/her work performance (Stamm, 2010). CS describes the pleasure a nurse feels from being able to perform well in his/her professional role. The nurse may possess positive feelings towards coworkers or feel he/she contributes to the greater good of humanity. Stamm (2010) postulated the negative attributes of CF are broken into two parts. The first part encompasses areas of concern such as frustration, exhaustion, depression, and anger, all of which can be typical of burnout. Job-related trauma can be direct (primary) and/or secondary trauma. Secondary Traumatic Stress (STS) described the negative fear and work-related trauma feelings from being exposed to patients' traumatic stressful events (Stamm, 2010). The effects in the nurse may include intrusive images, sleep difficulties, and/or avoidance of memories of the patient's traumatic experiences (Stamm, 2010). Vicarious trauma and STS share many similarities (Stamm, 2010). One of elements of CF from the negative effects of caring is burnout (BO), which is a well-known term. According to Hayes (2013), BO reflected a person's psychological health in the workplace with symptomatology examples representing a gradual inclination to indifference, cynicism, reduced personal accomplishments, and uncaring attitudes. Stamm (2010) agreed that BO typically has a gradual onset and can be associated with a lack of work environment support, higher than average workload, and may reflect feelings of efforts at work not making a difference. The negative

feelings are perceived as hopelessness by the affected person with difficulty in performing duties or dealing with work (Stamm, 2010). The STS scale of the ProQOL addresses fear while the burnout (BO) scale does not (Stamm, 2010).

The ProQOL v. 5 survey was chosen for this study because of the tool's demonstrated construct validity and reliability as a measure of CF (Stamm, 2010). In addition, the survey was chosen because of the ease of use for administration and analysis, is readily available, and can be administered to individuals and/or groups. The positive and negative attributes measured by the survey reflect the likelihood of the same attributes experienced by nurses in the inpatient GBH setting. The participants in this research study were asked to rate each of the 30 statement items based on a Likert scale. The scale was designed for the participant to self-rate each item based on the frequency of the occurrence within the last 30 days. The Likert scale consists of a frequency range of 1 to 5, with 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often. The survey includes three distinct subscales consisting of CS, BO, and STS (Stamm, 2010). Each subscale represents 10 questions in each of the three categories. A CS score of 22 or less depicts low levels of CS, scores in the range of 23-41 reflect average levels, while scores 42 and above advocates high CS levels. For BO and STS, scores of 22 or less are indicative of low levels, 23-41 represent average levels, and scores 42 or higher depict high BO and STS levels (Stamm, 2010).

The *Concise ProQOL Manual* (Stamm, 2010) was obtained from the www.proqol.org website. The manual includes background information, scale definitions, scale properties, administration, scoring, interpretation, and usefulness in decision-making of the ProQOL v. 5 survey. The ProQOL manual was used as a guide to

calculate scores and interpret the collected data from the research study. The provision of a platform for change toward improved resiliency at the individual and/or organization level is attributed as a valuable rewarding aspect of the ProQOL (Stamm, 2010).

Data Collection

The participants' data were collected for this quantitative research study through an online survey accessed through the QuestionPro website. A convenience sample was obtained from nurses who practice within the similarly sized inpatient GBH units of two hospitals. Data collection began on September 13, 2016, and ended three weeks later on October 4, 2016. The data specifically consisted of the ProQOL v. 5 survey tool which consisted of a Likert scale of usually occurring characteristics of CF as identified and determined from previous research studies (Stamm, 2010). In addition, data collection consisted of demographic characteristics of age, gender, length of time as a nurse, length of time as a GBH nurse, RN or LPN designation, and whether the nurse worked in *Hospital A* or *B*. A total of 26 nurses (11 nurses from *Hospital A* and 15 nurses from *Hospital B*) were invited to participate in the study. A total of 18 nurses (eight nurses or seven RN's and one LPN from *Hospital A* and 10 nurses or seven RN's and three LPN's from *Hospital B*) voluntarily participated in this study.

Identical scripting was used to invite voluntary participation in the research study from both hospitals (see Appendix A). The invitation included a direct website link to participate in the study (see Appendix A). In *Hospital A*, participants were given a printed copy of the voluntary participation invitation from the inpatient GBH unit Director (see Appendix A). In *Hospital B*, participants were invited via interorganizational email. When the participants accessed the hyperlink for the survey

they were directed to the QuestionPro website to the informed consent (see Appendix B). If the participants chose to volunteer, they were immediately directed to the survey. If they did not agree to complete the survey, they were directed out of the survey. The survey was designed where participants could voluntarily opt out of the survey at any time. Near the end of survey completion, participants were given information regarding two sites to obtain psychological assistance, if needed. The survey concluded with thanking respondents for their participation in the survey. A reminder was sent to the participants of *Hospital A* via the unit director in the middle of the data collection window which was 1.5 weeks. *Hospital B* nurses were sent a reminder via interorganizational email by the PI at the same time with an identical reminder. The QuestionPro website method was used for assurance of confidentiality and anonymity of the participants.

Data Analysis

The collected survey data was amassed from the QuestionPro survey site and analyzed (www.questionpro.com). Two methods of quantitative data analysis were used in this study. The resultant study data of the ProQOL v. 5 surveys were analyzed using descriptive statistics and inferential statistics. This data analysis consisted of noting the frequency of occurrence in which the respondents stated they had experienced each of the 30 survey item statements from the ProQOL v. 5 surveys within the last 30 days. Descriptive statistics were utilized to categorize the central tendencies of each scored statement's item rankings. These rankings were presented as a group representation from *Hospital A* and followed by a group representation of *Hospital B*. The combined rankings of all reported surveys were scored by the means of the ProQOL v.5 scoring tool

(see Appendix D) to determine the presence or absence of CF within the two sample groups. Generalizations and conclusions of the research study findings were established and presented through the utilization of inferential statistics. The research study data were reported noting the prevalence of commonly identified characteristics of CF within the two population settings as well as the incidence of CF within the two sample sizes.

Summary

The study focus of this quantitative, descriptive research study was to ascertain if nurses experienced the emotional cost of caring in the form of CF, within the inpatient setting of the GBH units of two healthcare organizations. Research study data were collected from demographics and the ProQOL v. 5 survey tool distributed to a convenience sample of GBH nurses from two hospitals by the means of a QuestionPro survey website. The ProQOL v. 5 questionnaires were used with a Likert scale item ranking of frequently experienced traits of CF as previously identified by Stamm (2010). Prior to survey distribution, IRB approval was obtained from Arkansas Tech University. Respondent participation was confidential and voluntary with obtainment of informed consent prior to survey participation.

Chapter IV: Results

Introduction

This chapter presents the findings of the study to determine if nurses working within the inpatient geriatric behavioral health (GBH) setting of two hospitals experience compassion fatigue (CF). The ProQOL v. 5 survey tool (Stamm, 2010) was utilized for data collection. In addition, demographic data was collected related to whether participants worked in *Hospital A* or *Hospital B*, were an RN or LPN, age, gender, length of time in years as a nurse, and length of time in years as a nurse caring for inpatient geriatric behavioral health patients (see Tables 1-3). Demographic results are presented first, followed by the ProQOL survey results.

The ProQOL survey results are divided into two categories representative of individual and group results from *Hospital A* followed by the same from *Hospital B*. The individual results were combined for each of the 30 ProQOL survey items (see Tables 4-14) to show the incidence of responses according to a 5 item Likert scale ranking of 1=Never, 2=Rarely, 3=Sometimes, 4=Often, and 5=Very Often. Each table includes results representative of *Hospital A* and *Hospital B*.

The group results were calculated according to the ProQOL scoring tool (see Appendix D) for six categories. The categories are surveyed GBH RN's from *Hospital A*, the GBH LPN from *Hospital A*, GBH RN's from *Hospital B*, GBH LPN's from *Hospital B*, combined GBH RN's and LPN's from *Hospital A*, and combined GBH RN's and LPN's from *Hospital B*. Scores are calculated by placing the Likert score (1-5) with the greatest percentage of response rate for each survey item. The group scores were transposed to the ProQOL v. 5 interpretation tool (see Appendix E) within the categories

of compassion satisfaction (CS), burnout (BO), and secondary traumatic stress (STS) to determine if each group risk level of high, average, or low. The higher risk level scores are indicative of the increased likelihood of experiencing CF within the last 30 days for the group, according to the ProQOL v. 5 scoring tool.

Demographic Results

The demographic section of the survey data consisted of whether participants worked in *Hospital A* or *B*, were an RN or LPN, age, gender, length of time in years as a nurse, and length of time in years as a nurse caring for inpatient geriatric health patients. A total of 26 nurses working within an inpatient geriatric behavioral health unit at two hospitals were invited to participate in this study. A total of 11 nurses were invited from *Hospital A* which included seven RN's and four LPN's. Fifteen nurses were invited from *Hospital B* which included 12 RN's and three LPN's. A total of 21 nurses accessed the survey, although, only $N=18$ completed the survey. This left an attrition rate of three participants. The overall response rate for this study was 69%, which falls within the initial participation goal set between 50-75% for this study. Seven RN's and one LPN completed the survey from *Hospital A* which represents an organizational participation rate of 73%. This further represents 100% of RN's and 25% of LPN's participated in this study from *Hospital A*. Seven RN's and three LPN's completed the survey from *Hospital B* which represents an organizational participation rate of 67%. This further represents 58% of RN's and 100% of LPN's participated in this study from *Hospital B*.

One male participated in the study from *Hospital A*. The gender of the remaining participants of this study was all female. However, both female and male nurses were invited to participate in this study from both hospitals.

Table 1

Age of Participants

Hospital A			Hospital B		
Age Group	Responses	%	Age Group	Responses	%
18-25	0	0%	18-25	0	0%
25-34	3	38%	25-34	1	10%
35-44	1	13%	35-44	4	40%
45-54	2	25%	45-54	3	30%
55+	2	25%	55+	2	20%
Totals	8	100%		10	100%

Respondents to this study from *Hospital A* who are 18-25 years of age (n=0, 0%), 25-34 years of age (n=3, 38%), 35-44 years of age (n=1, 13%), 45-54 years of age (n=2, 25%), and 55+ years of age (n=2, 25%). Respondents from *Hospital B* who are 18-25 years of age (n=0, 0%), 25-34 years of age (n=1, 10%), 35-44 years of age (n=4, 40%), 45-54 years of age (n=3, 30%), and 55+ years of age (n=2, 20%). An interesting finding is that neither hospital had respondents from the 18-25 age group.

Table 2

Length of Time in Years as a Nurse

Hospital A			Hospital B		
Number of Years as a Nurse	Responses	%	Number of Years as a Nurse	Responses	%
0-5	0	0%	0-5	1	10%
6-15	4	50%	6-15	6	60%
16-25	3	38%	16-25	1	10%
26+	1	13%	26+	2	20%
Totals	8	100%		10	100%

Respondents from *Hospital A* indicated length of time in years as a nurse as 0-5 years (n=0, 0%), 6-15 years (n=4, 50%), 16-25 years (n=3, 38%), and 26+ years as a nurse (n=1, 13%). Respondents from *Hospital B* specified length of time in years as a nurse are 0-5 years (n=1, 10%), 6-15 years (n=6, 60%), 16-25 years (n=1, 10%), and 26+

years as a nurse (n=2, 20%). Only one respondent from *Hospital B* indicated the number of years as a nurse in the 0-5 year category. The majority of respondents from *Hospital A* reported being a nurse for 6-25 years (n=7, 88%), while the majority of respondents from *Hospital B* reported being a nurse for 6-15 years (n=6, 60%).

Table 3

Length of Time in Years as a Geriatric Behavioral Health Nurse

Hospital A			Hospital B		
Number of Years as a Geriatric Behavioral Health Nurse	Responses	%	Number of Years as a Geriatric Behavioral Health Nurse	Responses	%
0-5	5	63%	0-5	4	40%
6-15	3	38%	6-15	5	50%
16-25	0	0%	16-25	1	10%
26+	0	0%	26+	0	0%
Totals	8	100%		10	100%

Respondents from *Hospital A* indicated length of time in years as a nurse caring for geriatric behavioral health patients as 0-5 years (n=5, 63%), 6-15 years (n=3, 38%), 16-25 years (n=0, 0%), and 26+ years as a nurse (n=0, 0%). Respondents from *Hospital B* specified length of time in years as a nurse caring for geriatric behavioral health patients as 0-5 years (n=4, 40%), 6-15 years (n=5, 50%), 16-25 years (n=1, 10%), and 26+ years as a nurse (n=0, 0%). All of the respondents from *Hospital A* indicated 0-15 years as the length of time as a geriatric behavioral health nurse (n=8, 100%). The same was true for *Hospital B* with 90% (n=9) of respondents reported 0-15 years as a geriatric behavioral health nurse.

Individual Results

The ProQOL v.5 part of the survey consisted of 30 questions postulated as statements. These statements pertain to the positive (CS) and negative (CF) involvement

of the professional quality of life experienced by the respondent from working in a helping role in the last 30 days. The statements along with the individual response rates of both hospitals are presented in the following tables (see Tables 4-13).

Table 4

ProQOL v. 5 Items 1-3

1. I am happy.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	1	0%	100%	0	0	0%	0%
Often	4	0	57%	0%	3	1	43%	33%
Very Often	3	0	43%	0%	4	2	57%	67%
Totals	8		100%		10		100%	
2. I am preoccupied with more than one person I care for.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	1	1	14%	33.3%
Sometimes	1	0	14%	0%	4	1	57%	33.3%
Often	5	0	71%	0%	2	0	29%	0%
Very Often	1	1	14%	100%	0	1	0%	33.3%
Totals	8		100%		10		100%	
3. I get satisfaction from being able to help people.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	0	0%	0%	0	0	0%	0%
Often	1	1	14%	100%	1	0	14%	0%
Very Often	6	0	86%	0%	6	3	86%	100%
Totals	8		100%		10		100%	

The majority of surveyed GBH RN's and LPN's from both hospitals indicated experiencing happiness often or very often within the last 30 days. The exception was one GBH LPN at *Hospital A*, who reported experiencing happiness sometimes within the last 30 days.

The majority of surveyed GBH RN's (71%) at *Hospital A* reported they were often preoccupied with caring for more than one person. The GBH LPN at *Hospital A* indicated being preoccupied with caring for more than one person 100% of the time within the last 30 days. Six of seven GBH RN's at *Hospital B* reported being preoccupied with caring for more than one person as sometimes and very often. The GBH LPN's at *Hospital B* were evenly dispersed over feeling preoccupied with caring for more than one person as rarely, sometimes, and very often.

The majority of surveyed GBH RN's (86%) at both hospitals and the GBH LPN's (100%) at *Hospital B* rated feelings of satisfaction as occurring very often from being able to help people within the last 30 days. The GBH LPN at *Hospital A* indicated often feeling satisfaction from being able to help people.

Table 5

ProQOL v. 5 Items 4-6

4. I feel connected to others.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	1	0%	100%	0	0	0%	0%
Often	2	0	29%	0%	2	0	29%	0%
Very Often	5	0	71%	0%	5	3	71%	100%
Totals	8		100%		10		100%	
5. I jump or am startled by unexpected sounds.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	4	1	57%	100%	3	1	43%	33.3%
Sometimes	1	0	14%	0%	1	1	14%	33.3%
Often	1	0	14%	0%	2	1	29%	33.3%
Very Often	1	0	14%	0%	1	0	14%	0%
Totals	8		100%		10		100%	
6. I feel invigorated after working with those I care for.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	2	1	29%	100%	0	0	0%	0%
Sometimes	1	0	14%	0%	2	1	29%	33.3%
Often	0	0	0%	0%	1	1	14%	33.3%
Very Often	4	0	57%	0%	4	1	57%	33.3%
Totals	8		100%		10		100%	

Seventy-one percent of surveyed GBH RN's from both hospitals reported feeling connected to others very often while 29% indicated they often feel connected to others. The GBH LPN at *Hospital A* reported sometimes feeling connected to others while 100% of the GBH LPN's at *Hospital B* indicated feeling connected to others very often.

The frequency of occurrence of responses to jumping or being startled by unexpected sounds is relatively diverse. The greatest frequency of occurrence falls in the rarely category with representation of 57% of surveyed GBH RN's and 100% of GBH

LPN's at *Hospital A*; followed by 43% of GBH RN's and 33.3% of GBH LPN's at *Hospital B*.

Fifty-seven percent of surveyed GBH RN's from both hospitals indicated feeling invigorated after working with those cared for within the last 30 days. The GBH LPN at *Hospital A* reported rarely feeling invigorated after working with those cared for while results for GBH LPN's at *Hospital B* evenly reported one-third (33.3%) as rarely, sometimes, or often feeling invigorated after working with those cared for.

Table 6

ProQOL v. 5 Items 7-9

7. I find it difficult to separate my personal life from my life as a nurse.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	1	0%	100%	1	1	14%	33%
Rarely	4	0	57%	0%	4	2	57%	67%
Sometimes	2	0	29%	0%	2	0	29%	0%
Often	1	0	14%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I care for.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	5	0	71%	0%	3	1	43%	33%
Rarely	1	0	14%	0%	3	2	43%	67%
Sometimes	1	1	14%	100%	1	0	14%	0%
Often	0	0	0%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
9. I think that I might have been affected by the traumatic stress of those I care for.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	4	0	57%	0%	1	1	14%	33%
Rarely	1	1	14%	100%	5	0	72%	0%
Sometimes	2	0	29%	0%	1	2	14%	67%
Often	0	0	0%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	

Fifty-seven percent of surveyed GBH RN's from both hospitals reported they rarely experienced difficulty in separating their personal life from their life as a nurse. The same was true for the GBH LPN's (67%) from *Hospital B*. However, 29% of GBH RN's from both hospitals reported it is sometimes difficult to separate their life as a nurse from their personal life.

Seventy-one percent of surveyed GBH RN's indicated productivity at work never suffered as a result of losing sleep over the traumatic experiences of their patients.

Eighty-six percent of GBH RN's at *Hospital B* reported they rarely experienced lost productivity at work because of losing sleep over the traumatic experiences of a patient(s). The majority of GBH LPN's at *Hospital B* indicated they rarely experienced decreased productivity at work related to losing sleep over the traumatic experience of someone they cared for within the last 30 days.

The surveyed GBH LPN (100%) at *Hospital A* along with the GBH RN's (72%) at *Hospital B* indicated they rarely thought they had been affected by the traumatic stress of those they cared for within the last 30 days. Sixty-seven percent of GBH LPN's at *Hospital B* reported they are sometimes affected by the traumatic stress of patients in their care.

Table 7

ProQOL v. 5 Items 10-12

10. I feel trapped by my job as a nurse.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	4	0	57%	0%	5	2	71%	67%
Rarely	2	0	29%	0%	2	0	29%	0%
Sometimes	1	1	14%	100%	0	1	0%	33%
Often	0	0	0%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
11. Because of my nursing, I have felt “on edge” about various things.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	5	0	71%	0%	1	2	14%	67%
Rarely	0	0	0%	0%	3	0	43%	0%
Sometimes	2	1	29%	100%	3	1	43%	33%
Often	0	0	0%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
12. I like my work as a nurse.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	1	0%	100%	0	0	0%	0%
Sometimes	0	0	0%	0%	1	0	14%	0%
Often	3	0	43%	0%	0	0	0%	0%
Very Often	4	0	57%	0%	6	3	86%	100%
Totals	8		100%		10		100%	

Eighty-six percent of surveyed GBH RN's at *Hospital A*, 100% of GBH RN's and 67% of GBH LPN's at *Hospital B* reported having never to rarely felt trapped by their job as a nurse. However, the GBH LPN at *Hospital A* and 33% of GBH LPN's at *Hospital B* reported sometimes feeling trapped by their job as a nurse.

Seventy-one percent of surveyed GBH RN's at *Hospital A* and 67% of GBH LPN's at *Hospital B* reported that they never feel “on edge” about things because of their job as a nurse. The GBH LPN at *Hospital A*, 43% of GBH RN's and 33% of GBH

LPN's at *Hospital B* report sometimes feeling “on edge” about various things because of their job as a nurse.

The surveyed GBH LPN at *Hospital A* indicated rarely liking work as a nurse while 100% of GBH RN's at *Hospital A* reported often to very often liking their work as a nurse. Eighty-six percent of GBH RN's and 100% of GBH LPN's at *Hospital B* indicated they very often liked their work as nurses. A lower amount of GBH RN's (14%) at *Hospital B* reported they only sometimes liked their work as a nurse.

Table 8

ProQOL v. 5 Items 13-15

13. I feel depressed because of the traumatic experiences of the people I care for.									
	Hospital A				Hospital B				
	Responses		%		Responses		%		
	RN	LPN	RN	LPN	RN	LPN	RN	LPN	
Never	3	0	43%	0%	2	1	29%	33.3%	
Rarely	3	0	43%	0%	5	1	71%	33.3%	
Sometimes	1	1	14%	100%	0	1	0%	33.3%	
Often	0	0	0%	0%	0	0	0%	0%	
Very Often	0	0	0%	0%	0	0	0%	0%	
Totals	8		100%		10		100%		
14. I feel as though I am experiencing the trauma of someone I have cared for.									
	Responses		%		Responses		%		
	RN	LPN	RN	LPN	RN	LPN	RN	LPN	
Never	6	0	86%	0%	2	2	29%	67%	
Rarely	1	0	14%	0%	4	0	57%	0%	
Sometimes	0	1	0%	100%	1	1	14%	33%	
Often	0	0	0%	0%	0	0	0%	0%	
Very Often	0	0	0%	0%	0	0	0%	0%	
Totals	8		100%		10		100%		
15. I have beliefs that sustain me.									
	Responses		%		Responses		%		
	RN	LPN	RN	LPN	RN	LPN	RN	LPN	
Never	0	0	0%	0%	0	0	0%	0%	
Rarely	0	0	0%	0%	0	0	0%	0%	
Sometimes	0	0	0%	0%	0	2	0%	67%	
Often	2	0	29%	0%	0	0	0%	0%	
Very Often	5	1	71%	100%	7	1	100%	33%	
Totals	8		100%		10		100%		

Eighty-six percent of surveyed GBH RN's at *Hospital A* along with 100% of GBH RN's at *Hospital B* reported they rarely or never feel depressed because of the traumatic experiences of those cared for. However, 100% of GBH LPN's and 14% of GBH RN's from *Hospital A*, and 33% of GBH LPN's at *Hospital B* reported sometimes experiencing feelings of depression as the result of the traumatic experiences of those cared for within the last 30 days.

All of the surveyed GBH RN's (100%) at *Hospital A* along with 86% of GBH RN's at *Hospital B* indicated they never or rarely feel as though they are experiencing the trauma of someone they have cared for. One-hundred percent of GBH LPN's from both hospitals reported they sometimes feel as though they are experiencing the trauma of someone they cared for.

Seventy-one percent of surveyed GBH RN's and 100% of GBH LPN's from *Hospital A* and 100% of GBH RN's along with 33% of GBH LPN's at *Hospital B*, indicated they possessed beliefs of sustainment. Twenty-nine percent of GBH RN's at *Hospital A* and 67% of GBH LPN's at *Hospital B* indicated often and sometimes having self-sustaining beliefs respectively.

Table 9

ProQOL v. 5 Items 16-18

16. I am pleased with how I am able to keep up with nursing techniques and protocols.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	1	0	14%	0%	0	0	0%	0%
Sometimes	1	0	14%	0%	1	0	14%	0%
Often	4	1	57%	100%	3	0	43%	0%
Very Often	1	0	14%	0%	3	3	43%	100%
Totals	8		100%		10		100%	
17. I am the person I always wanted to be.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	1	0	14%	0%	1	1	14%	33%
Often	4	1	57%	100%	2	2	29%	67%
Very Often	2	0	29%	0%	4	0	57%	0%
Totals	8		100%		10		100%	
18. My work makes me feel satisfied.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	0	0%	0%	1	0	14%	0%
Often	2	1	29%	100%	1	0	14%	0%
Very Often	5	0	71%	0%	5	3	71%	100%
Totals	8		100%		10		100%	

Four of seven surveyed GBH RN's (57%) and 100% of GBH LPN's from *Hospital A* reported they are often pleased with the ability to keep up with nursing protocols and techniques. Eighty-six percent of GBH RN's from *Hospital B* equally indicated often or very often, while 100% of GBH LPN's from *Hospital B* indicated they are pleased very often in the ability to keep up nursing protocols and techniques.

The majority of surveyed GBH RN's (57%), 100% of GBH LPN's from *Hospital A*, and 67% of GBH LPN's from *Hospital B* indicated they were often the person they always wanted to be in the past 30 days. Moreover, 57% of GBH RN's from *Hospital B* reported they were the person they always wanted to be within the past 30 days.

The majority of surveyed GBH RN's (71%) from both hospitals indicated their work made them feel satisfied very often. The remaining GBH RN's (less than 30%) from both hospitals reported their work made them feel satisfied sometimes or often. One-hundred percent of GBH LPN's from *Hospital A* and 100% of GBH LPN's from *Hospital B* reported feelings of satisfaction from their work as respectively often and very often. None of the respondents reported feeling never or rarely satisfied from their work.

Table 10

ProQOL v. 5 Items 19-21

19. I feel worn out because of my work as a nurse.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	1	0	14%	0%	1	1	14%	33.3%
Rarely	1	0	14%	0%	1	0	14%	0%
Sometimes	3	0	43%	0%	4	1	57%	33.3%
Often	1	0	14%	0%	0	1	0%	33.3%
Very Often	1	1	14%	100%	1	0	14%	0%
Totals	8		100%		10		100%	
20. I have happy thoughts and feelings about those I care for and how I could help them.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	2	1	29%	100%	0	0	0%	0%
Often	3	0	43%	0%	3	1	43%	33%
Very Often	2	0	29%	0%	4	2	57%	67%
Totals	8		100%		10		100%	
21. I feel overwhelmed because my case work load seems endless.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	1	0	14%	0%	0	0	0%	0%
Rarely	1	0	14%	0%	3	2	43%	67%
Sometimes	3	0	43%	0%	4	1	57%	33%
Often	2	0	29%	0%	0	0	0%	0%
Very Often	0	1	0%	100%	0	0	0%	0%
Totals	8		100%		10		100%	

The surveyed GBH nurses from both hospitals indicated varying responses from never to very often in their feelings of being worn out as the result of being a nurse. The majority of GBH RN's (43%) from *Hospital A* and GBH RN's (57%) from *Hospital B* reported feeling worn out from their work as a nurse. The GBH LPN from *Hospital A* reported feeling worn out as a nurse very often, while an equal one-third of GBH LPN's from *Hospital B* reported never, sometimes, and often worn out as a result of work.

Over 40% of surveyed GBH RN's from both hospitals reported they often have happy thoughts and feelings of those cared for in addition to feelings of how to help them. The majority of GBH nurses from *Hospital B* (RN 57%, LPN 67%) reported they have happy thoughts and feelings about those cared for and how to help them very often.

Over 70% of surveyed GBH RN's from *Hospital A* reported feeling overwhelmed by their work often or some of the time. All of the GBH nurses from *Hospital B* reported feeling rarely or some of the time that their case work load seems endless. One GBH LPN from *Hospital A* reported feeling very often overwhelmed because of the seemingly endless case work load.

Table 11

ProQOL v. 5 Items 22-24

22. I believe I can make a difference through my work.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	1	1	14%	100%	0	0	0%	0%
Often	2	0	29%	0%	3	0	43%	0%
Very Often	4	0	57%	0%	4	3	57%	100%
Totals	8		100%		10		100%	
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I care for.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	4	0	57%	0%	7	2	100%	67%
Rarely	2	1	29%	100%	0	1	0%	33%
Sometimes	1	0	14%	0%	0	0	0%	0%
Often	0	0	0%	0%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
24. I am proud of what I can do to help.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	0	0%	0%	0	0	0%	0%
Often	1	1	14%	100%	2	0	29%	0%
Very Often	6	0	86%	0%	5	3	71%	100%
Totals	8		100%		10		100%	

The majority of surveyed GBH nurses from both hospitals indicated often or very often in the belief of making a difference through their work. One GBH RN and one GBH LPN from *Hospital A* reported their belief in making a difference through their work as occurring some of the time.

The majority of surveyed GBH nurses from both hospitals reported never or rarely avoiding situations or activities as the result of being reminded of the traumatic

experiences of those they care for as a nurse. The exception was one GBH RN from *Hospital A*, who indicated the avoidance of activities or situations as sometimes occurring from the result of being reminded of the frightening experiences of those cared for as a nurse.

One-hundred percent of surveyed respondents from both hospitals reported they are often or very often proud of what they can do as a nurse to help others. None of the nurses from both hospitals reported feeling never, rarely, or some of the time proud of what they can do to help others as a nurse.

Table 12

ProQOL v. 5 Items 25-27

25. As a result of my nursing, I have intrusive, frightening thoughts.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	6	0	86%	0%	6	2	86%	67%
Rarely	1	0	14%	0%	0	1	0%	33%
Sometimes	0	1	0%	100%	0	0	0%	0%
Often	0	0	0%	0%	1	0	14%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
26. I feel “bogged down” by the system.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	2	2	29%	67%
Rarely	2	0	29%	0%	2	0	29%	0%
Sometimes	3	0	43%	0%	3	1	43%	33%
Often	2	1	29%	100%	0	0	0%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
27. I have thoughts that I am a “success” as a nurse.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	0	0%	0%	0	1	0%	33.3%
Often	5	1	71%	100%	5	1	71%	33.3%
Very Often	2	0	29%	0%	2	1	29%	33.3%
Totals	8		100%		10		100%	

Overall, the majority of surveyed GBH RN's (100%) from *Hospital A* and the GBH RN's (86%) and GBH LPN's (100%) from *Hospital B* indicated never or rarely having intrusive, frightening thoughts from the results of nursing. One GBH LPN from *Hospital A* reported having intrusive, frightening thoughts as the result of nursing some of the time. In addition, one GBH RN from *Hospital B* reported often experiencing frightening, intrusive thoughts as the result of nursing.

Over 40% of surveyed GBH RN's at *Hospital A* reported being "bogged down" by the system some of the time, while the remaining 60% of GBH RN's reported feeling "bogged down" by the system an evenly split often or rarely occurring experience. The GBH LPN at *Hospital A* reports feeling "bogged down" by the system often. At *Hospital B*, over 40% of surveyed GBH RN's reported feeling "bogged down" by the system some of the time. The remaining 60% of GBH RN's reported they never and rarely feel "bogged down" by the system. One-third of GBH LPN's at *Hospital B* reported being "bogged down" by the system some of the time. However, over 65% of GBH LPN's at *Hospital B* reported never experiencing feeling "bogged down" by the system.

The overwhelming majority of surveyed GBH nurses from both hospitals reported having thoughts as a successful nurse as often to very often. The exception is one-third of GBH LPN's from *Hospital B* felt thoughts of being a success as a nurse some of the time within the last 30 days. None of the nurses reported feelings of rarely or never having thoughts of being a success as a nurse.

Table 13

ProQOL v. 5 Items 28-30

28. I can't recall important parts of my work with trauma victims.								
	Hospital A				Hospital B			
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	4	0	57%	0%	3	1	43%	33.3%
Rarely	2	0	29%	0%	3	1	43%	33.3%
Sometimes	0	1	0%	100%	0	1	0%	33.3%
Often	1	0	14%	0%	1	0	14%	0%
Very Often	0	0	0%	0%	0	0	0%	0%
Totals	8		100%		10		100%	
29. I am a very caring person.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	0	0	0%	0%	0	0	0%	0%
Often	2	0	29%	0%	1	1	14%	33%
Very Often	5	1	71%	100%	6	2	86%	67%
Totals	8		100%		10		100%	
30. I am happy that I chose to do this work.								
	Responses		%		Responses		%	
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
	RN	LPN	RN	LPN	RN	LPN	RN	LPN
Never	0	0	0%	0%	0	0	0%	0%
Rarely	0	0	0%	0%	0	0	0%	0%
Sometimes	1	1	14%	100%	0	0	0%	0%
Often	4	0	57%	0%	2	0	29%	0%
Very Often	2	0	29%	0%	5	3	71%	100%
Totals	8		100%		10		100%	

Eighty-six percent of surveyed GBH RN's from both hospitals and 66% of GBH LPN's from *Hospital B* reported the experience of not recalling important parts of working with trauma victims as never or rarely occurring. One GBH RN from both hospitals reported they often cannot recall important events of working with trauma victims. The one GBH LPN from *Hospital A* reported not being able to recall important events of trauma victims as occurring some of the time.

The majority of surveyed GBH nurses from both hospitals reported they were very often a very caring person. The remaining 33% or less of GBH nurses from both hospitals indicated they were often very caring people.

Eighty-six percent of surveyed GBH RN's from *Hospital A* reported they were often or very often happy with the work they chose to do. The remaining GBH RN and LPN from *Hospital A* indicated they were happy some of the time with the work they chose to do. Seventy-one percent of surveyed GBH RN's and 100% of GBH LPN's at *Hospital B* reported they were very often happy with the work they chose to do. The remaining 29% of GBH RN's at *Hospital B* indicated they were often happy with their chosen work.

Group Results

The group results for the surveyed GBH nurses were calculated according to the ProQOL scoring tool (see Appendix D) for the six categories which consisted of surveyed GBH RN's from *Hospital A*, the GBH LPN from *Hospital A*, GBH RN's from *Hospital B*, GBH LPN's from *Hospital B*, both GBH RN's and LPN's from *Hospital A*, and both GBH RN's and LPN's from *Hospital B* (see Table 14). Calculation of scores occurred by placing the Likert score (1-5) with the greatest percentage of response rate for each survey statement item to the appropriate section on the ProQOL scoring tool. For calculating the risk value of a sample for the level of CS, statement items 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30 were used. Statement items 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29 were used to calculate the risk value for BO for a given sample. Lastly, statement items 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28 were used to calculate the risk value for STS.

The group scores were then transferred to the ProQOL v. 5 interpretation scoring tool (see Appendix E) within the three categories of CS, BO, and STS to determine each group risk level of high, average, or low. The higher the risk level score, the greater the indication of experiencing CF within the last 30 days, according to the ProQOL v.5 scoring interpretation tool. The following table depicts the ProQOL v. 5 survey results for the GBH nurses.

Table 14

Group ProQOL v. 5 Scores & Interpretation

Geriatric Behavioral Health Nurse Groups from Hospital's A & B	Compassion Satisfaction		Burnout		Secondary Traumatic Stress	
	Group Score	Risk Level	Group Score	Risk Level	Group Scores	Risk Level
<i>Hospital A RN's</i>	46	High	20	Low	16	Low
<i>Hospital A LPN</i>	34	Average	29	Average	29	Average
<i>Hospital A Combined Nurses</i>	46	High	19	Low	16	Low
<i>Hospital B RN's</i>	49	High	17	Low	20	Low
<i>Hospital B LPN's</i>	49	High	17	Low	17	Low
<i>Hospital B Combined Nurses</i>	49	High	15	Low	19	Low

Concerning CS, the majority of the groups of nurses scored in the high risk category or negative category, with the exception of the GBH LPN at *Hospital A* which scored in the average risk category. Per the ProQOL v. 5 interpretations, higher scores reflect GBH RN's possess great satisfaction in the ability to be an effective caregiver in their job as a nurse. Further, these nurses likely feel they contribute to others and the greater good of society through their role as a nurse per the ProQOL v. 5 interpretations.

The majority of nurse groups scored in the low risk or negative category for BO. Again, the exception was the average category score range of the GBH LPN from

Hospital A. As a result, per the ProQOL v. 5 interpretations GBH nurses do not experience feelings of difficulties and hopelessness in their ability to perform their job well. According to Stamm (2010), burnout represented one constituent of CF through the gradual onset of negative feelings of ineffective work performance associated with dealing with the aspects of nursing such as high workloads, lack of work environment support, and feelings of helplessness.

The majority of surveyed GBH nurse groups indicated low or negative levels for STS, with the exception of the average scores as indicated by the GBH LPN from *Hospital A.* STS represented the second element of CF which usually relates to rapid symptom onset following exposure to traumatic stressful events in the workplace (Stamm, 2010).

This study's findings indicated that nurses working within the inpatient geriatric behavioral health setting of two hospitals have not significantly experienced CF within the last 30 days based on the group mean scores and interpretation results. In fact, the risk for CF was determined to be low to average based on the interpretations and findings of this study. As a result, the research problem that nurses working within the inpatient geriatric behavioral health setting experience CF has not been supported according to the results of this study.

Summary

Overall, this research study proved a null hypothesis in that the inpatient geriatric behavioral health nurses practicing within the defined hospital settings have not experienced CF within the last 30 days. The combined survey response rate of both hospitals was 69%, which falls within the upper participation goal range of between 50-

75% for this study. The survey response of only one GBH LPN from *Hospital A* coupled with zero survey responses representative of the 18-25 age group of both hospitals may indicate a deficiency in the support of generalizability of this study. This may affect future comparisons of the study findings to other inpatient geriatric behavioral health settings.

Chapter V: Summary

Introduction

This chapter will encompass a discussion of the research study, characteristics of the sample of geriatric behavioral health nurses, and research study findings. The relevance of research study findings in relation to the previous studies in the literature review, the theoretical framework, and the research study question will be discussed. Additionally, the research study limitations, conclusions, implications for nursing, and recommendations for future research will be discussed.

The Research Study

This quantitative research study examined the emotional effects of caring on geriatric behavioral health nurses working within the inpatient setting of geriatric behavioral health. More specifically, this study examined the prevalence of compassion fatigue (CF), burnout (BO), and compassion satisfaction (CS) in geriatric behavioral health nurses. The lack of empirical research studies in the literature related to CF in nurses within the inpatient geriatric behavioral health setting solidified the need to conduct such a study. Both CF and BO are relatively known to cause adverse effects on nurses and additional research was needed to distinguish the prevalence of CF and BO within the geriatric behavioral health nursing population. Further research was also needed to determine if there was an influence of possible protective factors such as compassion satisfaction (CS) that nurses within the geriatric behavioral health environment employ as a way to shield themselves from absorbing the emotional trauma of their patients. This research study contributes to the geriatric behavioral health field of nursing as the future geriatric population is expected to dramatically increase while the

nursing shortage is predicted to worsen.

This quantitative, non-experimental descriptive dual-site research study was conducted to determine if nurses who work within an inpatient geriatric behavioral health setting experience CF. Data collection consisted of demographic characteristics in addition to completion of the Professional Quality of Life (ProQOL v.5) survey to determine the prevalence of CF among the inpatient geriatric behavioral health nurses of two mid-sized rural hospitals in Arkansas. Demographic data collection included age, gender, length of time in years as a nurse, length of time in years as a geriatric behavioral health nurse, and whether the respondent was a registered nurse (RN) or licensed practical nurse (LPN) in *Hospital A* or *Hospital B*. Twenty-six nurses from the two hospitals were invited to voluntarily participate in the research study while 18 nurses ($N=18$) completed the survey. Individual data was analyzed via narrative descriptions from the results of the ProQOL v.5 scoring tool. Group data was analyzed through the ProQOL v. 5 interpretation tool and presented via narrative descriptions. Overall, results of this research study found low to average risk levels for CF and BO along with average to high levels of CS, therefore suggesting compassion satisfaction as a possible protective factor.

Study Findings for the Sample Characteristics

Eighteen geriatric behavioral health nurses working within the setting of inpatient geriatric behavioral health, participated in this research study. The majority of the sample surveyed for this study were female ($n=17$, 94.4%) which means there was one male respondent ($n=1$, 5.6%). Incidentally, it is a well-known fact that the majority of nurses within the arena of nursing are female, which coincides with other study results on

CF wherein the gender of participants were included (Kelly et al., 2015; Sacco et al., 2015). Sacco et al. (2015) reported the existence of significant differences in the CS and CF scores for male nurses, but the data was not included. In contrast, Hunsaker et al. (2015) reportedly found no significant differences between the response rates based on gender. The results of the data from the male respondent in this study showed an average risk for CS, CF, and BO, while the female nurses from both study sites showed a low risk for CF and BO and a high risk for CS. However, these results may have been different if more male nurses had responded.

The respondents from *Hospital A* consisted on seven RN's and one LPN while *Hospital B* consisted of seven RN's and three LPN's. For the most part, there was not a vast degree of reporting differences in the responses of RN's versus LPN's from *Hospital B*. There was significance in survey responses as mentioned above in that *Hospital A* consisted of one LPN which was also the one male in the study. More respondents in this category are needed to determine the validity and significance of these results. Smart et al. (2013) and Sacco et al. (2015), conducted studies on the prevalence of CF within various healthcare providers. However, the differences between the various levels of providers were not reported or reported as not significant.

There were no respondents representative of the 18-25 age group, although, nurses from both hospitals in this age group were invited to participate in this study. This is concerning as empirical studies report younger nurses are often more vulnerable to CF as they may not have fully developed self-protective mechanisms yet, to help prevent them from absorbing the traumatic events of their patients (Sacco et al., 2015; Smart et al., 2013). Moreover, it is possible these newer nurses did not feel comfortable reporting

their attitudes toward CF or perhaps may not express an interest in study participation at this early point in their careers. The ages of the nurses in the other groups are well dispersed in the remaining age categories.

The results for the length in years as a nurse are significantly different than the length in years as a geriatric behavioral health nurse. In *Hospital A*, half of the nurses (n=4, 50%) have been a nurse for 6-15 years, while 38% (n=3) have been a nurse for 16-25 years, and one nurse (13%) has been a nurse for greater than 26 years. In *Hospital B*, six (60%) nurses have been a nurse for 6-15 years, while one nurse (10%) has been a nurse for 16-25 years, and two nurses (20%) have been nurses for over 26 years. The results for length of time as a geriatric behavioral health (GBH) nurse for *Hospital A* shows 63% (n=5) of nurses have been a GBH nurse for 0-5 years, while 38% (n=3) of nurses have been a GBH nurse for 6-15 years, and zero nurses from the 16+ years categories. In *Hospital B*, 40% (n=4) have been GBH nurses for 0-5 years, while 50% (n=5) have been GBH nurses for 6-15 years, and 10% (n=1) nurse has been a GBH nurse for 16-25 years. These findings are significant in that it occurred in both hospitals. The literature showed some reasons that could potentially explain these statistical differences. The first possible explanation for the decreased length of time as a GBH nurse versus a long-term nurse is that both hospitals may have experienced managerial change within the last year (Sacco et al., 2015). However, this is not the case as both managers in both hospitals have been there significantly longer than one year. Sacco et al. (2015) reported another reason may have represented a change in the acuity or age-mix levels in these units. Again, this is not the case as both hospitals have had the same patient and age

acuity level for many years. The statistical meaning of these results warrants further research to determine the resultant significance.

Study Findings for the Theoretical Framework

This study was guided by Erickson, Tomlin, and Swain's Modeling and Role Modeling Theory (MRM, 1983). The MRM theory was designed for the delivery of patient care by nurses. However, the theory can be easily adapted for nurses at risk for CF development. According to Petiprin (2016), the focus of the MRM theory enabled the healthcare organization, nurse leaders, and nurses as peers to deliver focused respectful and nurturing self-care interventions to nurses at risk for, or who have experienced CF. This is accomplished through understanding and honoring the uniqueness of each individual nurse to be able to assist in their self-care management towards achievement of optimal well-being (Petiprin, 2016). The process of Modeling encompasses understanding each nurse's perspective of stress adaptation. The process of Role Modeling refers to the development and implementation of unique interventions aimed at CF prevention and management (Petiprin, 2016).

The MRM theory is applied through three roles. Petiprin (2016) claimed the first role is facilitation wherein the CF affected nurse is provided and guided with the necessary steps to attain resources for CF management. The second role is nurturing wherein the CF affected nurse is assisted in self-choosing the best course of action to decrease stressors and employ adaptation strategies (Petiprin, 2016). The final role is unconditional acceptance of the CF affected nurse through interactions with others (Petiprin, 2016).

According to Erickson et al. (2013), there are five goals of nursing interventions: (1) to build trust; (2) to promote positive orientation of the client; (3) to promote the client's control; (4) to promote and affirm the client's strength's; and (5) to set health-directed mutual goals. With these five goals in mind, sound evidence-based nursing interventions can be developed and implemented to prevent and manage CF in this nursing population. The overall goal of the sound nursing interventions is to create and promote a healthy positive work environment to prevent and minimize the prevalence of CF development in nurses.

Overall, the study results showed the prevalence of CF in the GBH nurses as average or low risk. However, several of the ProQOL v. 5 survey item statements revealed areas of concern that show improved courses of action aimed at decreasing stress, risk for burnout, and preventing CF would be beneficial for both hospitals. Moreover, it should be noted these areas of concern were more prominent in *Hospital A* than *Hospital B*. The first following paragraph indicates data results reflective of burnout while the second paragraph indicates data results reflective of being at risk for or indicating the prevalence of CF in some of the GBH nurses.

Fifty percent of GBH nurses in *Hospital A* reported they only rarely and sometimes feel invigorated after working with patients they care for. Similarly, 30% of GBH nurses in *Hospital B* reported they sometimes feel invigorated after working with their patients. Seventy-one percent of GBH nurses from *Hospital A* stated they were often preoccupied with more than one person they cared for, while 25% of GBH nurses stated they were very often preoccupied with more than one person they cared for in the past 30 days. *Hospital B* showed varied responses and percentages on this item statement

with 50% of GBH nurses stating they were sometimes preoccupied with more than one person being cared for. These responses signify increased stress likely from needing time off to care for those they are preoccupied about. One GBH nurse from *Hospital A* reported rarely liking their job as a nurse. Seventy-five percent of GBH nurses from *Hospital A* and 70% of GBH nurses from *Hospital B* report they sometimes, often, and very often feel worn out because of their work as GBH nurse. Thirty-eight percent of GBH nurses from *Hospital A* reported they only sometimes have happy thoughts about their patients and how they could help them. Seventy-five percent of GBH nurses from *Hospital A* and 50% of GBH nurses from *Hospital B* reported feeling overwhelmed because their case work load seems endless sometimes, often, and very often. Twenty-five percent of GBH nurses from *Hospital A* reported they felt they made a difference through their work as a GBH nurse only some of the time. Seventy-five percent of GBH nurses from *Hospital A* and 40% of GBH nurses from *Hospital B* reported feeling “bogged down” by the nursing system sometimes, often, and very often. The resultant data from the aforementioned statement item responses likely indicate BO (at the very least) which stems from the nursing practice environment itself (Coatzee & Klopper, 2010). Moreover, the resultant data indicates a depressive atmosphere from the type and acuity of patients cared for, heavy patient caseloads, new and evolving technology, from the overall environment in the nursing unit they work in, or from the need for self-rest (Barkin, 2007). Coatzee and Klopper (2010) described weariness, decreased enthusiasm and ability, and desensitization as compassion discomfort which can be relieved by self-rest.

Thirty-eight percent of GBH nurses in *Hospital A* reported they often found it difficult to separate their personal life from their work as a GBH nurse, while 20% of GBH in *Hospital B* reported finding it sometimes difficult to separate their personal life from their life as a GBH nurse. Twenty-five percent of GBH nurses from *Hospital A* and 10% of GBH nurses from *Hospital B* reported finding they are not as productive at work because of losing sleep from experiencing the traumatic experiences of patients cared for some of the time. More startlingly, 50% of GBH nurses from *Hospital A* and 80% of GBH nurses from *Hospital B* reported they have been affected by the traumatic stress of their patients rarely to some of the time. Fifty percent of the GBH nurses from *Hospital A* and 30% of GBH nurses from *Hospital B* reported feeling trapped by their job as a nurse at least some of the time. Thirty-eight percent of GBH nurses from *Hospital A* and 40% of GBH nurses from *Hospital B* reported feeling on “edge” about various things some of the time because of their job as a GBH nurse. All of the nurses (100%) from both study sites reported being startled or jumping at unexpected sounds from rarely to very often. Sixty-three percent of GBH nurses from *Hospital A* and 70% of GBH nurses from *Hospital B* reported feeling depressed related to experiencing the trauma of their patients. One GBH LPN from *Hospital A* and one GBH RN from *Hospital B* reported often and sometimes having intrusive, frightening thoughts because of their nursing work. Empirical literature stated these findings reflect symptoms of developing or having CF which likely occurs from working in an emotionally stressful environment such as inpatient behavioral health (Coatzee & Klopper, 2010; Sabo, 2011; Peterson-Owen & Wanzer, 2014). Coatzee and Klopper (2010) recommended effacing CF in its early stages to hopefully assist nurses in self-restoration before it’s too late. It is

imperative for the healthcare organization to ensure the development and adoption of interventions aimed at CF and BO prevention and management are available and encouraged for use for nurses working within the GBH inpatient setting.

Coaching and mentoring/preceptorship of newer nurses by more seasoned nurses reflects one step in preventing and recognizing CF (Coatzee & Klopper, 2010; Hunsaker et al., 2015; Perry et al., 2011). This is important because a study of the prevalence of CF in nurses by Kelly et al. (2015) showed younger nurses often leave the nursing profession after experiencing BO and CF. Moreover, a study by Sacco et al. (2015) found nurses over 50 have likely developed protective mechanisms against the development of CF. A study by Berg et al. (2016) recommended managers with strong supportive working relationships are key in recognizing ineffective coping in nurses to intervene before BO and CF develops. Erickson et al. (2013) recommended the availability of confidential employee assistance programs (EAP's) are beneficial for nurses to seek self-guidance for CF self-management. However, it is imperative to ensure there are no perceived social stigma's associated with seeking EAP assistance which was described as existing in a healthcare organization in a study performed in various nursing areas by Berg et al. (2016). Finally, a study conducted by Van Sant and Patterson (2013) in various inpatient psychiatric units showed nurses can benefit from self-protecting themselves from the emotional connectedness that occurs between the nurse and the patient. The results of the study showed the benefits of educating psychiatric nurses on how to know when to emotionally connect and disconnect from their patients to prevent emotionally absorbing their traumatic experiences. This is known as self-protection wherein positive outcomes

are associated with knowing when to self-replenish/refill to self-release from experiencing the patient's emotional pain (Van Sant & Patterson, 2013).

Ensuring the existence of a sound, healthy practice environment will help retain experienced nurses, decrease nursing turnover, and provide patients with the best chances for favorable outcomes. This is paramount with the ever-increasing nursing shortage, predicted increased rise in the geriatric population, and ongoing tighter economical healthcare restraints.

Study Findings for the Research Question

Do nurses experience CF on an inpatient geriatric behavioral health unit?

This question was answered with descriptive narrative statistics that revealed high levels of CS in three of the group categories of nursing with the exception of an average level of CS in the LPN group from *Hospital A* (see Table 14). Again, the LPN group from *Hospital A* represents one nurse without other respondents in this category for result comparison. The risk for BO in the GBH nurses was low in all nurse categories with the exception the LPN from *Hospital A* which posed an average risk for BO. The same results were identified for the STS category which BO and STS combined reflect the risk or prevalence of CF in a given sample. While no other known studies exist in the literature with specificity to GBH nurses working within an inpatient setting, a study by Berg et al. (2016) found higher stress triggers in trauma staff when caring for geriatric patients who have experienced traumatic events. Peterson-Owen and Wanzer (2014) conducted an integrative review of military healthcare teams to attempt to find a uniform definition of CF. The study identified CF as an occupational hazard from the repeated exposure to trauma placing healthcare staff at increased risk to their mental and physical

well-being. GBH patients often continuously re-live their past traumatic events related as a result of their worsening psychological impairments as a result of increasing age. All too common these patients will converse about the traumatic experiences of their younger lives (especially if they were victims of repeated abuse or had high stress occupations such as war veteran, police, social work, etc.) as if it is repeatedly recurring. Lastly, a study conducted by Van Sant and Patterson (2013) on the emotional connectedness of psychiatric nurses in various inpatient psychiatric units, reported many of the nurses self-protected themselves in knowing when to connect and disconnect with their psychiatric patients. Further examination of ProQOL statement item responses show some nurse response groups at possible risk for BO and CF as previously discussed in the theoretical section of this paper. With these results in mind, GBH nurses are theoretically a vulnerable population for CF which shows a demonstrated need for increased study, awareness, and education within this population about CF prevalence.

Overall, this research study found that the inpatient GBH nurses within the inpatient GBH unit setting of two hospitals have not significantly experienced CF within the last 30 days. The combined survey response rate of 69%, falls within the upper rate of participation goal range of between 50-75% for this study. All of the nurse groups of GBH nurses fall in the low risk category for experiencing CF with the exception of the one LPN which indicated average risk for CF. The lack of respondents from the 18-25 age group may have been a factor as current empirical literature supports this age group as potentially being more vulnerable to CF. Future studies on the prevalence of CF in GBH nurses in the inpatient setting would be beneficial in supporting the results of this study.

Study Limitations

Limitations of this study include a small sample size, a lack of respondents in the young adult category, and only one male LPN respondent. Additional demographics of degree certification, currently in higher education, shift worked, hours worked, and marriage status could have added depth and meaning to this study.

Study Conclusions

Four major conclusions can be made from this study. The first conclusion can be inferred from the demographic characteristics of this study. First of all, there were no respondents in the 19-25 years old age category from either hospital. This infers a lack of interest in responding to this study for unknown reasons. The second noticeable demographic characteristic was that, overall, only one nurse had been a geriatric behavioral health nurse greater than 15 years although 39% of nurses from both hospitals reported being a nurse greater than 16 years. This may infer a lack of organization retention/recruitment of GBH nurses with greater than 15 years of geriatric nursing experience. The last demographic characteristic difference based on the results of this study reflects an overall lack of difference in the responses from GBH RN's to GBH LPN's from *Hospital B*. There are a few differences, however, these differences are only by one higher or lower on the Likert response scale the majority of the time. Regarding the RN/LPN difference from *Hospital A*, there is only one respondent from the LPN category, making it difficult to infer reasoning differences related to the presence of only one LPN response from *Hospital A*. The LPN responses from *Hospital A* were markedly different for the most part, from the responses from the GBH RN's from *Hospital A*. Again, a larger GBH LPN sample is needed to determine if this data represents outlier

data or the overall group of GBH LPN's from *Hospital A* data would change within a larger sample group.

The second major conclusion from this study reflects a generally high level of CS in the inpatient GBH nurses from both hospitals. Seventeen of 18 nurses from both hospitals scored 46 to 49 on the CS scale while a score of 50 represents the national average, according to Stamm (2010). Higher levels of CS infer GBH nurses feel pleasure and satisfaction in their ability to help others at work and outside of work. One-hundred percent of GBH nurses stated they were often or very often proud of what they can do to help others.

The third major conclusion based on the results of this study shows low levels (average in the one LPN respondent group from *Hospital A*) in the likelihood of BO in the GBH nurses from both hospitals. BO represents one element of CF, usually has a slow onset, is indicative of heavy workloads or non-supportive work environment, and encompasses the negative feelings of dealing with work and the perception of the inability to perform well in the role of a nurse (Stamm, 2010). The overall average score for BO for both hospitals was 17, which was very low in comparison to 50 being the national average on the ProQOL scores for BO. The organizational promotion of prevention and management strategies aimed at reducing work-related stress and coping strategies coupled with ensuring manageable work-loads would be very beneficial for GBH nurses to minimize development of BO, which can ultimately progress to CF.

The fourth and last major conclusion based on the results of this study shows a predominately low overall risk level for the prevalence or development of CF in the sample group. STS represents the second element of CF according to the ProQOL v.5

survey scoring tool. The GBH nurses score on STS ranged from 16 to 19 (29 on the one GBH LPN group from *Hospital A*) which signifies low risk for STS as 50 reflects the average score. According to Stamm (2010), STS usually develops rapidly after a triggering recent traumatic event experience. Symptoms of STS may include trouble sleeping, upsetting mind images of the event, being easily afraid, and avoidance of event reminders (Stamm, 2010). Seeking professional help or guidance is advised if CF develops.

Summary

In summary, the purpose of this study was to examine the prevalence of CF in nurses who care for patients in the inpatient GBH setting. CF in nursing is an ongoing problem that is currently receiving increased awareness. McHolm (2006) described CF as physical, social, spiritual, and emotional fatigue that overcomes a person, causing an omnipresent decline in the ability, desire, and energy to care for others (Clifford, 2014). Nurses can be more vulnerable to CF because they become partners instead of observers in the healthcare journeys of their patients and of those around them in their personal lives (Boyle, 2011).

The combined findings and interpretations of this research study revealed that the inpatient geriatric behavioral health nurses from both hospitals have not significantly experienced CF within the last 30 days. The risk for CF is defined as low risk in five of the six groups of nursing categories with the exception of average risk within the LPN category of *Hospital A* (see Table 14). However, it should be noted that there was only one LPN respondent in *Hospital A* which indicates the results of average risk may have been different if more respondents were represented in this sample group. Nonetheless, a

risk level for average in this category falls within the range of not experiencing CF within the last 30 days reflects the same end result as the other remaining five categories.

The demographic results for age were relatively well-represented in the various age groups. There were no respondents in the 19-25 age group in either hospital even though respondents in this age group were invited to participate in this research study from both hospitals. This could potentially infer a lack of interest in this study on the prevalence of CF in GBH nurses for this age group. The demographic results of age were not included in the narrative descriptive format of the table related to the relatively well-dispersed age groups of each reporting age category. The length of time in years as a nurse, were longer than the length of time in years as a nurse in the geriatric behavioral health setting (see Tables 2 & 3). This may represent increased turnover or decreased retention of nurses within the inpatient geriatric behavioral health setting as these results were present in both hospitals. Seven of eighteen (44.4%) nurses from both hospitals were representative of being a nurse for greater than 16 years, while only one nurse reported working as an inpatient geriatric behavioral health nurse in the 16-25-year range. The results showed 94.4% of nurses have worked in the inpatient geriatric behavioral setting 0-15 years.

The results of the ProQOL v. 5 survey showed 17 of 18 nurses from both hospitals reported high levels of compassion satisfaction (CS). According to Stamm (2010), CS reflected the pleasure derived from the ability to perform his/her job well. All respondents from the study reported they often or very often receive satisfaction from being able to help others. However, one-third of geriatric behavioral health licensed

practical nurses (GBH LPN's) from *Hospital B* and the GBH LPN from *Hospital A* reported they felt invigorated by those they care for only some of the time.

Burnout (BO) is an element of CF associated with feelings of hopelessness or ineffective coping mechanisms and having difficulty in job performance (Stamm, 2010). As a group, the nurses from both hospitals reflected a total BO risk score of less than 29 which is very low as the average risk level score in this area is 50. Ninety-four percent of the nurses from both hospitals reported experiencing happiness and connectedness to others often or very often within the last 30 days. However, half of the respondents reported they sometimes or rarely feel trapped by their job as a nurse or lose sleep over experiencing the traumatic events of those cared for within the last 30 days. The range of scores for feeling worn out from working as a nurse are very scattered throughout all categories suggesting the need to take more time for energy replenishment. Fifty-six percent of respondents reported sometimes or often feeling "bogged down" by the system within the last 30 days. This could signify feelings of not being able to make a difference reflective of a very high work-load or a non-supportive work environment (Stamm, 2010). All of the GBH nurses reported being a caring person often or very often.

The secondary traumatic stress (STS) scale reflects the second component of CF which encompasses the secondary or work-related exposure to tremendously traumatic stressful occurrences (Stamm, 2010). Patients in the geriatric behavioral health environment may often experience traumatically violent psychological outbursts related to their acute (and often chronic) geriatric behavioral conditions such as dementia or Alzheimer's disease (Hiskey, 2012; King, 2012). Being alert to this ever-constant possibility can signify a working environment of heightened awareness which intensifies

potential stressors for GBH nurses. Interestingly, as a group, the GBH nurses reported rarely to very often being pre-occupied with caring for more persons than currently being cared for within the last 30 days. All of the respondents reported never to very often being startled or jumping at unexpected sounds. Ninety-four percent of respondents find it at least sometimes difficult to separate their personal life as a nurse. Eighty-three percent of GBH nurses reported they were very often satisfied in their ability to help others. Moreover, 94.4% of GBH nurses reported they were happy in choosing to work as a GBH nurse. Contemplating these results, the sample has adequate personal or organizational effective self-protective or stress-coping mechanisms in place within the inpatient geriatric behavioral health setting. The literature shows increased recognition and understanding of CF coupled with effective prevention and management plans and policies are key to reducing CF in caregiving professions (Boyle, 2011).

Some of the key question items have outlier scores while the average ProQOL v.5 survey tool item ranking scores were used to infer group scores. These outlier scores may be more significant in a larger survey response. The category of one GBH LPN from *Hospital A* represented such an outlier as this signified the only respondent from this group. Further, there were no respondent's representative of the 19-25 age group and only one male respondent while 94.4% of respondents were female. Therefore, based on this sample size and demographic characteristics, it is difficult to generalize the findings.

Overall, in comparing existing empirical literature conducted on CF, this study found a predominately low risk of CF and a high level of CS in regards to the care that nurses provide within the inpatient geriatric behavioral health setting at two hospitals. Advancements in medical technology have increased the average life expectancy in most

countries. This increasing geriatric population has resulted in an even greater demand for nurses in the acute care setting as well as in the community setting. Failure to recognize and take steps to reduce CF can further reduce the availability of competent nursing staff to provide high quality care. The American Institute of Stress website (n.d.) claimed that even Mother Theresa made it mandatory for nuns to take a year off every four or five years to emotionally heal from caregiving (www.stress.org).

Recommendations for Future Research

As the complexities in care provision increase coupled with the projected doubling in the aging population, nurses will likely increase their risk for experiencing CF with the continued feelings of the increased burden to provide optimal nursing care with fewer resources. Additional empirical research studies on areas of nursing affected by CF can lead to increased recognition and organizational implementation of interventions aimed at reducing the occurrence of CF. The results of this study indicated it was possible to work as a clinical nurse within highly stressful environments such as the inpatient geriatric behavioral health setting where patients experience traumatic experiences, and have a predominately low risk of experiencing CF.

A research study conducted on the prevalence of CF within the inpatient GBH setting of multi-site healthcare organizations with larger sample sizes would be beneficial for comparison of the results from this study. Additional demographic collection of degree certification, if currently in higher education, shift worked, hours worked, and marriage status could potentially add depth to this study. The determination if social stigma regarding CF exists within the nursing environment and the availability or lack of organizational and personal resources for CF prevention and management could further

add to existing empirical literature on CF in nursing. Further, it would be beneficial to conduct studies on the prevalence of CF within the inpatient GBH setting and other clinical areas of nursing for a longer period of time such as every other month or quarterly for a period of one year to determine the probability of any seasonal differences or the existence of other variables affecting the prevalence of CF in this study group. Future studies on the prevalence of CF within the geriatric behavioral health would be beneficial if additional survey tools could be employed to determine if GBH nurses utilize self-protection and self-coping strategies aimed at minimizing or blocking the effects of repeated exposure to the traumatic events experienced by geriatric behavioral health patients. Further, the inclusion of research study questions to identify and determine the presence of organizational interventions to promote nursing self-care and minimize stress to be able to lead to the development of strategies that could be employed in other healthcare organizations to minimize the risk for CF in GBH nurses and in other clinical nursing areas.

On a global scale, research studies on large national nursing groups such as the American Nurses Association or within a state level nursing chapter, would be beneficial in determining which clinical areas of nursing are more prone to the development of CF. Further studies could be conducted at local levels on the identified higher risk clinical nursing areas. While global studies on the prevalence of CF within nursing have been conducted in countries such as Canada, Great Britain, and Australia, there has been limited empirical research studies of the same magnitude conducted in similar settings within the United States.

Implications for Nursing

Research studies on the prevalence of CF in nursing have been conducted in the settings of the emergency room, general psychiatry, oncology, critical care, hospice, pediatrics and, the military. There has been limited empirical research conducted on those taking care of the geriatric population. The results of this study indicated it was possible to work as a nurse in highly stressful environments such as inpatient geriatric behavioral health and have a low risk of developing CF. A more in-depth study on GBH nurses would be beneficial in determining if nurses in this area employ self-protective and self-coping mechanisms as a way to guard against experiencing the traumatic stressful events of inpatient geriatric behavioral health patients. This is because while several of the survey item statement responses reflected the possibility of experiencing stressful events, the overall group results showed a low probability of CF development.

A more detailed look into why few nurses remain in the geriatric behavioral health environment beyond 15 years is needed. The study results showed the type of GBH nurse (RN or LPN) was not a significant factor in whether one would develop CF over the other as the resultant differences were minimal. However, these results may have changed if there were more GBH LPN respondents from *Hospital A* to ensure a more adequate comparison to other nurse groups.

Research to recognize and define the existence of CF is ongoing in the realm of clinical nursing. The results of research studies can help to identify and develop strategies and interventions for organizational implementation to aid in the prevention and management of CF in the inpatient geriatric behavioral health setting and other nursing care based areas.

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APPENDIX A

Survey Participation Invitation

You are invited to participate in a voluntary survey for a research study that will take approximately 15-20 minutes to complete. Thank you in advance for your valuable time and opinion. Your participation is strictly voluntary and you may withdraw at any time from the study with no direct effect on the participant's job or position. Please use the following link to access the consent form followed by the survey:

<http://cfstudyatususancampbell.questionpro.com>.

APPENDIX B

Informed Consent Statement

Informed Consent Form for Participation in a Professional Quality of Life Scale Survey Arkansas Tech University

Title of Research Study

The Emotional Cost of Caring: Compassion Fatigue Experienced by Nurse Staff on an Inpatient Geriatric Behavioral Health Unit.

Principal Investigator

Susan A Campbell, BSN, RN

Research Participation Request

You are invited to take part in this research study because you are a Registered Nurse or Licensed Practical Nurse who cares for geriatric patients within the geriatric behavioral health setting. This study seeks to determine if nurses on an inpatient geriatric behavioral health unit experience compassion fatigue through the completion of the Professional Quality of Life Scale (ProQOL) survey, Version 5 (B. Hudnall Stamm, 2009). Additional questions will be asked regarding demographics to determine age, gender, length of time as a nurse, length of time as a nurse caring for geriatric behavioral health patients and, if respondents are a Registered Nurse or Licensed Practical Nurse.

Research Purpose

The aim of this study is to determine if Registered Nurses and Licensed Practical Nurses on an inpatient geriatric behavioral health unit experience compassion fatigue.

Research Participation

Taking part in this study by completing the survey questionnaire is entirely voluntary. Within the inpatient geriatric behavioral health setting, all Registered Nurses and Licensed Practical Nurses are invited to voluntarily participate in survey completion.

Time Duration of Survey

It will take approximately 15-20 minutes to complete the survey questionnaire if you agree to take part in this research study.

Research Study Risks

There are no known risks to the participant associated with this research study.

Potential Benefits

You will not directly benefit from taking part in this research study. However, nursing science may gain further understanding of the incidence of compassion fatigue in nurses who care for inpatients in the geriatric behavioral health unit setting as little empirical research has been completed in this focus area. It will be impossible to discern who did or did not complete a survey as all surveys will be aggregated anonymously.

Statement of Confidentiality

Participation in this research study will only be known by you. The survey will be accessible for three weeks to allow ample time for survey completion. The data collected through this study will be kept for a period of one year or less in a secure location and then destroyed. No personally identifiable information will be shared in the event of any publication or presentation resulting from this research. The nurse classification question and Professional Quality of Life survey results are numerically scored by frequency of occurrence without the inclusion of personal identifying information to ensure anonymity and confidentiality. The primary investigator will use the numeric survey results to analyze and input data into expressive statistics. The data information obtained from the nurse classification question and the ProQOL surveys will be reported as grouped data for ensured identity protection.

Compensation for Participation

You will not receive any compensation for participation in this research study.

Research Funding

There are no grantors, institutions, or companies involved in the funding or grants for this research study. The primary investigator does not have any conflicts of interest about any consultative or financial relationships regarding this study.

Voluntary Participation

Taking part in this research study is voluntary. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time.

Contact Information for Questions or Concerns

You have the right to ask any questions you may have about this research study or survey questionnaire. If you have questions, complaints, or concerns, please contact Susan A. Campbell, Primary Investigator, at 417-372-1788 or via email scampbell21@atu.edu. You may also contact Dr. Shelly Randall by email at srandall@atu.edu or through the Arkansas Tech University (ATU) Nursing Department at 479-498-2832.

If you have questions regarding your rights as a research participant or you have concerns or general questions about the research, contact Dr. Jack Tucci, Chair of the ATU Institutional Review Board at jtucci@atu.edu.

For more information about participation in a research study and about the Institutional Review Board (IRB), a group of people who review the research to protect your rights, please visit Arkansas Tech University's IRB web site at <http://www.atu.edu/research/humansubjects>.

Consent

By completing the attached ProQOL survey and the additional demographic questions regarding designation of Registered Nurse or Licensed Practical Nurse, age, gender, length of time in years as a nurse, and the length of time in years of caring for geriatric behavioral health patients, you are indicating that you consent to participate in this study. If desired, please print a copy of the consent form for your records.

Thank you for your time and consideration,

Susan A. Campbell, BSN, RN

Please check the acceptance box if you choose to consent to participate in this completely voluntary survey.

APPENDIX C

ProQOL v.5 Questionnaire

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE

(PROQOL) VERSION 5 (2009)

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

	1=Never	2=Rarely	3=Sometimes	4=Often	5=Very Often
_____ 1. I am happy.					
_____ 2. I am preoccupied with more than one person I [help].					
_____ 3. I get satisfaction from being able to [help] people.					
_____ 4. I feel connected to others.					
_____ 5. I jump or am startled by unexpected sounds.					
_____ 6. I feel invigorated after working with those I [help].					
_____ 7. I find it difficult to separate my personal life from my life as a [helper].					
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].					
_____ 9. I think that I might have been affected by the traumatic stress of those I [help].					
_____ 10. I feel trapped by my job as a [helper].					
_____ 11. Because of my [helping], I have felt "on edge" about various things.					
_____ 12. I like my work as a [helper].					
_____ 13. I feel depressed because of the traumatic experiences of the people I [help].					
_____ 14. I feel as though I am experiencing the trauma of someone I have [helped].					
_____ 15. I have beliefs that sustain me.					
_____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.					
_____ 17. I am the person I always wanted to be.					
_____ 18. My work makes me feel satisfied.					
_____ 19. I feel worn out because of my work as a [helper].					
_____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.					
_____ 21. I feel overwhelmed because my case [work] load seems endless.					
_____ 22. I believe I can make a difference through my work.					
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].					
_____ 24. I am proud of what I can do to [help].					
_____ 25. As a result of my [helping], I have intrusive, frightening thoughts.					
_____ 26. I feel "bogged down" by the system.					
_____ 27. I have thoughts that I am a "success" as a [helper].					
_____ 28. I can't recall important parts of my work with trauma victims.					
_____ 29. I am a very caring person.					
_____ 30. I am happy that I chose to do this work.					

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APPENDIX D

ProQOL v. 5 Scoring Tool

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section**, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

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

Total: _____

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

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about

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

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

the effects of helping when you are *not* happy so you reverse the score

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

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

APPENDIX E

ProQOL v.5 Interpretation Tool

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

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

Compassion Satisfaction _____

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

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

Burnout _____

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

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

Secondary Traumatic Stress _____

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

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

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