12-11-2013

Compassion fatigue In nurse faculty

Patricia Price

Compassion Fatigue In Nurse Faculty

by

Patricia M. Price

A Dissertation
Submitted to the
Department of Educational Leadership
College of Education
In partial fulfillment of the requirement
For the degree of
Doctor of Education
at
Rowan University
December 4, 2013

Dissertation Chair: Burton R. Sisco Ed.D.

Dedication

I would like to dedicate this dissertation to my husband of thirty-six years, Paul F. Price Sr. Without his continued support and dedication I would not have been able to accomplish this endeavor.
Thank you for being the man of my dreams.

I would also like to extend my gratitude and appreciation to my friend, Rachel for her guidance, understanding, and always being there when I needed support.

Acknowledgments

I would like to extend my sincere gratitude and appreciation to Dr. Burton R. Sisco for his unfaltering commitment to me as my mentor. Dr. Sisco, with his precise and intricate attention to detail, has transformed me into a researcher. I would like to make this analogy to pay tribute to an expert clocks man. Dr. Sisco observed the value of my quest to become a Doctor of Educational Leadership. Similar to an antique clock that needs careful attention to its intricate workings; Dr. Sisco stressed the importance of my research and nurtured me as his student to create a research study that attempted to identify a gap in the field of professional nursing. He guided my research, reviewed my work and disassembled the intricacies of the manuscript repairing it as if it were a treasured old clock. In the same manner he would disassemble, repair, oil and reassemble the clock so it was truly a working antique that was able to keep time, he paid that meticulous attention to my research. Just as he would adjust and repair an antique clock, he has led me in this dissertation which too has undergone revisions and adjustments to meet the high expectations of research he set. Dr. Sisco, thank you for your dedication and commitment to me as a student in the Educational Leadership Program at Rowan University.

In addition I would like to thank my committee members Dr. James Coaxum III and Dr. Jacqueline Galbaiti for their continued support, encouragement and time that they have provided to me. It has been a pleasure working with professionals who are extremely dedicated to the education of doctoral students

Abstract

Patricia M. Price
COMPASSION FATIGUE IN NURSE FACULTY
2013/2014
Burton R. Sisco, Ed.D.
Doctor of Education

There is a paucity of extant research on compassion fatigue in nurse faculty. The literature contextualized the existence of compassion fatigue in nurses practicing in the clinical area as well as those in service professions. This explanatory mixed methods study examines the risk of compassion fatigue among full time nurse faculty teaching in three four-year baccalaureate generic nursing programs. The relationship between compassion fatigue and nurse faculty's attitudes of stress in their work environment was further explored with the *Margin In Life* instrument to determine if there was a relationship between compassion fatigue and an individual's power, load and margin.

The research consisted of two phases. The first phase involved the distribution of research packets containing the *Professional Quality Of Life* instrument, *Margin-In-Life* instruments, and open ended questions. The second phase of the study consisted of one-on-one interviews. Results indicate nurse faculty are generally satisfied with their chosen profession; however, compassion fatigue was identified in 20% of the subjects. Leadership and the work related perceptions of faculty had an impact on job satisfaction. This study provides empirical evidence that compassion fatigue does exist in this sample. Further research on a larger scale is required for generalizability of the findings.

Table of Contents

Table of Contents (Continued)

Table of Contents (Continued)

Table of Contents (Continued)

Table of Contents (Continued)

List of Figures

List of Tables

List of Tables (Continued)

Chapter I

Introduction

Nursing is a helping profession. Nurses treat and care for the sick, the injured, the dying, and their families. The physical and emotional demands resulting from the rigors of the nursing profession are further intensified by the phenomena of high patient acuity, the aging nursing population, and the shortage of qualified nurses (Harrison, 2004; Peterson, 2009). According to the Institute of Medicine's (IOM) landmark report: *The Future of Nursing: Leading Change, Advancing Health* (2010), the average age of nurses has increased from 38 in 1988, to 46 in 2010. Each year this statistic is climbing, with the average age of nurses approaching retirement. The nursing shortage and the need to prepare new nurses will continue far into the future. In order to place more nurses into the workforce, there needs to be sufficient nursing faculty to educate nursing students. While there are various types and levels of nursing programs such as the diploma program, associate degree program, and the baccalaureate level program, the American Nurses Association (ANA) issued a position statement stating that the entry level for the nursing profession should be at the baccalaureate level (Cherry & Jacobs, 2012; Huber, 2010; Taylor, 2008; Yoder-Wise, 2011).

As early as 1964, the American Nurses Association (ANA) supported the baccalaureate degree for entry into nursing practice, more recently stating that baccalaureate nursing education is necessary to prepare the nursing work force for the challenges of a complex and changing health care system (2000). The IOM recommends

increasing the number of baccalaureate prepared nurses to 80% of all nurses to meet the evolving needs of patients and the health care system (2010). Additionally, increasing the number of nurses, especially those with baccalaureate degrees, improve patient outcomes (American Association of Colleges of Nursing [AACN], 2011). In 2008, the number of registered nurses with bachelor's degrees as their highest level of education was only 36.8% (AACN, 2011). In *The future of Nursing: Leading Change, Advancing Health*, at the time of the publication in 2010, the IOM listed the number of baccalaureate prepared nurses as 50%. The nursing profession has a long way to go to meet the IOM recommendations. An adequate number of nurse faculty are required in order to educate new baccalaureate prepared nurses. Nursing students pursuing a baccalaureate degree graduate with a Bachelor's Degree in Nursing Science (BSN). In 2011, over 75,000 qualified applicants were not admitted to BSN and graduate nursing programs due to insufficient faculty, clinical sites, clinical preceptors, and budget constraints (AACN, 2012a; Dattilo, Brewer, & Street, 2009).

According to the AACN's *Faculty Vacancy Survey*, almost two-thirds of nursing schools pointed to faculty shortages as a reason for not accepting all qualified applicants into their programs (AACN, 2012a). A total of 1,181 baccalaureate and or graduate faculty vacancies were identified and an additional 103 faculty positions were needed to accommodate student demand (AACN, 2012b). The data show a national nurse faculty vacancy rate of 7.6 with the highest rate of vacancy among faculty with primary teaching responsibilities in baccalaureate nursing programs (AACN, 2012b). One of the most critical issues faced by nursing programs related to faculty recruitment included high faculty workload (AACN, 2012b).

It is apparent that a nursing shortage exists; however according to Dattilo et al. (2009), the real shortage is the number of faculty available to educate nursing students. Nurse faculty are charged with the education, training, and supervision of nursing students in the classroom and in the clinical setting. Nurse faculty interface with patients, students, other health care professionals, and educational administrators. Nurse faculty support students in developing strategies to assist them in dealing with patients' needs as well as their own needs (Burtson & Stichler, 2010). Nurse faculty are also required to fulfill the goals of the academic institutions they represent, which may include research, scholarship, teaching, and service (Ballantine, 2004).

Due to the multifaceted role of the nurse faculty, a condition called compassion fatigue may be present, similar to that of the clinical nurse. This condition was first identified by Joinson (1992), a registered nurse who looked at compassion fatigue and burnout in emergency room nurses. Compassion fatigue results from giving care to an individual for a prolonged period of time while they are suffering and not seeing any improvement (McHolm, 2006). Oncology nurses develop compassion fatigue from witnessing the aggressive treatments that may be futile in prolonging the quality of life in the oncology patients (Potter et al., 2010). Compassion fatigue and compassion satisfaction relate to individuals and their perception of how their work affects their quality of life. Stamm (2010), addresses the analytical approaches that encompass compassion satisfaction and compassion fatigue. An individual's quality of life, according to Stamm, is the perception one feels in relation to personal work as a helper. Compassion satisfaction is characterized by feelings of satisfaction with one's work. Individuals with positive work experiences feel invigorated by their work, are able to

keep up with the demands of work, and are capable of adhering to the policies and procedures of the institution. In general, when the work environment is positive, there is capacity building and the faculty feels content and satisfied with their work experience (Epstein & Kalleberg, 2004; Stamm, 2010). Individuals with compassion satisfaction feel as though they make a difference in the lives of the people they come in contact with (Stamm, 2011). The opposite of compassion satisfaction is compassion fatigue.

Compassion fatigue and burnout are often linked as concepts. Stamm and Figley treat compassion fatigue and burnout as related yet separate concepts. Yoder-Wise (2010) states that burnout occurs when one cannot achieve personal goals and compassion fatigue occurs when the individual is unable to save the other individual. According to Stamm (2010), burnout is associated with feelings of hopelessness and difficulty in dealing with work or doing one's job efficiently. The feelings of burnout have an insidious onset. The negative feelings associated with burnout reflect an individual's feelings of having no impact, and that personal efforts make no difference. The inability to make a difference, increased workloads, and a non-supportive work environment also contribute to burnout. The second element of compassion fatigue is Secondary Traumatic Stress (STS). STS is related to work circumstances where traumatic or stressful events have occurred. An example of a STS event would be a student committing suicide and leaving the last exam grade at the site of the suicidal incident. The negative effects of STS include fear, sleep disturbances, avoidance of situations, and feelings of being overwhelmed at work. It is my perception that nurse faculty are unable to save all students as evidenced by the high attrition rate in nursing schools which could have the result of compassion fatigue in nurse faculty.

The conceptual definition of compassion fatigue is the feelings of hopelessness or avoidance with regards to one's work (Hoffman, 2000). With compassion fatigue a lack of caring, increased absenteeism from work and loss of focus while at work occurs. Compassion fatigue is especially detrimental to the well-being of the individual and also to the organization and its governance structure. Compassion fatigue has financial, emotional and morale consequences for administrators and institutions. The stress associated with individuals leaving the organization, rehiring, training, and mentoring can result in financial and psychological hardships for the governance structures of the institution (Coetzee & Klopper, 2010; Hoffman, 2000).

The professions most noted for experiencing compassion fatigue are the service professions such as firefighters, police officers, social workers, and nurses. Nurses who work in demanding areas such as trauma, critical care units, burn centers, and cancer treatment centers experience an even higher rate of compassion fatigue due to the increased stress associated with these life altering experiences. Upon synthesizing and critiquing the literature the question arises, to what extent do nursing faculty experience compassion fatigue in higher education?

When individuals come into contact with people who have a chronic illness and are in the helping profession there is a cost to helping an individual that has an effect on their own health and well-being (Figley, 2002). When dealing with the care of individuals who are ill and often dying, clinical nurses experience compassion fatigue. The theoretical definition of compassion fatigue, according to Coetzee and Klopper (2010), is the final result of a progressive and cumulative process that is caused by prolonged, continuous, and intense contact with patients. Fransden (2010) states

individuals experiencing compassion fatigue will give more than they receive. Since those experiencing compassion fatigue give more than they receive, there is emotional and physical exhaustion. According to Hoffman (2000), compassion fatigue is the feeling of hopelessness or avoidance with regards to one's work. When someone is experiencing compassion fatigue, they may have a lack of caring, increased absenteeism from work, or loss of focus while at work. Compassion fatigue is especially detrimental to the well-being of an individual.

Background of the Problem

Social workers, firefighters, police officers, and nurses come into contact with daily experiences of life and death situations, which have an impact on their physiological and psychological well-being. Nurses often deal with people with catastrophic conditions such as cancer patients, trauma patients, patients requiring intensive care, and patients whose only hope is for a peaceful death. Patients and their families experience an emotional roller coaster as a result of their diagnosis and complications. Nurses are often called upon to navigate the emotional ups and downs of patient care. Nurses often provide help and care to patients at the expense of their own physical and emotional health. Hoffman (2000) theorizes that compassion fatigue occurs in the helping professions. Putting others before themselves is often detrimental and can result in a phenomenon called compassion fatigue.

Nurse faculty experience the same stressors as the clinical nurse however; their position is unique because in addition to the stressors experienced by the clinical nurse, the nurse educator has additional stressors. Stress in the workplace is often described as the emotional and physical outcome when the demands of work become excessive and

when there is a disparity in the amount of control the nurse has in meeting those demands (Lambert & Lambert, 2008). This can result in compassion fatigue due to the imbalance of the work and the emotional consequences related to stress.

The additional stressors nurse faculty may experience include the training of the neophyte nurse, interactions with clinical staff and administrators in the clinical facility, and the academic challenges of research, teaching, scholarship, and service. Healthy work environments in the academic setting are critical for the recruitment and retention of nurse faculty (Brady, 2010). The workload for nurse faculty members may include any or all of the following: classroom teaching, clinical instruction, advising, committee participation, clinical practice, research, and/or service. The faculty member's ability to balance these competing responsibilities is critical if the environment is to be perceived as healthy (Brady, 2010). Many nursing programs use an unbalanced ratio, which devalues clinical teaching by making two or three hours of clinical instruction equivalent to one hour of classroom instruction. This means that faculty teaching 24 clinical hours have a workload equivalent to 12 credits of classroom hours, when one classroom hour is equal to two clinical hours (Brady, 2010). The intensity of the clinical faculty role far exceeds that of the basic-science-laboratory setting to which it is compared in the academic setting. Due to faculty shortages, frozen positions, increasing faculty-to-student ratios, and increasing enrollments, nurse faculty workload is increasing while the flexibility and autonomy that has long been associated with the faculty role is decreasing (Brady, 2010). Consequently, more than one in four nurse educators said they were likely to leave their current faculty position related to the desire for a reduced workload (National League for Nurses (NLN), 2007).

Due to the multifaceted role of the nurse educator, compassion fatigue may be present similar to that of the clinical nurse. When nurses consistently deal with the same patient population with similar problems, they may experience compassion fatigue (Figley, 2002). Hoffman (2000) states that nurses may deal with compassion fatigue by turning off emotionally. It is my assumption that nurse faculty may experience compassion fatigue and turn off emotionally as a result of the demands placed on them as an educator and also as a nurse.

Compassion fatigue is especially detrimental to the well-being of the individual and also the person being served (Lester, 2010). Compassion fatigue has financial, emotional, and morale consequences for the organization governance (Yoder-Wise, 2010). Work related coping strategies to deal with compassion fatigue result in an increase in absenteeism, the need for support groups, changing work assignments, and leaving or changing jobs (Yoder-Wise, 2010). The stress associated with individuals leaving the organization, rehiring, training, and mentoring can result in financial and psychological hardships for the governance structure of the institution (Coetzee & Klopper, 2010; Hoffman, 2000).

Statement of the Problem

There is an inadequate number of nurse faculty to educate the number of students wishing to pursue nursing. Studies show that nursing students experience compassion fatigue (Sheppard, 2011). Nurses in clinical practice also experience compassion fatigue (Hoffman, 2000; Mulligan, 2004; Young, Derr, Cicchillo, & Bressler, 2011). It is my assumption that nurse faculty may also experience the emotional and physiological aspects of compassion fatigue. With the multifaceted demands placed on the educator by

themselves, the student, clinical agencies and the institution of higher learning, nurse faculty may experience compassion fatigue. The problem addressed in this research study was to determine if nurse faculty experience compassion fatigue.

Purpose of the Study

The intent of this explanatory mixed methods research study was to examine the risk of compassion fatigue among nurse faculty teaching in three religious four year baccalaureate generic nursing programs in the state of Pennsylvania. In addition the relationship between compassion fatigue and nurse faculty's perceptions of stressors in their work and personal environment was explored. In this study, a homogenous purposive sampling of nurse faculty teaching in a four year BSN generic religious university in the state of Pennsylvania was used. The 30-item *Professional Quality of Life* (*ProQOL*) instrument was used to determine if compassion fatigue was present in nurse faculty. The *Margin-In Life* instrument (*MIL*) determined the margin, power, and load of the nurse faculty. Factors contributing to compassion fatigue were explored through open-ended qualitative survey items. These questions prompted the participants to describe stress as it related to their personal, work, and academic environments. By combining the quantitative and qualitative data, this mixed methods explanatory design provided complementary data to examine the risk for compassion fatigue in nurse faculty.

For the purpose of this study, compassion fatigue was defined as the emotional and physical consequences resulting from the multifaceted responsibilities of the nurse faculty role, as well as prolonged, continuous, and intense interactions with students. Faculty experiencing compassion fatigue feel as though they are giving more of themselves to the students with little or no return. Faculty who experience compassion

fatigue may exhibit physiological and psychological alterations such as disrupted sleeping patterns, anxiety, and altered nutritional status. Compassion fatigue may result in gradual withdrawal from contact with students. When experiencing compassion fatigue, faculty have decreased empathy for students, increased absenteeism from work, or loss of focus while at work. Compassion fatigue is detrimental to the health and well-being of faculty and should be identified early so measures may be implemented to decrease the effects of compassion fatigue.

The altruistic values of the nurse educator, the desire to help students and patients, and the stressors and burdens of everyday life may result in compassion fatigue among nurse faculty. There is a paucity of research with regards to compassion fatigue among nurse faculty. Compassion fatigue is apparent among workers in the helping professions (Hoffman, 2000). Compassion fatigue is especially detrimental to the well-being of the individual and also the person being served (Lester, 2010). Compassion fatigue has financial, emotional, and morale consequences for the organization governance (Yoder-Wise, 2010). The stress associated with individuals leaving the organization, rehiring, training, and mentoring can result in financial and psychological hardships for the governance structure of the institution (Coetzee & Klopper, 2010; Hoffman, 2000).

The professional values of the nurse educator, challenged by the lack of social and institutional support, poor collaborative work environment, and the burdens of everyday life may make nurse faculty vulnerable to compassion fatigue (Sabo, 2008; 2011). Little research has been conducted with regard to nurse faculty and compassion fatigue. The purpose of this explanatory mixed methods research study was to determine if nurse

faculty working in selected four year generic religious based baccalaureate nursing programs in the state of Pennsylvania are experiencing compassion fatigue.

Operational Definition of Terms

1. Bachelor of Science in Nursing (BSN): Entry level degree for a professional registered nurse.

2. Compassion fatigue: Compassion fatigue is defined as the emotional and physical consequences resulting from the multifaceted responsibilities of the nurse faculty role, as well as prolonged, continuous, and intense interactions with students.

3. Compassion satisfaction: Compassion satisfaction is defined as the positive feelings people experience related to their work environment.

4. External Load Factors: The societal demands imposed on an individual. Examples of societal demands include career, socioeconomic factors and family stress.

5. Internal Load Factors: Those demands which are self-imposed. Examples of internal load factors are factors which are personal expectations and goals.

6. Load: Demands placed on an individual.

7. Load Factors: Consist of internal and external groups.

8. Margin: Formulae that looks at the relationship of load a person has and the resources available. Margin = Load/ Power

9. *Margin-In-Life-Scale*: Instrument developed by Joanne Stevenson (1980) to measure power, load and margin in nurses.

10. National Council and Licensing Exam (NCLEX): Exam that ensures minimal competency to the graduates who are able to practice as a Registered Nurse.

11. Nurse Faculty: Educators teaching in a four year generic nursing baccalaureate program with an emphasis on the attainment of a Bachelor of Science degree in Nursing.

12. Power: Those resources available to an individual to deal with the load one has in life.

13. *Professional Quality of Life* Questionnaire: Instrument adapted by Figley and Stamm to identify the presence of compassion fatigue.

Research Questions

This study utilized a mixed methods design to answer the following research questions:

1. Is compassion fatigue a risk for full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs?

2. Is there a significant relationship between the demographic variables of age, gender, marital status, presently attending school, number of credits, full time work load, presently doing clinical, teaching load, number of years in nursing education, and participation in committees and compassion fatigue?

3. To what extent do full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs experience compassion fatigue?

4. Is there a significant relationship between *MIL* scores of faculty who are experiencing compassion fatigue and those who are experiencing compassion satisfaction?

5. How do full-time nurse faculty in selected four-year baccalaureate generic nursing programs describe their stressors in their work and academic environments?

Significance and Potential Contribution of the Study

This study provides significance to both higher education and the profession of nursing. The findings of this study will impart guidance to faculty and nurses in practice, research, and policy. In addition, this study adds to the body of nursing knowledge.

Research. Nurses care for patients and save lives. Research reveals that nurses in the clinical setting experience compassion fatigue. The emotional and physical consequences resulting from the multifaceted responsibilities of the clinical nurse helping patients who are suffering may result in compassion fatigue. There is a paucity of research that explores the extent to which nurse faculty may experience compassion fatigue. As a result of this research study, I was able to identify if nurse faculty in three religious based schools in the state of Pennsylvania are experiencing compassion fatigue. Nurse faculty experience prolonged, continuous, and intense interactions with students. These interactions may occur with students who may not be prepared for the rigors of nursing curriculum, and also with students who are experiencing a stressful college life and separation from their families.

After it has been established if nurse faculty are experiencing compassion fatigue additional research can be initiated to implement measures to identify and treat compassion fatigue in nurse faculty. Compassion fatigue should be identified early so that measures may be initiated to prevent complications and decrease the effects of compassion fatigue.

Practice/Education. This research deliberately narrowed the focus to ascertain if nurse faculty experience compassion fatigue. There is a shortage of nurse faculty. According to Allen (2008), factors affecting faculty shortages are job satisfaction, stress,

and burnout. Nurse faculty are charged with the education, training, and supervision of nursing students in the classroom and in the clinical setting. Nurse faculty interface with patients, students, other health care professionals and education administrators. Nurse faculty support students in developing strategies that assists the students to deal with patients' needs and self-care (Burtson & Stichler, 2010). Nurse faculty also fulfill the goals of the academic institutions they represent which may include research, scholarship, teaching, and service (Ballantine, 2004). With the multitude of responsibilities nurse faculty experience, it is no wonder they become overwhelmed. It is my assumption that nurse faculty may also experience the emotional and physiological aspects of compassion fatigue due to the multifaceted demands placed on the educator by themselves, the student, the clinical agencies, and institution of higher learning. The identification of compassion fatigue in this population may lead to institutional changes that support nurse faculty. This may result in an increase in the number of nurse faculty which could assist in alleviating the nurse faculty and professional nurse shortage.

Organizational Policy. University policy could potentially be influenced by the exploration of compassion fatigue in nurse faculty. According to Mortimer and Sathre (2007), the responsibilities that consume the time of the academic president consist of "fundraising, planning, budgeting board relations, and personnel issues" (p. 77). The responsibilities of the vice president of academic affairs "in descending order of importance are faculty relations and morale, recruitment of faculty, curriculum work, budget, promotions, personnel evaluations, committee work, routine administration, and student counseling" (Mortimer & Sathre, 2007, p. 77). The priority responsibility of the vice president of academic affair's is faculty relations. This research intentionally

addressed the issue of compassion fatigue. Policies may be considered by the governance structures in higher education to decrease compassion fatigue in full-time faculty members at four-year baccalaureate nursing programs. Policies related to the present role of the vice president of academic affairs include the success of the students (Tolson, 2012). According to Dosal (2011), initiatives at the University of South Florida have been directed to the success of students and their completion rates. The success of students is multifaceted and includes identification of policies, procedures, programs, and initiatives to provide students with a successful educational experience.

Policies related to increasing funding to baccalaureate degree nursing programs enable academic institutions to review nurse faculty workload requirements. This may also lead to an increase in the number of full-time faculty at the institution. As a result, decreases in demands made on nurse faculty may enable nurse faculty to provide more time for the remediation and counseling of their students. The incidence of compassion fatigue may lessen, as the appreciation of the workload of nurse faculty in higher education is increased. This may also contribute to increased enrollment and completion in nursing programs, providing more nurses to meet the health care demands of the future.

Assumptions and Limitations

As with all research studies, there are assumptions and limitations that need to be acknowledged and addressed prior to beginning the research. This study was an explanatory study to determine if compassion fatigue existed in full-time nursing faculty. First, the findings for this study are limited to three generic religious nursing programs in the state of Pennsylvania. The research study is context-dependent because of the three

religious affiliated nursing programs (Creswell & Plano-Clark, 2011; McMillan, 2007). As a result, the quantitative findings are not generalizable to other institutions that are dissimilar to those included in the study.

Secondly, my own personal bias may be a limitation to this study. I have to acknowledge that I do believe nurse faculty experience compassion fatigue. I was aware of this bias and sought to make certain I did not permit my bias to be exhibited to my participants. Additionally, the same exact written instructions and script with the purpose and intent of the study being explained was distributed to the participants. I also had open-ended questions at the end of the questionnaire for the participants to answer. According to Creswell and Plano-Clark (2011) an open-ended questionnaire helps to minimize the potential bias.

Thirdly, I asked for volunteers and those individuals who tend to want to volunteer have an interest in the material being presented and are more likely to have an interest in the topic. Some individuals may have volunteered because lunch was provided. The participants were conveniently chosen and may not be representative of all nurse faculty. Consequently, these quantitative finding are not be generalizable beyond this study. Volunteering is a common selective factor and those that volunteer are different than those who do not. According to Krathwohl and Smith (2005), those that volunteer are generally more educated and have an interest in the pursuit of research.

Fourthly, plausible alternative explanations for a study may include the time during the semester when the research study was conducted. In the beginning of the semester there may be extraneous circumstances that come into play such as getting acclimated to the class and the drop/add period. Consequently, I conducted my study at

the end of the semester when the drop/add period was over. Granted there may be some stress associated with end of semester work, however, the semester was close to completion.

Fifth, the research collected for this study was gathered at the end of the semester. The timing of the collection of the data may affect faculty perception of their workload and stressors. There may be periods during the semester when workload demands are more or less intense.

I have chosen specific measures to eliminate plausible alternatives to my study. To compensate for the limitations of this study I deliberately chose an explanatory mixed methods design so experimental mortality among participants was eliminated. The only plausible manners in which experimental mortality could have occurred were if participants refused to continue with the study due to distress they were experiencing while answering the questions or if the participants were unable to be contacted for the follow-up one-on-one interview. To compensate for this inability to contact nurse faculty convenience sampling with replacement was implemented if needed for the one-on-one interview.

Additionally, one particular manner in which I controlled for alternative explanations was to be the only individual administering the instrumentations. I attended each of the three generic baccalaureate nursing programs and distributed the instruments. I prepared an identical script, printed instructions and had the participants drop the instruments in a sealed envelope in a sealed drop box.

Furthermore, to prevent plausible alternative explanations I utilized triangulation and asked a colleague to also look at my results and data. Triangulation was

accomplished by looking at the demographic data, the *ProQOL* instrument, the *MIL* instrument, qualitative open-ended questions, and the one-on-one interviews. The one-on-one interview were transcribed verbatim to identify themes and contribute to triangulation. I controlled for extraneous variables and made accommodations for the variables I was unable to control for.

When doing the qualitative piece of the mixed methods study I accommodated for instrument decay. There were no changes in the recording instrument over time because the participants wrote their response to the qualitative questions and I had a hard copy of their written responses to share with my doctoral dissertation committee.

The participants completed the research packets. After completing the packets, participants placed them in a sealed envelope and then into a sealed box. The sealed box remained separate from the informed consents, which were placed in a locked boxed prior to the distribution of the research packets. All of the participants, regardless if they participated or choose not to participate in the study, had the opportunity to enjoy the provided lunch.

A random sample of the participants who volunteered to participate in Phase Two was conducted from each school. Phase Two was conducted at a time and place convenient to the participant. A separate consent form asking for the participant to agree to the interview and the taping of the interview was obtained prior to proceeding with the interview. A script was read prior to the interview, and the participants also received a copy of the questions that were asked. In conclusion, the explanatory mixed methods design is the optimal methodology to answer my research question. My bias was not conveyed to the participants because I had a written script and specific directions for the

participants to read and follow. I believe there were inherent limitations to my study including barriers to generalization; however, I do believe I made accommodations and plausible alternatives for those limitations that are inherent in this research study. As with all research, additional exploration is needed. Further research in the area of compassion fatigue should examine measures that can be implemented and initiated to treat compassion fatigue in nurse faculty.

Conclusion

The complexity of the health care system, the aging population of nurses, and the nurse and nurse faculty shortage lend to the need for an exploration of compassion fatigue in nurse faculty. Compassion fatigue has been documented in helping professions, clinical nurses, and student nurses; however, there is a paucity of research related to compassion fatigue and nurse faculty. The multifaceted role of nurse faculty with regards to teaching, research, education, service, and practice; in addition to the stressors of everyday life, contribute to the necessity to explore whether nurse faculty experience compassion fatigue.

Chapter II

Literature Review

Introduction

The aging population in the United States will create a need for a larger workforce to provide healthcare. Complicating the problems of an aging population are multiple social issues, an increase in patient acuity, and a workforce that is facing a shortage of nurses (Dohm & Shniper, 2007; Harrison, 2004; Houde & Melillo, 2009; Peterson, 2009). One point is clear; the need for a well-prepared workforce of registered nurses to provide care to patients is required. Nurses are the fastest growing workforce in the United States for first and second careers. By the year 2020, there will be a need for approximately 350,000 nurses, and by the year 2016 587,000 new jobs will be created for registered nurses (Gazza, 2009; Kuehn, 2007). With this impending shortage, nurse faculty will be called upon to educate students to fulfill the deficit. Additionally, nurse faculty are challenged to educate nurses to meet the needs of modern global society (Gazza, 2009).

The term compassion fatigue, in reference to nurses, was first used by Joinson (1992). Joinson (1992) looked at the effect of caring for patients who were traumatized, and found that the nurses were turning off emotionally as a result of caring for their patients. When nurses are turning off, the potential for termination of employment is present which further compounds the nursing shortage. In order to place more nurses into the workforce, there needs to be sufficient nurse faculty to educate nursing students.

While there are various types and levels of nursing programs such as diploma, associate, and baccalaureate level programs, the American Nurses Association (ANA) issued a position statement declaring that the entry level for the nursing profession should be at the baccalaureate level (ANA, 2010.,Taylor, 2008). In 2011, 75,587 qualified applicants were turned away from baccalaureate and graduate nursing programs due to insufficient faculty, clinical sites and clinical preceptors, and budget constraints (AACN, 2012a; ANA, 2010.,Daltilo, Brewer, & Street, 2009).

Nurse faculty have intense interactions with up and coming future nurses who are exposed to the rigors of a nursing education. Therefore, the intense interactions faculty have with students may add to the development of compassion fatigue. According to Coetzee and Klopper (2010), compassion fatigue is the result of a progressive and cumulative process that is caused by prolonged, continuous and intense contact with patients. Fransden (2010), states the individual experiencing compassion fatigue will give more than they receive. Since those experiencing compassion fatigue give more than they receive, there is emotional and physical exhaustion. According to Hoffman (2000), compassion fatigue is the feelings of hopelessness or avoidance with regards to one's work. When someone is experiencing compassion fatigue they may have a lack of caring, increased absenteeism from work or loss of focus while at work. Compassion fatigue is especially detrimental to the well-being of the individual (Collins & Long, 2003; Grafton, Gillespie, & Henderson, 2010; Lombardo & Eyre, 2011).

Compassion Fatigue in Nurses

When an individual comes in contact with people who have a chronic illness, and are in a helping profession, there is a cost to helping an individual that has an effect on

the care givers own health and well-being (Figley, 2002). As a result of caring for patients and their families, nurses are directly affected by these situations and can experience compassion fatigue (Abendroth & Flannery, 2006). Compassion fatigue is a multi-factorial phenomenon that emphasizes the cost of caring, empathy, and the emotional effects for the individual who is helping the person who is suffering (Figley, 2002). Nurses in clinical practice also experience compassion fatigue (Hoffman, 2000; Mulligan, 2004; Young, Derr, Cicchillo, & Bressler, 2011). Hoffman (2000) further states that nurses may deal with compassion fatigue by turning off emotionally as a result of identifying and caring for patients. Nurses who work in demanding areas such as trauma, critical care units, burn centers, and cancer treatment centers experience an even higher rate of compassion fatigue due to the increased stress associated with these life altering experiences (Harrison, 2004; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Newell & MacNeil, 2010).

Compassion fatigue is especially detrimental to the well-being of the nurse and also the patient being cared for or served (Lester, 2010). According to Aberndoth and Flannery (2008), 78% of nurses who were caring for cancer patients were at a risk for developing compassion fatigue. Emergency room nurses, nurses in the intensive care units, and those caring for the abused and children were identified as experiencing compassion fatigue.

Compassion fatigue among workers in the helping profession is the feeling of hopelessness or avoidance with one's work. Compassion fatigue is characterized by the lack of caring, increased absenteeism, and loss of focus while at work. Compassion

fatigue has unfavorable effects for the individual serving and also the person being served (Lester, 2010).

Compassion Fatigue in Helping Professions

Compassion fatigue occurs in the helping professions (Figley, 2002; Hoffman, 2000). A helping profession is a profession in which the employee provides a human service involving interactions to a consumer such as social workers, therapists, police and firefighters, and nurses. Hoffman (2000) theorizes that individuals working in helping professions are at risk for empathetic over-arousal and familiarity bias. According to Hoffman (2000), a limitation in caring for individuals who are in distress can bring about empathetic over-arousal. Familiarity bias occurs when individuals help others in distress with needs and concerns similar to their own (Hoffman, 2000). Hoffman further states that those in a helping profession may deal with compassion fatigue by turning off emotionally as a result of familiarity bias. Social workers, firefighters, police officers, and nurses come in contact with daily experiences of life and death situations, which have an impact on their physiological and psychological well-being. Civil service employees including police, firefighters, disaster responders, and social service professionals have documented cases of compassion fatigue.

Hoffman (2000) theorizes that compassion fatigue occurs in the helping professions. Putting others before themselves is often detrimental and can result in a phenomenon called compassion fatigue. Work related coping strategies to deal with compassion fatigue resulted in an increase in absenteeism, formation of support groups, changing work assignments, and leaving or changing jobs (Yoder-Wise, 2010).

Compassion fatigue occurs quickly, but when identified can be treated and it will subside (Yoder-Wise, 2010).

Killian (2008) suggests that helping professionals who assist in disasters and also those who listen to the stories of devastation, child abuse, and traumatic occurrences often experience emotional distress. The stress associated with trauma therapy can accumulate over time and cause psychological and physiological symptoms for helping professionals. The symptoms evident in helping professionals are manifested as sleeping disorders, difficulty concentrating, and changes in mood. People expressed that they were edgy, less patient, and anxious. Feeling stress even after work hours and while at home can lead to compassion fatigue. The helping professions can be quite stressful. When protecting the health professional there has to be a paradigm shift from individual training and education to an approach of advocacy for healthier working conditions (Killian, 2008).

Nurse Faculty Roles and Responsibilities

At first glance it may seem like only nurses working in the clinical area experience compassion fatigue; however, the initial perception fails to take into account the multitude of responsibilities associated within academia, coupled with the rigors of dealing with patients, students, and administrators in the clinical and academic setting. Consequently, one explanation for the shortage of nurse faculty may be that they are experiencing compassion fatigue. There is a paucity of research understanding the multi-faceted role and work of nurse faculty (Gazza, 2009).

Nurse faculty interface with patients, students, other health care professionals and educational administrators, in addition to supporting students in developing strategies that

will assist them to deal with patients' needs as well as their own (Burtson & Stichler, 2010). Nursing faculty also fulfill the goals of the academic institutions they represent which may include research, scholarship, teaching, and service (Ballantine, 2004). Nursing students and clinical nurses experience compassion fatigue (Hoffman, 2000; Mulligan, 2004; Sheppard, 2011; Young et al., 2011). The professional values of nurse faculty, challenged by the lack of social and institutional support, a poor collaborative work environment, coupled with the burdens of everyday life, may make nurse faculty vulnerable to compassion fatigue (Sabo, 2011).

There is a paucity of existing research to support the risk for compassion fatigue in nurse faculty. The literature contextualizes the existence of compassion fatigue in nurses practicing in clinical settings, as well as in individuals in helping professions. Further research is necessary to identify if nurse faculty also suffer from compassion fatigue.

Nurse faculty experience the same stressors as the clinical nurse however; their position is unique. In addition to the stressors experienced by the clinical nurse, the nurse educator has additional stressors including the training of the neophyte nurse, interactions with clinical staff and administrators, and the academic challenges of research, teaching, scholarship, and service. Due to the multifaceted role of the nurse educator, compassion fatigue may be present similar to that of the clinical nurse. Nurse faculty are charged with the education, training and supervision of nursing students in the classroom and clinical setting, and often times nurse faculty maintain active clinical practice as well.

Shortage of Nurses

The predicted demand for additional nurses between 2000 and 2020 is estimated to be 2.8 million (Auerbach, Buerhaus, & Staiger, 2007). There are multiple factors contributing to this number, including longevity, medical advances, an aging nursing work force, and an inadequate number of successful graduates from accredited BSN programs. It is obvious from the literature that a well-prepared workforce of registered nurses is essential to provide care to future generations. An understanding of compassion fatigue, what causes it, the signs and symptoms exhibited by nurses experiencing compassion fatigue, and the measures to deal with and prevent compassion fatigue, may prove beneficial to alleviate the shortage of nurses and to prevent nurses from leaving the profession (Yoder-Wise, 2010). Nursing education programs are experiencing a shortage of nurse faculty (AACN, 2012b; Kovner, Fairchild, & Jacobson, 2006).

Shortage of Nurse Faculty

In 2011, over 75,000 qualified applicants were not admitted to baccalaureate and graduate nursing programs due in part to insufficient nurse faculty (AACN, 2012b; Dattilo et al., 2009). It is apparent a nursing shortage exists; however, Dattilo et al., (2009), state the real shortage is the number of faculty available to educate nursing students. According to Gazza (2009), to understand the experiences of nurse faculty, it is imperative to examine their roles and responsibilities within the context of their environment. The findings from the study suggest that recruitment and retention strategies should revolve around five themes: making a difference in the students' world, incorporate remediation programs that will be calculated into the workload, balance the multiple roles of nurse faculty and understand the workload, and support on the job and

work place relations. Durham, Merritt and Sorrel (2007) suggest that favorable and equitable perceptions of workload will increase nurse faculty satisfaction and increase the entry and retention of nurse faculty. It is important for administrators to be cognizant of workload equity, scholarly productivity, job satisfaction, decreasing work pressures, and maintaining high morale for faculty.

Theoretical Lenses

When discussing the theoretical framework for this research study, three particular theorists were selected. Figley is a pioneer in research involving compassion fatigue. McClusky has worked intensively on power load margin and adult education. Stamm has utilized the *Professional Quality of Life* instrument to determine the presence of compassion fatigue and compassion satisfaction in individuals.

Figley Compassion Fatigue. According to Figley's (2002) theoretical framework, when an individual comes in contact with people who have a chronic illness and are in the helping profession, there is a cost to helping an individual that has an effect on their own health and well-being. The term used to coin this phenomenon is compassion fatigue. Compassion fatigue is a multi-factorial concept that emphasizes the cost of caring, empathy, and the emotional affects for the individual who is helping the person who is suffering. Figley (2002) concludes that the act of caring for an individual places a burden on the individual doing the caring. The cost of the emotional involvement may result in symptoms of compassion fatigue to the individual doing the caring. Caring is related to the clinical nurse, those in social service, and other professions that provide care to an individual.

Initially, Figley (2001) studied traumatized individuals after the Vietnam War and noticed that the individuals who cared for war heroes never forgot the experiences they heard from those who were in the war. Corpsman years after the Vietnam War would recant stories of how they wished they could have done more for the sick, injured, and even those that died. Two characteristics of the caregivers were guilt and regret.

Figley's model is based on the assumption that empathy and emotional energy are required to provide care to those that are suffering. When an individual provides care there is a cost to the individual providing the care. To provide care to an individual requires energy and a cost, when the cost to caring exceeds the personal satisfaction compassion fatigue results (see Figure 2.1). According to Figley there are eleven variables that predict compassion fatigue. When reviewing the model, the causes of compassion fatigue are described.

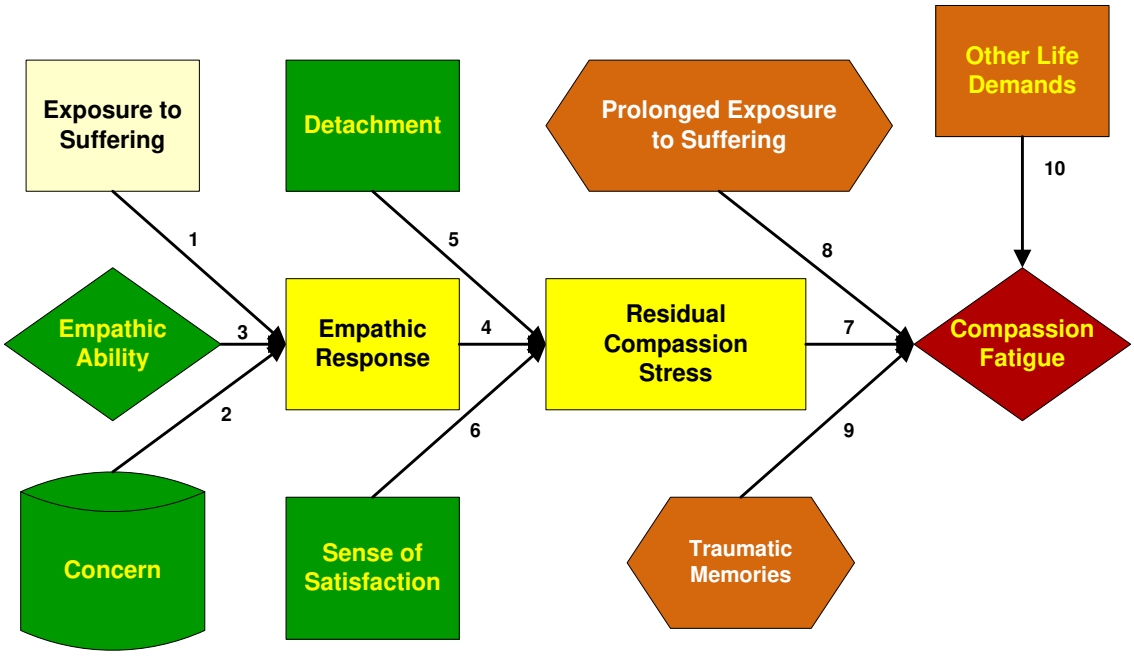


Figure 2.1. The compassion fatigue process as described by Figley (2001).

Application of Figley's model to nurse faculty. When nurse faculty are *exposed* to the trials and the tribulations the students are suffering, faculty have *concerns* about the student and their ability to succeed in the nursing program. As a result, nurse faculty experience *empathetic ability* (Figley, 1995; Figley, 2002). Empathetic ability occurs when nurse faculty identify with the pain and suffering the student is experiencing. Empathetic ability is essential for the development of compassion fatigue, if nurse faculty do not recognize the suffering of the student, then nurse faculty will not be able to assist or help the student. This creates vulnerability to the development of the compassion fatigue.

Empathetic concern occurs when nurse faculty respond and are motivated to help and assist the students who are in need or suffering. Faculty must be willing to give of themselves in order to help students. Nurse faculty, due to their concern for students and

their altruistic tendencies, will provide the care and knowledge to assist the students to be successful. As nurse faculty are helping students, they are having repeated exposure to the students. Nurse faculty assist students in the clinical area, after class, or during their office hours. At times, exposure to students will take the form of multiple interactions through email or phone conversations.

Empathetic response is the extent to which the nurse faculty "makes an effort to reduce the suffering of the sufferer through empathetic understanding" (Figley, 2002, p. 1437). As a former student and also as a member of a helping profession, nurse faculty may project thoughts and feelings into what the student is experiencing. As a result of this projection, nurse faculty may relive those same experiences they may have had as a student or those feelings that a former student may have experienced. Nurse faculty will give more than they receive and may, in fact, be subjecting themselves to the repeated trauma from former students. As a result of the empathetic response and projection, nurse faculty may be continually experiencing the hurt, regret, and feelings of suffering from interactions with previous students. It is devastating for nurse faculty to witness and hear the multiple stories of rejection, abuse, and failure from students. The benefits are rewarding to nurse faculty on those numerous occasions when the students are helped; however, the time has come to evaluate the effect on nurse faculty to determine if they are suffering from compassion fatigue as of result of these repeated exposures.

Compassion stress is the result of the empathetic response nurse faculty are continuously providing to students. The repeated stress felt by nurse faculty and intense interactions with students may result in distress. This distress, like all stress, is cumulative and can have negative consequences for the physical, emotional, and

psychosocial dimensions of nurse faculty. Consequently, residual compassion stress may result. Compassion fatigue results from the repeated accumulation of compassion stress (Figley, 2001).

With the beginning of each new semester, faculty inherently come in contact with additional students. Nurse faculty will also remain responsible for students from previous semesters. Helping students may extend over the entire four years of their education and beyond. As a result of this helping relationship, nurse faculty may have recollections from previous students that may ignite memories. When nurse faculty recall these past experiences, these recollections may result in traumatic experiences manifesting through alterations in sleep, ineffective coping, and additional emotional reactions.

As a result of the repeated, intense, prolonged, and continuous interactions, life disruptions may ensue leading to compassion fatigue. Nurse faculty may experience alterations in self-care activities and experience psychosocial alterations. It is important to realize that these alterations may have an effect on the caregiver. The cost of caring for another will have a cost to the nurse faculty giving the care.

The Theory of Margin. McClusky (1970) states that Power, Load, and Margin are integral parts of how an individual copes with stressors in life. Margin is the relationship or ratio between the load and the power. Margin equals load over power with load being the numerator and power the denominator. If the power or resources are high then the individual is capable of handling more load. The optimal range for the margin would be between .30 and .80. This number will typically provide an individual with an adequate margin to handle the emergencies and stressors in life. Load refers to

the demands placed on an individual. For example, if nurse faculty have a heavy load, such as stressors at home and at work, then there needs to be an adequate amount of resources or power for nurse faculty to deal with the load. If there is an inadequate amount of power or an excess in load, nurse faculty may exhibit compassion fatigue. If an individual has a high number in load and an inadequate amount of power, then it may result in a negative approach to life events.

The *Margin-In-Life* instrument is a 58-item scale that looks at an individual's power, load, and margin. This instrument requires the participant to rate the 58 questions and then the margin is calculated; Margin =Load/Power. The more resources or power the individual has the better able the individual is able to carry the load. Margin is the result of the load over the power. If the margin is between .30 to .80 then the individual should have enough margin to meet the demands of life. The instrument consists of three separate components: a 10 point Likert scale to determine the importance of the descriptor, a 5 point Likert scale to determine the load experienced by the individual, and a 5 point Likert scale to determine the power. There is also a category if the item is not applicable to the individual (Hiemstra, 2002). Written permission was obtained prior to using the instrument (see Appendix X).

The purpose of the *Margin- In-Life* instrument is to assess the power individuals have to deal with the load they are experiencing to determine their margin-in-life. The lower the load number and the higher the power number the better able the individual can deal with the load he/she is experiencing (Hiemstra, 2002; Main, 1979).

McClusky (1970) suggests that people survive in life through the use of margin, the extra reserve of energy. He viewed each person as experiencing a load which are

those demands that use up energy. McClusky (1970) defined load as the responsibilities a person has. They can be internal aspirations, or needs, or external activities and obligations. Power is the resources which are available to the individual to deal with the load. McClusky, an adult educator, saw margin as a crucial element in the adult years.

Seminal research in developing a instrument to measure load and power was completed by Joanne S. Stevenson and first published in 1980, with a follow up study in 1982. Stevenson and colleagues first developed a 211-item instrument incorporating six areas of life, including religious/spirituality, self-concept, body, family, human relationships, and environment (Stevenson, 1980). After reviewing the test it was revised and shortened to 94 items. At this time the participants were asked to weigh an item from 1 to 10 on its importance this was the weighing factor, and also requested to rank the load or burden of that item currently in their life on a scale of 1 to 5. In addition, the participants also rated the power or resource on a scale of 1 to 5. To further reduce and refine the items on the scale, Stevenson (1982) produced a manual for researchers interested in utilizing the *MIL* instrument. The newest version of the *MIL* instrument was reduced from 94 items to 58 items.

Application to nurse faculty. The *Margin-In-Life* instrument may be intuitive in understanding the load power relationship in understanding compassion fatigue in nurse faculty. The *Margin-In-Life* instrument takes into account internal and external factors that are rated on importance from a scale of 1 to 10. Participants select how important an item is to them personally. The participants then rate the load (burden) and power (the amount of resources) this item represents at that point in their life on a scale of 1 to 5. McClusky (1970) further correlated load with stress, and power with resilience. Margin

is a net profit or surplus that provides energy to participate in activities that are above maintenance. An individual who has a margin has more available options available, to deal with life's demands. A person with higher load than power may be more likely to experience compassion fatigue.

A review of the literature related to the *Margin In Life* instrument reveals that students should be monitored to identify their margin since a low margin may be reflective in attrition. With a low margin, support services or interventions should be introduced to increase an individual's margin (Piper, 2012). This particular review suggests that faculty support should be directed to maintaining faculty and providing support for new faculty to adjust to the unique roles of academia.

According to Kalynych (2010), the *Margin In Life* Theory is difficult to measure. When reviewing the *Margin In Life* Theory as it applies to residents and their training, the theory provides a means to identify those residents who may require remediation or those who are in jeopardy of leaving the medical residency program. Kalynych, from her dissertation, states "the margin in life scale requires modifications to become more useful" (2010, p. 111). The use of the *MIL* to provide interventions for residents in training will benefit medical training. This instrument will provide useful information in identifying those nurse faculty who may be experiencing compassion fatigue. With regards to medical residency programs additional studies are needed to identify measures that can be incorporated in medical training that will build a residents margin.

Yoder-Wise (1984), in her dissertation, states that the *Margin In Life* instrument was too confusing and long for the participants in the study. As a result of the literature review, the instrument presently being used is a 58-item instrument as opposed to the 94

item scale, which was shortened from the original 211-item scale (Stevenson, 1980; 1982). The instrument has construct validity as determined through factor analysis, and internal reliability with an alpha reliability coefficient of .87 with regards to health on both the five and six subscale versions (Yoder-Wise, 1984).

Stamm's *Professional Quality of Life*. Stamm (2010) presents the analytical approach that addresses compassion satisfaction and compassion fatigue (see Figure 2.2). This figure illustrates the concepts incorporated in the *Professional Quality of Life*, the positive is Compassion Satisfaction and the negative is Compassion Fatigue (Stamm, 2010). An individual's quality of life according to Stamm (2010) is the perception one feels in relation to their work as a helper. Stamm revised the *ProQOL* instrument. The *ProQOL* is a valid and reliable instrument to indicate compassion fatigue. Typically, compassion fatigue is not addressed by the administrators of nursing programs. Therefore, more research is needed to explore the extent to which nurse faculty are experiencing compassion fatigue and what measures governance should initiate to support affected faculty.

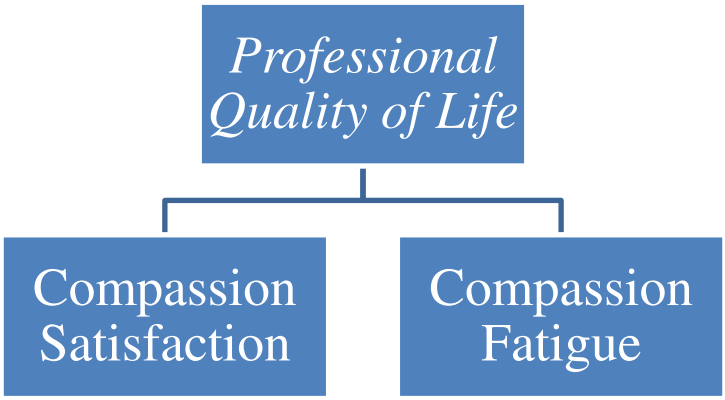


Figure 2.2. Components incorporated in the *Professional Quality of Life* instrument.

Compassion satisfaction is characterized by feelings of satisfaction with one's work. Individuals with positive work experiences feel invigorated by their work, are able to keep up with the demands of work, and are capable of adhering to the policies and procedures of the institution. In general, when the work environment is positive, individuals feel content and satisfied with their work experience (Epstein & Kalleberg, 2004; Stamm, 2010). Individuals with compassion satisfaction feel as though they make a difference in the lives of the people they come in contact with (Stamm, 2011). The opposite of compassion satisfaction is compassion fatigue.

Summary of Theoretical Lens. Concepts maps are graphic representations to show the interrelationships among concepts being studied. This concept map provides a summary of my theoretical lens (see Figure 2.3).

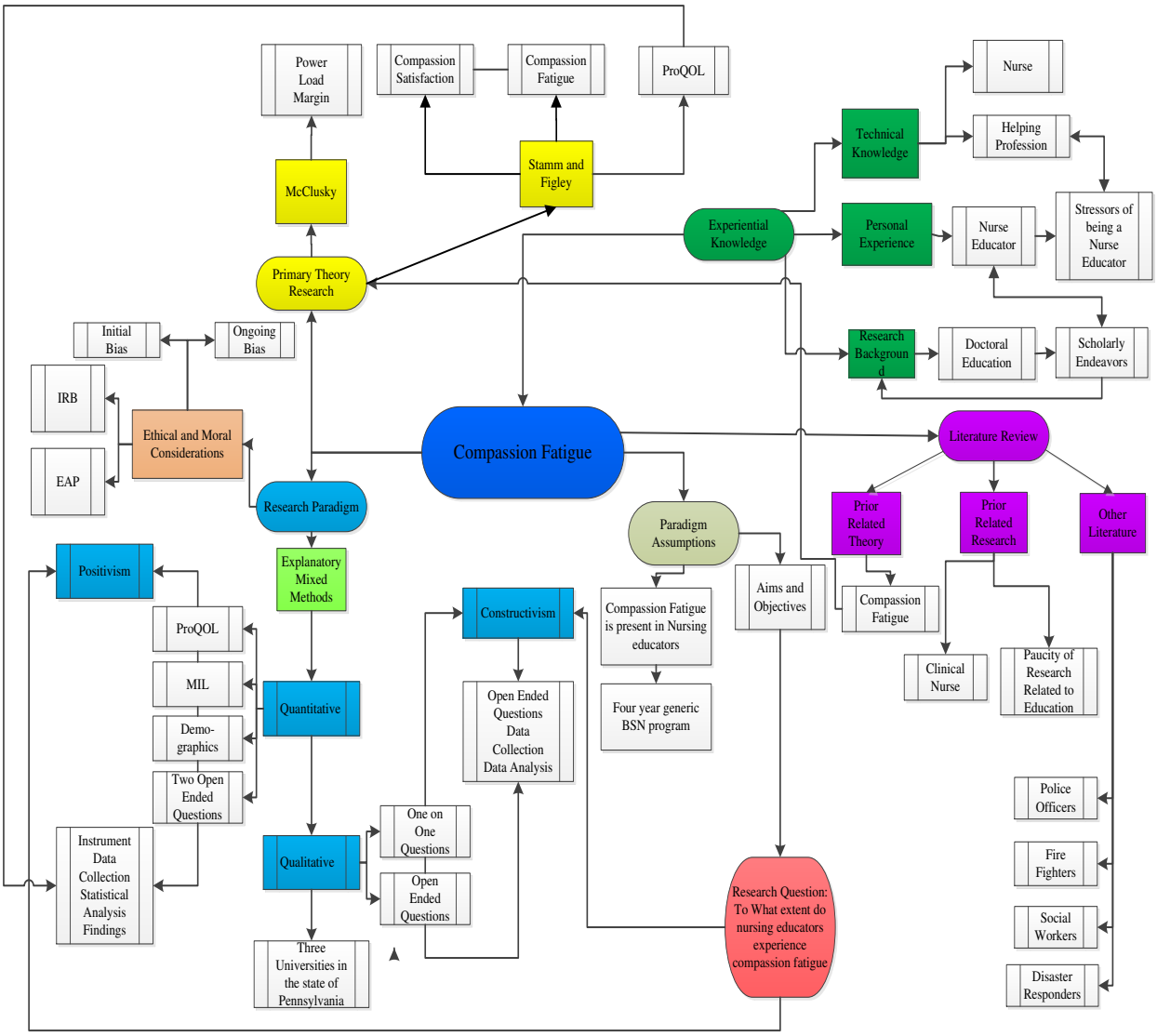


Figure 2.3. Theoretical concept map.

In the center of my concept map is the identified problem of *Compassion Fatigue*. As previously stated, in addition to the nursing faculty shortage, there is also a decrease in baccalaureate prepared Registered Nurses. There will be an insufficient number of nurses to care for the increasing demands of the health care delivery system. In order to meet the needs of the aging population, a decrease in the nursing workforce, and the multiple social issues associated with health care, more nurses are needed to provide quality patient care (Houde & Melillo, 2009; Peterson, 2009). In order to place more nurses in the workforce, there needs to be sufficient nurse faculty to educate nursing students. While there are various types and levels of nursing programs such as the diploma, associate degree, and baccalaureate degree programs, the ANA issued a position statement asserting that the entry level for the nursing profession should be at the baccalaureate level (Taylor, 2008). In 2011, over 75,000 qualified applicants were not admitted to baccalaureate and graduate nursing programs due to insufficient faculty, clinical sites, clinical preceptors, and budgets constraints (AACN, 2012a; Dattilo et al., 2009). It is apparent a nursing shortage exists; however Dattilo et al., (2009), state the real shortage is the number of faculty available to educate nursing students.

Looking at my concept map there are major headings branching off of the central concept *Compassion Fatigue*. The major headings according to Maxwell (2005) that I included in my concept map were experiential knowledge, research paradigm, paradigm assumptions, primary theory research, literature review, and ethical and moral considerations. My research question sought to identify if compassion fatigue was a risk in full-time nurse faculty teaching in four-year baccalaureate generic nursing programs? Nurse faculty are charged with the education, training and supervision of nursing students

in the classroom and clinical setting. Nursing faculty interface with patients, students, other health care professionals, and educational administrators in addition to supporting students in developing strategies that will assist them in dealing with patient needs as well as their own self-care (Burtson, & Stichler, 2010). Nurse faculty also fulfill the goals of the academic institutions they represent which may include research, scholarship, teaching, and service (Ballantine, 2004).

The *Experiential Knowledge* branch examines the technical knowledge, personal knowledge, and the research background that I personally possess. The technical knowledge that exists is the fact that I am a nurse and also in a helping profession. As a professional nurse I experience the stressors inherent in the profession of nursing. In addition to being a nurse, I am also a nurse educator who comes in contact with students in the classroom and clinical setting. I am a doctoral student, read research studies, and also undertake scholarly activities such as scholarship, research, and teaching.

The *Literature Review* branch presents how compassion fatigue is abundant in helping professions. Nursing students experience compassion fatigue (Sheppard, 2011). Nurses in clinical practice also experience compassion fatigue (Hoffman, 2000; Mulligan, 2004; Young et al., 2011). Additionally, civil service employees including police, firefighters, disaster responders, and social service professionals have documented cases of compassion fatigue. It is my assumption that nurse faculty may also experience the emotional and physiological aspects of compassion fatigue due to the multidimensional demands placed on the educator by themselves, the student, clinical agencies, and the institution of higher learning. Little to no research has been documented with regards to compassion fatigue existing in nurse faculty. As a result of the paucity of research

related to nurse faculty and the nurse faculty shortage, there is a gap in the research and one could question to what extent are nursing faculty experiencing compassion fatigue. This question connects to my *Paradigm Assumption* branch and is subordinate to my *Aims and Objectives* branch. To contextualize my research, the ANA supports the entry level for the professional nurse as the baccalaureate degree (Taylor, 2008). As a result of the ANA position statement, my study is limited to three four-year religious based baccalaureate generic nursing programs.

The *Research Paradigm* branch presents the explanatory mixed methods design. This design was deliberately chosen. According Creswell and Plano-Clark (2011), a mixed methods design as a methodology is the most difficult design. Mixed methods research combines the quantitative and the qualitative aspect of research by analyzing, collecting, integrating the findings, and providing triangulation (Tashakkori & Creswell, 2007). The mixed method design provides a complete picture of the data from both the quantitative and qualitative designs (Ostlund, Kidd, Wengstrom, & Rowa-Dewar, 2011).

The design is an explanatory mixed methods design. The quantitative data were collected initially. The quantitative data research packets consisted of four instruments. The quantitative data included 9 demographic questions (see Appendix A), a 30 question *ProQOL* instrument (see Appendix B), a 58 item *MIL* instrument (see Appendix C) and two quantitative questions on the open ended questionnaire (see Appendix D). The *ProQOL* and the *MIL* instruments consisted of a Likert scale.

The qualitative instruments included 4 open-ended questions on the open ended questionnaire (see Appendix D). In addition, a follow up one-on-one interview occurred with two volunteers from each school to answer 10 questions which were audio taped.

The one-on-one interview had a signed consent (see Appendix E), a script (see Appendix F) and a list of the questions for the volunteers (see Appendix G). The qualitative instruments focused on the personal and academic environment of the participants and the stressors that they perceived. All instruments supply information to inform both the quantitative and the qualitative pieces of the research and provide for triangulation.

The *Ethical and Moral Considerations* branch presents the plan to ensure the protection of participants and is linked to the Institutional Review Board at Rowan University. In addition, a disclaimer was placed on my instruments stating that if the questions I asked were causing any anxiety, the individual should seek assistance from their Employee Assistance Program (EAP). Participants of my study were informed that participation in the study was voluntary and their responses would be shared as a group and not individually. Additionally, under ethical and moral considerations there were inherent initial and ongoing biases that I must be cognizant of so that the biases would not contaminate my results.

The *Primary Theory Research* branch imparts that compassion fatigue is present in the helping professions. When individuals are content and function at a high level they have compassion satisfaction with their work. Compassion fatigue and compassion satisfaction relate to individuals and their perception of how their work affects their quality of life. Stamm (2010) presents the analytical approaches that address compassion satisfaction and compassion fatigue. An individual's quality of life according to Stamm (2010) is the perception one feels in relation to their work as a helper. Stamm revised the *ProQOL* instrument previously used by Figley. The *ProQOL* is a valid and reliable instrument to indicate compassion fatigue.

Compassion satisfaction is characterized by feelings of satisfaction with one's work. Individuals with positive work experiences feel invigorated by their work, are able to keep up with the demands of work, and are capable of adhering to the policies and procedures of the institution. In general, when the work environment is positive, individuals feel content and satisfied with their work experience (Epstein, 2004; Stamm, 2010). Individuals with compassion satisfaction feel as though they make a difference in the lives of the people they come in contact with (Stamm, 2011). The opposite of compassion satisfaction is compassion fatigue.

According to Figley's (2002), theoretical framework when an individual comes in contact with people who have a chronic illness and are in the helping profession there is a cost to helping an individual that has an effect on their own health and wellbeing. The term to coin this phenomenon is compassion fatigue. Compassion fatigue is a multifactorial approach that emphasizes the cost of caring, empathy and the emotional effects for the individual who is helping the person who is suffering.

McClusky (1970) states that Power, Load and Margin are integral parts of how an individual copes with stressors in life. Margin is the relationship between the load and the power. Margin equals Load over power. Load is the numerator and the power is the denominator. If the power or resources are high then the individual is capable of handling more load. The optimal range for the margin would be between .30 and .80. This number will typically provide an individual with an adequate margin to handle the emergencies and stressor in life. Load refers to the demands placed on an individual, for example if the nurse faculty has a heavy load such as stressors at home and at work then there needs to be an adequate amount of resources or power for the nurse faculty to deal

with the load. If there is an inadequate amount of power or excess in load the nurse faculty may exhibit compassion fatigue. If an individual has a high number in the load and an inadequate amount of power then it may result in a negative approach to life events.

The intent of this study was to determine if compassion fatigue is present in nursing faculty using an explanatory mixed methods design. The concept map of my conceptual framework presents on overview of the key factors, concepts, and the presumed relationships among them (Miles & Huberman, 1994). The key concepts of *Experiential Knowledge*, *Literature Review*, *Paradigm Assumptions*, *Research Paradigm*, *Ethical and Moral Considerations*, and *Primary Theory Research* are organized and connections are presented and explored.

Researcher's Paradigm/World View

The Research Paradigm that I used was an explanatory mixed methods study which consisted of a positivist and a constructivism worldview. This paradigm was intentionally chosen to include both a quantitative and a qualitative component. The positivist paradigm quantitatively examined if nurse faculty are experiencing compassion fatigue by answering a *ProQOL* instrument, and the *MIL,* both of which have established validity and reliability. The purpose of the *MIL* instrument is to assess the power an individual has to deal with the load he/she is experiencing, and this determined their margin in life. The lower the load number the better able the individual can deal with the load he/she is experiencing (Hiemstra, 2002; Main, 1979). The higher the power, the better able the individual can deal with the load.

The constructivism paradigm was explored by asking nurse faculty to respond to questions related to the stressors they perceived in their personal life and while at work. I sought to understand the world in which the participants lived and worked (Creswell, 2009). The results of the qualitative data were explored, provided a voice for my participants and enriched my study. Using both the instruments and the short answers provided the integration and joining of the qualitative and quantitative data (Creswell, 2009). The one-on-one interview provided the participants inthe second phase a voice to answer specific questions related to their personal and work environments.

Summary of the Literature Review

The complexity of the health care system, the aging population of nurses, and the nurse and nurse faculty shortage lend to the need for an exploration of compassion fatigue in nurse faculty. Compassion fatigue has been documented in helping professions, clinical nurses, and student nurses; however, there is a paucity of research related to compassion fatigue and nurse faculty. The multifaceted role of nurse faculty with regards to teaching, research, education, service, and practice, in addition to the stressors of everyday life, contributes to the necessity to explore whether nurse faculty experience compassion fatigue.

Inherent in both the *ProQOL* and the *MIL* is a balance. Specifically, related to the *ProQOL* is a balance between personal satisfaction and cost to caring, while looking at the *MIL* there is a balance between power and load (see Figure 2.4). This research study sought to explore the relationship of this balancing act.

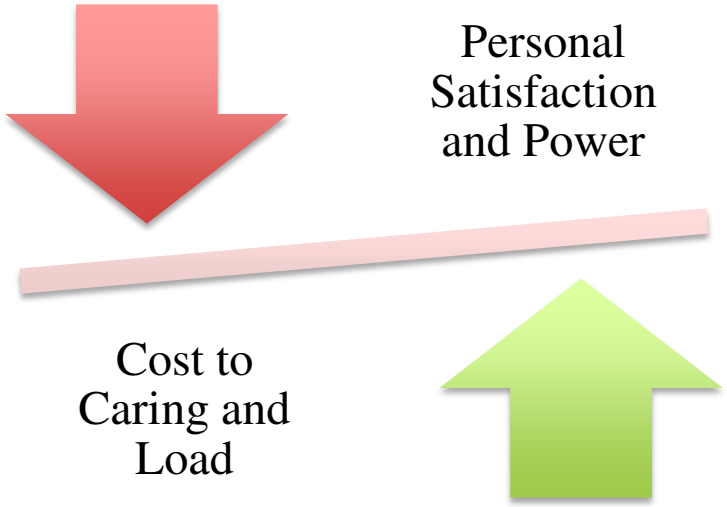


Figure 2.4. The balancing act between the *ProQOL* and the *MIL*.

Theories are used throughout the research study to identify the extent to which nurse faculty experience compassion fatigue. According to Miles and Huberman (1994), a conceptual framework will "explain either graphically or in narrative form, the main things to be studied…the key factors, concepts or variables and the presumed relationship among them" (p. 18). I have exhausted the literature about compassion fatigue in nurse faculty, organized the key concepts, demonstrated the connections and began my research topic and study. The framework I used is the basis for the research study. The conceptual framework provided the structure for my research study based on the literature and personal experiences.

Chapter III

Methodology

The purpose of this explanatory mixed methods study was to examine the risk of compassion fatigue among selected nurse faculty teaching in three religious four year generic baccalaureate nursing programs in the state of Pennsylvania. The research questions guided the research study. For the purpose of this study, a mixed methods approach was used, which combines the quantitative and the qualitative components of the study (Bryman, 2007). Mixed methods research, occurs when the researcher combines the quantitative and the qualitative aspects of research by analyzing, collecting, integrating the findings, and providing triangulation (Hanson, Creswell, Plano-Clark, Petska, & Creswell, 2005; Teddlie & Tashakkori, 2009).

The research occurred in two separate phases, which were labeled as Phase One and Phase Two. Phase One consisted of both quantitative and qualitative instruments; while Phase Two was purely qualitative in nature (see Table 3.1, Study Instruments).

Table 3.1

Study Instruments

Phase	Quantitative	Qualitative
One	*Professional Quality of Life* (*ProQOL*) *Margin-In-Life* (*MIL*) Demographic Data Open-Ended Questions (1 and 6)	Open-Ended Questions (2-5)
Two		One-on-One Interviews

Research Design

The explanatory mixed methods study design allowed for triangulation, utilizing all of the research instruments to assist in explaining the logical relations between the quantitative and qualitative data (see Figure 3.1). The qualitative data followed a phenomenologic approach with the use of open-ended questions; in addition, there were one-on-one interviews with six randomly chosen volunteers, two from each school.

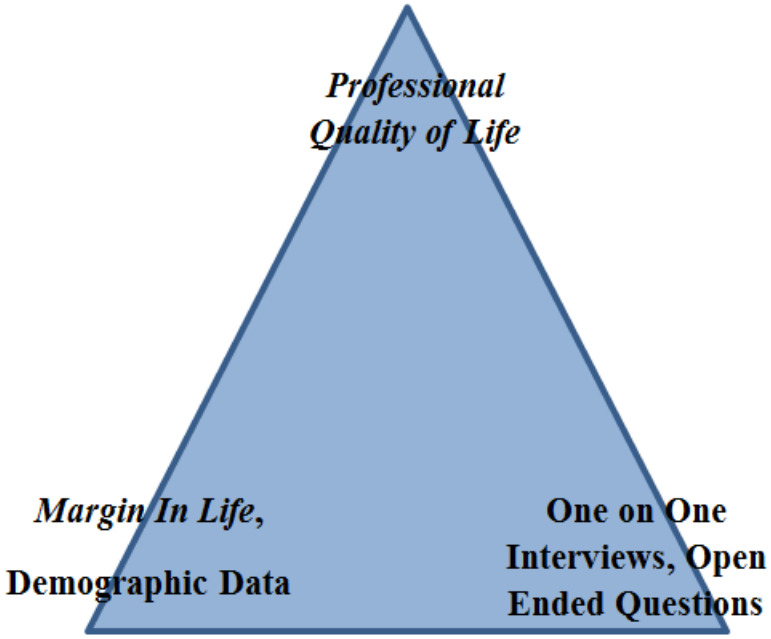


Figure 3.1. Mixed methods triangulation approach.

Johnson and Onwuegbuzie (2004), state that current research is becoming more complex and should be complemented through a mixed method approach. Together, the quantitative and qualitative designs were considered when analyzing the findings (Kettles, Creswell, & Zhang, 2011). The findings of this research study supplemented each other and provided breadth, depth and a voice to the participants. Figure 3.2 provides a schematic of the mixed method research design utilized to obtain my findings. The mixed method design provides a complete picture of both the quantitative and qualitative data to answer the research question (Leech & Onwuegbuzie, 2009; Ostlund, Kidd, Wengstrom, & Rowa-Dewar, 2011).

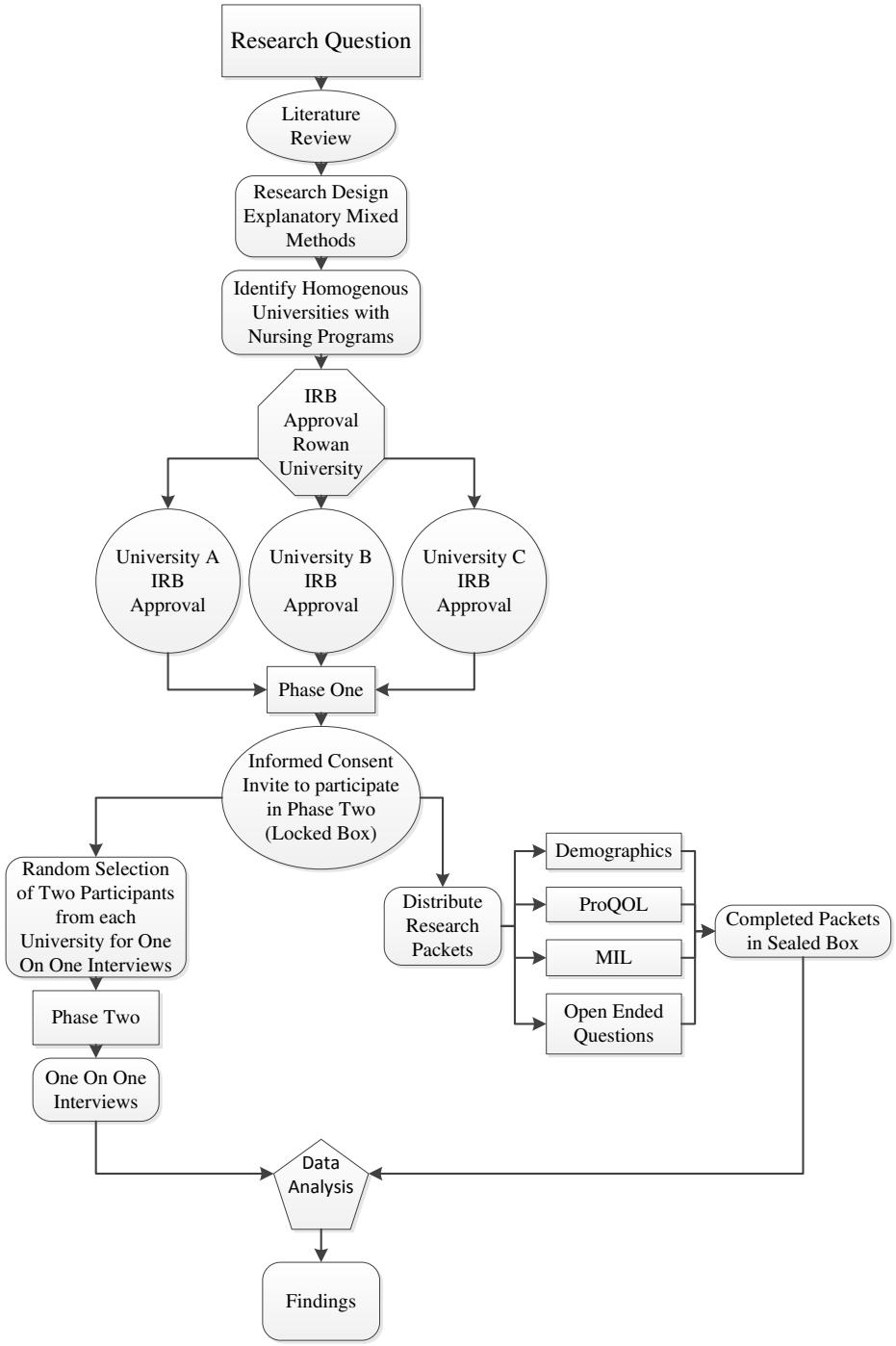


Figure 3.2. Schematic of research design.

Site Selection

The site selections for this exploratory mixed methods study were three private religious generic baccalaureate nursing programs in the state of Pennsylvania. Each school was deliberately chosen to provide the greatest number of participants who have similar experiences. The schools were situated in the state of Pennsylvania, each within a 75 mile radius. The homogeneity of the schools and nurse faculty were a factor in the selection of the setting. Each school selected has a generic nursing program that allows students an entry level for the professional nurse into practice. The goal of the research study was to learn about compassion fatigue among nurse faculty. The desire was to learn about a human experience, specifically compassion fatigue in nurse faculty.

Sample Selection

The sample was a homogenous group who provided a generic baccalaureate nursing education. According to Onwuegbuzie and Collins (2007), in homogeneous sampling, the participants have similar characteristics. "A homogenous sampling involves sampling individuals, groups, or settings because they all possess similar characteristics or attributes. Participants are selected for the study based on membership in a subgroup or unit that has specific characteristics" (Onwuegbuzie & Leech, 2007, p. 112). The sampling selection had a profound effect on the quality of the research because the sample provided a greater number of participants with similar experiences (see Table 3.2, Sampling Selection)

The criteria selected for the homogenous group were similar philosophy and mission statements, tuition, university recognition, National Counsel Examination Scores (NCLEX), the absence of a collective bargaining unit, the number of faculty present at

each school, the use of both urban and rural clinical agencies, religious affiliation, and the number of students in the program. NCLEX scores provide minimal competency for the beginning nurse. Each school selected had a commitment to the liberal arts plus a focus on the nursing curriculum.

Table 3.2

Sampling Selection

	School Characteristics		
	A	B	C
Mission and Philosophy	Respect, integrity, service, responsibility, and lifelong learning	Teaching, service, caring, and lifelong learning	Integrity, responsibility, respect, and service
Tuition Average	$29,000 annually	$29,000 annually	$29,000 annually
NCLEX Pass Rate	93%	85.51%	94%
Collective Bargaining Unit	No	No	No
Number of Faculty	20	20	18
Terminal Degree Faculty	12	8	4
Clinical Settings	Yes: Located in Pennsylvania with clinical sites in rural, urban, and suburban settings	Yes: Located in Pennsylvania with clinical sites in rural, urban, and suburban settings	Yes: Located in Pennsylvania with clinical sites in rural, urban, and suburban settings
Religious Affiliation	Yes	Yes	Yes

The sample selection was directed by the research questions and the research questions drove the sampling process. A purposeful sample was chosen so that knowledge was learned about the phenomenon of compassion fatigue (Burns & Grove, 2011). Three schools with similar characteristics were handpicked to create a study that

provided rich data for the research. The decision to use the sample was predetermined prior to the start of the research. Nurse faculty in three BSN programs were selected as the experts to answer the research questions and impart knowledge to enhance the research.

According to Coyne (1997), the sample provides large amounts of information and knowledge to answer a research question. Nurse faculty from three schools were sampled to gather relevant data about the phenomenon of compassion fatigue. The sample was chosen prior to the start of the study with a preconceived set of criteria including: those teaching in a generic nursing program at a private religious educational institution, with comparable NCLEX pass rates, no collective bargaining unit, and similar philosophy and mission statements that included the importance of service.

Data Collection

Data collection is an integral part of the research process. Representative schools were contacted so a site visit was preformed prior to applying for the Institutional Review Board (IRB) approval from each school (see Appendix H). IRB applications were then submitted after the deans at the respective colleges of nursing gave verbal and written permission to perform the research with the faculty at the schools. Due to the request for privacy, letters were received from the 3 institutions and IRB approval was obtained from all 3 schools in addition to Rowan University. The IRB approvals from each institution were obtained but not place in the appendix to ensure privacy to the schools. IRB approval from Rowan University is included in the appendix (see Appendix I). Phase One of the research commenced on a date mutually agreed upon by the researcher and the schools of nursing. The deans of the nursing program were contacted to the assist with

scheduling and organizing the optimal time when all faculty would be present to conduct the research. The participants were attending faculty meetings at the university and were given lunch while they were participating in the research.

Phase One. Phase One consisted of retrieval of the informed consents after directions by way of a script were read to the nurse faculty (see Appendix J). Informed consents were signed (see Appendix K), collected and placed in a sealed locked box prior to distributing the research packets. The informed consent had an area where the participants could volunteer to take part in a one-on-one interview to obtain additional data. Once the informed consents were signed, they were placed in a sealed box separate from the research packets and secured by lock and key.

Nurse faculty were informed that participation was voluntary and at any time during the process they could stop if they were experiencing any distress. Lunch was provided complimentary to the faculty even if they choose not to participate in the study. The research packets contained the 30 item *Professional Quality of Life (ProQOL)* instrument, a 58 item *Margin-In-Life* instrument, nine demographic data questions, four open-ended questions and two quantitative questions.

I provided directions and distributed the research packets to consenting nurse faculty. The participants were instructed to complete the packets and place in a sealed envelope and then place in a sealed box provided by me. Only full time nurse faculty with primary teaching responsibilities in the nursing program were eligible to participate in the study; part time, adjunct faculty, administrators, and laboratory staff were excluded. It took approximately 30-45 minutes to complete the research packets. To

enhance the response rate pizza and soda were provided to all participants, even those declining to participate.

Phase Two While completing the initial consent the subjects were asked if they would like to volunteer to participate in a one-on-one interview that would take approximately 15 to 30 minutes to answer questions. The subjects were asked to sign their name and also supply their email address if they would like to take part in phase two. Volunteers were used because those who tend to volunteer have an interest in the material being presented and are more likely to have an interest in the topic. Volunteering is a common selective factor and those that volunteer are different than those decline. According to Krathwohl and Smith (2005), those that volunteer are generally more educated and have an interest in the pursuit of research.

Two participants from each school were randomly chosen and notified by the information they supplied on the consent form. After communicating with the volunteers a place, time, and location convenient to the participant was chosen. If the participants did not respond to the communication to be involved in the one-on-one interview a random sampling with replacement was conducted. In other words, another individual was randomly chosen out of the volunteer pool to replace the original participant from that particular school. The rich data obtained by the one-on-one interviews provided yet another means to obtain data from the participants and provide the participants with a voice.

Phase Two included six individual interviews (two each from the participating institutions) with consenting nurse faculty. Those participants who agreed to participate in the one-on-one interview were supplied with a copy of the consent for the interview,

the consent for the taping, the script of the instructions, and also the list of questions they would be asked (see Appendix E, F, G). Phase Two occurred in a participant's home, a book store, two separate restaurants, and places of employment. Before conducting the interview, consents were obtained, scripts were read and questions were distributed. Each interview took approximately 15 to 30 minutes to complete.

Ethical Considerations. IRB, or appropriate approval was received from all three nursing programs as well as from Rowan University. Confidentiality was ensured during the data collection process. Informed consents were administered and collected, then stored separately from the research packets and one-on-one interview materials. The research packets and research instruments did not contain any identifying information. Once completed, the subjects placed the research packets in a sealed box. Informed consents were stored separate from the research packets and one-on-one interview materials in a locked file cabinet at my residence of which I possess the sole key. All research material will be destroyed in three years. Research material is stored in an office with the consents stored in a separate location with a locked box and key.

Participation in this research was voluntary. Subjects were not coerced to participate in any way, nor did declining to participate hold any negative consequences. Subjects were also instructed that the decision to participate, or to withdraw participation once the study commenced, would not hold any negative consequences. There was minimal risk involved with participation in this study regarding previous stressful experiences. In the event that the participant experienced undue stress, he/she was referred to the Employee Assistance Program. Certificates of Completion for the National Institutes of Health (NIH) Office of Extramural Research "Protecting of Human

Research Participants" and the Collaborative Institutional Training Initiative (CITI) (see Appendix L, M). "Social and Behavioral Research–Basic/Refresher Curriculum Completion Report" were completed by the researcher prior to commencing this study.

Quantitative Data

The quantitative data were retrieved from the use of four instruments, the *Professional Quality of Life* (*ProQOL*), *Margin-In-Life*, and the demographic data tool, and two quantitative questions on the open ended questions found in the research packets. Statistical analysis was obtained by using the Statistical Package for the Social Sciences (SPSS) version 20.

Instruments. The quantitative component of the research used two instruments the *ProQOL* and the *Margin–In–Life* both with established validity and reliability to answer the research question. In addition, demographic data were collected from the participants through the demographic data tool. The demographic data provided the data needed for the independent variable.

Professional Quality of Life (ProQOL). The *ProQOL* instrument is a 30 question Likert scale to assess for the presence of compassion fatigue and compassion satisfaction. A Likert scale required the participants to answer the questions with a ranked response. The 5 level Likert instrument permitted the nurse faculty to choose an answer from a five ordered response level (1= never, 2= rarely, 3= sometimes, 4= often, 5= very often) that best represented the nurse faculty level of agreement to each statement asked. According to Stamm (2010), the *ProQOL* may be freely copied as long as the author is given credit for developing the tool and there are no changes made in the tool and there are no monetary gains from utilizing the tool (see Appendix O).

The *ProQOL* instrument has good construct reliability with over 200 published papers and an alpha score reliability of .81 (Stamm, 2010). The *ProQOL* instrument has a calculated method available to analyze the data to determine the Z scores and T scores (see Appendix N). The statistical analysis consisted of a T score and Z score which will be completed using the recommend code provided by the *ProQOL.*

Margin-In-Life (MIL) . The *Margin -In-Life* instrument is a 58-item scale that looks at an individual's power, load, and margin (see Appendix C). The instrument was developed by Joanne Stevenson, a nurse. This instrument requires the subject to rate the 58 questions using a Likert based scale. The margin was then calculated. Margin is the result of the load over the power (Margin =Load/Power). The instrument looks at the ratio of an individual's load (burden) and power (resources) to determine if there are adequate margin to meet the demands of life. The more resources or power the individual has the easier it is for the individual is to carry the load. If the margin is between .30 to .80 then the individual should have enough margin or resources to meet the demands of life. The instrument consist of three separate components a 10 point Likert scale to determine the importance of the descriptor, a 5 point Likert scale to determine the load experienced by the individual, and a 5 point Likert scale to determine the power. There is also a category if the item is not applicable to the individual. As individuals age it become more difficult to handle the load (Hiemstra, 2002). Written permission was obtained prior to using the scale (see Appendix P). The *MIL* was analyzed using descriptive statistics, and chi square to compare multiple means.

Demographic Data Tool. Demographic data were collected to explore the characteristics of the participants in the study (see Appendix A). The demographics

assisted in answering the research question: how do nurse faculty demographics such as age, gender, marital status, currently attending school, number of credits, teaching load, and participation in committees contribute to the risk for compassion fatigue? The demographics were the independent variable and compassion fatigue was the dependent variable. Demographic data were analyzed by calculating descriptive statistics, specifically, the mean, median, mode, and standard deviation.

Open Ended Questions (1&6). The open-ended questions added rich data from the perceptions of the subjects to answer the research questions (see Appendix D questions 1&6). The quantitative questions asked the participant to indicate the percentage of time spent on their work responsibilities throughout the week and to rate their satisfaction with work using a Likert-based scale.

Qualitative Data

The qualitative component of the mixed methods study consisted of open-ended questions and one-on-one interviews following a phenomenologic design. The open-ended questions followed the quantitative data questionnaires. Using the answers to both the instruments and the open-ended questions provided the integration and joining of the qualitative and quantitative data (Creswell, 2009).

Instruments. The qualitative component used open ended questions 2-5. In addition, one-on-one interviews were conducted. There were a total of 10 open ended questions included on the interviews.

Open Ended Questions (2-5). The open-ended questions added rich data from the perceptions of the participants to answer the research question (see Appendix D, questions 2-5). These questions looked at the satisfaction level, and the amount of time

spent doing faculty responsibilities, university expectations, university support, the influence of the work environment on personal life and work satisfaction. The participants were asked to supply short answers to the questions. The qualitative data analysis followed the Rules and Procedures for Logical Analysis of Written Data (Sisco, 1981), (see Appendix Q). The open-ended statements provided nurse faculty the opportunity to offer their own perceptions, which may not have been uncovered with the other research instruments.

One-on-One Interviews. The one-on-one interview questions asked the participants to describe their perceptions of their work experiences including stress levels, student demands, and reasons why they choose to remain at or leave an institution. Participants were also asked about their perceptions of leadership and what could be done to improve the quality of life of faculty. In addition, faculty were asked if they had to do it over again, would they do anything different (see Appendix G).

Data Analysis

Data were collected then analyzed. SPSS Version 20 was used to analyze the quantitative data. According to Hanson et al. (2005), the quantitative data were collected followed by the qualitative data. The *ProQOL* instrument has a calculated method available to analyze the data to determine the Z and T scores (see Appendix N). The *Margin-In-Life* was analyzed using descriptive statistics and Chi square to compare multiple means. The demographic data were analyzed using descriptive statistics. The qualitative open-ended questions were analyzed using the Rules and Procedures for Logical Analysis of Written Data (Sisco, 1981) (see Appendix Q).

Summary of Methodology

The findings from analyzing the research provided data to answer the research questions. Nursing faculty from three homogenous schools participated in this explanatory research study to determine the presence of compassion fatigue. Deans of the participating schools were contacted asking for permission to conduct the research prior to the initiation of the IRB process. All schools contacted were very gracious and permitted me to perform the data collection at their institution.

The purpose of the explanatory mixed methods design was to pull the pieces of the quantitative and the qualitative research together so that the strengths of each would provide rich data (see Figure 3.3). The use of varied instruments added to the ability to triangulate the findings. Mixed methods designs, even though considered a difficult method of research design, adds to the breadth and depth of the research by not only looking at the quantitative findings but also by giving the participants a voice.

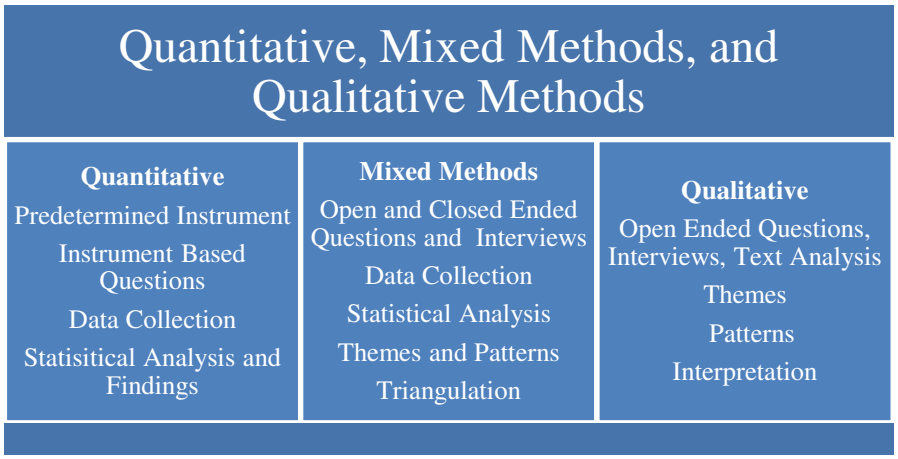


Figure 3.3. Mixed methods methodology.
Adapted from "Quantitative, Mixed Methods, and Qualitative Methods," by J. W. Creswell, 2009. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Thousand Oaks CA: Sage.

Chapter IV

Reflection on Leadership Development

This section of the dissertation is a reflection on my life and leadership qualities. Included in this chapter are those factors and incidents that were instrumental in influencing my leadership style. These circumstances have helped to shape my character, desire to learn, and leadership qualities.

Formative Years

I was born to two devoted and loving parents. My father was a butcher who worked in the Atlantic and Pacific Tea Company (A&P), while my mother stayed home to care for the family. I am the oldest of three children, with two brothers. Both of my parents were hard working and instilled in their children values that would make them productive members of society. Often my father would not be seen for days due to the long hours of work that was required to support his family. There are eight years difference between my next sibling and myself. As a child, I did not realize it but my mother had numerous miscarriages prior to having a full term child. I can recall my mother on the sofa resting when I would return from school. During those times I would assist with the household duties since my mother was on bed rest and she required my assistance. I would run errands and assist with the preparations for dinner. Due to my father's hectic work schedule, my mother and I would often have dinner without the presence of my father. He would arrive home later and I would rejoice at the prospect of seeing him and hearing about his day. Even though my father worked long hours and

then assumed a second job, my parents always spoke about the value of an education and insisted that all three children attend college.

As a result of my parents' passion for education, I am a first generation college graduate. With that being said I was expected to attend college, but I was not permitted to "go away" to college. I would attend a school within driving distance to my hometown. The cost of college was expensive and with two children after me, I choose to attend a community college. My goal was to be a nurse. Even though I attended a community college they did not have a nursing program. After one year of being in the community college I applied to Cooper Hospital School of Nursing and was accepted. The tuition was insignificant at $750.00 for three years including room and board, and the school was a relatively short distance from home. Cooper Hospital School of Nursing was a diploma program. The low cost was due to the service provided by the students to staff the hospital. Thus I was able to embark in my lifelong dream to help others.

Hallmarks of Leadership Development

My formative years played a role in developing the leader I am today. My history has instilled in me the characteristics of a servant leader. As I have grown in my profession and education I have been exposed to leaders with qualities that I have both admired and disfavored. These experiences have molded me into a transactional and transformational leader. I have had the great fortune to work under transformational leaders, and these individuals are the ones I espouse to emulate in my daily life.

Transactional Leadership

Transactional leadership occurs when one person takes the initiative in making contact with others for the purpose or exchange of something valued. The exchange

could be economic, political, or psychological in nature (MacGregor–Burns, 2003). The exchange I am speaking about is attainable knowledge to assist students to become a professional nurse. It is my belief that education should include culturally sensitive and responsive teaching to assist students to achieve and meet outcomes (Brooks, Jean-Marie, Normore, & Hodgins, 2007; Lalas & Morgan, 2006; Lalas & Valle, 2007). When reflecting on my interactions with students, I incorporate transactional leadership. I encounter students who have decided that their goal in life is to become a registered professional nurse. In order to assist the students in achieving this particular goal I assume an active role in their educational process. The students wish to succeed and as a result will make sacrifices to attain their goal. As an educator I provide students with clear measurable objectives so students will successfully pass the course. There is a reward for a job that is well done. The exchange or reward is a passing grade.

Transactional leadership is based on contingency (Thomas, 2003). This means that a reward or punishment is contingent upon performance. The student is required to read the material, pass the exams and be present for the clinical experience. In addition, professional conduct and providing safe competent nursing care is expected. For example, should a student decide to insert an intravenous catheter (IV) into a patient and, takes this action without the guidance of the instructor present, or lacks sufficient knowledge in the procedure, the student would be considered unsafe in the clinical area and would not be successful. The contingency is removal from the clinical area and a less than passing grade.

In transactional leadership as an educator, there is a give and take among myself and the students. I will provide assistance to the students in academic, educational and

personal advisement however the student will also have to be accountable for the work that is required (MacGregor–Burns, 2003). Students endure long hours of study, stressful days in the clinical area and achieve outcomes and competencies to be successful. This is the give and take that occurs in the education of students in becoming professional nurses. The students are aware of their requirements and they have to be motivated and persistent so that they are successful and competent in taking care of sick and dying patients. I too believe I have a moral and ethical responsibility to advise the students and assist students in meeting their outcomes. I believe I should provide opportunities for students so they will be successful (Everson & Bussey, 2007).

I would like to believe that I am capable of always being able to motivate the students to do their best however, I feel as though this is an unrealistic goal. I attempt to motivate and stress the importance of students' actions and their relation to success. In the real-life situation, the students must attain a certain grade point average in order to progress to the next level, so no matter how much I inspire and motivate the students they must also be accountable. If they do not successfully pass the theoretical component of the course they will not be permitted to advance to the next course.

Even though I have stated the various leadership styles that I tend to use, it does not mean that I use all at any given time and in all situations. I adhere to my deep rooted integrity when making decisions based on my knowledge of leadership styles, and the interpersonal dynamics of the group to do the right thing for the organization. I would tend to believe that I use transactional and servant leadership models when I am with the students, however; when working on a committee with my colleagues, my style may change. I would like to espouse a transformational leadership style. I expect my

colleagues to be aware of the organizational goals, and to support the vision of the university. They must be willing to transcend their personal interest for the good of the university. There is not one particular style, model, or theory that works all the time. The leader should be aware of the individuals they are dealing with, and modify their leadership style to accommodate the goals of the group (Chemers, 1995).

Servant Leadership

When reflecting on leadership I also incorporate servant leadership. According to Greenleaf (1995, 2002), leadership is evident in individuals when they realize a particular action needs to be taken and are willing to take the risk and act in order to serve others. When reflecting over my years at Rowan University, I initially believed my leadership style was transactional, however, as I reflect on my personal and professional code of ethics and reflect more deeply inside myself, I believe my predominate leadership style, in addition to transactional, is actually a servant leadership style. According to Ciulla (2003), a servant leader is one who is a servant first. I serve my patients so that they will then be able to care for themselves. I care for my patients in hopes that they will be able to maintain their optimal level of functioning even after they leave my care. In serving my patients, I advocate for them and educate them so they can care for themselves and become healthier and autonomous once they leave the hospital setting. In the event of a death, I help my patients to have a peaceful death with dignity.

I also apply servant leadership in my contacts with students. I believe all students should have the opportunity to benefit from their education, and I will go the extra mile to ensure that students are meeting learning objectives. I will often hear from my students that they hate to bother me and my response is always it is no bother; you are the

reason why I am here. I am present and available to assist my students in their educational endeavors.

Even though I assist my students in their educational endeavors, I have witnessed how some individuals are not giving their all to the students. I feel as though they have been overburdened and are not functioning in a manner that is conducive to learning. As a result of my observations I see faculty being withdrawn and not giving all that they can to their students. Nurse faculty, who are members of a helping profession, have a predisposition for servant leadership and servant leadership, in and of itself, may contribute to the risk for compassion fatigue. This observation in particular has had a direct effect on the choice of my dissertation topic, compassion fatigue in nurse faculty. I believe that it is a privilege to assist students in their learning, and when I see nurse faculty being depleted I wonder if they are suffering from compassion fatigue. If, in fact, nurse faculty are experiencing compassion fatigue, it is my belief that it will have a direct impact on the students, their learning and the care that the students will provide to their patients.

Marriage and Family Life Foster Leadership Development

I am married with two children. After my first child was born, I became a stay at home mother. My husband worked two jobs so that I would be able to care for my son. During his third month of life I went in to check on my sleeping son. I found him blue, unresponsive, and as limp as a dishcloth. I immediately began Cardio pulmonary resuscitation (CPR). After CPR was initiated, my son would have intermittent episodes of breathing and not breathing (apnea). In the event of apnea I continued with CPR measures. Unfortunately my husband was not home, so the responsibility fell on me to

call for the emergency personnel. I was alone. When the emergency personnel came I asked them to take over but they stated they wanted me to continue since I was doing a "good" job. The stress was insurmountable. As soon as I was able to hand over my son to the nurses in the hospital emergency department I fainted. CPR was successful in reviving my son. My son is presently 33 years old and if it were not for me he probably would not be here today.

I believe that this situation was a time when I exhibited servant leadership. As a mother I lead by fostering independence in my children. To this day I encourage my children to make their own decisions so that they will be able to have control of their own lives. According to Greenleaf (2002), I became selfless with my children and encourage them to always do the right thing. I try to lead by example for my children. I would be remiss if I did not mention my daughter. I am very proud of the person she has become. She graduated from Philadelphia College of Pharmacy and she is a mature young woman who is consistently proving that she is a leader and comfortable in making her own decisions in life.

I have been married for 35 years. My husband retired from work due to cancer. We have enjoyed many years together. Often work and education take precedence and I am certain one day I will regret the amount of time that has been taken from the life we could have been together. I look forward to the days when I will have extra time to spend with my husband.

Professional Career

I have the best of both worlds, teaching and nursing. I have a passion for both, and consider myself very fortunate to be able to practice nursing and teach. I have

enjoyed the various positions I have experienced. I began teaching nursing at Helene Fuld School of Nursing at Camden County College. I had always thought that I would remain at Helene Fuld; however, this did not occur. When the Dean retired another dean took her place, leadership methods drastically changed. At that time I never realized how important leadership is and how it sets the tone for the entire organization. To put it succinctly, the initial dean was a transformational leader and the second dean closed the school. Under the leadership of the original dean, we as a school were doing well and our National Council Licensure Examination for Registered Nurses (NCLEX-RN) first-time pass rate was 99%. When the leadership changed, the nursing program was directly affected. Even though I was comfortable at Helene Fuld, I knew the future of the school would not be positive. Eventually, I had the courage to leave.

After leaving Helene Fuld School of Nursing I began teaching at Holy Family University. After my first semester, I embarked on my doctoral education at Rowan University in January of 2008. I enjoy my classes at Rowan and have found all the professors competent and willing to assist students. I knew when I started classes that I would really like to work at Rowan University. Each semester during spring break I would look at the employment opportunities and submit my resume for employment in the RN to BSN nursing program. I eventually became an employee as a temporary faculty member at Rowan University. I was so excited I immediately took the position; I knew the culture at Rowan was where I wanted to be. Unfortunately I was hired as a temporary faculty member, and my employment will be over shortly.

Even though I have really enjoyed my teaching positions, I have made poor career choices for my retirement. I will not receive a pension and do not know what will happen

once my employment contract with Rowan expires, but one thing is for certain-I will hopefully have my Ed.D. and be in a better position to navigate the employment search.

I am a servant leader and transactional leader when teaching my students. While on the clinical area I will always inform students that I will not ask then to do anything that I would never do. I provide exceptional care to all the patients and their families. I go the extra mile to make certain the patients and families are educated about their disease process. The person in the bed is someone's mother, father son, or daughter and should receive optimal care.

Conclusion

The courses, professors and my colleagues at Rowan University have had a profound effect on me as a person and also as an educational leader. Leadership is essential for any organization to function efficiently and effectively. Educational leadership has been accentuated by the results of my research. I always knew that leadership is crucial, yet from the qualitative aspect the participants and their voices were insightful stating the importance of the leadership role in each particular organization.

There are numerous leadership theories which address organizations and those individuals in leadership roles. Anderson (2009), contends that the authentic leaders base their actions on the ethically and morally correct thing to do. The question then is; what is an authentic or good leader, what makes a leader in one situation and a follower in another, and how can we develop our leadership abilities? It was at one time believed that leaders were born and not made (Cronin, 1995). This belief is less widely held today; I believe one can learn to lead. The experiences encountered, mentors, and a theoretical understanding assisted in the development of my leadership abilities.

Leadership is visible in all situations and organizations. Without effective leadership there is a grave negative impact in the functioning of an organization. Even though I have stated that I perceive my major types of leadership as transactional leader and servant leader and, I especially espouse to be a transformational leader.

I aspire to be a transformational leader. As a transformational leader, I can advance my colleagues and students to a higher level where they will be motivated to achieve the prescribed goals. I would like to inspire others to change and accomplish goals for the good of the organization, and also for themselves. Transformational leadership occurs when one engages with others to rise to a higher level. I challenge students to become the best possible nurse and to not be content with mediocrity (MacGregor Burns, 1995). I motive my colleagues to continue in lifelong learning, to be committed to the advancement of the nursing profession, and to respect all as unique individuals. To lead the educational system into the future an educational leader is essential.

According to Bennis (2003) a leader should have a vision, passion, integrity, and a willingness to lead and explore new situations. As a leader, I hope to possess all the qualities needed to be an effective leader in all types of situations. I continue to use my espoused leadership theory and my emotional intelligence to accomplish goals which are relevant to the organization. I am aware of my emotional intelligence and the impact it will have not only on my students, but all of the individuals with whom I interact. According to Goleman, Boyatzis, & McKee, (2002) emotional intelligence is not innate; it is learned and should be practiced in all situations. Leaders are required to be cognizant of individual needs and show consideration and respect to others.

Even though I have stated my leadership style will vary based on the situation I come in contact with, I rely on my strong degree of integrity and ethics when making a decision. I adhere to my sense of integrity when making decisions to do what is morally right based on my knowledge of leadership styles, and the interpersonal dynamics of the group. There is not one particular style, model, or theory that works best all of the time. The leader should be aware of the individuals they are dealing with, and modify their leadership style to accommodate goals (Chemers, 1995). In order to produce change in an organization it will require framing issues, building coalitions, and creating arenas where conflict can be surfaced and agreements negotiated (Bolman & Deal, 2003). The frame that is most essential for leaders to be aware of is the human resource frame. Whenever there is change there is inherent resistance to the change. People are typically uncomfortable with change and want to do things as they were done in the past. As an educational leader, it is essential to build new skills while including all involved with the change, and also to provide psychological support (Bolman & Deal, 2003). When faced with changes I will implement Kotter's eight specific stages to bring about effective change as a leader (Kotter, 1996). Fullan (2001) discusses a process whereby a leader incorporates five core competencies that will bring about positive change. The competencies include: establishing a moral purpose, understand the change process, building relationships, knowledge building, and coherence making. Once again it is increasingly obvious to me how imperative it is to consistently have a goal or vision, and to be certain that all stakeholders of the organization understand and are encouraged to buy into the agenda.

I am a strong believer in lifelong learning. I came to Rowan with years of teaching experience, however; I have never been so aware of the need for a Doctorate in Educational Leadership. I have learned a tremendous amount from my classes and professors. Realizing that you have made a difference in someone's life is one of the greatest rewards of teaching, and I can honestly say the classes at Rowan University have made me a better person. In conclusion, life is good. I have had some struggles, yet I believe I am better because of them. I am a leader incorporating both my transactional and servant leadership qualities, while espousing to be transformational. I aspire to be the best I can and foster those same values to my patients and students. I am not sure what the future will hold for me, but one thing is certain when I leave this earth, I believe I have made the world a better place. I believe I have been a positive mentor to many and have provided many individuals with the opportunities to also better themselves and the nursing profession.

Chapter V

Data Analysis

In this chapter, the findings of the explanatory mixed methods research study will be examined. There were a total of 61 questionnaires distributed with a response rate of 90.2%. The quantitative data were analyzed using SPSS 20 to evaluate each research question, while the qualitative data were examined to identify codes and themes. Each research question was individually considered while evaluating the findings. Figure 5.1 illustrates the schematic of the data analysis process.

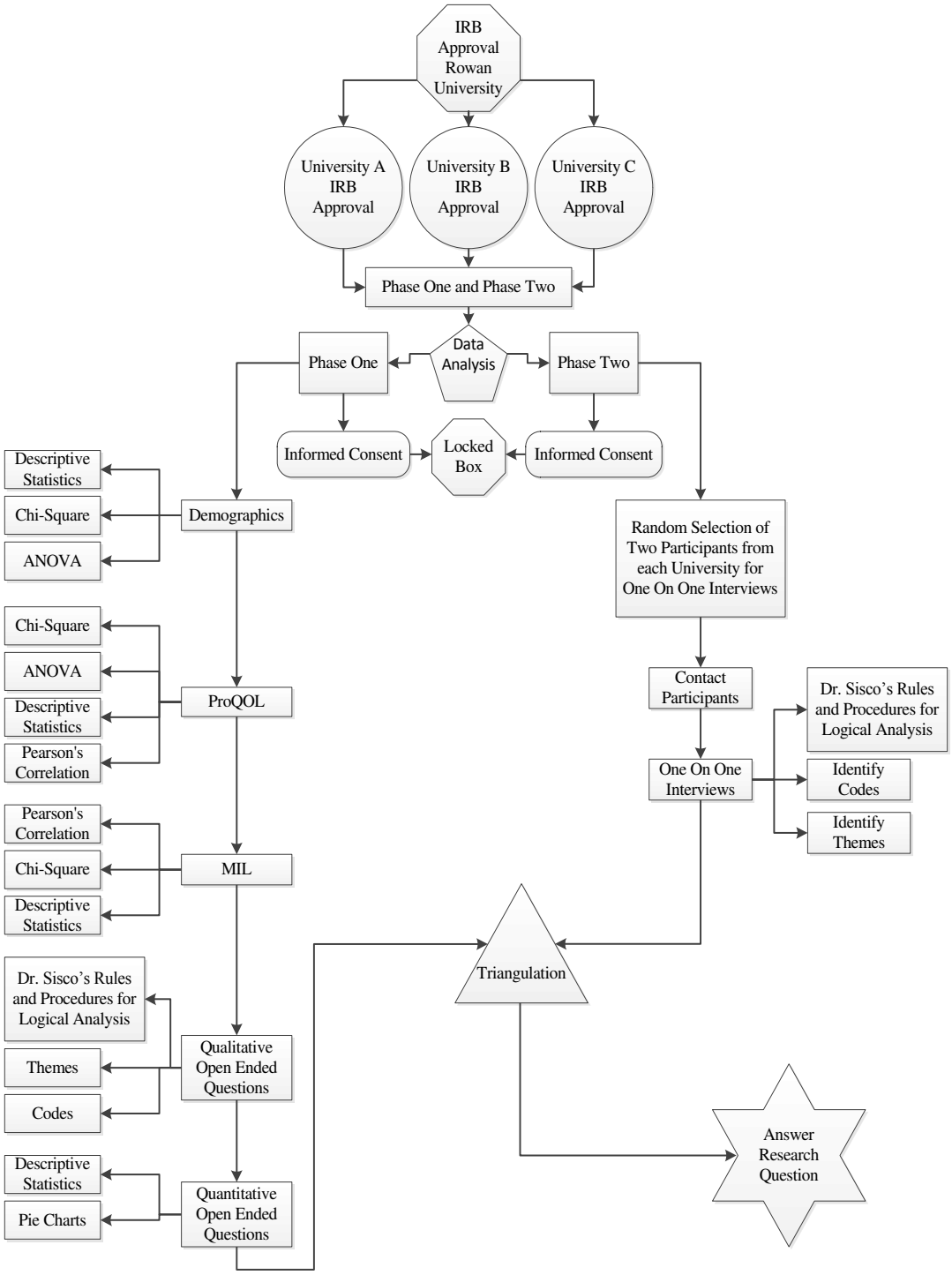


Figure 5.1. Data analysis process.

In order to answer the research questions, nurse faculty members from three religious based universities were utilized, each with a generic baccalaureate nursing program. The study was conducted during the months of April and May of 2013 after receiving IRB approval from Rowan University and approvals from the institutions where the research was collected. The quantitative phase provided the numerical information, while the qualitative phase provided the attitudes and perceptions of the nurse faculty studied. The integration and triangulation of the data provide more in-depth information to answer the research questions.

Profile of Survey Sample

Table 5.1 displays the demographic data obtained through the research instrument. There were a total of 61 subjects who were given the quantitative data instruments. There were a total of six subjects who were disqualified because they did not meet inclusion criteria. They were in administration or not full time nurse faculty. One subject submitted the instruments in a sealed envelope without completing any of the instruments. There was a 90.2% response rate.

The faculty ranged in age from 22 to 71, with the mean age being 55. There were a total of two males among the subjects (3.6%) and 53 females (96.4%). The majority of the subjects were married (46= 84%), one widowed (1.8%), one single (1.8%), five divorced (9%), and 2 responded other (3.6%). The mean number of years in nursing education was 18.09, ranging from 2 to 44 years. Nine were presently attending school for a terminal degree (16%). The mean numbers of credits being taught for full time load by the faculty were 13.07. The question regarding the number of credits being taught was a mean number of 18.65. I question if the faculty misinterpreted this statement and

were answering for a full academic year versus a semester. In the future I will ask the question per semester. The number of faculty currently practicing clinical nursing was 28 (50.01%).

Table 5.1

Profile of Survey Sample

Variable	School A		School B		School C	
	F	%	*F*	%	*f*	%
	(n=14)		(n=27)		(n=14)	
Mean Age	56.57		55.00		53.92	
Female	13	93	26	96	14	100
Male	1	7	1	4	0	0
Married	11	79	22	82	13	93
Widowed	0	0	1	4	0	0
Divorced	1	7	4	15	0	0
Other	1	7	0	0	1	7
Number of years in nursing education	18.67		18.14		17.46	
Faculty presently attending school	2	14	6	22	1	7
Number of credits for fulltime load	13.71		13.55		11.96	
Number of credits being taught	13.5		19.88		12.57	
Presently working in Clinical Setting	3	21	16	59	9	64

Research Question 1: Is compassion fatigue a risk for full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs?

The *ProQOL* (Stamm, 2010) examines compassion satisfaction and total burnout and total secondary traumatic stress scores to determine if individuals are experiencing compassion fatigue. The *ProQOL* utilizes three separate steps for scoring, which assess a

nurse faculty member's compassion satisfaction, or compassion fatigue, in which both burnout and secondary traumatic stress are present (see Appendix N). During the steps of the analysis, *z* scores were converted to *t* scores, with the raw score mean equal to 50 and the raw score standard deviation equal to 10. The *t* scores were then described as a percentage to compare to the given cut scores of the *ProQOL* as indicated in the *ProQOL* analysis. If the scores were lower than the 50^{th} percentile, which was set as the cut point, the indication was that the subjects did not exhibit that trait. If the compassion satisfaction score was above 50, then it is assumed that the subject has compassion satisfaction. In order to have compassion fatigue, the subject must have both a burn out and secondary traumatic stress scores above 50. Subjects can experience both compassion satisfaction and compassion fatigue at the same time (Stamm, 2010). Therefore the subjects experiencing compassion satisfaction, compassion fatigue, or neither or both of these traits, may exceed or total less than 100% of the sample numbers (*n*). Subjects who did not qualify for CS, CF or both were designated as "non-qualified" and are not included in the percentages in Table 5.2, but for clarity are included in subsequent tables (see Table 5.2).

Table 5.2

Overall ProQOL Crosstabulation by Location

Location			Overall *ProQOL* CS	CF	Both	Total
	A	Count	8	4	2	14
		% within location	57.1%	28.6%	14.3%	100.0%
		% within Overall*ProQOL*	26.7%	36.4%	33.3%	29.8%
		% of Total	17.0%	8.5%	4.3%	29.8%
	B	Count	16	6	3	25
		% within location	64.0%	24.0%	12.0%	100.0%
		% within Overall*ProQOL*	53.3%	54.5%	50.0%	53.2%
		% of Total	34.0%	12.8%	6.4%	53.2%
	C	Count	6	1	1	8
		% within location	75.0%	12.5%	12.5%	100.0%
		% within Overall*ProQOL*	20.0%	9.1%	16.7%	17.0%
		% of Total	12.8%	2.1%	2.1%	17.0%
Total		Count	30	11	6	47
		% within location	63.8%	23.4%	12.8%	100.0%
		% within Overall*ProQOL*	100.0%	100.0%	100.0%	100.0%
		% of Total	63.8%	23.4%	12.8%	100.0%

When reviewing the data, School A exhibited both compassion satisfaction and compassion fatigue, with compassion satisfaction outweighing compassion fatigue. Eight subjects out of the 14 surveyed qualified for compassion satisfaction giving School A 57.1% compassion satisfaction. Four subjects qualified for compassion fatigue or 28.6%. Two subjects qualified for both compassion satisfaction and compassion fatigue or 14.3% (see Table 5.3).

Table 5.3

School A Results of ProQOL

CS, CF, Both	*N*=14	Percentage
CS	8	57.1%
CF	4	28.6%
CS and CF	2	14.3%

School B had a mean compassion satisfaction score of 64.0% (16 subjects), compassion fatigue score of 24.0% (6 subjects), and both compassion satisfaction and compassion fatigue score of 12.0% (3 subjects), two subjects were non-qualified (NQ) in the testing standards and were not counted in the overall percentages. Non-qualified indicates that the subjects did not score above 50 in the compassion satisfaction cut-off point or in both total burnout and total secondary traumatic stress cut-off points. When reviewing the data, School B exhibited both compassion satisfaction and compassion fatigue, with compassion satisfaction outweighing compassion fatigue. Sixteen subjects of the 27 surveyed qualified for compassion satisfaction, or 64.0%, while six exhibited compassion fatigue, or 24%. Three subjects, or 12%, exhibited scores that qualify for both compassion satisfaction and compassion fatigue (see Table 5.4).

Table 5.4

School B Results of ProQOL

CS, CF, Both	*N*=27	Percentage
CS	16	64%
CF	6	24%
CS and CF	3	12%
Non-qualified	2	

School C had a mean compassion satisfaction score of 75.0% (6 subjects), compassion fatigue score of 12.5% (1 subject), and both compassion satisfaction and compassion fatigue score of 12.5% (1 subject), six subjects were subjects who were NQ and were not counted in the overall percentages. When reviewing the *ProQOL* data, School C by cut-off point definition, exhibited both compassion satisfaction and compassion fatigue, with compassion satisfaction outweighing compassion fatigue. Six subjects out of the 14 surveyed qualified for compassion satisfaction, or 75.0%, while one exhibited compassion fatigue, or 12.5%. One subject, or 12.5%, exhibited scores that qualify for both compassion satisfaction and compassion fatigue (see Table 5.5).

Table 5.5

School C Results of ProQOL

CS, CF, Both	*N*=14	Percentage
CS	6	75.0%
CF	1	12.5%
CS and CF	1	12.5%
Non-qualified	6	

An *ANOVA* test was completed comparing the *ProQOL* scores of all three universities studied. The compassion satisfaction mean scores of the subjects of the three schools were compared using a one-way *ANOVA*. No significant differences were found.

The total secondary traumatic stress mean scores of subjects of the three schools were compared using a one-way *ANOVA*. No significant differences were found.

Interpretation: There were no statistical significance in the differences between the three schools with Compassion Satisfaction, Total Burnout or Total Secondary Traumatic Stress values. Twenty percent, 11 of the 55 subjects surveyed in the three universities, exhibited compassion fatigue. However, the majority of faculty from which data were collected exhibited compassion satisfaction, 55% or 30 of the 55 subjects surveyed.

Research Question 2: Is there a significant relationship between the demographic variables of age, gender, marital status, presently attending school, number of credits, full time work load, presently doing clinical, teaching load, number of years in nursing education, and participation in committees and compassion fatigue?

Question number two was analyzed using descriptive statistics, calculating crosstabulations of the demographic variables, and running a Pearson chi-square test to see if there were any significant relationships among the subjects. The data showed no statistical significance between the demographic variables and the categories of compassion satisfaction, compassion fatigue, CSCF, and non-qualifiers.

Interpretation: When looking at research question two, there were no significant relationships between the demographic variables of age, gender, marital status, presently attending school, number of credits, full time work load, clinical work, teaching load, and

participation in committees, and compassion fatigue. Nurse faculty, regardless of the identified demographic data, are experiencing compassion fatigue. Nurse faculty had compassion satisfaction at an overall percentage rate of 55%. However, even with the majority of the faculty being studied, 20% of the nurse faculty studied are experiencing compassion fatigue.

Research Question 3: To what extent do full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs experience compassion fatigue?

Question number three builds upon research question number one by exploring the total group effect of compassion satisfaction (CS), compassion fatigue (CF), both compassion satisfaction and compassion fatigue (CSCF), and non-qualified (NQ) in the testing standards as measured by the *ProQOL* instrument. The statistics from question number one were combined and displayed in a pie chart to enhance the visualization of the data (see Figure 5.2).

School A had eight subjects with CS, four with CF, and two nurse faculty with both CS and CF. School B had 16 subjects with CS, six with nurse faculty with CF, three nurse faculty with both CS and CF and two NQ which indicates that the nurse faculty were not experiencing either compassion satisfaction or compassion fatigue. School C had six subjects with CS, one nurse faculty with CF, one subject with CS, and CF and six NQ which indicates that the nurse faculty were not experiencing either compassion satisfaction or compassion fatigue. Looking at all three universities there was a total of 30 or (55%) of nurse faculty experiencing CS, 11 or (20%) of nurse faculty with CF, six or (11%) of nurse with both CS and CF, and eight or (14%) NQ for the 55 subjects. The

following chart shows the numbers of subjects in total for the four categories indicated (see Figure 5.2).

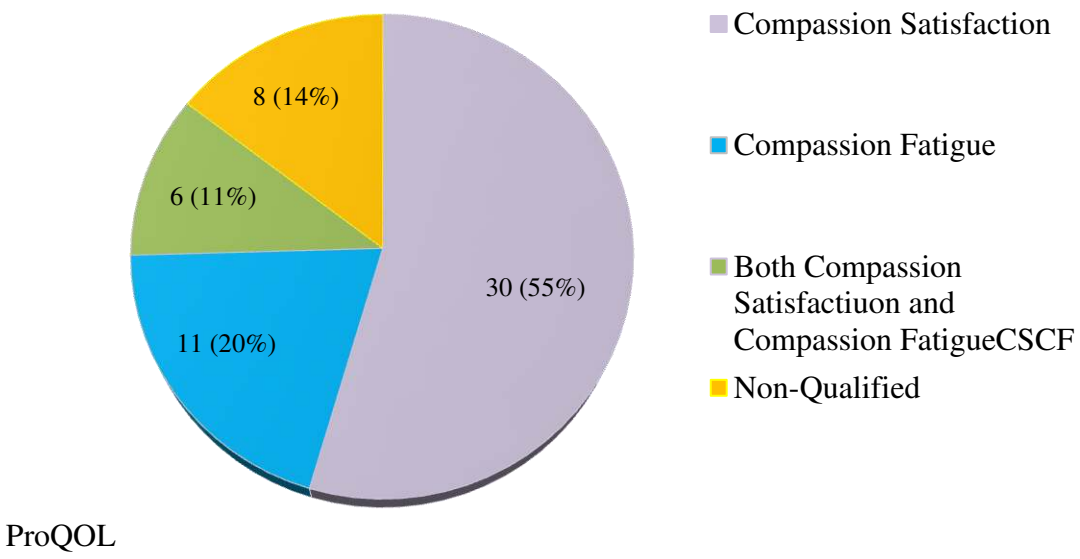


Figure 5.2. Number and percentages of subjects with CS, CF, CSCF, and NQ.

Interpretation: Fifty five percent of nurse faculty were experiencing compassion satisfaction. Moreover 20% are experiencing compassion fatigue. In conclusion, the values from the *ProQOL* instrument show that nurse faculty teaching in the selected four year baccalaureate religious based generic nursing programs experience compassion fatigue within 20% of the population of the subjects from the three schools. Clearly one fifth of the nurse faculty report experiencing compassion fatigue. This statistic would indicate that further study is needed to see if the results affect a larger population of nurse faculty.

Research Question 4: Is there a significant relationship between *MIL* scores of faculty who are experiencing compassion fatigue and those who are experiencing compassion satisfaction?

The *Margin In Life* instrument is a 58 item Likert scale questionnaire which examines how an individual copes with stress in life. It is described as margin (M) equals load (L) divided by power (P) or M=L/P. Load equals the amount of stress or demand an individual has in life. Power is the amount or resources available to deal with life's demands. The *ProQOL* instrument measures whether individuals are experiencing compassion satisfaction in their work and has been used in various service professions. To answer research question number four, a Pearson correlation was used to determine the strength of the relationships of the data collected with the two different measuring instruments. If the relationship is positive, the variables move in the same direction and if the relationship is negative the variables move in opposite directions. The Pearson correlation coefficient is between -1.0 and +1.0. Relationships near 0.0 represent a weak relationship and coefficients close to 1.0 or -1.0 represent very strong relationships. Generally speaking, coefficients with values greater than 0.7 are considered moderately strong or high and those below 0.3 are considered weak. Correlations with values between 0.3 and 0.7 are considered a reasonable or less moderate relationship (Cronk, 2010; Harris & Taylor, 2009; Holcomb, 2010).

A Pearson correlation was calculated examining the relationship between the *ProQOL* and *Margin In Life* instruments. No significant relationships were found (see Table 5.6).

Table 5.6

Margin In Life and ProQOL Pearson Correlations

Correlations		*MIL*	TCS	TBO	TSTS
MIL	Pearson Correlation	1	-.051	-.067	-.168
	Sig. (2-tailed)		.714	.625	.221
	N	55	55	55	55
TCS	Pearson Correlation	-.051	1	-.420**	-.249
	Sig. (2-tailed)	.714		.001	.066
	N	55	55	55	55
TBO	Pearson Correlation	-.067	-.420**	1	.716**
	Sig. (2-tailed)	.625	.001		.000
	N	55	55	55	55
TSTS	Pearson Correlation	-.168	-.249	.716**	1
	Sig. (2-tailed)	.221	.066	.000	
	N	55	55	55	55

**Correlation is significant at the 0.01 level (2-tailed).

While there were no significant correlations between the two instruments, there was a relationship in the sub-scales of the *ProQOL.* Namely, those subjects who had compassion satisfaction (CS) showed a moderate negative correlation to those who experienced Total Burnout (TBO), (r = -.420, p = .001) and less moderate relationship with Total Secondary Traumatic Stress (TSTS), (r = -.249, p = .066) while those with TBO and TSTS showed a moderate strong positive correlation between those sub-scales (r = .716, p = .000) (see Table 5.6).

Following the mixed-method design, and to further answer the research question, the qualitative phase of the research was conducted with the participants. This particular phase was enlightening and provided a wealth of information. The participants were given a voice. Initially I thought the participants' one–on–one interviews would take approximately 15 to 30 minutes; however, the majority of the interviews took 45 minutes.

As a matter-of-fact, even after the qualitative research questions were answered by the participants and the tape recorder was turned off, the participants still continued to talk.

Profile of One-on-One Interviews

Six interviews were held with two faculty members from each university. During phase one of the study, subjects were asked if they would like to participate in the one-on-one interview on the informed consent. If subjects were willing to be interviewed they were instructed to designate their interest by placing contact information on the consent form. The identifying contact information was used to contact the participants to schedule an interview. After the research packets were completed they were kept separate from the consents which were placed in a locked box separate from the research packets. The consent forms were colored coded for each university. Two participants were randomly chosen from each university. The participants, when contacted, were asked about a convenient time and place so an interview could be scheduled. Contact was made with all participants except for one. Numerous attempts were made to contact this individual via email and work phone number. Due to the inability to contact this participant another one was chosen through random replacement sampling.

After communicating with the randomly chosen participants, each participant was asked where he/she would like to be interviewed. The participants chose various locations and places for the interviews. The interviews occurred in the participant's offices, book stores, fast food places, and restaurants. The participants chose a date, time and place that would meet their schedule.

Prior to meeting with the participants, an electronic copy of the informed consent, audiotaping consent, and a list of the questions were supplied to each participant. Cell

phone numbers were exchanged so that on the day of the interview it would be possible to determine if the participants were at the predetermined place to conduct the interview. On the day of the interviews, the participants were also asked what they were wearing so that the participants could be identified when they entered the place where the interview would be conducted.

After the introductions, the participants were asked to sign the consent forms for audio taping and the interview prior to beginning the interview. The participants were informed that they could stop the interview process at any time and that the interview was voluntary. The two participants from School A represented 14.3% of the School A group. The two participants from School B represented 7% of the School B group, and the two participants from school C represented 14.3% of the School C group. The one-on-one interviews represented 11% of the total 55 participants who volunteered to be involved in the research.

The one-on-one interviews consisted of 83.3% females. The number of years in nursing ranged from 13 to 44 years. Nursing was the second career choice for 17% of the participants who did the one-on-one interviews. The interviews began after consents were signed and the audio taping started at that time (see Appendix G). The interviews lasted for approximately 45 minutes and each consisted of approximately 20 pages of double spaced verbatim transcription. After the transcription was completed the information was read and reread to identify codes and themes from the interviews.

Tables are provided for the themes for the open ended questions the participants answered from each of the universities. The probative question is listed with the identified category, subcategory, and frequency of occurrences. The research packets

were analyzed using content analysis describe in Appendix Q (Sisco,1981). In addition, the one-on-one interviews were also analyzed using the same process. Phrases and clauses were the basis of analysis, verbiage not considered as essential was eliminated and the verb noun syntax was corrected where appropriate. Clarifications were added to understand the context when appropriate. The priority when analyzing the data were to organize the data and become familiar with the data. Themes and categories were generated and then coded. Coding the data was accomplished by hand to identify themes. The data from the participants were read and reread multiple times, classified and then reduced and collapsed into categories and ranked. Verbatim quotes were also provided to explore and understand the voices of the participants from the one-on-one interviews.

Research Question 5: How do full-time nurse faculty in selected four-year baccalaureate generic nursing programs describe their stressors in their work and academic environments?

The qualitative component of the research project provided a voice for the participants. Open ended questions and one-on-one interviews were used to answer this research question allowing the participants to describe their thoughts and feelings. According to Seidman (2009), as a result of the interviewing process, I had an appreciation for the lived experiences of the nurse faculty and how the faculty were able to make meaning of their teaching experiences. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the expectations of the university regarding scholarship, research, and service are depicted in Table 5.7

Table 5.7

Institutional Expectations Regarding Scholarship, Research, and Service

Category	Subcategory	School A	School B	School C	Total
Expected					32
	Expected	4	6	2	
	High Expectations	2	3	3	
	Expected for Promotion	0	5	2	
	Expected for Tenure	0	0	5	
Time					5
	Not Enough Time	1	0	1	
	Done on "Own Time"	1	2		
Resources/Support					3
	Little Resources	0	1	0	
	No Support	0	0	2	
Boyer's Model		5	1	0	6

From the question it was evident that research scholarship and service is an expectation in each university with a limited amount of resources available for the participants. The Boyer Model was also mentioned in two of the three schools as a theme. According to Pape (2000), the Boyer model emphasizes the model of scholarship for the nursing profession with an emphasis of four specific functions. The functions include discovery, integration, application, and teaching. The art of teaching is a social practice that is enhanced by nurse faculty and the engagement that occurs between students and faculty to foster interactive learning and scholarship (Drummond-Young et al., 2010). Comments centered around the concept of time.

Open Ended Question- What expectations does your institution have for you regarding scholarship, research and service?

Participants-“Expected for promotion”

Participant-“Too little time and need to do a lot”

Participant-“Burned out”

The second open ended question focuses on support given to the faculty by their institution. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the support provided by the institution are depicted in Table 5.8

Table 5.8

Institutional Support Provided to Nurse Faculty

Category	Subcategory	School A	School B	School C	Total
Education					14
	Reimbursement for Conferences	1	5	1	
	Faculty Development Opportunities	1	5	1	
Support					14
	Faculty Support Each Other	1	1	1	
	No Support	1	2	4	
	Little Support	0	0	3	
	Not Sure How University Supports Faculty	1	0	0	
Financial					10
	Budget Cuts decrease support for faculty	5	0	0	
	Little Financial Resources	0	0	2	
	Salary Only	1	1	1	
Mentor		1	2	4	7
Input					5
	Asks for Input	2	0	1	
	Listens	0	0	1	
	Hears Concerns	0		1	

Nurse faculty commented that the educational institutions were contributing to the academic development of the faculty; however, this may be changing due to the economic constraints that are facing institutions of higher education. Fourteen of the comments included support from colleagues yet, little support from administration.

Open Ended Question- Please give examples of how your institution supports you in your role as a nurse faculty member?

Participant-"Economic shortfalls and the decrease in the amount of financial resources available to pursue educational opportunities"

Participant-"Funding taken away due to budget cuts"

Participant-"No support"

Participant-"Mentoring"

The third open ended question concentrates on instances when the institution was not supportive. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding lack of support are depicted in Table 5.9

Table 5.9

Examples of Institutions Not Being Supportive to Nurse Faculty

Category	Subcategory	School A	School B	School C	Total
Resources					12
	No Financial Resources	5	0	1	
	No Secretarial Support	0	2	0	
	Need more Current Technology	0	1	0	
	Increased Enrollment and Decreased Faculty	0	1	2	
Class					5
	Class Size too Large	1	0	3	
	Not Enough Class Room Space	0	1	0	
Overload					4
	Overload of Responsibility	1	0	0	
	Overload Every Semester	0	1	1	
	Teaching Load too Heavy	0	0	1	
Bullying Admin		0	0	2	2
	Don't Understand the Rigors of a Nursing Program	1	1	0	2
Students					2
	Admitting Students that Are Not Academically Prepared	0	1	0	
	Admitting students that are Unqualified	0	0	1	

Comments from nurse faculty were related to a lack of available resources. Nurse faculty cited specific comments about bullying that were not elaborated on, so the question becomes: Is the faculty being bullied by administration or is there bullying among faculty? Nurse faculty voiced concern related to enrollment issues and admission criteria. Additional comments included that the administration does not understand the rigors of the nursing programs related to clinical and NCLEX performance.

Open Ended Question- Please give examples of situations when you felt your institution was not supportive of you as a faculty member?

Participant- "Outdated technology"

Participant- "Educational programs were being cut"

Participant- "No support for travel to conferences"

Participant- "Lack of secretarial support for the department"

Participant- "Bullying"

Participant- "Enrollment and acceptance of students into the nursing program that were not academically ready for the rigors of the nursing program"

The fourth open ended question discusses the influence of the work environment on nurse faculty's satisfaction with their personal life. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the influence of the work environment on satisfaction with their personal life are depicted in Table 5.10

Table 5.10

Influences From Work That Impact Satisfaction With Personal Life

Category	Subcategory	School A	School B	School C	Total
Too Much Work					10
	At Home	3	1	2	
	At the Office	3	1	0	
Tired					5
	Exhausting	1	2	0	
	Tired after Work	0	1	0	
	Always Tired	0	0	1	
Stress					4
	Stress	2	0	1	
	Puts Stress in Personal Life	1	0	0	
Interferes					4
	Interferes with Home Life	0	2	1	
	Interferes with Personal Satisfaction	0	1		

Comments from the nurse faculty included that the amount of work was overwhelming. They also felt there was an increased amount of stress. The nurse faculty felt as though they were exhausted after the work week.

Open Ended Question- How does your work environment influence your satisfaction with your personal life?

Participant-“I take home the baggage of my work”

Participant-“Sometimes the stories of my students make me sad”

Participant-“I need to bring work home and it interferes with my home life,”

Participant-“Not as much flexibility”

Participant-"There has to be a balance between personal life and work situation, and this was difficult to find, which leads to a negative effect on my personal life"

The first question in the one-on-one interview centers on why the nurse faculty member chose to become a nurse. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the reasons why they became a nurse are depicted in Table 5.11

Table 5.11

Reasons for Becoming a Nurse Faculty

Category	Subcategory	Total
Teaching		4
	Someone told me I would be good at teaching	
	Always thought about teaching	
	I liked teaching	
	I liked being a teacher	
Schedule		2
	Wanted summers off	
	Schedule	
Helping		2
	Helping new nurses	
	Mentoring people and helping them become new nurses	

Five of the six nurse faculty who participated on the one-on-one interviews choose nursing as their initial profession and continued in the nursing field. Nurse faculty, except for one individual, have been a nurse as their primary profession. One participant had a career change from a truck driver to the role of a nurse in later life. The academic calendar accommodates the schedules of many nurse faculty.

Interview Question- Can you tell me a little about yourself? Thinking back when you became a nurse faculty, what was the chief reason you became a nurse faculty?

Participant-"I enjoy teaching

Participant-"I feel as though I make a contribution to society"

Participant-"I have a desire to help others"

Participant-"I like the summers off and the schedule"

Participant-I like helping students become a nurse"

The second question in the one-on-one interview focuses on unhealthy levels of stress. The nurse faculty were asked to describe what they thought contributed to the unhealthy levels of stress. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the their perceptions are depicted in Table 5.12

Table 5.12

Explanations for Unhealthy Levels of Stress

Category	Subcategory	Total
Accepts additional responsibilities		2
	Inability to say no to things	
	Takes on additional work	
Negativity		2
	Very negative	
Complaining		2
	Vocally complaining about stress	
	Complaining	
Communication		
	Gossiping	2

Faculty comments centered on lack of self-care and increasing demands placed on them by those in leadership positions. The inability of nurse faculty to set boundaries on their time and availability directly impacted their level of stress. Nurse faculty were preoccupied with their perceived inequalities in the workplace.

Interview Question- Think of a colleague in your department who you think exhibits unhealthy levels of stress. Can you describe what you think contributes to this?

Participant- “She was kind of pushed into that position and doesn’t know how to say no."

Participant- “She is constantly having physical symptoms of her asthma. She is constantly experiencing ailments; I can physically see her becoming much more hunched over”

Participant- “Never eating, never taking a break for lunch”

Participant- “Um… I can see over the past couple of years physically, she seems more drawn and more um… just you know, just the only way I can describe it is more kind of into herself. Kind of physically aging, forgetfulness probably. Very unhappy"

Participant- “Everybody worrying too much about what everybody else is doing instead of focusing on a goal"

Participant-"I think kind of threatened by where other people are, what they do or who they think you are aligned with”

Participant- “There was constant change and administration was not forthcoming with information. The leadership actually made it (stress) worse because we (the faculty) did not receive enough information from administration.”

The third question in the one-on-one interview concentrates on the differences between present and past students. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the their perceptions are depicted in Table 5.13

Table 5.13

Comparisons of Former Students

Category	Subcategory	Total
Spoon fed		2
	They want to be spoon fed	
	Unable to problem solve	
Entitled		2
	They feel entitled	
	Less motivated	
	Want to be entertained	

Comments from the faculty centered on problem solving and motivation. Access to technology, such as email, increases the demands placed on faculty by students as well as decreases the ability of students to problem solve on their own. Faculty also felt that some students expressed entitlement to their education and there is much more parental involvement when a student does not meet course objectives.

Interview Question-How would you compare the students of today from students you have had in the past?

Participant- “Email is on the tip of their tongues, well in the past I would say students would spend more time self-identifying or self-resolving their own issues”. Today it’s; Oh let me send that professor an email, and so the students expect you to answer all their problems”

Participant- “I’ve seen more parents getting involved, wanting to know why my child failed this test, or what are you doing about this...very specific types of questions."

Participant- “Students feel that they are entitled to their education and it is the responsibility of the nurse educator to make the student pass”

Participant- “Students want to be entertained are immature, and lack academic skills”

Participant- “I have nothing but good things to say about the students that come here, they work really hard. Many of them are supporting their own families, including their parents, by working part-time or full-time while they are here, and so I have no tolerance for people complaining about these students today. Because you know, they are perfectly capable and probably more capable than we were when we were in school.”

The fourth question in the one-on-one interview concentrates on the explaining a time when a nurse faculty member has felt exasperated. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding the their experiences are depicted in Table 5.14

Table 5.14

Emotional Impact of Students on Nurse Faculty

Category	Subcategory	Total
Feelings		7
	Drained	
	Angry	
	Frustrated	
	Exasperated (2)	
	Litigious society	
Lost it		7
	No, not yet	

Nurse faculty recalled circumstances when they had feelings of anger, frustration, being drained and exasperated. Even though the nurse faculty felt exasperated, they did possess self-control and were able to control their emotions so that they did "not lose it." Comments centered around the nurse faculty's feelings.

> Interview Question- Has there been a time when you felt exasperated with a student and just "lost it?" Can you give me an example? Describe the experience and the effect it had on you.
>
> Participant- **"**When you see lack of motivation and give me, give me, give me, it just makes me angry"
>
> Participant- "I hear over and over again the sense of entitlement. I know I am a lot older than them (the students) and I know I am a different generation but you gotta work for what you get"
>
> Participant- "Have I felt exasperated, yes, did I just lose it, no…not yet"

The fifth question in the one-on-one interview focuses on doing things differently if given the opportunity. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their experiences are depicted in Table 5.15.

Table 5.15

Reactions to Career Choice

Category	Subcategory	Total
Yes		4
Not sure		1
No		1

This particular question had yes responses from the faculty with four nurse faculty stating they would be a nurse and also teach. Those that like teaching do it for the personal rewards and gratification they have from seeing students achieve. One of the nurse faculty who said yes, would have wanted to be a nurse, would have gone into the military. The reason for this is because the participant's colleagues were in the military and all have retired.

> Interview Question- If you had to do it over again, would you do it differently?
>
> Participant- "The problem in nursing is, I've worked 30 plus years, I don't have a pension, I don't have insurance when I retire. So I often say why wasn't I a public school teacher? The problem is after 30 years of being a nurse; I don't have the ability to just quietly retire. And so from a pure self-perspective, I work just as hard as anybody from the state or the government or wherever but I don't have these benefits."

The sixth question in the one-on-one interview spotlights leadership roles that would improve the quality of life of the faculty. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their perceptions are depicted in Table 5.16.

Table 5.16

Leadership Initiatives to Improve the Quality of Life of Nurse Faculty

Category	Subcategory	Total
Communication		5
	Confront things head on when they happen	
	Put things on the table rather than sweeping under rug	
	Address the problems	
	Transparent	
	Forthright	
Support		5
	Faculty support (2)	
	Increase morale	
	Work on teambuilding	
	Let faculty know they are valued	

Participants' comments emphasized communication and support. Faculty also valued recognition and appreciation from those in leadership positions. It is evident faculty desire to be valued for their contributions to the nursing program and academic community at large. Monetary remuneration was not mentioned, it was more a feeling of worth or respect and a supportive environment that was crucial to the faculty.

Interview Question- If you were in a leadership role as head of this department, what three things would you do to affect the quality of life of the faculty?

Participant- “Open communication is needed”

Participant- “Addressing situations when they occur”

Participant- “More faculty support and recognition by the leadership”

Participant- “More appreciation”

Participant- “Value the faculty”

The seventh question in the one-on-one interview focuses on nurse faculty’s experiences with students when they first began teaching at the university. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their experiences (see Table 5.17).

Table 5.17

Nurse Faculty Experiences With Students When They First Began Teaching

Category	Subcategory	Total
Fear		2
	Afraid	
	Complaining	
	Overwhelmed	
Rule enforcement		2
	Less strict	
Communication		2
	More direct communication	
Manners		2
	Better behavior	

In the beginning of their teaching career, faculty were fearful that they would not have all of the answers and were intimidated by their students. It was difficult for faculty to realize that students have a responsibility in their education and have to be accountable. Fear, manners, and communication were overriding themes with this question.

Interview Question- How would you explain your experiences with students when you first began teaching at the university?

Participant- "I even enjoy them (students) more because I am not so afraid of them. In the beginning I was so nervous about getting things wrong or getting bad evaluations because I know how much weight we put on evaluations. Now I am at a place where that doesn't preoccupy my thoughts. I am really worried mostly about doing my best to help them be successful. And allowing them to have 50% of the ownership of that success because you know, half of it is on them."

Participant- "You are waiting for the one who was going to challenge you and then maybe you don't have the answer, and so as you mature you come to realize you are not always going to have the answer."

Participant- "Rule enforcement was much more evident in the early careers of participants. Class sizes were smaller then and rule enforcement is more difficult now with students."

Participant- "The overall behaviors of students have changed, now there is a general lack of manners.

The eighth question in the one-on-one interview highlights nurse faculty's experiences with students and how they have changed. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their experiences are depicted in Table 5.18.

Table 5.18

Changes in Students When Nurse Faculty First Began Teaching

Category	Subcategory	Total
Accountability		3
	Sense of Entitlement	
	Boundaries pushed	
	When they don't do well it's my fault	

Faculty feel as though students have changed because now they have a sense of entitlement. If students feel that they are not successful it is a reflection on the educator rather than themselves. Comments from nurse faculty were centered on lack of accountability of the students.

Interview Question- Have your experiences with students changed, and in what way? Please give examples.

Participant- “Students have a sense of entitlement, and when they don’t do well it is my fault.”

Participant- “I have had students in this semester who told me they didn’t buy the book.”

Participant- “Students feel if material is not on a PowerPoint it should not be on the test.”

Participant- “Students want knowledge based questions instead of application or higher level questions."

The ninth question in the one-on-one interview centers on nurse faculty’s perceptions for the reasons the students have changed. The frequency of each unit and

subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their perceptions are depicted in Table 5.19.

Table 5.19

Perceived Reasons for Changes in Students

Category	Subcategory	Total
Technology		4
	Email	
	Texting	
	Facebook	
	Instantaneous	

Technology was the major perceived causative factor for the change in students from the past. Comments focused on the speed and instantaneous access that technology provides to the students. Technology has also impacted students' learning styles.

Interview Question- What do you perceive as the reason for the changes?

Participant- "Everything is instantaneous."

Participant-"They (students) don't take the time to process things. Rather than try to think things through on their own, students will send an email and will expect an immediate response."

Participant- "If they are spending too much time on their cell phone or they are doing things that distract them, it is going to become apparent that they are not going to be successful and that is up to them."

Participant- "Technology certainly has had an impact on education; however, students must learn to balance their use of technology and their learning styles."

The final question in the one-on-one interview focuses on nurse faculty's thoughts on deciding factors that would have an impact on their decision to remain or leave their place of employment. The frequency of each unit and subcategory were counted and ranked in order of occurrences. The themes identified by the nurse faculty regarding their thoughts are depicted in Table 5.20.

Table 5.20

Factors That Influence Nurse Faculty to Remain at a University

Category	Subcategory	Total
Leadership (Leave)		5
	Leadership did not foster individuality	
	A change in leadership would make me leave	
	Leadership would make me consider leaving	
	Lack of shared governance	
Leadership (Remain)		2
	A leader would decide whether I like my job or not	
	Visionary Leader	
	Opportunities for growth	
Stress		4
	Stress related health factors	
	What is causing stress	
	Jobs are not stress free	
	You feel it is unhealthy for you	
Support		2
	Not having enough support	
	Unrealistic expectations	

Leadership has a tremendous impact on the moral of nurse faculty. It is evident that leadership strongly influences a faculty member's to desire to remain or leave an

institution. Monetary compensation was not mentioned as a deciding factor in the faculty's choice to leave or remain at a nursing program.

Interview Question- Can you give me examples of factors that make you remain at the university? What factors would be influential in your decision to leave?

Participant- "A change in leadership would absolutely make me leave."

Participant -"The leader will decide whether I like my job or not."

Participant- "Not having support and having unrealistic expectations."

Participant- "Leadership would make me consider leaving."

Participant- "If the leadership did not foster individuality, I would probably consider what in the job is causing the stress, and is there something that I can do about that at the job, or I would pick up and say, I am done with this."

In summary, the qualitative findings provided an opportunity for nurse faculty to have a voice in the questions being asked in the one-on-one interviews. My perception was that this was the first time nurse faculty were asked about their experiences regarding their academic and personal life. Nurse faculty were willing to share their multiple experiences and even after the audio taping was completed, nurse faculty continued to express their thoughts, beliefs and perceptions for the future of nursing and especially the important role of nurse faculty. Nurse faculty are faced with multiple demands being place on them from their respective institutions, students and also themselves.

The demands of the nurse faculty include doing more with less. There is less technological support, less secretarial support, less money available for continuing education, students who are not adequately prepared for the academic challenges of the nursing profession, and there are more students enrolled in classes. In addition, nurse

faculty expressed that the issues facing the students of today are complex such as many students are working fulltime, raising a family and dealing with life altering situations like divorce, pregnancy, violence, and mental health issues.

As a result of these issues nurse faculty spend additional time interacting and supporting nursing students. Nurse faculty are often with students in the classroom situation in addition to 10 or 12 hours of contact on the clinical area. The students seek out nurse faculty for their support and guidance and this is primarily due to the increase in interaction with nurse faculty during the clinical experience and also in the classroom.

Even though nurse faculty have been found to predominately have compassion satisfaction in this study, they are also experiencing the high expectations of society, academia, and those expectations they self-impose upon themselves. Nurse faculty are encountering NCLEX scoring shifts, more research based institutions that are requiring grants, and the requirements of service, and scholarship. From the results of the qualitative component of this mixed methods research, nursing faculty want, need, and require positive leadership that values and communicates with nurse faculty in a timely and consistent manner so that they will be able to fulfill the responsibilities of healthcare, educational institutions, and also the high expectations they have for themselves and their students.

Chapter VI

Summary, Discussion, Conclusions, Recommendations, and Leadership Reflections

Summary of the Study

The purpose of this study was to identify if selected nurse faculty experience compassion fatigue. This study looked at full time nurse faculty and identified if faculty were suffering from compassion fatigue. To identify the presence of compassion fatigue three religious-based baccalaureate nursing programs were chosen to participate in the research study. In addition to looking at the presence of compassion fatigue, the *Margin-In-Life* instrument was also administered to determine if there was a relationship between an individual's level of work satisfaction and the presence of power, load, and margin in their everyday life. The instruments included a demographic data tool, open-ended questions for all participants, a 30 item *ProQOL* instrument and a 58 item *Margin-In-Life* instrument. The *Margin-In-Life* asked the participants to rate the importance, power, and load, for each question. In addition, one-on-one interviews were conducted with six nurse faculty.

From the data analysis of the *ProQOL* findings, the mean score for all nurse faculty who exhibited compassion satisfaction was 50.58. The mean score for the faculty who exhibited TBO was 49.17 and the mean score for TSTS was 49.38. The results of the data indicate that one in five nurse faculty in this research study have compassion fatigue, or approximately 20%. The findings of this study indicate that the majority of nurse faculty are experiencing compassion satisfaction (55%). According to Stamm

(2010), participants can experience CS, CF, both CS and CF, or be non-qualified for both CS or CF. There were no relationships found between the *ProQOL* findings and the *MIL* results. Additionally, there was no relationship found between the demographic data and the risk for compassion fatigue.

The qualitative findings provided a much richer picture of challenges facing today's nurse faculty. Content analysis of the one- on-one interview data suggested images of multiple professional obligations of nurse faculty, tempered by the realities of operating in a high stress environment, student expectations, and administrative demands for efficiency and high test success. While the emergent themes provided a generally positive view, leadership in the organization had a profound impact on nurse faculty satisfaction/fatigue. Moreover, overriding themes of support, resources, stress, and communication were noted from the content analysis of the qualitative data.

Discussion of Findings

A portion of the nurse faculty included in this research study exhibited compassion satisfaction. On a scale of 1 to 10, nurse faculty as a group rated their mean level of satisfaction with their present employment as a 6.9. When asked to break down how their time spent performing job responsibilities was presently divided, the subjects responded that they expended most of their time on didactic teaching at 22%, followed by clinical practice which consumed 18% of their normal work week. The remaining amount of time spent during the average week in descending order was, lesson plans (13%), meetings (9%), student advising (9%), service (7%), research (7%), other (7%), and office hours (7%). Each research question will be answered to discuss the findings of this research study.

Research Question 1: Is compassion fatigue a risk for full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs? Compassion fatigue is a risk in this sample. The *ProQOL* results from the selected nurse faculty documented that even though the majority of nurse faculty are experiencing compassion satisfaction there are still 45% of nurse faculty who are not experiencing compassion satisfaction. There is a risk for compassion fatigue in nurse faculty selected for this study. Nurse faculty are members of a helping profession and research has shown that those in helping professions have an increased risk for compassion fatigue (Figley, 2002; Hoffman 2000). Additionally, nurse faculty must balance the requirements of scholarship, research, and service, yet maintain a balance in their personal life (Brady, 2010). The intensity of the clinical faculty role far exceeds that of the basic-science-laboratory setting to which it is compared in the academic setting. Due to faculty shortages, frozen positions, increasing faculty-to-student ratios, and increasing enrollments, nurse faculty workload is increasing while the flexibility and autonomy that has long been associated with the faculty role is decreasing (Brady, 2010). Consequently, more than one in four nurse educators said they were likely to leave their current faculty position related to the desire for a reduced workload (NLN, 2007).

Research Question 2: Is there a significant relationship between the demographic variables of age, gender, marital status, presently attending school, number of credits, full time work load, presently doing clinical, teaching load, number of years in nursing education, and participation in committees and compassion fatigue?

Even though 55% of nurse faculty experienced compassion satisfaction there were no significant relationships between the demographic data measured and the existence of compassion fatigue in the three selected religious based nursing programs studied.

Research Question 3: To what extent do full-time nurse faculty teaching in selected four-year baccalaureate generic nursing programs experience compassion fatigue? This question further explores the total group effect of compassion fatigue. The findings indicate the majority of nurse faculty are experiencing compassion satisfaction at a rate of 55%. Even though nurse faculty are predominately happy, what about the remaining 45% of nurse faculty? The findings indicate that 20% of the subjects have compassion fatigue, 11% have both compassion satisfaction and compassion fatigue, and 14% of the subjects did not qualify for either compassion satisfaction or compassion fatigue. Clearly one fifth of the subjects are experiencing compassion fatigue. It is interesting to note that some subjects did have both compassion fatigue and compassion satisfaction. Stamm (2010) states that it is possible for an individual to have both compassion satisfaction and compassion fatigue at the same time. Of interesting note is a quote from Todaro-Franceschi (2012):

> There are times when I am notably feeling compassion fatigued. You simply cannot help co-suffering when teaching about death and dying. But I love what I do. I love teaching the topic and can't imagine doing anything else. The work I am doing is meaningful. (p. 62)

Research Question 4: Is there a significant relationship between *MIL* scores of faculty who are experiencing compassion fatigue and those who are experiencing compassion satisfaction? In order to answer this research question a Pearson's

correlation was done to look at the strength of the relationships among the *ProQOL* and the *MIL* instrument. There were no significant relationships between the *ProQOL* and the *MIL* instrument. The ProQOL looks at the level of satisfaction in the work environment whereas the *MIL* looks at the level of stress an individual is having in their daily life experiences. Even though there was no significant correlation in the instruments per se, there was a as a strong relationship between the subscales. If subjects were experiencing TBO or TSTS there was a significant positive relationship between the subscales ($r = .716$, $p = .000$). The subjects with compassion satisfaction (CS) displayed a negative correlation with those who experienced Total Burnout (TBO), ($r = -.420$, $p = .001$) and Total Secondary Traumatic Stress (TSTS), ($r = -.249$, $p = .066$).

Research Question 5: How do full-time nurse faculty in selected four-year baccalaureate generic nursing programs describe their stressors in their work and academic environments? Research question five was answered by the open ended questions given to all participants in the research study and also the 10 one-on-one interview questions with representatives from each school. The findings indicate that there is a perceived lack of support and communication provided to the nurse faculty as answered by the question if the nurse faculty were in a leadership role what would they do to increase the quality of life of the nurse faculty. The stressors expressed by the nurse faculty indicate a sense of balance is required to be effective in their personal and work environments. Leadership was also mentioned as the deciding factor that would have an impact on the nurse faculty member either staying or leaving an institution. According to Ribelin (2003), a nurse's relationship with their immediate manager has a direct relationship on productivity, retention, and attrition rates.

The results of the qualitative findings suggest that faculty do enjoy teaching. It is challenging, yet rewarding and fulfilling. There are changes that have occurred including technological advances and a sense of entitlement by the students, however; faculty are generally content. The major impetus for faculty to remain or leave an institution is leadership. No mention of monetary remuneration was cited. It is essential that communication be continuous and forthright. It is also imperative for organizational leadership to realize that faculty want to feel appreciated, valued, and supported. Leadership was mentioned by all participants as the impetus to remain or stay at an institution. Findings of this study substantiate the findings of previous research regarding leadership, collaboration, and support. Zimmerman and Thormann (2010) acknowledge that rewarding people is a concrete sign of appreciation that builds respect and makes people feel better about the leadership; moreover, people also need to feel heard and understood.

Conclusions

It is vital to note that this study identified that nurse faculty do for the most part experience compassion satisfaction. Nurse faculty have expressed joy with teaching. It is important to assist nurse faculty to hold onto that joy. According to Gazza (2009), nurse faculty believe they make a difference in the lives of their students, the profession of nursing, and the patients who are being cared for by nurses. During the qualitative phase of the research, it was identified that nurse faculty sought recognition for a job well done. It is imperative to celebrate the successes and contributions of nurse faculty. Creating learning institutions where happiness and hopefulness exist should be a top priority (Rydeen, 2008). Recognizing happy nurse faculty routinely fosters a positive

work environment. Current clinical research shows that supportive working conditions are factors that not only appeal to nurses, they also contribute to better health care outcomes (Wood, 2013). It is only logical that this would transfer to academia and nurse faculty as well. Additional research is needed in this area.

There is a paucity of research studies to explore compassion fatigue in full time nurse faculty in four year religious based baccalaureate nursing programs. The purpose of this explanatory mixed methods research study was to determine if nurse faculty working in a four year generic religious based baccalaureate nursing program in the state of Pennsylvania were experiencing compassion fatigue. This study provides initial empirical evidence that compassion fatigue does exist in nurse faculty. Further research on a larger scale is required for generalizability of the findings.

This study provides implications to both higher education and the profession of nursing. The demands of nursing education may cause the development of compassion fatigue in nurse faculty. The impact of those in leadership positions in nursing programs should be investigated to determine if there is a correlation between compassion fatigue and leadership styles. Institutional support is required to prevent compassion fatigue in nurse faculty. This will result in impending health care needs being met by nurse faculty so they can educate future nurses to care for the ever increasing complex demands of society.

This study focused around compassion. Nurses have been known throughout history for their compassion for humankind. Compassion has been defined as the humane quality of understanding the suffering of others and wanting to do something about it (Compassion, 2013). It is important for nurse faculty to take the time to have

compassion for themselves and for each other. Most of all, it is important to take a deep breath and enjoy the moment. Laugh and enjoy what life has given you. Give yourself permission to relax and realize that all problems cannot be solved. Set limits and boundaries on your time and on the amount of responsibilities you assume. Have balance and set priorities.

Recommendations for Practice

This study provides implications to both higher education and the profession of nursing. The implications of the findings of this research for practice suggest that the presence of compassion fatigue does exist among nurse faculty. Even with the occurrence of compassion fatigue, it is also preventable once identified. To that effect, there are several implications for education that necessitate mentioning.

First, it is important to recognize the importance of the contributions that nurse faculty make while training the neophyte nurse to navigate the ever increasing demands of the health care system. It is also essential to accept that the demands of nursing education may cause the development of compassion fatigue. It is not only important to recognize the potential existence of compassion fatigue among nurse faculty; but also the benefits of educational programs for nurse faculty that teach about how to recognize compassion fatigue symptoms. Compassion fatigue preventative and interventional programs are also essential for nurse faculty.

As identified through the qualitative phase of this research, open and transparent communication between administration and nurse faculty is vital to a healthy work environment. Communication plays a vital role in the achievement of interpersonal and organizational goals (Watt, 2010). Some participants also identified balance as central.

It is essential to maintain balance. Nursing is a helping profession. It is important to care for one's self before being able to care for others. If not, this may lead to the development of compassion fatigue (Tellie, 2008). Nurse faculty need to make realistic short-term and long-term goals for themselves and also need to be given realistic goals to achieve. Reciprocal relationships among nurse faculty need to be encouraged. Reciprocal relationships increase collegiality and strengthen communication bonds within the work situation. This research, although not generalizable beyond this sample, adds to nursing science.

It has been recognized that there is a nurse faculty shortage. Organizations must make an effort to reduce shortages by preventing burnout by addressing stressful issues in the work environment (Walvoord, 2013). This research has identified that there is a potential for nurse faculty to be at risk for compassion fatigue. Policy supporting the allocation of funds to promote further research in the area of compassion fatigue and nurse faculty is essential. At the institutional level, policies that support a balanced workload for nurse faculty should be investigated and implemented; as well as policies designed to reduce compassion fatigue and promote compassion satisfaction.

Recommendations for Further Research

The purpose of this explanatory mixed methods research study was to determine if nurse faculty working in a four year generic religious based baccalaureate nursing program in the state of Pennsylvania are experiencing compassion fatigue. Overall, 20% of subjects reported exhibiting compassion fatigue. Within this specific sample, nurse faculty are at risk for compassion fatigue. Research in the area of compassion fatigue is currently growing and there is a scarceness of research specifically related to compassion

fatigue and nurse faculty. This research, although not generalizable beyond this sample, adds to nursing science knowledge base.

Even though this study will add to the body of nursing research there are several areas worth investigating further. There is a need for additional research in looking at the leadership style in baccalaureate nursing programs, and the need for improved communication among nurse faculty and administration. Additionally, it would be prudent to investigate factors that influence compassion satisfaction in nurse faculty. Furthermore, because compassion fatigue has been identified in this sample, replication studies and future research exploring the risk of compassion fatigue in nurse faculty is necessitated. Action research to implement measures, to decrease the level of compassion fatigue in nurse faculty is critical as well. Positive coping strategies and a work life balance is crucial to promote positive mental health in nurse faculty. Additionally interventions should be initiated for nurse faculty so that a renewal could be accomplished at the end of each semester to regenerate and reinvigorate nurse faculty.

Further qualitative research could investigate and focus on student interactions with nurse faculty to determine the role the student plays in the development of compassion fatigue. Benefits of this research would be useful in developing strategies to promote a healthy work life balance to prevent the development of compassion fatigue.

Reflections on Leadership and Change

As I reflect on my leadership it is important for me not to deny my biological being as a female of the 1950s. When I was a child there were basically two professions for females, a teacher and a nurse. I am a caring individual with the propensity and desire to please. I was considered as a nurturing child; I always had a baby doll under my

care. I was an obedient child and wanted to delight others. As I reflect on my leadership journey, I display characteristics of a feminist leader, which I now realize have an impact on my leadership. Feminist leaders are collaborators, aware of the needs of others and the organization, and are effective leaders in all aspects of society.

My family especially my father, always believed in educational opportunities and the necessity of an education. Dad believed females required an education to become active and productive in society, even more so than males. As a union worker in a male centric society he witnessed the responsibility of child rearing falling on the shoulders of females. He always believed females were at a disadvantage if they were unable to care for themselves and their children, especially in the event of a divorce. My parents never wanted me to be dependent on anyone else for my livelihood. My family instilled in me the belief that I should be able to support myself, provide for my children, and be independent.

Due to the need to be independent, an education was essential. I began my educational voyage at a community college and discovered my calling as a nurse. Nursing provided me with the skills, knowledge, and abilities to care for myself and my future children, while providing an adequate long term future income. As a nurse, I was able to serve the patients and provide them with the necessary information and skills to care for themselves. I believe as a servant leader, I am able to serve my students and patients by assessing the circumstances, think critically, and apply the nursing process to the various situations. As a servant leader I mentor others and empower my students.

I mentor and have also been the recipient of meaningful mentoring. I have had the experience of being a protégé of 2 transformational leaders. Transformational

leaders influence others to achieve a common goal and are visionary. Goals are transparent, stated, and then accomplished by the members using their knowledge and experiences. Micromanaging is not a trait of a transformational leader; work is seen as an accomplishment, not as a job. There is a sense of achievement in a professional atmosphere. Under the leadership of my transformational leaders I felt valued and respected. I aspire to emulate many of the leadership qualities of my former administrators. Individuals should be aware of the goals of the organization and have an ingrained stake in the vision to make the goals and objectives attainable. I encourage collaboration and promote a non-threatening team building atmosphere where differences can be freely discussed without retaliation. I encourage others to go beyond their comfort zone and foster team building and collaboration among all members. As a transformational leader, I believe in morale building, providing respect to others, and the appreciation of all members' contributions for the good of the organization. This inspires growth in the individual and also benefits the organization in its success.

Collaboration among members of the team is a trait of the transformational leader. I value all input and celebrate the achievement of others. I encourage people to take a chance and listen to colleagues and students. In addition to listening, a transformational leader must provide clear verbal communication. As a transformational leader, I provide quality direction while adhering to my integrity and personal code of ethics. Change in any organization is constant. Without change there is no growth.

A challenge in leadership is to get others involved with change for the good of the organization. From recent readings on leadership, I especially see myself applying Kouzes and Posner's *Transformational Leadership Model*. Empirical evidence suggests

that leadership, especially transformational leadership, encourages and mobilizes others to get things done and enact change (Abu-Tineh, Khasawneh, & Al-Omari, 2008). The five components of the *Transformation Leadership Model* are modeling the way, inspiring a shared vision, challenging the process, enabling others and encouraging the heart (Kouzes & Posner, 2012; Krugman, Heggem, Kinney & Frueh, 2013). These five practices of exemplary leadership provide me with the ability and skills to transform others allowing me to inspire my colleagues and provide them with recognition and support. This enables me to lead while encouraging collaboration with others and also promotes recognition for a job well done and for their contributions for the good of the organization. People often resist change; this is why effective leadership is important. The degree of resistance to change is due to poor communication (Kelly, 2010). This is why effective communication, whether it be through listening or words, is imperative. My transformational leadership qualities transpire when situations arise.

In addition to being a transformational leader I also see myself as a transactional leader. I have high expectations of myself and my students. I expect students to work diligently to accomplish their goals and be successful. I foster their development and contributions to nursing while operating ethically and morally.

In conclusion, I see myself as a versatile leader using various leadership styles (see Figure 6.1). I promote leadership development in others, encourage the advancement of new knowledge and skills, yet I am cognizant of the value of each individual I encounter and what they individually offer to the final outcomes. I have become a versatile leader based on the incorporation of my many life experiences and the

encouragement and respect provided to me by those I have encountered on my journey toward leadership.

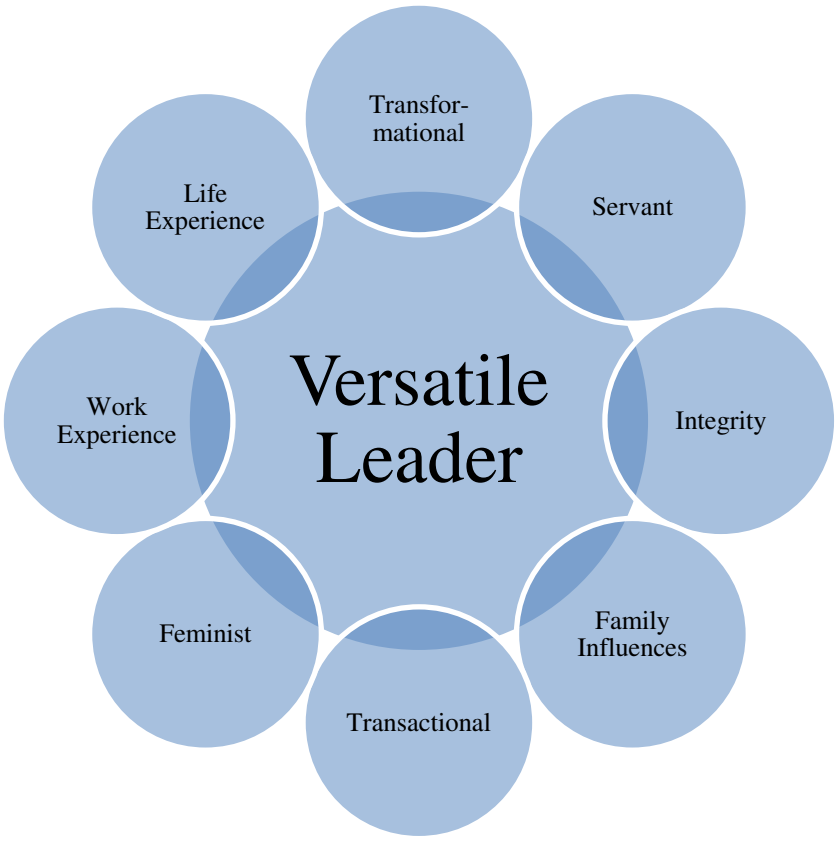


Figure 6.1. Versatile leader.

References

AACN. (2011). Nursing fact sheet. Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-fact-sheet

AACN. (2012a). New AACN data show an enrollment surge in baccalaureate and graduate programs amid calls for more highly educated nurses. Retrieved from http://www.aacn.nche.edu/news/article/2012/enrollment-data

AACN. (2012b). Special survey on vacant faculty positions for academic year 2012-2013. Washington, DC: Author.

Abu-Tineh, A. M., Khasawneh, S. A., & Al-Omari,A. (2008). Kouzes and Posner's transformational leadership model in practice: The case of Jordanian schools. *Leadership and organizational Development Journal,* 29(8), 648-660. doi:10.1108/01437730810916613

Abendroth, M., & Flannery, J. (2006). Predicting the risk of compassion fatigue. *Journal of Hospice & Palliative Nursing, 8*(6), 346-56.

Allen, L. (2008). The nursing shortage continues as faculty shortage grows. *Nursing Ecconomic$, 26*(1), 35-40.

ANA. (2000). ANA reaffirms commitment to BSN for entry into practice. Retrieved from http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/2000/CommitmenttoBSN.html

Anderson, G. L. (2009). *Advocacy leadership:Toward a post reform agenda in education.* New York, NY: Routledge.

Auerbach, D., Buerhaus, P., & Staiger, D. (2007). Better late than never: Workforce supply implication of later entry into nursing. *Health Affairs, 26*(1), 178-185.

Ballantine, L. (2004). On education. The nurse educator and research. *CAANT Journal, 14*(3), 55-56.

Bennis, W. (2003). *On becoming a leader. The leadership classic updated and expanded*. New York, NY: A Member of the Perseus Books Group.

Bolman, L. G. & Deal, T. E. (2003). *Reframing organizations: Artistry, choice, and Leadership* (3rd ed.). San Francisco, CA: Jossey-Bass.

Brady, M. (2010). Healthy nursing academic work environment. *The Online Journal of Issues in Nursing, 1*(15). Retrieved from http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No1Jan2010/Academic-Work-Environments.html#Kaufman07c

Brooks, J. S., Jean-Marie, G, Normore, A., & Hodgins, D. (2007). Distributive leadership for social justice: Exploring how influence and equity are stretched over an urban high school. *Journal of School Leadership, 17*(4), 378-408.

Bryman, A. (2007). Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research, 1*(1) 8-22.

Burns, N., & Grove, S. (2011). *Understanding nursing research: Building an evidenced based practice*. Maryland Heights, MO: Elsevier Saunders.

Burtson, P., & Stichler, J. (2010). Nursing work environment and nurse caring: Relationship among motivational factors. *Journal of Advanced Nursing, 66*(8), 1819-31.

Chemers, M. (1995). Contemporary leadership theory. In J. T. Wren (Ed.), *The leaders companion: Insights on leadership through the ages*. (pp. 83-99). New York, NY: The Free Press.

Cherry, B., & Jacob, S. R. (2012). *Contemporary nursing: Issues, trends & management*. St. Louis, MO: Elsevier Mosby.

Ciulla, J. B. (2003). *The ethics of leadership.* Belmont, CA: Wadsworth Cengage Learning.

Collins, S., & Long, A. (2003). Too tired to care? The psychological effects of working with trauma. *Journal of Psychiatric and Mental Health Nursing, 10*, 17-27.

Coetzee, S., & Klopper, H. (2010). Compassion fatigue within nursing practice: A concept analysis. *Nursing and Health Sciences, 12*, 235-43.

Compasion, (2013). In www.thefreedictionary.com/compassion

Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling; Merging or clear boundaries? *Journal of Advanced Nursing, 26*(3), 622-630. Doi:10.1046j.1365-2648.1997.t01-25-00999.x

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA: Sage.

Creswell, J. W., & Plano - Clark, V. (2011). *Designing and conducting mixed methods research* (2nd ed).Thousand Oaks, CA: Sage.

Cronin, T. E. (1995). Thinking and learning about leadership. In J.T. Wren (Ed.), *The leader's companion: Insights on leadership through the ages* (pp. 27-33). New York, NY: The Free Press.

Cronk, B. (2010). *How to usePAWS statistics: A step by step guide to analysis and interpretation*. Glendale, CA: Pyrczak Publishing.

Dattilo, J., Brewer, M.K., & Streit, L. (2009). Voices of experience: Reflections of nurse educators. *Journal of Continuing Education in Nursing, 40*(8), 367-370.

Dohm, A., & Shniper, L. (2007). Occupation employment projections to 2016. *Monthly Labor Review Online,130*, 86-125.

Dosal, P. (2011). In the trenches…Initative at the University of South Florida. *The Hispanic Outlook in Higher Education, 21*(*8*).Retrieved from http://www.search.proquest.com/docview/848571669

Durham, S., Merritt, J. & Sorrell, J. (2007). Implementing a new faculty workload formula. *Nursing Education Perspectives, 28*(4), 184-189.

Drummond-Young, M., Brown, B., Nosegaard, C.,Lunyk-Child, O., Maich ,N. M., Mines,C., & Linton, J. (2010). A comprehensive faculty development model for nursing education. *Journal of Professional Nursing, 26*(3), 152-161.

Epstein, C., & Kalleberg, A. (2004). *Fighting for time: Shifting boundaries of work and social life.* New York, NY: Russell Sage Foundation.

Everson, S. T., & Bussey, L. H. (2007). Educational leadership for social justice: Enhancing the ethical dimension of educational leadership. *Catholic Education, 11*(2), 176-187.

Figley, C. (1995). The transmission of trauma. In Figley, C. (Ed.). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. London, ENG: Brunner-Routledge.

Figley, C. (2001). Gift from within-PTSD: Resources for survivors and caregivers. Retrieved from www.giftfromwithin.org\html\whatis-compassion-fatigue-dr.charles-figley.html

Figley, C. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441.

Fransden, B. (2010). Burnout or compassion fatigue? *Long Term Living, 50,* 50-53.

Fullan, M. (2001). *Leading in a culture of change.* San Francisco, CA: Jossey-Bass.

Gazza, E. (2009). The experience of being a full-time nursing faculty member in a baccalaureate nursing education program. *Journal of Professional Nursing, 25*(4), 218-226.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *Primal Leadership: Learning to lead with emotional intelligence.* Boston, MA: Harvard Business School Press.

Grafton, E., Gillespie, B., & Henderson, S. (2010). Resilience: The power within. *Oncology Nursing Forum, 37*(6), 698-705.

Greenleaf, R. (1995). Leadership for social justice: An agenda for 21st century schools. *Educational Forum, 72*(4), 340-354.

Greenleaf, R. (2002). *Servant Leadership: A journey into the nature of legitimate power and greatness.* Mahwah, NJ: Paulist Press.

Hanson, W., Creswell, J., Plano-Clark, V., Petska, K., Creswell, D. (2005). Mixed methods designs in counseling psychology. *Journal of Counseling Psychology, 52*(2), 224-235. doi: 10/0022-0167.52.2.224

Harris, M., & Taylor, G. (2009). *Medical and health science statistics made easy* (2nd ed.). Boston, MA: Jones and Bartlett Publishers.

Harrison, J. (2004). Addressing increasing patient acuity and nursing workload. *Nursing Management, 11*(4), 20-25.

Hiemstra, R. (2002). *The theory of margin*. Retrieved from http://www-distance.syr.edu/margin.html

Hoffman, M. (2000). *Empathy and moral development: Implications for caring and justice*. New York, NY: Cambridge University Press.

Holcomb, Z. (2010). *Interpreting basic statistics: A guide and workbook based on excerpts from journal articles* (6th ed.). Glendale, CA: Pyrczak Publishing.

Hooper, C., Craig, J., Janvrin, D., Wetsel, M., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency room nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nursing, 35*(5), 420-427.

Houde, S. C., & Melillo, K. D. (2009). Caring for an aging population. *Journal of Gerontological Nursing, 35*(12), 8-13.

Huber, D. L. (2010). *Leadership and nursing care management* (4th ed). Maryland Heights, MO: Saunders Elsevier.

Institute of Medicine (IOM). (2010). *The future of nursing: Leading change, advancing health.* Washington, DC: National Academies Press.

Johnson, R. B., & Onwuegbuzie, A. (2004). Mixed methods research: A research paradigm whose time has come. *American Educational Research Association, 33*(7), 14-26.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing, 22*(4), 118-121.

Kalynych, C. J. (2010). *The application of Margin in Life theory in regard to attrition and remediation among emergency medicine residents*. (Doctoral Dissertation). Retrieved from UNF Thesis and Dissertations. Paper 238. http://digitalcommons.unf.edu/etd/238

Kelly, R. (2010). A formal approach to facilitating change. In *Academic leadership qualities for meeting today's higher education challenges.* Retrieved from www.facultyfocus.com

Kettles, A. M., Creswell, J. W., & Zhang, W. (2011). Mixed methods research in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 18,* 535-542.

Killian, K. D. (2008). Helping till it hurts? A multi-method study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology, 14*(2), 32-44. doi:10.1188/1534765608319083

Kotter, J. P. (1996). *Leading change.* Boston, MA: Harvard Business School Press.

Kovner, C., Fairchild, S., & Jacobson, L. (2006). *Nurse educators 2006: A report of the faculty census survey of RN and graduate programs.* New York: National League for Nursing.

Kouzes, J. & Posner, B. (2012). Leadership Challenge. *Leadership Excellence, 29*(8), 1-3.

Krathwohl, D. R., & Smith, N. L. (2005). *How to prepare a dissertation proposal: Suggestions for students in education and the social and behavioral sciences*. Syracuse, NY: Syracuse University Press.

Krugman, M., Heggem, L., Kinney, L. J., Frueh, M. (2013). Longitudinal charge nurse leadership development and evaluation. *The Journal of Nursing Administration, 43*(9), 438-446.

Kuehn, B. (2007). No end in sight to nursing shortage: Bottle neck at nursing schools a key factor. *Journal of American Medical Association, 298*(14), 1623-1625.

Laalas, J. W., & Morgan, R. D. (2006). Training school leaders who promote educational justice. *Educational Leadership and Administration, 18,* 21-34.

Laalas, J. W., & Valle, E. (2007). Social justice lenses and authentic student voices: Enhancing leadership for educational justice. *Educational Leadership and Administration, 19,* 75-102.

Lambert, V., & Lambert, C. (2008). Nurse's workplace stressors and their coping strategies. *Indian Journal of Palliative Care, 14*(1), 38-44. Retrieved from http://www.jpalliativecare.com/article.asp?issn=0973-1075;year=2008;volume=14;issue=1;spage=38;epage=44;aulast=Lambert

Leech, N. L., & Onwuegbuzie, A. (2009). A typology of mixed methods research design. *Quality & Quantity 43*(2), 265-275. Doi:10.1007/s11135-007-9105-3.

Lester, N. (2010). Compassion fatigue. *Mental Health Practice, 14*(2), 11.

Lombardo, B., & Eyre, C. (2011). Compassion fatigue: A nurse's primer. *Online Journal of Issues in Nursing, 16*(1), 1.

MacGregor-Burns, J. (2003). *Transforming leadership: A new pursuit of happiness*. New York, NY: Grove Press.

Main, K. (1979). The power load margin formula of Howard Y. McClusky as the basis for a model of teaching. *Adult Education Quarterly, 30*(19), 19-33.

Maxwell, J. A. (2005). *Qualitative research design: An interactive approach* (2nd ed.). Thousand Oaks, CA: Sage.

McClusky, H. (1970). A dynamic approach to participation in community development. *Journal of Community Development Society,* 1, 25-32.

McHolm, F. (2006). Rx for compassion fatigue. *Journal of Christian Nursing, 23,* 12-19.

McMillan, J. H. (2007). *Educational research: Fundamentals for the consumer* (5th ed.). New York, NY: Allyn & Bacon.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.

Mortimer, K. P., & Sathre, C. O. (2007). *The art and politics of academic governance: Relations among boards, presidents and faculty*. Landham, MD: Rowan & Littlefield.

Mulligan, L. (2004). Overcoming compassion fatigue. *Kansas Nurse, 79*(7), 1-2.

NLN. (2007). Nationwide NLN-Carnegie Foundation study examines nurse faculty workload: Implications revealed for recruitment and retention. Retrieved from http://www.nln.org/newsreleases/carnegie_092007.htm

Newell, J., & MacNeil, G. (2010). Professional burnout, vicarious trauma, secondary traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health, 6*(2), 57-68.

Onwuegbuzie, A. J., Collins, K. M. T. (2007). A typology of mixed methods sampling designs in social science research. *The Qualitative Report*, *12*(2), 281-316.

Onwuegbuzie, A. J., & Leech, N. (2007). A call for qualitative power analysis. *Quality and Quantity,41,* 105-121.

Ostuland, U., Kidd, L., Wengstrom, Y., & Rowa-Dewar, N. (2011). Combining qualitative and quantitative research within mixed methods research designs: A methodological review. *International Journal of Nursing Studies, 48,* 369-383. doi: 10.1016/j.ijnurstu.2010.10.005.

Pape, T. (2000). Boyer's model of scholarly nursing applied to professional development. *AORN, 71*(5), 995-1003.

Peterson, V. (2009). Predictors of academic success in first semester baccalaureate nursing students. *Social Behavior and Personality, 37*(3), 411-417. doi:102224/sbp.2009.37.3411.

Piper, L. (2012). *No nursing student left behind: Non-cognitive screening.* (Doctoral dissertation, Rowan University) Retrieved from ProQuest Digital Dissertations.

Potter, P., Deshields, T., Divanbeigi, J., Berger, J., Cipraniano, D., Norris, L., & Olsen, S. (2010). Compassion fatigue and burnout: Prevalence among oncology nurses. *Clinical Journal of Oncology Nursing, 14*(5), 56-62.

Ribelin, P. J. (2003). Retention reflects leadership style. *Nursing Management, 34*(8), 18-19.

Rydeen, J. E. (2008). Happy school=success. *American School & University*, *81*(4), 49.

Sabo, B. (2008). Adverse psychosocial consequences: Compassion fatigue, burnout, and vicarious traumatization: Are nurses who provide palliative and hematological cancer care vulnerable? *Indian Journal of Palliative Care, 14*(1), 23-9.

Sabo, B. (2011). Reflecting on the concept of compassion fatigue. *Online Journal of Issues Nursing, 16*(1).

Seidman, I (2009). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* New York, NY: Teachers College Press.

Sheppard, K. (2011). Compassion fatigue hits students too. *Nursing Standards, 25*(42), 7.

Sisco, B. R. (1981). Rules and procedures for logical analysis of written data.

Stamm, B. H. (2010). The concise *ProQOL* Manual 2nd ed. Pocatello, ID. Retrieved from www.*ProQOL*.org

Stamm, B. H. (2011). Professional quality of life: Compassion satisfaction and fatigue Version 5 (*ProQOL*). www.*ProQOL*.org.

Stevenson, J. (1980). Load, power, and margin in older adults. *Geriatric Nursing,* 52-55.

Stevenson, J. (1982). Construction of a scale to measure load, power, and margin in life. *Nursing Research, 31*(4), 222-228.

Tashakkori, A., & Creswell, J. W. (2007). Exploring the nature of research questions in mixed methods. *Journal of Mixed Methods Research, 1*(3), 207-211.

Taylor, D. L. (2008). Should the entry into nursing practice be the baccalaureate degree? *AORN Journal, 87*(3), 611-620.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Los Angeles, CA: Sage Publications.

Tellie, M. J. (2008). Compassion fatigue: The cost of caring. *Nursing Update*, 32(8), 34-37.

Thomas, G. (2003). What is transactional leadership? In *Leading Today.* Retrieved February 16, 2009, from We Lead Web http://www.leadingtoday.org?Onmag?jan03?transactional1203.html.

Todaro-Franceschi, V. (2012). *Compassion fatigue and burnout in nursing: Enhancing professional quality of life*. New York, NY: Springer.

Tolson, P. (2012). Robert Wright appointed as interim provost. *Westside Gazette, (3).* Retrieved from http://search.proquest.com/docview/1040866290

Walvoord, K. H. (2006). Understanding sonographer burnout. *Journal of Diagnostic Medical Sonography*, *22* (3), 200-205

Watt, W. (2010). 10 recommendations towards effective leadership. In *Academic leadership qualities for meeting today's higher education challenges*. Retrieved from www.facultyfocus.com

Wood, D. (2013). Creating a great nurse work environment to improve the bottom line. *AMN Healthcare.* Retrieved from www.AMNhealthcare.com/creating-a-great-nurse-work-environment-to-improve-the -bottom-line/

Yoder-Wise, E. (1984). Health locus of control scale and the margin in life scale in older people. Retrieved from ProQuest Digital Dissertations.

Yoder-Wise, E. (2010). Compassion fatigue in nurses. *Applied Nursing Research, 23*(4), 191-197. doi:10.1016/j.apnr.2008.09.003.

Yoder-Wise, E. (2011). *Leading and managing in nursing* (5th ed.).St. Louis, MO: Elsevier Mosby.

Young, J., Derr, D., Cicchillo, V., & Bressler, S. (2011). Compassion satisfaction, burnout, and secondary traumatic stress in heart and vascular nurses. *Critical Care Nursing Quarterly, 34*(3), 227-234.

Zimmerman, I. & Thormann, J. (2010). Techniques of leadership. In *Academic leadership qualities for meeting today's higher education challenges*. Retrieved from www.facultyfocus.com

Appendix A

Demographic Questions

Demographic Questions

1. Age at last birthday in years _____.
2. Gender _____.
3. Marital Status _____.
4. Number of years in nursing education _____.
5. Are you presently attending school for your terminal degree? (circle) Yes/No
6. Number of teaching credits required for full-time load _____.
7. Number of teaching credits you have_____.
8. Are you presently working in the clinical area? (circle) Yes/No
9. Names of committees you are serving on:

   _____
   _____
   _____
   _____
   _____
   _____

Appendix B

Professional Quality of Life (ProQOL)

Professional Quality of Life (ProQOL)

Compassion Satisfaction and Compassion Fatigue

(ProQOL) Version 5 (2009)

When you educate people you have direct contact with their lives. As you may have found, your compassion for those you educate can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a nurse educator. Consider each of the following questions about you and your current work situation. Circle 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

Question	Never	Rarely	Sometimes	Often	Very Often
1. I am happy.	1	2	3	4	5
2. I am preoccupied with more than one person I educate.	1	2	3	4	5
3. I get satisfaction from my role as a nurse educator.	1	2	3	4	5
4. I feel connected to others.	1	2	3	4	5
5. I jump or am startled by unexpected sounds.	1	2	3	4	5
6. I feel invigorated after working with those I educate.	1	2	3	4	5
7. I find it difficult to separate my personal life from my life as a nurse educator.	1	2	3	4	5

8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I educate.	1	2	3	4	5
9. I think I might have been affected by the traumatic stress of those I educate.	1	2	3	4	5
10. I feel trapped by my job as a nurse educator.	1	2	3	4	5
11. Because of my role as a nurse educator, I have felt "on edge" about various things.	1	2	3	4	5
12. I like my work as a nurse educator.	1	2	3	4	5
13. I feel depressed because of the traumatic experiences of the people I educate.	1	2	3	4	5
14. I feel as though I am experiencing the trauma of someone I have educated.	1	2	3	4	5
15. I have beliefs that sustain me.	1	2	3	4	5
16. I am pleased with how I am able to keep up with nursing education techniques and protocols.	1	2	3	4	5

17. I am the person I always wanted to be.	1	2	3	4	5
18. My work makes me feel satisfied.	1	2	3	4	5
19. I feel worn out because of my work as a nurse educator.	1	2	3	4	5
20. I have happy thoughts and feelings about those I educate and how I could help them.	1	2	3	4	5
21. I feel overwhelmed because my work load seems endless.	1	2	3	4	5
22. I believe I can make a difference through my work.	1	2	3	4	5
23. I avoid certain activities or situations because they remind me of frightening experiences related to my role as an educator.	1	2	3	4	5
24. I am proud of what I can do as a nurse educator.	1	2	3	4	5
25. As a result of my role as a nurse educator, I have intrusive, frightening thoughts.	1	2	3	4	5

26. I feel "bogged down" by the system.	1	2	3	4	5
27. I have thoughts that I am a "success" as a nurse educator.	1	2	3	4	5
28. I can't recall important parts of my work with trauma victims.	1	2	3	4	5
29. I am a very caring person.	1	2	3	4	5
30. I am happy that I chose to do this work.	1	2	3	4	5

Appendix C

Margin-In-Life (MIL)

Margin In Life **Instructions:**

1. **IMPORTANE OF ITEM COLUMN:** In the IMPORTANE OF ITEM column you will find a row of numbers from 1 to 10. The object is for you to circle any number from 1 to 10 to indicate the relative importance of the ***Generally Speaking. . .*** item in your life. The higher the number, the more important the item is to you.
2. **LOAD COLUMN:** In the LOAD column you will find a row of numbers from 1 to 5. Load refers to the amount of burden or responsibility each ***Generally Speaking. . .*** item puts upon you. The object is for you to circle any number from 1 to 5 to indicate the relative LOAD that item places on your life. The higher the number the higher the LOAD, or burden the item places on you.
3. **POWER COLUMN:** In the POWER column you will find a row of numbers from 1 to 5. POWER refers to the joy, pleasure, strength, or richness, added to your life by each ***Generally Speaking. . .*** item. The object is for you to circle any number from 1 to 5 to indicate the relative POWER that item places on your life. The higher the number the higher the POWER, or added richness that item gives you.
4. **ITEM NOT APPLICABLE COLUMN:** If a ***Generally Speaking. . .*** item does not apply to you, for example, you are asked about your children, and you do not have children, place an X in the column labeled ITEM NOT APPLICABLE.
5. **PLEASE NOTE:** It is necessary that you circle both a POWER and a LOAD number for all ***Generally Speaking. . .*** items that are applicable to you.

For example:

Generally Speaking:	IMPORTANCE OF ITEM (Circle One)	LOAD (Circle One)	POWER (Circle One)	ITEM NOT APPLICABLE
2. My eyesight is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
3. Living with my spouse is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	X

In this example, this person feels eyesight is very important because (s)he assigned an IMPORTANCE of 10 to the item. Eyesight is not a burden to this person, because (s)he assigned a LOAD of 1, and (s)he believes that eyesight adds richness to life as evidenced by the POWER score of 4. This person must not be married because (s)he placed an X in the ITEM NOT APPLICABLE COLUMN when asked about a spouse.

Generally Speaking:	IMPORTANCE OF ITEM (Circle One)	LOAD (Circle One)	POWER (Circle One)	ITEM NOT APPLICABLE
1. My health is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
2. My eyesight is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
3. Living with my spouse is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
4. Our children are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
5. Frequent prayer is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
6. My hearing is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
7. My physical health is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
8. Reading religious material is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
9. My sense of smell is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
10. I would rate my present life as	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
11. Breathing is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
12. My sense of taste is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
13. Religious faith is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
14. My ability to concentrate is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
15. Belief in God (a higher power) is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
16. My blood circulation is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
17. My appetite is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	

Generally Speaking:	IMPORTANCE OF ITEM (Circle One)	LOAD (Circle One)	POWER (Circle One)	ITEM NOT APPLICABLE
18. The extent to which my family members cooperate with each other is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
19. Having goals in life is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
20. Being independent is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
21. My children's attitude toward me is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
22. My sexual abilities are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
23. Making decisions is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
24. My hands and arms are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
25. Being married is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
26. My type of employment is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
27. Being responsible is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
28. My digestion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
29. My back is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
30. Belief in religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
31. My family's way of coping with problems is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
32. My feet and legs are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
33. Self-reliance is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
34. Relating with my co-workers is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	

Generally Speaking:	IMPORTANCE OF ITEM (Circle One)	LOAD (Circle One)	POWER (Circle One)	ITEM NOT APPLICABLE
35. The way my children and I get along is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
36. Having a few close friends is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
37. Controlling my temper is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
38. A high standard of morality is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
39. My coordination is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
40. Consideration of others is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
41. The way my children act to each other is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
42. My body is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
43. The way my spouse handles responsibility is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
44. Mobility is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
45. My children's progress in school is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
46. The need for religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
47. The people I've met at church are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
48. My attitude toward my family is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	

Generally Speaking:	IMPORTANCE OF ITEM (Circle One)	LOAD (Circle One)	POWER (Circle One)	ITEM NOT APPLICABLE
49. Membership in religion is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
50. My muscles are	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
51. Getting along with people is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
52. A spiritual way of life is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
53. Rest is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
54. Frequent finding it necessary to stand for what I believe in is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
55. Self-confidence is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
56. Participating in religious practices is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
57. Manual dexterity is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	
58. My concern for my family is	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5	1 2 3 4 5	

(Stevenson, 1982)

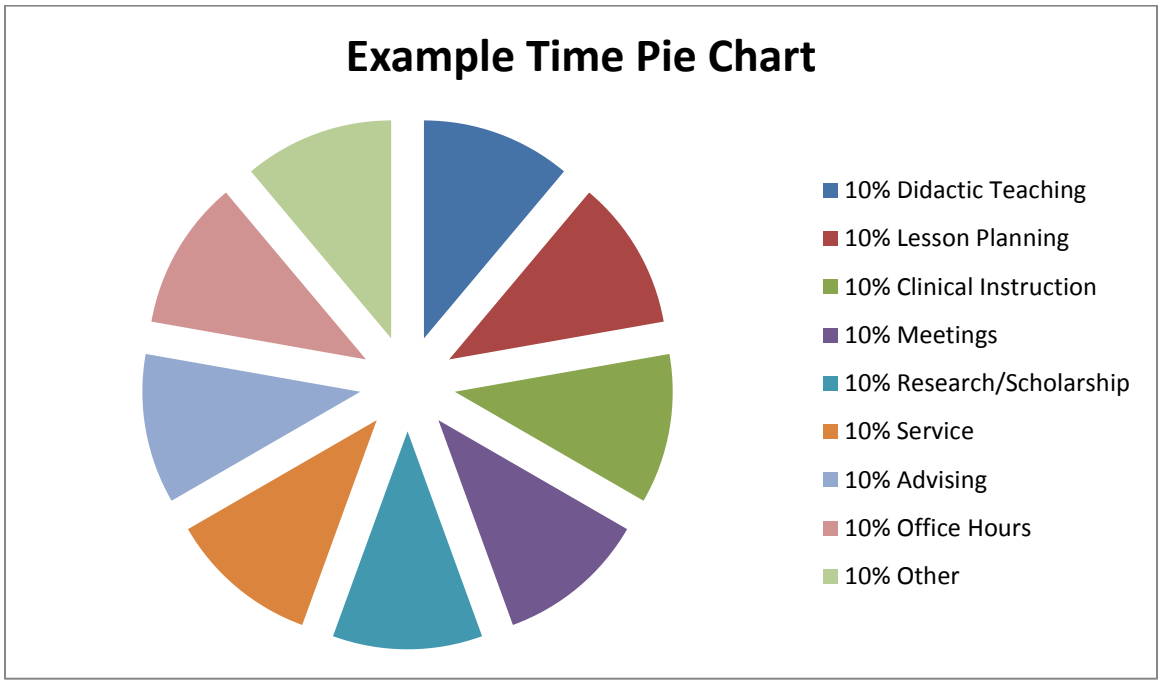
Thank you very much for your participation this research endeavor.

Appendix D

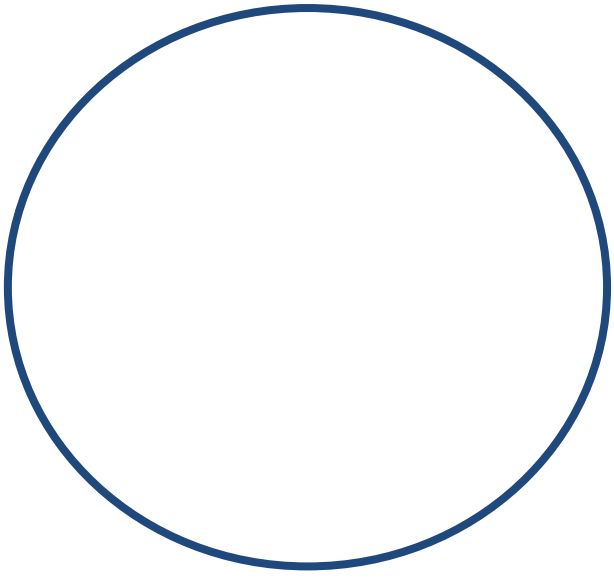
Open-Ended Questions

Open-Ended Questions

1. Using a pie chart, please indicate the percentage of time you spend on various work responsibilites throughout the week. See the example below.



PLEASE COMPLETE USING THE ABOVE AS AN EXAMPLE



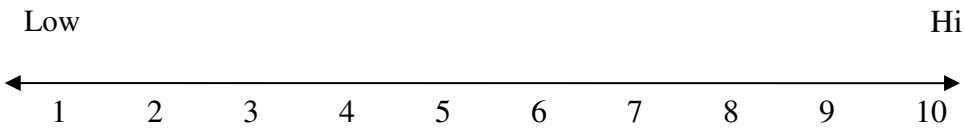
2. What expectations does your institution have of you regarding scholarship, research, and service?

3. Please give examples of how your institution supports you in your role as a nurse faculty member.

4. Please give examples of situations when you felt your institution was not supportive of you as a nurse faculty member.

5. How does your work environment influence your satisfaction with your personal life?

6. Please circle on the continuum below your satisfaction with work with 10 being highly satisfied and 1 being extremely dissatisfied.



Appendix E

Informed Consent for Interview and Audio Taping

Informed Consent for Interview and Audio Taping

I agree to participate in a study entitled "Compassion Fatigue in Nurse Faculty", which is being conducted by Patricia M. Price a doctoral student at Rowan University.

The purpose of this study is to examine if nurse faculty experience compassion fatigue. The data collection in this second phase of the study will consist of an audio-taped interview. By completing this consent form, I attest to being 18 years of age or older.

I understand that my responses will be confidential and that all the data gathered will be destroyed in three years. My participation in this interview will take between 15 to 30 minutes.

I agree that any information obtained from this study may be used in anyway thought best for publication or education provided that I am in no way identified and my name is not used.

I understand there are no undo physical or psychological risks involved in this study, and that I am free to withdraw my participation at any time without penalty.

I understand that I do not have to respond to all questions.
I understand that my participation does not imply employment with the state of New Jersey, Rowan University, or the principal investigator.

If I have any questions or problems concerning my participation in this study, I may contact Patricia Price at pricep@rowan.edu or (856) 546 -6714
I may also contact Dr. Burton Sisco at sisco@rowan.edu (856) 256-3717

Signature of Participant_____Date_____
Please print your name_____
Signature of Researcher_____Date_____

In addition I am aware that my responses are being audio-taped and the data will be kept confidential and all information will be destroyed in a period of three years. Audio recording will be destroyed using a degausser (demagnetizes analog data) technology.
I give my permission for the audio-taping of the interview.

Signature of Participant_____Date_____
Please print your name_____
Signature of Researcher_____Date_____

Appendix F

Script for One-on-One Interview

Script for One-on-One Interview

Hello _____

My name is Patricia Price. I am a doctoral student at Rowan University pursuing my Ed.D. and I am grateful for the privilege to interview you for the additional collection of qualitative data. Thank you for volunteering on the informed consent to the one on one individual interview. The faculty who indicated a desire to volunteer were chosen to participate in the interview.

I will be asking you some questions and the interview should take between 15 – 30 minutes. I appreciate you taking time out of your busy schedule to answer the questions.

Before beginning will you please sign the informed consent stating that you are willing to answer my questions? The information used for our interview will be kept confidential and will be shredder in three years after the study. If at any point during the study you are experiencing feelings of stress you may stop. There will be no repercussions.

I want you to be fully aware that audio-taping will be done, however the destruction of the tape will occur after three years from the study. In no way will your name be connected to the transcribing of the information. I have provided you with a list of the questions I will be covering during our interview.

Appendix G

List of Questions for One-on-One Interview

List of Questions for One-on-One Interview

1. Can you tell me a little about yourself? Thinking back when you became a nurse faculty, what was the chief reason you became a nurse faculty?

2. Think of a colleague in your department who you think exhibits unhealthy levels of stress. Can you describe what you think contributes to this?

3. How would you compare the students of today from students you have had in the past?

4. Has there been a time when you felt exasperated with a student and just "lost it"? Can you give me an example? Describe the experience and demands that have been placed on you.

5. If you had to do it over again, would you do anything different?

6. If you were in a leadership role as head of this department, what three things you would do to affect the quality of life of the faculty?

7. How would you explain your experiences with students when you first began teaching at the university?

8. Have your experiences with students changed, in what way? Please give examples?

9. What do you perceive as reason for the changes?

10. Can you give me examples of factors that make you remain at the university? What factors would be influential in your decision to leave?

Appendix H

Form Letter Sent to Deans Requesting Permission to do Research

Form Letter Sent to Deans Requesting Permission to do Research

Dear_____,

I am a doctoral student at Rowan University in Glassboro New Jersey. I am researching the topic of compassion fatigue among nurse faculty. I am requesting permission to attend _____ University in the spring of 2013 to distribute a survey to nurse faculty to obtain their feedback. The questionnaire will take approximately 20 – 30 minutes to complete. I would like to reach as many nurse faculty as possible, so I would like to disseminate the questionnaire prior to a meeting of all nurse faculty. I will provide pizza and soda to faculty who would like to volunteer to complete the questionnaire. The information obtained will be anonymous and will be used to complete my dissertation research.

Once I have received your endorsement, I will follow-up with the submission procedure of obtaining an official Internal Review Board process through _____ University. I appreciate your consideration and the value you place on evidenced based research in the nursing profession.

Thank you very much,

Patricia M. Price RN, MSN

Appendix I

IRB Approval, Rowan University

IRB Approval, Rowan University

Rowan University

April 3, 2013

Patricia Price
445 Washington Terrace
Audubon, NJ 08106

Dear Patricia Price:

In accordance with the University's IRB policies and 45 CFR 46, the Federal Policy for the Protection of Human Subjects, I am pleased to inform you that the Rowan University Institutional Review Board (IRB) has approved your project:

IRB application number: 2013-171

Project Title: Compassion Fatigue in Nurse Faculty

In accordance with federal law, this approval is effective for **one calendar year** from the date of this letter. If your research project extends beyond that date or if you need to make significant modifications to your study, you must notify the IRB immediately. Please reference the above-cited IRB application number in any future communications with our office regarding this research.

Please retain copies of consent forms for this research for three years after completion of the research.

If, during your research, you encounter any unanticipated problems involving risks to subjects, you must report this immediately to Dr. Harriet Hartman (hartman@rowan.edu or call 856-256-4500, ext. 3787) or contact Dr. Shreekanth Mandayam, Associate Provost for Research (shreek@rowan.edu or call 856-256-5150).

If you have any administrative questions, please contact Karen Heiser (heiser@rowan.edu or 856-256-5150).

Sincerely,

Harriet Hartman

Harriet Hartman, Ph.D.
Chair, Rowan University IRB

c: Burton Sisco, Educational Services, Administration, Higher Education, James Hall

Office of Research
Bole Hall
201 Mullica Hill Road
Glassboro, NJ 08028-1701
856-256-5150
856-256-4425 fax

Appendix J

Script to Participate in Phase One

Script to Participate in Phase One

Request for Permission to Perform Doctoral Research and Responses

Dear Nursing Faculty Colleague,

I am inviting you to participate in a research study that will examine the risk for compassion fatigue in nurse educators. Compassion fatigue for the purpose of this study is defined as the emotional and physical consequences from the multifaceted responsibilities of the nurse faculty role, as well as the prolonged, continuous, and intense interactions with students. The phenomenon of compassion fatigue is documented in the role of the clinical nurse and other service professions such as social worker, firefighters and police officers. It is the aim of this study to examine the extent to which nurse faculty may experience compassion fatigue. This dissertation study is part of the requirements of my Ed.D. at Rowan University.

Completion of the survey should take no longer than 30-45 minutes. The survey consists of 30 rating scale items, six (6) open-ended questions, and demographic questions.

There are no anticipated personal risks or benefits to participate in this study. Your participation in this study is completely voluntary. If the questions in the study should make you uncomfortable please contact your employee assistance program at your institution (EAP). You are under no obligation to participate in this study and may terminate your participation in the study at any time without any repercussions. If you have any questions concerning your participation in this project or your rights as a research subject, you should contact the investigator Patricia Price at pricep60@rowan.edu. This research study has been approved by the Rowan University Institutional Review Board. For information about your rights as a participant in this study; please contact the Rowan University Office of Research (Office of Research) Dr. Shreek Mandayam, Associate Provost for Research at 856-256 5333.

If you agree to participate in this study, please complete the attached survey and place it in the provided envelope. Thank you in advance for your participation in this important research. If you would like to receive an electronic copy of the research findings, please contact me at pprice60@.rowan.edu .

Thank you for considering my request,

Patricia Price RN, MSN

Appendix K

Informed Consent for Phase One

Informed Consent for Phase One

University A, B, and C

Consent Form for Participation in Research

I agree to participate in a study entitled "Compassion Fatigue in Nurse Faculty" which is being conducted by Patricia M. Price, RN, MSN, a student in the Ed.D. program at Rowan University.

The **purpose of this research** is to determine if nurse faculty experience compassion fatigue.

By completing this consent form, I attest to being 18 years of age or older.

Those who voluntarily participate in this research study will be asked to complete a Research Packet which contains a 30-item questionnaire, a 58-item questionnaire, six open-ended questions and eight demographic questions. The actual time involved in answering the questions will take approximately 30-45 minutes. It is not necessary that you answer all of the questions. Financial compensation will not be provided for participation in this research, nor will this research result in uncompensated costs to you.

Participation in this research study is voluntary and refusal to participate will involve no penalty or loss of benefits to which you are entitled, and you may discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

If when answering the questions you as the subject encounter discomfort such as unpleasant memories you may withdraw from the study. In the event you feel additional uneasiness, you may contact the Employee Assistance Program at your institution for additional support.

Participation in this research study may include the following **benefits:** It may assist in the identification of compassion faculty in nurse faculty. If compassion fatigue is identified then measures may be initiated to prevent or deal with compassion fatigue. In addition lunch will be provided for the volunteering of your time for this research study.

Participation in this research study may include the following risks: There are **no major risks identified in this research study other than a feeling of uneasiness or discomfort when answering the questions.**

This research is anonymous. If you choose to participate, do not write your name on the Research Packet or on any of the research instruments. Your participation in this research

will be kept anonymous. There will be no place on the research packets that will ask for your name, address, or any other personal identifying information.

If you are willing to participate in a follow up individual interview to discuss additional questions, please signify by providing your name and email address

_____

The time involved for the interview will be approximately 15- 30 minutes, scheduled at a convenient time and place for you either on or off the campus. I understand that my responses to the interview questions will be confidential.

The material for this study will be kept for three years and then the contents will be shredded.

If you have any questions or comments regarding the study, please feel free to contact me at Patricia Price, 445 Washington Terrace, Audubon, NJ. 08106. Telephone 856- 546-6714. pricernmsn@aol.com or Dr. Burton Sisco at Rowan University James Hall #3030, Glassboro New Jersey, Sisco@rowan.edu

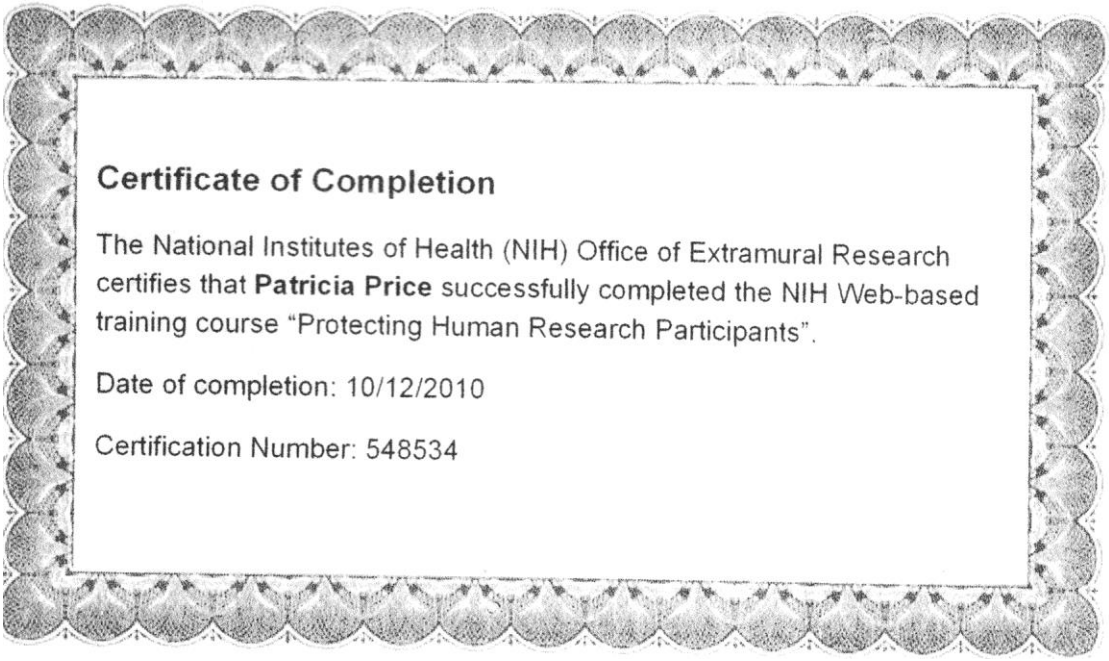
Participants Signature_____

Investigators Signature_____

Appendix L

NIH Completion Certificate

NIH Completion Certificate



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Patricia Price** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/12/2010

Certification Number: 548534

Appendix M

CITI Certificate

CITI Certificate

CITI Collaborative Institutional Training Initiative

Social & Behavioral Research - Basic/Refresher Curriculum Completion Report
Printed on 9/16/2012

Learner: Patricia Price (username: pricep60)
Institution: Rowan University
Contact Information Department: Nursing
Email: pricep60@rowan.edu

Social & Behavioral Research - Basic/Refresher: Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

Stage 1. Basic Course Passed on 09/16/12 (Ref # 8698558)

Required Modules	Date Completed	Score
Conflicts of Interest in Research Involving Human Subjects	09/11/12	4/5 (80%)
History and Ethical Principles - SBR	09/11/12	4/5 (80%)
Defining Research with Human Subjects - SBR	09/11/12	4/5 (80%)
The Regulations and The Social and Behavioral Sciences - SBR	09/15/12	4/5 (80%)
Assessing Risk in Social and Behavioral Sciences - SBR	09/15/12	4/5 (80%)
Informed Consent - SBR	09/15/12	5/5 (100%)
Privacy and Confidentiality - SBR	09/15/12	5/5 (100%)
Research with Prisoners - SBR	09/15/12	4/4 (100%)
Research with Children - SBR	09/15/12	4/4 (100%)
Research in Public Elementary and Secondary Schools - SBR	09/16/12	4/4 (100%)
International Research - SBR	09/16/12	2/3 (67%)
Internet Research - SBR	09/16/12	4/5 (80%)
Belmont Report and CITI Course Introduction	09/16/12	2/3 (67%)

For this Completion Report to be valid, the learner listed above must be affiliated with a CITI participating institution. Falsified information and unauthorized use of the CITI course site is unethical, and may be considered scientific misconduct by your institution.

Paul Braunschweiger Ph.D.
Professor, University of Miami

Appendix N

Directions for Statistical Analysis of

Professional Quality of Life (*ProQOL*) Instrument Using SPSS

Directions for Statistical Analysis of Professional Quality of Life (*ProQOL*) Questionnaire Using SPSS.

There are three steps to calculate the Professional Quality of Life (*ProQOL*). The first is to reverse some items, the second is to sum the items by subscale and the third is to convert the raw score to a *t* score.

The SPSS Code for scoring is

Step 1- Score *ProQOL* IV or 5 variables names in syntax assume pq# for each item. This routine reverses items 1,14,15,17 and 29 then scores the three scales of the *ProQOL* IV; Secondary Traumatic Stress the new scale name for compassion fatigue.

```
RECODE pq1, pq4,pq15,pq17,pq29
        (1=5) (2=4) (3=3) (4=2) (5=1)
INTRO pq1R pq4R pq15R pq17R pq29r
Compute CS= SUM (pq3,pq6,pq12,pq16,pq18,pq20,pq22,pq24,pq27,pq30).
Compute BO= Sum(pq1r, pq4r,pq8,pq10,pq15r,pq17r,pq19,pq21,pq26,pq29r)
Compute STS = Sum (pq2,pq5,pq7,pq9,pq11,pq13,pq14,pq23,pq25,pq28).
EXECUTE
```

Step 2: Convert raw score to Z score. This routine produces an extraneous output file with n and means that can be deleted.

```
DESCRIPTIVES
VARIABLES=CS BO STS/SAVE
```

Step 3 convert Z scores to *t* scores.

COMPUTE tCS = (ZCS*10) +50.

VARIABLES LABELS tCS'CS *t* scores

EXECUTE

COMPUTE tBO= (ZBO*10) +50

VARIABLES LABELStBO 'BO t score'

EXECUTE

COMPUTE tSTS' STS t score

EXECUTE

Appendix O

Written Permission to Use *ProQOL*

Written Permission to Use *ProQOL*

Appendix P

Written Permission to use *Margin-In-Life* scale

Written Permission to use *Margin-In-Life* scale

February 5, 2012

Dear Ms. Price,

Before she died Dr. Joanne Stevenson granted the Associate Dean for Research in the College of Nursing permission to release the Margin in Life scale to any investigator who requests it. I have sent the scale to other investigators who requested access. I ask that you cite Dr. Stevenson's work when you publish anything using the scale.

Best wishes for success in your scholarship,

Donna McCarthy Beckett, PhD, RN, FAAN
Associate Dean for Research, and
Mildred E. Newton Professor of Nursing

Sent:Tuesday, February 05, 2013 7:49 AM
To: Price, Patricia M.
OK, if you have not heard from him by Friday let me know and I'll look in my mterial. Hopefully I made a copy of what I sent him so it will be easy! I want to help you as I know this is not an easy process and we have to help each other! Colleen

-----Original Message-----
From: Price, Patricia M. [mailto:pricep@rowan.edu]
Sent: Monday, February 04, 2013 7:11 PM
To: Kalynych, Colleen
Subject: RE: Margin In Life Scale

Yes I have contacted Michael, but have not heard from him yet.
Thank you
Pat Price

From: Kalynych, Colleen [colleen.kalynych@jax.ufl.edu]
Sent: Monday, February 04, 2013 4:06 PM
To: Price, Patricia M.
Subject: RE: Margin In Life Scale

I just wanted to be sure you saw this email so you can contact Michael and see if he has his copies handy. It may take me longer to get my hands on the items as they are now packed away and I am redoing my floors! Just let me know. Colleen

---

From: Kalynych, Colleen
Sent: Saturday, February 02, 2013 4:09 PM
To: Price, Patricia M.
Subject: RE: Margin In Life Scale

I found his name, Michael Calendine and it looks like I mailed him copies and did not email them. It may be faster to see if he has the copy I sent him handy. His email is mcalendine@edmc.edu

Let me know if that works out for you! Colleen

From: Kalynych, Colleen
Sent: Saturday, February 02, 2013 4:02 PM
To: Price, Patricia M.
Subject: RE: Margin In Life Scale

Hi Patricia!
So good to hear from you and that you are pursuing utilizing the Margin In Life Scale. I obtained the original scale from Ohio State University School of Nursing and spoke to and emailed with Dr. Stevenson. I purchased the scale for $50. I was contacted last year by another doctoral student who was inquiring about using the scale and unfortunately, I believe Dr. Stevenson may have passed and no one else was left at the school who knew how to access the information. So, I copied my packet for him and emailed it to him. As you know from my dissertation, I modified Dr. Stevenson's scale.

I will search for the email I sent to the other student; hopefully it is saved in my sent box, as I outlined some issues with the scale that you will find helpful. Especially as I recall, the directions in the packet had 2 errors that is better not to learn the hard-way like I had to!

Please let me know if you would like for me to try to find that email! Dr. Kalynych-- Colleen!

From: Price, Patricia M. [pricep@rowan.edu]
Sent: Saturday, February 02, 2013 10:40 AM
To: ckalynyc@unf.edu
Subject: Margin In Life Scale

Dear
Dr. Kalynych
I am a doctoral student at Rowan University in Glassboro New Jersey. My dissertation is using the Margin In Life scale to examine compassion fatigue in nurse educators. I have hit a brick wall, could you please tell me where you obtained permission to use the scale in your study. I have personally spoken with Patricia Yoder-Wise , however she could not assist me because her study was awhile back.
Thank you in advance for your continued support of nursing education.
Patricia Price
pricep@rowan.edu
856- 256- 5158

Appendix Q

Rules and Procedures for Logical Analysis of Written Data

(Sisco, 1981)

Rules and Procedures for Logical Analysis of Written Data (Sisco, 1981)

The following decisions were made regarding what was to be the unit of data analysis:

1. A phrase or clause will be the basic unit of analysis.

2. Verbiage not considered essential to the phrase or clause will be edited out--e.g., articles of speech, possessives, some adjectives, elaborative examples.

3. Where there is a violation of convention syntax in the data, it will be corrected.

4. Where there are compound thoughts in a phrase or clause, each unit of thought will be represented separately (unless one was an elaboration of the other).

5. Where information seems important to add to the statement in order to clarify it in a context, this information will be added to the unit by using parentheses.

6. The following decisions were made regarding the procedures for categorization of content units:

    a. After several units are listed on a sheet of paper, they will be scanned in order to determine differences and similarities.

    b. From this tentative analysis, local categories will be derived for the units.

    c. When additional units of data suggest further categories, they will be added to the classification schema.

    d. After all the units from a particular question response are thus classified, the categories are further reduced to broader clusters (collapsing of categories).

    e. Frequencies of units in each cluster category are determined and further analysis steps are undertaken, depending on the nature of the data--i.e., ranking of categories with verbatim quotes which represent the range of ideas or opinions.