A STUDY OF THE INTERRELATIONSHIP OF COMPASSION FATIGUE, COMPASSION SATISFACTION AND SELF-CARE STRATEGIES FOR CARDIOVASCULAR INTENSIVE CARE UNIT NURSES: A PILOT STUDY

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by

Maureen Ann Parsons

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Abstract

A Study of the Interrelationship of Compassion Fatigue, Compassion Satisfaction and Self-Care Strategies for Cardiovascular Intensive Care Unit Nurses: A Pilot Study

by

Maureen Ann Parsons

Statement of Problem
Caring for patients in a cardiovascular intensive care unit (CVICU) generates significant work-related stress and can result in employee dissatisfaction and mental exhaustion. This stress comes from burnout, the chronic psychological syndrome of perceived demands from work outweighing perceived resources in the work environment (Potter et al., 2010). The repeated exposures of the CVICU RN to work-related critical incidents are related to adverse health outcomes such as compassion fatigue (CF) and burnout (BO) (Prati, Pietrantoni, & Cicognani, 2011). CF, defined as the traumatization of helpers through their efforts to help others, is a relational source of stress that also weighs heavily on CVICU RN’s. Research has shown that CF can take a toll on the caregiving professional as well as the workplace, causing decreased productivity, more sick days used and, higher turnover (Pfifferling & Gilley, 2000).

Sources of Data
Data were collected from a convenience sample of 47 intensive care unit nurses working in a twelve-bed CVICU at the Sulpizio Cardiovascular Center at the University of California in San Diego. Nurses completed a demographic data sheet and two surveys. These surveys were the Self-Care Assessment Worksheet (SCAW) (Saakvitne & Pearlman, 1996), and the Professional Quality of Life Scale (Pro-QOL version 5) which measures compassion satisfaction (CS) and CF. CF has two subscales: secondary traumatic stress and BO (Stamm, 2009).

Conclusions Reached
There was a moderately strong correlation between secondary traumatic stress and years of working in the CVICU (.481, p=.000). The spiritual self-care subscale of SCAW was positively correlated with CS (r=.263, p = .037). Secondary traumatic stress was significantly, negatively correlated to all other subscales of self-care at the .05 level. Based on these preliminary findings, it is highly recommended that intensive care nurses engage in activities that impact emotional or psychological well-being to reduce secondary traumatic stress and burnout in the workplace.

Committee Chair
JoAnn Daughertry, Ph.D., RN, CNL

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CHAPTER ONE: INTRODUCTION

Cardiovascular Intensive Care Unit Nurses (CVICU RNs) play a vital role in the physical, emotional and spiritual care of their acutely ill patients. An integral component of the CVICU RNs workday is to assist in the treatment of patients who suffer from advanced heart failure and/or multiple comorbidities as well as other related critical issues. The variety and seriousness of clinical conditions that are typical to the CVICU RNs experience in caring for the critically and chronically ill can, and often does, lead to intense emotional distress and an increasing sense of mental and physical exhaustion. Clearly, one of the more recurrent and significant challenges for those working with patients involved in advanced or end-stage heart failure, is the development of strategies that are adequate to the task of coping well, not only with the patient’s immediate crises but also with those stress factors that are an inherent part of longer-standing relationships formed with the chronically ill patient and their families.

Certainly, the CVICU RNs participation in his or her patient’s death is generally recognized as an “emotional stressor.” However, when the demise of one’s patient is protracted, at times extending over a multiple of months, the challenges of coping well with death are intensified and dealing well with the complications of dying become ever more problematic. Extended care given to the acutely and often chronically ill also entails the growth of the nurse’s emotional involvement and personal commitment to her patient’s recovery (Potter et al., 2010).

In the CVICU RNs setting, attachments are naturally formed to their patients and their families. The increase of the patients suffering serves to exacerbate the nurse’s angst concerning the outcome of her caregiving. As her patient continues to decline, the nurse is
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repeatedly confronted with the difficult task of coming to terms with the fact that in spite of one’s best intentions, efforts and applied learning, her dedication to the patient’s recovery often proves unsuccessful (Potter et al., 2010).

Within the healthcare industry there has grown an increasing awareness about the need to not only identify the particular causes of stress-related exhaustion and burnout, but also to provide practical remedies or ‘self-care’ strategies that will help improve the quality of the CVICU RNs personal life and work experience. It is hoped that the right discovery and successful implementation of such strategies would aid not only in the work-satisfaction experience and job-retention rate of its nurses but likewise help ensure the industry’s ability to provide a sustainable high level of care for its patients.

The genesis of this study derives in part from having read the previous research study conducted by Alkema, Linton, and Davies (2008), investigating the relationship between self-care, compassion satisfaction, compassion fatigue, and burnout among hospice care professionals (HCPs). This study’s discussion of the elements of compassion satisfaction, compassion fatigue and burnout, and their significance for nurses working in intensive care conditions functions as a model statement of the core issues involved in this proposed study and provides useful methods that might be employed in the pursuit of a remedy.

Unlike the specific focus and limited application of the Alkema and colleagues research to HCPs, this research study borrows useful categories of classifications from Alkema and colleagues (2008) and expands them to address the unique issues and situations of the CVICU RN. The major difference between the study of stress-related issues in the setting of the HCP context and that of the CVICU RN is the palliative versus curative expectation, specifically, while the HCP practice takes place in a situation where the expectation of death is a given and
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thereby the care rendered is palliative in nature, the CVICU RNs work is by design committed to curative care procedures. The significant impact these differing work “orientations” have upon both nurses and their patients is essential to the purpose and value of this study.

In order to facilitate the discovery and presentation of practical stress-reducing or eliminating strategies, this research study incorporated the well-recognized and often employed theoretical model provided by Lazarus and Folkman’s Stress and Coping Model (1984). In brief, this theoretical framework provides both a manner with which to account for various kinds of stress while also incorporating useful methods of coping with it. The theory will be discussed more thoroughly in Chapter Two.

**Background and Significance**

In July of 2002, the U.S. Department of Health and Human Services (USDHHS) issued a statement regarding the projected shortage of registered nurses in hospitals throughout the United States (U.S. Department of Health & Human Services, 2002). This progressive shortfall of employable caregivers has directly impacted the work-related demands made upon all registered nurses. Given the global increase in the aged population, the growing intensity of healthcare problems and the expanding incidence of chronic illnesses, nurses are being faced with an ever-increasing variety of workplace sources of stress.

The increase of workplace demands and challenges in the often fast-paced and chaotic environment of an intensive care unit has lead a significant number of hospitals to be concerned about how to provide ways for nurses to deal with workplace stress and the psychosocial conditions of burnout and compassion fatigue (Maiden, Georges, & Connelly, 2011). Clearly, the essential elements of burnout are present in any work-related environment.
The specific form of burnout that directly affects those involved in care-giving professions has been termed “compassion fatigue” (Stamm, 2010). Unlike the generic or conventional use of the term “burnout,” compassion fatigue is exclusively associated with particular professions, namely; nurses, social workers, counselors and those involved in care giving professions (Stamm, 2010).

The importance of stress-oriented studies is obvious. The impact of failing to discover and cope with conditions that are stress-sourced negatively impacts nearly every aspect of the caregiving profession (e.g., job satisfaction, staff recruitment and work retention) (Hays, All, Mannahan, Cuaderes, & Wallace, 2006). It is noteworthy that as early as 2004, Medland, Howard-Ruben, and Whitaker argued for the fostering of psychosocial wellness in the workplace as a crucial strategy for promoting nurse retention and improving practice environments.

The Problem

Caring for patients in a cardiovascular intensive care unit generates significant work-related stress and can result in employee dissatisfaction and mental exhaustion. This stress comes from burnout, the chronic psychological syndrome of perceived demands from work outweighing perceived resources in the work environment (Potter et al., 2010).

The repeated exposures by the CVICU RN to work-related critical incidents are related to adverse health outcomes such as compassion fatigue and burnout (Burgess, Irvine, & Wallymahmed, 2010; Prati, Pietrantoni, & Cicognani, 2011). Compassion fatigue, defined as the traumatization of helpers through their efforts to help others, is a relational source of stress that also weighs heavily on CVICU RNs. Researchers have shown that compassion fatigue can take a toll on the caregiving professional as well as the workplace, causing decreased productivity, more sick days used and, higher turnover (Pfifferling & Gilley, 2000).
Purpose of the Research

Gaining a better understanding of the extent to which CVICU RNs are affected by conditions such as burnout and compassion fatigue is critical for the development of a positive and nurturing practice environment.

Thus, the purpose of this research study was to explore the relationship between compassion fatigue, compassion satisfaction and self-care for CVICU RNs caring for cardiac patients at the Sulpizio Cardiovascular Intensive Care unit at University of California San Diego (UCSD).

Research Question/ Hypothesis

The research question is: “Is there a relationship between compassion fatigue, compassion satisfaction and self-care among CVICU RNs?”

Experimental Hypothesis: “CVICU RNs who engage in several self-care activities experience higher levels of compassion satisfaction and lower levels of compassion fatigue.”

It was hypothesized that there would be a direct positive relationship between the participant’s level of self-care and his or her compassion satisfaction. Also hypothesized was that as the participant’s scores on the self-care subscales increased, his or her scores on compassion fatigue subscales would decrease indicating a direct negative or inverse relationship.

Research Variables

The dependent variables in the study were the CVICU RNs self-reported compassion satisfaction and compassion fatigue scores measured by the Professional Quality of Life Survey version 5 (Pro QOL) (Stamm, 2009) on the quality one feels in relation to their work as a helper.

The independent variables were the reported level of engagement in self-care activities on the Self Care Assessment Worksheet (SCAW). This assessment delineated the six dimensions of
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CHAPTER TWO: LITERATURE REVIEW

Introduction

In order to base this study on sound evidence, a search of current literature was conducted. The databases employed for this literary review include CINAHL, PubMed, and Google Scholar using key words: compassion satisfaction, self-care, compassion fatigue, burnout, secondary traumatic stress, vicarious traumatization and occupational stress. The key words were entered in various combinations. References from the initial review of 64 articles led to other pertinent studies. Within the final literary review of 42 articles, the focus was to present those studies in current literature which have a direct bearing upon the three fundamental elements of this study: compassion fatigue, compassion satisfaction and self-care strategies for the critical care nurse.

Review of the literature on the health of nurses in today’s society leaves little doubt that their work takes a toll on their psychosocial and physical health and well-being (Potter et al., 2010). Nurses who work in specialty practice areas such as intensive care and oncology have been found to be particularly vulnerable to work-related stress (Potter, et al, 2010; Shorter & Stayt, 2009).

The negative aspects of stress and burnout are an inherent part of the nursing profession (Potter et al., 2010). Stressors can have an impact on most bodily systems, producing measureable transient effects which can lead to severe, chronic, or even acute physical health problems (Burgess, Irvine, & Wallymahmed, 2010). From a psychological perspective, stress is associated with the feelings of anxiety, depression, subjective fatigue, reduced confidence and low self-esteem. All of these psychological symptoms have been shown to influence the ability to perform work-related tasks (Kincey et al., 2005).
In view of the demanding workplace environment experienced by critical care nurses, it is perhaps not surprising that Mealer, Shelton, Berg, Rothbaum, and Moss (2007) in their comparative study of intensive care unit (ICU) and general nurses (n=490), found that there was evidence of post-traumatic stress disorder (PTSD) in ICU nurses that related specifically to their working environment; about 25% of ICU nurses tested positive for PTSD compared with 14% of the general floor nurses ($p=0.03$). Mealer and colleagues (2007) claimed that some of the traumatic events associated with PTSD in ICU nurses are similar to those experienced by war veterans; the cited causes include handling of the dead bodies and caring for trauma victims.

**Stress**

Stress can be defined as a multitude of interactions between a person and his or her environment where certain life events or situations are perceived as taxing or going beyond the person’s abilities or skills and jeopardizing his or her well-being (Lazarus & Folkman, 1984). The HCP is exposed to a multitude of stressful events such as frequent encounters with death and dying, grieving families, personal grief, traumatic stories, observing extreme physical pain in their patients, strong emotional states such as anger and depression, and emotional and physical exhaustion (Alkema, Linton, & Davies, 2008). These stressful events are also experienced by the CVICU RN. In addition, the CVICU RN is working in a fast-paced and often chaotic environment that requires the ability to make immediate critical decisions in a highly stressful situation amidst distractions and competing priorities (Maiden, Georges, & Connelly, 2011). Over time, these effects can lead to overwhelming fatigue and burnout (Jenkins & Warren, 2012).

Within the discussion of compassion fatigue the outstanding feature and major contributor to fatigue are the manifold forms of stress (Potter et al., 2010). Stress can be simply defined is
an increased intention between a particular person’s abilities and the demands of their environment. Highly tasked environments with continuous demands placed upon a person’s coping skills, unavoidably place “wear and tear” on the caregivers’ own wellbeing (Lazarus & Folkman, 1984).

Exposure to stressful events in most professions is occasional, but for the CVICU RN it is one of the essential characteristics of their work environment (Jenkins & Warren, 2012). This has given rise in the literature to the expression of a “stress continuum” that is particular to this occupation (Sabo, 2011). A common profile of the CVICU RNs day is likely to include situations that require adequate response to death and the dying, and by extension the suffering and grief of family and friends. Also fundamental are encounters with extreme physical pain in patients and a variety of distressed emotional states in the patient and concerned relatives - mainly depression, helplessness, anger, and futility (Di Tullio & Mc Donald, 1999; Keidel, 2002; Payne, 2001). These findings can easily be applied to the recognized condition in the CVICU RN of a growing state of emotional and physical exhaustion. This, in turn, has understandably produced research in the area of self-care strategies for the CVICU RN in the hopes of providing some beneficial strategies in managing these forms of stress (Dean, 1998; Hawkins, Howard & Oyebode, 2007; Jones, 2005; Payne 2001; Vachon et al. 1978).

**Burnout**

The cumulative effect of prolonged exposure to the variety of stress sources in the CVICU RN profession can result in the condition termed “burnout” (Stamm, 2010). The most accepted definition may be found in the writings of Jenaro, Flores, and Arias (2007), “burnout is a syndrome composed of emotional exhaustion, depersonalization, and reduction of personal accomplishments” (p. 80). In short, burnout is a type of psychological collapse resulting from
work-related expectations and demands exceeding the provider’s resources to meet them well (Payne, 2001).

Building upon the above definition by Jenaro and colleagues (2007), Keidel, (2002) has also extended its application to other work-related factors. This research has shown that certain identifiable features of the CVICU RNs environment may also contribute to the creation and continuance of the “burnout syndrome”. Most notably, the work related factors of (a) demanding work schedules; (b) questionable salary compensation; (c) challenging and attitudinal patients; and (d) protracted and unexpected work assignments, all of which are unavoidably encountered throughout the course of the CVICU RNs work. While significant in their negative contribution to the burnout condition and as important to every CVICU RN as they may be, these latter features are in varying degrees thought of as ancillary or secondarily related to burnout. In other words, these latter factors are not presented as primary causes of burnout since the research tends to indicate that there is a sliding scale of importance given to them amongst different medical professions (Payne, 2001).

The wide range of applications of Jenaro’s (2007) definition of burnout to all work-related factors that could be identified as “stressors” or elements of the condition became too vast and unmanageable to be serviceable in providing a basis for the construction of self-care strategies. Consequently, there has emerged in recent literature on the subject, a necessary limiting of focus to what are perceived to be the core issues involved for CVICU RNs and that most directly and immediately sets her/him on the path to burnout. The verbal construct of “compassion fatigue” has appeared in recent literature (Joinson, 1992) in order to identify it’s meaning specifically and hopefully provide a reliable foundation upon which some useful self-care practices could be developed.
Compassion Fatigue

The definition of compassion fatigue was first formulated by Joinson (1992). His or her study confined itself to the identification of those elements of stress particularly involved in a critical care context. Since that time compassion fatigue has been defined as “a deep physical, emotional and spiritual exhaustion accompanied by acute emotional pain” (Pfifferling & Gilley, 2000).

Compassion fatigue is a possibility for the CVICU RN only because of a certain susceptibility inherent to the positive capacity of empathy. As a form of care, empathy opens us or makes us emotionally receptive and to that degree, vulnerable to another (Adams, et al., 2006; Figley, 2002b). When what is met or received in empathic openness includes the present suffering of another’s life, then the term used for the kind of care that willingly bears the suffering of another is called compassion. Thus, compassion fatigue is the degeneration of a healthy capacity for empathy per se, which is defined helpfully by Radley & Figley (2007) as “a deep sense or quality of knowing or an awareness [among helping professionals] of the suffering of another coupled with the wish to relieve it” (p.207). Compassion in this context is an essential component in the character of the “good nurse.” Without it, the CVICU RN is unable to meet and serve the needs of patients and their families (DiTullio & MacDonald, 1999).

The work environment of the CVICU RN is such that the demands of her/his patients can easily exceed both the emotional capacity for empathic response and it may easily frustrate her compassionate concern to relieve her patient’s suffering (Jenkins & Warren, 2012). After continued exposures to such situations, where the natural interest of the compassionate nurse to relieve the patient is unsuccessful, then a kind of defeatism begins to ensue (Radley & Figley, 2007) and symptoms of “continuously-frustrated compassion” may be exhibited. Chief among
the symptoms of “continuously-frustrated compassion” is an unnatural fatigue; thus, the construct “compassion fatigue.”

Many studies indicate that the symptoms of fatigue that accompany frustration are apparently inseparable from it and many present as: irritability, troubled sleep or insomnia, increased susceptibility to the startle response, avoidance or anxiety over facing what is perceived as helpless and increased moodiness (Figley, 1995). One of the most often repeated findings in the literature is that nurses caring for patients who are critically ill are at greater risk for developing this syndrome than other healthcare professionals (Keidel, 2002). Unlike the burnout syndrome, which is observed to develop cumulatively from a myriad of sources over an extended period of time, the onset of compassion fatigue is comparatively rapid and results directly from stress factors that are specifically work related. For example, CVICU RN’s may experience compassion fatigue after listening to family members describe a loved one’s traumatic suffering and death (Stamm, 2009).

Research findings often note the suddenness and unsuspected or “without warning character” of compassion fatigue (Figley, 2002b). Not only is its manifestation eruptive and unanticipated, but compassion fatigue also imparts feelings of being utterly daunted - that one is caught in a hopeless circumstance in which one feels totally helpless. The overlap involved in comparing the conditions of burnout and compassion fatigue is readily apparent and many differences are reducible to being simply a matter of degree. However, apart from the prevalence of both conditions throughout the healthcare industry, the most noted significance of both phenomena is that either condition has been demonstrated to be the predominant source of both nurse turnover and decline in patient care (Garman, Corrigan & Morris 2002; Halbesleben, Wakefield, Wakefield, & Cooper, 2008).
Even though compassion fatigue and burnout are unavoidable as ‘real possibilities’ inherent to all CVICU RNs, fortunately they are not on that account understood to be either necessary or inevitable “actualities” that must result from consistent compassionate care giving.

**Compassion Satisfaction**

Current literature (Stamm, 2010) has made it a point to note that positive empathic rewards are not an uncommon result in the ICU setting. The expression “compassion satisfaction” has been coined to identify this positive affect and has been well defined by Stamm (2010) as “the pleasure derived from being able to do your work well” (p.12). The most commonly noted source involved for promoting this type of pleasure fulfillment is very specific; namely, the recognition on the part of the CVICU RN that their patients quality of life has palpably improved as a result of the efforts and actions that they have performed (Radley & Figley, 2007).

To some extent, either the prevention or the remedy for the negative conditions of burnout and compassion fatigue must involve the maintenance and/or the recovery of this specific experience by the CVICU RN. All work experience that does not have the benefit of an intrinsic reward experience is on that account susceptible to becoming involved unwittingly with what leads to the debilitating effects of either compassion fatigue or burnout. Consequently, the elements and practices involved in proper “self-care” are crucial in responding adequately to these issues.

**Self-Care**

The articulation and implementation of a program of self-care is a crucial element in the promotion of compassion satisfaction and the decrease of compassion fatigue and burnout (Payne, 2001). The most recommended strategies for the achievement and maintenance of self-care tend to be holistic in character, i.e.: they attempt to provide a comprehensive approach to the
issues and elements involved in self-care as necessarily including both the personal and professional domains of one’s life. Keidel (2002) provides the following specific strategies as essential to any adequate self-care program: (1) getting adequate sleep, (2) eating a healthy diet, (3) Striving for personal and professional balance, (4) developing an enjoyable and supportive social network and (5) adapting job environments rather than accepting them as is. In the same vein, the studies of O’Halloran & Linton (2000) offer six areas of one’s personal and professional life that must be rightly understood and correctly addressed if one’s self-care strategies are to succeed in the promotion and preservation of the compassion satisfaction experience: (1) spiritual, (2) cognitive, (3) emotional, (4) physical, (5) vocational, and (6) social.

Alkema et al. (2008) explored the relationship between self-care, compassion fatigue, burnout and compassion satisfaction among HCPs, a strong negative correlation was observed between compassion satisfaction and burnout ($r = - .612, p = \leq .05$). There was also a negative correlation observed between compassion satisfaction and compassion fatigue ($r = - .300, p = \leq .05$). Data analysis revealed a strong positive correlation between compassion fatigue and burnout ($r = .761, p = \leq .05$). With the exception of compassion fatigue and physical care, burnout and compassion fatigue were negatively correlated to all aspects of self-care ($p \leq .05$). Compassion satisfaction was significantly correlated with emotional care ($r = .375, p \leq .05$), spiritual care ($r = .294, p \leq .05$), and having balance between work and personal life ($r = .320, p \leq .05$).

While there have been some assessment studies that focus upon the relation of self-care to compassion satisfaction, compassion fatigue and burnout, there is little research within the current literature that has made an effort to explore the specifics and unique variables involved in the CVICU RNs practice. It is this need that justified this study.
Major Variables Defined

**Demographic Variables.** The demographic variables were defined as follows: Number of years working as a CVICU RN referred to the number of years working as a cardiovascular intensive care unit nurse and number of years in the profession was defined by how many years the participant had been a registered nurse. Job title was defined as the credentials that the nurse had in addition to being a registered nurse. Certified Critical Care Registered Nurses (CCRNs) have demonstrated acquisition of a specific high level of knowledge in their specialty area of critical care through successful completion of a rigorous psychometrically valid, job-related examination (AACN, 2012). Cardiac Medicine Certification (CMC) is a subspecialty certification for nurses providing care to acutely and/or critically ill cardiac patients (AACN, 2012). Cardiac Surgery Certification (CSC) is also a subspecialty certification for nurses providing care to acutely and/or critically ill patients during the first 48 hours after cardiac surgery (AACN, 2012). According to L. Lee, who is the Principle Compensation Analyst for UCSD (personal communication, November 14, 2012), the definition of a Clinical Nurse level I (CNI) is the first six months of employment (probationary period), Clinical Nurse level II (CNII) is the post-probationary period, and Clinical nurse level III (CNIII) is a level of nursing skill that involves the care of patient populations exhibiting more complex problems with less predictable outcomes as well as participation in staff development, clinical training and education.

Educational background was defined as the level of education the nurse has completed in nursing i.e.: associates, bachelors or masters degree. Age referred to the chronological age of the participant. Gender was defined as self-reported male, female or other. Race was defined as Asian, Black/African American, Hawaiian/Pacific Islander, White or other. Ethnicity was defined as Hispanic/Non-Hispanic or Latino/Non Latino.
Compassion Fatigue. Stamm (2010) defined compassion fatigue as the negative aspects of providing care to those who have experienced extreme or traumatic stressors. These negative responses include feelings of being overwhelmed by the work that are distinguished from feelings of fear associated with the work. Compassion fatigue breaks into two parts: burnout and secondary traumatic stress.

Burnout is the part of compassion fatigue that is characterized by feelings of unhappiness, disconnectedness, and insensitivity to the work environment. It can include exhaustion, feelings of being overwhelmed, bogged down, being “out-of-touch” with the person he or she wants to be, while having no sustaining beliefs (Stamm, 2010).

Burnout is associated with feelings of hopelessness and difficulties in dealing with work or doing one’s job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that one’s efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment (Stamm, 2010).

Secondary traumatic stress is an element of compassion fatigue that is characterized by being preoccupied with thoughts of people one has helped. Caregivers report feeling trapped, on edge, exhausted, overwhelmed, and infected by others’ trauma. Characteristics include an inability to sleep, sometimes forgetting important things, and an inability to separate one’s private life and his or her life as a helper, and experiencing the trauma of someone helped, even to the extent of avoiding activities to avoid reminders of the trauma. It is important to note that developing problems with secondary traumatic stress is rare but it does happen to many people (Stamm, 2010).

Secondary traumatic stress is about work-related secondary exposure to people who have experienced extremely or traumatically stressful events. The negative effects of secondary
traumatic stress may include fear, sleep difficulties, intrusive images, or avoiding reminders of the person’s traumatic experiences. Secondary traumatic stress is related to vicarious trauma as it shares many characteristics (Stamm, 2010).

**Compassion Satisfaction.** Stamm (2010) defined compassion satisfaction as feeling satisfied by one’s job and from the helping itself. It is characterized by people feeling invigorated by work that they like to do. They feel they can keep up with new technology and protocols. They experience happy thoughts, feel successful, are happy with the work they do, want to continue to do it, and believe that they can make a difference.

**Self-care.** Self-care can be defined as the behavioral actions a person takes to decrease the amount of stress, anxiety, and emotional reactions he or she experiences while working with patients in a critical care setting (Williams, Richardson, Moore, Eubanks, & Keeling, 2010). Gentry (2002) suggested self-care is to compassion fatigue, as seat belts are to driving an automobile. While Gentry’s analogy referred to one’s professional life, the absence of self-care can have negative effects on one’s personal life as well (Williams et al., 2010). It is imperative for the caregiver to learn and practice the skills necessary to attend to all of the needs a person has in his or her life including personal, familial, emotional, and spiritual needs, all the while attending to the needs of the patient (Figley, 2002a; Stamm, 2009).

**Theoretical Framework**

As introduced in Chapter One, this research study was based on the theoretical framework of Richard Lazarus and Susan Folkman’s Stress and Coping Model (Lazarus & Folkman, 1984). Lazarus et al. assert that stress consists of two appraisal processes: namely, the primary appraisal of the threat and secondary appraisal of how to respond, and these interact with the individual’s execution of the coping response (Lazarus & Folkman, 1984). The coping
response is categorized by Lazarus into problem-focused coping which involves efforts to solve the problem or master the situation; and emotion-focused coping, where there is an attempt to reduce the negative feelings associated with the threat rather than alter the source of the threat. Emotion-focused coping also encompasses avoidance-coping, where an individual withdraws mentally from dealing with the situation or uses substances such as alcohol or drugs (Burgess, Irvine, & Wallymahmed, 2010). The theory states that coping skills may be learned and that stress reduction occurs in individuals who improve their coping methods. This is how self-care relates to the model. It proposes that self-care methods may help an individual to reduce stress, provide positive feelings of being in control of one’s life and promoting general well-being. The individuals must change their perception, learn strategies, and increase their confidence level and this will result in improved coping skills and reduced stress levels (Lazarus & Folkman, 1984).

Summary

The extensive review of available literature clearly demonstrates that working with acutely critically-ill patients who are in pain, suffering, or at the end of life may take a toll on the psychosocial health and wellbeing of nurses. Over the past decade, compassion fatigue has received considerable attention as a potential source of occupational stress experienced by the intensive care nurse. In addition, limited research has been conducted in the area of self-care and its effect on levels of compassion fatigue and compassion satisfaction in the CVICU RN.
CHAPTER THREE: METHODS PROPOSAL

Introduction

Anecdotal evidence suggests that Cardiovascular Intensive Care Unit Nurse’s (CVICU RNs), consistently encounter the two elements of compassion fatigue: secondary traumatic stress and burnout. The subject matter of the current study was discovered through the investigation of professional journals related to the stressors of healthcare professionals. The article by Alkema, Linton, and Davies (2008) focuses upon and examines the relationships of self-care, compassion satisfaction and compassion fatigue to one another in the context of the hospice care setting. The current study has replicated this methodology with CVICU RNs.

The goal of this study is to demonstrate how the transferred application of Alkema, Linton and Davies model may contribute to a better understanding of the CVICU RNs’ setting.

Purpose of the Research

The purpose of this study was to explore the relationship between compassion fatigue, compassion satisfaction and self-care for CVICU RNs’ caring for cardiac patients at the Sulpizio Cardiovascular Intensive Care unit at University of California San Diego (UCSD).

Research Question/ Hypothesis

The research question was: “Is there a relationship between compassion fatigue, compassion satisfaction and self-care among CVICU RNs?”

H₁: CVICU RNs who engage in several self-care activities experience higher levels of compassion satisfaction and lower levels of compassion fatigue.

Hypothesis #1: There will be a direct positive relationship between the participant’s level of self-care and his or her compassion satisfaction.
Hypothesis #2: As the participant’s scores on the self-care subscales increase, his or her 
scores on the compassion fatigue as measured by the burnout and secondary traumatic stress 
subscales will decrease indicating a direct negative relationship.

**Sample/Sampling Plan**

A total of 59 nurses employed in the CVICU were given the opportunity to participate. 
In total, 47 CVICU nurses participated in the study. The study took place in a twelve-bed 
CVICU located in an academic medical center in Southern California. A convenience 
(nonprobability) sample of intensive care nurses working in a metropolitan cardiovascular center 
was used for this study. The age ranges of the sample were 20-59 and consisted of 37 females 
and 12 males. Educational status within this sample included 20 Certified Critical Care RNs 
(CCRNs), 40 had a bachelor’s degree in nursing and 2 had a master’s degree in nursing. There 
were 14 nurses who were Clinical Nurse level III (CNIII) nurses.

The sample size was based on a power of 0.80, and an effect size of .30. Using the 
software, G-power 3.1 determined that a minimum sample size of 49 was adequate at a .10 
(alpha) significance level (Faul, Erdfelder, Buchner, & Lang, 2009) 
(Appendix E). This significance level has been determined to be satisfactory for a pilot study 
(Windsor, Baranowski, Clark, & Cutter, 1994).
Exclusion criteria for this study included non-CVICU RNs and non-RNs. Inclusion criteria included English speaking, voluntary participation and any CVICU RN working in the Sulpizio Cardiovascular Center at UCSD.

The limits of the sample’s generalizability were the small sample size and the fact that it was conducted in a highly specialized unit staffed with nurses trained in critical care. The study results were also limited by geographic variables. The data that was gathered from participants located in only one hospital located in Southern California, which may limit the application of these findings to other regions of the country. Finally, because this study was cross-sectional in design, the analysis did not provide an understanding of changes over time.

**Research Design**

The research study was a descriptive, cross-sectional, correlational design. The researcher controlled for threats of internal validity by using the ProQOL scale, which has established reliability and validity (Stamm, 2010). The reliability and validity of the SCAW has not yet been established; however, it has been used in other studies where significant correlations were found (Alkema et al., 2008). Cronbach’s alpha was reported for the current study in Chapter 4.

**Data Collection Process**

After obtaining Institutional Review Board approval from UCSD and CSUSM, potential participants were approached, informed consent was obtained and data was then collected from staff RNs in the CVICU using three pencil-and-paper questionnaires. Each participant was given adequate verbal and written information concerning the study and was provided ample opportunity to have all of their questions answered prior to obtaining informed consent.

To protect anonymity, all subjects were assigned a unique identifying number to label all surveys and data collection sheets. All subject’s names and potential identifiers were kept
strictly confidential by the investigator. All study forms and data collection were returned to and kept in a locked cabinet in the clinical nurse educator’s office.

There were three data collection instruments used in this study: A basic demographic information sheet, the ProQOL (Stamm, 2009) and the SCAW (Saakvitne & Pearlman, 1996). All data was analyzed using SPSS software IBM (2011).

**Demographic Information Sheet.** The demographic information sheet included items such as age, gender, race, ethnicity, job title, credentials, educational background, number of years as a CVICU RN, number of hours per week working as a CVICU RN and number of years as a nurse (Appendix A).

**Professional Quality of Life Assessment (Pro-QOL) Version 5.** Compassion Satisfaction and Compassion Fatigue was evaluated using the Professional Quality of Life Assessment (ProQOL). It is the most commonly utilized assessment to measure the positive and the negative effects of trauma on the helper [nurse] (Stamm, 2010) (Appendix B). It contains 30 items, and has three subscales: Compassion Satisfaction (CS), Burnout (BO), and Secondary Traumatic Stress (STS). The concept Compassion Fatigue (CF) is measured by the two subscales BO and STS. Each subscale contains 10 items, and participants must rate each item on a 6-point scale (0 = never, 5 = very often) based on their experience in the past 30 days. Subscale scores range from 0-50, with higher scores indicating higher levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. Stamm, (2010) reported that the construct validity upon which this test is based has been “well established in over 200 published papers” (p.13).

The compassion satisfaction score refers to the pleasure one derives from helping others and being able to do their work well (Stamm, 2009). The average score is 50. About 25% of people score higher than 57 and about 25 % of people score below 43. The alpha scale reliability
is .88. Higher scores indicate work satisfaction and scores that fall in the lower range may indicate that the participant is dissatisfied with the work that they do.

The burnout score is an indicator of feelings of hopelessness, difficulties in dealing with one’s work, and poor work performance. The average score is 50. About 25% of people score above 57 and about 25% of people score below 43. Alpha scale reliability is .75. Scores below 18 reflect a positive attitude about work and a score greater than indicates that the participant is at risk for burnout.

The secondary traumatic stress score denotes secondary exposure to traumatic events through exposure to a patient’s trauma. The average score is 50. About 25% of people score below 43 and about 25% of people score above 57. Alpha scale reliability is .81. Higher scores indicate that the participant may want to examine how he or she feels about their work environment.

<table>
<thead>
<tr>
<th></th>
<th>CS</th>
<th>BO</th>
<th>STS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bottom Quartile (25\textsuperscript{th} Percentile)</td>
<td>44</td>
<td>43</td>
<td>42</td>
</tr>
<tr>
<td>Mean (50\textsuperscript{th} Percentile)</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Top Quartile (75\textsuperscript{th} Percentile)</td>
<td>57</td>
<td>56</td>
<td>56</td>
</tr>
</tbody>
</table>

Self-Care. The Self-Care Assessment Worksheet (SCAW) was used to evaluate Self-Care (Appendix C). The SCAW is a self-care indicator that measures the degree to which individuals engage in a variety of self-care activities and strategies (Saakvitne & Pearlman, 1996). The instrument delineates the six dimensions of self-care: physical, psychological, emotional, spiritual, professional workplace, and balance. Each of these six subscales contain a different number of items by which the respondent would rate from one to five in terms of how often he or she practices each activity (1= never occurred to me; through 5= frequently occurs). The higher
the total score is for each subscale, the more engaged the respondent is in that dimension of self-care and the lower the score, the less engaged. This measure has not been tested for reliability or validity (Saakvitne & Pearlman, 1996), but has been determined to have content validity for this subject matter. Reliability statistics are reported in the Results section of this proposed pilot study.

**TABLE 2. Number of Items in Each Area of the Self-Care Assessment Worksheet**

<table>
<thead>
<tr>
<th>Self-Care Area</th>
<th>Number of Items</th>
<th>Minimum Score Possible</th>
<th>Maximum Score Possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Care</td>
<td>14</td>
<td>14</td>
<td>70</td>
</tr>
<tr>
<td>Psychological Care</td>
<td>12</td>
<td>12</td>
<td>60</td>
</tr>
<tr>
<td>Emotional Care</td>
<td>10</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Spiritual Care</td>
<td>16</td>
<td>16</td>
<td>80</td>
</tr>
<tr>
<td>Workplace Self-Care</td>
<td>11</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>Balance</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

**Data Analysis**

Results were tabulated and correlated to determine whether any significant relationship existed within and between subscales on the ProQOL and the SCAW. All demographic data gathered for the study was also considered in the analysis. The Pearson Product-moment correlation was used to measure the strength and direction of association between the CVICU RN’s self-reported compassion satisfaction and compassion fatigue. The demographic variables included age in years, work hours per week, years of service as an RN and years of service in the CVICU. The level of measurement used was ratio. For compassion fatigue, compassion satisfaction and self-care, interval measurement was used. A Cronbach’s alpha coefficient was used to determine the internal validity of the Professional Quality of Life (ProQOL) and Self-Care Assessment Worksheet (SCAW) surveys.
CHAPTER FOUR: RESULTS

Introduction

Chapter Four provides the results for the research question “Is there a relationship between compassion fatigue, compassion satisfaction and self-care among CVICU RNs?”

A post hoc power analysis was performed using G-Power (Faul, & et al., 2009) with the total number included participants. The actual sample size (n=49) allowed for a .30 effect size in a cross sectional analysis with a significance value of .10 and a power of .79. (Appendix F)

The data was examined using IBM SPSS Statistics 20 software (2011) for frequency, mean, median and mode. Following frequency distribution analysis, data were analyzed for correlations using Pearson’s correlation.

Sample

Forty-seven CVICU RNs working in a critical care setting participated in this study. Twelve participants were male and 35 were female. Regarding racial and ethnic background, 29 participants identified as Caucasian, 2 as African-American, 9 as Asian American, and 7 as Hawaiian Native/Pacific Islander. The average age for participants was 38.04 years (range 27-58).

Participants were classified by three different job titles. These were clinical nurse I (n = 1), clinical nurse II (n = 32) and clinical nurse III (n = 14). In addition to job titles, credentials were also collected. Critical Care Registered Nurse (CCRN) (n = 13), CCRN and Cardiac Medicine Certification (CMC) (n = 4), CCRN, CMC, and Cardiac Surgery Certification (CSC) (n = 3). At the time of data collection, the average length of time as an RN was 12 years and the average number of years in the CVICU was 6.19 years. Hours the participants worked each week was between 24 and 48. 24 hours per week (n =7), 36 hours per week
(n = 33), 40 hours per week (n = 6), 48 hours per week (n = 1). Regarding highest degree obtained, 7 participants reported an Associates degree (AD), 35 a Bachelor’s degree (BSN/BA) and 5 a Masters degree (MSN/MA).

**TABLE 3. Qualifications of Participants**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>CVICU RN</th>
<th>Frequency</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNI</td>
<td>1</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>CNII</td>
<td>32</td>
<td>68.1</td>
<td></td>
</tr>
<tr>
<td>CNIII</td>
<td>14</td>
<td>29.8</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>27</td>
<td>57.4</td>
<td></td>
</tr>
<tr>
<td>CCRN</td>
<td>13</td>
<td>27.7</td>
<td></td>
</tr>
<tr>
<td>CCRN N CMC</td>
<td>4</td>
<td>8.5</td>
<td></td>
</tr>
<tr>
<td>CCRN N CMC N CSC</td>
<td>3</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>AD</td>
<td>7</td>
<td>14.9</td>
<td></td>
</tr>
<tr>
<td>BSN/BA</td>
<td>35</td>
<td>74.5</td>
<td></td>
</tr>
<tr>
<td>MSN/MA</td>
<td>5</td>
<td>10.6</td>
<td></td>
</tr>
</tbody>
</table>

n = 47

**TABLE 4. Measures of Central Tendency for Continuous Demographic Variables**

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>YrsasRN</th>
<th>YrsCVICU</th>
<th>Hrsperweek</th>
</tr>
</thead>
<tbody>
<tr>
<td>N Valid</td>
<td>47</td>
<td>47</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>38.04</td>
<td>12.01</td>
<td>6.19</td>
<td>34.98</td>
</tr>
<tr>
<td>Median</td>
<td>37.00</td>
<td>11.00</td>
<td>5.00</td>
<td>36.00</td>
</tr>
<tr>
<td>Mode</td>
<td>33 a</td>
<td>7.0</td>
<td>2.00</td>
<td>36</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>7.07</td>
<td>6.47</td>
<td>4.77</td>
<td>5.11</td>
</tr>
<tr>
<td>Minimum</td>
<td>27</td>
<td>2.0</td>
<td>.58</td>
<td>24</td>
</tr>
<tr>
<td>Maximum</td>
<td>58</td>
<td>28.0</td>
<td>21.00</td>
<td>48</td>
</tr>
</tbody>
</table>
A STUDY OF THE INTERRELATIONSHIP

TABLE 5. Measures of central tendency for Compassion Satisfaction and Compassion Fatigue

<table>
<thead>
<tr>
<th></th>
<th>CS</th>
<th>BO</th>
<th>STS</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>47</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Missing</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>37.53</td>
<td>23.15</td>
<td>21.40</td>
</tr>
<tr>
<td>Median</td>
<td>38.00</td>
<td>22.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Mode</td>
<td>38.00</td>
<td>28.00</td>
<td>22.00</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>5.65</td>
<td>5.30</td>
<td>6.30</td>
</tr>
<tr>
<td>Minimum</td>
<td>25.00</td>
<td>14.00</td>
<td>11.00</td>
</tr>
<tr>
<td>Maximum</td>
<td>49.00</td>
<td>39.00</td>
<td>39.00</td>
</tr>
</tbody>
</table>

TABLE 6. Measures of Central Tendency for SCAW

<table>
<thead>
<tr>
<th></th>
<th>PhysSC</th>
<th>PsychSC</th>
<th>EmSC</th>
<th>SpSC</th>
<th>WPSC</th>
<th>Bal</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>47</td>
<td>47</td>
<td>47</td>
<td>47</td>
<td>47</td>
<td>47</td>
</tr>
<tr>
<td>Missing</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mean</td>
<td>56.04</td>
<td>44.00</td>
<td>38.51</td>
<td>60.60</td>
<td>41.23</td>
<td>8.28</td>
</tr>
<tr>
<td>Median</td>
<td>56.00</td>
<td>44.00</td>
<td>38.00</td>
<td>62.00</td>
<td>42.00</td>
<td>8.00</td>
</tr>
<tr>
<td>Mode</td>
<td>62.00</td>
<td>40.00</td>
<td>41.00</td>
<td>55.00</td>
<td>42.00</td>
<td>8.00</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>5.96</td>
<td>6.11</td>
<td>4.27</td>
<td>9.25</td>
<td>6.19</td>
<td>1.47</td>
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<tr>
<td>Minimum</td>
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<td>29.00</td>
<td>30.00</td>
<td>39.00</td>
<td>25.00</td>
<td>4.00</td>
</tr>
<tr>
<td>Maximum</td>
<td>70.00</td>
<td>54.00</td>
<td>50.00</td>
<td>77.00</td>
<td>55.00</td>
<td>10.00</td>
</tr>
</tbody>
</table>

Self-Care Assessment Worksheet (SCAW)

Cronbach’s alpha for this sample was .795 indicating a high level of internal consistency among the six subscales of the tool. Mean Scores for each of the subscales in the SCAW are presented in Table 6. Low scores on each subscale indicated participation in a low number of self-care activities while high scores indicated more participation in self-care activities. Because there are not an equal amount of items on each subscale of this instrument (Table 2), direct comparison of scores between the scales is not possible (Stamm, 2010).
Correlational results for the ProQOL- version 5, the SCAW and participant demographics are presented in Table 7. As expected a strong negative correlation was observed between compassion satisfaction and burnout ($r = -0.521, p = .000$). A non-significant, negative correlation was also observed between compassion satisfaction and secondary traumatic stress ($r = -0.301, p = 0.20$). Data analysis also revealed a strong positive correlation between secondary traumatic stress and burnout ($r = 0.624, p = .000$). With the exception of secondary traumatic stress and spiritual self-care, burnout and secondary traumatic stress were negatively correlated to all aspects of self-care ($p \leq 0.05$). Compassion satisfaction was significantly correlated ($p \leq 0.05$) with spiritual self-care ($r = 0.263$), workplace self-care ($r = 0.280$) and having balance between work and personal life ($r = 0.351$). There was a significant negative correlation between spiritual self-care and burnout ($r = -0.225, p = .10$).

In the area of personal characteristics, participants’ age was significantly positively correlated ($p \leq 0.05$) with burnout but not secondary traumatic stress or compassion satisfaction. The total years in the profession was significantly positively correlated ($p \leq 0.05$) with all aspects of self-care. Ironically, there was a significant negative correlation between burnout and hours per week worked ($r = -0.223, p = .10$). No significant relationships were observed between any other demographic variables and burnout, compassion fatigue, compassion satisfaction, or self-care.
### TABLE 7. Correlation Between Scales and Subscores

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>YrsasRN</th>
<th>YrsCVICU</th>
<th>Hrsperweek</th>
<th>CSS</th>
<th>STS</th>
<th>BOS</th>
<th>PhysSC</th>
<th>PsychSC</th>
<th>EmSC</th>
<th>SpSC</th>
<th>WPSC</th>
<th>Bal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1</td>
<td>0.701**</td>
<td>0.333*</td>
<td>0.114</td>
<td>-0.002</td>
<td>-0.106</td>
<td>-0.005</td>
<td>0.006</td>
<td>-0.189</td>
<td>0.028</td>
<td>0.015</td>
<td>0.032</td>
<td></td>
</tr>
<tr>
<td>YrsasRN</td>
<td>1</td>
<td>0.428**</td>
<td>0.012</td>
<td>-0.174</td>
<td>0.06</td>
<td>0.116</td>
<td>0.024</td>
<td>-0.058</td>
<td>-0.101</td>
<td>-0.024</td>
<td>-0.061</td>
<td>-0.048</td>
<td></td>
</tr>
<tr>
<td>YrsCVICU</td>
<td>1</td>
<td>0.015</td>
<td>0.481**</td>
<td>0.184</td>
<td>0.013</td>
<td>-0.028</td>
<td>-0.001</td>
<td>0.088</td>
<td>-0.102</td>
<td>-0.031</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hrsperweek</td>
<td>1</td>
<td>0.071</td>
<td>-0.144</td>
<td>-0.223+</td>
<td>-0.333*</td>
<td>-0.017</td>
<td>-0.035</td>
<td>0.048</td>
<td>0.134</td>
<td>-0.066</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSS-Compassion Satisfaction</td>
<td>1</td>
<td>-0.301*</td>
<td>0.521**</td>
<td>0.107</td>
<td>0.134</td>
<td>0.135</td>
<td>0.263*</td>
<td>0.280*</td>
<td>0.351**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STS- Secondary Traumatic Stress</td>
<td>1</td>
<td>.624**</td>
<td>-0.209</td>
<td>-0.076</td>
<td>-0.044</td>
<td>0.13</td>
<td>-0.388*</td>
<td>0.310*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOS- Burnout Scale</td>
<td>1</td>
<td>-0.134</td>
<td>-0.183</td>
<td>-0.338*</td>
<td>-0.225+</td>
<td>-0.572*</td>
<td>-0.388*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PhysSC- Physical Self-Care</td>
<td>1</td>
<td>0.469**</td>
<td>0.359**</td>
<td>0.300*</td>
<td>0.448**</td>
<td>0.522**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PsychSC- Psychological Self-Care</td>
<td>1</td>
<td>0.570**</td>
<td>0.619**</td>
<td>0.339**</td>
<td>0.477**</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EmSC- Emotional Self-Care</td>
<td>1</td>
<td>0.626**</td>
<td>0.560**</td>
<td>0.469**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SpSC- Spiritual Self-Care</td>
<td>1</td>
<td>0.474**</td>
<td>0.501**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WPSC- Workplace Self-Care</td>
<td>1</td>
<td>0.638**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bal- Balance</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Note:** **Correlation is significant at the 0.01 level (1-tailed)**
*Correlation is significant at the 0.05 level (1-tailed)
+Correlation is significant at the .10 level (1-tailed)
TABLE 8. Average Self-Care Assessment Worksheet Scores

<table>
<thead>
<tr>
<th>Self-Care Area</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
<th>Min. Score</th>
<th>Max. Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Care</td>
<td>47</td>
<td>56</td>
<td>5.9</td>
<td>44</td>
<td>70</td>
</tr>
<tr>
<td>Psychological Care</td>
<td>47</td>
<td>44</td>
<td>6.1</td>
<td>29</td>
<td>54</td>
</tr>
<tr>
<td>Emotional Care</td>
<td>47</td>
<td>38.5</td>
<td>4.3</td>
<td>30</td>
<td>50</td>
</tr>
<tr>
<td>Spiritual Care</td>
<td>47</td>
<td>60.6</td>
<td>9.2</td>
<td>39</td>
<td>77</td>
</tr>
<tr>
<td>Workplace Self-Care</td>
<td>47</td>
<td>41.2</td>
<td>6.2</td>
<td>25</td>
<td>55</td>
</tr>
<tr>
<td>Balance</td>
<td>47</td>
<td>8.27</td>
<td>1.5</td>
<td>4</td>
<td>10</td>
</tr>
</tbody>
</table>

Summary

Forty-seven CVICU RNs participated in this descriptive, correlational study. Description of the sample included a mean age of 38.04, mean years as an RN 12.01 and mean years working in CVICU 6.19. The average hours worked per week was 34.98. A Cronbach’s alpha was determined to be .795 indicating a high level of internal consistency among the subscales of the SCAW. The study examined how participation in self-care activities, as measured by SCAW, influenced the CS, STS and BO.

Significant negative correlations were observed between CS and BO and CS and STS. The strength of these relationships differ somewhat, supporting the suggesting that STS and BO are in fact, different constructs. Another interesting finding was the significantly positive correlation between CS and the spiritual, workplace and balance subscales of the SCAW but not with the emotional, physical and psychological subscales. This implies that while engaging in a variety of self-care strategies may prevent CF, only spiritual self-care, and personal-professional workplace balance are correlated with higher levels of CS. This result has implications for the ways in which CVICU RNs take care of themselves related to job stress and satisfaction.
The study also revealed a strong positive correlation between STS and BO suggesting that these are related, but different constructs. Significant negative correlation was found between spiritual self-care and BO. Ironically however, there was a significant negative correlation between BO and hours worked per week ($r = -0.223$, $p = .10$) indicating that when hours per week decrease, burnout increases.

With the exception of spiritual self-care, STS was significantly negatively correlated to all aspects of self-care. This is a clear indication that as STS increased, the number of self-care activities that the CVICU RNs reported decreased. A similar pattern of significant negative correlations emerged in the relationship between BO and all aspects of self-care.
CHAPTER 5: DISCUSSION

Introduction

This purpose of this study was to examine the relationship between compassion fatigue, compassion satisfaction and self-care among CVICU RNs caring for cardiac patients at the Sulpizio Cardiovascular Intensive Care unit at University of California San Diego (UCSD). It was hypothesized that the CVICU RNs who engage in multiple self-care activities would have lower levels of stress and burnout.

Major Findings by Research Question

Throughout the analysis of the data, several interesting findings surfaced concerning the variables. First, significant, negative correlations were observed between compassion satisfaction and burnout and compassion satisfaction and secondary traumatic stress. The strength of these relationships differs somewhat, supporting the previous findings that secondary traumatic stress and burnout are in fact different constructs. Data analysis also revealed that there was a strong positive correlation between secondary traumatic stress and burnout ($r = .624$, $p = .000$), again suggesting that these are related, but different constructs as the degree of inter-scale correlation is not higher than $r = .624$. These results were expected and appear consistent with the literature in this area as Stamm (2010) found inter-scale correlation as high as $r = .58$.

Second, with the exception of spiritual self-care, secondary traumatic stress was significantly negatively correlated to all aspects of self-care. This is a clear indication that as secondary traumatic stress increased, the number of self-care activities that the CVICU RNs reported decreased. A similar pattern of significant negative correlations emerged in the relationship between burnout and all aspects of self-care. These results suggest that participating in a variety of self-care strategies may assist CVICU RNs in the management of symptoms.
associated with compassion fatigue. Because these results are correlational in nature, one cannot predict a causal relationship between self-care and compassion fatigue. Nonetheless, if these results hold true, future research should examine ways in which CVICU RN employers can assist, and perhaps require, their workers to take part in holistically focused self-care activities. In addition, it is also recommended that future research focus on the specific types of self-care activities that can assist the CVICU RN in the management of compassion fatigue and enhancement of compassion satisfaction. (COMPARISONS TO HOSPICE GROUP)

Also interesting to note was the significantly positive correlation between compassion satisfaction and the spiritual, workplace and balance subscales of the SCAW but not with the emotional, physical and psychological subscales. This implies that while engaging in a variety of self-care strategies may prevent compassion fatigue, only spiritual self-care, and personal-professional workplace balance are correlated with higher levels of compassion satisfaction. This result has implications for the way in which CVICU RNs take care of themselves related to job stress and satisfaction. First, taking part in self-care strategies that are effective in promoting compassion satisfaction may not be directly linked to low levels of compassion fatigue. Second, CVICU RNs who are not experiencing compassion fatigue, but wish to increase their compassion satisfaction, may find it most effective to focus their self-care efforts in the spiritual and personal-professional workplace balance areas of life. Therefore it is suggested that CVICU RN, along with their employers, match the types of self-care strategies they participate in with their desired outcome; either to reduce compassion fatigue, increase compassion satisfaction, or both.

Additionally, it was interesting to note in both the current study and the study done by Alkema, et al, 2008, significant positive correlations were found between all areas of self-care
measured by the SCAW. These results suggest that both the HCPs and CVICU RNs that take care of themselves in one area are more likely to take care of themselves in several other areas. In other words, those who engage in healthy behaviors in one area of life are more likely to engage in beneficial self-care activities in all areas of life. This suggests that self-care may be more of a holistic tendency rather than area specific as the Self Care Assessment Worksheet (SCAW) suggests.

Finally, several results of interest pertaining to the relationship between age and number of years in the profession, and self-care, compassion satisfaction and compassion fatigue were observed. The results suggested that CVICU RNs with more years of service in the profession seem to be deficient in all areas of self-care than those with less experience. There is also a somewhat obvious relationship between the age of the participants and their experience in the profession ($r = .701, p = .000$). One possible explanation for this result might be that those who take care of themselves in the various areas of self-care are less likely to leave the profession early due to compassion fatigue. Interesting to note was that older participants were less likely to indicate experiencing symptoms of secondary traumatic stress ($r = -.106, p = .240$) and burnout ($r = -.005, p = .487$), but there was not a corresponding association between more years of experience and burnout ($r = .116, p = .218$).

An additional finding that was surprising to the researcher was that the number of years worked in the CVICU showed higher levels of secondary traumatic stress ($r = .481, p = .000$) indicating that the CVICU itself is a highly stressful environment for the nurse. Interesting to note was that the data collection period was conducted during a time where several patients had died and stress was high in the CVICU. This fact could have skewed the samples results and may not be applicable to every CVICU. During that time there were high-risk cutting edge
surgeries such as the Total Artificial Heart (TAH) that were being performed to keep the end-stage heart failure patient alive while awaiting a heart transplant.

**Limitations**

While the results of this study are revealing, there are some limitations and all results should be interpreted with caution. First, the study was limited due to its small sample size of 47 participants. In order to make more definitive conclusions regarding compassion satisfaction, compassion fatigue and self-care, the sample size needs to be larger. The results of this study could be complimented and more thoroughly examined by the collection of qualitative data from participants relating to their specific experience with compassion satisfaction, compassion fatigue and self-care. The results of this study are also limited due to the fact that correlational research design was used. Interpretations of these correlational results should be considered tentative, and definitive conclusions regarding causation cannot be offered. As a general rule, correlational studies are weak in their ability to support causal inferences (Polit & Beck, 2012). Future research in this area should apply mixed methods including qualitative methods and research designs exploring cause and effect.

Additionally, the study is limited by a lack of diversity in the sample. While CVICU RNs of all racial and ethnic backgrounds were approached, the majority of the sample was Caucasian (29 of 47 participants) indicating that the extension of these results to non-Caucasian RNs should be made with caution. A similar limitation in this study pertains to the lack of gender diversity in the sample. Due to the fact that the majority of the participants were female (35 females and 12 males) means that the results may not be generalizable to male CVICU RNs. Additionally, study results may be limited by geographic variables such as the fact that the study was
conducted at one hospital located in southern California which may limit its application of these findings to other regions of the country.

**Generalizability**

The findings of this study are generalizable to an urban teaching medical center, with predominantly Caucasian and female staff. In order to make this generalizable to a broader range of nurses, future research studies should recruit larger sample sizes, more racial and ethnic diversity and more males. Mixed methods of data collection such as qualitative interviews in addition to quantitative measures would improve evaluation of constructs of interest.

**Implications for Nursing Research**

This research adds to the body of knowledge about how self-care activities can be correlated to changes in self-reported levels of compassion fatigue and compassion satisfaction. There is sufficient evidence to design and implement interventions to reduce the self-reported levels of compassion fatigue among CVICU RNs.

In spite of the limitations mentioned, the results of this study can be useful in improving the overall emotional well-being and work efficacy of CVICU RNs. Based on these preliminary findings, it is highly recommended that intensive care nurse’s and their employers implement as well as engage in activities that impact emotional or psychological well-being to reduce secondary traumatic stress and burnout in the workplace. This may include the employer offering structured activities that promote self-care and a sense of well-being such as having a garden or patio area for employees to enjoy during their breaks and designated walking paths around the grounds of the workplace. These kinds of activities could assist with increased scores on the SCAW in the areas of physical and psychological well-being. Additionally, providing support groups or debriefing meetings with social-workers to manage work-related stress could
A STUDY OF THE INTERRELATIONSHIP

improve emotional well-being scores on the SCAW Survey. Increasing funds available for professional development, creating outlets for patients and their families to express their appreciation for the services and care they receive, and providing training that focuses on the concepts of compassion fatigue, compassion satisfaction, self-care. These activities as well as others may create work environments where compassion satisfaction can flourish and compassion fatigue can be reduced. Ultimately, this will lead to improved care for all patients in the CVICU setting.

**Summary**

In closing, the results of this study indicate a relationship between self-care, compassion fatigue and compassion satisfaction. Future research should build on the results of this study and further investigate ways in which CVICU RNs can effectively engage in self-care strategies. If CVICU RNs emotional health and patient care is to be improved in critical care settings, continued research in this area will be important.
Appendix A

Basic Demographic Questionnaire

Please answer the following questions by checking response or writing the answer in the space provided.

1) What is your gender?
   □ 1. Male
   □ 2. Female
   □ 3. Transgender

2) What is your age?

3) What race do you identify with?
   □ American Indian
   □ Asian
   □ Black/African American
   □ Hawaiian Native/Pacific Islander
   □ White
   Other (please specify):

4) What is your ethnicity?
   □ Hispanic or Latino
   □ Non Hispanic or Non Latino

5) Number of years as an RN (if < 1 year of experience, list in months)

6) Number of years working as a CVICU RN (if < 1 year of experience, list in months)

7) Number of hours per week working as a CVICU RN

8) Job title; Credentials in addition to being an RN (select all that apply)
   □ CNI  □ CNII  □ CNIII  □ CCRN  □ CSC
   □ other:

9) Educational background
   □ Associate degree  □ BSN  □ MSN
   □ Other:
Appendix B

VOLUNTARY PARTICIPATION CONSENT FORM

Your participation is entirely voluntary, and you may withdraw at any time. If you volunteer to be in this study, and you withdraw, there are no consequences of any kind.

To Participate in this study participants must: Be a Cardiovascular Intensive Care Unit (CVICU) Nurse currently working in the Sulpizio Cardiovascular Center at UCSD Medical Center in La Jolla, CA.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

Although your participation will yield minimal or no direct benefits to you, we believe that the study has the potential to positively affect on the professionalism in Nursing.

The researcher hopes to use this information from the study to benefit the future of the nursing profession and organizations where nurses are employed.

The potential significance of this proposed study lies in the possibility that it may further both the personal and professional education of the CVICU RN’s by specifying for them those self-care strategies that will enable them to take better care of themselves and their patients.

POTENTIAL RISKS, DISCOMFORTS, INCONVENIENCES

There are minimal risks to participating in this study. These include:

• Loss of personal time necessary to participate in the surveys (15min)

• Potential of stress or ill memories of past experiences

• Potential breach in confidentiality
SAFEGUARDS

Safeguards put in place to minimize risk include:

• Surveys sessions will be offered at staff meetings and during work in the CVICU
  
  • Should one experience psychological effects and or require medical assistance during or
  after participation in the study, all participants can seek counseling and medical assistance at
  
  • All survey data will be kept confidential, available only to the research team for analysis
purposes and no identifying data will be collected.

QUESTIONS/CONTACT INFORMATION

If you have any questions or concerns about the research, please feel free to contact the
primary investigator Maureen Parsons at parso010@cougars.csusm.edu. The faculty supervisor
for this research is Dr. Joanne Daugherty and she may be contacted at jdaugher@csusm.edu. The
IRB committee at UCSD and CSUSM is charged with protecting the rights of the participants in
any study conducted. If you have any questions about your rights as a research participant, you
may contact CSUSM Institutional Review Board at 760-750-4029.

By signing below, I am agreeing to participate in this research study

_________________________________
Appendix C

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.

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

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Appendix D

*Self-Care Assessment Worksheet*

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

- 5 = Frequently
- 4 = Occasionally
- 3 = Rarely
- 2 = Never
- 1 = It never occurred to me

**Physical Self-Care**

___ Eat regularly (e.g. breakfast, lunch and dinner)
___ Eat healthy
___ Exercise
___ Get regular medical care for prevention
___ Get medical care when needed
___ Take time off when needed
___ Get massages
___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
___ Take time to be sexual—with yourself, with a partner
___ Get enough sleep
___ Wear clothes you like
___ Take vacations
___ Take day trips or mini-vacations
___ Make time away from telephones
___ Other:

**Psychological Self-Care**

___ Make time for self-reflection
___ Have your own personal psychotherapy
___ Write in a journal
___ Read literature that is unrelated to work
___ Do something at which you are not expert or in charge
___ Decrease stress in your life

___ Identify what in meaningful to you and notice its place in your life
___ Meditate
___ Pray
___ Sing
___ Spend time with children
___ Have experiences of awe
___ Contribute to causes in which you believe
___ Read inspirational literature (talks, music, etc.)
___ Other:

**Workplace or Professional Self-Care**

___ Take a break during the workday (e.g. lunch)
___ Take time to chat with co-workers
___ Make quiet time to complete tasks
___ Identify projects or tasks that are exciting and rewarding
___ Set limits with your clients and colleagues
___ Balance your caseload so that no one day or part of a day is “too much”
___ Arrange your work space so it is comfortable and comforting
___ Get regular supervision or consultation
___ Negotiate for your needs (benefits, pay raise)
___ Have a peer support group
___ Develop a non-trauma area of professional interest
___ Other:

**Balance**

___ Strive for balance within your work-life and workday
___ Strive for balance among work, family, relationships, play and rest

Let others know different aspects of you
Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
Practice receiving from others
Be curious
Say “no” to extra responsibilities sometimes
Other:

**Emotional Self-Care**

Spend time with others whose company you enjoy
Stay in contact with important people in your life
Give yourself affirmations, praise yourself
Love yourself
Re-read favorite books, re-view favorite movies
Identify comforting activities, objects, people, relationships, places and seek them out
Allow yourself to cry
Find things that make you laugh
Express your outrage in social action, letters and donations, marches, protests
Play with children
Other:

**Spiritual Self-Care**

Make time for reflection
Spend time with nature
Find a spiritual connection or community
Be open to inspiration
Cherish your optimism and hope
Be aware of nonmaterial aspects of life
Try at times not to be in charge or the expert
Be open to not knowing

Appendix E

Figure 1. Power analysis prior to data collection.

(Faul, et al, 2009)
Appendix F

Figure 2. Power analysis post hoc.

(Faul, et al, 2009)
References


A STUDY OF THE INTERRELATIONSHIP

Psychotherapy in Practice, 58(11), 1433-1441.


IBM. (2011). SPSS statistics 20 brief guide. Chicago, IL: IBM Corporation


