Preventing Compassion Fatigue in Oncology Nurses by Increasing Knowledge on Stress Reduction Techniques

by

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Dedication

I dedicate this work to Dr. Rita Ferguson, my research advisor who I could not have done this without, and to my family who continuously offered unconditional love and support throughout my nursing school journey.
Abstract

Background:

Compassion fatigue is a state of exhaustion experienced by those who help others that leads to limited engagement in future caring relationships (Nolte, Downing, Temane, & Hastings-Tolsma, 2017). This study aimed to decrease compassion fatigue in oncology nurses. Through teaching stress reduction techniques, nurses learned how to handle the stress of working with oncology patients, and therefore decrease their compassion fatigue.

Methods:

Participants were recruited from an Oncology Nursing Society (ONS) chapter located in the southeastern United States. Participants completed the Professional Quality of Life (ProQOL) scale and a demographic survey before the study. Participants then completed the ProQOL scale again after learning about stress reduction methods, through email content, for six weeks. This study was a quasi-experimental study.

Results:

The results support that stress reduction exercises increase compassion satisfaction (42.6 to 45.4) and decrease both burnout (21.5 to 18.1) and secondary traumatic stress (22.1 to 20.3).

Discussion:

Our results showed that compassion fatigue decreases when nurses learn stress reduction techniques. On average, compassion satisfaction scores increased after the six-week intervention while burnout and secondary traumatic stress scores decreased. The results showed that taking time to reduce stress when not working is essential to decreasing compassion fatigue levels.
Introduction

As one of the most necessary traits for a nurse, compassion remains important because compassionate care allows patients to feel empowered and therefore better able to participate in their own health and well-being. Compassion fatigue is defined as a state of exhaustion experienced by those who help others that leads to limited engagement in future caring relationships (Nolte, Downing, Temane, & Hastings-Tolsma, 2017). Wu, Singh-Carlson, Odell, Reynolds, and Su (2016) declared that oncology nurses are the most vulnerable to compassion fatigue because they developed strong relationships with patients and family members, causing grief and distress after a death or unexpected prognosis. Perry, Toffner, Merrick, and Dalton (2011) stated that nurses who have compassion fatigue might experience an increase in mistakes. Nursing mistakes can have many consequences, from medication errors to misidentifying patients, which may put the patient’s safety at risk. Other consequences of compassion fatigue include sleep disturbance, difficulty concentrating, feeling overwhelmed or hopeless, and lack of motivation (Nolte et al., 2017). Day and Anderson (2011) argued that compassion fatigue is a factor in patient safety while Slatten, David Carson, and Carson (2011) included that compassion fatigue also increased accidents and poor quality of care.

The purpose of this study was to decrease compassion fatigue in oncology nurses by asking this question: In nurses working with oncology patients, will increasing their knowledge on stress reduction techniques have an effect on their level of compassion fatigue? Through teaching stress reduction techniques such as meditation and yoga, nurses learned how to handle the stress of working with oncology patients, and therefore decrease their compassion fatigue. Preventing compassion fatigue can positively impact the health, well-being, and performance of oncology nurses.

Review of Literature
One intervention to prevent and decrease compassion fatigue was the resiliency program which educated participants about compassion fatigue, including contributing factors and the effects of stress. Potter and colleagues (2013) conducted a resiliency program that included four 90-minute sessions for nurses. The program was designed to promote resiliency through teaching self-regulation, intentionality, self-validation, connection, and self-care. Participants learned how to decrease negative arousal during stressful times through self-regulation, how to live intentionally by doing their best each day, how to work with integrity, how to develop social support in the workplace, and how to perform self-care to refuel and restore their energy and passion. Participants completed a set of questionnaires to measure compassion fatigue before and immediately after the program as well as three months and six months after. Participants from the program reported personal and professional benefits (Potter et al., 2013). The participants explained how learning the use of relaxation during a perceived threat, such as caregiving, was the most helpful. Participants also felt that learning they were not alone was particularly helpful (Potter et al., 2013).

Another intervention was the mindfulness based intervention performed by Duarte and Pinto-Gouveia (2016). This intervention was a six-week mindfulness-based group intervention where each session introduced a new theme and practice. The first four sessions taught mindfulness of the breath, body, emotions, and thoughts while the last two sessions taught loving-kindness, interpersonal relationships, and mindful communication. Participants also received a CD with guided meditation to practice at home. Participants completed questionnaires before and immediately after the six-week training program and then three months later. The outcomes included 98% of participants stated they learned something important, 72.5% made change in their lifestyle, and 70.6% reported they changed the way they perceive and respond to stress (Duarte et al., 2016). A significant reduction in compassion fatigue followed the intervention.
Nurses identified with compassion fatigue who implemented a resiliency or mindfulness program may be assisted to overcome compassion fatigue and therefore increase their satisfaction as well as improve patients’ outcomes.

This study is based on the intervention by Duarte and Pinto-Gouveia (2016). The mindfulness-based group intervention had an impact on participants as many made changes in their lifestyle. It was also noted that many participants in mindfulness interventions changed the way they perceived and responded to stress (Duarte and Pinto-Gouveia, 2016). This study focused on oncology nurses to see if the same results were transferred to different groups.

**Theoretical Framework**

Lombardo and Eyre (2011) explained Watson’s theory of human caring and Koloroutis’ theory in comparison to compassion fatigue. Watson’s theory of human caring involved relationship-based nursing (RBN). RBN included empathy and communication of that empathy to the patient and family. Empathy is the ability to understand a patient’s feelings, understand the situation from patient’s perspective, and communicate that understanding to the patient (Lombardo & Eyre, 2011, para. 6). On the other hand, Koloroutis identified three core aspects of RBN which included the nurse’s relationship with patients and families, the nurse’s relationship with self, and the nurse’s relationship with colleagues. As is evident by Watson (2010) and Koloroutis (2007), the concept of an empathic relationship between the nurse and patient is essential for nursing; however, this relationship can also contribute to compassion fatigue if steps are not taken to avoid the condition. Compassion fatigue occurs when a nurse continues to be empathic towards their patients without allotting time for self-care. This results in limited engagement in caring relationships with patients (Nolte et al., 2017). Koloroutis explained how
the relationship with self is essential for improving one’s health, being empathic, and being productive in a healthcare facility (Lombardo and Eyre, 2011). Although patient relationships are important, it is also essential for the nurse to care for the relationship with themselves in order to provide an empathic and influential relationship to their patients.

**Methods**

**Population, Sample and Setting**

Participants were recruited from an Oncology Nursing Society (ONS) chapter located in southeastern United States. A convenience and snowball sample of nurses were recruited through the ONS chapter. At the June 2018 meeting, the purpose of the study was explained to members and they were invited to participate in the study. The principal investigator (PI) provided a short program during the June meeting regarding compassion fatigue and stress reduction measures. The study process, length of time, and benefits that the participants would gain to include continuing education units were explained during the meeting. Informed consent was obtained at the meeting. ONS members who agreed to participate in the study provided email contact information to the principal investigator (PI) for continued contact and participation in the study.

Demographic data included age, ethnicity, highest degree or level of school completed, marital status, and gender.

IRB approval was received prior to initiating the study. See Appendix A for notification letter of IRB approval.

**Data Collection**

The Professional Quality of Life (ProQOL) Version 5 self-report survey was utilized as a pre-survey and post-survey for data collection. Permission to use the survey was stated by the original author on the survey document. Participants completed the survey at the beginning of the study to measure their level of compassion fatigue. After participants completed the six-week
program of learning and applying stress reduction techniques, they took the ProQOL self-report
survey again to compare their level of compassion fatigue before and after the program.

A demographic survey was also completed by the participants at the beginning of the
study. The demographic survey addressed age, ethnicity, highest degree or level of school
completed, marital status, and gender. This survey was to determine what factors may influence
respondent’s answers and opinions.

Qualtrics, a web-based survey tool, was used to administer the surveys and to collect the
anonymous data.

**Research Design**

This study was quasi-experimental study as participants were invited to participate
through convenience and snowball sampling and were not randomly assigned. A single group
pre-test and post-test design was utilized to obtain information regarding participants' compassion fatigue, compassion satisfaction, and burnout prior to implementation of the mindfulness intervention program. The same survey was administered post intervention to
determine any changes in participants' scores after completing the program.

**Instruments**

Professional Quality of Life (ProQOL) Version 5 is a self-report survey that was utilized
to assess compassion fatigue, compassion satisfaction, and burnout. It contained 30 items rated
on a 5-point Likert scale, ranging from 1 (Never) to 5 (Very Often). See Appendix B for a copy
of the ProQOL.

Demographics survey was used to determine what factors might influence respondent’s
answers and opinions such as differing age, gender, ethnicity, or education level. See Appendix
C for demographic survey.

**Procedure**
Participants received an email with a survey link to complete the Professional Quality of Life (ProQOL) scale to assess the level of compassion fatigue before the project and they also received a survey to gather the demographics of the subjects participating. See Appendix B for the ProQOL survey and Appendix C for the demographic survey. All participants completed the survey online via Qualtrics and opening the Qualtrics link provided implied consent. After the initial surveys were completed, the participants received weekly emails for six weeks. The emails included quotes, videos, reading supplements, and practice techniques in order to learn about and apply stress reduction methods. There was also a 5-question knowledge quiz at the end of each email that asked short questions about the material covered. At the end of the six-week period, participants were given the ProQOL survey again via Qualtrics to assess changes in the levels of compassion fatigue.

**Results**

The majority of participants were between ages 35-44 (50%), 37.5% were 45-54 years old, and 12.5% were 25-34 years old.

87.5% of participants were White while 12.5% were Hispanic or Latino.

62.5% of participants held a Bachelor’s degree while 37.5% held a Master’s degree.

The majority of participants were female (87.5%) while 12.5% were male.

75% of participants were either married or in a domestic partnership, 12.5% were divorced, and 12.5% were separated.

The results of the study supported that mindfulness type stress reduction exercises increased compassion satisfaction and decreased both burnout and secondary traumatic stress. These are the three concepts that the Professional Quality of Life survey addressed both before and immediately after the study.
Compassion satisfaction is the gratification that you feel from being able to do your work well. Higher scores represent a greater sense of pleasure in your ability to be an effective caregiver. The average compassion satisfaction score of the Pre-Pro QOL survey was 42.6. The average compassion satisfaction score of the Post-Pro QOL survey was 45.4.

Burnout is an essential element of compassion fatigue. It includes feelings of hopelessness, the opinion that one’s efforts are not making a difference, as well as struggles in fulfilling the job effectively. Higher scores mean that one is at risk for burnout. Scores below 18 reflect positive feelings about one’s ability to be effective. The average burnout score in the Pre-Pro QOL was 21.5. The average burnout score in the Post-Pro QOL was 18.1.
Secondary Traumatic Stress involves the secondary exposure to traumatic or stressful events. Symptoms include being afraid, difficulty sleeping, or avoiding things that remind you of traumatic events. Higher scores do not mean that there is a problem, but it is an indication that the person needs to be examined to find the reason for their elevated score. The average Secondary Traumatic Stress score of the Pre-Pro QOL was 22.1. The average Secondary Traumatic Stress score of the Post-Pro QOL was 20.3.
Age differences were one of the contributing factors to compassion fatigue scores. Those between the age of 35-44 years old had a greater increase in compassion satisfaction after the study as well as a greater decrease in burnout and secondary traumatic stress.

Limitations

One notable limitation in this research includes the demographics of those participating. 87.5% of participants were white, 62.5% had a Bachelor’s degree, 75% were married or in a domestic relationship, and 87.5% were female. Since a majority of the study did not include a diverse population, this data may not be applicable to those of a different ethnicity, education level, relationship status, or gender. Small convivence sample with no control group also limits generalization and interpretation of the results. A study including a more diverse and larger sample size is advised.

Discussion

The primary purpose of this study was to decrease compassion fatigue in oncology nurses through teaching stress reduction techniques such as meditation and yoga. Earlier research suggested that teaching self-regulation and self-care helped participants to relax when encountering a perceived threat, such as caregiving (Potter et al., 2013). Another study focused on the mindfulness intervention, a six-week program where each session introduced a new theme and practice. This study found that there was a significant reduction in compassion fatigue following the intervention (Duarte and Pinto-Gouveia, 2016).

The results revealed that compassion fatigue does decrease when nurses learn stress reduction techniques. On average, the compassion satisfaction scores increased after the six-week intervention while the burnout and secondary traumatic stress scores decreased. The
circumstances that the participants were dealing with while on the job did not change, but they instead learned how to deal with those circumstances. The results from the study supported that setting aside time to reduce levels of stress when not working is essential. This included managing stress through yoga and meditation techniques. A lower level of stress allowed the participants to change their perception of the situation that they were dealing with at work which led to an increased satisfaction and decreased burnout and secondary traumatic stress.

Although this study showed that stress-reduction techniques can decrease compassion fatigue, it may not be applicable to all populations. The majority of participants in this study were 35-44 years old, white, held a bachelor’s degree, were married or in a domestic partnership, and were female. Further studies need to be performed in order to see how populations of varying age, ethnicity, education level, relationship status, and gender will react after learning stress reduction techniques.

**Implications to Nursing Practice**

When oncology nurses experience compassion fatigue, it negatively impacts the care that their patients are receiving. Nurses are required to provide safe and quality care; however, compassion fatigue compromises both of these factors. As seen in this study, learning and implementing stress reduction techniques helped to decrease levels of compassion fatigue. In this study, 50 minutes per week helped to increase levels of compassion satisfaction while decreasing levels of burnout and secondary traumatic stress. Although nurses may be busy outside of work, it is essential for them to set aside time to practice stress reduction techniques such as meditation, yoga, or another method that works for them. This action does not affect the environment that the nurses work in, but instead changes the way the nurse interprets the situation. Nurses providing compassionate care exemplifies the important concept of safe and quality care to all patients.
Conclusion

In this study, learning stress reduction techniques and the impact of the level of compassion fatigue was examined. Participants’ level of compassion fatigue both before and after the intervention was compared using the Professional Quality of Life Survey. After the participants completed the six weeks of learning different stress reduction techniques, the data from the pre- and post-Pro QOL surveys was gathered. The data showed that learning how to reduce one’s stress, through techniques such as yoga and meditation, helped to increase the level of compassion satisfaction while decreasing the level of burnout and secondary traumatic stress.

It is possible that results may vary if the study focused on a more diverse population and if results were measured over a longer period of time. Future researchers should consider investigating the impact of stress reduction techniques on compassion fatigue in varying age, ethnicity, education level, relationship status, and gender groups. They may also examine the long-term effects of stress reduction techniques on compassion fatigue such as over one or two years.

These results support the idea that learning stress-reduction techniques helps nurses to manage their compassion fatigue by increasing their compassion satisfaction and decreasing both their burnout and secondary traumatic stress.

Dissemination of Scholarly Work

Principal investigator participated in the 18th Annual University of Alabama System Honors Research Conference: Friday, November 2, 2018
Poster title: Preventing Compassion Fatigue in Oncology Nurses by Increasing Knowledge on Stress Reduction Techniques
See Appendix D for poster presented
References


Appendix A
IRB Approval

April 16\textsuperscript{th} 2018

Logan Baker

Department of Nursing

University of Alabama in Huntsville

Dear Ms. Baker,

The UAH Institutional Review Board of Human Subjects Committee has reviewed your proposal, \textit{Preventing Compassion Fatigue in Oncology Nurses by Increasing Knowledge on Stress Reduction Techniques}, and found it meets the necessary criteria for approval. Your proposal seems to be in compliance with this institution's Federal Wide Assurance (FWA) 00019998 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Please note that this approval is good for one year from the date on this letter. If data collection continues past this period, you are responsible for processing a renewal application a minimum of 60 days prior to the expiration date.

No changes are to be made to the approved protocol without prior review and approval from the UAH IRB. All changes (e.g. a change in procedure, number of subjects, personnel, study locations, new recruitment materials, study instruments, etc) must be prospectively reviewed and approved by the IRB before they are implemented. You should report any unanticipated problems involving risks to the participants or others to the IRB Chair.
If you have any questions regarding the IRB’s decision, please contact me.

Sincerely,

Bruce Stallsmith

IRB Chair

Professor, Biological Sciences

**Expedited:**

- Clinical studies of drugs and medical devices only when condition (a) or (b) is met. (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review. (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

- Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

- Prospective collection of biological specimens for research purposes by noninvasive means. Examples: (a) hair and nail clippings in a nondisfiguring manner; (b) deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction; (c) permanent teeth if routine patient care indicates a need for extraction; (d) excreta and external secretions (including sweat); (e) uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue; (f) placenta removed at delivery; (g) amniotic fluid obtained at the time of rupture of the membrane prior to or during labor; (h) supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques; (i) mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings; (j) sputum collected after saline mist nebulization.

- Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications).

- Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

- Collection of data from voice, video, digital, or image recordings made for research purposes.
Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Exempt

Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (a) research on regular and special education instructional strategies, or (b) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods. The research is not FDA regulated and does not involve prisoners as participants.

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interviews, or observation of public behavior in which information is obtained in a manner that human subjects cannot be identified directly or through identifiers linked to the subjects and any disclosure of the human subject’s responses outside the research would NOT place the subjects at risk of criminal or civil liability or be damaging to the subject’s financial standing, employability, or reputation. The research is not FDA regulated and does not involve prisoners as participants.

Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement) survey procedures, interview procedures, or observation of public behavior if (a) the human subjects are elected or appointed public officials or candidates for public office, or (b) Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter. The research is not FDA regulated and does not involve prisoners as participants.

Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. The research is not FDA regulated and does not involve prisoners as participants.

Research and demonstration projects which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs. The protocol will be conducted pursuant to specific federal statutory authority; has no statutory requirement for IRB review; does not involve significant physical invasions or intrusions upon the privacy interests of the participant; has authorization or concurrent by the funding agency and does not involve prisoners as participants.

Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug
Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture. The research does not involve prisoners as participants.

Surveys, interviews, or observation of public behavior involving children cannot be exempt.
Appendix B
ProQOL Survey

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. 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.


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.

© B. Hudnall Stamm, 2009. Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). /www.isu.edu/~bhstamm or www.proqol.org. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.
Appendix C
Demographics Survey

- What is your age?
  - 18-24 years old
  - 25-34 years old
  - 35-44 years old
  - 45-54 years old
  - 55-64 years old
  - 65 years or older

- Please specify your ethnicity:
  - White
  - Hispanic or Latina
  - Black or African American
  - Native American or American Indian
  - Asian/ Pacific Islander
  - Other

- What is the highest degree or level of school you have completed? If currently enrolled, highest degree received.
  - Associate degree
  - Bachelor’s degree
  - Master’s degree
  - Doctorate degree

- What is your marital status?
  - Single, never married
  - Married or domestic partnership
  - Widowed
  - Divorced
  - Separated

- What is your gender?
  - Male
  - Female
  - Other: specify...
### Appendix D

**Poster**

**Preventing Compassion Fatigue in Oncology Nurses by Increasing Knowledge on Stress Reduction Techniques**

Logan Baker  
The University of Alabama in Huntsville

#### BACKGROUND/DESCRIPTION OF THE PROBLEM

- Compassion fatigue (CF) is a state of exhaustion experienced by those who help others that leads to limited engagement in future caring relationships.  
- Nurses experiencing CF have an increase in mistakes, decline in their overall health, and a desire to leave the profession.  
- CF is a factor in patient safety and it increases both accidents and poor quality of care.  

#### METHODS

- Participants, recruited from the Oncology Nursing Society (ONS) in Huntsville, Alabama, signed an informed consent and provided email contact information.  
- An email with the Professional Quality of Life (ProQOL) scale assessed level of compassion fatigue with a focus on compassion satisfaction, burnout, and secondary traumatic stress.  
- Weekly emails were sent for six weeks. Focused on mindfulness and included videos, readings, and practice techniques to learn and apply stress reduction methods.  
- After six weeks, participants received ProQOL survey to assess changes in the levels of compassion fatigue.

### RESULTS

The results of the study support that mindfulness type stress reduction exercises increase compassion satisfaction and decrease both burnout and secondary traumatic stress.

- **Compassion Satisfaction**  
  - The pleasure you derive from being able to do your work well. Higher scores represent a greater satisfaction.
  
- **Burnout**:  
  - Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores mean higher risk for burnout.

### FINDINGS FROM THE LITERATURE

- Risk factors for CF - neuroticism and passive coping skills.  
- Lack of a support system, challenges in the workplace, and having family at home make a nurse more vulnerable to CF.  
- Symptoms of CF - fatigue, sleepiness, lack of energy, hopelessness, feelings of incompetence.  
- Mindfulness-based intervention decreases CF following the intervention.  
  - 70.6% reported they changed the way they perceive and respond to stress.

### METHOD

#### Background/Description of the Problem

- Compassion fatigue (CF) is a state of exhaustion experienced by those who help others that leads to limited engagement in future caring relationships.  
- Nurses experiencing CF have an increase in mistakes, decline in their overall health, and a desire to leave the profession.  
- CF is a factor in patient safety and it increases both accidents and poor quality of care.  

#### Methods

- Participants, recruited from the Oncology Nursing Society (ONS) in Huntsville, Alabama, signed an informed consent and provided email contact information.  
- An email with the Professional Quality of Life (ProQOL) scale assessed level of compassion fatigue with a focus on compassion satisfaction, burnout, and secondary traumatic stress.  
- Weekly emails were sent for six weeks. Focused on mindfulness and included videos, readings, and practice techniques to learn and apply stress reduction methods.  
- After six weeks, participants received ProQOL survey to assess changes in the levels of compassion fatigue.

### Results

The results of the study support that mindfulness type stress reduction exercises increase compassion satisfaction and decrease both burnout and secondary traumatic stress.

- **Compassion Satisfaction**  
  - The pleasure you derive from being able to do your work well. Higher scores represent a greater satisfaction.

- **Burnout**:  
  - Burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. Higher scores mean higher risk for burnout.

#### Findings from the Literature

- Risk factors for CF - neuroticism and passive coping skills.  
- Lack of a support system, challenges in the workplace, and having family at home make a nurse more vulnerable to CF.  
- Symptoms of CF - fatigue, sleepiness, lack of energy, hopelessness, feelings of incompetence.  
- Mindfulness-based intervention decreases CF following the intervention.  
  - 70.6% reported they changed the way they perceive and respond to stress.

### References