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Differences in Perceptions of Compassion Fatigue, Compassion Satisfaction, and Burnout Among Nurse Faculty

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DIFFERENCES IN PERCEPTIONS OF COMPASSION FATIGUE,

COMPASSION SATISFACTION, AND BURNOUT

AMONG NURSING FACULTY

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Title: Differences in Perceptions of Compassion Fatigue, Compassion Satisfaction, and Burnout Among Nursing Faculty

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Nurses, who assume the role of educator, experience different levels of compassion satisfaction (CS), compassion fatigue (CF), or burnout (BO) regardless of their age, years of experience as a registered nurse (RN) or nurse educator, the level at which they teach (undergraduate, master's, doctoral), their area of expertise, or the setting in which they teach their content (classroom, clinical lab, on-line). CF, and its subcomponents, BO and secondary traumatic stress (STS) manifest themselves in the nurse as an experience of gradual diminishment in the capacity to care which is characterized by a deep emotional sense of exhaustion, depersonalization, and lack of accomplishment.

The purpose of this study was to investigate the extent to which nurse educators in academia experienced CF, CS, and BO across levels at which they teach (undergraduate, master's, doctoral), and to identify stressors unique to nursing academia which impact professional quality of life.

This mixed-methods study explored differences in perceptions of CF, CS, and BO among a convenience sample of nursing faculty (N=46) who taught in 11 nursing programs in the Pennsylvania State System of Higher Education system at the baccalaureate, master's, and/or doctoral levels. Using data from responses to open-ended questions and by analyzing descriptive statistics from the Professional Quality of Life

Scale Version 5 survey, this study compared age groups, years as an RN, years as a nurse educator, and background expertise to levels CS, BO, and STS. Using multiple regression analyses, this investigation discovered that psychiatric nursing background expertise was the only area of expertise that was a statistically-significant predictor of CS only. Furthermore, regardless of the levels (undergraduate, master’s, doctoral) taught at (career) and levels taught at (during the last 12 months), these parameters were not significant predictors of CS, BO, or STS.

These study findings may be used to promote a better understanding of the perceptions of CS, CF, and BO in nurse faculty and enhance Professional Quality of Life in the context of nursing academia. Understanding the needs of this distinct group of nurse educators offers valuable insight into the development of a resilience plan that resists CF.

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DEDICATION

This research is dedicated in memory of my father, Rev. Fred J. Gardner, who went home to be with the Lord in 2005. My dad was an African missionary, pastor, theologian, author, and scholar. It was his dream to see his eldest son return to graduate school, become a teacher of the nursing profession, and to model compassion to his family, colleagues, church, community, and students everywhere. This research is also dedicated to my colleague, Natalie George RN, who passed away suddenly in 2011 at the beginning of our journey to become doctorally prepared nurse educators.

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INTRODUCTION

Patients and other members of the public expect nurses to be altruistic, compassionate, caring, empathetic, and competent. They often gauge the quality of the healthcare they receive based on the emotional and physical accessibility of nurses and their observable levels of compassion (Graber & Mitcham, 2004). These high expectations may often go unmet among consumers in the current healthcare community. Because of the challenging nature of today's healthcare work environment, nurses may experience stress, whether at the bedside or in the classroom. The stressful experiences of nurses' work environments often result in deep-seated emotional impressions that may forever traumatize the caregiver and produce emotional, as well as, physical fatigue. Certain risk factors, such as lack of social support systems, personal life experiences and stressors, and stressful work environments, combine to leave the caregiver at a heightened risk for the development of burnout or emotional exhaustion leading to its extreme form, known as compassion fatigue (CF) where there is "loss of self" (Bush, 2009, p. 28).

Caregivers, by the very nature of their profession, must identify a need for a balance between compassionate care of self and empathy (Larson & Bush, 2006). These same compassionate attributes which attract nurses to the nursing profession and are essential for optimal care (Watson, 1988) often leave nurses feeling hopeless and ineffective, eventually leading them down a dysfunctional pathway to the development of burnout (BO) or secondary traumatic stress (STS), the two subcomponents of CF. Stamm (1999) warned caregivers that they should not be lulled into a false sense of security, that they are somehow immune from the pain and loss of patients and other care recipients. Stamm argued that the combined efforts of continuing education, research, and training in higher education might be insufficient to shield helping professionals from the detrimental effects of CF or assist them to maintain balance and objectivity. This research was dedicated to investigating the awareness of nurses, educators in particular; so that they will be able to identify, acknowledge, and overcome the impact compassion fatigue can have on their careers. This chapter discusses the background, statement of the problem, significance, theoretic framework, research questions, hypothesis, research design overview, definition of terms, limitations, delimitations, and assumptions of the study.

Background

Compassion Fatigue is the term used to describe the emotional effect of being indirectly traumatized by helping someone who has experienced primary traumatic stress (Figley, 2002). CF was first identified in nursing as "a unique form of burnout that affects people in the care giving professions" (Joinson, 1992, p. 116). Joinson, a nurse, reported that nurses are very susceptible to compassion fatigue and, as such, need to be better equipped to confront this stressor which they are certain to experience at some point in their careers. Figley (1995) later defined CF as a state of tension and preoccupation with the individual or cumulative traumas of clients and described this state as the high cost a caregiver or helping professional experiences as a result of caring for others. This phenomenon may emerge without warning thereby producing a sense of helplessness, confusion, and ultimately loss of self or inability to separate from others' trauma at the end of the day. Yoder also noted "those who care for, or otherwise assist, those individuals who are working through a traumatic life event, may also experience devastating stress when they cannot emotionally detach themselves from the care receiver's trauma" (Yoder, 2010, p. 191). The cumulative effects of CF from daily exposure to patients' suffering may have a crippling effect on nurses' ability to compassionately care for the sick, the wounded, traumatized, and the weak in their charge (Coetzee & Klopper, 2010). Nurses, regardless of the arena in which they practice, need to be equipped to recognize the debilitating symptoms of CF and build resilience to maintain efficacy amidst all the negative stress in their work environments. There are strategies that assist these helping professionals to build resilience, enhance compassion satisfaction, stave off burnout, and maintain efficacy in the midst of such challenging circumstances.

Stebnicki (2008) reminded helping professionals of the importance of preparing the body, mind, soul, and spirit to build resilience, especially when working with intense interpersonal dysfunction. Resilience may be supported by resourcefulness, the ability to be in touch with one's feelings, having vision and goals, and a strong desire to help others. Social support offers the best protection in such highly stressful environments (Teater, 2011). Social support, in this context, is particularly beneficial to enhance feelings of compassion satisfaction with one's work. Compassion satisfaction (CS) is described as the pleasure derived from being able to do one's work well, where there are positive feelings about your colleagues, your contribution toward the greater good of society, and your ability to help others through your work (Stamm, 2010; Teater, 2009). Feeling productive and helpful to those for whom the nurse cares assists nurses experiencing burnout, a phenomenon associated with CS and CF. Burnout (BO), a psychological term for the experience of long-term exhaustion and diminished interest, develops gradually over time with prolonged emotional and physical exhaustion, often resulting in widespread apathy, a disinterest in work and relationships (Maslach, 1982). "People who are burned out and work in health care are often seen as dispassionate because their apathy appears to indicate a lack of caring" (Todaro-Franceschi, 2013, p. 5). Enhancing CS in the nursing workplace environment may prove beneficial in the mitigation of the symptoms of BO before it progresses to its more incapacitating form, secondary traumatic stress (STS), now known by its more modern term, CF.

Statement of the Problem

The scope of the problem of CF in professional nursing practice is actually quite staggering and not just limited to the nursing profession in the United States. "Everyone in a helping profession is susceptible to compassion fatigue, from teachers, to administrators, to flight attendants, to financial advisors" (Hoover, 2012, p. 2). Hoover (2012) noted there are numerous variables that come into play to produce compassion fatigue in these and other helping professions. These individuals often deal with members of the public who do not feel well or who are experiencing some type of crisis requiring the helping professional to intervene and emotionally stabilize traumatized individuals or diffuse situations (Hoover, 2012). The subsequent burden of caring for others can upset the balance between objectivity and empathy in the helping professional resulting in compassion fatigue. According to Hoover (2012), CF among helping professionals, such as physicians or nurses, manifests itself in the increasing number of mistakes in medication administration, procedural error, misreading orders or other data entered into the medical record.

CF affects the nursing profession worldwide and the potential for BO exists regardless of sub-specialty, including academia, critical care, pediatrics, obstetrics, geriatrics, or psychiatric nursing (Chen & McMurray, 2001; Jenkins & Elliot, 2004). Overcoming CF presents one of the greatest challenges, personally and professionally, for many nurses whether they function in acute care, as a bedside primary caregiver, manager of an acute care unit, or in academia as an educator or faculty mentor.

Despite the growing body of research describing the impact of CF among bedside nurses; existing studies are sparse in its description of the residual effects of CF on nurse educators and the impact of CF on the nurse educator's ability to care for students. Very little attention has been given to the phenomenon of CF in nurses who no longer care for patients at the bedside, but find themselves caring for students in academia. Stressors unique to academia present their own set of demands on resilience and include activities common to the Academy such as scholarship, teaching excellence, and university, and community service. The stress of pursuing an education to become a nurse educator also presents unique challenges to nurses where many nursing programs require the minimum of a master's degree in nursing or a doctorate in nursing in order to obtain promotion and tenure. Administrative and collegial support that values the connectedness among research, teaching, and promotion for tenure track nurse faculty is essential to avoid faculty role strain (Paskiewicz, 2003). The cumulative effect of these negative stressors may produce BO and CF in the nurse educator (Sarmiento, Laschinger, & Iwasiw, 2004). Nurse educators remain a vulnerable population even after they leave bedside nursing because of the impact of the added responsibility of being a nurse educator, caring for the patients to whom their students are assigned, and caring for the needs of individual nursing students. Presently, a gap exists in the literature regarding the experiences of CF in nursing academia and is sparse on strategies for alleviating its deleterious effects. What is the present state of the knowledge base concerning the relevance of such a study in nursing education?

According to Benner, Staphan, Leonard, Day, and Shulman (2009, as cited in Todaro-Franceschi, 2013), a transformation in leadership in nursing education is urgently needed if nurse educators are to keep pace with the rapid remodeling of health care policy and narrow the gap between education and practice. Gaining a better understanding of the extent to which nurse educators in academia are affected by conditions such as BO and CF is crucial to the development of positive and nurturing practice environments which enhance CS (Potter, Deshields, Divanbeigi et al., 2010). Thus, nurse educators facilitate the development of moral courage in their students by emulating nurturing behaviors and modeling those strategies which resist CF (Todaro-Franceschi, 2013, p. 105).

This research was dedicated to the exploration of the incidence of CF, CS, and BO among nurse educators in academia. This study began by tracking this CF phenomenon in the career of the professional nurse, following the transition from the bedside to academia, to determine whether this extreme form of BO follows them into the academic environment. This study provides additional insight into best practices for nurses who successfully make the transition from the bedside into academia. This research identified strategies to equip nurse educators with a better understanding of CF and provides insight for mitigating the detrimental effects of CF on their students and themselves.

Purpose of the Study

The purpose of this study was to investigate the extent to which nurse educators in academia experienced (CF), (CS), and (BO) across levels at which they teach (undergraduate, masters, doctoral), and to identify stressors unique to nursing academia which contributes to or mitigates these phenomena. Regardless of the context in which it occurs, a diminished capacity to care, which often accompanies CF, can be catastrophic for any nurse, whether at the bedside or in the education arena, and may adversely impact his or her nursing career. According to Vahay, Aiken, Sloan, Clarke, and Vargas (2004), consequences of this level of burnout may include decreased job performance, absenteeism, tardiness, job turnover, drug and alcohol abuse, and physical illness, such as hypertension and gastric ulcers, resulting in the nurse leaving the profession altogether.

Since the literature makes very little mention of CF within the context of nursing education, this study explored the incidence of this phenomenon to narrow this gap in the current literature. This study also aimed to assess the prevalence of CS, CF, and BO in nursing academia for the purpose of enhancing the nurse educator's quality of life and teaching practice and to mitigate any detrimental effects CF and BO might have on the practice of nursing education. Identifying and celebrating the positive aspects or CS in nursing academia will enhance the quality of life of the nurse educator (Potter, Deshields, Divanbeigi, Berger, Cipriano, Norris & Olsen, 2010).

Significance of the Study

This study focused on discovery of the extent to which nurse educators in academia are affected by the everyday impact of the stressful work environmental conditions and performance expectations of nursing academia. Developing a better grasp of how these stressors are experienced and how they contribute to BO and CF is crucial for the development of a positive and nurturing practice environment that will enhance the quality of life and promote positive outcomes in academia for nurse educators and their students (Potter et al., 2010). Perhaps of even greater relevance is the consideration of the impact of CF upon nursing students. According to Todaro-Franceschi, (2013), "Just as compassion is contagious, so is compassion fatigue" (p. 160). Thus, how nurses are taught plays a pivotal role in their ability to be caring at work and to model these caring behaviors in the patient care environment (Todaro-Franceschi, 2013). This study was also undertaken to narrow the gap in the literature concerning the incidence and impact of CF, CS, and BO upon the nurse educator, and to contribute to the enhancement of the quality of life in the work environment of nursing academia.

Theoretical Framework

Caring is an essential construct in professional nursing as identified by nursing grand theorist, Jean Watson (1988). Watson, in her theory of human caring, conceptualized nursing as an intersubjective human process that places a high value on the caring relationship between the nurse and the recipient of care. Watson assumed that human beings are unitary, subjective, and unique. They possess inner resources and strength that promote resilience and can be accessed to meet certain health challenges including stress in the nursing work environment. A healthy work environment may be achieved through unity within mind, body, and soul and, as such, is a harmony that can be achieved in nursing through stress alleviation (Schroeder & Neil, 1992).

Watson's (1988) theoretical model describes 10 carative factors essential for compassionate nursing practice: (a) Humanistic/altruistic value system, (b) Faith and hope, (c) Sensitivity and empathy, (d) Helping-trusting relationships, (e) Promotion and acceptance of both positive and negative feelings in communication, (f) Scientific problem-solving, (g) Interpersonal teaching /learning, (h) Mental, physical, socio-cultural, spiritual support, protection, correction and safety, (i) Gratification of human needs, and (j) Allowances for existential-phenomenological forces that may affect the caring experience. Interruption of any of these carative factors may impair the caregivers' ability to model caring behaviors and affect outcomes for the care receiver (Watson, 1988). For the purpose of this study, the care receiver is identified as the baccalaureate or graduate nursing student. The caregiver or helping professional investigated in this study was the nurse educator in academia and was the focus of queries posed in the study's research questions.

Research Questions

This study aimed to address the following four questions pertaining to the experiences of nurse educators in 11 Pennsylvania State System of Higher Education (PASSHE) (Appendix A) education programs which offer a baccalaureate, masters, or doctorate in nursing:

1. To what extent do the variables of age, gender, years of teaching experience, and academic background in nursing academia shape the experiences of compassion fatigue?

2. To what extent does the level of compassion fatigue experienced by nurse educators in academia vary among groups as determined by type of nursing program taught in (baccalaureate, graduate)?

3. To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by faculty teaching assignments (undergraduate, masters, doctoral) and method of course delivery (classroom, clinical lab, on-line)?

4. What are the experiences of compassion fatigue among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)?

Hypothesis

Nurses, who assume the role of educator, experience different levels of compassion fatigue, compassion satisfaction, and burnout regardless of the level at which they teach (undergraduate, masters, doctoral), their age, their area of expertise, their years of experience, or the setting in which they teach their content (classroom, clinical lab, on-line).

Research Design Overview

In order to assess the impact of CS, CF, and BO on teaching practice in nursing academia and to determine the extent to which nurse educators in academia experience these phenomena, this study specifically targeted nursing faculty in 11 PASSHE nursing education programs at the baccalaureate, masters, and doctoral levels. This study employed a mixed-method design combining quantitative data from the Professional Quality of Life Scale English Self-Score Version 5 (ProQOL 5) (Stamm, 2010) (Appendix D) and qualitative data from open-ended questions placed at the end of the demographic portion of the study's survey instrument (Appendix C). This study examined qualitative data of nurse educators' experiences of CF using interpretative description (Thorne, Reimer-Kirkham, & O'Flynn-Magee, 2004). Interpretative description is a human science research model used is this study to reflect the unique aspects of nursing research that directly impact the practice of professional nursing. Interpretive description is a "non-categorical approach to qualitative research which is appropriate for small-scale qualitative research projects" (Austin, Goble, Leier, & Byrne, 2009, p. 201). This study of CS, CF, and BO in nursing academia sought to capture certain themes and patterns to help nurse educators in academia screen for CF and understand its implications for clinical practice.

This study employed a mixed-method approach to investigate the phenomena of CS, CF, and BO, within the context of nursing academia, for its ability to support the study's hypothesis using multiple and complementary types of data. This approach enhanced validity of the study by using multiple complementary forms of data in this manner (Polit & Beck, 2014). Triangulation of data in this manner also provided opportunities for testing alternative interpretations of the data and for determining the extent to which the context helped to shape the results of this research in nursing academia (Polit & Beck, 2014).

This research explored the essence of these phenomena as they occurred in the context of nursing academia through a descriptive analysis of statistical data gathered from March 1, 2014 to April 9, 2014 via an electronic survey tool. For the purposes of this study, the investigator utilized the Qualtrics® survey system to distribute a survey containing the assessment instrument, the ProQOL 5 (Stamm, 2010), to all eligible participants in 11 PASSHE university nursing programs as determined by levels at which they taught (undergraduate, masters, doctoral).

Research Instrument

The ProQOL 5 is an assessment instrument, developed by Beth Hudnall-Stamm (2010) to measure CS and the two components of STS, CF, and BO, among helping professionals. For the purposes of this study, the targeted helping professional was the nurse educator in academia. The ProQOL 5 is a 30-item scale screening tool used for measuring CS, and the two negative components of STS, CF, and BO as experienced over the last 30 days (Stamm, 2010). This well-validated instrument has been tested on more than 3,000 individuals (healthcare providers, children or family workers, school personnel) and is a fifth revision of the originally titled *Compassion Fatigue Self-Test* survey tool (Figley, 1995). Completion of the ProQOL 5 involved selecting responses 0 (never) – 5 (very often) on a Likert Scale. Stamm (2010) strongly recommended that this tool be used for screening purposes only and not for psychotherapeutic diagnosis or treatment. Accompanying the ProQOL 5 was a self-scoring instrument that provided participants with instructions for tallying their respective scores for each subscale, then explaining the scores describing the levels of CS, and CF, and BO.

Definition of Terms

Key terms central to this study are defined as follows:

Burnout—A sub-component of CF, BO is a psychological term which describes the experiences of long-term exhaustion and diminished interest. BO develops gradually with prolonged emotional and physical exhaustion, often resulting in widespread apathy, a disinterest in work and relationships (Maslach, 1982). "People who are burned out and work in health care are often seen as dispassionate because their apathy appears to indicate a lack of caring" (Todaro-Franceschi, 2013, p. 5). Such feelings of empty-heartedness and hopelessness may arise from one's own work environment and frequently spill over into the caregiver's personal life, impeding the enjoyment of daily living that enhance the caregiver's professional quality of life. The nurse educator can ill afford to be ostensibly heartless, and "these displays of dispassionate care can be extremely disturbing, especially to undergraduate students" (Todaro-Franceschi, 2013, p. 5). A heightened risk of BO exists among nurse educators because of the considerable amount of time they spend with students who require assistance acquiring knowledge, critical judgment, and psychomotor skills (Sarmiento, Laschinger & Iwasiw, 2004, p. 135). Given this context, this study focused on the nurse educator in academia in an effort to determine the impact of BO and CF on the nurse educator's professional quality of life, as influenced by stressors experienced in the settings in which they teach.

Compassion—A feeling of deep sympathy and sorrow for someone struck by misfortune, accompanied by a strong desire to alleviate the suffering or remove its cause (Figley, 1982, 2002). Compassionate care exists as a central construct in professional nursing practice which is critical to healing and positive outcomes for patient care (Watson, 1988).

Compassion Fatigue—This term was first identified in nursing as a unique form of BO that affects people in the care giving professions (Joinson, 1992). CF can be subdivided into its two subcomponents, BO and STS. CF is the more contemporary term referring to a gradual diminishment of the capacity to care over time, and is characterized by a deep emotional, spiritual, and physical exhaustion. Most commonly, this phenomenon is associated with the "cost of caring" for others in emotional pain and results in a " loss of self" where the helping professional absorbs the trauma of those they help and cannot detach emotionally at the end of the day (Figley, 1982).

Compassion Satisfaction—Compassion satisfaction may be described as the pleasure derived from being able to do one's work well, feeling positive about relationships with colleagues, your contribution toward the greater good of society, and one's ability to help others through your work (Stamm, 2010; Teater, 2009). Despite much of the negativity surrounding the controversy of stress and the workplace environment, there are many helping professionals who derive a great deal of satisfaction from being a helping professional and are not burned out even after many years of service. Much of this ability to experience compassion satisfaction stems from the helping professionals' support systems and resiliency (Figley 2002; Teater, 2009).

Resilience—This term describes an individual's ability to cope with stress by "bouncing back" to a state of previously normal functioning and not show any ill effects from the traumatic exposure to the suffering of others. Resiliency skills are essential to the development of healthy lifestyles with minimal distress and optimal satisfaction, and those who "maintain the essential skills of a non-anxious presence and self-validated care giving will enjoy an increased sense of resiliency to compassion fatigue" (Figley, 2002, p. 131).

Secondary Traumatic Stress—CF is a more user- friendly synonymous term for secondary traumatic stress disorder. STS, a sub-component of CF, is best described as the development of fear as a consequence of "trauma sustained by caregivers when helping suffering people in harm's way" (Figley, 2002, p. 3). STS/CF is measured in one of three subscales of the instrument (Appendix D) used in this research study, ProQOL 5 (Stamm, 2010).

Helping Professional—This term describes the helper or the professional that help to nurture the growth of or address the problems of an individual's physical, psychological, intellectual, emotional, or spiritual well-being including nursing, education, medicine, psychotherapy, psychological counseling, social work, life coaching, and ministry of clergy. According to Teater (2011), CF is experienced by certain high-risk groups of "helpers" or helping professionals that include nurses, doctors, emergency and first responder personnel, therapists, clergy, educators, relief and humanitarian workers, insurance adjusters, funeral workers, social workers, children's and adult protective service workers, disaster responders, law enforcement officers, fire fighters, attorneys, juries, correctional officers, and animal rescue personnel. The term "helper" is used in the survey instrument of this research study, the ProQOL 5 (Stamm, 2010) survey (Appendix D).

Caregiver—For the purpose of this study, nurses who care for individuals within the healthcare environment including patients and the nursing students they nurture. The nurse educator, as caregiver, cares for the needs of his or her students but may inadvertently absorb the trauma of the care setting, in the case of the clinical practice environment. Nurse educators may develop CF as a "cost of caring" as a result of exposure to the suffering of their students as they listen to accounts of their struggles and failures associated with their academic and personal lives. Inability to detach from the suffering of others may result in secondary traumatic stress for any caregiving professional (Figley, 1982).

Quality of Life—The term references the general well-being of individuals and societies. The term is used in a wide range of contexts, including the fields of international development, healthcare, and politics. Quality of life should not be confused with the concept of standard of living, which is based primarily on income. Instead, standard indicators of the quality of life include not only wealth and employment but also the built environment, physical and mental health, education, recreation and leisure time, and social belonging (Gregory, Johnston, Pratt, Watts, & Whatmore, 2009; Nussbaum & Sen, 1993). This study sought to capture insight of nurse educator colleagues so that workplace environmental stress might be lessened in such a way that enhances the quality of life of the nurse educator and associated stakeholders (i.e., nursing colleagues and students) within the teaching environment.

Assumptions of the Study

Levels of CS, CF, and BO may be measured by ProQOL 5 (Stamm, 2010) survey and the experiences of these phenomena may be described among nurse educators in academia. Nurses, who assume the role of educator, experience various levels of CF, CS, STS, and BO regardless of the level at which they teach (undergraduate, masters, doctoral) or the context in which they teach (classroom, clinical lab, on-line). This study also assumed that nurse educators had prior bedside nursing practice experience which informs the emergence of measureable levels of CS, CF, and BO.

Limitations of the Study

Study limitations included reluctance to participate for fear that perceived CF might infer the nurse educator is weak, ineffective, or has lost the capacity to care, a central construct in professional nursing practice. For this reason, they may have been reluctant participants and questionnaire ProQOL 5 (Stamm, 2010) answers may have been skewed or participants untruthful in answering experiential, open-ended survey questions. Nurse educators may experience more stress during different parts of the academic year, and thus may have reported more symptoms of CF or BO resulting in a reporting change within the questionnaire. Factors such as longevity in the profession, the breadth of experiences, support systems, previous experience with trauma, and resiliency may also vary among participants affecting the manner in which they deal with CF (Teater, 2011), effectively altering the reporting level of experienced CS, CF. or BO.

Delimitations of the Study

The investigator restricted or controlled certain factors in this study. Participants in this mixed-method study were limited to a convenience sample of nurse educators in 11 PASSHE Registered Nursing (RN) education programs that offer a baccalaureate, masters or doctorate in nursing. RN diploma, RN associate degree, and licensed practical nursing (LPN) programs were not included in this study, limiting the addition of the perspective viewpoints of this population of nurse educators. Incomplete questionnaires were not used. Students were not surveyed as part of this study.

Summary

Chapter 1 discussed the background, statement of the problem, significance, theoretic framework, research questions, hypothesis, research design overview, definition of terms, limitations, delimitations, and the assumptions of the study. This study tracked CS, CF, and BO among the professional careers of nurses in academia across different programs in which they teach and across different levels at which they instruct. Using such research mechanisms as surveys to screen (Stamm, 2010) for signs and symptoms of

CS, CF, and BO and qualitative questions within the survey tool to study experiences, the investigator examined perceptions of CS, CF, and BO among nurse educators and compared them with peers who teach in different program types and across different levels of academia. The aim of this study was to define CS, CF, and BO within the teaching practice of nurse educators in university nursing programs.

When it comes to reducing the desire to quit their profession, nurses from all walks of life, whether they are nurse educators or hospital bedside nurses, can benefit by learning how to recognize emerging signs and symptoms of CF and improve their professional quality of life. Empowered by this discovery, nurses can then take concrete steps to formulate a personalized care plan; one where they can continue to give of themselves without risking their capacity to care for others. Whether it is a nurse educator caring for the learning needs of his or her students, or the nurse at the bedside, caring for the needs of the patient, the implications for improving outcomes and efficacy are important and far-reaching. This study will equip nurses, regardless of arena of practice, with strategies to improve their quality of life, identify and overcome the potential career ending effects of CF, prevent them from leaving their profession altogether, and enhance outcomes for all of the students' lives they touch. In order to put this all into perspective for the nurse educator as a helping professional in academia, a review of the existing literature in Chapter 2 is necessary to identify current trends in CS, CF, and BO, and to uncover current gaps in research where these phenomena in nursing academia are concerned.

Chapter 2 begins by describing the background of the identification and the incidence of CF as it pertains to helping professionals. Next, this research explored the incidence of CS and compared and contrasted related concepts such as STS disorder and its two subcomponents, CF and BO. Finally, this literature review investigated the impact of CS, CF, and BO on the practice of nursing education with the intent of capturing the essence of what it is like to teach nursing in various settings, the stressors unique to nursing academia, and suggested strategies for enhancing the quality of life for the educator and student alike.

CHAPTER 2

REVIEW OF THE LITERATURE

A review of the related literature concerning CF and its crippling effects identifies this as a phenomenon that affects not just nurses but also other helping professionals such as teachers, clergy, social workers, childcare workers, and counselors who have been exposed to trauma and loss (Maslach, 1993). Compassion fatigue among health-care professionals is becoming increasingly more common and occurring at much earlier stages in their professional careers. There are approximately 3.1 million RNs who represent one of the largest groups of healthcare providers in the United States (Health Resources and Services Administration, 2010). Providing empathic, relationship-based care is an occupational hazard for many nurses that may profoundly impact the development of CF. According to Lombardo and Eyre (2011), CF may lead to the development of stress-related symptoms and job dissatisfaction resulting in decreased productivity and increased attrition among the ranks of these healthcare providers (Medical News Today, 2010). Cumulative research in this area explains that, "Compassion fatigue is more common today among professional caregivers because of increased patient loads, a shortage of nurses and other health care personnel, and financial constraints" (Lanier, 2012, p. 6). Additionally, the physical environment and the organizational culture that contributes to stressful working conditions may enhance or hinder employment contentment, and nurses who work in certain areas may be more likely to develop CF and/or BO over time (Todaro-Franceschi, 2013). In today's challenged economy, CF and BO can be very costly personally and professionally for nurses and financially for the institutions in which they practice (Lombardo & Eyre, 2011), underscoring the importance of the development of an expanded knowledge base and interventional strategies to ameliorate its symptoms.

Overcoming compassion fatigue represents one of the greatest personal and professional challenges to many nurses regardless of the area in which they practice. The detrimental consequences for the professional nurse are clear, especially when it comes to practicing in areas with high incidence of CF such as oncology or critical care nursing (Aycock & Boyle, 2009). Sabo (2011) confirms nurses have been identified among at-risk groups of health care professionals who are exposed to high levels of occupational and environmental stress: those practicing in certain specialty areas including, but not limited to, oncology, intensive care, mental health, and pediatrics. Nurses who practice in these environments have demonstrated particular vulnerability for the development of occupational stress such as BO, CF, and vicarious traumatization (Sabo, 2011). However, minimal research exists which describes CF in nurses who leave the bedside and pursue other avenues of professional nursing practice outside the acute care setting of the hospital environment such as in nursing education.

A gap in the literature exists concerning the prevalence of CF among nurses who become educators, the extent to which these nurses experience CF, and the associated impact on teaching practice in nursing higher education. While the emphasis of this study was on CF in the nurse educator, BO, a related form of occupational stress, was also explored along with its polar opposite, CS.

Since the position of the literature lacks clarity concerning the impact of CF on teaching practice in nursing academia, the investigator began this chapter with a review of the related literature by discussing CF in the nurse outside the academic arena, such as at the bedside in the acute care setting of the hospital. Much of the research surrounding the issue of CF, and its two subcomponents, BO and STS revolves around discussions about the negative stress generated in the helping professionals' environment, in this case nursing academia, and its impact on effective practice, positive outcomes and attrition (Figley, 2002; Stamm, 2010).

Concern certainly exists for the impact a compassion-fatigued nurse educator might have on a vulnerable student nurse population. Because caring is an essential cornerstone of nursing practice (Watson, 1988), great care should be taken to emulate caring to students. Eric Gentry, a leading traumatologist, has suggested that individuals who are attracted to the care giving professions often enter this field already compassion fatigued (as cited in Lanier, 2012).

A growing body of literature discusses the occurrence of such phenomena in nursing based upon the presence or absence of compassionate care, an essential character trait in nursing. In professional nursing, dialogue concerning CF must be framed within the context of caring because of its centrality in safe and effective nursing care (Watson, 1988). Nurses, who successfully embrace and effectively dissipate the negative stress of their workplace, may possess an advantage that could overcome the detrimental effects of compassion fatigue. Nurses who experience CF at the bedside and carry this into nursing academia may negatively impact the care recipient, the nursing student, in the same manner in which it negatively affects (Espeland, 2006) the patient at the bedside. Patient safety may be compromised when nurses experience a diminished capacity to care creating a reduction in vigilance with patient care. Resultant decreased productivity and medication or procedural errors associated with fatigue may occur, producing tremendous guilt in the nurse (Espeland, 2006).

Research on CF among nurse educators in academia raises concern for the impact on the teaching efficacy of compassion-fatigued nurse educators and on student learning and students' perception of caring behaviors in their instructor. According to Purnell (2006), an effective educator demonstrates genuine caring and empathy that is threaded throughout teaching practice. Exploring the incidence of CF and attempting to track its essence across various levels of teaching and nursing program types is a timely endeavor especially as it pertains to nurses who make a career transition from the bedside into academia. In this next section, the investigator discusses the impact of empathy on care giving to support it as an essential component threaded throughout teaching practice.

Terms such as empathy are often used synonymously with compassionate care. Empathy may be described as identification with and an understanding of another's situation, feelings, and motives. According to LaRowe (2005), "The core competence for all care providers and all care giving is the capacity for and the ability to develop empathy" (p. 11). Empathy may arouse feelings of sympathy and sorrow over another's suffering. No matter how well-meaning the compassionate interaction of the caring professional is with others, there are certain risks to the caregiver and the care receiver. Teater (2010) notes "Very caring people have a higher incidence of compassion fatigue and compassion fatigue can lessen empathic abilities over time leading to erosion of our compassionate connection."

Compassion fatigue refers to reactions that emerge from the therapist's over-exposure to client suffering namely, human brutality, disease, death and dying, famine, the ravages of war, natural and man-made disasters, and other catastrophes (Figley, 1995). Figley goes on to explain that therapists and other medical professionals often absorb the emotional weight of their client's traumatic experiences in ways that negatively impact them personally and professionally. According to Teater (2010), CF is most similar to post-traumatic stress disorder usually including some type of exposure to trauma that has progressed to the point that may require more than just a change in career. Teater further described the symptoms of BO as most similar to depression that may not be trauma related. Joinson (1992), in her study of CF among emergency room personnel, was the first to describe this phenomenon of CF as endemic not only to psychotherapists, but as an epidemic that afflicts other helping professionals such as nurses who work in the healthcare environment as part of the interdisciplinary team. Joinson contended that the degree to which helping professionals experience CF in healthcare settings may influence career BO.

In order to effectively understand CF and its impact on career BO in the nurse educator, this literature review next examines the phenomenon of CF and identifies certain distinguishing characteristics that differentiate it from other related phenomena such as countertransference, BO, STS disorder, vicarious traumatization and post-traumatic stress disorder. CF is quite prevalent among health care professionals. David Hilfiker (1985) cited hundreds of examples of Harvard University-trained physicians who suffered the untoward effects of compassion fatigue on the social and psychological aspects of medicine. Hilfiker went on to say, "All of us who attempt to heal the wounds of others will ourselves be wounded; it is, after all inherent in the relationship" (Hilfiker, 1985, p. 207, as cited in Todaro-Franceschi, 2013). As primary stakeholders in today's health care arena, nurses, like their physician colleagues, are constantly exposed to patient suffering and they have a certain “duty to compassionately care for the sick, wounded, traumatized and weak patients in their charge” (Coetzee & Klopper, 2010, p. 235). The literature is clear on the damaging impact of compassion fatigue on psychotherapeutic process (Figley, 2002). But, what of its effects on professional nursing? Figley (2002) credits the introduction of this concept to Nurse Carla Joinson who “first used the term in a nursing magazine” (p. 1) to describe her research of the trauma experienced by Emergency Room (ER) nurses. ER nurses’ description of emotional exhaustion, depersonalization, and lack of personal accomplishment and fit the description of nurses who were worn down by daily hospital emergencies (Maslach, 1982). When chronic feelings of fatigue emerge as a result of being emotionally drained, depersonalization, or the indifference of feelings about helping, combine with a sense of lack of personal accomplishment to produce BO, consider the plight of one of the highest areas of stress from exposure to the trauma and the suffering of others, the ER.

Strommer (2011), in her study of CF among Alaskan ER nurses, suggested that the negative aspects of an impaired response to stress in the nursing work environment can consume the nurse during the “work of caring.” CS, or the positive aspects realized during this process of helping, sustains nurses’ ability to continue the work of caring when facing potential emotional harm or distress. Failure to derive satisfaction from the work of caring may result in the development of negative stress which often leads to CF (Stamm, 2002). Figley (1999) confirmed this premise noting that the helping professional’s “capacity to experience compassion and empathy appears to be at the core of their ability to work or be wounded by the work” (p. xv). Strommer (2011), in her study of CF among ER nurses in Alaska, suggested “this duality is reflected in nurses who may be frequently required to provide care to very sick and complicated patients placing them at risk for secondary traumatic stress or its subcomponents, compassion fatigue and burnout” (p. 38). This secondary exposure might be especially true of nurses who teach in the clinical setting and relive traumatic experiences during their own bedside careers. Strommer (2011) also noted that these same nurses might also be able to derive CS from their caregiving role regardless of the situation’s outcome. Joinson (1992), a nurse, and the first to coin the term CF, also studied and confirmed this phenomenon among nurses in the high stress environment of the ER. Despite the risks of developing CF associated with the cost of caring, there are many nurses who derive an abundance of CS from their work and demonstrate remarkable resilience even when faced with distress.

The term “compassion fatigue” was first used by Joinson (1992), a nurse, who described this as a syndrome that occurred when nurses were traumatized after caring for patients facing life-threatening changes as a result of an illness or accident. Joinson (1992) saw CF as an expanded but distinctive form of BO. Joinson further described CF as a unique form of BO that has progressed to a higher level. More recently, CF was identified as a resultant cost of caring for the traumatized as “a severe malaise that results from caring for patients who are in pain or suffering” (Aycock & Boyle, 2009, p.183). This impairment may negatively effect how the nurse delivers patient care, negatively impacting outcomes. Not only do environmental stressors of the workplace negatively affect nurse caregivers, but the patient’s physical needs of discomfort and emotional needs of fear and anxiety (Bush, 2009). Compassion fatigue unfolds differently as it manifests itself in professional nursing and contributes to nurses' fatigue, depression, anger, decreased efficacy ultimately leading to detachment and apathy (Bush, 2009).

Nurses often face the daily challenge of serving as healer, rescuer, and helper not only when caring for patients, but also when caring for their families and other members of the community. It is important for nurses to be equipped to recognize symptoms of BO before it progress to CF and further impairs nurses' ability to care for themselves, their patients, and other consumers in the healthcare community.

Helping professionals, including nurses, are just beginning to identify and understand CF as a direct consequence of tending to the discomfort and even the suffering of others. This daily burden of carrying out the role of healer and rescuer is just one of many stressors confronting helping professionals including nurses (Figley, 2002). According to Teater (2010), the antidote for CF is CS and is an important strand in the literature which identifies effective approaches to recognizing and overcoming the struggle with CF.

Teater (2010) specifically defined compassion satisfaction as "the pleasure derived from being able to do your work well where you feel positive about your colleagues, your contribution towards the greater good of society, and your ability to help others through your work." According to Lanier (2012), health care professionals who regularly listen to experiences of fear, pain, and suffering are at risk for the development of CF, but still give of themselves, gradually losing objectivity. By contrast, anyone who works in a stressful workplace is at risk for BO. These individuals cease to give of themselves as they become increasingly exhausted, producing a diminishment in empathy (Lanier, 2012). Next, this literature review discusses the related concept of career BO, an extreme form of CF (Bush, 2009). In this next section, the investigator explored symptoms, etiology, and related impact among helping professionals, particularly educators, and bedside nurses.

Symptoms of Career Burnout

During the July 2010 Mid-Atlantic Addiction Research and Training Institute (MARTI) conference, Dr. Robert Ackerman, conference director, author, and professor of Sociology at Indiana University of Pennsylvania, described the impact that high-risk people have on the health care professionals' self-esteem. According to Ackerman (2010), symptoms of BO also occur among educators and other helping professionals and may include: a feeling of lack of control over commitments, an incorrect belief that one is accomplishing less, a growing tendency to think negatively, a loss of a sense of purpose and energy, and an increasing detachment from relationships. Ackerman also noted that one of the causes of educator BO is CF.

Aiken, Clarke, Sloan, et al. (2001) noted that more than 40% of hospital nurses have BO levels that exceed the norms for healthcare workers, and one out of every three hospital nurses under the age of 30 was planning to leave his or her current job in the next year because of job dissatisfaction.

These symptoms may describe many professional nurses who may be accustomed to demanding behaviors from patients, their families, physicians, nursing colleagues, and other members of the healthcare team. In this context, nurses frequently feel overworked and overwhelmed by competing demands on their time. Nurses who experience these feelings may be at risk for career BO or may already be burned out (Laschinger, 2007).

According to Espeland (2006), BO is different from being overworked or depressed. "BO is actually a subtle process in which an individual is gradually caught up in a state of mental fatigue and is completely drained of all energy. Maslach (1982), a pioneer in the study of BO, describes this as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people on a daily basis" (p.178). Interestingly, Espeland (2006) further describes stress and BO as being unrelated events and calls for a differentiation between the terms of positive and negative stress opining that stress may motivate either positive or negative outcomes.

Positive stress has the potential to produce energy and urgency; however, BO, as a consequence of negative stress, produces a sense of helplessness, hopelessness, and subsequent distress. Negative stress may result in counterproductive effects that lead to BO. Therefore, it is imperative that nurses recognize and understand the causes and symptoms of BO, so they can minimize the impact of their occurrence. Stress dealt with negatively may lead to the development of a whole host of physiological and psychologically devastating illnesses including, but not limited to: stress ulcers, hypertension, eating disorders, clinical depression and depletion of self-esteem. Five key dimensions of this response are an overwhelming exhaustion, feelings of cynicism, a detachment from the job, a sense of ineffectiveness, and a lack of accomplishment (Maslach, 1993). Current research suggests causes for career BO are multifactorial.

Etiology of Career Burnout

Causes for career BO are numerous and vary among individuals. A review the literature suggests some causative factors for BO may include a breakdown in community, self-conflict, stress in the workplace, and the dilemma of the incurable client. Maslach and Leiter (1997) confirm this assertion noting several causes of BO exist among helping professionals: a breakdown in community, self-conflict, stress in the workplace, and working with the terminally ill client. Lanier (2012) argues that "burnout is more than a sense of frustration or tiredness, and is associated with a situation rather than with a person" (p. 5), as is true of the compassion fatigued helper. Next, this literature review examines the erosive impact of a breakdown in community on BO.

Breakdown in Community

A breakdown in community might occur when fast-paced work destroys the sense of camaraderie among co-workers. When evaluations, promotions, benefits, time off, and other workplace treatments are not fairly applied, workers may perceive unfair treatment. Team spirit may soon erode resulting in an increase in the stress of the workplace environment contributing to BO.

Self-Conflict

Self-conflict is a frequently overlooked source of internal negative stress that can lead to BO (Musick, 1997). According to Espeland (2006), nurses are often their own worst enemies. Those who consistently place unreasonable and unrealistic expectations on themselves may be setting themselves up for BO. There is increasing evidence that inadequate nurse staffing leads to adverse patient outcomes such as medication or procedural errors and contributes to increased nurse BO (Garrett, 2008). According to Garrett (2008), hospital administrators frequently rely on the use of mandatory or voluntary overtime to cover staff nurse vacancies. The use of overtime, whether mandatory or voluntary, may lead to practitioner fatigue and may adversely impact patient safety in terms of increased potential for medical errors. There are other sources of practitioner fatigue such as those that create ethical dilemmas for the nurse.

Consider also situations where a nurse is asked to perform a task that he or she finds unethical, such as the removal of a life support device. A conflict of values may arise. These events can serve as negative stressors, which often push the nurse in the direction of career BO. Repeated exposure to fatigue of this nature may promote nursing career BO.

Stress in the Workplace

Another possible cause of BO among nursing professionals may be the negative stress of the workplace which may be produced when orienting new employees or supervising student nurses. This process may lead to the development of negative stress, and typically is not monetarily rewarding. The stressful events of a busy daylight shift may have a cumulative effect on levels of negative stress distracting the focus of care as the nurse struggles to coordinate multiple activities and assume multiple, sometimes conflicting roles such as counselor, patient and family advocate, mediator, educator, spiritual advisor, and nutritionist. The absence of humor in the workplace may breed a toxic workaholic environment that may diminish the nurse's capacity to care, lead to BO, and ultimately physical illnesses and disability (Old, 2012). Old goes on to state that "often nurses are under a lot of stress, due to multiple pressures, including staff shortages, burnout, and poor management of resources" (p. 18). Problematic working conditions contribute to BO especially where negative stress is unabated.

Problematic working conditions such as working 16-hour night shifts or other inflexible scheduling, working holidays and weekends were also among the reasons cited by Demir, Ulusoy, and Ulusoy (2003) as causes of BO. These difficult working conditions may take away from personally revitalizing recreation and family time.

The Incurable Client

According to Meltzer and Huckabay (2004), another factor, which may contribute to nursing BO, is the "incurable client." In these situations, no matter how much compassionate care the nurse delivers, the patient is not going to survive anyway. Such disconnect produced by the futility of caring for the terminally ill may provide the ingredients necessary to precipitate BO. Nurses must learn to recognize stress in their workplace and effectively dissipate its energy-sapping effects before it consumes them and affects their relationships with patients and colleagues. There are other consequences to BO that warrant additional exploration.

Consequences of Burnout

The emotional and physical cost of BO on a nursing career may have an effect on physical performance and efficiency of nursing care. Consequences may include a diminished sense of personal satisfaction in certain professional accomplishments, anger, a sense of nonspecific free floating anxiety, restlessness, depression, low self-esteem, reduced enjoyment of work or home life, and a hopeless loss of control over one's own destiny (Lanier, 2012). BO may ultimately produce psychosomatic symptoms that may impair physical performance and raise the likelihood of increased medical or procedural errors (Espeland, 2006).

Impaired Physical Performance

According to Vahay et al. (2004), consequences of BO may include decreased job performance (decreased vigilance and increased medical errors), absenteeism, tardiness, job turnover, drug and alcohol abuse, and physical illness, such as hypertension and gastric ulcers. Some physical symptoms which may result from the destructive effects of negative stress include: persistent fatigue and exhaustion that does not go away with sleep, insomnia, dizziness, colds, headaches and migraines, neck and backaches, nausea, allergies, shortness of breath, chest pain, digestive problems, such as anorexia or overeating and skin rashes (Vahay et al., 2004).

Caring behaviors often characterize nurses, especially those new to the profession, who are eager to make a good first impression and often assume unrealistic goals of successful outcomes for all patients. These behaviors may become increasingly difficult to sustain a life-long career in nursing. So for nurses, BO, which is often a precursor to CF, may produce catastrophic and crippling side effects affecting patient safety. According to Aycock (2009), such crippling side effects may progress to compassion fatigue manifesting symptoms such as “substance abuse, tardiness, absenteeism, cynicism, and medication errors” (p. 185). When it comes to medication administration or procedural errors, nurses can ill afford to risk the safety of those they care for as a result of these symptoms.

Increased Medical Errors

Patient safety may be compromised when nurses experience a diminished capacity to care creating a reduction in vigilance with patient care. Resultant decreased productivity and medication or procedural errors associated with fatigue may occur, producing tremendous guilt (Espeland, 2006). In the event the nurse is unable to detach from these feelings at the end of the workday, the resultant negative stress may propagate the effects of CF. Concern exists for those nurses who are either unable to cope or face discipline due to medication or procedural errors, forcing them to leave their profession altogether. However, for many nurses, leaving the workforce may not be an option.

Recognizing the difficult state of the current global economy, many nurses cannot afford to escape the stress of the workplace environment by simply resigning his or her position. Research provides some helpful tips to empower nurses to mitigate career BO symptoms which may contribute to CF and give cause for nurses to leave their vocation altogether. Despite all the negativity surrounding burnout, it need not lead to its incapacitating form of CF. The literature suggests a multi-pronged approach to combat BO before it incapacitates the nurse to the point of contributing to workforce attrition. The following section suggests seven strategies for ameliorating the symptoms of BO before it progress to CF.

Strategies for Success

Research suggests nurses may overcome BO by recognizing its symptoms, becoming a proactive agent of change, practicing assertiveness, considering transfer, stopping bullying behaviors, forming focus groups, and engaging oneself in the life-long learning process of continuing education.

Recognize the Symptoms

Some key strategies that nurses may use to overcome the detrimental effects of BO and prevent progression to CF include, but may not be limited to, knowing the symptoms, becoming a proactive change agent, practicing assertiveness, considering transfer, stopping bullying, forming focus groups, and continuing education to raise awareness of this blight on professional nursing. Dealing with these symptoms begins with adequate self-care and developing sound coping strategies that lessen compassion fatigue such as:

> Taking frequent breaks from your work, learning to say "no," sharing the workload with others, finding humor in every situation, asking for help, giving credit to yourself and to others, where credit is due, and breathing deeply as often as possible. (Lanier, 2012, p. 7)

Joinson (1992) suggests that a good place to start is educating nurses to identify risk factors in their work environments that may negatively impact their abilities to surmount detrimental stress leading to BO. The critical element in preventing CF before it progresses to burnout is to know the symptoms. According to Joinson (1992), "It is almost impossible to recognize symptoms of compassion stress/fatigue unless you are looking for them. Raising awareness is the key . . ." (p. 119). Nurses must become more proactive to bring about needed change in attitudes toward BO and CF in the workplace.

Become a Proactive Change Agent

Nurses must begin to take ownership of their career destiny and become proactive in revitalizing their careers. Espeland (2006) described important strategies for avoiding BO as a process of developing assertiveness, setting boundaries, changing negative thinking processes, avoiding negative communication, taking care of one's emotional and physical health, cultivating positive relationships with colleagues, and committing to become life-long learners and mentors. Taking these important steps requires courage and assertive problem solving.

Practice Assertiveness

Espeland (2006) also notes that practicing assertiveness means refusing to be manipulated, abused, or threatened by others and not engaging in these behaviors with others. To guard against BO, Rager (2005) advocates a culture of trust, open communication, and respect to promote a healthy workplace environment. For example, rather than complaining about scheduling policies or low pay scales and counterproductive workplace policies, nurses might establish cost containment committees or form focus groups to formulate workable solutions.

Consider Transfer

Nurses may consider transfer to another unit or different specialty within the hospital when they are experiencing symptoms of BO (Teater, 2010), however leaving the nursing profession altogether should not be a first option. According to Bruce (2003), employees universally need hope in order to survive the stress of the workplace. Experiencing hope and a daily-renewed sense of personal worth may enhance retention in the nursing profession by thwarting BO.

Stop Bullying

Nurses must recognize the destructive force of verbal aggression and anger and avoid channeling anger onto colleagues or patients. Studies confirm the notion that verbal abuse is a very real problem for the health care industry. "Nurses have become a significant source of verbal aggression, a position formerly held by doctors" (Rowe & Sherlock, 2005, p. 247). Since this problem emerges as a patient safety issue, education of staff is warranted to increase awareness of this problem. Prompt disciplinary action should be initiated to stop workplace bullying and harassment. More discussion is certainly needed among nurses to develop meaningful and realistic solutions to these and other problematic areas of the work environment.

Form Focus Groups

Development of Nurse-Physician liaison committees or other focus groups involves nurses in the decision making process and may help channel energy into dialogue about constructive projects to enhance morale and improve outcomes (Rowe & Sherlock, 2005). According to Espeland (2006), "Praise and recognition of colleagues is essential in all areas of nursing and may be another effective way to build teams and to inoculate against burnout" (p. 182).

Continuing Education

As life-long learners, nurses must give more urgent priority to self-assessment of risk factors, identify signs and symptoms of career BO, and intensify efforts to educate peers in the identification of strategies that change the destructive thought processes of CF.

Current literature is unclear regarding the levels of CF, CS, and BO that accompany nurses from the bedside into academia. This study does not assume that nurses bring a predetermined level of CF, CS, or BO to academia. However, as helping professionals, nurses might advocate for their peers in nursing academia to identify and prevent CF, BO, and enhance CS, to maintain a rewarding career by opening lines of communication to enhance the health of the nursing workplace environment (Rager, 2005). Education is paramount to reducing BO and enhancing nursing practice and nurses have an obligation of advocacy to raise awareness of this plight among their peers and within all environments of professional nursing practice. "Educating clinicians about risks and protective factors, as well as providing resources to enhance protection, might help reduce levels of compassion fatigue and burnout" (Sprang, Clark, & Whitt-Woosley, 2007, p. 276).

These discussions about etiology and strategies for overcoming CF and BO and increasing CS may be helpful in assisting nurse educators to heighten personal awareness of these issues in their teaching careers and equip them with strategies to overcome its devastating effects. Since research is sparse concerning the levels of, or the effects of CF, CS, and BO in nursing education, this study is dedicated to improving the professional and personal quality of life of the nurse educator in academia by uncovering the incidence of these phenomena. Ultimately, this study hopes to improve the quality of educators' life experiences, their students' outcomes, and build the community in which they serve as lifelong learners and providers of compassionate care.

Summary

This second chapter began with a discussion of CF as a phenomenon that affects not just nurses, but also other helping professionals such as teachers, clergy, social workers, child care workers, and counselors who have been exposed to trauma and loss (Maslach 1993). Next, this chapter explored, from an historical perspective, the origins and impacts of stress on the workplace environment in the helping professions with an emphasis on the incidence and impact of CF, CS, and BO in professional nursing practice, whether at the bedside or in academia. A discussion of the theoretical underpinnings of Watson's (1988) theory of caring sets the stage for a discussion that explores symptoms, etiology, and consequences among nurses who lose the ability to care resulting in diminished CS and an increased propensity toward BO and ultimately, CF. Finally, this chapter discussed perspectives in the literature identifying strategies that may be used by nurses to combat workplace environmental stress and overcome BO and CF. Since this study focused on CF, CS, and BO among nurse educators, the investigator identified links to nursing education noting that Purnell (2006) posited that an effective educator emulates genuine caring and empathy that is threaded throughout teaching practice. For this reason, this research makes a concerted effort to explore the current literature to identify the extent to which nurses experience CF and associated phenomena including BO and CS and the impact of stress in the nurses' workplace environment. Unfortunately, the current literature is unclear regarding the levels of CF, CS, and BO that accompany nurses from the bedside into academia.

In Chapter 3, the investigator discusses the methodology for this mixed-methods approach to exploring the incidence and the experiences of CF, CS, and BO among nurse educators in academia. This research study used a mixed-method design combining quantitative data concerning CF, CS, and BO from ProQOL 5 (Stamm, 2010) (Appendix C) and qualitative data from open-ended questions in the demographics survey (Appendix D) which preceded the completion of the ProQOL5 study instrument. This portion of the study of nurses' experiences of CF used interpretative description (Thorne et al., 2004), a human science research model developed by nursing theorist Sally Thorne, to reflect the unique aspects of nursing research that directly impact the practice of professional nursing. In addition to the methodology for this study, Chapter 3 includes a review of the research questions, study design, a discussion of human subject selection and sampling plan, study setting, research instrumentation with associated reliability and validity, and methods of data collection, management, and analysis. Gaining a better understanding of the extent to which nurse educators in academia are affected by conditions such as BO and CF is crucial to the development of positive and nurturing practice environments which enhances CS (Potter et al., 2010). Since exposure to the trauma of others is inevitable, regardless of the environment in which nurses practice, developing an ongoing plan that builds resilience, is critical to positive outcomes at the bedside, and beyond, into the world of nursing academia.

CHAPTER 3

METHODOLOGY

The purpose of this mixed-methods study was to investigate the extent to which nurse educators in academia experienced CF, CS, and BO across levels at which they teach (undergraduate, masters, doctoral), and to identify stressors unique to nursing academia which may contribute to or mitigate these phenomena. Regardless of the context in which CF occurs, a diminished capacity to care, which often accompanies CF, may be catastrophic for any nurse and may adversely impact nursing career quality of life. This mixed-methods study investigated the levels of CF, CS, and BO among nurse educators while exploring some of the stressors unique to the arena of nursing academia not experienced by the bedside nurse. In this chapter, the investigator discusses the study's research questions, design, human subject/ethical issues, setting, sample, recruitment procedure, data collection, and methods used to analyze the data.

Research Questions

This study aimed to address the following four questions pertaining to the experiences of nurse educators in Pennsylvania nursing education programs which offered a baccalaureate, masters, or doctorate in nursing. The following questions guided this study:

1. To what extent do the variables of age, gender, years of teaching experience, and academic background in nursing academia shape the experiences of compassion fatigue, compassion satisfaction, and burnout?

2. To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by the levels at which they teach (baccalaureate, masters, doctoral)?

3. To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by faculty teaching assignments (undergraduate, masters, doctoral) and method of course delivery (classroom, clinical lab, on-line)?

4. What are the experiences of compassion fatigue among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)?

Study Design

This study employed a mixed-method design combining quantitative data from ProQOL 5 (Stamm, 2010) (Appendix D), and qualitative data from open-ended questions placed at the end of the demographic portion of the study's survey instrument (Appendix C). This study examined qualitative data of nurse educators' experiences of CF using interpretative description (Thorne et al., 2004). Interpretative description is a human science research model developed by nursing theorist, Sally Thorne (2004), and was used is this study to reflect the unique aspects of nursing research that directly impacted the practice of professional nursing. Interpretive description is a "non-categorical approach to qualitative research which is appropriate for small-scale qualitative research projects" (Austin et al., 2009, p. 201). This study of the perceptions of CS, CF, and BO in nursing academia sought to capture certain themes and patterns which might promote collaboration among its ranks and enhance nurse educators' quality of life.

This study employed a mixed-method approach to investigate the phenomena of CF, BO, and CS within the context of nursing academia for its ability to support the study's hypothesis using multiple and complementary types of data. This approach enhances validity of the study by using multiple complementary forms of data in this manner (Polit & Beck, 2014). Triangulation of data in this manner also provides opportunities for testing alternative interpretations of the data and for determining the extent to which the context helped to shape the results of this research in nursing academia (Polit & Beck, 2014).

Method of Subject Selection

Using forwarded e-mail addresses obtained from the on-line listed contact information of university nursing program directors of 11 PASSHE university nursing programs (Appendix A), an e-mail consent/cover letter (Appendix B) containing an electronic survey link to the survey instruments (Appendices C and D) was electronically administered through the *Qualtrics®* electronic survey system. A convenience sample of nursing faculty was contacted from among willing participants who teach in these 11 nursing programs at the baccalaureate, master's, and/or doctoral levels.

Research Instrument

The evolution for the development of this study's survey instrument began with Figley's formulation of the Compassion Fatigue Self-Test (CFST) (Figley, 1995). The CFST was the most commonly used instrument and was "perhaps one of the first measures originally developed for this purpose. The original CFST was developed based on clinical experience and designed to assess both compassion fatigue and burnout," or the negative consequences suffered as a result of helping others (Bride, Radey, & Figley, 2007, p. 156). Stamm and Figley (1996) more fully developed the CFST with the addition of positively-oriented questions paralleling the negative orientation of the CF and BO items with the intention of also measuring CS, or the positive rewards associated with helping professions (Bride et al., 2007). The renamed ProQOL 5 (Stamm, 2002) was the resultant revised version of Figley's (1995) Compassion Fatigue Self-Test and was comprised of three distinct subscales, each having 10 items. The first subscale measured compassion satisfaction or the pleasure derived from helping others. A higher score on this subscale represented heightened satisfaction with being an effective caregiver. The second subscale measured BO or the feelings of hopelessness which helping professionals experience as a result of difficulties in dealing with work or performing that work effectively. A higher score on this subscale would indicate an increased propensity for BO. The third subscale measured STS/CF. A higher score on this subscale would represent higher levels of STS/CF on the ProQOL 5 (Bride et al., 2007). Next, the specific attributes of this study's instrument, the ProQOL5, are discussed.

Professional Quality of Life Scale English Self-Score Version 5

For the purpose of conducting this research, an on-line (Stamm, 2010), a survey instrument (Appendix D) with established reliability and validity (Bride et al., 2007), was administered to eligible participants in nursing academia in Pennsylvania. Eligible participants (Appendix A) were nurse educators who taught at the undergraduate and graduate levels in nursing programs at 11 PASSHE nursing academic institutions across Pennsylvania which offered baccalaureate, master's, or doctoral degrees in nursing. Internal consistency reliability estimates for each of the three subscales in the ProQOL 5 (Stamm, 2010) were reported as "0.87 for the compassion satisfaction scale, 0.72 for the burnout scale, and 0.80 for the compassion fatigue/secondary traumatic stress scale" (Bride et al., 2007, p. 159). The ProQOL 5 is "an appropriate screening instrument suitable for use by clinicians who provide services to a wide variety of traumatized clients regardless of the trauma experienced" (Bride et al., 2007, p. 156). Permission to use this instrument was obtained from the instrument's designer, Dr. Beth Hudnall-Stamm (Appendix E). The ProQOL 5 is a 30-item scale used for measuring CS, and the two components of STS, CF and BO (Stamm, 2010). This well-validated instrument, in use for more than 20 years, has been tested on more than 3,000 individuals (healthcare providers, children or family workers, school personnel) and is a fifth revision of the originally titled *Compassion Fatigue Self-Test* survey tool (Figley, 1995). Completion of the ProQOL 5 involved selecting responses 0 (never) – 5 (very often) on a Likert Scale. Stamm (2010) strongly recommended that this tool be used for screening purposes only and not for diagnosis.

Scoring and interpretation of the results for each of these three sub-scales (CS, BO, STS) is described in detail in Appendix D. Participants were provided with a link to this self-scoring English version of the ProQOL 5 and were instructed to fill in their scores for each of the three sub-scales. Additionally, survey participants were directed to discuss any concerns arising from the results of the screening with a physical or mental health care professional (Stamm, 2010b).

Instrument Validity

According to Stamm (2010b), this survey instrument "demonstrates good construct validity with over 200 published papers. Of the 100 published research papers on compassion fatigue, secondary traumatic stress, and vicarious traumatization, nearly half have utilized the ProQOL or one of its earlier versions" (p. 13). The three sub-scales measured separate constructs. The inter-scale correlations showed 2% shared variance ($r = -.23$; co-$\sigma = 5\%$; $n = 1187$) with STS and 5% shared variance ($r = .-.14$; co-$\sigma = 2\%$; $n = 1187$) with BO (Stamm, 2010b, p. 13). While there was shared variance between BO and STS, the two scales measured different constructs with the shared variance likely reflecting the distress that is common to both conditions. The shared variance between these two scales was 34% ($r = .58$; co-$\sigma = 34\%$; 14$n = 1187$). The scales both measured negative affect but are clearly different; the BO scale does not address fear while the STS scale does (Stamm, 2010b).

Human Subjects/Ethical Issues

Prior to conducting this study, approval was obtained from the Institutional Review Board (IRB) at Indiana University of Pennsylvania (Appendix F). This study began with the distribution of the survey tool, ProQOL 5 (Stamm, 2010). This two-part survey (Appendix C and D) was distributed electronically via Qualtrics® to eligible participants and forwarded by department chairs to faculty colleagues within their respective nursing departments (Appendix A). Survey participants taught at the undergraduate and graduate levels in nursing programs at 11 PASSHE nursing academic institutions across Pennsylvania offering baccalaureate, master's, or doctoral degrees in nursing. The survey was preceded by an e-mail consent/ cover letter (Appendix B) explaining the study's purpose and provided an explanation of the confidentiality agreement with consent for participation. Submission of the two-part survey to the link provided at the end of the e-mail consent/cover letter implied consent to participate.

To maintain privacy/confidentiality, each participant was given a unique numerical identifier code that could not be linked to the person's identity. There were no foreseeable jeopardies, risks, or discomforts associated with this study.

Participants were informed that they were under no obligation to take part in this study. Additionally, participants were advised of their freedom to withdraw their consent at any point during this study, and for any reason, without penalty. No monetary or other forms of compensation were provided to the participants.

Study Setting

The setting for this research study included nurse educators who taught at the undergraduate and graduate levels in nursing programs at 11 PASSHE nursing academic institutions across Pennsylvania which offered baccalaureate, master's, or doctoral degrees in nursing. The researcher established e-mail contact with nursing program chairs/directors (Appendix A) and requested their forwarding the survey link to their nursing colleagues.

Methods and Procedures

This section describes the sampling methodology and recruitment procedures for the current research study and discusses characteristics of the subject population including the study site, age range, gender, and inclusion/exclusion criteria. This study incorporated an electronic convenience sampling of nursing faculty from Pennsylvania, who taught in 11 PASSHE university nursing programs, utilizing the Qualtrics®

electronic survey system of the Applied Research lab at Indiana University of Pennsylvania. The investigator invited participants who were between the ages of 20 and 76 years old. No effort was made to exclude participants based on gender, race, ethnicity, religious preference, or sexual orientation. In order to be included in this study, participants had to be RN, licensed to practice in the Commonwealth of Pennsylvania, who were also teaching in a baccalaureate or graduate university nursing program. These nurse educators could also have taught at the undergraduate level and/or at multiple levels at the graduate level including masters and doctoral students. Participants were asked about their experiences as they related to teaching at one or more levels in their practice environments to explore whether there were any significant differences in the levels of CS, CF, and BO experienced across these various levels in the context of nursing education. This study excluded Pennsylvania RN educators teaching in a licensed practical or vocational, diploma, or associate degree nursing program and nurse educators who practiced in a staff development role within any healthcare organizations.

Data Collection and Analysis

Methodology and procedures for the collection and analysis of the data which addressed the study's research questions are summarized in Table 1.

Table 1

Summary of Procedure for Data Collection and Analysis

Research Questions	Data Collection	Data Analysis
To what extent does age, years of teaching experience and academic background in nursing academia shape the experience of compassion fatigue?	Participants complete the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL5) Survey (Stamm, 2010) via Qualtrics software electronic survey distribution system. Participants completed survey questions concerning demographic information such as age, years of teaching experience, and background of nursing expertise.	Using IBM SPSS-21 statistical analysis software, descriptive statistics were used to describe and analyze demographic information, including age, years of teaching, and academic background. A series of crosstabs tables were constructed to describe the relationships between demographic variables and total scores on each of the three subscales (CS, CF/STS, BO) of the ProQOL5.

Table 1 (continued

Summary of Procedure for Data Collection and Analysis

Research Questions	Data Collection	Data Analysis
To what extent does the level of compassion fatigue experienced by nurse educators in academia vary among groups as determined by type of nursing program taught in (baccalaureate, graduate)?	Participants complete the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL 5) survey (Stamm, 2010) via Qualtrics software electronic survey distribution system. Participants completed questions 3, 4 and open-ended question 9 from the demographics survey which inquires about the contribution of teaching nursing at more than one level (baccalaureate, masters, and doctoral) to the experiences of CF, CS, and BO.	Using IBM SPSS-21 statistical analysis software, descriptive statistics were used to describe and analyze demographic information, including age, years of teaching, and academic background. A series of crosstabs tables were constructed to describe the relationships between demographic variables and total scores on each of the three subscales (CS, CF/STS, BO) of the ProQOL5. NVivo 10 (QSR, 2010) qualitative research software was used to gather, organize, and analyze information from responses to open-ended question 9 into common themes and coding structures, tying similar information together.

Table 1 (continued)

Summary of Procedure for Data Collection and Analysis

Research Questions	Data Collection	Data Analysis
To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by faculty teaching assignments (undergraduate, masters, doctoral) and method of course delivery (classroom, clinical lab, on-line)?	Participants complete the Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL 5) survey (Stamm 2010) via Qualtrics software electronic survey distribution system. Participants completed open-ended question 10 from the demographic survey which inquires about feelings concerning the contribution of educational setting (classroom, clinical lab, on-line) to experiences of CF, CS, and BO.	NVivo 10 (QSR, 2012) qualitative research software was used to gather, organize, and analyze information from responses to open-ended question 10 into common themes and coding structures, tying similar information together.
What are the experiences of compassion fatigue among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)?	Participants completed open-ended question 8 which inquires about stressors unique to nursing academia and 10 from the demographics survey which inquires about feelings concerning the contribution of educational setting (classroom, clinical lab, on-line) to experiences of CF, CS, and BO.	NVivo 10 (QSR, 2012) qualitative research software was used to gather, organize, and analyze information from responses to open-ended questions 8 and 10 into common themes and coding structures, typing similar information together.

This mixed-methods study employed two types of computer software packages, the Statistical Package for Social Sciences Version 21.0 (SPSS-21) (SPSS Incorporated 1999) and NVivo10 (QSR, 2012), as tools to analyze the results of the responses to the study's survey instruments (Appendices C and D). Proposed data analyses included the use of descriptive statistics to summarize the overall results and the use of t-tests to compare group responses of nurse educators who taught in a university nursing program offering baccalaureate, masters, and/or doctorate in nursing. In order to analyze quantitative data, IBM SPSS-21 statistical analysis software was used to examine descriptive statistics to describe and analyze demographic information, including age, years of teaching, and academic background. SPSS was chosen as the statistical software package to conduct this study's statistical analyses because it is "by far the most commonly used statistical software package in the behavioral sciences" (Howell, 2013, p. 9). Using SPSS-21 statistical analysis software package (Howell, 2013), descriptive statistics were used to describe the relationships between demographic variables and total scores on each of the three subscales (CS, CF/STS, BO) of the ProQOL5. A series of crosstabs tables were then constructed to describe the relationships between these demographic variables and total scores on each of the three subscales (CS, CF/STS, BO) of the ProQOL5. The investigator also performed a multiple regression analysis to study the relationships between levels taught at (career), levels taught at in the last 12 months, and level of expertise compared with nurse educators' levels of CS, CF, and BO obtained from the demographics survey (Appendix C) and the ProQOL5 (Appendix D) respectively.

For the purpose of data reduction from the comparative analysis of groups' experiences, the investigator used NVivo10 (QSR, 2012*)* qualitative analysis software to develop a coding scheme to identify common themes from the responses to four open-ended questions in the demographics survey (Appendix C). Coding was accomplished by organizing information into nodes where common themes could be discovered then grouped into categories to be analyzed. Nodes can be described as "virtual filing boxes" that permit the researcher to organize, summarize, and analyze the information for common themes (Bloomberg & Volpe, 2012).

Copies of all original data forms from Qualtrics surveys and analyses of responses to the four open-ended questions from NVivo10 (QSR, 2012) were kept in a locked file in the investigator's office or stored in the investigator's password protected computer file and viewed only by the researcher and persons assisting the researcher in the data collection and analysis process.

Summary

American author, James Baldwin (1963), wrote, "One can give nothing whatever without giving oneself, that is to say, risking oneself" (Baldwin, 1963, p. 100). Nurses risk giving of themselves every day in order to help all those around them improve their compassion satisfaction and quality of life, including patients, families, students, other members of the health care team, and their colleagues. While noble in their cause, nurses, regardless of the setting in which they practice, may experience BO or worse, CF, reducing the ability to care for self, especially in areas where high levels of empathy are required (Teater, 2010). Despite a growing body of research that suggests bedside nurses experience CF secondary to "exposure to patients' pain, trauma and suffering on a daily basis" (Coetzee & Klopper, 2010, p. 235), a gap in the literature exists that measures the extent to which nurse educators experience CF. Therefore, this study focused a lens on stressors unique to nursing education in academia and explored the extent to which these nurse educators experienced not only the negative aspects of helping others (CF and BO), but also explored the positive aspects of helping others (CS) and the associated rewards that accompany that sense of accomplishment.

Chapter 3 began by reiterating the purpose of this study which was to define levels of CS, CF, and BO among nurse educators in academia. Using a mixed-methods approach, this study investigated the levels of CS, CF, and BO among nursing faculty while exploring some of the stressors (age, gender, years of experience, area of expertise, levels taught, teaching setting) unique to the nursing academia. This study conducted a comparative analysis of faculty perceptions of CS, CF, and BO from 11 PASSHE nursing programs combining quantitative data from the ProQOL (Stamm, 2010) (Appendix C) and qualitative data from a textual analysis of common themes from responses to open-ended questions in the demographics questionnaire (Appendix D). The study's results and analyses follow in Chapter 4.

Chapter 4 discusses the data and analyses of the demographic variables and provides a description of the sample, research tools, hypothesis, and how the quantitative and qualitative results inform the study's four research questions. The quantitative results will include analyses of the ProQOL 5 (Stamm, 2010) (Appendix C) subscales (CS, STS/CF, and BO) scores for all nursing faculty participants. The qualitative results discussion will center on common threads of the shared experiences of CS, CF, and BO unique to the nursing academic setting uncovered from analyses of responses to the open-ended questions in the demographics survey (Appendix D). Discoveries from the examination of these open-ended queries may link the experiences of CS, CF, and BO to the broader predefined structure of the health care education environment and the practice of nursing education.

CHAPTER 4

ANALYSIS

This mixed-methods study was designed with the intent to explore nursing faculty's perceptions of CS, CF, and BO and uncover strategies which might mitigate CF and BO and enhance CS in the context of nursing academia. An analysis of the study results revealed that there are many nursing faculty who maintain high levels of career CS, regardless of their age, years of practice, levels taught at, area of expertise, or educational setting. Still, there were those nurse faculty in this study who indicated they had succumbed to the detrimental effects of negative stress in their teaching settings, developing CF symptoms of emotional exhaustion and hopelessness characteristic of BO indicated a propensity to burn out prematurely and deteriorate to develop STS or its more contemporary term, CF. Gaining a better understanding of the extent to which nurse educators in academia are affected by conditions such as BO and CF is crucial to the development of positive and nurturing practice environments which enhance CS (Potter, et al., 2010). Nurse educators can learn from one another about how to facilitate the development of moral courage in their students by emulating nurturing behaviors and modeling those strategies which resist CF (Todaro-Franceschi, 2013.

This chapter presents the results of data analyses of the demographic variables, provides a description of the study's sample and research tools, and describes the study's outcomes in light of four research questions. This chapter also provides an overview of the quantitative and qualitative results of this study's survey instruments (Appendices C and D) and how they informed the study's hypothesis and research questions.

Sample Description

Using e-mail addresses obtained from the on-line listed contact information of nursing program directors for 11 PASSHE university nursing programs (Appendix A), an e-mail consent/cover letter (Appendix B) containing a survey link to the survey instruments (Appendices C and D) was administered electronically through *Qualtrics®* survey software. The convenience sample included nursing faculty (N = 145) who taught in 11 nursing programs in the PASSHE system at the baccalaureate, masters, and/or doctoral levels. Nursing faculty were invited to participate in a two-part electronic survey that assessed the extent to which nurse educators in 11 university nursing programs in the PASSHE system experienced CS, CF, and BO in the teaching contexts of the classroom, on-line, and clinical settings. Of those 145 faculty contacted electronically, 46 participants (31.7%) returned completed surveys. The sample size for this study was N = 46. Descriptive statistics were used to define and analyze the demographics of the study sample's gender, age, years of Registered Nurse (RN) experience, and years of experience as a nurse educator. The next section begins this discussion starting with findings concerning participants' gender.

Gender

Of the 46 participants, respondents were primarily female (91.3%) and males were minimally represented with only one participant disclosing male gender. Three participants (6.5%) did not disclose their gender (Table 2). These findings were consistent with the literature's findings concerning the underrepresentation of men in nursing in this geographical area and within the United States in general. The nursing workforce in the United States is overwhelmingly Caucasian and female with men comprising 50% of the population, yet less than 6% of American nurses are male (Trossman, 2003). There are important implications here for the underrepresentation of men in nursing academia that warrant further exploration.

Table 2

Description of the Study Sample: Gender

Variable Percent	Frequency (*n*)	Percent	Valid Percent	Cumulative
Unlisted	3	6.5	6.5	6.5
Male	1	2.2	2.2	8.7
Valid				
Female	42	91.3	91.3	100.0
Total	46	100.0	100.0	

Nursing academia has long experienced a shortage of male faculty. According to Kippenbrock (1990), a shortage of male role models in nursing, among both peers and educators, has existed for some time (as cited in Ellis, Meeker, & Hyde, 2006). More recently, Mullan and Harrison (2008) confirmed that only 5% to 10% of the nursing workforce in the USA, UK, and Canada was male (as cited in Brown, 2009).

Age

Participants (n = 46) ranged in age from 26 to 65+ with primary representation (n = 17) or 37% coming from the 51-55 age bracket with one respondent not disclosing age. Table 3 provides a description of the age of the study sample.

Table 3

Description of the Study Sample: Age

Variable	Frequency (n)	Percent	Valid Percent	Cumulative Percent
26-30 years old	2	4.3	4.4	4.4
31-35 years old	1	2.2	2.2	6.7
36-40 years old	2	4.3	4.4	11.1
41-45 years old	1	2.2	2.2	13.3
46-50 years old	10	21.7	22.2	35.6
51-55 years old	17	37.0	37.8	73.3
56-60 years old	4	8.7	8.9	82.2
61-65 years old	5	10.9	11.1	93.3
65+ years	3	6.5	6.7	100.0
Total	45	97.8	100.0	
Missing System	1	2.2		
Total	46	100.0		

Years of Registered Nurse Experience

In this study, participants ranged in years of RN experience from 0-36+ years with 32.6% of participants representing the largest group with 31-35 years of experience as a RN. A detailed description of the study's Years of Registered Nurse Experience is summarized in Table 4.

Table 4

Description of the Study Sample: Years of Registered Nurse Experience

Variable	Frequency (n)	Percent	Valid Percent	Cumulative Percent
0-5 years	1	2.2	2.3	2.3
6-10 years	1	2.2	2.3	4.5
11-15 years	3	6.5	6.8	11.4
16-20 years	3	6.5	6.8	18.2
Valid				
21-25 years	2	4.3	4.5	22.7
26-30 years	10	21.7	22.7	45.5
31-35 years	15	32.6	34.1	79.5
36+ years	9	19.6	20.5	100.0
Total	44	95.7	100.0	
Missing System	2	4.3		
Total	46	100.0		

Years as a Nurse Educator

In this study, participants ranged in years as a nurse educator from 0-36+ years with the greatest representation (23.9%) reporting 11-15 years of experience as an educator in nursing academia. Two participants' responses were missing concerning this particular variable. A detailed summary of the study's Years as a Nurse Educator is displayed in Table 5. This next section discusses the research tools used to analyze the data.

Table 5

Description of the Study Sample: Years as a Nurse Educator

Variable Percent	Frequency (*n*)	Percent	Valid Percent	Cumulative
0-5 years	5	10.9	11.1	11.1
6-10 years	10	21.7	22.2	33.3
11-15 years	11	23.9	24.4	57.8
16-20 years	3	6.5	6.7	64.4
Valid				
21-25 years	8	17.4	17.8	82.2
26-30 years	4	8.7	8.9	91.1
31-35 years	3	6.5	6.7	97.8
36+ years	1	2.2	2.2	100.0
Total	45	97.8	100.0	
Missing System	1	2.2		
Total	46	100.0		

Research Tools

This mixed-methods study employed two types of computer software packages as tools to analyze the results of the responses to the study's survey instruments (Appendices C and D). In order to analyze quantitative data, IBM SPSS-21 statistical analysis software was used to examine descriptive statistics to describe and analyze demographic information, including age, years of teaching, and academic background. SPSS was chosen as the statistical software package to conduct this study's statistical analyses because it is "by far the most commonly used statistical software package in the behavioral sciences" (Howell, 2013, p. 9). A series of crosstabs tables was then constructed to describe the relationships between these demographic variables and total scores on each of the three subscales (CS, CF/STS, BO) of the ProQOL5. The investigator also performed a multiple regression analysis to study the relationships between levels taught at (career), levels taught at in the last 12 months, and level of expertise compared with nurse educators' levels of CS, CF, and BO obtained from the demographics survey (Appendix C) and the ProQOL5 (Appendix D) respectively.

NVivo 10 (QSR, 2012) qualitative research software was used to gather, organize, and analyze information from responses to open-ended questions from the survey (Appendix C) into common themes and coding structures, tying similar information together (Bloomberg & Volpe, 2012). This next section discusses an overview of the quantitative and qualitative results of this study's survey instruments (Appendices C and D) and how they informed the study's hypothesis and research questions.

Research Questions

This mixed-methods study aimed to address four research questions pertaining to the experiences of CS, CF, and BO among nurse educators in 11 PASSHE nursing education programs which offered a baccalaureate, masters, or doctoral degree in nursing. This section presents a description of the tools used to analyze the data from both a quantitative and qualitative perspective. This study's four research questions are reviewed along with an analysis of the data that informed the design and purpose of this study.

To summarize answers to these research questions, a series of crosstabs tables (or contingency tables) (Polit & Beck, 2014) was constructed to describe this study's quantitative perspective by presenting descriptive statistics obtained from the study's survey questionnaires (Appendices C and D). Qualitative data were analyzed and summarize using NVivo10 (QSR, 2012) and presented to inform the discussion concerning the perceptions of CS, CF, and BO among nurse faculty in research questions 2, 3, and 4.

Research Question 1

Research Question 1: To what extent do the variables of age, gender, years of teaching experience, and academic background in nursing academia shape the experiences of compassion fatigue? To answer this question, descriptive statistics were used to define the relationship between the variables of age, gender, years of experience as a nurse educator, and academic background in nursing academia; and mean scores for CS, CF, BO from each of the three subscales (CS, BO, STS) of the study's survey instrument, the ProQOL 5 (Stamm, 2010). Of the 46 participants, respondents were primarily female (91.3%) and males were minimally represented with only one participant disclosing male gender. Three participants (6.5%) did not disclose their gender (Table 2). Since only one participant disclosed male gender, discussion concerning the contribution of male gender to the incidence of CS, CF, BO could not be equivocally entertained nor could conclusions be extrapolated from this data concerning cause and effect or the influence on gender bias. Therefore, the ensuing discussion will focus on the relationship between the variables of age, years of teaching experience, and academic background in nursing academia.

In order to gauge levels of CS, CF, and BO experienced by nurses in academia, participants were given the ProQOL5 survey to complete. The 30 questions in the

ProQOL5 were divided into three subscales: CS, BO, and STS. A review of terms and definitions is provided next to clarify what is measured in each of the three subscales of the ProQOL5 (Appendix D).

STS and CF are synonymous terms which may be used interchangeably throughout this study. CF is a more user-friendly synonymous term for secondary traumatic stress disorder. It is best described as the "trauma suffered by caregivers when helping suffering people in harm's way" (Figley, 2002, p. 3). STS/CF is measured in the third subscale of the instrument used in this research study (ProQOL 5) (Stamm, 2010). Higher scores on this scale indicate a higher risk for BO/STS and lower CS (Stamm, 2010).

BO is a psychological term for the experience of long-term exhaustion and diminished interest; BO develops gradually over time with prolonged emotional and physical exhaustion, often resulting in widespread apathy, a disinterest in work and relationships (Maslach, 1982). "People who are burned out and work in health care are often seen as dispassionate because their apathy appears to indicate a lack of caring" (Todaro-Franceschi, 2013, p. 5).

CS may be described as the pleasure derived from being able to do one's work well, feeling positive about relationships with colleagues, your contribution toward the greater good of society, and one's ability to help others through your work (Stamm, 2010; Teater, 2009). This study revealed there are many nurse educators who experience a great deal of satisfaction despite the many years as a nurse educator. These results from the ProQOL5 are expounded upon in Chapter 5.

The ProQOL 5 (Appendix D) is a 30-item, 5-point Likert scale survey instrument with 30 questions. Participants were asked to reflect on their caregiving or helping experiences in nursing academia within the last 30 days. Each subscale in the ProQOL5 contained 10 items. Participants self-scored (Appendix D) each item with the following numerical values: 1 = Never, 2 = Rarely, 3 = Sometimes, 4 = Often, and 5 = Very Often (Figure 1). The English self-score version of this survey with key (Appendix D) was provided to participants to assist with calculating and interpreting their scores for each subscale.

Subscale	***Question #***
Compassion Satisfaction	*3, 6, 12, 16, 18, 20, 22, 24, 27, 30*
Burnout	*1, 4, 8, 10, 15, 17, 19, 21, 26, 29*
Secondary Traumatic Stress/ Compassion Fatigue	*2, 5, 7, 9, 11, 13, 14, 23, 25, 28*

Figure 1. Professional quality of life (ProQOL) scale questions for scoring.

For scoring levels of CS, participants summed the scores from questions 3, 6, 12, 16, 18, 20, 22, 24, 27, and 30. If the sum of these scores was 22 or less, the levels of CS were scored (Low). For CS scores of 23 to 41, the levels of CS were scored (Average). For scores of 42 or more, participants were rated as having (High) levels of CS.

For scoring levels of BO, participants summed the scores from questions 1, 4, 8, 10, 15, 17, 19, 21, 26, and 29. If the sum of these scores was 22 or less, the levels of BO were scored (Low). For CS scores of 23 to 41, the levels of CS were scored (Average). For scores of 42 or more, participants were rated as having (High) levels of BO.

In order to score levels of STS/CF, participants summed the scores from questions 2, 5, 7, 9, 11, 13, 14, 23, 25, and 28. If the sum of these scores was 22 or less, the levels of STS were scored (Low). For STS scores of 23 to 41, the levels were scored (Average). For scores of 42 or more, participants were rated as having (High) levels of STS. Participants were advised in the cover letter introducing this study (Appendix B) that the scores from the ProQOL5 were for screening purposes only and not for diagnosis (Stamm, 2010). The next section describes the data's expression of the relationship between the variables of age, years of teaching experience, and background of expertise in nursing academia and participants' mean scores of CS, CF, BO obtained from the study's survey instrument, the ProQOL5.

Age

Those participants with ages ranging 26-35, 41-60, and 65+ demonstrated average levels of CS, but high levels of CS were noted in the age brackets of 36-40 and 61-65 years-old. The overall average score of CS for all age groups revealed a score of 40.93 representing an average level of this phenomenon.

When comparing the variable age with scores for the levels of BO, study participants demonstrated average levels of BO for those ranging in ages 26-40; however, those listing ages ranging 41-65+ demonstrated low levels of BO. The overall average score of BO for all age groups revealed a score of 22.24 representing a low level of this phenomenon.

When comparing the variable age with scores for the levels of STS/CF, participants demonstrated average levels of STS for those ranging in ages 26-35, 46-55, and those of age 65+; however, those with ages ranging 36-45 and 56-65 demonstrated low levels of STS. The overall average score of STS/CF for all age groups revealed a score of 22.49 representing a low level of this phenomenon. Table 6 summarizes the mean scores for participants when comparing the variable age with scores for levels of CS, BO, and STS/CF.

Table 6

Age Compared to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Age	Compassion Satisfaction Scale	Burnout Scale	Secondary Traumatic Stress Scale
26-30 years old	45.00	16.00	15.00
31-35 years old	33.00	33.00	34.00
36-40 years old	34.50	31.50	31.00
41-45 years old	42.00	22.00	21.00
46-50 years old	41.40	22.30	20.00
51-55 years old	41.65	21.76	23.47
56-60 years old	39.00	26.00	24.25
61-65 years old	39.80	21.80	21.60
65-100 years old	43.67	15.00	20.33

Years of Experience as a Nurse Educator

Those participants with 0-10 and 26-30 years of experience as nurse educators demonstrated high levels (scores of 42 or more) of CS, whereas those with 11-25 and 31-36+

years of experience demonstrated average levels (scores of 23-41) of CS. Low levels (scores of 22 or less) of CS were not found among this particular group. This study group demonstrated an average BO score 23.3 indicating an overall low level of BO. These findings were consistent with results from a study of 89 Canadian nurse educators by Sarmiento et al. (2004) who confirmed that years of teaching experience were not significantly related to levels of BO with low levels being demonstrated. However, satisfaction, as it pertained to attitudes of the work place, was most strongly correlated with access to peer support, and all BO subscales were strongly related to job satisfaction. The average score of CS for all groups was 40.93 indicating an average level of CS overall.

When comparing the variable Years of Experience as a Nurse Educator to levels of BO, study participants (N = 46) failed to demonstrate high levels of BO. This particular group of nurse educators with 16-30 years of nurse educator experience demonstrated average levels of BO with scores of 23-41. However, those participants listing 0-15 and 31-36+ years of nurse educator experience demonstrated low levels of BO (scores of 22 or less). Strommer (2011) confirmed similar findings in her study of a comparable sample size of 38 Alaskan ER nurses who were assessed for levels of CS and CF (STS, BO). The average score of BO for all groups was 21.6 indicating a relatively low level of STS overall.

Table 7

Years as a Nurse Educator Compared to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Levels

Nurse Educator (Years)	Compassion Satisfaction Mean (Comparison)	Burnout Scale Mean (Comparison)	Secondary Traumatic Stress Mean (Comparison)
0-5	43.20	19.20	19.40
6-10	43.00	20.90	22.30
11-15	39.36	22.64	22.91
16-20	36.33	27.67	22.33
21-25	40.13	24.75	23.88
26-30	43.75	23.00	23.75
31-35	40.00	19.67	23.33
36+	38.00	15.00	17.00

When comparing the variable Years of Experience as a Nurse Educator to levels of STS/CF, study participants did not demonstrate high levels of STS/CF. Participants in this study with 6-35 years of experience demonstrated average levels of STS (scores of 23-41). However, those listing 0-5 and 36+ years of experience or those at the very beginning or the very end of their nursing academia career, demonstrated low levels of STS/CF (scores of 22 or less). This low level may be explained by the newness of the beginning work experience such as that lived through by the beginning nurse. This low level of CF/STS may be explained, in part, by the sense of anticipation associated with the prospects of career completion and retirement. The average score of STS for all groups was 22.49 indicating a relatively low level of STS overall. Table 7 summarized the mean scores for participants when comparing the variable Years of Experience as a Nurse Educator with scores for levels of CS, BO, and STS.

Years of Experience as a Registered Nurse

When comparing the variable Years of Experience as a Registered Nurse with levels of CS, the average score was 40.93 representing an average level of CS. When comparing this variable to levels of BO, the average score was 22.2, a low level of this phenomenon. When comparing Years of Experience as a Registered Nurse with levels of STS, it was discovered that a relatively low level of 22.5 was determined. This represented a low risk for STS among this particular population. A summary of these findings are included in Table 8.

Table 8

Years as a Registered Nurse Compared to Compassion Satisfaction, Burnout, and Secondary Traumatic Stress Levels

Registered Nurse (Years)	Compassion Satisfaction Mean (Comparison)	Burnout Scale Mean (Comparison)	Secondary Traumatic Stress Mean (Comparison)
0-5	40.00	18.00	12.00
6-10	50.00	14.00	18.00
11-15	39.00	27.67	26.67
16-20	37.00	26.33	28.67
21-25	44.50	18.50	23.00
26-30	40.60	22.90	19.80
31-35	41.87	22.47	23.20
36+	40.00	20.00	22.44

Background of Nursing Expertise in Academia

In question 7 from the demographics portion of the survey (Appendix C), participants were asked identify their background of nursing expertise. Those nurse faculty citing background expertise in Psychiatric/Mental Health and Oncology nursing demonstrated the highest levels of CS with scores of 46. None of the study participants scored low for levels of CS regardless of the identified background area of expertise in nursing academia (Table 9). Although unsupported in the current body of literature, this variance might be explained by a reduction of direct exposure to patients' suffering experienced by instructors who go into patients' homes, either as an actively practicing community health or psychiatric nurse or while leading students during a community or psychiatric nursing clinical rotation. In these situations, the presence of students may insulate the instructor from primary exposure to patient suffering thus reducing the level of secondary traumatic stress. Participants citing education as their area of nursing expertise demonstrated the lowest levels of CS while oncology and psychiatric nurse educators scored the highest levels of CS and the lowest level of BO. These participants seemed to be happiest to be away from the bedside and teaching in their area of expertise. Participants citing expertise in the area of education scored the highest for BO with a score of 22.4, although this level is considered an average amount according to the scoring key on page 3 of the ProQOL 5 (Appendix D). Participants declaring medical-surgical area of expertise demonstrated the highest level of STS/CF and oncology area of expertise again showing the lowest levels of STS. No frame of reference exists in the present body of literature to explain these results, however, it should be noted that only two participants had declared oncology as an area of expertise, whereas those citing Education area of expertise had greater representation (n = 25), likely skewing the results.

Table 9

Comparing Area of Expertise With Levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

Area of Expertise	Frequency (*n*)	Compassion Satisfaction (Mean)	Burnout Scale (Mean)	Secondary Traumatic Stress (Mean)
Education	25	39.96	23.08	22.12
Pediatrics	10	41.20	22.80	23.50
Critical Care	12	40.42	22.67	23.67
Medical-Surgical	18	41.83	21.61	24.39
Community Health	9	41.78	20.89	20.89
Obstetrics	8	43.13	20.38	22.13
Psychiatric/ Mental Health	4	46.00	19.75	19.25
Anesthesia	0	0	0	0
Oncology	2	46.00	16.00	18.50
Other	15	42.93	20.00	20.87

Research Question 2

Research Question 2: To what extent does the level of compassion fatigue experienced by nurse educators in academia vary among groups as determined by type of nursing program taught in (baccalaureate, graduate)? From question 3 of the demographics survey (Appendix C) (At what levels have you taught during your career in Nursing Academia?) and question 4 from the same survey (In the last 12 months, at what levels have you taught in a Nursing education program?), the following mean scores were recorded for levels for CS, BO, and STS/CF as compared to academic levels taught in their careers (Table 10) and levels taught at in the last 12 months (Table 11).

Table 10

Comparing Levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress With Levels Taught at (Career)

Levels Taught (Career)	Frequency (*n*)	Compassion Satisfaction (Mean)	Burnout (Mean)	Secondary Traumatic Stress (Mean)
Associate	16	41.75	21.81	22.94
Baccalaureate	43	41.1	22.05	22.28
Masters	25	40.16	22.44	22.56
Doctoral	9	38.44	26.00	25.00

Table 11

Comparing Levels of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress With Levels Taught (Last 12 Months)

Levels Taught (Last 12 Months)	Frequency (*n*)	Compassion Satisfaction (Mean)	Burnout (Mean)	Secondary Traumatic Stress (Mean)
Associate	2	46.00	18.50	22.50
Baccalaureate	40	41.00	22.20	22.90
Masters	16	38.81	23.63	21.75
Doctoral	6	38.00	27.67	26.33

Levels Taught at (Career) and Levels Taught at (Over the Last 12 Months)

In an effort to further understand the relationships between the incidence of CS, CF, and BO among those nurse educators teaching at more than one level, multiple regression analyses were also performed to predict these phenomena by levels taught at (career) and levels taught in the last year. There was no statistically significant difference, where $p < .05$, between levels taught at (career) (Tables 12, 13, 14) and levels taught at (in the last 12 months) and levels of CS, CF, and BO (Tables 15, 16, 17). This study hypothesized that nurses who assume the role of educator, experience different levels of CS, CF, and BO regardless of age, the level at which they teach, their area of expertise, years of teaching experience or the teaching setting (classroom, clinical, on-line). The null hypothesis was therefore rejected noting that there were no statistically significant differences found in the relationships between the levels of CS, CF, and BO and levels taught at (career) and at levels taught at (in the last 12 months). Considering their entire career of teaching, those nurse faculty who indicated they taught at the doctoral level showed the lowest levels of CS, although their small number of representation of seven participants should be taken into consideration when interpreting these data sets. Those faculty who made a career of teaching at the associate degree level demonstrated the highest scores of CS. In this study, BO was highest among those declaring a career of teaching at the doctoral level but lowest at the baccalaureate level. STS levels were highest in those teaching careers at the doctoral level and lowest among those teaching careers at the master's level. The small number of respondents at the doctoral level in this portion, where $n = 9$, may have skewed these results. No explanation exists in the current literature and participants did not comment on this in the open-ended questions. Additionally, this study did not delve into the possibility that some faculty were teaching simultaneously at two or three levels in the same semester, increasing stress. This increase in responsibility and the challenge of remembering all the requirements for all three levels (baccalaureate, masters, and doctoral) is a concern addressed in the qualitative portion of the results analyses of open-ended questions later in this chapter.

Table 12

Predicting Burnout From Levels Taught at (Career)

Levels Taught	*β* Coefficient	Significance (*P*)
Associates	-.057	.747
Bachelors	.084	.605
Masters	.190	.387
Doctoral	-.023	.929

Table 13

Predicting Secondary Traumatic Stress From Levels Taught at (Career)

Levels Taught	*β* Coefficient	Significance (*P*)
Associates	-.003	.998
Bachelors	.281	.093
Masters	-.024	.912
Doctoral	.043	.869

Table 14

Predicting Compassion Satisfaction From Levels Taught (Career)

Levels Taught	*β* Coefficient	Significance (*P*)
Associates	-.104	.452
Bachelors	.040	.816
Masters	-.341	.134
Doctoral	-.009	.973

Table 15

Predicting Burnout From Levels Taught in the Past 12 Months

Levels Taught	β Coefficient	Significance (*P*)
Associates	.224	.164
Bachelors	.099	.547
Masters	-.043	.818
Doctoral	-.359	.188

Table 16

Predicting Compassion Satisfaction From Levels Taught in the Past 12 Months

Levels Taught	β Coefficient	Significance (*P*)
Associates	-.164	.327
Bachelors	.075	.665
Masters	.195	.326
Doctoral	.179	.526

Table 17

Predicting Secondary Traumatic Stress From Levels Taught in the Past 12 Months

Levels Taught	β Coefficient	Significance (*P*)
Associates	-.010	.952
Bachelors	-.106	.524
Masters	.125	.513
Doctoral	-.315	.251

Area of Clinical Expertise

In an effort to better understand the relationships between the incidence of CS, CF, and BO as these related to clinical areas of expertise, multiple regression analyses were also performed. The results are summarized in Table 17 through Table 19. CS was highest among those who declared expertise in education ($P = 0.057$, $\beta = 0.306$) and highest among those who declared expertise in psychiatric nursing with statistical significance where $P < 0.05$ ($\beta = -0.298$, $P = 0.047$). There were several instances of support in the existing body of literature for these findings (Fong, 1990; Sarmiento, et al., 2004; Strommer, 2011); however there were many identified gaps in the literature, the future investigation of which will be suggested in Chapter 5 of this study.

BO was highest among those who identified their area of expertise as community health ($\beta = 0.279$, $P = 0.078$,) and lowest among those citing expertise in education ($P = 0.310$, $\beta = -0.169$). STS/CF was highest in medical/surgical area of expertise ($P = 0.085$, $\beta = -0.264$) and lowest in oncology area of expertise ($P = 0.258$, $\beta = 0.177$). Again, psychiatric nursing area of expertise was the only area demonstrating statistically-significantly low levels of CS ($\beta = -0.298$, $P = 0.047$) where $p < 0.05$.

Table 18

Predicting Burnout Levels by Area of Expertise

Area of Expertise	β Coefficient	Significance (*P*)
Education	-.169	.310
Pediatric	-.133	.406
Critical Care	-.076	.631
Medical Surgical	.110	.471
Community Health	.279	.078
OB-GYN	.037	.812
Psychiatric	-.007	.964
Oncology	.164	.300

Table 19

Predicting Secondary Traumatic Stress Levels by Area of Expertise

Area of Expertise	β Coefficient	Significance (*P*)
Education	.126	.443
Pediatric	-.098	.536
Critical Care	-.164	.297
Medical Surgical	-.264	.085
Community Health	.166	.281
OB-GYN	.068	.659
Psychiatric	.163	.289
Oncology	.177	.258

Table 20

Predicting Compassion Satisfaction Levels by Area of Expertise

Area of Expertise	β Coefficient	Significance (P)
Education	.306	.057
Pediatric	.002	.988
Critical Care	.190	.209
Medical Surgical	-.005	.972
Community Health	-.073	.620
OB-GYN	.019	.896
Psychiatric	-.298	.047*
Oncology	-.202	.180

Note. *p<0.05.

Qualitative Data Analysis

To provide additional insight into answering this research question, the investigator also examined qualitative data obtained from open-ended questions of nurse educators' experiences of CF, CS, and BO using interpretative description (Thorne et al., 2004). Interpretative description is a human science research model used in this study to reflect the unique aspects of nursing research that directly impact the practice of professional nursing. Interpretive description is a "non-categorical approach to qualitative research which is appropriate for small-scale qualitative research projects" such as this particular study (Austin et al., 2009, p. 201). A qualitative analysis computer software package, NVivo10 (QSR, 2012), was used to conduct a textual content analysis of open-ended questions from the demographics survey (Appendix C). The qualitative analysis of this data will be explored next discussing first some of the negative perceptions and conclude with comments from those participants who felt there were positive aspects to teaching at more than one level.

Using NVivo 10 (QSR,2012), the investigator analyzed written responses to open-ended question 9 of the demographics survey (Appendix C) where participants were asked to express the extent to which they felt that teaching at more than one level in nursing academia contributed to CS, CF, or BO. Next, answers concerning the impact of teaching at more than one level in nursing academia were categorized into negative and positive responses. There were four neutral responses given by those who either wrote a response of "no opinion" or did not teach at more than one level in nursing academia and therefore wrote "no opinion."

Twenty-one of the 46 respondents (45.6%) agreed that teaching at more than one level had a negative impact on CS and increased the degree of CF and BO experienced. Several respondents cited specific challenges and burdens imposed on those teaching at more than one level: time constraints, dealing with larger numbers of students, and working with students with varying levels of maturity and learning needs (the teenager vs. non-traditional or the older student).

Several respondents cited time constraints noting that teaching at three levels (baccalaureate, masters, doctoral) made it "difficult to keep all the policies straight." One respondent complained it was "particularly time consuming and there was no downtime for my brain to rest." "Preparing for a graduate course, especially a doctoral level course, requires a lot of preparation time." Having to repeatedly "change gears in the same day or within the same week" increased the amount of preparation time as the educator moved from one level to the next. One respondent agreed that "time was already at a premium and teaching at more than one level required I attend more than one level of faculty meetings." Another individual cited other required work such as "accreditation preparation" as an added drain on time in the workday and the requirements were different across undergraduate, masters and doctoral levels. Several nurse educators agreed it was "harder to manage all the demands and maintain focus" while having to "be in two or three different mind sets." However, not everyone felt that teaching at more than one level negatively impacted them, but actually contributed to increased levels of CS. One respondent said there was a higher propensity toward burnout when teaching at multiple levels due to "having to teach to two types of learners." Some learners were described as " immature" and "just out of high school" while other learners were older and their learning styles different. Several respondents cited frustration with the shear increase in the numbers of students and the challenges associated with keeping track of multiple students at multiple levels stating,

"I don't think that people who only teach at one level understand how challenging it is to manage multiple levels of workload and students." Citing concerns with increased numbers, one respondent remarked, "The more students you have, 100 or more per semester, it is more difficult to know them all personally or connect or serve the students adequately by meeting all their educational and/or psychological needs." One respondent agreed, simply noting, "The more students I have, the more compassion fatigue I have."

Despite the approximately 21of 46 (45.6%) of the respondents who negatively described influence of teaching at more than one level, there were approximately 14 of 46 (30%) respondents who felt this had "no bearing on CF or BO." As a matter of record, there were approximately six respondents out of 46 (13%) who felt that teaching at more than one level actually had a positive impact and might enhance CS and have no effect on either CF or BO. One respondent noted, “I don’t think it adds to burnout at all because it keeps me intellectually stimulated and not bored.” Another nurse educator who taught at all three levels disregarded the impact of teaching nursing at more than one level saying “I appreciate being flexible.”

Research Question 3

Research Question 3: To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by faculty teaching assignments (undergraduate, masters, doctoral) and method of course delivery (classroom, clinical lab, on-line)? This research question concerning the influence of the educational setting was analyzed solely from a qualitative analysis perspective probing data obtained from responses to open-ended questions about nurse educators’ experiences of CF, CS, and BO. The researcher again used NVivo 10(QSR, 2012), qualitative analysis software package, applying interpretative description (Thorne et al., 2004) to describe the following results.

Using the NVivo10 (QSR, 2012), a comparative analysis of textual content was conducted from responses to questions 10 of the demographics portion of the survey (Appendix C) in which participants were asked, “Do you feel that nurse educators experience similar levels of CS or CF/BO in the clinical setting as compared to the classroom or on-line teaching settings?” The responses were categorized into two nodes: (1) “Yes, those who teach in the clinical setting experience similar levels of CS or CF/BO when compared to those who teach in the other settings (classroom, on-line),” or (2) “No, those who teach in the clinical setting don’t experience similar levels of CS or CF/BO when compared to those who teach in the other settings." The "yes" responses will be discussed first.

Not one respondent agreed that the levels of experienced CS, CF, or BO were similar in any of these teaching settings but were vastly different because of the uniqueness of each environment. The investigator took a closer look at each of the three settings of inquiry (clinical, classroom, on-line) and summarized the remarks referencing first the clinical environment, then the classroom, and finally the on-line teaching setting.

For those respondents who said, "No, those who teach in the clinical setting do not experience similar levels of CS or CF/BO as compared to those who teach in the other settings (classroom, on-line)," the researcher noted a consensus among the respondents that there were different stressors unique to each of the three settings (classroom, clinical, on-line) and their experiences were vastly different. However, there were several differences in faculty perceptions of CS, CF, and BO in the clinical teaching environment. Quotes will be provided to amply common themes which supported respondents' positions.

With respect to the clinical teaching setting, the common theme which buoyed the educator and promoted CS was predominantly one of a sense of closeness or familiarity fostered by small class size. In the clinical setting, most instructors had no more than 10 students for whom they were responsible. They met twice a week for eight hours at a time, working one-on-one throughout the clinical day. One instructor remarked, "By dealing with these individual student issues on the clinical site, I got to know these students in a personal way." These educators remarked that just having "a smaller number of students with whom you met face-to-face" for longer periods of time in the clinical setting created more satisfaction, a greater sense of accomplishment, and a greater closeness. Developing a greater sense of accomplishment and sensing hope for the future is a hallmark of compassion satisfaction (Stamm, 2010). One instructor said they could “see the student progressing” from working so closely one-on-one in the clinical setting for the entire semester. The perception of familiarity was different when considering the relationships between the instructor and the large number of students in a lecture auditorium. However, not everyone surveyed agreed with this assessment.

Some respondents found the clinical setting to be associated with lower levels of compassion satisfaction and higher levels of STS or that component of CF where people develop problems such as fear or insomnia following work related secondary exposure to stressful events (Stamm, 2010). Todaro-Franceschi (2013) echoed concerns for this at-risk population of nurse educators noting, “Nurses who work in these highly traumatic areas where patients usually do not return to a previous level of wellness are especially at risk of compassion fatigue” (p. 76). Several respondents cited the uniqueness of the experiences confronting instructors and students in the clinical setting such as “the ever present trauma of life and death issues.” The trauma of real-life death and dying issues may not be experienced to the same extent compared to the more insulted teaching settings of the lecture hall or the on-line classroom. One nurse educator agreed, “There is no comparison; there are life and death issues here.” For those who taught on-line, respondents described a very distant relationship because they did not speak face-to-face or interact on a personal level like they could in a small group of 10 or fewer students in the clinical setting. Many remarked it was more difficult to get to know students individually because the “level of interaction just wasn’t there.” One educator said “Each area can produce very real stress and there were very different levels of CS, CF, and BO in every teaching setting." Another clinical educator agreed stating, "Luckily we have fewer students in our clinical groups, usually around 10; we get the privilege to know our students on a deeper more meaningful level and get to help them more individually." Most commented that small class size was not a luxury afforded them in the lecture room or on-line setting.

Concerning the classroom teaching environment, there were several common themes which shaped teaching experience producing increased CF and BO and reduced CS. Some shared themes among these respondents included classroom size, student incivility, the high expectations to perform university and community service, conduct scholarly activity, and increased amount of preparation time.

Some respondents cited large classroom size as a factor where levels of CS were not similar to other teaching settings. One classroom nursing instructor cited mounting stress in this environment declaring, "The classroom can be frustrating due to class size." Classroom size was not an expressed concern in the clinical setting, since instructors noted they often had fewer students (no more than 10) to supervise in the clinical area. Because of the complexity of the clinical environment and the large number of tasks requiring experienced nursing supervision, some clinical nurse teachers cited stress over worry about the safety and competency of the inexperienced nursing student. No concerns were expressed in this survey concerning a large size on-line class population. With the advent of technologies to enhance distance education such as Skype®, which offer opportunities for face-to-face interaction with on-line class participants, there may be more opportunities to interact and a large class size might present certain challenges for such video conferencing technologies. With current advances in all technologies, including those in health care, nurse educators' skills may quickly become obsolete and the pressure exerted by time constraints to keep ahead and to maintain clinical currency produce distress (Sarmiento et al., 2004). Distress may lend itself to uncivil behaviors, especially where no forum exists for discussion of these and other issues which negatively impact CS in the workplace.

Concerning student incivility and its negative impact on CS, one faculty complained, "In the classroom, students are quicker to judge and blame the instructor for doing poorly on an exam. Students seem less appreciative than in the classroom setting." Another classroom nursing instructor observed, "Some students are actively engaged and others may be distracted." Some students demonstrated poor behavior conveying a sense of entitlement noting "incivility is often displayed in the classroom by students who feel that they are deserving of a degree."

Citing pressures such as increased preparation time, some faculty reported more preparation time required for classroom teaching than in clinical instruction remarking "I have taught in classroom combined with clinical, and just as a clinical instructor. The amount of prep time for lecture is triple (at least) the amount of prep time for clinical." Nurse educators often complain about time constraints in which they must counsel students, provide teaching excellence, conduct scholarship, serve on committees, as well as engage in clinical practice with students (Sarmiento et al., 2004).

The on-line teaching setting was not associated with high levels of CF, again because of a lack of face-to-face interaction where it was difficult to establish a strong relationship without proximity. One educator confirmed this insulation from trauma created by the on-line distance educational environment noting:

> In the clinical setting and the classroom, I feel compassion fatigue is similar, but with on-line education I believe that it is less because there is so no face to face contact with students. I think a totally online class is more “anonymous” than the clinical or classroom settings.

The sense of anonymity created by the on-line teaching environment may insulate the educator from traumatic secondary exposure which may differ from the experiences of educators who teach in the same room as their care receiver, in this case, the student.

There were several respondents who felt that on-line teaching environments were associated with high levels of CF and BO due to technological problems or feelings of technological inefficacy. One participant remarked:

> On-line teaching comes in as a close second for compassion fatigue/burnout. All the technology failure and students who are not technology savvy—these things are all are stressful and require much time and effort that is not related to teaching the content.

Still, there were others who saw no relationship at all among these variables to the environment in which they taught, but placed the onus on the instructor themselves.

> Anyone who does their job in a professional and caring manner is at risk for compassion burnout. I don't believe they are vastly different. Just a different level of stress and source of stress that can be relayed to patients or students alike.

Several common stressors such as large class size, time constraints, heavy workload, and pressures to conduct scholarship along with teaching responsibilities also emerged as shared themes in responses to question 8 of the demographics survey (Appendix C). In this question, nurse educators were asked about their experiences concerning stressors unique to nursing academia unexperienced by the bedside nurse. Those common stressors will be more fully discussed next in Research Question 4.

From the responses to open-ended question #10 in which participants were asked, "Do you feel that nurse educators experience similar levels of CS or CF/BO in the clinical setting as compared to the classroom or on-line teaching settings?," not one respondent agreed that the levels of experienced CS, CF, or BO were similar in any of these teaching settings but were vastly different because of the uniqueness of each environment. For those respondents who said, "No, those who teach in the clinical setting do not experience similar levels of CS or CF/BO as compared to those who teach in the other settings (classroom, on-line)," the researcher noted a consensus among the respondents that there were different stressors unique to each of the three settings (classroom, clinical, on-line) and their experiences, vastly different. However, there were several differences in faculty perceptions of CS, CF, and BO in the clinical teaching environment. With respect to the clinical teaching setting, the common theme which buoyed the educator and promoted CS was predominantly one of a sense of closeness or familiarity fostered by small class size. Concerning the classroom teaching environment, there were several common themes, which shaped teaching experience producing increased CF and BO and reduced CS, including increased preparation time, large classroom size, student incivility, the high expectations to perform university and community service, conduct scholarly activity, and time constraints imposed by the pressures of multi-tasking in order to fulfill the job description. Finally, concerning distance education conducted in the on-line setting, nurse faculty cited negative stressors which lowered CS and increased levels of CF and BO associated with feelings of technological inefficacy or competency. However nurse faculty experienced reduced levels of CF and BO which they associated with insulation from direct exposure to the traumatic stress associated with the anonymity and emotional distance characteristic of the on-line setting.

Research Question 4

Research Question 4: What are the experiences of CF among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)? To help answer this question, the researcher asked participants to respond to an open-ended question (8) in the demographics survey (Appendix C) that requested a list of the negative stressors they believed were unique to nursing academia unexperienced by the nurse at the bedside.

Using NVivo10 software, the researcher also examined and analyzed responses to open-ended question 8 in which nurse educators were asked to comment about stressors that are unique to nursing academia unexperienced by the bedside nurse. Common themes were again organized and categorized into nodes or "virtual filing cabinets" (Bloomberg & Volpe, 2012). Some shared themes which emerged during this process identified contractual obligations, faculty incivility, scholarship and service obligations, and student-related issues as stressors unique to the environment of the nurse educator. These issues will be discussed next beginning with concerns about fulfilling the contractual obligations in the job description of the nurse educator.

Most of the comments about stressors unique to the nurse educators' environment were related to the stress created by pressure to satisfy academic contractual obligations inherent in the job description. There were many respondents who expressed classic symptoms of BO (Stamm, 2002, 2010) noting, "The job is never done" and "There is no such thing as punching out and leaving all your worries behind." Some faculty described many instances of taking work home with them on weekends, holidays, during parties, and other family festivities. Some often took time away from those activities to grade papers or prepare for the next lecture.

Recognizing the pressures to conduct research, publish, and perform other scholarly activities expected in academia, several professors expressed concern about an impaired ability to attend to personal continuing education and scholarship requirements which, if not met, can jeopardize promotion and advancement in the academic setting and prohibit the renewal of the nurse's license. The expectation that academics publish and disseminate research findings, information, and knowledge is increasingly becoming a component of nursing and academic practice (Wilson, Sharrad, Rasmussen, & Kernick, 2013). One nurse educator cited this concern noting, "Working at the doctoral level, you put so much time into your doctoral students' research that your research gets neglected. This puts you at risk for not getting promoted."

Another common theme identified from response to this open-ended question about stressor unique to nursing academia spoke to time constraints and the mandate of continuing education and licensure renewal required satisfying contractual obligations. One nursing faculty noted, "Work doesn't stop at the end of a shift, but continues into the evening, weekend, holidays, and breaks. Nurse practitioner (NP) faculty are expected to maintain national licensure, which means holding an outside NP job in addition to teaching." These continued obligations that exist outside the workplace aggravate stress. These symptoms may describe many professional nurses who may be accustomed to demanding behaviors from patients, their families, physicians, nursing colleagues, and other members of the healthcare team. In this context, nurses may often feel overburdened and overcome by these competing time constraints. "Maslach (1982), a pioneer in the study of BO, described this as a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people on a daily basis" (Espeland, 2006, p. 178). These symptoms were displayed among a number of participants' comments.

Concerning faculty incivility, the issue of bullying by other faculty or faculty administration emerged as a shared theme and reason for diminished CS and higher levels of CF and BO. One faculty noted specific examples citing:

> Favoritism of faculty who are politically connected by those in positions of power or authority that are designed to assist them to advance professionally over others based solely on their agreeing to do whatever these powerful people want them to do . . . and not at all on the existing criteria of teaching, scholarship & service.

Another faculty identified this stressor as.

> Bullying to do what those in positions of power or authority want via manipulation of the existing rules/regulations or policy statements (or creating them if they do not already exist under the guise of "helping" students, faculty, department or university.

Another instructor confirmed these feelings noting “lack of respect between instructors.” Still, other comments cited student issues as a source of stress in nursing academia.

Student incivility was a recurrent theme again expressed here as in open-ended question 10. Those comments were previously discussed in Research Question 3 and reappeared occasionally using different wording in responses to open-ended question 8 which inquired about stressors unique to academia unexperienced by the bedside nurse. Other student issues about which faculty expressed concern and identified as negative stressors included concerns for students’ and patients’ safety. Some instructors feared their license was constantly in jeopardy concerned the novice nursing student might make a mistake and injure a patient. Such stress was evident in comments made by many instructors who responded to this open-ended query. Several instructors in the clinical setting expressed most of these concerns with such comments as, “Clinical teaching is the most difficult and anxiety producing because you’ve added in the patient factor.” There are many more opportunities to be exposed to traumatic situations in the clinical environment from both patients and their families. “Clinical can be emotionally exhausting. You are responsible for the students and their care of the patient as well as trying to teach them how to critically think, looking at the big picture.” There are also stressors associated with dealing with other members of the healthcare team and concerns for patient safety and student safety, as well. One instructor observed, “The clinical setting is much more stressful. You are constantly vigilant and worried about safety.” For many nurse educators, these stressors combined to make clinical teaching a setting of high stress, perhaps reminiscent of their days as a bedside nurse.

The experiences of CF among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)? To help answer this question, the researcher asked participants to respond to an open-ended question (8) in the demographics survey (Appendix C) and list the stressors they believed were unique to nursing academia unexperienced by the nurse at the bedside. Some shared themes which emerged during this process identified contractual obligations, faculty incivility, scholarship and service obligations, and student-related issues as stressors unique to the environment of the nurse educator.

Summary

Chapter 4 presented the study's quantitative and qualitative data and analyses of the demographic variables within the context of the study's four research questions. This chapter provided a description of the data and corresponding analyses of the demographic variables, provided a description of the sample, and reviewed the study's four research questions, hypothesis, and results from the study's survey instruments (Appendices C and D). Descriptive statistics were reported to describe the quantitative data's expression of the relationships between the variables of age, years of teaching experience, and background of expertise in nursing academia; and mean scores for CS, CF, and BO from each of the three subscales (Compassion Satisfaction, Burnout, Secondary Traumatic Stress) of the study's survey instrument, the ProQOL 5 (Stamm, 2010). A summary of the quantitative portion of this study will be discussed first as it pertains to a comparison of the variables of age, years of experience as a RN, years of experience as a nurse educator, and level of expertise, and levels taught at.

Summary of Quantitative Results

Analysis of the average mean scores of CS for all age groups revealed a score of 40.93 representing an average level of this phenomenon. The average score of BO for all age groups revealed a score of 22.24 representing a low level of this phenomenon. The average score of STS/CF for all age groups revealed a score of 22.49 representing a low level of this phenomenon.

When comparing the variable Years of Experience as a Registered Nurse with levels of CS, the average mean score was 40.93 representing an average level of CS. When comparing this variable to levels of BO, the average score was 22.2, a low level of this phenomenon. When comparing Years of Experience as a Registered Nurse with levels of STS, it was discovered that a relatively low level of 22.5 was determined. This represented a low risk for STS among this particular population.

When comparing the variable Years of Experience as a Nurse Educator, this study group demonstrated a mean score of CS of 40.93 indicating an average level of CS overall and BO score of 23.3 indicating an overall low level of BO. The average mean score of STS for all groups was 22.49 indicating a relatively low level of STS.

When comparing Area of Nursing Expertise with levels of CS, the following findings were noted. Those citing education as their area of nursing expertise demonstrated the lowest levels of CS while oncology and psychiatric nurse educators scored the highest levels of CS and the lowest level of BO. These participants seemed to be happiest to be away from the bedside and teaching in their area of expertise. Participants citing expertise in the area of education scored the highest for BO with a mean score of 22.4, although this level is considered an average amount according to the scoring key on page 3 of the ProQOL 5 (Appendix D). Participants declaring medical-surgical area of expertise demonstrated the highest level of STS/CF and oncology area of expertise again showing the lowest levels of STS.

In order to predict levels of CS, BO, and STS/CF by level of nursing expertise, multiple regression analyses were performed. CS was highest among those who declared expertise in education ($P = 0.057$, $\beta = 0.306$) and lowest among those who declared expertise in psychiatric nursing with statistical significance where $P < 0.05$ ($p = 0.047$, $\beta = -0.298$). BO was highest among those who identified their area of expertise as community health ($P = 0.078$, $\beta = 0.279$) and lowest among those citing expertise in education ($P = 0.310$, $\beta = -0.169$). STS/CF was highest in medical/surgical area of expertise ($P = 0.085$, $\beta = -0.264$) and lowest in oncology area of expertise ($P = 0.258$, $\beta = 0.177$). Again, psychiatric nursing area of expertise was the only area of nursing expertise demonstrating statistically-significantly low levels of CS ($\beta = -0.298$, $P = 0.047$) where $p < 0.05$.

Concerning the predictive relationship of nurse faculty's level of CS, BO, and STS/CF and levels taught at, whether over the entire career or just over the last 12 months, multiple regression analyses revealed no statistically significant differences found in the relationships between the levels of CS, CF, and BO and levels taught at (career) and at levels taught at (in the last 12 months). Considering their entire career of teaching, those nurse faculty who indicated they taught at the doctoral level showed the lowest levels of CS. There were several instances of support in the existing body of literature for these findings (Fong, 1990; Sarmiento, et al., 2004; Strommer, 2011); however there were many identified gaps in the literature, the investigation of which will be suggested in Chapter 5 of this study. To close these gaps, a qualitative analysis of responses to open-ended questions in the survey (Appendix C) supplemented the quantitative results as mentioned above.

Summary of Qualitative Results

The qualitative portion of this study also uncovered several interesting shared themes which add to these study findings and supplement the body of literature concerning the perceptions of CS, CF, and BO among nurse faculty. Some common threads which emerged during this process identified contractual obligations, faculty incivility, scholarship and service obligations, and student-related issues including incivility, as stressors unique to the environment of the nurse educator.

Using NVivo10 (QSR, 2012) software, this chapter also described the qualitative data's expression of nurse faculty's perceptions of stressors unique to nursing academia unexperienced by the bedside nurse, the extent to which teaching at more than one level contributed to CS, CF, and BO, the similarity of experience regarding perceived levels of CS, CF, and BO in the comparative context of the clinical, classroom, and on-line teaching settings, and perceptions of the impact of CF on teaching practice in nursing higher education. Some shared themes which emerged during this process identified contractual obligations, faculty incivility, scholarship and service obligations, and student-related issues including incivility, as stressors unique to the environment of the nurse educator. Comments concerning the clinical teaching setting produced a majority of the negative comments citing this as an area of highest stress because of concerns for students' and patients' safety. Some instructors feared their license was constantly in jeopardy concerned the novice nursing student might make a mistake and injure a patient.

Still, for some instructors, the clinical setting was the most rewarding because they dealt with small numbers of students and could interact in groups, face-to-face for the entire semester, and, thus get to know one another very closely. Still, there were other participants who saw no relationship at all among these variables to the environment in which they taught, but placed the onus on the instructor themselves stating, “Anyone who does their job in a professional and caring manner is at risk for compassion burnout.” Since what is traumatic to one person may not be perceived the same way by another, “It is imperative that we consider the possibility that someone else might be traumatized, even if we are not” (Todaro-Franceschi, 2013, p. 77). These implications for practice will be discussed next in Chapter 5 along with a summary discussion of the results, and recommendations for future research.

CHAPTER 5

DISCUSSION, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of this study was to investigate the extent to which nurse educators in academia experienced compassion fatigue (CF), compassion satisfaction (CS), and burnout (BO) across levels at which they taught (undergraduate, masters, doctoral) and to identify stressors unique to nursing academia which may contribute to or mitigate these phenomena. This research was conducted to enrich the quality of life of nurse faculty, regardless of the setting in which nurse faculty practice. This study identified the positive attributes of the nurse faculty work place that contributed to CS, but also pointed out several negative stressors in this environment that might precipitate the two subcomponents of CF, BO, and secondary traumatic stress (STS). This research will equip nurse educators in academia with tools that raise their awareness of areas of compassion stress and then build levels of CS in order to ameliorate CF, and its subcomponents, BO and STS.

According to Stamm's (2010) Professional Quality of Life model (Figure 2), CF and CS can affect a caregiver's professional quality of life. Stamm (2010) conceptualized this perception based on the feelings experienced by the helping professional. Professional Quality of Life can be categorized into two related, but not mutually exclusive, elements: CS, the positive aspect, and CF, the negative element. These elements are associated with the cost of caring (Strommer, 2011). CF can be subdivided further into two distinct aspects, BO and STS. Professional quality of life is affected by a complexity of outside forces coming from the work, client, and personal environments (Figure 3) (Stamm, 2010), or that component of CF where people develop problems such as fear or insomnia following work-related secondary exposure to stressful events such as the suffering of others (Stamm, 2010). Figley (1995) described BO as a chronic syndrome characterized by frustration, anger, and depression leading to emotional exhaustion and a decreased sense of personal accomplishment. By contrast, STS includes the acute onset of fear from occupationally-related exposure to traumatic circumstances, either directly or being subjected to the trauma of those in harm's way.

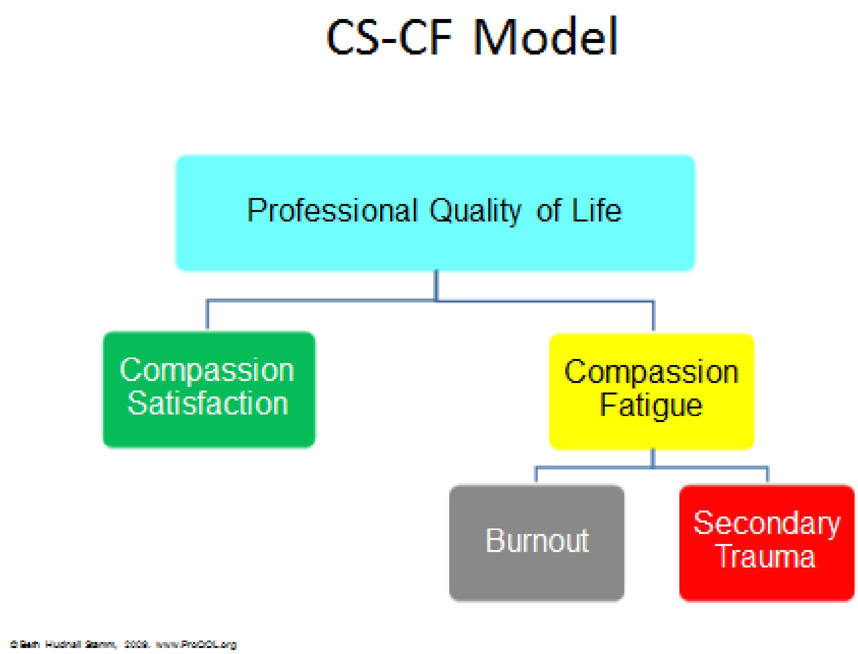

Figure 2. Compassion satisfaction-compassion fatigue model.

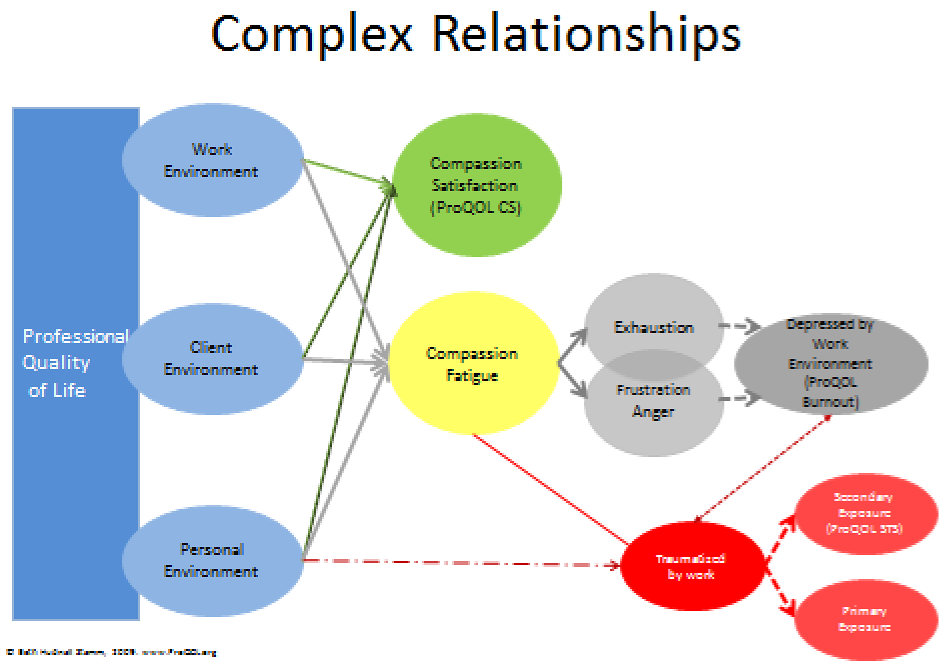

Figure 3. Complexities of professional quality of life.

To blunt the effects of CF, or its subcomponents, BO and STS, this study suggested instituting measures in the workplace which enhance one's ability to compassionately care for those in need without wounding the health care provider (Stamm, 2010). A healthy work environment may be achieved through unity within mind, body, and soul and, as such, is a harmony that can be achieved in nursing through stress alleviation (Schroeder & Neil, 1992). In support of this concept, Watson's (1988) theoretical framework, upon which this study was based, is a model of caring and compassion which can be implemented in the nurse educators' workplace settings to enhance the positive aspects of being productive "helpers" in the context of nursing academia.

Watson's (1988) theoretical model of caring describes ten carative factors essential for compassionate nursing practice: (a) Humanistic /altruistic value system, (b)

Faith and hope, (c) Sensitivity and empathy, (d) Helping-trusting relationships, (e) Promotion and acceptance of both positive and negative feelings in communication, (f) Scientific problem-solving, (g) Interpersonal teaching /learning, (h) Mental, physical, socio-cultural, spiritual support, protection, correction and safety, (i) Gratification of human needs, and (j) Allowances for existential-phenomenological forces that may affect the caring experience. Interruption of any of these carative factors may impair the caregivers' ability to model caring behaviors and affect outcomes for care receivers (Watson, 1988). Increased levels of CS can be achieved and the positive aspects of stress can be realized by focusing on caring and one's ability to work through negative stress.

The results of this study support the premise that not all nurse faculty experience CS, CF, or BO to the same degree but, rather, vary in their perceptions of these phenomena and their associated impacts on their professional quality of life. This study focused on nurse faculty and their perceptions of CS, CF, and BO in the context of various teaching settings in nursing education. By highlighting stressors which aggravated the negative feelings associated with CF and BO and focusing on strategies which enhanced levels of CS, this study's goal was to enhance the quality of life of nurse faculty by equipping them with strategies, identified by their peers in academia, to recognize negative stressors and overcome their detrimental effects. This study hypothesized that these experiences varied among nurses who practiced in the academic setting.

Nurses, who assume the role of educator, experience different levels of CS, CF, or BO regardless of their age, years of experience as an RN or nurse educator, the level at which they teach (undergraduate, masters, doctoral), their area of expertise, or the setting in which they teach their content (classroom, clinical lab, on-line). In support of this hypothesis, a summary and discussion of the study's quantitative and qualitative results, implications for future nursing education practice, and recommendations for future research will be presented.

Summary and Discussion of Results

This mixed-methods study explored differences in perceptions of CF, CS, and BO among a convenience sample of nursing faculty (N = 46) who taught in 11 nursing programs in the Pennsylvania State System of Higher Education (PASSHE) system at the baccalaureate, masters, and/or doctoral levels. Nursing faculty were invited to participate in a two-part electronic survey that assessed the extent to which they experienced either CS, CF, or BO. Quantitative data results were analyzed and summarized using SPSS-21(Howell, 2013) computer software. A series of crosstabs tables (Polit & Beck, 2014) were constructed describing descriptive statistics obtained from the study's survey questionnaires (Appendices C and D). Qualitative data were analyzed and summarized using NVivo10 computer software (QSR, 2012) to tie similar information together (Bloomberg & Volpe, 2012). A summary of the conclusions drawn from these analyses inform a discussion of the perceptions of CS, CF, and BO among these nurse faculty and are presented next in the context of the study's four research questions and hypothesis.

Quantitative Data

Research question 1 was answered by examining quantitative data using descriptive statistics to define the relationships between the variables of age, gender, years of experience as a nurse educator, academic background in nursing academia, and mean scores for CS, CF, BO. Research question 2 was answered by analyzing quantitative data from question 3 of the demographics survey (Appendix C) (At what levels have you taught during your career in Nursing Academia?) and question 4 from the same survey (In the last 12 months, at what levels have you taught in a Nursing education program?). Multiple regression analyses were conducted to predict CS, CF, BO by levels taught at during the nursing academic career and levels taught at in the last 12 months. Participants were also asked in question 7 of the demographic survey (Appendix C) to identify their area of nursing expertise. In an effort to determine whether one could predict nurse faculty levels of CS, CF, and BO by area of nursing expertise, multiple regression analyses were also performed. To provide additional insight into answering research question 2, the investigator also examined qualitative data obtained from open-ended questions of nurse educators' experiences of CF, CS, and BO using interpretative description (Thorne et al., 2004).

Research Question 1

To what extent do the variables of age, gender, years of teaching experience, and academic background in nursing academia shape the experiences of compassion fatigue? To answer this question, descriptive statistics were used to define the relationship between the variables of age, gender, years of experience as a nurse educator, academic background in nursing academia, and mean scores for CS, CF, BO from each of the three subscales (CS, BO, STS) of the study's survey instrument, the ProQOL 5 (Stamm, 2010). Of the 46 participants, respondents were primarily female (91.3%) and males were minimally represented with only one participant disclosing male gender. Three participants (6.5%) did not disclose their gender (Table 2). Since only one participant disclosed male gender, discussion concerning the contribution of male gender to the incidence of CS, CF, BO could not be equivocally entertained nor could conclusions be extrapolated from this data concerning cause and effect or the influence on gender bias. Therefore, the ensuing discussion will focus on the relationship between the variables of age, years of teaching experience, and academic background in nursing academia.

Those participants with ages ranging 26-35, 41-60, and 65+ demonstrated average levels (score of 23-41) of CS, but high levels (scores of 42 or more) of CS were noted in the age brackets of 36-40 and 61-65 years-old. When comparing the variable *Age* with scores for the levels of BO, study participants demonstrated average levels of BO for those ranging in ages 26-40; however, those listing ages ranging 41-65+ demonstrated low levels (scores of 22 or less) of BO. When comparing the variable *Age* with scores for the levels of STS/CF, participants demonstrated average levels of STS (scores of 23-41) for those ranging in ages 26-35, 46-55, and those of age 65+; however, those with ages ranging 36-45 and 56-65 demonstrated low levels (scores of 22 or less) of STS.

When comparing nurse educator Years of Experience with levels of CS, those with 26-30 years of experience scored the highest with an average score of 43.75 on the ProQOL 5 survey. BO and STS/CF was lowest in the 36+ years of experience category with scores of 13 and 17 respectively (Table 7).

A review of the literature, as described in Chapter 2 of this study, identified gaps in the literature because no studies have been done which examined CS from the perspective of nurse faculty. Stebnicki (2008) reminded helping professionals, including nurses, of the importance of preparing the body, mind, soul, and spirit to build resilience, especially when working with intense interpersonal dysfunction. Resilience may be supported by resourcefulness, the ability to be in touch with one's feelings, having vision and goals, and a strong desire to help others. Nurse faculty with advanced years of experience may have perfected coping techniques and improved their skills with problems-solving with both colleagues and students, built greater support systems and thus enhanced their resiliency. According to Teater (2011), social support may offer the best protection in such highly stressful environments. Social support, in this context, may be particularly beneficial to enhance feelings of compassion satisfaction with one's work where there are positive feelings about colleagues, the contribution towards the greater good of society, and the ability to help others through the work of caring (Stamm, 2010; Teater, 2009). The support modeled by age similar faculty peers among similar age groups in this study may have provided the backing necessary to assist nurse faculty with effective coping.

Although high levels of BO were not associated with any particular age group of nurse faculty in this study, low levels of BO were discovered among those ages 41 or more. This finding was contradicted in part by Ilhan, Durukan, Taner, Maral, and Bumin (2007) and Strommer (2011) who found high STS/CF scores among nurses age 50 or more and higher BO scores among younger nurses in this group. Ilhan et al. (2007) suggested that perhaps these high BO scores were indicative of the vulnerability of young nurses, especially those beginning their careers in a challenging environment where they are still a novice (Benner, 1984) at adapting to the real-time stressors of the modern workplace setting. Fong (1990) first identified BO as an issue in nursing education. In a study of 141 nurse educators from eight campuses in the California State University system, Fong (1990) concluded that attempts to alleviate BO must directly address the extent of work overload and the lack of administrative or collegial support. However, any attempt to ameliorate the overload-burnout relationship by merely amplifying the amount of support alone is not likely to be effective (Fong, 1990).

In this study, CS was highest among those participants who declared expertise in education ($p = 0.057$, $\beta = 0.306$) and lowest among those who declared expertise in psychiatric nursing with statistical significance where $p < 0.05$ ($p = 0.047$, $\beta = -0.298$). While there were no specific references in the literature to nurse educators and their quantifiable risks of CF, Teater (2011) noted CF is typically experienced by those directly exposed to others' suffering such as therapists, social workers, doctors (especially psychologists), nurses, emergency medical service (EMS) personnel, clergy, relief and humanitarian workers, journalists, insurance adjusters, and mortuary workers. Since psychologists were particularly vulnerable to STS/CF and BO (Figley, 2002) because of their exposure to people's suffering and low levels of CS, concern exists that psychiatric nurses might have similar experiences that place them at risk for STS/CF and BO.

BO was highest among participants in this study who identified their area of expertise as community health ($p = 0.078$) (β 0.279) and lowest among those citing expertise in education ($p = 0.310$, $\beta = -0.169$). STS/CF was highest in medical/surgical area of expertise ($p = 0.085$, $\beta = -0.264$) and lowest in oncology area of expertise ($p = 0.258$, $\beta = 0.177$). This study found that nurse faculty with declared expertise in psychiatric nursing was a significant predictor of low levels of CS ($p = 0.047$) where $p < 0.05$. This study hypothesized that nurses who assume the role of educator, experience different levels of CS, CF, and BO regardless of age, the level at which they teach, their area of expertise, years of teaching experience, or the teaching setting (classroom, clinical, online). The null hypothesis was, therefore, rejected noting that there were no statistically-significant differences found in the relationships between the levels of CS, CF, and BO neither among those who taught at the associate, baccalaureate, masters, or doctoral level over their entire career or within the last 12 months.

Research Question 2

To what extent does the level of compassion fatigue experienced by nurse educators in academia vary among groups as determined by type of nursing program taught in (baccalaureate, graduate)? From question 3 of the demographics survey (Appendix C) (At what levels have you taught during your career in nursing academia?) and question 4 from the same survey (In the last 12 months, at what levels have you taught in a nursing education program?), the following levels were recorded for CS, BO, and STS/CF as compared to academic levels taught in their careers (Table 9) and levels taught at in the last 12 months (Table 10). Table 9 notes that CS was highest among those who taught at the Associate Degree level but, overall, participants demonstrated average scores in these categories. For those who identified a career as a nurse educator at the doctoral level, overall scores were average in terms of levels of BO and STS/CF but doctoral nurse educators showed the highest levels of BO/STS/CF when compared to colleagues who taught at other levels. Several doctoral nurse educators, noting unique stressors at this level, agreed, “The level of preparation, time grading papers and reading dissertations presented much greater challenges and used up more time” than at other levels. Sarmiento et al. (2004) suggested in their research that nurse educators who assume multiple roles, teach at multiple levels, and have greater responsibilities by virtue of their rank and level of advanced degree preparedness, face increased risk of burnout and job dissatisfaction. To better define the extent to which nurse faculty experienced CS, CF, and BO in their workplace, participants were asked in open-ended questions in the study's demographic survey (Appendix C) leading questions which answered the study's research questions 3 and 4. It is from the perspective of these responses that the study obtained the qualitative data which describe the differences in perceptions nurse faculty experience in the context of nursing academia.

Summary

The researcher conducted quantitative analysis of the demographic data comparing averages of mean scores from the ProQOL 5 (Stamm, 2010) for all age groups, years as an RN, and years as a nurse educator to levels CS, BO, and STS. This comparison revealed these groups all demonstrated average levels of CS, but low levels of BO and STS. The researcher also looked at the mean scores from the ProQOL5 survey and found that nurse faculty citing education background of expertise had the lowest levels of CS, while psychiatric and oncology background expertise had the highest levels of CS, but the lowest levels of BO and STS. Using multiple regression analyses, this investigation discovered that psychiatric nursing background expertise was the only area of expertise that was a statistically-significant predictor of CS only. There were no backgrounds of expertise that were significant predictors of BO or STS. This finding is counter to the position in the literature which showed the psychiatric arena to be highest among at-risk helping professionals, by virtue of low levels of CS, for the increased incidence of CF, STS, and BO (Figley, 2002; Teater, 2011). This suggests a resilience experienced by nurse educators with psychiatric expertise unexperienced by the bedside psychiatric nurse. The clinical, on-line, or classroom settings seemed to provide insulation from direct exposure to the trauma of patients. Respondents to open-ended questions in the survey noted a certain insulation that students provide between the patient and the clinical instructor which blunted secondary exposure to patients' traumas. Furthermore, regardless of the levels (undergraduate, masters, doctoral) taught at (career) and levels taught at (during the last 12 months), these parameters were not significant predictors of CS, BO, or STS. No other variables in this study were found to be statistically-significant predictors of CF, BO or STS. This study also failed to detect high levels of BO or STS when considering participants' age, years of experience, and years of experience as a nurse educator in academia, or area of expertise. CS was highest among those who declared expertise in education ($P = 0.057$, $\beta = 0.306$) and highest among those who declared expertise in psychiatric nursing with statistical significance where $p < 0.05$ ($P = 0.047$, $\beta = -0.298$). Currently, this study is the first of its kind to assess the relationship between medical-surgical and community health nursing areas of expertise as a predictor of CS, CF. or BO. In this study, BO was highest among those who identified their area of expertise as community health ($P = 0.078$) (β 0.279) and lowest among those citing expertise in education ($P = 0.310$, $\beta = -0.169$). Although unsupported in the current body of literature, this variance might be explained by the direct exposure to patients' suffering experienced by instructors who go into patients' homes, either as an actively practicing nurse or while leading students during a clinical mental health rotation. STS/CF was highest in medical/surgical area of expertise ($P = 0.085$, $\beta = -0.264$) and lowest in oncology area of expertise ($P = 0.258$, $\beta = 0.177$).

Qualitative Data

To complete the answer to research question 2, the investigator also analyzed the textual content of written responses to open-ended question 9 of the demographics survey (Appendix C) where participants were asked to express the extent to which they felt that teaching at more than one level in nursing academia contributed to CS, CF, or BO. Research question 3 was answered exclusively by analyzing qualitative data obtained from a comparative analysis of textual content from responses to open-ended question 10 of the demographics portion of the survey (Appendix C) in which participants were asked, “Do you feel that nurse educators experience similar levels of CS or CF/BO in the clinical setting as compared to the classroom or on-line teaching settings?” Research question 4 was answered by analyzing qualitative data obtained from a comparative analysis of textual content from responses to open- ended question 8 in which nurse educators were asked to comment about stressors they felt were unique to nursing academia unexperienced by the bedside nurse.

Research Question 3

To what extent does the level of compassion fatigue, compassion satisfaction, and burnout experienced by nurse educators in academia vary among groups as determined by faculty teaching assignments (undergraduate, masters, doctoral) and method of course delivery (classroom, clinical lab, on-line)? This research question concerning the influence of the educational setting was analyzed solely from a qualitative analysis perspective probing data obtained from responses to open-ended questions about nurse educators' experiences of CF, CS, and BO. The researcher used NVivo 10 (QSR, 2012) qualitative analysis software package, applying interpretative description (Thorne et al., 2004) to define the following results. Several quotes are provided to amplify key themes.

Analysis of the qualitative data from this study also produced some surprising results supported in the literature. Although the literature was sparse concerning the experiences of CS, CF, and BO among nurse educators, there were many instances where similar feelings were expressed concerning the stressors and associated risks of increased BO and CF in professional nursing practice. According to Sarmiento et al. (2004), "The consequences of burnout have serious implications for nurse educators, students, educational institutions, and ultimately the profession" (p. 135). Sarmiento et al. (2004) suggested that nurse educators face considerable challenges in faculty shortages, declining enrollments, and increased class sizes, along with considerable funding shortages due to the financial constraints imposed on programs experiencing government cutbacks. The following sections underscore the impact that dissatisfying workplace factors (Sarmiento et al., 2004) can contribute to BO and negative stress in nurse educators.

Using NVivo10 (QSR, 2012) software, this chapter also described nurse faculty's perceptions of dissatisfying stressors unique to nursing academia unexperienced by the bedside nurse. This study also probed the extent to which teaching at more than one level contributed to CS, CF, and BO. Examining the similarity of nurse faculty's experiences concerning perceived levels of CS, CF, and BO in the comparative context of the clinical, classroom, and on-line teaching settings was also an important priority for its contribution to body of literature. By analyzing the textual content of thoughts recorded in response to open-ended questions, the researcher hoped to identify common ground and effective coping strategies utilized by nurse faculty to mitigate the impairments of CF and BO on teaching practice. Some shared themes which emerged during this process identified contractual obligations, faculty incivility, scholarship and service obligations, and student-related issues including incivility, as stressors unique to the environment of the nurse educator that contributed greatly to a dissatisfying and negative work environment. Fong (1990) identified these and other issues as compounding the issue of BO and job dissatisfaction for nurse educators. Several common stressors such as large class size, time constraints, heavy workload, and pressures to conduct scholarship along with teaching responsibilities also emerged as shared themes in responses to question 8 of the demographics survey (Appendix C). In this question, nurse educators were asked about their experiences concerning stressors unique to nursing academia unexperienced by the bedside nurse. Several references to role strain were repeated throughout participants' comments in these open-ended questions with the clinical setting producing a majority of these complaints.

Comments concerning the clinical teaching setting produced a majority of the negative comments citing the hospital clinical environment as an area of highest stress with the greatest propensity towards BO because of concerns for students' and patients' safety. According to Brown (1991), nurse educators frequently complained about time constraints and their effects on role strain. Brown (1991) also reported that nurse educators assume many roles as a teacher and counselor of students, serve on multiple committees, and engage in clinical practice on their own time to remain abreast of changes in technological advancement and best clinical practices. These themes were revealed in participants' answers, especially in the last open-ended question of the study's survey where participants were given another opportunity to reflect on the impact of CF on teaching practice in nursing higher education.

In this study, some nurse faculty expressed fear that their license to practice was constantly in jeopardy worrying that the novice nursing student might make a mistake and injure a patient. Still, for other instructors, the clinical setting was the most rewarding because they dealt with small numbers of students and could interact in groups, face-to-face for the entire semester, and, thus get to know one another very closely. However, there were other participants who saw no relationship at all among these variables to the environment in which they taught, but placed the onus on the instructor themselves stating, "Anyone who does their job in a professional and caring manner is at risk for compassion burnout." Since what is traumatic to one person may not be perceived the same way by another, "It is imperative that we consider the possibility that someone else might be traumatized, even if we are not" (Todaro-Franceschi, 2013, p. 77). Therefore, nurse faculty must take appropriate steps to minimize or even deflect the impact of the suffering or trauma of others on nurse faculty practice.

Research Question 4

What are the experiences of compassion fatigue among nurse educators in academia as determined by type of nursing program in which they teach (baccalaureate, masters, doctoral) and the environment in which they deliver their content (classroom, clinical lab, on-line)? To help answer this question, the researcher asked participants to respond to an open-ended question (8) in the demographics survey (Appendix C) and list the stressors they believed were unique to nursing academia unexperienced by the nurse at the bedside.

Most of the comments about stressors unique to the nurse educators' environment were related to meeting academic contractual obligations inherent in the job description. There were many respondents who expressed classic symptoms of burnout (Stamm, 2002, 2010) noting, "The job is never done" and "There is no such thing as punching out and leaving all your worries behind." Some faculty described many instances of taking work home with them on weekends, holidays, during parties, and other family festivities. Some often took time away from those activities to grade papers or prepare for the next lecture.

Recognizing the pressures to conduct research, publish, and perform other scholarly activities expected in academia, several professors expressed concern about an impaired ability to attend to personal continuing education and scholarship requirements which, if not met, can jeopardize promotion and advancement in the academic setting and prohibit the renewal of the nurse's license. The expectation that academics publish and disseminate research findings, information, and knowledge is increasingly becoming a component of nursing and academic practice (Wilson et al., 2013). One nurse educator cited this concern noting, "Working at the doctoral level, you put so much time into your doctoral students' research that your research gets neglected. This puts you at risk for not getting promoted." These commonly expressed concerns were echoed by Sarmiento et al. (2004) who contended that increasing access to empowerment structures of information, support, resources, and opportunities for college nurse educators may reduce the negative aspects of the workplace, such as BO and STS, and increase the positive aspects of a satisfying workplace, one that promotes CS. Enhancing nurse educators' quality of life has important implications for quality improvement and positive outcomes in nursing education practice.

Implications for Nursing Faculty

Gaining a better understanding of the extent to which nurse educators in academia are affected by conditions such as BO and CF is crucial to the development of positive and nurturing practice environments which enhance CS (Potter et al., 2010). Administrative and collegial support that values the connectedness among research, teaching, and promotion for tenure track nurse faculty is essential to avoid faculty role strain (Paskiewicz, 2003). In a study of 89 Canadian college nurse educators, Sarmiento et al. (2004) reported higher levels of nurse educator workplace empowerment associated with lower levels of BO and greater work satisfaction. This research suggests nurses may overcome CF and BO by recognizing its symptoms, becoming a proactive agent of change, practicing assertiveness, considering teaching assignment changes, interrupting incivility, forming focus groups, and engaging oneself in the life-long learning process of continuing education, especially in the art of self-care. Faculty mentoring programs strongly support this process. Thus, a study of those factors which create negative work environments and increase BO and CF is a timely endeavor and finding strategies which improve self-care and increase CS in the nursing academic setting is an urgent matter, if the nurse educators' quality of life is to be enhanced. This next section describes key strategies, identified in this study, for developing a resilience plan that focuses on methods of self-care which provide daily refreshment and stress relief critical to recovery from CF and BO (Teater, 2011).

Recognize Symptoms

Some key strategies that nurse faculty may use to overcome the detrimental effects of BO and prevent progression to CF include, but may not be limited to, knowing the symptoms, becoming a proactive change agent, practicing assertiveness, considering transfer, stopping bullying, forming focus groups, and continuing education to raise awareness of this blight on professional nursing. Dealing with these symptoms begins with adequate self-care and developing sound coping strategies that identify factors which contribute to role strain reduce CF and BO such as:

> Taking frequent breaks from your work, learning to say “no,” sharing the workload with others, finding humor in every situation, asking for help, giving credit to yourself and to others, where credit is due, and breathing deeply as often as possible. (Lanier, 2012, p. 7)

The results of this study suggest that a good place to start is raising awareness by educating nurse faculty to identify risk factors in their work environments that may negatively impact their abilities to surmount detrimental stress leading to BO. The critical element in preventing CF before it progresses to BO is to know the symptoms. According to Joinson (1992), “It is almost impossible to recognize symptoms of compassion stress/fatigue unless you are looking for them. Raising awareness is the key” (p. 119).

Become a Change Agent

Nurse educators must begin to take ownership of their career destinies and become proactive in revitalizing their careers should the need arise. This research study described important strategies for avoiding BO as a process of developing assertiveness, setting boundaries, changing negative thinking processes, avoiding negative communication, taking care of one's emotional and physical health, cultivating positive relationships with colleagues, and committing to become life-long learners and mentors (Espeland, 2006). Taking these important steps requires great courage and assertive problem solving capabilities.

Practice Assertiveness

Results of this study confirm that practicing assertiveness is essential and means refusing to be manipulated, abused, or bullied by others and not engaging in these behaviors with others (Espeland, 2006). To guard against BO, this research advocates the development of a culture of trust, open communication, and respect to promote a healthy workplace environment (Rager, 2005). For example, rather than complain about scheduling policies or low pay scales and counterproductive workplace policies, nurse educators might establish cost containment committees or form focus groups which opens dialogue and fosters collaboration to discuss and devise workable solutions.

Consider Teaching Assignment Changes

Nurse educators may consider transferring to another area or being open to teaching at a different level within the hospital or academic institution when they are experiencing symptoms of BO and reduced CS (Teater, 2010); however, leaving nursing academia altogether should not be a first option. There were several examples expressed in this study's open-ended questions about teaching at different levels where nurse faculty noted a rejuvenation that came from teaching novice undergraduate nurses and then following their progress through to graduation. Several nurse faculty expressed hope and an increased feeling of self-worth by seeing first hand their students' maturation and success as they progressed in their respective nursing courses. This study also demonstrated that it was essential for nurse faculty to experience CS from the rewards of their labor by witnessing student and faculty success within their work environment. When nurse educators feel that they are no longer contributing to students' development, they may experience a lack of personal accomplishment, develop emotional exhaustion, and sense of depersonalization where they feel indifferent about their students' learning and growth (Sarmiento, et al., 2004). These feelings are characteristic of those who are experiencing BO and steps such as mobility within an organization might mitigate the costly effects of inefficacy and decreased productivity as a result of the physical and psychological toll of BO (Maslach, 1993). Still, there were others in this study who found greater satisfaction teaching at the graduate level in the classroom or on-line. Despite identified challenges of time constraints associated with increased preparation time and grading assignments in these writing intensive courses, or experiences with the technological challenges of certain programming, many of these responding nurse faculty were buoyed by the flexibility and the credit-release associated with these types of graduate course schedules. Thus, time could be used more efficiently for scholarship or spending time with family. In any event, regardless of levels taught at, or the setting in which they teach their content, educators universally need hope to be productive and must be able to sense they are making a difference. Experiencing hope and a daily-renewed sense of personal worth in the workplace may enhance retention in nursing academia by thwarting BO (Bruce (2003).

Interrupt Incivility

There were numerous references in the qualitative data from this study to faculty-faculty and student-faculty bullying behaviors and their counter productivity where nursing faculty workplace health and satisfaction was critically important. Nurses must recognize the destructive force of verbal aggression and anger and avoid channeling anger onto colleagues or patients. This research and other studies confirm the perception that verbal abuse is a very real problem for the health care industry. “Nurses have become a significant source of verbal aggression, a position formerly held by doctors” (Rowe & Sherlock, 2005, p. 247). At the university level in nursing academia, Hoffman (2012) confirmed that student perceptions of nurse faculty incivility, such as bullying, had a detrimental impact on students. Nurse faculty might reduce the stress in the teaching environment by addressing bullying behaviors among students and between faculty and modeling civil behaviors which promote a positive teaching environment. Nurses must recognize the destructive force of verbal aggression and anger and avoid channeling anger onto colleagues or patients. Nurse educators are uniquely positioned to model to their students how to reduce role strain by being effective managers of time and resources and organizing their care accordingly. Students, likewise, are well-positioned to model civil conduct that reflects professional nursing practice. These behaviors include avoiding verbal and other detrimental behaviors they see demonstrated among themselves. Nurse educators can learn from one another about how to facilitate the development of moral courage in their students by emulating nurturing behaviors and modeling those strategies which resist compassion fatigue (Todaro-Franceschi, 2013). Perhaps a good forum for sharing this information is in the setting of a student advisory board where students have a voice and faculty may also open dialogue concerning the importance of civil behavior in professional nursing practice that should be demonstrated by both students and faculty throughout their academic careers.

Shared themes emerging from this study also included student and faculty incivility as a source of distress which resulted in increasing levels of CF and BO and a dissatisfying workplace. The perpetration of incivility by students upon nurse faculty arose as an increasing problem in participants' classrooms, clinical areas, and distance (on-line) education settings. In this study, nurse faculty confirmed shared examples in the literature of incivility, including rude or disruptive behaviors and their dissatisfying consequences, often resulted in psychological or physiological distress for the people involved, especially faculty who deal with these issues on a daily basis (Hoffman, 2012). Such venues as focus groups provide nurse educators with opportunities to open and to continue dialogue concerning the harmful physiological and psychological burdens that workplace stress places upon all members of the academic community.

Form Focus Groups

Development of interdepartmental or university-wide forums, committees, or other reflective practice seminars empower nurse educators by encouraging collaborative involvement in the university-wide decision making process. This formation of groups fosters partnerships by channeling energy into open dialogue about constructive projects which enhance morale and promote positive outcomes in nursing academia (Rowe & Sherlock, 2005).

Continuing Education

As life-long learners, nurse educators must give more urgent priority to self-assessment of risk factors which impair learning and diminish professional quality of life that contributes to an escalation in CF and career BO. Nurse faculty in this study identified a shortage of time and financial support for continuing education opportunities that include self-improvement, self-reflection, and support for licensure renewal or certification maintenance. This study confirmed the concerns of many nurse educators who cited time constraints associated with heavy workload to attend conferences where they could present research or simply sit among their peers and learn about best practices, effective teaching strategies and new approaches for dealing with issues such as incivility in the various teaching settings. Study participants acknowledged the difficult financial state of higher education associated with mandated government cutbacks and rising costs which diminish available funds for professional development. However, nurse faculty in this study contended that allotting time for scholarship and activities which promoted teaching excellence was a priority. Insufficient time for scholarship jeopardized career advancement, promotion, and tenure. Continuing education provides a cornerstone for enhancing professional quality of life because it supports physical and mental health, creates a sense of belonging, and builds a supportive environment, while at the same time allowing for personal refreshment associated with conference recreation and leisure time (Gregory et al., 2009; Nussbaum & Sen, 1993).

Identifying signs and symptoms of career BO among nurse educators and intensifying efforts to educate peers in the identification of strategies that change the destructive thought processes of compassion fatigue should be at the forefront of staff development education. Opportunities exist for the renewal of dialogue about the issue of incivility in nursing academia. Open forums which headline discussions about issues in nursing academia raise awareness of these issues and offer nurse educators numerous opportunities to self-improve and root out dissatisfying factors that contribute to stress and subsequent BO in nurse educators' workplace (Sarmiento et al., 2004). Attending conferences about these topics or leading in-house staff development discussions about these issues allows for opportunities to problem solve out loud lending support to better outcomes in nursing education. Many opportunities arise during these conferences for praise and recognition of colleagues and the sharing of accomplishments and research. These elements are essential in all areas of nursing and may be another effective way to build teams and to inoculate against BO (Espeland, 2006).

Little is known about the occurrence of CS, CF, and BO in academia; however, this research draws inferences from what is known about these phenomena in nurses who practice outside academia and uses these discoveries to raise awareness and promote efforts that might enhance the quality of life of nurse faculty. Age of faculty and years of experience were among those predictive factors influencing the incidence of CS and the subcomponents of CF, STS, and BO in nursing academia.

Age was a predictive factor for high STS/CF scores in other studies (Dominguez-Gomez & Rutledge, 2009); however, it was not found to be a contribution in this research. This research noted a relationship between years of experience and readiness to deal with workplace stress, suggesting senior faculty could aid junior faculty in using effective coping techniques to successfully manage workplace stress. Education of junior faculty by senior faculty reduced BO and enhanced CS and was a strategy suggested by several participants as a means of enhancing the quality of life of new nurse faculty. New faculty would be an important audience to target for educational support (Ilhan et al., 2007) because younger, less experienced nurses demonstrated an increased propensity toward premature BO. Young, inexperienced nurses face an initial shock when confronted with the realities of career they have chosen. This discomfort often leads to experiences of feelings of incompetency and uncertainty in their work. These less experienced nurses may go through a difficult time adapting to their new job due to lack of skill and early feelings of great expectations may quickly deteriorate into feelings of poor self-worth (Ilhan et al., 2008). These feelings were echoed by those nurses just beginning their careers in this survey suggesting they looked up to senior faculty for guidance and support such as that found in mentoring relationships.

Faculty Mentoring Programs

Mentoring eases the transition of novice nursing faculty from practice into academe by decreasing the degree of role ambiguity and role conflict that they experience (Spect, 2013). Hence, this research strongly recommends the assignment of a faculty mentor to support newer, more inexperienced nurse faculty as a way to ease the stress of transition from novice to expert (Benner, 1984) and reduce attrition as a result of CF and BO while enhancing CS. One participant observed that the impetus that drives attrition stems from institutional forces and not so much from student-teacher interaction stating, "The forces that impact faculty to quit/move/relocate are more in line with political/social structures than student/teacher interaction." Nurse educators may also acquire formal empowerment from political and social alliances with sponsors such as mentors, coaches, and faculty of higher rank within the organization that sponsor junior faculty's mobility by providing approval, prestige or other support for advancement (Sarmiento et al., 2004). Thus, the availability of a faculty mentoring can significantly influence new faculty member's decision to stay by reducing the frustration and hopelessness sometimes experienced during the process of navigation through the organization's requirements for tenure and promotion. Since many of this study's participants cited time constraints as barriers to engaging in reflective practice, scholarship and service, faculty mentors might target areas which emphasize time management and engagement in collaborative learning groups. These collaborative learning groups, with the encouragement of the faculty mentor or coach, support the engagement in reflective practice promoting mutual success in the advancement of career development and thus might blunt the impact of CF among novice nursing faculty (Sarmiento, et al., 2004).

Current literature is unclear regarding the levels of CF, CS, and BO that accompany nurses from the bedside into academia. This study does not assume that nurses bring a predetermined level of CF, CS, or BO to academia. However, as is true of all at-risk helping professionals, all nurses are at -risk by virtue of the very nature of their caregiving obligations. All nurses, where caring and compassion are essential constructs to effective nursing practice (Watson, 1988), have an obligation of advocacy to raise awareness of this plight among their peers and within all environments of professional nursing practice. Therefore, educating nurse faculty about risks and protective factors, as well as providing resources that enhance protection, might help reduce levels of compassion fatigue and burnout (Sprang et al., 2007). Adopting such team building strategies also has implications which are not just isolated to faculty but also has far reaching implications for the nursing students with whom they interact. These findings identify opportunities for change and growth, and collaboration to enhance communication, thereby reducing workplace distress. However, the generalizability of these study findings may be restricted by a number of methodological limitations.

Limitations

This study had several limitations that included reluctance to participate, timing of sampling, longevity in the profession, response bias, small sample size, untested open-ended questions or survey among participants, and limited inclusion criteria.

The first limitation to this study is an anticipated reluctance to participate. Hesitancy to participate may have occurred out of fear that perceived CF would infer the nurse educator was weak, ineffective, or had lost the capacity to care, a central construct in professional nursing practice. For this reason, they might have been reluctant participants and their questionnaire (Appendices C & D) answers might have been skewed or untruthful in answering experiential, open-ended survey questions. Since Stamm (2010) noted that the ProQOL5 should be used for screening purposes only and not for diagnosis, participants who score high in CF, STS, or BO may not fully pursue treatment or take seriously the implications of one screening tool.

Timing of the administration of surveys might have precluded an enhanced degree of stress associated with the month of April where students and faculty were experiencing the rush to complete final projects and papers coupled with final exams looming in the very near future. Nurse educators might experience more stress during different parts of the academic year, and thus may have reported more symptoms of CF or BO resulting in a reporting change within the questionnaire.

Factors such as longevity in the profession, the breadth of experiences, support systems, previous experience with trauma, and resiliency might also vary among participants affecting the manner in which they deal with CF (Teater, 2011), effectively altering the reporting level of experienced CS, CF, and BO.

Response bias poses another concern when self-report instruments are used (Sarmiento, 2004). Although participants were assured anonymity, findings were based on self-reported data, which could have been altered to appear favorable in the eyes of the researcher, imposing another limitation on the validity and reliability of the results (Polit & Beck, 2014). Due to small sample size (N = 46), the findings of this study of nurse educators in academia in Pennsylvania PASSHE schools may not be generalizable to the population of nurse faculty in the United States. Additional studies should be conducted which incorporate a larger sample size encompassing a more comprehensive nurse faculty population. A revision to sampling methodology might also include changing the process to acquire a more inclusive recruitment of nurse educators. Adjusting sampling procedure to include all types of nursing programs including licensed practical nurse (LPN), RN diploma, and RN associate degree programs not included in this study.

Recommendations for Future Research

This study calls for additional research to explore CS, CF, and BO among all levels of nursing education. Future surveys should be extended to two-year, diploma, or associate degree RN programs. Studies should be replicated with a larger population of nurse faculty which also encompasses those who teach in LPN programs to understand their levels of stress and how they cope effectively or ineffectively and associated impacts on resiliency and career longevity. Information from this study may be used to further research strategies that explore a larger sample size for CF and BO and increased levels of CS, improving the professional quality of life for the novice or the veteran nurse faculty. Additional research is also called for in exploring faculty to faculty incivility (Hoffman, 2012) and associated impacts on program outcomes and workplace productivity. Greater efforts should also be made by nurse faculty to study strategies which enhance workplace empowerment, regardless of rank. Sarmiento et al. (2004) suggested that this strategy may produce nurse educators who are more satisfied with their jobs promoting their ability to engage themselves in their work and model CS, with greater joy and a sense of accomplishment, throughout their academic careers. Consequently, student learning will be enhanced and the nursing profession is more likely to gain highly-qualified graduates who ensure that patients receive a high quality of care. This research suggests that a replication of longitudinal study which includes larger populations, considers nurse faculty in other parts of the United States, and includes other helping professionals such as clergy, paramedics, fire-fighters, social workers, child care caseworkers, doctors, counselors and students in these professions as they work toward their degree or coursework and certification completion. It would also be useful to longitudinally survey bedside nurses' perceptions and follow their levels of CS, CF, and BO when they cross over into academia, become a nurse practitioner or nurse anesthetist, or teach in their area of expertise.

Conclusions

This mixed-method study sought to add to the body of research concerning nurse faculty's perceptions of CS and the CF syndromes of BO and STS, by investigating the extent to which these nurse faculty experienced the positive facets of their workplace, (CS), which enhanced professional quality of life, or those negative stressors contributing to the compassion fatigue (CF) syndromes of BO and STS. The purpose of this study was to gain a better understanding of the extent to which the professional quality of life of nurse faculty is affected by conditions such as CF's components BO and STS. Promoting a healthy professional quality of life is crucial to the development of positive and nurturing practice environments which enhance CS among nurse faculty and promotes student learning, producing graduates who are more likely to ensure that patients receive the high quality of care they deserve. The researcher explored nurse faculty's perceptions of CS and CF across levels taught (undergraduate, masters, doctoral), in the contexts of the classroom, clinical, and on-line teaching settings. This investigation specifically studied a convenience sample of 46 nurse faculty in 11 universities of the PSSHE. During this study, the researcher utilized demographic surveys (Appendix C) and the ProQOL 5 (Stamm, 2010) (Appendix D) questionnaire to gather data which examined the relationships between nurse faculty's gender, age, years as a RN, years of experience as a nurse educator, and background of expertise; and levels of CS, and CF's two subcomponents, BO and STS. An analysis of the study results revealed that there are many nursing faculty who maintain high levels of career CS, especially those in psychiatric and oncology nursing education, regardless of their age, years of practice as an RN, years of experience as a nurse educator, levels taught, area of expertise, or educational setting while others indicated a propensity to burn out prematurely and deteriorate to develop fear associated with emotional exhaustion or a more severe form of CF, STS.

The researcher conducted quantitative analysis of the demographic data comparing averages of mean scores from the ProQOL 5 (Stamm, 2010) for all age groups, years as an RN, and years as a nurse educator to levels CS, BO, and STS. This comparison revealed these groups all demonstrated average levels of CS, but low levels of BO and STS. The researcher also looked at the mean scores from the ProQOL5 survey and found that nurse faculty citing educational background of expertise had the lowest levels of CS, while psychiatric and oncology background expertise had the highest levels of CS, but the lowest levels of BO and STS. Using multiple regression analyses, this investigation discovered that psychiatric nursing background expertise was the only area of expertise that was a statistically significant predictor of CS only. There were no backgrounds of expertise that were significant predictors of BO or STS. Furthermore, regardless of the levels (undergraduate, masters, doctoral) taught at (career) and levels taught at (during the last 12 months), these parameters were not significant predictors of CS, BO, or STS. This finding is counter to the position in the literature which showed the psychiatric arena to be highest among at-risk helping professionals, by virtue of low levels of CS, for the increased incidence of CF, STS, and BO (Figley, 2002; Teater, 2011). This suggests a resilience experienced by nurse educators with psychiatric expertise unexperienced by the bedside psychiatric nurse. The clinical, on-line, or classroom settings seemed to provide insulation from direct exposure to the trauma of patients. Respondents to open-ended questions in the survey noted a certain insulation that students provide between the patient and the clinical instructor which blunted secondary exposure to patients' traumas. Furthermore, regardless of the levels (undergraduate, master's, doctoral) taught at (career) and levels taught at (during the last 12 months), these parameters were not significant predictors of CS, BO, or STS.

This study supports contentions in the theoretical model of Professional Quality of Life (Stamm, 2010) and Watson's (1988) theoretical model of caring which amplify the importance of reducing dissatisfying behaviors in the workplace which negatively impact the work, client, and personal environments and promoting positive feelings of well-being that lead to greater compassionate care and CS. This research suggested that the process begins first with nurse faculty recognizing symptoms of CF and BO within themselves. Then, nurse faculty should become an agent of change, practice assertiveness, considering transfer or change of teaching assignment, interrupt bullying and other uncivil behaviors, organize forums such as focus groups to discuss and plan strategies of change, engage in continuing education, and acknowledge that nurse educators are life-long learners. Implications for students are important and far reaching when enhancing outcomes which lead to the mitigation of CF and BO for those students who model nurse faculty's behaviors of civility and mutual respect. Reflecting CS and moving away from the negative behaviors which characterize a dysfunctional work environment are supportive behaviors which build a positive and caring environment in the context of nursing academia. Nurse faculty have multiple opportunities to model positive behaviors that reflect a caring and compassionate attitude which is critical for positive patient outcomes for every patient with whom the student comes in contact. Further research is needed which explores these differences of perceptions of CS, CF, and BO among all types of nurse faculty and across all nursing program types. In an ever-changing global academic environment characterized by increasing faculty and resource shortages and increased technological complexity, research that provides a better understanding of these differences in perceptions may lead to a better professional quality of life. This study suggested that adjustments in approach are imperative to enhance the professional quality of life among nurse faculty. Such a collaborative plan begins with the self-reflective nurse faculty arming themselves with an arsenal of supportive and empowering strategies, and then modeling these behaviors to enhance positive outcomes for nurse faculty and the students they teach every day.

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Appendices

Appendix A

E-Mail List of Contact Information for 11 PASSHE University Nursing Programs

PASSHE Institution	**Nursing Department Chair/ Asst. Chair**	**e-mail addresses**
East Stroudsburg	Laura Waters Ph.D., RN	lwaters@esu.edu
California	Debra Shelapinsky MS, RN	shelapinsky@calu.edu
Clarion	Angela West MS, RN	awest@clarion.edu
Bloomsburg	Michelle Ficca Ph.D., RN	mficca@bloomu.edu
Edinboro	Thomas White, D.Ed., CRNP, CEN	twhite@edinboro.edu
IUP	Elizabeth A. Palmer Ph.D., RN, CNE Riah Hoffman Ph.D., RN,CSN Assistant Chair	lpalmer@iup.edu r.l.skavang@iup.edu
Lock Haven	Kimberly Owens, MS, RN	kowens@lhup.edu
Mansfield	Janeen Sheehe, Ph.D., RN, CNE	jsheehe@mansfield.edu
Millersville	Barbara J. Zimmerman, PhD, CNS, RN, FNASN	Barbara.Zimmerman@millersville.edu
Slippery Rock	Dr. Diana Jones	diana.jones@sru.edu
West Chester	Charlotte Mackey, Ed. D, RN	cmackey@wcupa.edu

Appendix B

E-Mail Consent/Cover Letter

Indiana University of Pennsylvania

Department of Professional Studies in Education
Davis Hall, Room 303
570 S. Eleventh Street
Indiana, Pennsylvania 15705-1087

724-357-2400
Internet: *http://www.iup.edu*

Email Consent/Cover Letter

Greetings! My name is Earl Gardner and I am presently a doctoral student in the Curriculum & Instruction program at Indiana University of Pennsylvania. I have been a Registered Nurse with current expertise in Critical Care for more than 26 years having dedicated these last six years of my career to full time nursing education in a baccalaureate nursing program. Because you have recently served as a nurse educator in a baccalaureate, master's or doctoral program, you are cordially invited to participate in this research study exploring the impact of compassion satisfaction, compassion fatigue, and burnout on teaching practice in nursing academia. Your opinion is essential to the successful collection of meaningful data and your participation is sincerely appreciated. The following information is provided to assist you in making an informed decision whether or not to participate in this study.

You and the nurse educator colleagues in your department are cordially invited to participate in a two- part electronic survey that assesses the extent to which nurse educators in 11 university nursing programs in the Pennsylvania State System of Higher Education (PASSHE) experience compassion satisfaction, compassion fatigue, and burnout in the practice environments of both the classroom and the clinical settings. First, participants are invited to complete a demographics survey which includes four open-ended questions concerning the experiences and challenges facing today's nurse educators in the teaching environments of the classroom and the clinical setting. Next, participants are invited to complete the ProQOL 5 [Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5] (Stamm, 2010) survey. The ProQOL 5 is a 30- item scale used for measuring compassion fatigue, compassion satisfaction, and burnout and is a tool used for screening purposes only and not for diagnosis. Completion of the ProQOL 5 involves selecting responses 0 (never) – 5 (very often) on a Likert Scale. The Self-Score version of this survey is provided for you to assist you with calculating and interpreting your score. Completion of these two surveys may require approximately twenty minutes of your time depending on the extent to which you wish to comment in the open-ended questions portion of the first survey. Thank you for offering your valuable time to advance research in nursing education which may promote the health of our workplace environment.

Your participation in this study is voluntary. To maintain privacy/confidentiality, copies of all original data forms from *Qualtrics* surveys will be kept in a locked file in the investigator's office or stored in the investigator's password protected computer file and will be viewed only by the researcher and persons assisting the researcher in the data collection and analysis process. All responses to the surveys will be anonymous. You are free to decide not to participate in this study by simply not submitting your results. For your convenience, a self-scoring version of the ProQOL 5 is provided to you so you may assess your own levels of Compassion Fatigue, Compassion Satisfaction, and Burnout. Your responses will be considered only in combination with those from other participants. The information obtained in the study may be published in academic journals or presented at academic conferences, but your identity will be kept strictly confidential.

If you are willing to participate in this study, please signify by clicking on the link https://s.qualtrics.com/SE/?SID=SV_cSDnCNOsfELzu4t&Preview=Survey&BrandID=qtrial contained in this email. Your willingness to participate in this study is confirmed by your completion of the electronic survey administered and submission via email through *Qualtrics*. Please print and keep a copy of this email for your own records. Thank you so much for forwarding this to the nurse educator colleagues in your department.

Your expert opinions and wealth of experiences are deeply respected and will significantly contribute to the greater body of knowledge in this endeavor to understand compassion satisfaction, compassion fatigue and burnout within the context of nursing education.

Your valuable time and consideration are deeply appreciated.

Principal Investigator:

Earl K. Gardner MSN, RN
(e.k.gardner@iup.edu)
228 Johnson Hall
Indiana University of Pennsylvania
Indiana, PA 15705
Phone: 724-357- 3268

Faculty Sponsor:

Dr. Kelli Paquette
(kpaquett@iup.edu)
329 Davis Hall
Indiana University of Pennsylvania
Indiana, PA 15705
Phone: 724-357-2400

This project has been approved by the Indiana University of Pennsylvania Institutional Review Board for the Protection of Human Subjects (Phone: 724/357-7730).

Appendix C

Demographic and Qualitative Survey Questions

Compassion Fatigue in Nursing Academia: Exploring the Impact of Compassion Fatigue on Teaching Practice in Higher Education

1) How many years have you been an RN?

a) 0 –5

b) 6-10

c) 11-15

d) 16-20

e) 21-25

f) 26-30

g)31-35

h) 36 or more

2) How many years have you been a nurse educator in academia?

a) 0 –5

b) 6-10

c) 11-15

d) 16-20

e) 21-25

f) 26-30

g)31-35

h) 36 or more

3) What levels have you taught at during your career in Nursing Academia? Select all that apply.

a) Associate Degree Program

b) Baccalaureate

c) Masters

d) Doctoral

4) In the last 12 months, at what levels have you taught at in a Nursing education program? Select all that apply.

a) Associate Degree Program

b) Baccalaureate

c) Masters

d) Doctoral

5)What is your gender?

a)Male

b) Female

6) What is your age?

a) 20-25

b) 26-30

c) 31-35

d) 36- 40

e) 41- 45

f) 46-50

g) 51-55

h) 56- 60

i) 61-65

j) 66 or older

7) What is your area(s) of nursing expertise? Select all that apply.

a) Education

b) Pediatrics

c) Critical Care

d) Medical-Surgical

e) Community Health

f) Obstetrics

g) Psychiatric/Mental Health

h) Anesthesia

i) Oncology

j) Informatics

8) In the space below, please list the stressors you believe are unique to nursing academia that may not be experienced by the nurse at the bedside.

9) To what extent do you feel that teaching at more than one level in nursing academia contributes to Compassion Satisfaction or Compassion Fatigue/ Burnout?

10) Do you feel that nurse educators experience similar levels of Compassion Satisfaction or Compassion Fatigue /Burnout in the clinical setting as compared to the classroom or in on-line education programs?

11) Please include below any additional comments you would like to make concerning the Impact of Compassion Fatigue on Teaching Practice in Nursing Higher Education.

Appendix D

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

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

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

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

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

Compassion Satisfaction Scale

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

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

Total: _____

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

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

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

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

Total: _____

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

Secondary Traumatic Stress Scale

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

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

Total: _____

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

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

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

Compassion Satisfaction _____________

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

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

Burnout_____________

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

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

Secondary Traumatic Stress_____________

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

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

Appendix E

Permission for Use of the ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.proqol.org

Accompanied by the email to you, this document grants you permission to use for your study or project

> ***The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue) www.ProQOL.org***

Prior to beginning your project and at the time of any publications, please verify that you are using the latest version by checking the website. All revisions are posted there. If you began project with an earlier version, please reference both to avoid confusion for readers of your work.

This permission covers non-profit, non-commercial uses and includes permission to reformat the questions into a version that is appropriate for your use. This may include computerizing the measure.

Please print the following reference or credit line in all documents that include results gathered from the use of the ProQOL.

Stamm, B. H. (2010). The ProQOL (*Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue*). Pocatello, ID: ProQOL.org. retrieved [date] www.proqol.org

Permission granted by
Beth Hudnall Stamm, PhD
Author, ProQOL
ProQOL.org
info@proqol.org

Help us help all of us. Please consider donating a copy of your raw data to the data bank. You can find more about the data bank and how you can donate at www.proqol.org and www.proqol.org/Donate_Data.html. Data donated to the ProQOL Data Bank allow us to advance the theory of compassion satisfaction and compassion fatigue and to improve and norm the measure itself.

Appendix F

Institutional Review Board at Indiana University of Pennsylvania Approval

Indiana University of Pennsylvania
www.iup.edu

Institutional Review Board for the
Protection of Human Subjects
School of Graduate Studies and Research
Stright Hall, Room 113
210 South Tenth Street
Indiana, Pennsylvania 15705-1048

P 724-357-7730
F 724-357-2715
irb-research@iup.edu
www.iup.edu/irb

February 21, 2014

Earl Gardner III
613 College Rd.
Indiana, PA 15701

Dear Mr. Gardner:

Your proposed research project, "Compassion Fatigue in Nursing Academia: Exploring the Impact of Compassion Fatigue, Compassion Satisfaction, and Burnout on Teaching Practice," (Log No. 14-084) has been reviewed by the IRB and is approved. In accordance with 45CFR46.101 and IUP Policy, your project is exempt from continuing review.

<u>You should read all of this letter, as it contains important information about conducting your study.</u>

Now that your project has been approved by the IRB, there are elements of the Federal Regulations to which you must attend. IUP adheres to these regulations strictly:

1. You must conduct your study <u>exactly as it was approved</u> by the IRB.
2. <u>Any additions or changes</u> in procedures <u>must</u> be approved by the IRB <u>before</u> they are implemented.
3. You must notify the IRB promptly of <u>any</u> events that affect the safety or well-being of subjects.
4. You must notify the IRB promptly of any modifications of your study or other responses that are necessitated by any events reported in items 2 or 3.

The IRB may review or audit your project at random or for cause. In accordance with IUP Policy and Federal Regulation (45CFR46.113), the Board may suspend or terminate your project if your project has not been conducted as approved or if other difficulties are detected

Although your human subjects review process is complete, the School of Graduate Studies and Research requires submission and approval of a Research Topic Approval Form (RTAF) before you can begin your research. If you have not yet submitted your RTAF, the form can be found at http://www.iup.edu/page.aspx?id=91683 .

I wish you success as you pursue this important endeavor.

Sincerely,

John A. Mills, Ph.D., ABPP
Chairperson, Institutional Review Board for the Protection of Human Subjects
Professor of Psychology

JAM:js

cc: Dr. Kelli Reefer Paquette, Dissertation Advisor
Ms. Brenda Boal, Secretary